RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S PARTS I, II & III**

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 06/04/2018 Time: 15:33 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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 the Balance Sheet and Statement of Revenue and Expenses prepared by RH OF NORTHWEST INDIANA, LLC (15-2024) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 02/01/2017 and ending 01/31/2018, 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.

[X] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this cerficication statement to be the legally binding equivalent of my original signature.

(Signed) SCOTT A ROMBERGER
Chief Financial Officer or Administrator of Provider(s)

VICE PRESIDENT
Title

06/04/2018 15:33
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		469,248				1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		469,248				200

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to resopnd 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 this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 4321 FIR STREET, 4TH FLOOR	P.O. Box:		1
2	City: EAST CHICAGO	State: IN	ZIP Code: 46312	County: LAKE 2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	RH OF NORTHWEST INDIANA, LLC	15-2024	23844	2	02 / 01 / 2004	N	P	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 02 / 01 / 2017	To: 01 / 31 / 2018	20
21	Type of control (see instructions)	4		21

	Inpatient PPS Information	1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments 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§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this 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)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to 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.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 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.	3	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, 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.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	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, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? 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) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or '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)	N	N	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved 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 Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary 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)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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 FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

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 direct the GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64 through 67. (see instructions)	N			63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident 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 oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. 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)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident 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)				66

Enter in lines 67-67.49, column 1 the program name. 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)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 is yes: Column 1: Did the facility have a teaching program in the most recent cost report filed 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 and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 is yes: Column 1: Did the facility have a teaching program in the most 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 and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	Y		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	Y		81

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no.	N		87

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	N	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers				1	2	
105	Does this hospital qualify as a CAH?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.					107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.		N	N	N	109

		1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110
		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-healsh services.			111

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	63,491			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		N		121
122	Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

Transplant Center Information				
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.		N	125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
140	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)	Y	HB0312	140

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name: NAME: SELECT MEDICAL	Contractor's Name: NOVITAS SOLUTIONS INC.		Contractor's Number: 12001	141
142	Street: STREET: 4714 GETTYSBURG ROAD	P.O. Box:			142
143	City: CITY: MECHANICSBURG	State: PA	ZIP Code: 17055		143
144	Are provider based physicians' costs included in Worksheet A?			Y	144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.			Y	N 145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and '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.			N	146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.			N	147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.			N	148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.			N	149

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)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	Y	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	
	RH OF NORTHWEST INDIANA	LAKE	IN	46312	23844	60.39	
	RH OF PORTER COUNTY	PORTER	IN	46368	23844	66.30	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	N		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)			168
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	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in 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 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	C		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	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 instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	Y		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

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

Capital Related Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.		29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: CODY	Last name: WAGNER	Title: REIMBURSEMENT ANALYST	41
42	Employer: SELECT MEDICAL			42
43	Phone number: 717-884-7307	E-mail Address: CWWAGNER@SELECTMEDICAL.COM		43

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	61	22,265			8,596		14,562	1
2	HMO and other (see instructions)						1,345	2,195		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		61	22,265			8,596		14,562	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		61	22,265			8,596		14,562	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		61							27
28	Observation Bed Days									28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days						258			33
33.01	LTCH site neutral days and discharges						189			33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					340		544	1
2	HMO and other (see instructions)					45	75		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		143.57			340		544	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		143.57						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges					9			33.01

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif-ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	9,989,752			298,620.85		1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B							5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)			44,452		1,533.89		10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)							11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		189,379			1,341.00		13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries							14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)							17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas							19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related							25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		47,398			1,145.08		26
27	Administrative & General		1,379,727	-44,452		32,762.31		27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant							30
31	Laundry & Linen Service							31
32	Housekeeping							32
33	Housekeeping under contract (see instructions)							33
34	Dietary		74,653			2,671.14		34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		234,056			4,137.85		38
39	Central Services and Supply							39
40	Pharmacy							40
41	Medical Records & Medical Records Library		109,881			5,216.08		41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	9,989,752		9,989,752	298,620.85	33.45	1
2	Excluded area salaries (see instructions)		44,452	44,452	1,533.89	28.98	2
3	Subtotal salarles (line 1 minus line 2)	9,989,752	-44,452	9,945,300	297,086.96	33.48	3
4	Subtotal other wages & related costs (see instructions)	189,379		189,379	1,341.00	141.22	4
5	Subtotal wage-related costs (see instructions)						5
6	Total (sum of lines 3 through 5)	10,179,131	-44,452	10,134,679	298,427.96	33.96	6
7	Total overhead cost (see instructions)	1,845,715	-44,452	1,801,263	45,932.46	39.22	7

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance		15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only		17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes		20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)		24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost			1
2	Hospital			2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				937,887	937,887		937,887	1
2	00200	Cap Rel Costs-Mvble Equip		1,261,514	1,261,514	-1,042,639	218,875	55,776	274,651	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	47,398	5,612	53,010	24,781	77,791		77,791	4
5	00500	Administrative & General	1,379,727	1,623,580	3,003,307	7,673	3,010,980	476,991	3,487,971	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant		495	495		495		495	7
8	00800	Laundry & Linen Service		74,042	74,042		74,042		74,042	8
9	00900	Housekeeping		5,916	5,916		5,916		5,916	9
10	01000	Dietary	74,653	226,078	300,731		300,731		300,731	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	234,056	46,585	280,641		280,641		280,641	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	109,881	49,590	159,471		159,471	-5,230	154,241	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	6,017,037	1,586,480	7,603,517		7,603,517	-32,094	7,571,423	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room		551,739	551,739		551,739		551,739	50
54	05400	Radiology-Diagnostic		252,563	252,563		252,563		252,563	54
60	06000	Laboratory		1,066,942	1,066,942		1,066,942		1,066,942	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	872,750	243,147	1,115,897		1,115,897		1,115,897	65
66	06600	Physical Therapy	229,627	55,813	285,440		285,440		285,440	66
67	06700	Occupational Therapy	192,041	44,519	236,560		236,560		236,560	67
68	06800	Speech Pathology	81,337	13,895	95,232		95,232		95,232	68
69	06900	Electrocardiology		42,700	42,700		42,700		42,700	69
71	07100	Medical Supplies Charged to Patients	103,986	1,508,343	1,612,329		1,612,329		1,612,329	71
73	07300	Drugs Charged to Patients	647,259	1,252,066	1,899,325		1,899,325		1,899,325	73
74	07400	Renal Dialysis		659,149	659,149		659,149		659,149	74
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	9,989,752	10,570,768	20,560,520	-72,298	20,488,222	495,443	20,983,665	118
		NONREIMBURSABLE COST CENTERS								
194	07950	PROVIDER RELATIONS NRCC				72,298	72,298		72,298	194
194.01	07951	NRCC SUBLEASED SPACE								194.01
200		TOTAL (sum of lines 118-199)	9,989,752	10,570,768	20,560,520		20,560,520	495,443	21,055,963	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	FACILITY RENT	A	Cap Rel Costs-Bldg & Fixt	1		937,887	1
500	Total reclassifications					937,887	500
	Code Letter - A						
1	EMPLOYEE BENEFITS	B	Employee Benefits Department	4		24,781	1
500	Total reclassifications					24,781	500
	Code Letter - B						
1	CAPITAL RECONCILIATION	C	Administrative & General	5		104,752	1
500	Total reclassifications					104,752	500
	Code Letter - C						
1	PROVIDER RELATIONS NRCC	D	PROVIDER RELATIONS NRCC	194	44,452	27,846	1
500	Total reclassifications				44,452	27,846	500
	Code Letter - D						
	GRAND TOTAL (Increases)				44,452	1,095,266	

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

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	FACILITY RENT	A	Cap Rel Costs-Mvble Equip	2		937,887	10	1
500	Total reclassifications					937,887		500
	Code letter - A							
1	EMPLOYEE BENEFITS	B	Administrative & General	5		24,781		1
500	Total reclassifications					24,781		500
	Code letter - B							
1	CAPITAL RECONCILIATION	C	Cap Rel Costs-Mvble Equip	2		104,752	12	1
500	Total reclassifications					104,752		500
	Code letter - C							
1	PROVIDER RELATIONS NRCC	D	Administrative & General	5	44,452	27,846		1
500	Total reclassifications				44,452	27,846		500
	Code letter - D							
	GRAND TOTAL (Decreases)				44,452	1,095,266		

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

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements								2
3	Buildings and Fixtures								3
4	Building Improvements	259,917					259,917		4
5	Fixed Equipment								5
6	Movable Equipment	1,716,830	103,302		103,302		1,820,132		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	1,976,747	103,302		103,302		2,080,049		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	1,976,747	103,302		103,302		2,080,049		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip	198,493	937,887		104,752	20,382		1,261,514	2
3	Total (sum of lines 1-2)	198,493	937,887		104,752	20,382		1,261,514	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	259,917		259,917	0.124957					1
2	Cap Rel Costs-Mvble Equ	1,820,132		1,820,132	0.875043					2
3	Total (sum of lines 1-2)	2,080,049		2,080,049	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt		937,887					937,887	1
2	Cap Rel Costs-Mvble Equip	254,269				20,382		274,651	2
3	Total (sum of lines 1-2)	254,269	937,887			20,382		1,212,538	3

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

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-32,094				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	557,918				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests						14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	CHARITABLE CONTRIBUTIONS	A	-346	Administrative & General	5		33
34							34
35	OTHER PERSONNAL EXPENSE	A	-23,974	Administrative & General	5		35
36	AHA DUES	A	-831	Administrative & General	5		36
37	MEDICAL RECORDS INCOME	B	-5,230	Medical Records & Library	16		37
38							38
39							39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		495,443				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	2	Cap Rel Costs-Mvble Equip	HOME OFFICE CAPITAL	55,776		55,776	9	1
2	5	Administrative & General	HOME OFFICE ADMIN	1,098,594	596,452	502,142		2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			1,154,370	596,452	557,918		5

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

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

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B			SELECT MEDICAL	100.00	HEALTHCARE	6
7							7
8							8
9							9
10							10

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

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

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics A	15,000		15,000	211,500	120	12,202	610	1
2	30	Adults & Pediatrics B	14,813		14,813	211,500	119	12,100	605	2
3	30	Adults & Pediatrics C	15,000		15,000	211,500	120	12,202	610	3
4	30	Adults & Pediatrics D	14,400		14,400	211,500	96	9,762	488	4
5	30	Adults & Pediatrics E	9,070		9,070	211,500	55	5,592	280	5
6	30	Adults & Pediatrics F	4,006		4,006	211,500	24	2,440	122	6
7	30	Adults & Pediatrics G	10,050		10,050	211,500	80	8,135	407	7
8	30	Adults & Pediatrics H	15,000		15,000	211,500	120	12,202	610	8
9	30	Adults & Pediatrics I	10,000		10,000	211,500	67	6,813	341	9
10	30	Adults & Pediatrics J	16,640		16,640	211,500	104	10,575	529	10
11	30	Adults & Pediatrics K	138	138		211,500				11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	124,117	138	123,979		905	92,023	4,602	200

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics A					12,202	2,798	2,798	1
2	30	Adults & Pediatrics B					12,100	2,713	2,713	2
3	30	Adults & Pediatrics C					12,202	2,798	2,798	3
4	30	Adults & Pediatrics D					9,762	4,638	4,638	4
5	30	Adults & Pediatrics E					5,592	3,478	3,478	5
6	30	Adults & Pediatrics F					2,440	1,566	1,566	6
7	30	Adults & Pediatrics G					8,135	1,915	1,915	7
8	30	Adults & Pediatrics H					12,202	2,798	2,798	8
9	30	Adults & Pediatrics I					6,813	3,187	3,187	9
10	30	Adults & Pediatrics J					10,575	6,065	6,065	10
11	30	Adults & Pediatrics K							138	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					92,023	31,956	32,094	200

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	937,887	937,887					1
2	Cap Rel Costs-Mvble Equip	274,651		274,651				2
4	Employee Benefits Department	77,791	4,791	1,403	83,985			4
5	Administrative & General	3,487,971	126,446	37,029	11,279	3,662,725	3,662,725	5
6	Maintenance & Repairs							6
7	Operation of Plant	495	270,651	79,257		350,403	73,789	7
8	Laundry & Linen Service	74,042	15,011	4,396		93,449	19,679	8
9	Housekeeping	5,916	8,719	2,553		17,188	3,620	9
10	Dietary	300,731	7,442	2,179	631	310,983	65,488	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	280,641	8,208	2,404	1,977	293,230	61,749	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	154,241	5,142	1,506	928	161,817	34,076	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	7,571,423	409,268	119,849	50,829	8,151,369	1,716,543	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	551,739				551,739	116,187	50
54	Radiology-Diagnostic	252,563				252,563	53,185	54
60	Laboratory	1,066,942	5,589	1,637		1,074,168	226,202	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,115,897	11,977	3,507	7,372	1,138,753	239,802	65
66	Physical Therapy	285,440	6,675	1,955	1,940	296,010	62,335	66
67	Occupational Therapy	236,560	6,675	1,955	1,622	246,812	51,974	67
68	Speech Pathology	95,232	3,034	889	687	99,842	21,025	68
69	Electrocardiology	42,700				42,700	8,992	69
71	Medical Supplies Charged to Patients	1,612,329	23,507	6,884	878	1,643,598	346,114	71
73	Drugs Charged to Patients	1,899,325	22,836	6,687	5,467	1,934,315	407,334	73
74	Renal Dialysis	659,149				659,149	138,806	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	20,983,665	935,971	274,090	83,610	20,980,813	3,646,900	118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS NRCC	72,298	1,916	561	375	75,150	15,825	194
194.01	NRCC SUBLEASED SPACE							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	21,055,963	937,887	274,651	83,985	21,055,963	3,662,725	202

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B**
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	MEDICAL RECORDS + LIBRARY	
		7	8	9	10	13	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	424,192						7
8	Laundry & Linen Service	11,880	125,008					8
9	Housekeeping	6,901		27,709				9
10	Dietary	5,889		403	382,763			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	6,496		444		361,919		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	4,070		278			200,241	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	323,893	125,008	22,137	382,763	361,919	72,334	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room						3,813	50
54	Radiology-Diagnostic						3,691	54
60	Laboratory	4,423		302			14,562	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	9,479		648			39,025	65
66	Physical Therapy	5,283		361			1,444	66
67	Occupational Therapy	5,283		361			1,895	67
68	Speech Pathology	2,401		164			630	68
69	Electrocardiology						6,007	69
71	Medical Supplies Charged to Patients	18,604		1,272			20,081	71
73	Drugs Charged to Patients	18,073		1,235			30,084	73
74	Renal Dialysis						6,675	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	422,675	125,008	27,605	382,763	361,919	200,241	118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS NRCC	1,517		104				194
194.01	NRCC SUBLEASED SPACE							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	424,192	125,008	27,709	382,763	361,919	200,241	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	11,155,966		11,155,966				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	671,739		671,739				50
54	Radiology-Diagnostic	309,439		309,439				54
60	Laboratory	1,319,657		1,319,657				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,427,707		1,427,707				65
66	Physical Therapy	365,433		365,433				66
67	Occupational Therapy	306,325		306,325				67
68	Speech Pathology	124,062		124,062				68
69	Electrocardiology	57,699		57,699				69
71	Medical Supplies Charged to Patients	2,029,669		2,029,669				71
73	Drugs Charged to Patients	2,391,041		2,391,041				73
74	Renal Dialysis	804,630		804,630				74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	20,963,367		20,963,367				118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS NRCC	92,596		92,596				194
194.01	NRCC SUBLEASED SPACE							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	21,055,963		21,055,963				202

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		4,791	1,403	6,194	6,194		4
5	Administrative & General	294	126,446	37,029	163,769	832	164,601	5
6	Maintenance & Repairs							6
7	Operation of Plant		270,651	79,257	349,908		3,316	7
8	Laundry & Linen Service		15,011	4,396	19,407		884	8
9	Housekeeping		8,719	2,553	11,272		163	9
10	Dietary		7,442	2,179	9,621	47	2,943	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		8,208	2,404	10,612	146	2,775	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		5,142	1,506	6,648	68	1,531	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		409,268	119,849	529,117	3,747	77,138	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room						5,222	50
54	Radiology-Diagnostic						2,390	54
60	Laboratory		5,589	1,637	7,226		10,166	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	52,073	11,977	3,507	67,557	544	10,777	65
66	Physical Therapy		6,675	1,955	8,630	143	2,801	66
67	Occupational Therapy		6,675	1,955	8,630	120	2,336	67
68	Speech Pathology		3,034	889	3,923	51	945	68
69	Electrocardiology						404	69
71	Medical Supplies Charged to Patients	384,070	23,507	6,884	414,461	65	15,555	71
73	Drugs Charged to Patients		22,836	6,687	29,523	403	18,306	73
74	Renal Dialysis						6,238	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	436,437	935,971	274,090	1,646,498	6,166	163,890	118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS NRCC		1,916	561	2,477	28	711	194
194.01	NRCC SUBLEASED SPACE							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	436,437	937,887	274,651	1,648,975	6,194	164,601	202

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	MEDICAL RECORDS + LIBRARY	
		7	8	9	10	13	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	353,224						7
8	Laundry & Linen Service	9,892	30,183					8
9	Housekeeping	5,746		17,181				9
10	Dietary	4,904		250	17,765			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	5,409		275		19,217		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	3,389		172			11,808	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	269,707	30,183	13,727	17,765	19,217	4,263	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room						225	50
54	Radiology-Diagnostic						218	54
60	Laboratory	3,683		187			859	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	7,893		402			2,302	65
66	Physical Therapy	4,399		224			85	66
67	Occupational Therapy	4,399		224			112	67
68	Speech Pathology	2,000		102			37	68
69	Electrocardiology						354	69
71	Medical Supplies Charged to Patients	15,491		788			1,184	71
73	Drugs Charged to Patients	15,049		766			1,775	73
74	Renal Dialysis						394	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	351,961	30,183	17,117	17,765	19,217	11,808	118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS NRCC	1,263		64				194
194.01	NRCC SUBLEASED SPACE							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	353,224	30,183	17,181	17,765	19,217	11,808	202

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	964,864		964,864				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,447		5,447				50
54	Radiology-Diagnostic	2,608		2,608				54
60	Laboratory	22,121		22,121				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	89,475		89,475				65
66	Physical Therapy	16,282		16,282				66
67	Occupational Therapy	15,821		15,821				67
68	Speech Pathology	7,058		7,058				68
69	Electrocardiology	758		758				69
71	Medical Supplies Charged to Patients	447,544		447,544				71
73	Drugs Charged to Patients	65,822		65,822				73
74	Renal Dialysis	6,632		6,632				74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,644,432		1,644,432				118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS NRCC	4,543		4,543				194
194.01	NRCC SUBLEASED SPACE							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,648,975		1,648,975				202

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	29,365						1
2	Cap Rel Costs-Mvble Equip		29,365					2
4	Employee Benefits Department	150	150	9,942,354				4
5	Administrative & General	3,959	3,959	1,335,275	-3,662,725	17,393,238		5
6	Maintenance & Repairs							6
7	Operation of Plant	8,474	8,474			350,403	16,782	7
8	Laundry & Linen Service	470	470			93,449	470	8
9	Housekeeping	273	273			17,188	273	9
10	Dietary	233	233	74,653		310,983	233	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	257	257	234,056		293,230	257	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	161	161	109,881		161,817	161	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	12,814	12,814	6,017,037		8,151,369	12,814	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room					551,739		50
54	Radiology-Diagnostic					252,563		54
60	Laboratory	175	175			1,074,168	175	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	375	375	872,750		1,138,753	375	65
66	Physical Therapy	209	209	229,627		296,010	209	66
67	Occupational Therapy	209	209	192,041		246,812	209	67
68	Speech Pathology	95	95	81,337		99,842	95	68
69	Electrocardiology					42,700		69
71	Medical Supplies Charged to Patients	736	736	103,986		1,643,598	736	71
73	Drugs Charged to Patients	715	715	647,259		1,934,315	715	73
74	Renal Dialysis					659,149		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	29,305	29,305	9,897,902	-3,662,725	17,318,088	16,722	118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS NRCC	60	60	44,452		75,150	60	194
194.01	NRCC SUBLEASED SPACE							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	937,887	274,651	83,985		3,662,725	424,192	202
203	Unit Cost Multiplier (Wkst. B, Part I)	31.938941	9.353005	0.008447		0.210583	25.276606	203
204	Cost to be allocated (Per Wkst. B, Part II)			6,194		164,601	353,224	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000623		0.009464	21.047789	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY PATIENT DAYS	NURSING ADMINIS-TRATION NURSING FTE'S	MEDICAL RECORDS + LIBRARY GROSS REVENUE		
		8	9	10	13	16		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	14,562						8
9	Housekeeping		16,039					9
10	Dietary		233	14,562				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		257		94			13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		161			109,390,986		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	14,562	12,814	14,562	94	39,533,801		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room					2,082,268		50
54	Radiology-Diagnostic					2,015,891		54
60	Laboratory		175			7,952,990		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		375			21,313,733		65
66	Physical Therapy		209			788,772		66
67	Occupational Therapy		209			1,035,043		67
68	Speech Pathology		95			344,071		68
69	Electrocardiology					3,280,955		69
71	Medical Supplies Charged to Patients		736			10,967,263		71
73	Drugs Charged to Patients		715			16,430,570		73
74	Renal Dialysis					3,645,629		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	14,562	15,979	14,562	94	109,390,986		118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS NRCC		60					194
194.01	NRCC SUBLEASED SPACE							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	125,008	27,709	382,763	361,919	200,241		202
203	Unit Cost Multiplier (Wkst. B, Part I)	8.584535	1.727601	26.285057	3,850.202128	0.001831		203
204	Cost to be allocated (Per Wkst. B, Part II)	30,183	17,181	17,765	19,217	11,808		204
205	Unit Cost Multiplier (Wkst. B, Part II)	2.072724	1.071201	1.219956	204.436170	0.000108		205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	11,155,966		11,155,966	31,956	11,187,922	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	671,739		671,739		671,739	50
54	Radiology-Diagnostic	309,439		309,439		309,439	54
60	Laboratory	1,319,657		1,319,657		1,319,657	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,427,707		1,427,707		1,427,707	65
66	Physical Therapy	365,433		365,433		365,433	66
67	Occupational Therapy	306,325		306,325		306,325	67
68	Speech Pathology	124,062		124,062		124,062	68
69	Electrocardiology	57,699		57,699		57,699	69
71	Medical Supplies Charged to Patients	2,029,669		2,029,669		2,029,669	71
73	Drugs Charged to Patients	2,391,041		2,391,041		2,391,041	73
74	Renal Dialysis	804,630		804,630		804,630	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	20,963,367		20,963,367	31,956	20,995,323	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	20,963,367		20,963,367		20,995,323	202

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	39,533,801		39,533,801				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,082,268		2,082,268	0.322600	0.322600	0.322600	50
54	Radiology-Diagnostic	2,015,891		2,015,891	0.153500	0.153500	0.153500	54
60	Laboratory	7,952,990		7,952,990	0.165932	0.165932	0.165932	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	21,313,733		21,313,733	0.066985	0.066985	0.066985	65
66	Physical Therapy	788,772		788,772	0.463294	0.463294	0.463294	66
67	Occupational Therapy	1,035,043		1,035,043	0.295954	0.295954	0.295954	67
68	Speech Pathology	344,071		344,071	0.360571	0.360571	0.360571	68
69	Electrocardiology	3,280,955		3,280,955	0.017586	0.017586	0.017586	69
71	Medical Supplies Charged to Patients	10,967,263		10,967,263	0.185066	0.185066	0.185066	71
73	Drugs Charged to Patients	16,430,570		16,430,570	0.145524	0.145524	0.145524	73
74	Renal Dialysis	3,645,629		3,645,629	0.220711	0.220711	0.220711	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	109,390,986		109,390,986				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	109,390,986		109,390,986				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[XX] Title XVIII, Part A
[ ] Title XIX
[XX] PPS
[ ] TEFRA

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	964,864		964,864	14,562	66.26	8,596	569,571	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	964,864		964,864	14,562		8,596	569,571	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 15-2024** **WORKSHEET D PART II**

Check Applicable Boxes:
[ ] Title V **[XX] Title XVIII, Part A** **[ ] Title XIX**
[XX] Hospital **[ ] IPF** **[ ] IRF**
[ ] SUB (Other)
[XX] PPS **[ ] TEFRA**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	5,447	2,082,268	0.002616	1,225,918	3,207	50
54	Radiology-Diagnostic	2,608	2,015,891	0.001294	1,236,866	1,601	54
60	Laboratory	22,121	7,952,990	0.002781	4,729,149	13,152	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	89,475	21,313,733	0.004198	11,843,410	49,719	65
66	Physical Therapy	16,282	788,772	0.020642	467,670	9,654	66
67	Occupational Therapy	15,821	1,035,043	0.015285	624,348	9,543	67
68	Speech Pathology	7,058	344,071	0.020513	221,014	4,534	68
69	Electrocardiology	758	3,280,955	0.000231	2,014,017	465	69
71	Medical Supplies Charged to Pat	447,544	10,967,263	0.040807	6,436,872	262,669	71
73	Drugs Charged to Patients	65,822	16,430,570	0.004006	9,372,027	37,544	73
74	Renal Dialysis	6,632	3,645,629	0.001819	2,147,690	3,907	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	679,568	69,857,185		40,318,981	395,995	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V
[XX] Title XVIII, Part A
[ ] Title XIX
[XX] PPS
[ ] TEFRA
[ ] Other

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [XX] PPS
[XX] Title XVIII, Part A [ ] TEFRA
[ ] Title XIX [ ] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	14,562		8,596		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	14,562		8,596		200

(A) Worksheet A line numbers

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

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[ ] Title XIX** | **[XX] Hospital** **[ ] IPF** **[ ] IRF** | **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** | **[ ] ICF/IID** | **[XX] PPS** **[ ] TEFRA** **[ ] Other**

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
54	Radiology-Diagnostic									54
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

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

Check Applicable Boxes:
[ ] Title V [XX] Title XVIII, Part A [ ] Title XIX
[XX] Hospital [ ] IPF [ ] IRF
[ ] SUB (Other) [ ] SNF [ ] NF
[ ] ICF/IID
[XX] PPS [ ] TEFRA [ ] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	2,082,268			1,225,918				50
54	Radiology-Diagnostic	2,015,891			1,236,866				54
60	Laboratory	7,952,990			4,729,149				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	21,313,733			11,843,410				65
66	Physical Therapy	788,772			467,670				66
67	Occupational Therapy	1,035,043			624,348				67
68	Speech Pathology	344,071			221,014				68
69	Electrocardiology	3,280,955			2,014,017				69
71	Medical Supplies Charged to Pat	10,967,263			6,436,872				71
73	Drugs Charged to Patients	16,430,570			9,372,027				73
74	Renal Dialysis	3,645,629			2,147,690				74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	69,857,185			40,318,981				200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 15-2024** **WORKSHEET D PART V**

Check Applicable Boxes: **[ ] Title V - O/P** **[XX] Title XVIII, Part B** **[ ] Title XIX - O/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] Swing Bed SNF** **[ ] Swing Bed NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.322600							50
54	Radiology-Diagnostic	0.153500							54
60	Laboratory	0.165932							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.066985							65
66	Physical Therapy	0.463294							66
67	Occupational Therapy	0.295954							67
68	Speech Pathology	0.360571							68
69	Electrocardiology	0.017586							69
71	Medical Supplies Charged to Pat	0.185066							71
73	Drugs Charged to Patients	0.145524							73
74	Renal Dialysis	0.220711							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX
[XX] PPS
[ ] TEFRA

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	964,864		964,864	14,562	66.26			30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	964,864		964,864	14,562				200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 15-2024** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[XX] PPS** **[ ] TEFRA**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	5,447	2,082,268	0.002616			50
54	Radiology-Diagnostic	2,608	2,015,891	0.001294			54
60	Laboratory	22,121	7,952,990	0.002781			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	89,475	21,313,733	0.004198			65
66	Physical Therapy	16,282	788,772	0.020642			66
67	Occupational Therapy	15,821	1,035,043	0.015285			67
68	Speech Pathology	7,058	344,071	0.020513			68
69	Electrocardiology	758	3,280,955	0.000231			69
71	Medical Supplies Charged to Pat	447,544	10,967,263	0.040807			71
73	Drugs Charged to Patients	65,822	16,430,570	0.004006			73
74	Renal Dialysis	6,632	3,645,629	0.001819			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	679,568	69,857,185				200

(A) Worksheet A line numbers

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX
[XX] PPS
[ ] TEFRA
[ ] Other

		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [XX] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [ ] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	14,562				30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	14,562				200

(A) Worksheet A line numbers

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

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [XX] Title XIX | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [XX] PPS [ ] TEFRA [ ] Other

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
54	Radiology-Diagnostic									54
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

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

Check Applicable Boxes:
[ ] Title V **[XX] Title XVIII, Part A** **[XX] Title XIX**
[XX] Hospital **[ ] IPF** **[ ] IRF**
[ ] SUB (Other) **[ ] SNF** **[ ] NF**
[ ] ICF/IID
[XX] PPS **[ ] TEFRA** **[ ] Other**

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	2,082,268							50
54	Radiology-Diagnostic	2,015,891							54
60	Laboratory	7,952,990							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	21,313,733							65
66	Physical Therapy	788,772							66
67	Occupational Therapy	1,035,043							67
68	Speech Pathology	344,071							68
69	Electrocardiology	3,280,955							69
71	Medical Supplies Charged to Pat	10,967,263							71
73	Drugs Charged to Patients	16,430,570							73
74	Renal Dialysis	3,645,629							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	69,857,185							200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 15-2024** **WORKSHEET D PART V**

Check Applicable Boxes:

[ ] Title V - O/P	[XX] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF
[ ] Title XVIII, Part B	[ ] IPF	[ ] SNF	[ ] Swing Bed NF
[XX] Title XIX - O/P	[ ] IRF	[ ] NF	[ ] ICF/IID

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.322600							50
54	Radiology-Diagnostic	0.153500							54
60	Laboratory	0.165932							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.066985							65
66	Physical Therapy	0.463294							66
67	Occupational Therapy	0.295954							67
68	Speech Pathology	0.360571							68
69	Electrocardiology	0.017586							69
71	Medical Supplies Charged to Pat	0.185066							71
73	Drugs Charged to Patients	0.145524							73
74	Renal Dialysis	0.220711							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-2024** **WORKSHEET D-1**
PART I

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[ ] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[ ] Other**

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,562	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,562	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	14,562	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	8,596	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	11,187,922	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	11,187,922	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	11,187,922	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-2024** **WORKSHEET D-1 PART II**

Check Applicable Boxes: [ ] Title V - I/P [XX] Title XVIII, Part A [ ] Title XIX - I/P | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) | [XX] PPS [ ] TEFRA [ ] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					768.30	38
39	Program general inpatient routine service cost (line 9 x line 38)					6,604,307	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					6,604,307	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,709,065	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					12,313,372	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					569,571	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					395,995	51
52	Total Program excludable cost (sum of lines 50 and 51)					965,566	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					11,347,806	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**	
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[ ] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[ ] Other**	

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					768.30	88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-2024** **WORKSHEET D-1**
PART I

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[XX] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[ ] Other**

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	14,562	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	14,562	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	14,562	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	11,187,922	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	11,187,922	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	11,187,922	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 15-2024** **WORKSHEET D-1 PART II**

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [XX] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [ ] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					768.30	38
39	Program general inpatient routine service cost (line 9 x line 38)						39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)						41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)		52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**	
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[XX] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[ ] Other**	

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

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

Check	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
Boxes:	**[ ] Title XIX**	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[ ] Other**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		23,111,011		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.322600	1,225,918	395,481	50
54	Radiology-Diagnostic	0.153500	1,236,866	189,859	54
60	Laboratory	0.165932	4,729,149	784,717	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.066985	11,843,410	793,331	65
66	Physical Therapy	0.463294	467,670	216,669	66
67	Occupational Therapy	0.295954	624,348	184,778	67
68	Speech Pathology	0.360571	221,014	79,691	68
69	Electrocardiology	0.017586	2,014,017	35,419	69
71	Medical Supplies Charged to Patients	0.185066	6,436,872	1,191,246	71
73	Drugs Charged to Patients	0.145524	9,372,027	1,363,855	73
74	Renal Dialysis	0.220711	2,147,690	474,019	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		40,318,981	5,709,065	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		40,318,981		202

(A) Worksheet A line numbers

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

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

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[XX] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[ ] Other**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.322600			50
54	Radiology-Diagnostic	0.153500			54
60	Laboratory	0.165932			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.066985			65
66	Physical Therapy	0.463294			66
67	Occupational Therapy	0.295954			67
68	Speech Pathology	0.360571			68
69	Electrocardiology	0.017586			69
71	Medical Supplies Charged to Patients	0.185066			71
73	Drugs Charged to Patients	0.145524			73
74	Renal Dialysis	0.220711			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 15-2024** **WORKSHEET E PART B**

Check applicable box: [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 15-2024** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				12,835,757			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50	10/18/2017	470,551			3.50
			.51	01/12/2018	104,720			3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		-575,271			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				12,260,486			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)							7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

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

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E-3 PART IV**

Check applicable box: **[XX] Hospital**

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	Net Federal PPS payment (see instructions)	13,084,298	1
1.01	Full standard payment amount	11,093,882	1.01
1.02	Short stay outlier standard payment amount	1,796,275	1.02
1.03	Site neutral payment amount - Cost		1.03
1.04	Site neutral payment amount - IPPS comparable	194,141	1.04
2	Outlier payments	632,464	2
3	Total PPS payments (sum of lines 1 and 2)	13,716,762	3
4	Nursing and allied health managed care payments (see instructions)		4
5	Organ acquisition DO NOT USE THIS LINE		5
6	Cost of physicians' services in a teaching hospital (see instructions)		6
7	Subtotal (see instructions)	13,716,762	7
8	Primary payer payments		8
9	Subtotal (line 7 less line 8)	13,716,762	9
10	Deductibles	10,505	10
11	Subtotal (line 9 minus line 10)	13,706,257	11
12	Coinsurance	1,169,527	12
13	Subtotal (line 11 minus line 12)	12,536,730	13
14	Allowable bad debts (exclude bad debts for professional services) (see instructions)	696,608	14
15	Adjusted reimbursable bad debts (see instructions)	452,795	15
16	Allowable bad debts for dual eligible beneficiaries (see instructions)	491,918	16
17	Subtotal (sum of lines 13 and 15)	12,989,525	17
18	Direct graduate medical education payments (from Wkst. E-4, line 49)		18
19	Other pass through costs (see instructions)		19
20	Outlier payments reconciliation		20
21	Other adjustments (specify) (see instructions)		21
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		21.50
22	Total amount payable to the provider (see instructions)	12,989,525	22
22.01	Sequestration adjustment (see instructions)	259,791	22.01
22.02	Demonstration payment adjustment amount after sequestration		22.02
23	Interim payments	12,260,486	23
24	Tentative settlement (for contractor use only)		24
25	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)	469,248	25
26	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	36,113	26

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3 Part IV, line 2 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the Time Value of Money (see instructions)		52
53	Time Value of Money (see instructions)		53

Check Applicable Boxes:

[ ] Title V	[XX] Hospital	[ ] NF	[XX] PPS
[XX] Title XIX	[ ] SUB (Other)	[ ] ICF/IID	[ ] TEFRA
	[ ] SNF		[ ] Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks					1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	4,659,129				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory					7
8	Prepaid expenses	1,929				8
9	Other current assets	109,171				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	4,770,229				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	259,917				15
16	Accumulated depreciation	-256,497				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	1,820,132				23
24	Accumulated depreciation	-1,274,895				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	548,657				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers	8,975,227				33
34	Other assets	16,538,105				34
35	Total other assets (sum of lines 31-34)	25,513,332				35
36	Total assets (sum of lines 11, 30 and 35)	30,832,218				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	597,748				37
38	Salaries, wages and fees payable	485,111				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	2,572,389				43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)	3,655,248				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)					50
51	Total liabilities (sum of lines 45 and 50)	3,655,248				51
	CAPITAL ACCOUNTS					
52	General fund balance	27,176,970				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	27,176,970				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	30,832,218				60

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		27,150,071			1
2	Net income (loss) (from Worksheet G-3, line 29)		26,896			2
3	Total (sum of line 1 and line 2)		27,176,967			3
4	Additions (credit adjustments) (specify)					4
5	FUND BALANCE RECON	3				5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		3			10
11	Subtotal (line 3 plus line 10)		27,176,970			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		27,176,970			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	FUND BALANCE RECON					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	39,533,801		39,533,801	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	39,533,801		39,533,801	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	39,533,801		39,533,801	17
18	Ancillary services	69,857,185		69,857,185	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	109,390,986		109,390,986	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		20,560,520	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	**DEDUCT BAD DEBT EXPENSE**			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		20,560,520	43

RH OF NORTHWEST INDIANA, LLC Provider CCN: 15-2024	In Lieu of Form **CMS-2552-10**	Period : From: 02/01/2017 To: 01/31/2018	Run Date: 06/04/2018 Run Time: 15:33 Version: 2018.04 (04/29/2018)

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	109,390,986	1
2	Less contractual allowances and discounts on patients' accounts	86,388,431	2
3	Net patient revenues (line 1 minus line 2)	23,002,555	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	20,560,520	4
5	Net income from service to patients (line 3 minus line 4)	2,442,035	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	5,231	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER REVENUE)	6,010	24
24.01	Other (PHYSICIAN REVENUE)		24.01
25	Total other income (sum of lines 6-24)	11,241	25
26	Total (line 5 plus line 25)	2,453,276	26
27	Other expenses (MANAGEMENT FEE)	1,573,782	27
27.01	Other expenses (INTERCOMPANY INTEREST)	-95,545	27.01
27.02	Other expenses (TAXES)	948,143	27.02
27.03	Other expenses (MISC)		27.03
28	Total other expenses (sum of line 27 and subscripts)	2,426,380	28
29	Net income (or loss) for the period (line 26 minus line 28)	26,896	29