This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-3046 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/24/2023 10: 10 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/24/2023 Time: 10:10 am] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Contractor use only (3) Settled with Audit number of times reopened = 0-9.

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

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PAM REHAB HOSP OF GREATER INDIANA (15-3046) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX ELECTRONI C				
		1	2	SI GNATURE STATEMENT			
1	Kari	ck Stober	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1		
2	Signatory Printed Name	Karick Stober			2		
3	Signatory Title	CF0			3		
4	Date	(Dated when report is electronica			4		

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	169, 071	0	0	0	1. 00
2.00	SUBPROVIDER - IPF	0	0	0		0	2. 00
3.00	SUBPROVIDER - IRF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
12.00	CMHC I	0		0		0	12.00
200.00	TOTAL	0	169, 071	0	0	0	200. 00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA

Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

In Lieu of Form CMS-2552-10 Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3046 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/24/2023 10:10 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2101 BROADWAY STREET 1.00 PO Box: 1.00 State: IN 2.00 City: CLARKSVILLE Zip Code: 47129 County 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Number Number Certi fi ed Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 PAM REHAB HOSP OF 153046 31140 5 04/16/2020 Ν 3.00 GREATER INDIANA Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospi tal -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 21.00 1.00 3.00 2.00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for Ν 22.01 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) 22.02 Is this a newly merged hospital that requires a final UCP to be 22.02 Ν Ν 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. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν N 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 23.00 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.

Heal th	Financial Systems PAM REHA	AB HOSP OF GRE	ATER INDIAN	A	I	n Lieu	of For	m CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION		Provider CC		Peri od: From 01/01	/2022 /2022	Workshop Part I Date/Ti 5/24/20	et S-2	pared:
		In-State Medicaid paid days	In-State Medi cai d el i gi bl e unpai d days 2.00	Out-of State Medicaid paid days		Medicai HMO day	id 0 ys Med c	ther li cai d lays	TO alli
24. 00	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 colu4, Medicaid HMO paid and eligible but unpaid days	umn			0	0.00	0		24.00
25. 00	column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-sta Medicaid eligible unpaid days in column 4, Medicai HMO paid and eligible but unpaid days in column 5.	id	99	0	0		455		25. 00
					Urban/Ru				-
26. 00	Enter your standard geographic classification (not		at the beg	jinning of 1	1. 00	1	2. ()()	26. 00
	cost reporting period. Enter "1" for urban or "2" Enter your standard geographic classification (not reporting period. Enter in column 1, "1" for urbar enter the effective date of the geographic reclass	t wage) status n or "2" for r sification in	ural. If ap column 2.	ppl i cabl e,		1			27. 00
35. 00	If this is a sole community hospital (SCH), enter effect in the cost reporting period.	the number of	periods SC	CH status ir	1	0			35.00
					Begi nni 1. 00		Endi 2. (-
36. 00	Enter applicable beginning and ending dates of SCF		script line	36 for numb					36. 00
37. 00	of periods in excess of one and enter subsequent of this is a Medicare dependent hospital (MDH), er		er of period	ds MDH statu	IS	0			37. 00
37. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for accordance with FY 2016 OPPS final rule? Enter "Y"								37. 01
38. 00	instructions) If line 37 is 1, enter the beginning and ending da greater than 1, subscript this line for the number enter subsequent dates.								38. 00
					Y/N 1. 00		Y/ 2. (
39. 00	Does this facility qualify for the inpatient hospi hospitals in accordance with 42 CFR §412.101(b)(2) 1 "Y" for yes or "N" for no. Does the facility med accordance with 42 CFR 412.101(b)(2)(i), (ii), or or "N" for no. (see instructions))(i), (ii), or et the mileage	(iii)? Ent requiremer	er in colum nts in	ime N nn		N		39. 00
40. 00	Is this hospital subject to the HAC program reduct "N" for no in column 1, for discharges prior to Oc no in column 2, for discharges on or after October	ctober 1. Ente	er "Y" for y				N		40. 00
	The Three diamin 2, Tell discharges on or after ectober	1. (300 11131	i de ti ons)			V	XVIII	XI X	
	Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
45. 00	Does this facility qualify and receive Capital pay with 42 CFR Section §412.320? (see instructions)	yment for disp	roporti onat	e share in	accordance	N	N	N	45. 00
46. 00	Is this facility eligible for additional payment e pursuant to 42 CFR §412.348(f)? If yes, complete V Pt. III.					N	N	N	46. 00
47. 00 48. 00	Is this a new hospital under 42 CFR §412.300(b) PF Is the facility electing full federal capital paym	'		,		N N	N N	N N	47. 00 48. 00
56. 00	Teaching Hospitals Is this a hospital involved in training residents	in approved (ME programs	2 For cost	roportina	l N			56. 00
30.00	periods beginning prior to December 27, 2020, enterost reporting periods beginning on or after December instructions. For column 2, if the response to involved in training residents in approved GME proand are you are impacted by CR 11642 (or applicable "Y" for yes; otherwise, enter "N" for no in column	er "Y" for yes mber 27, 2020, o column 1 is ograms in the le CRs) MA dir	or "N" for under 42 ("Y", or if prior year	no in colu CFR 413.78(b this hospit or penultin	umn 1. For b)(2), see al was nate year,	N			30.00
	For cost reporting periods beginning prior to Deceis this the first cost reporting period during whi at this facility? Enter "Y" for yes or "N" for no residents start training in the first month of thi "N" for no in column 2. If column 2 is "Y", complete Wkst. D, Parts III & IV and D-2, Pt. II, beginning on or after December 27, 2020, under 42 which month(s) of the cost report the residents we for yes, enter "Y" for yes in column 1, do not come	ember 27, 2020 ch residents o in column 1. is cost report lete Worksheet if applicable CFR 413.77(e ere on duty, i mplete column	in approved If column ing period? E-4. If column For cost (1)(iv) ar f the respons 2, and comp	I GME progra 1 is "Y", c 2 Enter "Y' Dlumn 2 is ' reporting p nd (v), rega onse to line Dlete Worksh	ms trained lid for yes or N", periods ardless of 56 is "Y" peet E-4.				57.00
58. 00	If line 56 is yes, did this facility elect cost reddefined in CMS Pub. 15-1, chapter 21, §2148? If ye			ans' service	es as				58. 00
_									

Heal th	Financial Systems PAM REHAB H	OSP OF	GREATER INDIAN	IA	In Lie	u of Form CMS-2	2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der CC	CN: 15-3046 P	eriod: rom 01/01/2022	Worksheet S-2 Part I	
				T		Date/Time Pre	
					V	XVIII XIX	io am
						2.00 3.00	
59. 00	Are costs claimed on line 100 of Worksheet A? If yes	s, compl	ete Wkst. D-2,	Pt. I. NAHE 413.85	Worksheet A	Pass-Through	59. 00
				Y/N	Li ne #	Qual i fi cati on	
						Criterion Code	
				1. 00	2.00	3.00	
	Are you claiming nursing and allied health education			N	2.00	0.00	60. 00
	any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col						
ļi	is "Y", are you impacted by CR 11642 (or subsequent 0	CR) NAHE					
	adjustment? Enter "Y" for yes or "N" for no in colum	n 2. Y/N	IME	Direct GME	IME	Direct GME	
		1711	I IVIL	DITECT GIVIL	I WIL	DITECT GIVIL	
		1.00	2. 00	3. 00	4.00	5. 00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61. 00
	column 1. (see instructions)						
	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports						61. 01
	ending and submitted before March 23, 2010. (see						
	instructions) Enter the current year total unweighted primary care						61. 02
	FTE count (excluding OB/GYN, general surgery FTEs,						01.02
	and primary care FTEs added under section 5503 of						
	ACA). (see instructions) Enter the base line FTE count for primary care						61. 03
l	and/or general surgery residents, which is used for						
	determining compliance with the 75% test. (see instructions)						
61.04	Enter the number of unweighted primary care/or						61. 04
	surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						
61.05	Enter the difference between the baseline primary						61. 05
	and/or general surgery FTEs and the current year's						
	orimary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						
	Enter the amount of ACA §5503 award that is being						61. 06
	used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						
		Pro	ogram Name	Program Code	Unweighted IME		
					FTE Count	Direct GME FTE Count	
			1. 00	2. 00	3. 00	4.00	
61. 10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents				0.00	0. 00	61. 10
	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.				0.00	0.00	(1.20
	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE				0.00	0.00	61. 20
ļ	residents for each expanded program. (see						
	instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column						
	3, the IME FTE unweighted count. Enter in column 4,						
	the direct GME FTE unweighted count.						
						1.00	
	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital				od for which	0.00	62. 00
	your hospital received HRSA PCRE funding (see instruc	ctions)				0.00	02.00
	Enter the number of FTE residents that rotated from a				your hospital	0.00	62. 01
F	during in this cost reporting period of HRSA THC proc Teaching Hospitals that Claim Residents in Nonprovide	er Setti	i ngs				
	Has your facility trained residents in nonprovider se					N	63. 00
ľ	"Y" for yes or "N" for no in column 1. If yes, comple	ete iine	es ou through 6	or. (see Enstru	ICTI OHS)		l

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 + column 4)). (see instructions)

yes or "N"	for no in the applicable column.			
91.00 Is this ho	spital reimbursed for title V and/or XIX through the cost report either in	N	N	91. 00
	part? Enter "Y" for yes or "N" for no in the applicable column.			
	XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		N	92. 00
	ns) Enter "Y" for yes or "N" for no in the applicable column.			
	facility operate an ICF/IID facility for purposes of title V and XIX? Enter	N	N	93. 00
	s or "N" for no in the applicable column.			
	V or XLX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94. 00
appl i cabl e				05.00
	is "Y", enter the reduction percentage in the applicable column.	0. 00	0.00	95. 00
	V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	N	N	96. 00
appl i cabl e				
97.00 If line 96	is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97. 00
-				
MCRI F32 - 19. 1. 17	5. 2			

Health Financial Systems PAW REHAB HUSP OF				u or Form CWS-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C		Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Pre	
				5/24/2023 10:	10 am
			1. 00	2. 00	-
98.00 Does title V or XIX follow Medicare (title XVIII) for the instepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y"			N N	N N	98. 00
column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the rock, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti			N	Y	98. 01
title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the ca	alculation of	observati on	N	Y	98. 02
bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a cri-			N	N	98. 03
reimbursed 101% of inpatient services cost? Enter "Y" for yefor title V, and in column 2 for title XIX.	no in column 1				
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.			N	N	98. 04
98.05 Does title V or XIX follow Medicare (title XVIII) and add by Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in a column 2 for title XIX.			N I	Y	98. 05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			N	Y	98. 06
Rural Providers					
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	-inclusive met	hod of payment	N		105. 00 106. 00
107.00 Column 1: If line 105 is Y, is this facility eligible for contraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded II	n 1. (see ins you train I&R PF and/or IRF	tructions) s in an			107. 00
Enter "Y" for yes or "N" for no in column 2. (see instruction 108.00 is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 42	N		108. 00
	Physi cal	Occupati onal		Respi ratory	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00	2.00	3.00	4. 00	109. 00
				1.00	1
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and World applicable.	"Y" for yes or	"N" for no. I	f yes,	N	110. 00
			1. 00	2.00	-
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this country "Y" for yes or "N" for no in column 1. If the response to contintegration prong of the FCHIP demo in which this CAH is particle all that apply: "A" for Ambulance services; "B" for an after tele-health services.	ost reporting olumn 1 is Y, or rticipating in	period? Enter enter the column 2.	N N	2.00	111. 00
		1. 00	2. 00	3. 00	
112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If or "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital ceaparticipation in the demonstration, if applicable.	eporting olumn 1 is pating in the	N			112. 00
113.00 Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no.					113. 00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, I in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided the definition in CMS Pub. 15-1, chapter 22, §2208.1.	B, or E only) 93" percent (includes	N			115. 00
116.00 Is this facility classified as a referral center? Enter "Y"	for yes or	N			116. 00
"N" for no. 117.00 Is this facility legally-required to carry malpractice insum "Y" for yes or "N" for no.					
	rance? Enter	N			117. 00
118.00 s the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurrence policy is occurrence.	licy? Enter 1	N 	1		117. 00

121.00 ld this Facility incur and report costs for high cost implantable devices charged to patients? Pater "" for yes or "N" for no in column 1. If column 1 is "", enter in column 2 the Worksheet A line number where these taxes are included. 122.00 lb the Worksheet A line number where these taxes are included. 123.00 lb the Facility and/or its subproviders (if applicable) perhase professional and/or management/consulting services. From an unrelated organization? In column 1, enter "Y" for yes or "N" for no. 11 column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations tocated in a CSSA outside of the main hospital CSSA? In column 2, enter "Y" for yes or "N" for no. 125.00 lb this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date (in column 1 and termination date, if applicable, in column 2. 127.00 lf this is a Medicare-certified where transplant program, enter the certification date (in column 1 and termination date, if applicable, in column 2. 129.00 lf this is a Medicare-certified liver transplant program, enter the certification date (in column 1 and termination date, if applicable, in column 2. 120.00 lf this is a Medicare-certified perhapsion program, enter the certification date (in column 1 and termination date, if applicable, in column 2. 130.00 lf this is a Medicare-certified perhapsion program, enter the certification date (in column 1 and termination date, if applicable, in column 2. 131.00 lf this is a Medicare-certified perhapsion program, enter the certification date (in column 1 and termination date, if applicable, in column 2. 132.00 lf this is a Medicare-certified perhapsion program, enter the certification date (in column 1 and termination date, if applicable, in column 2. 132.00 lf this is a Medicare-certified perhapsion program enter the certification date (in column 1 and termination date, if applic	120.00 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. 00
122.00 (Does the cost report contain heal theare related taxes as defined in \$1993(w)(3) of the ActEVENTER 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A I I ne number where these taxes are included. 123.00 in the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or 'N' for no. 125.00 (See the majority of the expenses, i.e., greater than 50% of total professional) services expenses, for services perchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or 'N' for no. 125.00 (See this facility operate a Medicare-certified transplant center? Enter "Y" for yes or 'N' for no. 126.00 (See this is a Medicare-certified didney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 126.00 (See this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 127.00 (See this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 128.00 (See this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130.00 (See this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00 (See this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 (See this is a hand termination date, if applicable, in column 2. 133.00 (Removed and reserved) 134.00 (See this is a hand termination date, if applicable, in column 2. 140.00 (See	121.00 Did this facility incur and report costs for high cost implantable devices charged to	N		121. 00
123.00 bid the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, From an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i. e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no. 125.00 boes this facility operate a Medicare-certified transplant center? Enter "Y" for yes or "N" for no incumn 1 and termination date, in column 1 and termination date, in column 2. 126.00 if this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 127.00 if this is a Medicare-certified hoart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 128.00 if this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 129.00 if this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130.00 if this is a Medicare-certified ung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00 if this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 if this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.00 if this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.00 if this is a hospital-based organ p	122.00 Does the cost report contain healthcare related taxes as defined in §1903(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	N		122. 00
If column 1 is "", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	123.00 Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y"			123. 00
CertIfied Transplant Center Information 125.00	If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations			
125.00 Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "W" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 if this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 127.00 if this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 128.00 if this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 129.00 if this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130.00 if this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00 if this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 if this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.00 Romeword and reserved 134.00 if this is a Medicare-certified slet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 135.00 if this is a Medicare-certified slet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 136.00 if this is a Medicare-certified slet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 137.00 in column 1 and termination date, if applicable, in column 2. 138.00 in column 1 and termination date, if applicable, in column 2. 139.00 in column 1 and termination date, if applicable, in column 2. 139.00 in column 1 and termination date, if applicable, in c				
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127. 00 if this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 128. 00 if this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 129. 00 if this is a Medicare-certified plane program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130. 00 if this is a Medicare-certified plane program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131. 00 if this is a Medicare-certified intereas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131. 00 if this is a Medicare-certified is let transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132. 00 if this is a hospital based organ procurement organization (0PO), enter the 0PO number in column 1 and termination date, if applicable, in column 2. 133. 00 Removed and reserved 134. 00 if this is a hospital based organ procurement organization (0PO), enter the 0PO number in column 1 and termination date, if applicable, in column 2. 134. 00 in column 1 and termination date, if applicable, in column 2. 135. 00 in column 1 and termination date, if applicable, in column 2. 136. 00 in column 1 and termination date, if applicable, in column 2. 137. 00 in column 1 and termination date, if applicable, in column 2. 138. 00 in column 1 and termination date, if applicable, in column 2. 139. 00 in column 1 and termination date, if applicable, in column 2. 140. 00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, and termination date, if applicable, in column 1. If yes, and home office costs are claimed, enter the home office costs and on the contractor number. 141. 00 Amer. PoST ACUTE MEDICAL Contractor's Name: NOVITAS SOLUTIONS Contractor's Number: 04011 11	126.00 If this is a Medicare-certified kidney transplant program, enter the certification date			126. 00
128.00 f this is a Medicare-certified liver transplant program, enter the certification date 128.00 129.00 129.00 15 this is a Medicare-certified lung transplant program, enter the certification date 129.00 130.00 15 this is a Medicare-certified pancreas transplant program, enter the certification date 129.00 130.00 15 this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130.00 15 this is a Medicare-certified is the string land transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00 15 this is a Medicare-certified is let transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 15 this is a Medicare-certified is let transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.00 134.00 15 this is a hospital-based organ procurement organization (0PO), enter the 0PO number 133.00 134.00 134.00 134.00 135.00 134.00 135.00 134.00 134.00 135.00 134.00 135.00 134.00 135.00 135.00 136.00	127.00 If this is a Medicare-certified heart transplant program, enter the certification date			127. 00
129.00 f this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130.00 f this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00 f this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 f this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 133.00 Removed and reserved 134.00 f this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, vhough 140.00 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) 1.00 2.00 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 141.00 Name: POST ACUTE MEDICAL Contractor's Name: NOVITAS SOLUTIONS Contractor's Number: 04011 141.00 142.00 143.00 144.	128.00 If this is a Medicare-certified liver transplant program, enter the certification date			128. 00
130.00 f this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00 f this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 f this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 133.00 Removed and remination date, if applicable, in column 2. 141.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "", 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) 15.00 F this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 141.00 Name: POST ACUTE MEDICAL Contractor's Name: NOVITAS SOLUTIONS Contractor's Number: 04011 141.00 142.00 143.00 144	129.00 If this is a Medicare-certified lung transplant program, enter the certification date			129. 00
131.00 If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 133.00 If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. All Providers 140.00 All Providers 14	130.00 of this is a Medicare-certified pancreas transplant program, enter the certification			130. 00
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133. 00 Removed and reserved 134. 00 If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. All Providers 140. 00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 1.00 1.00 1.1000 1.1000 1.1000 1.1000 1.1000 1.1000 1.1000 1.1000 1.1000 1.1000	132.00 If this is a Medicare-certified islet transplant program, enter the certification date			132. 00
in column 1 and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, Chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 1.00	133.00 Removed and reserved			
140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, Y H09790 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) 1.00 2.00 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 141.00 Name: POST ACUTE MEDICAL Contractor's Name: NOVITAS SOLUTIONS 142.00 Street: 1828 GOODHOPE DR PO Box: 143.00 City: ENOLA State: PA Zip Code: 17025 143.00 1.00 1.00 2.00 144.00 Are provider based physicians' costs included in Worksheet A? Y 144.00 1.00 1.00 2.00 145.00 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. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If	in column 1 and termination date, if applicable, in column 2.			134.00
1.00 2.00 3.00	140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs	Y	H09790	140. 00
home office and enter the home office contractor name and contractor number. 141.00 Name: POST ACUTE MEDICAL 142.00 Street: 1828 GOODHOPE DR 143.00 City: ENOLA State: PA 2i p Code: 17025 144.00 144.00 Are provider based physicians' costs included in Worksheet A? 1.00 144.00 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. 146.00 Has the cost allocation methodology changed from the previously filed cost report? N 141.00 Contractor's Number: 04011 141.00 142.00 142.00 144.00 1.00	1.00 2.00			
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144.00 Are provider based physicians' costs included in Worksheet A? 1.00 1.00 2.00 145.00 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. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If		1702	25	
145.00 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. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If			1.00	
145.00 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. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If	144.00 Are provider based physicians' costs included in Worksheet A?			144. 00
inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If		1. 00	2.00	
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If	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.			
	Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If	I N		146. 00

Health Financial Systems	PAM REHAB HOSP OF	GREATER INDIAN	IA		In Lie	eu of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CC	CN: 15-3046		/01/2022 2/31/2022	Date/Time Pi	repared:
						5/24/2023 10	D: 10 am
						1.00	
147.00 Was there a change in the statisti						N	147. 00
148.00 Was there a change in the order of						N	148. 00
149.00 Was there a change to the simplifi	ed cost finding method? E	Part A	es or "N" fo		tle V	N Title XIX	149. 00
		1. 00	2.00		3. 00	4.00	_
Does this facility contain a provi	der that qualifies for ar						
or charges? Enter "Y" for yes or							
155. 00 Hospi tal		N	N		N	N	155. 00
156.00 Subprovi der - IPF		N	N		N	N	156. 00
157.00 Subprovi der – I RF		N	N		N	N	157. 00
158. 00 SUBPROVI DER							158. 00
159. 00 SNF		N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY		N	N N		N	N	160.00
161. 00 CMHC 161. 10 CORF			N N		N N	N N	161. 00 161. 10
TOT. TO CORT] 11		IN	IV	101.10
						1.00	
Mul ti campus							
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has or	ne or more campu	uses in diff	erent CBS	SAs?	N	165. 00
, , , , , , , , , , , , , , , , , , , ,	Name	County	State Z	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each						0. (00 166. 00
campus enter the name in column							
O, county in column 1, state in column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
got anni e (eee riistrastrait)	'						
						1.00	
Health Information Technology (HI				ent Act			
167.00 Is this provider a meaningful user						N	167. 00
168.00 If this provider is a CAH (line 10			e 167 is "Y"), enter	the		168. 00
reasonable cost incurred for the H			s qualify fo	or a bard	chin		168. 01
exception under §413.70(a)(6)(ii)					siii þ		100.01
169.00 f this provider is a meaningful u					nter the	0.	00169.00
transition factor. (see instruction			(,,			
	•			Beg	ji nni ng	Endi ng	
					1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR Legendre period respectively (mm/dd/yyyy)	peginning date and ending	date for the re	eporting				170. 00
					1. 00	2.00	
171.00 If line 167 is "Y", does this prov							0 171. 00
section 1876 Medicare cost plans m "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3, Pt. umn 1. If column 1 is yes,	I, line 2, col	. 6? Enter	on			
"Y" for yes and "N" for no in colu	umn 1. If column 1 is yes,			on			

Ν

Ν

19.00

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

If line 16 or 17 is yes, were adjustments made to PS&R

Report data for corrections of other PS&R Report

cost report? If yes, see instructions.

information? If yes, see instructions.

Heal th	Financial Systems PAM REHAB HOSP OF	GREATER INDIA	NA	In Lie	eu of Form CM	IS-2552-10	
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od: From 01/01/2022 To 12/31/2022	Worksheet S Part II	S-2 Prepared:	
			iption	Y/N	Y/N		
	I	1	0	1. 00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00	
		Y/N	Date	Y/N	Date		
		1.00	2. 00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00	
					1.00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	IOSPLTALS)		1.00		
	Capital Related Cost						
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense		als made duri	na the cost	l N	23. 00	
	reporting period? If yes, see instructions.	• • •		3			
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost rep	porting period?	N	24. 00	
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see	N	25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	he cost reporti	ng period? If	yes, see	N	26. 00	
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportir	ng period? If	yes, submit	N	27. 00	
	Interest Expense						
28. 00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	ntered into dur	ing the cost	reporting	N	28. 00	
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see insti		ebt Service Re	eserve Fund)	N	29. 00	
30. 00	Has existing debt been replaced prior to its scheduled maturinstructions.		debt? If yes,	see	N	30. 00	
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes,	see	N	31. 00	
	Purchased Services				l		
32. 00	Have changes or new agreements occurred in patient care ser	rvi ces furni she	ed through cor	ntractual	N	32. 00	
	arrangements with suppliers of services? If yes, see instru		J				
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 applino, see instructions.	plied pertainir	ng to competit	tive bidding? If	N	33. 00	
	Provi der-Based Physi ci ans						
34. 00	Were services furnished at the provider facility under an a	arrangement wit	h provi der-ba	ased physicians?	Υ	34.00	
	If yes, see instructions.						
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		nts with the p		N	35. 00	
				Y/N	Date		
	I			1. 00	2. 00		
0/ 05	Home Office Costs					0. 25	
36.00	Were home office costs claimed on the cost report?		h 66' C	Y		36.00	
37. 00	If line 36 is yes, has a home office cost statement been pr	repared by the	nome office?	Y		37. 00	
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of			N		38. 00	
39. 00	the provider? If yes, enter in column 2 the fiscal year end of line 36 is yes, did the provider render services to other			N		39. 00	
40. 00	see instructions. .00 If line 36 is yes, did the provider render services to the home office? If yes, see N						
	instructions.						
		1	00	2	00		
	Cost Penort Prenarer Contact Information	1.	00	Ζ.	00		
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	the first name, last name and the title/position DAVID MULLER					
	respectively.						
42. 00	Enter the employer/company name of the cost report preparer.	POST ACUTE MED	ICAL LLC			42. 00	
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	210-592-5381		DMULLER@PAMHEA	LTH. COM	43. 00	
	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	1		1		Ш	

Health Financial Systems	PAM REHAB HOSP OF	F GRE	EATER INDIANA		In Lie	u of Form C	MS-2	552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provider CCN:		Peri od:	Worksheet	S-2	
					From 01/01/2022		D	
					To 12/31/2022	5/24/2023		
						072172020	10. 1	o diii
			3.00					
Cost Report Preparer Contact Information								
41.00 Enter the first name, last name and the		VP	OF REIMBURSEME	ENT				41.00
held by the cost report preparer in colur	mns 1, 2, and 3,							
respecti vel y.								
42.00 Enter the employer/company name of the co	ost report							42. 00
preparer.								
43.00 Enter the telephone number and email add								43.00
report preparer in columns 1 and 2, response	ecti vel y.							

Health Financial Systems PAM REHAB H

Provider CCN: 15-3046

					'	0 12, 01, 2022	5/24/2023 10:	10 am
	·						I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line No.			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		42	15, 330	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			42	15, 330	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31.00		0	C	0.00	0	8. 00
9.00	CORONARY CARE UNIT	32. 00		O	C	0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY							13. 00
14. 00	Total (see instructions)			42	15, 330	0.00	0	14. 00
15. 00	CAH visits				,		0	15. 00
16. 00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19.00
20. 00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE	46. 00		o	(21.00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00					l o	23. 00
24. 00	HOSPICE	116. 00		0	(24. 00
24. 00	HOSPICE (non-distinct part)	30.00		U		′		24. 00
25. 00	CMHC - CMHC	99. 00					0	25. 00
25. 00	CMHC - CORF	99. 00						25. 00
26. 00	RURAL HEALTH CLINIC	88. 00						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		40			0	26. 25
27. 00	Total (sum of lines 14-26)			42				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0	C)		32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	()	0	34.00

34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

34.00 Temporary Expansion COVID-19 PHE Acute Care

Provider CCN: 15-3046

0

Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

5/24/2023 10:10 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 10.00 6.00 7.00 8.00 9.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 9,814 13, 412 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 1,012 453 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider 0 4.00 0 Hospital Adults & Peds. Swing Bed SNF 5.00 0 0 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 9,814 13, 412 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 0 0 8.00 9.00 CORONARY CARE UNIT 0 0 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 Total (see instructions) 115. 28 14.00 9,814 13, 412 0.00 14.00 CAH visits 15.00 15.00 SUBPROVIDER - I PF SUBPROVIDER - I RF 16.00 16.00 17.00 17.00 18.00 SUBPROVI DER 18.00 19 00 SKILLED NURSING FACILITY 19 00 NURSING FACILITY 20.00 20.00 21.00 OTHER LONG TERM CARE 0.00 0.00 21.00 HOME HEALTH AGENCY 0.00 22.00 0 0 0 0.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 0.00 23.00 0 00 23.00 24.00 HOSPI CE 0 0 0.00 0.00 24.00 24. 10 HOSPICE (non-distinct part) 0 24. 10 25.00 CMHC - CMHC 0 0 0 0 0 0.00 0.00 25.00 CMHC - CORF 0 0.00 25.10 0 0.00 25. 10 0 26.00 RURAL HEALTH CLINIC 0 0.00 0.00 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0.00 26.25 Total (sum of lines 14-26) 0.00 115. 28 27.00 27.00 28 00 Observation Bed Days Ω 0 28 00 29. 00 Ambul ance Trips 0 29.00 30.00 Employee discount days (see instruction) 0 30.00 Employee discount days - IRF 0 31.00 31.00 32.00 Labor & delivery days (see instructions) 0 0 0 32.00 Total ancillary labor & delivery room 0 32.01 32.01 outpatient days (see instructions) 33.00 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3046

Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared:

5/24/2023 10:10 am Full Time Di scharges Equi val ents Title XVIII Title XIX Total All Component Nonpai d Title V Workers Pati ents 14.00 15.00 12.00 13.00 11.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 855 0 1, 124 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 88 38 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider ol 4.00 Hospital Adults & Peds. Swing Bed SNF 5.00 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 Total (see instructions) 0.00 855 1, 124 14.00 14.00 0 CAH visits 15.00 15.00 SUBPROVIDER - I PF SUBPROVIDER - I RF 16.00 16.00 17.00 17.00 SUBPROVI DER 18.00 18.00 19 00 SKILLED NURSING FACILITY 19 00 NURSING FACILITY 20.00 20.00 21.00 OTHER LONG TERM CARE 0.00 0 21.00 HOME HEALTH AGENCY 22.00 0.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 0 00 23 00 24.00 HOSPI CE 0.00 24.00 24. 10 HOSPICE (non-distinct part) 24.10 25. 00 CMHC - CMHC 0.00 25.00 25. 10 CMHC - CORF 25.10 0.00 26.00 RURAL HEALTH CLINIC 0.00 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26.25 Total (sum of lines 14-26) 0.00 27.00 27.00 28 00 Observation Bed Days 28 00 29. 00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 31.00 31.00 32.00 Labor & delivery days (see instructions) 32.00 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 0 33. 01 LTCH site neutral days and discharges 0 33.01 34.00 Temporary Expansion COVID-19 PHE Acute Care 34.00

Heal th	Financial Systems PAM	REHAB HOSP OF G	REATER INDIAN	IA .	In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		Period: From 01/01/2022 To 12/31/2022	Worksheet A Date/Time Pre 5/24/2023 10:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	[1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	GENERAL SERVI CE COST CENTERS		0		0 2 172 0/2	2 172 0/2	1 00
1. 00 2. 00 3. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		0		0 3, 173, 862 0 289, 227	3, 173, 862 289, 227 0	1. 00 2. 00 3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	69, 241	589, 489	658, 73	o o	658, 730	
5.00	00500 ADMINISTRATIVE & GENERAL	786, 794	5, 377, 698			2, 935, 883	
7.00	00700 OPERATION OF PLANT	173, 403	653, 549			826, 724	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	168, 951	168, 95		168, 951	
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	232, 126 405, 217	70, 860 264, 980			302, 986 670, 197	
12. 00	01200 MAI NTENANCE OF PERSONNEL	405, 217	204, 960 0	070, 19	0	070, 197	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	0		0 0	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	520, 353	520, 35	3 -492, 198	28, 155	1
15.00	01500 PHARMACY	0	0		0 0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	150, 488	29, 620			180, 108	
17. 00	01700 SOCIAL SERVICE	861, 751	105, 892	967, 64	3 -423, 456	544, 187	
18.00	01851 OTHER GENERAL CC	0	0		0	0	18.00
19. 00 20. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM	0	0		0	0	19. 00 20. 00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		o o	Ö	22. 00
23.00	02300 PARAMED ED PRGM	0	0		0 0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	3, 972, 095	2, 477, 357	6, 449, 45	2 312, 647	6, 762, 099	
31. 00	03100 I NTENSI VE CARE UNI T	0	0		0	0	31.00
32. 00 46. 00	03200 CORONARY CARE UNIT 04600 OTHER LONG TERM CARE	0	0		0	0	32. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>			01 0		40.00
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	111, 792			119, 549	
60.00	06000 LABORATORY	0	50, 352			50, 352	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	285, 836 882, 679	75, 962 95, 118				
67. 00	06700 OCCUPATI ONAL THERAPY	799, 510	64, 258			863, 768	
68. 00	06800 SPEECH PATHOLOGY	257, 232	22, 483			279, 715	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0 51, 503		
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	747, 400	747, 40	0 -66, 127	681, 273	
74. 00 75. 00	07400 RENAL DIALYSIS	0	0		0	0	74. 00 75. 00
77. 00	07500 ASC (NON-DISTINCT PART) 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	1
77.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		77.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	
	09000 CLINIC	0	0		0	0	
91.00	O9100 EMERGENCY OTHER REIMBURSABLE COST CENTERS	U U	Ü		0 0	0	91.00
98 00	09850 OTHER REIMBURSABLE CC	O	0		0 0	0	98. 00
	09900 CMHC	0	0		o o	0	1
	09910 CORF	0	0		0 0	0	99. 10
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0		100. 00
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		0	I	0 0	0	113. 00
	11400 UTI LI ZATI ON REVI EW-SNF	0	0		0 0		114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		o o		115. 00
116.00	11600 H0SPI CE	0	0		0 0	0	116. 00
118.00	, ,	8, 876, 372	11, 426, 114	20, 302, 48	6 -423, 456	19, 879, 030	118. 00
400.00	NONREI MBURSABLE COST CENTERS	1					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	100 740	0 50 007	240.72	0 422 454		190.00
	19001 MARKETING 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	188, 742	59, 987 0	248, 72	9 423, 456		190. 01
	19100 RESEARCH		0		o o		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES		Ö		o o		192. 00
193.00	19300 NONPALD WORKERS	0	0		0 0		193. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	9, 065, 114	11, 486, 101	20, 551, 21	5 0	20, 551, 215	200. 00

 Health Financial
 Systems
 PAM REHAB HOSP

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-3046

| Period: | Worksheet A | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 5/24/2023 10: 10 am

			5/24/202	3 10: 10 am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS		2 224 224		
1.00 O0100 CAP REL COSTS-BLDG & FIXT	207, 972	3, 381, 834		1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP	0	289, 227		2.00
3. 00 00300 OTHER CAP REL COSTS	0	(50.730		3.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT	140.073	658, 730		4.00
5.00 00500 ADMINISTRATIVE & GENERAL	-140, 073	2, 795, 810		5. 00
7. 00 00700 OPERATION OF PLANT	-31, 736	794, 988		7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	168, 951		8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	1 1	302, 986 657, 129		9. 00 10. 00
	-13, 068	057, 129		
	0	0		12.00
13.00 O1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY	0	20 155		13. 00 14. 00
15. 00 01400 CENTRAL SERVICES & SUPPLY	0	28, 155		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-21	180, 087		16.00
17. 00 01700 SOCIAL SERVICE	0	544, 187		17. 00
18. 00 01851 OTHER GENERAL CC		544, 167		18. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS		0		19. 00
20. 00 02000 NURSI NG PROGRAM		0		20.00
21. 00 02100 &R SERVI CES-SALARY & FRI NGES APPRV		0		21. 00
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV		Ö		22. 00
23. 00 02300 PARAMED ED PRGM	l ő	o		23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	9		20.00
30. 00 03000 ADULTS & PEDI ATRI CS	-272, 750	6, 489, 349		30.00
31. 00 03100 NTENSI VE CARE UNIT	0	0		31.00
32. 00 03200 CORONARY CARE UNIT	o	o		32. 00
46.00 04600 OTHER LONG TERM CARE	o	0		46. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0	0		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	119, 549		54.00
60. 00 06000 LABORATORY	o	50, 352		60.00
65. 00 06500 RESPIRATORY THERAPY	o	315, 050		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	976, 711		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	863, 768		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	279, 715		68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	51, 503		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	681, 273		73. 00
74. 00 07400 RENAL DI ALYSI S	0	0		74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75. 00
77.00 O7700 ALLOGENEIC STEM CELL ACQUISITION	0	0		77. 00
OUTPATIENT SERVICE COST CENTERS		_1		
88. 00 08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
90. 00 09000 CLI NI C	0	0		90.00
91. 00 09100 EMERGENCY	0	0		91. 00
OTHER REIMBURSABLE COST CENTERS 98. 00 09850 OTHER REIMBURSABLE CC	0	0		98. 00
99. 00 09900 CMHC	0	_1		99.00
99. 10 09910 CORF	0	0		99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0		100.00
101. 00 10100 HOME HEALTH AGENCY		0		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	O _I		101.00
113. 00 11300 I NTEREST EXPENSE	O	0		113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	o	0		115. 00
116. 00 11600 H0SPI CE	ol	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-249, 676	19, 629, 354		118. 00
NONREI MBURSABLE COST CENTERS		,,		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190, 00
190. 01 19001 MARKETI NG	-2, 400	669, 785		190. 01
190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190. 02
191. 00 19100 RESEARCH	o	ol		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	O	ol		192. 00
193. 00 19300 NONPALD WORKERS	O	o		193. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	-252, 076	20, 299, 139		200. 00
	·			•

Provider CCN: 15-3046

					То	12/31/2022	Date/Time Prepared: 5/24/2023 10:10 am
		Increases			•		
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4.00	5. 00			
	A - FACILITY LEASE & STORAGE EX	PENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	2, 749, 359			1.00
	TOTALS		0	2, 749, 359			
	B - INTEREST ON LOANS						
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	17, 901			1.00
	TOTALS		0	17, 901			
	C - EQUIPMENT LEASE EXPENSE						
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	253, 453			1.00
2.00		0.00	o	0			2.00
3.00		0.00	o	0			3.00
4.00		0.00	o	0			4.00
5.00		0.00	0	0			5. 00
6. 00		0.00	0	0			6. 00
7. 00		0.00	0	0			7. 00
7.00	TOTALS — — —		— — —	253, 453			7.00
	D - DEPRECIATION EXPENSE		<u> </u>	200, 100			
1. 00	CAP REL COSTS-MVBLE EQUIP	2.00	n	35, 774			1, 00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	0	3, 421			2.00
2.00	TOTALS			$ \frac{3,421}{39,195}$			2.00
	E - CAPITAL INSURANCE & PROPERT	V TAY	<u> </u>	37, 173			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	74, 222			1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	335, 801			2. 00
2.00	TOTALS			410, 023			2.00
		TINC	<u> </u>	410, 023			
1 00	F - EXT CASE MANAGEMENT & MARKE		270 (4/	44.010			1 00
1. 00	MARKETING	1 <u>90.</u> 01	378, 646	44, 810			1. 00
			378, 646	44, 810			
4 00	G - SUPPLIES	20.00		252 4/4			4.00
1.00	ADULTS & PEDIATRICS	30.00	0	352, 464			1. 00
2.00	MEDICAL SUPPLIES CHARGED TO	71. 00	O	18, 909			2. 00
	PATI ENT	+-	+				
	TOTALS		0	371, 373			
	H - OXYGEN COST	74 00		22 524			4.00
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	32, 594			1. 00
	PATI ENT	+		— _ 			
	TOTALS		0	32, 594			
	I - AMBULANCE	r	Г	T			
1.00	RADI OLOGY-DI AGNOSTI C	<u>54.</u> 00		<u>7, 7</u> 57			1. 00
	TOTALS		0	7, 757			
500.00	Grand Total: Increases		378, 646	3, 926, 465			500.00

PAM REHAB HOSP OF GREATER INDIANA
Provider CCN: 15-3046 Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2022 To 12/31/2022 Date/Ti me Prepared:

							5/24/2023 10:10 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10. 00		
	A - FACILITY LEASE & STORAGE	EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0_	2, 749, 359	10		1.00
	TOTALS		0	2, 749, 359			
	B - INTEREST ON LOANS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17, 901	11		1. 00
	TOTALS			17, 901			
	C - EQUIPMENT LEASE EXPENSE	<u> </u>	<u>'</u>		•		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	18, 973	10		1.00
2.00	OPERATION OF PLANT	7.00	o	228	10		2.00
3.00	ADULTS & PEDIATRICS	30.00	o	32, 060			3.00
4. 00	RESPIRATORY THERAPY	65.00	o	14, 154			4.00
5. 00	PHYSI CAL THERAPY	66.00	o	1, 086		l .	5. 00
6.00	CENTRAL SERVICES & SUPPLY	14. 00	o	120, 825			6. 00
7. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	66, 127		l .	7. 00
7.00	TOTALS	— /0. 00	— — — —	253, 453			7. 60
	D - DEPRECIATION EXPENSE	L	<u> </u>	200, 400	1		
1.00	ADMI NI STRATI VE & GENERAL	5.00	٥	35, 774	9		1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3, 421			2. 00
2.00	TOTALS	— — 1.00	 _ 		:		2.00
	E - CAPITAL INSURANCE & PROPE	DTV TAV	<u> </u>	37, 173	,		
1.00	ADMINISTRATIVE & GENERAL	5.00	٥	74, 222	12		1. 00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	335, 801			2. 00
2.00	TOTALS			3 <u>35, 6</u> 01 410, 023			2.00
	F - EXT CASE MANAGEMENT & MAR	DVETI NC	U	410, 023)		
1 00			270 (4)	44.010			1.00
1.00	SOCI AL SERVI CE	17.00	37 <u>8, 6</u> 46	4 <u>4, 810</u>			1.00
	TOTALS		378, 646	44, 810)		
4 00	G - SUPPLIES	44.00		050 4/4		I	
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	352, 464		1	1. 00
2.00	CENTRAL SERVICES & SUPPLY	14.00		1 <u>8, 9</u> 09			2. 00
	TOTALS		0	371, 373	8		
	H - OXYGEN COST					Í	
1.00	RESPIRATORY THERAPY	65.00	0_	3 <u>2, 5</u> 94			1. 00
	TOTALS		0	32, 594			
	I - AMBULANCE	,					
1.00	ADULTS & PEDIATRICS	30.00	0	<u>7, 7</u> 57			1.00
	TOTALS		0	7, 757			
500.00	Grand Total: Decreases		378, 646	3, 926, 465	5		500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-3046 Peri od: Worksheet A-7 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/24/2023 10:10 am Acqui si ti ons Begi nni ng Purchases Di sposal s and Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 0 1.00 2.00 Land Improvements 0 0 0 0 0 2.00 3.00 0 40, 333, 976 40, 333, 976 3.00 Buildings and Fixtures 0 4.00 Building Improvements 135, 848 68, 430 4.00 5.00 Fixed Equipment 0 5.00 6.00 Movable Equipment 27.928 492, 489 0 0 0 492, 489 0 6.00 7.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 163, 776 40, 826, 465 40, 826, 465 68, 430 8.00 9.00 Reconciling Items 0 9.00 163, 776 Total (line 8 minus line 9) 40, 826, 465 40, 826, 465 10.00 68, 430 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1.00 2.00 Land Improvements 0 2.00 3.00 Buildings and Fixtures 40, 333, 976 0 3.00 0 4.00 Building Improvements 67, 418 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 520, 417 6.00 7.00 HIT designated Assets 0 7.00

40, 921, 811

40, 921, 811

0

Health Financial Systems PAN	I REHAB HOSP OF	GREATER INDIA	NA	In Lie	u of Form CMS-	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-3046	Peri od:	Worksheet A-7	
				From 01/01/2022 To 12/31/2022	Part II Date/Time Pre	narodi
				10 12/31/2022	5/24/2023 10:	10 am
		Sl	UMMARY OF CAP	I TAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
				instructions)	instructions)	
	9. 00	10.00	11. 00	12. 00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	IN 2, LINES 1 a	and 2			
1.00 CAP REL COSTS-BLDG & FLXT	0	0)	0 0	0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2. 00
3.00 Total (sum of lines 1-2)	0	0		0 0	0	3. 00
	SUMMARY 0	F CAPITAL				
Cost Center Description	Other	Total (1) (sum	n			
	Capi tal -Relate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
DART III DESCRIPTION OF MANUEL FROM HIGH	14.00	15. 00				

0 0 0

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2
CAP REL COSTS-BLDG & FIXT
CAP REL COSTS-MVBLE EQUIP
O
0

0 0 0

1. 00 2. 00 3. 00

1. 00 2. 00

3.00 Total (sum of lines 1-2)

Heal th	Financial Systems PAN	1 REHAB HOSP OF	GREATER INDIA	NA	In Lie	u of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	F	Period: From 01/01/2022 To 12/31/2022	Worksheet A-7 Part III Date/Time Pre 5/24/2023 10:	pared:
		COME	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	40, 401, 394	0	40, 401, 394	0. 987283	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	520, 417	0	520, 417	0. 012717	0	2. 00
3.00	Total (sum of lines 1-2)	40, 921, 811		40, 921, 811			3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY 0		
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0)	-3, 421	2, 749, 359	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0)	35, 774		
3.00	Total (sum of lines 1-2)	0	0) (32, 353	3, 002, 812	3. 00
			Sl	JMMARY OF CAPI	ΓAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENITEDS					1

17, 901

0 17, 901

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT

74, 222

74, 222

243, 957

243, 957

299, 816

0 299, 816

3, 381, 834 1. 00 289, 227 2. 00 3, 671, 061 3. 00

1.00

2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)

Provider CCN: 15-3046

				Ţ	o 12/31/2022	Date/Time Prep 5/24/2023 10:	oared: 10 am
				Expense Classification on		072172020 10.	ro um
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description			Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00	5. 00	1. 00
1.00	COSTS-BLDG & FLXT (chapter 2)		0	CAP REL CUSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
4 00	(chapter 2)				0.00		4 00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5.00	Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7.00	suppliers (chapter 8)						7.00
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
	21)						
8. 00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9.00	Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provi der-based physician adjustment	A-8-2	-227, 543			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	73, 238			0	12. 00
	transactions (chapter 10)		70,200				
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В В	0 -13 068	DI ETARY	0. 00 10. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee	1	0	BI LIAKI	0.00	0	15. 00
16. 00	and others Sale of medical and surgical		0		0.00	0	16. 00
10.00	supplies to other than				0.00	J	10.00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
17.00	patients				0.00	Ŭ	17.00
18. 00	Sale of medical records and abstracts	В	-21	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00	Vendi ng machi nes		0		0.00	0	20.00
21. 00	Income from imposition of interest, finance or penalty	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
	repay Medicare overpayments	'					
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	COSTS-MVBLE EQUIP						
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of						
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest			ADMINI CTRATIVE & CEVERAL			
33.00	OTHER MISC REV	В	-600	ADMINISTRATIVE & GENERAL	5.00	O	33. 00

50.00

ADJUSTMENTS TO EXPENSES Provider CCN: 15-3046 Peri od: Worksheet A-8 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/24/2023 10:10 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 34.00 BUSINESS MEALS -723 ADMINISTRATIVE & GENERAL 5. 00 34. 00 Α -16, 189 OPERATION OF PLANT PHONE 35.00 Α 7.00 0 35.00 35.01 Α -15,547 OPERATION OF PLANT 7.00 35.01 35.02 MARKETING SPONSORSHIP -2, 400 MARKETI NG 190.01 35.02 Α ADMINISTRATION SPRONSORSHIP -1, 000 ADMINISTRATIVE & GENERAL 35. 03 35 03 5 00 ol Α 35.04 OTHER ADJUSTMENTS (SPECIFY) 0.00 35.04 (3) 35.05 START UP COSTS 88, 828 ADMI NI STRATI VE & GENERAL 35.05 Α 5.00 PROPERTY TAXES 35.06 -91,844 CAP REL COSTS-BLDG & FIXT 35.06 13 1.00 Α 35.07 NON-ALLOWABLE PHYSICIAN Α -21, 935 ADULTS & PEDIATRICS 30.00 35.07 **EXPENSE** 35.08 AMBULANCE -23, 272 ADULTS & PEDIATRICS 30.00 35.08 OTHER ADJUSTMENTS (SPECIFY) 35.09 35.09 0.00 35.10 OTHER ADJUSTMENTS (SPECIFY) 0.00 35.10 (3) 35. 11 OTHER ADJUSTMENTS (SPECIFY) 0.00 35.11 OTHER ADJUSTMENTS (SPECIFY) 35. 12 0.00 35. 12

-252, 076

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A, column 6, line 200.)

(3)

50.00

⁽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.

OFFICE COSTS

From 01/01/2022

			To 12/31/2022	Date/Time Pre 5/24/2023 10:	
Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
		·	Allowable Cost	Included in	
				Wks. A, column	
				5	
1. 00	2. 00	3. 00	4. 00	5. 00	
A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANI ZATI ONS OR	CLAI MED	
HOME OFFICE COSTS:					
5. 00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	1, 218, 547	1, 445, 125	1.00
1.00	CAP REL COSTS-BLDG & FIXT	MANAGEMENT FEES	299, 816	0	2.00
0.00			0	0	3. 00
0.00			0	0	4.00
TOTALS (sum of lines 1-4).			1, 518, 363	1, 445, 125	5.00
Transfer column 6, line 5 to					
Worksheet A-8, column 2,					
line 12.					
	1.00 A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS: 5.00 1.00 0.00 0.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	1.00 2.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF HOME OFFICE COSTS: 5.00 ADMINISTRATIVE & GENERAL 1.00 CAP REL COSTS-BLDG & FIXT 0.00 0.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	Line No. Cost Center Expense Items 1.00 2.00 3.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED OF HOME OFFICE COSTS: 5.00 ADMINISTRATIVE & GENERAL 1.00 CAP REL COSTS-BLDG & FIXT 0.00 0.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	Line No. Cost Center Expense Items Amount of Allowable Cost 1.00 2.00 3.00 4.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR HOME OFFICE COSTS: 5.00 ADMINISTRATIVE & GENERAL 1.00 CAP REL COSTS-BLDG & FIXT 0.00 0.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	Line No. Cost Center Expense I tems Amount of Allowable Cost Included in Wks. A, column 5 1.00 2.00 3.00 4.00 5.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 5.00 ADMINISTRATIVE & GENERAL 1.00 CAP REL COSTS-BLDG & FIXT 0.00 0.00 0.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,

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

 The been posted to her kender it of dimension and an arrest arrestable of our discount for the parti									
			Related Organization(s) and/	or Home Office					
Symbol (1)	Name	Percentage of	Name	Percentage of					
		Ownershi p		Ownershi p					
1. 00	2. 00	3. 00	4. 00	5. 00					
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:							

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

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

6. 00	В	100.00 POST ACUTE MED 100.00	6.00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- 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
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Heal th	n Financial Syste	ems		PAM REHAB	HOSP OF GR	EATER INDI	ANA			In Lieu	u of Form CMS	-2552-10
STATE	MENT OF COSTS OF	SERVICES FROM	RELATED (ORGANI ZATI ONS	AND HOME	Provi der	CCN:	15-3046	Perio		Worksheet A-	8-1
OFFIC	E COSTS								From	01/01/2022		
									To	12/31/2022	Date/Time Pr	epared:
											5/24/2023 10): 10 am
	Net	Wkst. A-7 Ref.										
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCUR	RED AND ADJUST	MENTS REQU	UIRED AS A RE	SULT OF TRA	ANSACTI ONS	WI TH	RELATED C	RGANI	ZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:										
1.00	-226, 578	(1.00

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

2.00

3.00

4.00

5.00

nas not	been posted to worksheet A,	cordinate and the amount arrowable should be murcated in cordinate and this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

	HOME OFFICE	6. 00
7.00		7. 00
8.00		8. 00
8. 00 9. 00		9. 00
10.00		10.00
10. 00 100. 00		100.00

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

2.00

3.00

4.00

5.00

299, 816

73, 238

0

0

14

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provi der CCN: 15-3046

Period: Worksheet A-8-2 From 01/01/2022

12/31/2022 Date/Time Prepared: 5/24/2023 10:10 am Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov Identi fi er Component ider Component Remuneration Component Hours 1. 00 2.00 3.00 4.00 5. 00 6. 00 7. 00 1.00 30.00 DR. A 414, 883 116, 500 298, 383 197, 500 1.973 1.00 2.00 0.00 0 2.00 3.00 0.00 0 3.00 4.00 0.00 0 0 0 0 0 4.00 0. 00 5.00 0 0 0 0 5.00 6.00 0.00 0 6.00 0 0 0 7.00 0.00 0 7.00 8.00 0.00 0 0 8.00 9.00 0.00 0 9.00 10.00 0.00 10.00 298, 383 1, 973 414, 883 116, 500 200.00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Limit Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col. Insurance Education 12.00 12 1. 00 2.00 8.00 9.00 13.00 14.00 30. 00 DR. A 187, 340 1. 00 1.00 9, 367 0 0 2.00 0.00 0 0 0 2.00 3.00 0.00 0 0 3.00 0 4.00 0.00 0 0 0 0 0 0 0 0 4.00 0 5.00 0.00 0 5 00 6.00 0.00 0 6.00 7.00 0.00 0 0 0 7.00 01 0 0 8.00 0.00 8.00 0.00 0 0 0 9.00 9.00 10.00 0.00 10.00 200.00 187, 340 9, 367 200.00 Adjusted RCE Wkst. A Line # Cost Center/Physician Provi der RCE Adjustment I denti fi er Component Limit Di sal I owance Share of col. 14 1. 00 2.00 15. 00 16. 00 17. 00 18. 00 30.00 DR. A 1. 00 1.00 187, 340 111,043 227.543 0 2.00 0.00 0 0 2.00 3.00 0.00 0 0 0 3.00 0 4.00 0.00 0 0 0 4.00 0.00 5.00 0 0 0 5 00 6.00 0.00 0 0 6.00 7.00 0.00 0 0 0 0 7.00 0 0.00 0 8.00 0 8.00 0.00 0 9.00 0 0 9.00 10.00 0.00 0 0 10.00

187, 340

111, 043

227, 543

200.00

200.00

Provider CCN: 15-3046

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared:

5/24/2023 10:10 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 3, 381, 834 00100 CAP REL COSTS-BLDG & FLXT 3, 381, 834 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 289, 227 289, 227 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 658, 730 15, 724 1, 345 675, 799 4.00 00500 ADMINISTRATIVE & GENERAL 2, 795, 810 3, 584, 908 5 00 672, 479 57, 513 59 106 5 00 7.00 00700 OPERATION OF PLANT 794, 988 90, 258 7, 719 13,027 905, 992 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 168, 951 45, 315 3, 875 218, 141 8.00 00900 HOUSEKEEPI NG 302, 986 17, 438 320, 424 9.00 9.00 01000 DI ETARY 18, 356 920, 552 10 00 10 00 657, 129 214, 626 30, 441 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 28, 155 0 0 28, 155 14.00 01500 PHARMACY 15.00 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 180, 087 18, 634 1,594 11, 305 211, 620 16.00 01700 SOCIAL SERVICE 17.00 544, 187 36, 292 580, 479 17.00 01851 OTHER GENERAL CC 0 18.00 18.00 0 0 0 0 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 0 19 00 02000 NURSING PROGRAM 0 0 0 20.00 20.00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 O 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 0 22.00 0 02300 PARAMED ED PRGM 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 489, 349 1, 710, 449 146, 284 298, 398 8, 644, 480 30.00 31.00 03100 INTENSIVE CARE UNIT C 0 31.00 32.00 03200 CORONARY CARE UNIT 0 C 0 0 0 32.00 04600 OTHER LONG TERM CARE 46.00 0 0 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM Λ Λ 50 00 05400 RADI OLOGY-DI AGNOSTI C 119, 549 54.00 38.319 3, 277 161, 145 54.00 60.00 06000 LABORATORY 50, 352 9, 100 778 60, 230 60.00 18, 510 06500 RESPIRATORY THERAPY 315,050 21.473 356, 616 65.00 1.583 65 00 66.00 06600 PHYSI CAL THERAPY 976, 711 251, 893 21, 543 66, 309 1, 316, 456 66.00 06700 OCCUPATIONAL THERAPY 863, 768 17, 191 60, 062 1, 142, 028 67.00 201, 007 67.00 06800 SPEECH PATHOLOGY 279, 715 3, 208 19, 324 339, 762 68.00 37, 515 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 51, 503 71.00 51, 503 \cap 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 681, 273 58,005 4, 961 0 744, 239 73.00 o 07400 RENAL DIALYSIS 74 00 C 0 0 74 00 07500 ASC (NON-DISTINCT PART) 75.00 0 0 0 0 75.00 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 88 00 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 C 0 0 0 89.00 09000 CLI NI C 0 0 0 90.00 90.00 C 0 91.00 09100 EMERGENCY 0 0 0 0 0 91.00 OTHER REIMBURSABLE COST CENTERS 98.00 09850 OTHER REIMBURSABLE CC 0 0 0 0 0 98.00 09900 CMHC 0 0 99.00 0 99.00 99. 10 09910 CORF 0 0 0 99. 10 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 0 100 00 C 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 116. 00 11600 HOSPI CE 0 116, 00 0 SUBTOTALS (SUM OF LINES 1 through 117) 19, 629, 354 3, 381, 834 289, 227 19, 586, <u>730</u> 118. 00 633, 175 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 712, 409 190. 01 190, 01 19001 MARKETI NG 669, 785 0 0 42,624 190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 Ω 0 190, 02 191. 00 19100 RESEARCH 0 0 191.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 Ω 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 193, 00 0 0 0 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201, 00 TOTAL (sum lines 118 through 201) 20, 299, 139 3, 381, 834 289, 227 675, 799 20, 299, 139 202. 00 202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3046

					5/24/2023 10:	10 am_
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7. 00	8.00	9. 00	10.00	
GENERAL SERVICE COST CENTERS	'		•			
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
						4.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0.504.000					
5.00 00500 ADMINISTRATIVE & GENERAL	3, 584, 908					5. 00
7.00 00700 0PERATION OF PLANT	194, 319	1, 100, 311				7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	46, 787	19, 152	284, 080			8. 00
9. 00 00900 HOUSEKEEPI NG	68, 725	. 0	· 0	389, 149		9. 00
10. 00 01000 DI ETARY	197, 442	90, 711	1	32, 650	1, 241, 355	•
	177, 442	70, / 11]	32, 030		
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	1 0	0	0	12. 00
13.00 01300 NURSING ADMINISTRATION	0	0	0	0	0	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	6, 039	0	0	0	0	14.00
15. 00 01500 PHARMACY	0	0	0	0	0	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	45, 389	7, 875	١	2, 835	Ö	16. 00
+ I	1	7,075	1	2, 033		•
17. 00 01700 SOCI AL SERVI CE	124, 502	0	1 0	0	0	17. 00
18. 00 01851 0THER GENERAL CC	0	0	1 0	0	0	18. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20. 00 02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21. 00 02100 I &R SERVICES-SALARY & FRINGES APPRV		0	ا آ	0	Ö	21. 00
		0	1	0		22.00
22. 00 02200 1 &R SERVICES-OTHER PRGM COSTS APPRV	٥	0	1	U	0	
23. 00 02300 PARAMED ED PRGM	0	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	1, 854, 092	722, 919	284, 080	260, 205	1, 241, 355	30. 00
31.00 03100 INTENSIVE CARE UNIT		. 0	. n	0	0	31.00
32. 00 03200 CORONARY CARE UNIT		0	1	0	0	32. 00
+ I	١	0		U		
46.00 O4600 OTHER LONG TERM CARE	0	0	1 0	0	0	46. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0	0	0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	34, 563	16, 196	0	5, 829	0	54.00
60. 00 06000 LABORATORY	12, 918	3, 846	1	l '	Ö	60.00
· · · · · · · · · · · · · · · · · · ·	1		1			•
65. 00 06500 RESPI RATORY THERAPY	76, 488	7, 823	1	2, 816	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	282, 356	106, 462	. 0	38, 320	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	244, 944	84, 955	0	30, 579	0	67.00
68. 00 06800 SPEECH PATHOLOGY	72, 873	15, 856	0	5, 707	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 046	,	1	0,101	0	71. 00
	11,040	0	1	0	0	•
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	١		1	0	_	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	159, 626	24, 516	0	8, 824	0	73. 00
74.00 07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	١		1	<u> </u>		77.00
					0	00.00
88.00 08800 RURAL HEALTH CLINIC	0	0	0	· ·	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 09000 CLI NI C	o	0	0	0	0	90.00
91. 00 09100 EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS	٦			٥	<u> </u>	7 00
					0	00 00
98. 00 09850 OTHER REI MBURSABLE CC	0	0	1 0	U	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	ol	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>		1	<u> </u>	0	1101.00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	l ol	0	l o	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 432, 109	1, 100, 311	284, 080	389, 149	1, 241, 355	
, J	3, 432, 109	1, 100, 311	204, 000	309, 149	1, 241, 300	1116.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
190. 01 19001 MARKETI NG	152, 799	0	0	0	0	190. 01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN		0	n	n		190. 02
191. 00 19100 RESEARCH		0	ا م	ام		191. 00
		0	1			
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	'l O	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	l 0	0	0	193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		Ω	n	n	ი	201. 00
202.00 TOTAL (sum lines 118 through 201)	3, 584, 908	1, 100, 311	284, 080	389, 149		
202.00 TOTAL (Sum TITIES TTO LITTOUGH 201)] 3,304,700	1, 100, 311	204, 000	307, 149	1, 241, 333	1202.00

5/24/2023 10:10 am

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3046

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared:

Cost Center Description MAINTENANCE OF NURSI NG CENTRAL PHARMACY MEDI CAL RECORDS & SERVICES & PERSONNEL ADMI NI STRATI ON SUPPLY LI BRARY 12.00 13.00 15.00 14.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 0000000000 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 34, 194 14 00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 344 268, 063 16.00 0 01700 SOCIAL SERVICE 17.00 17.00 529 0 18.00 01851 OTHER GENERAL CC C 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 0 0 0 20.00 02000 NURSING PROGRAM 0 0 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 21 00 C 0 Ω 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV C 0 0 0 22.00 02300 PARAMED ED PRGM 0 23.00 0 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 20, 580 0 135, 408 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 C 0 0 31.00 03200 CORONARY CARE UNIT 0 0 32.00 0 0 0 32.00 46.00 04600 OTHER LONG TERM CARE 0 0 0 0 46 00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 O 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 749 54.00 06000 LABORATORY 60.00 0 0 2, 523 60.00 65.00 06500 RESPIRATORY THERAPY 1, 199 17,730 65.00 06600 PHYSI CAL THERAPY 0000000 66.00 2, 581 0 38, 224 66.00 67 00 06700 OCCUPATIONAL THERAPY 327 30 494 67 00 06800 SPEECH PATHOLOGY 68.00 \cap 5, 692 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 4.323 10, 114 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 1,073 27, 129 73 00 Ω 73 00 0 74.00 07400 RENAL DIALYSIS 0 C 0 74.00 07500 ASC (NON-DISTINCT PART) 0 o 75.00 0 0 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00 09000 CLI NI C 0 0 90.00 90.00 0 0 0 0 91.00 09100 EMERGENCY 0 0 91.00 OTHER REIMBURSABLE COST CENTERS 09850 OTHER REIMBURSABLE CC 0 С n 98.00 09900 CMHC 0 0 0 99.00 99.00 0 0 0 99 10 09910 CORE 0 0 99 10 C 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115, 00 0 0 0 0 116. 00 11600 HOSPI CE 0 Ω 0 0 116, 00 SUBTOTALS (SUM OF LINES 1 through 117) 30, 956 268, 063 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 C 0 0 190, 00 0 190. 01 19001 MARKETI NG 0 C 3, 238 0 190. 01 190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 C 0 190. 02 0 0 191. 00 19100 RESEARCH 0 0 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192, 00 0 0 0 0 193.00 19300 NONPALD WORKERS 0 0 0 193.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00 0 268, 063 202. 00 202.00 TOTAL (sum lines 118 through 201) 34, 194

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared: | 5/24/2023 10: 10 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-3046

				1270172022	5/24/2023 10:	
		OTHER GENERAL			INTERNS &	
C+ C+ D	COCLAL CEDVICE	SERVI CE	NONDUNCI CLAN	NUDCLNC	RESI DENTS	
Cost Center Description	SOCI AL SERVI CE	CC CC	NONPHYSICIAN ANESTHETISTS	NURSI NG PROGRAM	SERVICES-SALAR Y & FRINGES	
			ANESTHETTSTS	I KOOKAW	APPRV	
	17. 00	18. 00	19. 00	20. 00	21.00	
GENERAL SERVICE COST CENTERS				,		
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9.00
10. 00 01000 DI ETARY 12. 00 01200 MAI NTENANCE OF PERSONNEL						10. 00 12. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 01500 PHARMACY						15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY						16.00
17.00 01700 SOCIAL SERVICE	705, 510					17. 00
18.00 01851 OTHER GENERAL CC	0	0				18. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19. 00
20. 00 02000 NURSI NG PROGRAM	0	0		0		20.00
21.00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0			0	21. 00
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0				22. 00
23. 00 02300 PARAMED ED PRGM	0	0				23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	705 540	_		ام		00.00
30. 00 03000 ADULTS & PEDI ATRI CS	705, 510	l e		0		30.00
31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT	0	0	1	0		31. 00 32. 00
32. 00 03200 CORONARY CARE UNIT 46. 00 04600 OTHER LONG TERM CARE	0			0		46. 00
ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	40.00
50. 00 05000 OPERATI NG ROOM	0	0	0	0	0	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	Ö		o		54. 00
60. 00 06000 LABORATORY	0	O	0	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	0	0	0	0	0	73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	-	74. 00 75. 00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0			0		77. 00
OUTPATIENT SERVICE COST CENTERS			<u> </u>	<u> </u>		77.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	O		0		89. 00
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
91. 00 09100 EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
98. 00 09850 OTHER REI MBURSABLE CC	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	Ö		o		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	705, 510			0		118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
190. 01 19001 MARKETI NG	0	0	0	0	ol	190. 01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190. 02
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
200.00 Cross Foot Adjustments	_	_	0	0		200. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	705, 510	0		0		201. 00 202. 00
202.00 TOTAL (Suil TITIES TTO THE OUGH 201)	1 700, 510	1	١	٩	υĮ	202. UU

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Pre 5/24/2023 10:	pared:
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	TO dill
	22.00	23. 00	24. 00	25. 00	26. 00	
GENERAL SERVI CE COST CENTERS 1. 00						1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 15. 00 16. 00 17. 00 18. 00 19. 00
21. 00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0				21. 00 22. 00 23. 00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 INTENSI VE CARE UNI T 32.00 03200 CORONARY CARE UNI T 46.00 04600 OTHER LONG TERM CARE	0 0 0	0 0 0 0	13, 868, 62	9 0 0 0 0 0 0 0	13, 868, 629 0 0 0	30. 00 31. 00 32. 00 46. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC 60. 00 06000 LABORATORY 65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATIONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART) 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	218, 48 80, 90 462, 67 1, 784, 39 1, 533, 32 439, 89 76, 98	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 218, 482 80, 901 462, 672 1, 784, 399 1, 533, 327 439, 890 76, 986 0 965, 407 0	50. 00 54. 00 60. 00 65. 00 66. 00 67. 00 68. 00 71. 00 73. 00 74. 00 75. 00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0	0 0 0 0	88. 00 89. 00 90. 00 91. 00
98. 00 09850 07HER REIMBURSABLE COST CENTERS 99. 00 09900 CMHC 99. 10 09910 CORF 100. 00 10000 I&R SERVI CES-NOT APPRVD PRGM 101. 00 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS	0 0 0 0	0 0 0 0 0		0 0 0 0 0 0 0 0 0 0		98. 00 99. 00 99. 10 100. 00 101. 00
113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	0 0 0	19, 430, 69	0 0 0 0 3 0		113. 00 114. 00 115. 00 116. 00 118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 MARKETING 190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 191. 00 19100 RESEARCH 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 193. 00 19300 NONPAID WORKERS 200. 00 Cross Foot Adjustments Negative Cost Centers 202. 00 TOTAL (sum lines 118 through 201)	0 0 0 0 0 0 0	0 0 0 0 0 0 0	868, 44 20, 299, 13	0 0 0 0 0 0 0 0 0 0 0 0	868, 446 0 0 0 0 0	190. 02 191. 00 192. 00 193. 00 200. 00 201. 00

Provider CCN: 15-3046

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | 5/24/2023 10: 10 am

					12/01/2022	5/24/2023 10:	10 am
			CAPITAL RELATED COSTS				
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	'	Assigned New				BENEFITS	
		Capital Related Costs				DEPARTMENT	
		0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	,					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P		15 704	1 245	17.0/0	17 0/0	2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0	15, 724 672, 479		17, 069 729, 992	17, 069 1, 493	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	0	90, 258		97, 977	329	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE		45, 315		49, 190	0	8. 00
9. 00	00900 HOUSEKEEPI NG		45, 519		47, 170	440	1
10.00	01000 DI ETARY	0	214, 626		232, 982	769	10.00
12. 00	01200 MAINTENANCE OF PERSONNEL	o	0	0	0	0	12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	О	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	O	0	0	O	0	14. 00
15. 00	01500 PHARMACY	0	0	0	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	18, 634	1, 594	20, 228	285	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	916	1
18.00	01851 OTHER GENERAL CC	0	0	0	0	0	18.00
19. 00 20. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM	0	0	0	U O	0	19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV		0	0	0	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV		0	0	ol Ol	0	22. 00
23. 00	02300 PARAMED ED PRGM	l ol	0	Ö	ő	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-1	-	-1	-1		
30.00	03000 ADULTS & PEDI ATRI CS	0	1, 710, 449	146, 284	1, 856, 733	7, 540	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	0	0	O	0	50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	38, 319	-1	41, 596	0	54.00
60.00	06000 LABORATORY	o o	9, 100		9, 878	0	60.00
65. 00	06500 RESPI RATORY THERAPY	O	18, 510	l	20, 093	542	65. 00
66.00	06600 PHYSI CAL THERAPY	0	251, 893		273, 436	1, 674	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	201, 007	17, 191	218, 198	1, 517	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	37, 515	3, 208	40, 723	488	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	58, 005	4, 961	62, 966	0	73. 00 74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	l ol	0	Ö	ő	0	77. 00
	OUTPATIENT SERVICE COST CENTERS			· · · · · · · · · · · · · · · · · · ·	- '		
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	I	0	0	89. 00
90.00	09000 CLINIC	0	0	-	0	0	
91.00	09100 EMERGENCY OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	91. 00
98. 00	09850 OTHER REIMBURSABLE CC	l ol	0	0	O	0	98. 00
	09900 CMHC	l ol	0	Ö	ő	0	
99. 10	09910 CORF	o	0	0	o	0	99. 10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	O	0	0	o	0	100. 00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	114. 00 115. 00
	11600 HOSPI CE		0	0	0		116. 00
118.00		l o	3, 381, 834	289, 227	3, 671, 061		118. 00
	NONREI MBURSABLE COST CENTERS	-1					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19001 MARKETI NG	0	0	0	0		190. 01
	19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190. 02
	19100 RESEARCH	0	0	0	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS		0		0		192. 00 193. 00
200.00			U		ol Ol	U	200. 00
201.00			0	О	ő	0	201.00
202.00		o	3, 381, 834	289, 227	3, 671, 061		202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3046

Peri od: Worksheet B From 01/01/2022 Part II Date/Time Prepared: 12/31/2022

5/24/2023 10:10 am Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 731 485 5 00 7.00 00700 OPERATION OF PLANT 39,650 137, 956 7.00 00800 LAUNDRY & LINEN SERVICE 9,547 8.00 2, 401 61, 138 8.00 9.00 00900 HOUSEKEEPI NG 14,023 14.463 9.00 0 286, 624 01000 DI ETARY 0 10.00 10.00 40, 287 11, 373 1, 213 01200 MAINTENANCE OF PERSONNEL 0 12.00 12.00 0 13 00 01300 NURSING ADMINISTRATION Ω 0 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 0 0 14 00 1, 232 C 0 14 00 15.00 01500 PHARMACY 0 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 9, 261 987 105 16.00 01700 SOCIAL SERVICE 17.00 25.404 17.00 0 0 01851 OTHER GENERAL CC 0 0 18.00 0 Ω 0 18.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 0 0 19.00 02000 NURSING PROGRAM 0 0 20.00 20.00 0 0 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 0 21.00 0 02200 L&R SERVICES-OTHER PRGM COSTS APPRV 0 22 00 0 r 0 0 22 00 02300 PARAMED ED PRGM 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 378, 321 61, 138 9, 672 286, 624 30.00 90, 639 30.00 31.00 03100 INTENSIVE CARE UNIT C 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 0 0 32.00 04600 OTHER LONG TERM CARE 0 0 0 46.00 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 r 0 0 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 7.052 2, 031 0 217 0 54.00 0 06000 LABORATORY 60.00 60.00 2.636 482 51 0 06500 RESPIRATORY THERAPY 15,607 0 65.00 981 105 0 65.00 66.00 06600 PHYSI CAL THERAPY 57,613 13, 348 1, 424 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 49, 980 10, 652 0 1, 136 0 67.00 68 00 06800 SPEECH PATHOLOGY 14.869 1, 988 0 212 68 00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 2, 254 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 32.571 3.074 0 328 0 73.00 07400 RENAL DIALYSIS 0 74.00 0 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 C 0 0 0 75.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 90.00 09000 CLI NI C 0 0 0 o 0 90.00 09100 EMERGENCY 0 0 91 00 91 00 0 0 0 OTHER REIMBURSABLE COST CENTERS 98.00 09850 OTHER REIMBURSABLE CC 0 0 0 0 0 98.00 99.00 09900 CMHC 0 0 0 99.00 0 0 0 0 99. 10 09910 CORF 99 10 Ω 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 C 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113 00 11300 INTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116, 00 SUBTOTALS (SUM OF LINES 1 through 117) 137, 956 118.00 700, 307 61, 138 14, 463 286, 624 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN C 0 190. 00 0 190, 01 190. 01 19001 MARKETI NG 31, 178 0 0 0 190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0 190, 02 191. 00 19100 RESEARCH 0 Ω 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 0 0 0 193. 00 19300 NONPALD WORKERS 0 r 0 0 0 193.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 731, 485 137, 956 286, 624 202. 00

61. 138

14, 463

TOTAL (sum lines 118 through 201)

202.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3046

					То	12/31/2022	Date/Time Pre 5/24/2023 10:	
		Cost Center Description	MAINTENANCE OF		CENTRAL	PHARMACY	MEDI CAL	
			PERSONNEL	ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
			12.00	13.00	14.00	15. 00	16. 00	
		AL SERVICE COST CENTERS		I				
1. 00 2. 00	1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	1	ADMINISTRATIVE & GENERAL						5. 00
7.00	1	OPERATION OF PLANT						7. 00
8.00	1	LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY						9. 00 10. 00
12. 00	1	MAINTENANCE OF PERSONNEL	0					12.00
	1	NURSING ADMINISTRATION	0	0				13. 00
14.00	1	CENTRAL SERVICES & SUPPLY	0	0	1, 232	_		14. 00
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	0	0	0 12	0	30, 878	15. 00 16. 00
17. 00	1	SOCIAL SERVICE	0	0	19	0	30, 878	17. 00
18. 00	1	OTHER GENERAL CC	0	0	O	o	0	18. 00
19. 00	1	NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
20. 00 21. 00	1	NURSING PROGRAM I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	20. 00 21. 00
21.00	1	I&R SERVICES-SALARY & FRINGES APPRV	0			0	0	21.00
23. 00		PARAMED ED PRGM	0	Ō		0	0	23. 00
		ENT ROUTINE SERVICE COST CENTERS		_		-1		
30. 00 31. 00	1	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	0	0	1	0	15, 609 0	30. 00 31. 00
32. 00		CORONARY CARE UNIT	0			0	0	ı
46. 00		OTHER LONG TERM CARE	0	Ö	1	Ö	0	
		LARY SERVICE COST CENTERS						
50. 00 54. 00		OPERATING ROOM	0	0	-	0	0	50. 00 54. 00
60. 00		RADI OLOGY-DI AGNOSTI C LABORATORY	0	0	0	0	86 290	60.00
65. 00	1	RESPI RATORY THERAPY	0	Ö	43	Ö	2, 041	65. 00
66. 00	1	PHYSI CAL THERAPY	0	0	93	0	4, 400	66. 00
67.00	1	OCCUPATIONAL THERAPY	0	0	12	0	3, 510	1
68. 00 71. 00	1	SPEECH PATHOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0 156	0	655 1, 164	ł
	1	IMPL. DEV. CHARGED TO PATIENTS	0	Ö	0	o	0	72.00
73.00		DRUGS CHARGED TO PATIENTS	0	0	39	0	3, 123	73. 00
74.00	1	RENAL DIALYSIS	0	0	0	0	0	74. 00
75. 00 77. 00		ASC (NON-DISTINCT PART) ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	75. 00 77. 00
77.00		TIENT SERVICE COST CENTERS			<u> </u>	<u> </u>		77.00
88. 00		RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	ł
90. 00 91. 00	1	CLI NI C EMERGENCY	0	0		0	0	90. 00 91. 00
71.00		REIMBURSABLE COST CENTERS			<u> </u>	<u> </u>		71.00
	09850	OTHER REIMBURSABLE CC	0	0	0	0		98. 00
99. 00			0	0	0	0	0	l .
99. 10	1	CORF L&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	99. 10 100. 00
		HOME HEALTH AGENCY	0			0		101.00
		AL PURPOSE COST CENTERS				-,		
		INTEREST EXPENSE						113. 00
		UTILIZATION REVIEW-SNF	0			0	0	114. 00 115. 00
		AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	0	0		0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	Ö		0		118. 00
		MBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1		0		190.00
		MARKETING GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	117	0		190. 01 190. 02
		RESEARCH	0	0		ol	0	191. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	o		192. 00
		NONPAI D WORKERS	0	0	0	0	0	193. 00
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers	0	_			0	200. 00 201. 00
201.00		TOTAL (sum lines 118 through 201)	0	0	1, 232	0	30, 878	
		,	•			-1		

Health Financial Systems In Lieu of Form CMS-2552-10 PAM REHAB HOSP OF GREATER INDIANA ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3046 Peri od: Worksheet B From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/24/2023 10:10 am OTHER GENERAL INTERNS & SERVI CE **RESI DENTS** Cost Center Description SOCIAL SERVICE OTHER GENERAL NONPHYSI CI AN NURSI NG SERVI CES-SALAR Y & FRINGES CC ANESTHETI STS **PROGRAM APPRV** 19.00 17.00 18.00 20.00 21.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01200 MAI NTENANCE OF PERSONNEL 12 00 12 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17.00 01700 SOCIAL SERVICE 26, 339 17.00 01851 OTHER GENERAL CC 18.00 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 19 00 0 19 00 20.00 02000 NURSING PROGRAM 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 02300 PARAMED ED PRGM 23 00 23 00 Ω INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 26, 339 30.00 0 31.00 03100 INTENSIVE CARE UNIT 0 31.00 03200 CORONARY CARE UNIT 0 0 32 00 32 00 04600 OTHER LONG TERM CARE 46.00 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54 00 60.00 06000 LABORATORY 0 60.00 0000000 06500 RESPIRATORY THERAPY 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0 66, 00 06700 OCCUPATIONAL THERAPY 67 00 Ω 67 00 06800 SPEECH PATHOLOGY 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 75.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 89.00 90.00 09000 CLI NI C 0 0 90.00 91.00 09100 EMERGENCY 0 0 91.00 OTHER REIMBURSABLE COST CENTERS 98.00 09850 OTHER RELMBURSABLE CC 0 C 98 00 99. 00 09900 CMHC 0 C 99.00 09910 CORF 0 99. 10 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 100.00 0 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115.00 116. 00 11600 HOSPI CE 0 116. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 26, 339 0 0 0 118.00 0 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 190. 01 19001 MARKETI NG 0 0 190. 01

0

0

0

0

0

0

0

0

0

190.02

191. 00

192.00

193. 00

0 200. 00

0 201. 00

0 202. 00

191. 00 19100 RESEARCH

200.00

201.00

202.00

193. 00 19300 NONPALD WORKERS

190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

192. 00 19200 PHYSICIANS' PRIVATE OFFICES

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3046 Peri od: Worksheet B From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/24/2023 10:10 am INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHER PARAMED ED Subtotal Intern & Total PRGM COSTS **PRGM** Residents Cost **APPRV** & Post Stepdown Adjustments 22.00 23. 00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01851 OTHER GENERAL CC 18.00 18.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 19 00 20.00 02000 NURSING PROGRAM 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 02300 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 733, 356 2, 733, 356 30.00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 0 32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 04600 OTHER LONG TERM CARE 46.00 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 50, 982 0 50, 982 54.00 54.00 60.00 06000 LABORATORY 13, 337 0 13, 337 60.00 06500 RESPIRATORY THERAPY 39 412 39, 412 65.00 65 00 66.00 06600 PHYSI CAL THERAPY 351, 988 351, 988 66.00 06700 OCCUPATIONAL THERAPY 67.00 285,005 0 0 0 285,005 67.00 06800 SPEECH PATHOLOGY 58, 935 58, 935 68.00 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 574 71.00 3, 574 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 102, 101 0 102, 101 73.00 07400 RENAL DIALYSIS 74 00 0 0 74 00 07500 ASC (NON-DISTINCT PART) 75.00 0 0 75.00 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 88 00 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 90.00 09000 CLI NI C 0 0 90.00 0 91.00 09100 EMERGENCY 0 0 0 91.00 OTHER REIMBURSABLE COST CENTERS 98.00 09850 OTHER REIMBURSABLE CC 0 0 0 98.00 99. 00 09900 CMHC 0 0 99.00 0 99. 10 09910 CORF 0 99. 10 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 100 00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 116. 00 11600 HOSPI CE 0 0 116, 00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 638, 690 118. 00 3, 638, 690 0 118, 00 0 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 190. 01 19001 MARKETI NG 0 0 0 0 0 32, 371 190. 01 32, 371 190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN C 0 190, 02 191. 00 19100 RESEARCH 0 191.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 193, 00 0 200.00 Cross Foot Adjustments 0 0 200.00 0 0 201.00 Negative Cost Centers 0 0 201.00 TOTAL (sum lines 118 through 201) 3, 671, 061 3, 671, 061 202. 00 202.00

Health Financial Systems PAM REHAB HOSP OF GREATER INDIANA In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3046 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/24/2023 10:10 am CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 54, 629 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 54, 629 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 254 254 8, 995, 873 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 10 863 786, 794 -3, 584, 908 16, 714, 231 5 00 10 863 00700 OPERATION OF PLANT 1, 458 7.00 1, 458 173, 403 905, 992 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 732 732 218, 141 8.00 0 00900 HOUSEKEEPI NG 232, 126 320, 424 9.00 9.00 01000 DI ETARY 10 00 920, 552 10 00 3.467 3, 467 405, 217 01200 MAINTENANCE OF PERSONNEL 12.00 0 0 12.00 01300 NURSING ADMINISTRATION 13.00 0 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 0 0 28, 155 14.00 0 01500 PHARMACY 15.00 0 0 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 301 301 150, 488 0 211, 620 16.00 01700 SOCIAL SERVICE 17.00 483, 105 580, 479 17.00 0 01851 OTHER GENERAL CC 0 18.00 18.00 0 0 0 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 19 00 20.00 02000 NURSING PROGRAM 0 0 0 20.00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 Ω 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV o 22.00 0 0 22.00 C 0 02300 PARAMED ED PRGM 0 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 27, 630 27, 630 3, 972, 095 8, 644, 480 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 0 31.00 32.00 03200 CORONARY CARE UNIT 0 C 0 0 0 32.00 04600 OTHER LONG TERM CARE 46.00 0 0 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 Λ 50 00 05400 RADI OLOGY-DI AGNOSTI C 619 161, 145 54.00 619 0 54.00 60.00 06000 LABORATORY 147 147 0 0 60, 230 60.00 06500 RESPIRATORY THERAPY 299 285, 836 356, 616 65.00 299 65 00 66.00 06600 PHYSI CAL THERAPY 4,069 4,069 882, 679 1, 316, 456 66.00 06700 OCCUPATIONAL THERAPY 799, 510 1, 142, 028 67.00 3, 247 3, 247 0 67.00 06800 SPEECH PATHOLOGY 257, 232 339, 762 68.00 68.00 606 606 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 C 0 51, 503 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 0 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 937 937 0 744, 239 73.00 07400 RENAL DIALYSIS 0 74 00 0 C 0 74 00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 0 C 0 75.00 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 88 00 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 C 0 0 0 89.00 90.00 09000 CLI NI C 0 0 0 90.00 0 0 91.00 09100 EMERGENCY 0 0 0 0 0 91.00 OTHER REIMBURSABLE COST CENTERS 98.00 09850 OTHER REIMBURSABLE CC 0 0 0 0 0 98.00 09900 CMHC 0 0 99.00 99.00 0 99. 10 09910 CORF 0 0 0 99. 10 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 0 100 00 C 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 116. 00 11600 HOSPI CE 0 116, 00 SUBTOTALS (SUM OF LINES 1 through 117) 8, 428, 485 -3, 584, 908 16, 001, 822 118. 00 54,629 54, 629 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 712, 409 190. 01 190. 01 19001 MARKETI NG 0 567, 388 0 0 190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 C C 0 190, 02 191. 00 19100 RESEARCH 0 0 0 191.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 o 0 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 200.00 Cross Foot Adjustments 200. 00

3, 381, 834

61. 905471

201.00

3, 584, 908 202. 00

0. 214482 203. 00

675, 799

0.075123

289, 227

5. 294386

Part I)

Negative Cost Centers

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part I)

201.00

202.00

203.00

Heal th Finar	ncial Systems PAN	N REHAB HOSP OF	GREATER INDIAN	NA .	In Lie	eu of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2022 Fo 12/31/2022	Worksheet B-1 Date/Time Pre 5/24/2023 10:	
		CAPITAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2. 00	4.00	5A	5. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)			17, 06	9	731, 485	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00189	7	0. 043764	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3046

Peri od: Worksheet B-1 From 01/01/2022 To 12/31/2022 Date/Ti me Prepared:

5/24/2023 10:10 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY MAINTENANCE OF (SQUARE FEET) (MEALS SERVED) PERSONNEL PLANT LINEN SERVICE (SQUARE FEET) (POUNDS OF (NUMBER LAUNDRY) HOUSED) 7.00 10.00 8.00 9.00 12.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 42,054 7.00 00800 LAUNDRY & LINEN SERVICE 100 8.00 732 8.00 00900 HOUSEKEEPI NG 9.00 41, 322 9.00 10.00 01000 DI ETARY 3, 467 3, 467 100 10.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 0 01300 NURSING ADMINISTRATION 0 0 13.00 Λ 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 14.00 15.00 01500 PHARMACY 0 C 0 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 301 301 16.00 0 01700 SOCIAL SERVICE 17.00 0 C 0 17.00 18.00 01851 OTHER GENERAL CC 0 0 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 0 0 0 19.00 02000 NURSI NG PROGRAM 20.00 Ω 0 0 20 00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 C 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 0 0 22.00 22.00 C 02300 PARAMED ED PRGM 0 0 0 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 27,630 100 27,630 100 0 30.00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 0 32 00 03200 CORONARY CARE UNIT 0 C O ol 32 00 0 04600 OTHER LONG TERM CARE 46.00 0 0 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 C 0 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 619 0 54 00 Ω 619 54 00 0 0 60.00 06000 LABORATORY 147 0 147 0 60.00 06500 RESPIRATORY THERAPY 299 299 65.00 0 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 4,069 4.069 0 66, 00 06700 OCCUPATIONAL THERAPY 3. 247 3 247 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 606 606 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 C 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 937 937 0 73.00 0 74.00 07400 RENAL DIALYSIS 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 0 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 o 0 89.00 09000 CLI NI C 0 0 0 90.00 0 0 90.00 91.00 09100 EMERGENCY C 0 0 0 91.00 OTHER REIMBURSABLE COST CENTERS 98.00 09850 OTHER REIMBURSABLE CC 0 0 0 0 0 98.00 0 09900 CMHC 0 0 99.00 99.00 C 0 99. 10 09910 CORF 0 0 0 99.10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 o C 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 C 0 0 0 115, 00 116. 00 11600 HOSPI CE C 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 42,054 100 41, 322 100 0 118.00 NONREI MBURSABLE COST CENTERS 0 190, 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 01 19001 MARKETI NG 0 0 0 0 190. 01 0 0 190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 190. 02 191. 00 19100 RESEARCH Ω 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 Cross Foot Adjustments 200.00 200. 00 Negative Cost Centers 201 00 201 00 202.00 Cost to be allocated (per Wkst. B, 1, 100, 311 284, 080 389, 149 1, 241, 355 0 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 26. 164241 2, 840. 800000 9. 417477 12, 413. 550000 0.000000 203.00 0 204.00 204.00 Cost to be allocated (per Wkst. B, 137, 956 61, 138 14, 463 286, 624 Part II)

Health Financial Systems PA	AM REHAB HOSP OF	I REHAB HOSP OF GREATER INDIANA				In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Period: From 01/01/2022	Worksheet B-1			
					Date/Time Pre 5/24/2023 10:			
Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	MAINTENANCE OF			
	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	PERSONNEL			
	(SQUARE FEET)	(POUNDS OF			(NUMBER			
		LAUNDRY)			HOUSED)			
	7. 00	8. 00	9. 00	10.00	12.00			
205.00 Unit cost multiplier (Wkst. B, Part	3. 280449	611. 380000	0. 350007	2, 866. 240000	0.000000	205. 00		
206.00 NAHE adjustment amount to be allocate	d					206. 00		
(per Wkst. B-2)								
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00		
Parts III and IV)								

		M KEHAB HUSP UF				Workshoot D 1	
CUS1 P	NLLOCATION - STATISTICAL BASIS		Provi der CCI		Period: From 01/01/2022 To 12/31/2022	Worksheet B-1 Date/Time Pre 5/24/2023 10:	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	RECORDS & LIBRARY (GROSS CHAR	SOCIAL SERVICE (TIME SPENT)	
		HRS) 13.00	REQUI S.) 14. 00	15. 00	GES) 16. 00	17. 00	
	GENERAL SERVICE COST CENTERS	13.00	14.00	13.00	10.00	17.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00 5. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						2. 00 4. 00 5. 00
7. 00 8. 00 9. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						7. 00 8. 00 9. 00
10.00	01000 DI ETARY						10.00
12. 00 13. 00	O1200 MAI NTENANCE OF PERSONNEL O1300 NURSI NG ADMI NI STRATI ON	0					12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	O	150, 770				14. 00
15. 00	01500 PHARMACY	0	O		0		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1, 515		0 43, 035, 550	100	16.00
17. 00 18. 00	O1700 SOCIAL SERVICE O1851 OTHER GENERAL CC	0	2, 332			100 0	
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	o		0 0	0	
20.00	02000 NURSING PROGRAM	0	o		0 0	0	1
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0		0 0	0	
22. 00 23. 00	02200 1&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM	0	0			0	
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	j U	U _I		0 0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	0	90, 744		0 21, 738, 905	100	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	0		0 0	0	
32. 00	03200 CORONARY CARE UNIT	0	0		0 0	0	
46. 00	O4600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	U _I		0 0	0	46. 00
50.00	05000 OPERATING ROOM	0	0		0 0	0	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	O		0 120, 257	0	
60.00	06000 LABORATORY	0	0		0 405, 109	0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	5, 288 11, 381		0 2, 846, 416 0 6, 136, 499	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0	1, 440		0 4, 895, 541	0	
68. 00	06800 SPEECH PATHOLOGY	0	0		0 913, 785	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	19, 060		0 1, 623, 686	0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	4, 731		0 4, 355, 352	0	
74. 00	07400 RENAL DIALYSIS	o	4, 731		0 4, 333, 332	0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0		ol ol	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	
90.00	09000 CLI NI C	0	ō		0 0	0	
91. 00	09100 EMERGENCY	0	0		0 0	0	91.00
98. 00	OTHER REIMBURSABLE COST CENTERS O9850 OTHER REIMBURSABLE CC	O	ام		ol ol	0	98. 00
99. 00	1 1	o	ő		o o	0	
	09910 CORF	0	O		0 0	0	
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0		100.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	U		0 0	0	101. 00
113.00	11300 I NTEREST EXPENSE						113. 00
114.00	11400 UTILIZATION REVIEW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116. 00 118. 00	11600 HOSPI CE	0	0 136, 491		0 0 43, 035, 550		116. 00 118. 00
110.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	<u> </u>	130, 491		0 43, 035, 550	100]118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
	19001 MARKETI NG	0	14, 279		0 0		190. 01
	19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0		190. 02
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES		0				191. 00 192. 00
	19300 NONPALD WORKERS		o		o o		193. 00
200.00	Cross Foot Adjustments						200. 00
201.00					0 000		201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	34, 194		0 268, 063	705, 510	202. 00
203. 00		0. 000000	0. 226796	0. 00000	0. 006229	7, 055. 100000	203. 00
203.00							
204.00	Cost to be allocated (per Wkst. B, Part II)	0	1, 232		0 30, 878	26, 339	204. 00

Health Financial S	ystems PAN	M REHAB HOSP OF	GREATER INDIAN	IA.	In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION -	STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2022 To 12/31/2022	Date/Time Pre	narodi
					10 12/31/2022	5/24/2023 10:	
Cost (Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(DIRECT NRSING	(COSTED		(GROSS CHAR		
		HRS)	REQUIS.)		GES)		
		13. 00	14.00	15. 00	16. 00	17. 00	
205.00 Unit	cost multiplier (Wkst. B, Part	0. 000000	0. 008171	0.00000	0. 000717	263. 390000	205. 00
11)							
206. 00 NAHE a	adjustment amount to be allocated						206. 00
(per V	Wkst. B-2)						
	unit cost multiplier (Wkst. D,						207. 00
Parts	III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS PAM REHAB HOSP OF GREATER INDIANA
Provider CCN: 15-3046 In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: Worksheet B-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

			OTUED OFNERAL			LUTERNO	5/24/2023 10:	10 am
			OTHER GENERAL SERVI CE			INTERNS &	RESI DENTS	
		Cost Center Description	OTHER GENERAL	NONPHYSI CI AN	NURSI NG	SERVI CES-SALAR		
			CC (TIME CDENT)	ANESTHETI STS	PROGRAM	Y & FRINGES	PRGM COSTS	
			(TIME SPENT)	(ASSIGNED TIME)	(ASSIGNED TIME)	APPRV (ASSI GNED	APPRV (ASSI GNED	
				<u> </u>	,	TIME)	TIME)	
	CENED	AL SERVICE COST CENTERS	18. 00	19. 00	20. 00	21. 00	22.00	
		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2. 00
		EMPLOYEE BENEFITS DEPARTMENT						4. 00
	1	ADMINISTRATIVE & GENERAL OPERATION OF PLANT						5. 00 7. 00
	1	LAUNDRY & LINEN SERVICE						8. 00
		HOUSEKEEPI NG						9. 00
	1	DI ETARY						10.00
	1	MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION						12. 00 13. 00
		CENTRAL SERVICES & SUPPLY						14. 00
		PHARMACY						15.00
		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE						16. 00 17. 00
	1	OTHER GENERAL CC	0					18. 00
		NONPHYSICIAN ANESTHETISTS	0	0				19. 00
	1	NURSING PROGRAM	0		0			20.00
		I&R SERVICES-SALARY & FRINGES APPRV I&R SERVICES-OTHER PRGM COSTS APPRV	0			0	0	21. 00 22. 00
		PARAMED ED PRGM	0					23. 00
		ENT ROUTINE SERVICE COST CENTERS						
		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	0	0			0	30.00
	1	CORONARY CARE UNIT	0	0			0	31. 00 32. 00
	1	OTHER LONG TERM CARE	0	0			Ö	46. 00
		LARY SERVICE COST CENTERS						
		OPERATING ROOM RADIOLOGY-DIAGNOSTIC	0	0			0	
	1	LABORATORY	0	0		0	0	60.00
	1	RESPI RATORY THERAPY	0	0	0	0	0	65. 00
		PHYSI CAL THERAPY	0	0	0	0	0	66.00
	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	0	0	0	67. 00 68. 00
	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	Ö	0	ő	71. 00
		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0	0 0	0	0	0	73. 00 74. 00
	1	ASC (NON-DISTINCT PART)	0	0		0	0	75. 00
77. 00	07700	ALLOGENEIC STEM CELL ACQUISITION	0	0	•		0	77. 00
		TIENT SERVICE COST CENTERS			I			00.00
		RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	_				
		CLI NI C	Ö				l	
		EMERGENCY	0	0	0	0	0	91. 00
		REIMBURSABLE COST CENTERS OTHER REIMBURSABLE CC	0	0	0	0	0	98. 00
	09900		0	0			0	•
99. 10			0	0	0	0	0	
	1	I &R SERVICES-NOT APPRVD PRGM	0	0		_		100.00
		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	U	0	0	U	0	101. 00
		INTEREST EXPENSE						113. 00
		UTILIZATION REVIEW-SNF						114. 00
		AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	0	0	0		0	115. 00 116. 00
118.00	1	SUBTOTALS (SUM OF LINES 1 through 117)	0	0			0	118.00
		MBURSABLE COST CENTERS	_					
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
		MARKETING GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	l e	190. 01 190. 02
		RESEARCH	0	0	Ö	0	l e	191. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
193. 00 200. 00		NONPALD WORKERS	0	0	0	0	0	193. 00
200.00	1	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202.00		Cost to be allocated (per Wkst. B,	О	0	0	0	0	202. 00
202.00		Part I)	0.000000	0 000000	0.000000	0.000000	0.000000	202 00
203. 00	<u> </u>	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0. 000000	0. 000000	0.000000	J∠U3. UU

					10 12/31/2022	5/24/2023 10:	
					From 01/01/2022	Date/Time Pre	nared:
COST ALLOCATION	- STATISTICAL BASIS		Provi der Co	CN: 15-3046	Peri od:	Worksheet B-1	
Heal th Financial	Systems PA	M REHAB HOSP OF G	GREATER INDIAN	IA.	In Lie	u of Form CMS-	2552-10

						5/24/2023 10:	io am_
		OTHER GENERAL SERVI CE			INTERNS &	RESI DENTS	
	Cost Center Description	OTHER GENERAL CC	NONPHYSICIAN ANESTHETISTS	NURSI NG PROGRAM	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	
		(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	APPRV	
			TIME)	TIME)	(ASSI GNED	(ASSI GNED	
					TIME)	TIME)	
		18. 00	19. 00	20.00	21.00	22. 00	
204.00	Cost to be allocated (per Wkst. B,	0	0	C	0	0	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0.000000	0.000000	0.000000	205. 00
	II)						
206.00	NAHE adjustment amount to be allocated			l c)		206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,			0.000000			207. 00
	Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS PAM REHAB HOSP OF GREATER INDIANA In Lieu of Form CMS-2552-10 Provider CCN: 15-3046

			Date/Time Prepared: 5/24/2023 10:10 am
	Cost Center Description	PARAMED ED	37 2 47 2023 TO. TO dill
		PRGM	
		(ASSI GNED	
		TIME) 23.00	
	GENERAL SERVICE COST CENTERS	23.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL		5. 00
7.00	00700 OPERATION OF PLANT		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY		9.00
12. 00	01200 MAINTENANCE OF PERSONNEL		12.00
	01300 NURSING ADMINISTRATION		13. 00
	01400 CENTRAL SERVICES & SUPPLY		14. 00
15.00	01500 PHARMACY		15. 00
	01600 MEDICAL RECORDS & LIBRARY		16. 00
	01700 SOCIAL SERVICE		17. 00
	01851 OTHER GENERAL CC		18.00
	01900 NONPHYSI CLAN ANESTHETI STS		19.00
	02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRV		20.00
21.00	02200 I&R SERVICES-SALARY & FRINGES APPRV		22.00
	02300 PARAMED ED PRGM	o	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	20.00
30.00	03000 ADULTS & PEDIATRICS	0	30.00
31.00	03100 INTENSIVE CARE UNIT	O	31. 00
32.00	03200 CORONARY CARE UNIT	0	32.00
46. 00	04600 OTHER LONG TERM CARE	0	46. 00
	ANCILLARY SERVICE COST CENTERS		50.00
50.00	05000 OPERATING ROOM	0	50.00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	54. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY		65. 00
66. 00	06600 PHYSI CAL THERAPY		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	o	67. 00
	06800 SPEECH PATHOLOGY	o	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	73. 00
	07400 RENAL DIALYSIS	0	74.00
	07500 ASC (NON-DISTINCT PART)	0	75. 00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	<u> </u>	77. 00
88. 00	08800 RURAL HEALTH CLINIC	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	89. 00
90.00	09000 CLI NI C	o	90.00
91.00	09100 EMERGENCY	0	91. 00
	OTHER REIMBURSABLE COST CENTERS		
	09850 OTHER REIMBURSABLE CC	0	98. 00
	09900 CMHC	0	99.00
	09910 CORF 10000 L&R SERVICES-NOT APPRVD PRGM	0	99. 10
	10100 HOME HEALTH AGENCY	0	100. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	101.00
113.00	11300 NTEREST EXPENSE		113. 00
	11400 UTILIZATION REVIEW-SNF		114. 00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	o	115. 00
	11600 H0SPI CE	0	116. 00
118. 00		0	118. 00
100.00	NONREI MBURSABLE COST CENTERS		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
	19001 MARKETING 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	190. 01 190. 02
	19100 RESEARCH	0	190. 02
	19200 PHYSICIANS' PRIVATE OFFICES	l ől	192. 00
	19300 NONPAI D WORKERS	o	193. 00
200.00			200. 00
201.00			201. 00
202.00	71	0	202. 00
202 27	Part I)	0.000000	222
203. 00 204. 00		0. 000000	203. 00
2U4. UU		ı U	204. 00
	Part II)	I	l

Heal th Finar	ncial Systems PAM	REHAB HOSP OF G	REATER INDIANA	In Lie	u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CCN: 15-3046	Peri od: From 01/01/2022	Worksheet B-1	
				To 12/31/2022	Date/Time Pre 5/24/2023 10:	pared: 10 am_
	Cost Center Description	PARAMED ED				
		PRGM				
		(ASSI GNED				
		TIME)				
		23. 00				
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000				205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0				206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0. 000000				207. 00

near tri	Titialiciai Systellis FAI	W KLIIAD 1103F OI	GREATER TINDIAL	VA.	III LI C	u or rorm cws	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider Co		Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/24/2023 10:	pared: 10 am
-			Title	XVIII	Hospi tal	PPS	
			11 110	, XVIII	Costs	110	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		26)	0.00	0.00	4.00	F 00	
	LABORT FAIT BOUTLAND OFFICE OF CONT. OFFITEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	10.010.100		100/0/0		40.070.470	
30. 00	03000 ADULTS & PEDI ATRI CS	13, 868, 629		13, 868, 62	111, 043	13, 979, 672	
31. 00	03100 I NTENSI VE CARE UNI T	0			0	0	
32. 00	03200 CORONARY CARE UNIT	0			0	0	02.00
46.00	04600 OTHER LONG TERM CARE	0			0 0	0	46. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0			0 0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	218, 482		218, 48	32 0	218, 482	54.00
60.00	06000 LABORATORY	80, 901		80, 90		80, 901	1
65. 00	06500 RESPI RATORY THERAPY	462, 672	1 0	462, 67		462, 672	1
66. 00	06600 PHYSI CAL THERAPY	1, 784, 399	l e	1, 784, 39		1, 784, 399	1
67. 00	06700 OCCUPATI ONAL THERAPY	1, 533, 327		1, 533, 32		1, 533, 327	
68. 00	06800 SPEECH PATHOLOGY	439, 890		439, 89		439, 890	
	1	1	l e			· ·	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	76, 986		76, 98	0		71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0			0	0	1
	07300 DRUGS CHARGED TO PATIENTS	965, 407		965, 40	0/	965, 407	
74. 00	07400 RENAL DIALYSIS	0			0	0	,
75. 00	07500 ASC (NON-DISTINCT PART)	0			0	0	1 , 0. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0			0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0			0 0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89. 00
90.00	09000 CLI NI C	0			0 0	0	90.00
	09100 EMERGENCY	0			0 0	0	1
	OTHER REIMBURSABLE COST CENTERS						1
98. 00		0			0 0	0	98. 00
	09900 CMHC					0	1
	09910 CORF	0				0	
	10000 I &R SERVICES-NOT APPRVD PRGM					J	100.00
		0			0		
101.00	10100 HOME HEALTH AGENCY	0			U	U	101. 00
	SPECIAL PURPOSE COST CENTERS		ı				
	11300 I NTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0			0		115. 00
	11600 HOSPI CE	0			0		116. 00
200.00	Subtotal (see instructions)	19, 430, 693	0	19, 430, 69	111, 043	19, 541, 736	200. 00
201.00		0			0		201. 00
202.00	Total (see instructions)	19, 430, 693	0	19, 430, 69	111, 043	19, 541, 736	202. 00

Health Financial Systems PAM REHAB HOSP OF GREATER INDIANA In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3046 Peri od: Worksheet C From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/24/2023 10:10 am Title XVIII Hospi tal PPS Charges TEFRA Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 21, 738, 905 21, 738, 905 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0 32.00 46.00 04600 OTHER LONG TERM CARE 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 0.000000 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 120, 257 0 120, 257 1.816792 0.000000 54.00 06000 LABORATORY 405, 109 0. 199702 60.00 405.109 0.000000 60.00 0 06500 RESPIRATORY THERAPY 0. 162545 0.000000 65.00 2, 846, 416 2, 846, 416 65 00 66.00 06600 PHYSI CAL THERAPY 6,048,349 88, 150 6, 136, 499 0.290785 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 4, 856, 807 38, 734 4, 895, 541 0.313209 0.000000 67.00 06800 SPEECH PATHOLOGY 912, 349 913, 785 0.000000 68.00 1, 436 0.481393 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 1, 623, 686 C 1, 623, 686 0.047414 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 4, 355, 352 0 4, 355, 352 0.221660 0.000000 73.00 07400 RENAL DIALYSIS 74 00 0 0.000000 0.000000 74 00 0 C 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0.000000 0.000000 75.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0.000000 0.000000 77.00 77.00 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 09000 CLI NI C 0 0.000000 90.00 0 0 0.000000 90.00 91 00 09100 EMERGENCY 0 0 0 0.000000 0.000000 91.00 OTHER REIMBURSABLE COST CENTERS 98.00 09850 OTHER REIMBURSABLE CC 0 0 0 0.000000 0.000000 98.00 0 0 99.00 09900 CMHC 0 99.00 0 99. 10 09910 CORF 99. 10 0 100.00 10000 I &R SERVI CES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 115. 00

42, 907, 230

42, 907, 230

0

0

43, 035, 550

43, 035, 550

128, 320

128, 320

116 00

200.00

201. 00

202.00

116. 00 11600 HOSPI CE

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

200.00

201.00

202.00

			10 12/31/2022	5/24/2023 10: 10 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
32. 00 03200 CORONARY CARE UNIT				32.00
46.00 04600 OTHER LONG TERM CARE				46. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1. 816792			54.00
60. 00 06000 LABORATORY	0. 199702			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 162545			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 290785			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 313209			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 481393			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 047414			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 221660			73.00
74.00 07400 RENAL DIALYSIS	0. 000000			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
OTHER REIMBURSABLE COST CENTERS				
98. 00 09850 OTHER REIMBURSABLE CC	0. 000000			98. 00
99. 00 09900 CMHC				99. 00
99. 10 09910 CORF				99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM				100.00
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 I NTEREST EXPENSE				113. 00
114.00 11400 UTILIZATION REVIEW-SNF				114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)				115. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202.00

Health Financial Systems PA	M KEHAB HOSP OF	GREATER INDIAN	NA	In Lie	U OT FORM CMS	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/24/2023 10:	pared: 10 am
		Titl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	13, 868, 629		13, 868, 62	9 111, 043	13, 979, 672	30.00
31. 00 03100 NTENSI VE CARE UNI T	13, 600, 627			0 0 0	13, 474, 072	31.00
· · · · · · · · · · · · · · · · · · ·				-	_	1
32. 00 03200 CORONARY CARE UNIT	0		1	0 0	0	32.00
46. 00 O4600 OTHER LONG TERM CARE				0 0	0	46. 00
ANCI LLARY SERVI CE COST CENTERS		T	ı	ما ما		
50. 00 05000 OPERATING ROOM	0		1	0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	218, 482	l .	218, 48		218, 482	1
60. 00 06000 LABORATORY	80, 901		80, 90	1 0	80, 901	60.00
65. 00 06500 RESPI RATORY THERAPY	462, 672	0	462, 67	2 0	462, 672	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 784, 399	0	1, 784, 39	9 0	1, 784, 399	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 533, 327	0	1, 533, 32	7 0	1, 533, 327	67.00
68. 00 06800 SPEECH PATHOLOGY	439, 890	0	439, 89	0 0	439, 890	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	76, 986		76, 98	6 0	76, 986	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			ol ol	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	965, 407		965, 40	7 ol	965, 407	73.00
74. 00 07400 RENAL DI ALYSI S	0			o	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)				ol ol	0	1
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON				o o	0	77. 00
OUTPATIENT SERVICE COST CENTERS		1		٥,	<u> </u>	1 00
88. 00 08800 RURAL HEALTH CLINIC	0			ol o	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER			•	o o	0	89.00
90. 00 09000 CLINI C			•		0	90.00
91. 00 09100 EMERGENCY					0	1
OTHER REIMBURSABLE COST CENTERS				<u> </u>	U	71.00
98. 00 09850 OTHER REI MBURSABLE CC	0			0 0	0	98. 00
99. 00 09900 CMHC					0	99.00
99. 10 09910 CORF			1	-	0	
	0			0	, and the second	
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0			0	0	
101. 00 10100 HOME HEALTH AGENCY				0	0	101. 00
SPECIAL PURPOSE COST CENTERS		T	ı	1		
113. 00 11300 NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				_		114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	1		0		115. 00
116. 00 11600 HOSPI CE	0			이		116. 00
200.00 Subtotal (see instructions)	19, 430, 693	0	19, 430, 69	3 111, 043		
201.00 Less Observation Beds	0			0		201. 00
202.00 Total (see instructions)	19, 430, 693	0	19, 430, 69	3 111, 043	19, 541, 736	202. 00
				·		

201. 00

202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3046 Peri od: Worksheet C From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/24/2023 10:10 am Title XIX Hospi tal PPS Charges TEFRA Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 21, 738, 905 21, 738, 905 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 03200 CORONARY CARE UNIT 0 0 32.00 32.00 46.00 04600 OTHER LONG TERM CARE 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 0.000000 50.00 120, 257 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 120, 257 1.816792 0.000000 54.00 06000 LABORATORY 405, 109 0. 199702 60.00 405.109 0.000000 60.00 0 06500 RESPIRATORY THERAPY 0. 162545 0.000000 65.00 2, 846, 416 2, 846, 416 65 00 66.00 06600 PHYSI CAL THERAPY 6,048,349 88, 150 6, 136, 499 0.290785 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 4, 856, 807 38, 734 4, 895, 541 0.313209 0.000000 67.00 06800 SPEECH PATHOLOGY 912, 349 913, 785 0.000000 68.00 1, 436 0.481393 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 1, 623, 686 C 1, 623, 686 0.047414 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 4, 355, 352 0 4, 355, 352 0.221660 0.000000 73.00 07400 RENAL DIALYSIS 74 00 0 0.000000 0.000000 74 00 0 C 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0.000000 0.000000 75.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0.000000 0.000000 77.00 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0.000000 0.000000 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.000000 0.000000 89.00 09000 CLI NI C 0 0.000000 90.00 0 0 0.000000 90.00 91 00 09100 EMERGENCY 0 0 0 0.000000 0.000000 91.00 OTHER REIMBURSABLE COST CENTERS 98.00 09850 OTHER REIMBURSABLE CC 0 0 0 0.000000 0.000000 98.00 0 0 99.00 09900 CMHC 0 99.00 0 99. 10 09910 CORF 99.10 0 100.00 10000 I &R SERVI CES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115. 00 116. 00 11600 HOSPI CE 0 116 00 200.00 Subtotal (see instructions) 42, 907, 230 128, 320 43, 035, 550 200.00

42, 907, 230

128, 320

43, 035, 550

201.00

202.00

Less Observation Beds

Total (see instructions)

| Peri od: | Worksheet C | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | 5/24/2023 10: 10 am

				5/24/2023 10:10 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
32.00 03200 CORONARY CARE UNIT				32.00
46.00 04600 OTHER LONG TERM CARE				46. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1. 816792			54.00
60. 00 06000 LABORATORY	0. 199702			60. 00
65. 00 06500 RESPIRATORY THERAPY	0. 162545			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 290785			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 313209			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 481393			68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 221660			73.00
74. 00 07400 RENAL DIALYSIS	0. 000000			74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77. 00
OUTPATIENT SERVICE COST CENTERS	0. 000000			77.00
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89. 00
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
OTHER REIMBURSABLE COST CENTERS	0. 000000			7.1.00
98. 00 09850 OTHER REI MBURSABLE CC	0. 000000			98. 00
99. 00 09900 CMHC	0.00000			99. 00
99. 10 09910 CORF				99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM				100.00
101. 00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				101.00
113. 00 11300 I NTEREST EXPENSE				113. 00
114.00 11400 UTILIZATION REVIEW-SNF				114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)				115.00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				200.00
202.00 Total (see instructions)				202. 00
202.00 Total (See Histiactions)	l l			1202.00

Heal th Financial Systems PAM REHAB HOSP
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Provider CCN: 15-3046

				11	0 12/31/2022	5/24/2023 10:	pared: 10 am
			Titl	e XIX	Hospi tal	PPS	TO dill
	Cost Center Description	Total Cost		Operating Cost		Operating Cost	
		(Wkst. B, Part			Reduction	Reduction	
		I, col. 26)		Cost (col. 1 -		Amount	
		, , ,	,	col . 2)			
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	,					
50.00	05000 OPERATI NG ROOM	0	0	0	0	0	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	218, 482	50, 982	167, 500	0	0	54.00
60.00	06000 LABORATORY	80, 901	13, 337		0	0	60. 00
65.00	06500 RESPIRATORY THERAPY	462, 672	39, 412		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 784, 399	351, 988	1, 432, 411	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 533, 327	285, 005		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	439, 890	58, 935		0	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	76, 986	3, 574		0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0, 0.1	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	965, 407	102, 101	863, 306	0	0	73. 00
74. 00	07400 RENAL DI ALYSI S	0	0	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	o	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	, -,		,			
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91. 00
	OTHER REIMBURSABLE COST CENTERS						
98.00	09850 OTHER REIMBURSABLE CC	0	0	0	0	0	98. 00
99.00	09900 CMHC	0	0	0	0	0	99. 00
99. 10	09910 CORF	0	0	0	0	0	99. 10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100. 00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
114.00	11400 UTILIZATION REVIEW-SNF						114. 00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116.00	11600 H0SPI CE	0	0	0	0	0	116. 00
200.00		5, 562, 064	905, 334	4, 656, 730	0	0	200. 00
201.00	Less Observation Beds	0	0	0	0	0	201. 00
202.00	Total (line 200 minus line 201)	5, 562, 064	905, 334	4, 656, 730	0	0	202. 00

Heal th Financial Systems PAM REHAB HOSP OF GREATER INDIANA CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Provider CCN: REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 Provider CCN: 15-3046

				10 12/31/2022	5/24/2023 10:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	Capital and	(Worksheet C,	Cost to Charge	е		
	Operating Cost	Part I, column	Ratio (col. 6			
	Reducti on	8)	/ col. 7)			
	6. 00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0. 000000)		50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	218, 482	120, 257	1. 81679:	2		54.00
60. 00 06000 LABORATORY	80, 901	405, 109	0. 19970:	2		60. 00
65. 00 06500 RESPI RATORY THERAPY	462, 672	2, 846, 416	0. 16254	5		65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 784, 399	6, 136, 499	0. 29078	5		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 533, 327	4, 895, 541	0. 31320	9		67. 00
68.00 06800 SPEECH PATHOLOGY	439, 890	913, 785	0. 48139	3		68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	76, 986	1, 623, 686	0. 04741	4		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 000000	O		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	965, 407	4, 355, 352	0. 221660	O		73. 00
74.00 07400 RENAL DIALYSIS	0	0	0. 000000	O		74. 00
75.00 07500 ASC (NON-DISTINCT PART)	O	0	0. 000000	O		75. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0. 000000	O		77. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0. 000000)		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 000000)		89. 00
90. 00 09000 CLI NI C	0	0	0. 000000)		90. 00
91. 00 09100 EMERGENCY	0	0	0. 00000)		91. 00
OTHER REIMBURSABLE COST CENTERS						
98. 00 09850 OTHER REIMBURSABLE CC	0	0	0. 000000)		98. 00
99. 00 09900 CMHC	0	0	0. 000000	O		99. 00
99. 10 09910 CORF	0	0	0. 000000)		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0. 000000	O		100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0. 00000	O		101. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0. 000000)		115. 00
116. 00 11600 HOSPI CE	0	0	0. 000000	D		116. 00
200.00 Subtotal (sum of lines 50 thru 199)	5, 562, 064	21, 296, 645				200. 00
201.00 Less Observation Beds	0	0				201. 00
202.00 Total (line 200 minus line 201)	5, 562, 064	21, 296, 645				202. 00

Health Financial Systems PA	M REHAB HOSP OF	GREATER INDIAN	NA	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/24/2023 10:	
		Title	XVIII	Hospi tal	PPS	TO dill
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2, 733, 356	0	2, 733, 35	6 13, 412	203. 80	30.00
31.00 INTENSIVE CARE UNIT	0			0	0.00	31. 00
32.00 CORONARY CARE UNIT	0			0	0.00	32. 00
200.00 Total (lines 30 through 199)	2, 733, 356		2, 733, 35	6 13, 412		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	9, 814	2, 000, 093				30.00
31.00 INTENSIVE CARE UNIT	0	0				31. 00
32. 00 CORONARY CARE UNIT	0	0				32. 00
200.00 Total (lines 30 through 199)	9, 814	2, 000, 093				200. 00

Heal th Financial	Systems	PAM REHAB HOSP OF GRI	EATER INDIANA	In Lie	In Lieu of Form CMS-2552-10	
ADDODTI ONMENT OF	INDATIENT ANCILLARY SERVICE (ADLIAL COCTS	Dravi dan CCN, 1E 2014	Dori od:	Workshoot D	

Health Financial Systems PAN	M REHAB HOSP OF	GREATER INDIAN	۱A	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Co		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Pre 5/24/2023 10:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		1,	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	_	T _	1	_1		
50. 00 05000 OPERATI NG ROOM	0	0	0.00000		0	50. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	50, 982					54.00
60. 00 06000 LABORATORY	13, 337		l .			1
65. 00 06500 RESPI RATORY THERAPY	39, 412					65. 00
66. 00 06600 PHYSI CAL THERAPY	351, 988					
67. 00 06700 OCCUPATI ONAL THERAPY	285, 005					1
68. 00 06800 SPEECH PATHOLOGY	58, 935					1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 574	1, 623, 686			3, 188	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	102, 101	4, 355, 352			76, 065	•
74. 00 07400 RENAL DI ALYSI S	0	0	0.00000		0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000		0	75. 00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.00000	0 0	0	77. 00
OUTPAȚI ENT SERVI CE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.00000		0	00.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	89. 00
90. 00 09000 CLI NI C	0	0	0.00000		0	90. 00
91. 00 09100 EMERGENCY	0	0	0.00000	0	0	91. 00
OTHER REIMBURSABLE COST CENTERS						
98. 00 09850 OTHER REIMBURSABLE CC	0	0	0.00000			98. 00
200.00 Total (lines 50 through 199)	905, 334	21, 296, 645	l	15, 913, 124	657, 632	200. 00

Health Financial Systems PAN	REHAB HOSP OF	GREATER INDIA	NA	In Li∈	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	TS Provider C		Period: From 01/01/2022	Worksheet D	
				To 12/31/2022		pared:
					5/24/2023 10:	<u>10 am</u>
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health		
	Program	Program	Post-Stepdown		Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			,			
30. 00 03000 ADULTS & PEDIATRICS	0	0)	0	0	00.00
31.00 03100 INTENSIVE CARE UNIT	0	0)	0	0	1 0 00
32. 00 03200 CORONARY CARE UNIT	0	0)	0	0	02.00
200.00 Total (lines 30 through 199)	0	0	(0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	13, 41:	0.00	9, 814	30.00
31.00 03100 INTENSIVE CARE UNIT		0)	0.00	0	31. 00
32. 00 03200 CORONARY CARE UNIT		0)	0.00	0	32. 00
200.00 Total (lines 30 through 199)		0	13, 41:	2	9, 814	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					

30. 00 31. 00 32. 00

200. 00

30. 00 | 03000 | ADULTS & PEDIATRICS | 03100 | O3100 | INTENSIVE CARE UNIT | O3200 | CORONARY CARE UNIT | Total (lines 30 through 199)

Health Financial Systems	PAM REHAB HOSP OF GR	EATER INDIANA	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-3046	Peri od:	Worksheet D	

	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PASS	Provider CO		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Pre 5/24/2023 10:	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1		1			
	05000 OPERATING ROOM	0	0		0 0	0	50. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		이	0	54.00
60.00	06000 LABORATORY	0	0		이	0	60. 00
65. 00	06500 RESPI RATORY THERAPY	0	0		이	0	65. 00
	06600 PHYSI CAL THERAPY	0	0		이	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0		0 0	0	68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
	07400 RENAL DI ALYSI S	0	0		0 0	0	74. 00
	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	1		·			
	08800 RURAL HEALTH CLINIC	0	0		이	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		이	0	89. 00
	09000 CLI NI C	0	0		0 0	0	90. 00
91. 00	09100 EMERGENCY	0	0		0 0	0	91. 00
	OTHER REIMBURSABLE COST CENTERS	,					
	09850 OTHER REIMBURSABLE CC	0	0		0 0	0	98. 00
200.00	Total (lines 50 through 199)	0	0		0 0	0	200. 00

Heal th	Financial Systems PA	M REHAB HOSP OF	GREATER INDIAN	NA .	In Lieu of Form CMS-2552-10			
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE SH COSTS	RVICE OTHER PASS	S Provider Co		Period: From 01/01/2022 To 12/31/2022		pared: 10 am	
			Title	XVIII	Hospi tal	PPS		
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,			
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.		
			4)	col s. 2, 3,	8)	7)		
				and 4)		(see		
						instructions)		
		4. 00	5. 00	6. 00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS				_			
50.00	05000 OPERATI NG ROOM	0	0		0	0. 000000		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 120, 257			
60.00	06000 LABORATORY	0	0		0 405, 109			
65. 00	06500 RESPI RATORY THERAPY	0	0		0 2, 846, 416			
66. 00	06600 PHYSI CAL THERAPY	0	0		0 6, 136, 499	0.000000	66. 00	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 4, 895, 541	0. 000000	67. 00	
68.00	06800 SPEECH PATHOLOGY	0	0		0 913, 785	0.000000	68. 00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 1, 623, 686	0.000000	71. 00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0.000000	72. 00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 4, 355, 352	0.000000	73. 00	
74.00	07400 RENAL DIALYSIS	0	0		0	0.000000	74.00	
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0	0.000000	75. 00	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0.000000	77. 00	
	OUTPATIENT SERVICE COST CENTERS							
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0.000000	88. 00	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.000000	89. 00	
00 00	00000 CLINIC		l	I	ما م	1 0000001	00 00	

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09100 EMERGENCY
OTHER REIMBURSABLE COST CENTERS

98. 00 | 09850 | OTHER REI MBURSABLE CC | 200. 00 | Total (Lines 50 through 199)

	REHAB HOSP OF				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der CO		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/24/2023 10:	pared: 10 am
		Title	XVIII	Hospi tal	PPS	TO dill
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.	ŭ	Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	0		0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	94, 157		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	312, 848		0 0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	2, 292, 460		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	4, 360, 585		0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	3, 502, 418		0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	657, 379		0 0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 448, 583		0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	3, 244, 694		0 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0. 000000	0		0 0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0	89. 00
90. 00 09000 CLI NI C	0. 000000	0		0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	91. 00

0.000000

0 15, 913, 124

0

0 98.00 0 200.00

91. 00 | 09100 ELINIC 91. 00 | 09100 EMERGENCY | 0THER REIMBURSABLE COST CENTERS | 09850 | 0THER REIMBURSABLE CC | 200. 00 | Total (lines 50 through 199)

PAM REHAB HOSP OF GREATER INDIANA In Lieu of Form CMS-2552-10 Health Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-3046 Peri od: Worksheet D From 01/01/2022 To 12/31/2022 Part V Date/Time Prepared: 5/24/2023 10:10 am Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1.816792 0 0 0 0 0 0 0 0 0 54.00 60. 00 06000 LABORATORY 0. 199702 0 0 60 00 0 0 06500 RESPIRATORY THERAPY 65.00 0.162545 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 290785 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0.313209 0 0 67.00 0 06800 SPEECH PATHOLOGY 0 68.00 0.481393 0 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.047414 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0.000000 0 0 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0. 221660 73 00 Ω 0 74.00 07400 RENAL DIALYSIS 0.000000 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 0 75.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.000000 0 77.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLI NI C 0.000000 0 0 90.00 0 0 09100 EMERGENCY 0.000000 0 0 91.00 91.00 0 0 OTHER REIMBURSABLE COST CENTERS 98.00 09850 OTHER REIMBURSABLE CC 0.000000 98.00 0 0 0 0 200.00 200.00 Subtotal (see instructions) 0 Less PBP Clinic Lab. Services-Program 201.00 201. 00 Only Charges 202.00 Net Charges (line 200 - line 201) 0 0 202.00

PAM REHAB HOSP OF GREATER INDIANA In Lieu of Form CMS-2552-10 Health Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-3046 Peri od: Worksheet D From 01/01/2022 To 12/31/2022 Part V Date/Time Prepared: 5/24/2023 10:10 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Reimbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0 0 0 54.00 60. 00 06000 LABORATORY 0 60.00 06500 RESPIRATORY THERAPY 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 67. 00 06700 OCCUPATIONAL THERAPY 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 74.00 07400 RENAL DIALYSIS 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLI NI C 0 90.00 0 09100 EMERGENCY 91.00 0 91.00 0 OTHER REIMBURSABLE COST CENTERS 98.00 09850 OTHER REIMBURSABLE CC 0 98.00

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0

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200.00

201. 00

202.00

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Health Financial Systems	PAM REHAB HOSP OF	GREATER INDIA	NA	In Lie	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2022 To 12/31/2022		pared:	
					5/24/2023 10:		
		Titl	e XIX	Hospi tal	PPS		
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.		
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)		
	(from Wkst. B,		Related Cost				
	Part II, col.		(col . 1 - col				
	26)		2)				
	1.00	2.00	3. 00	4. 00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	2, 733, 356	0	2, 733, 35	6 13, 412	203.80	30.00	
31.00 INTENSIVE CARE UNIT	C			0	0.00	31. 00	
32. 00 CORONARY CARE UNIT	C			0	0.00	32. 00	
200.00 Total (lines 30 through 199)	2, 733, 356		2, 733, 35	6 13, 412		200.00	
Cost Center Description	I npati ent	I npati ent					
	Program days	Program					
		Capital Cost					
		(col. 5 x col.					
		6)					
	6. 00	7. 00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	C	0)			30.00	
31.00 INTENSIVE CARE UNIT	C	0)			31. 00	
32.00 CORONARY CARE UNIT	C	0)			32. 00	
200.00 Total (lines 30 through 199)	c	0)			200. 00	

Health Financial Systems	PAM REHAB HOSP OF (∂REATER	I NDI	ANA		In Lie	u of Form	n CMS-2552-10	0
ADDODEL ONLIENT OF LUDATIENT	ANGLE ABY OFBY OF CARLEY COOPE			0011 45 0044	T				_

Heal th Financi	al Systems PAN	1 REHAB HOSP OF	GREATER INDIAN	NΑ	In Lie	eu of Form CMS-	2552-10
APPORTI ONMENT	OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider Co	CN: 15-3046	Period: From 01/01/2022 To 12/31/2022		
				e XIX	Hospi tal	PPS	
Co	ost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
			(from Wkst. C,			(column 3 x	
		(from Wkst. B,		1	I. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	RY SERVICE COST CENTERS					_	
	PERATING ROOM	0	0	0. 00000		0	00.00
	ADI OLOGY-DI AGNOSTI C	50, 982				0	0 00
	ABORATORY	13, 337	· ·			0	00.00
	ESPI RATORY THERAPY	39, 412		l .		0	65.00
	HYSI CAL THERAPY	351, 988	6, 136, 499			0	66. 00
67. 00 06700 0	CCUPATIONAL THERAPY	285, 005	4, 895, 541	0. 0582	17 (0	67. 00
68. 00 06800 SI	PEECH PATHOLOGY	58, 935	913, 785	0. 0644	95 (0	68. 00
71. 00 07100 MI	EDICAL SUPPLIES CHARGED TO PATIENT	3, 574	1, 623, 686	0. 00220	01 (0	71. 00
72.00 07200 11	MPL. DEV. CHARGED TO PATIENTS	0	0	0.0000	00	0	72.00
73. 00 07300 DI	RUGS CHARGED TO PATIENTS	102, 101	4, 355, 352	0. 0234	43 (0	73.00
74. 00 07400 RI	ENAL DIALYSIS	0	0	0.0000	00	0	74.00
75. 00 07500 AS	SC (NON-DISTINCT PART)	0	0	0.0000	00	0	75. 00
77. 00 07700 AI	LLOGENEIC STEM CELL ACQUISITION	0	0	0.0000	00	0	77. 00
OUTPATI	ENT SERVICE COST CENTERS				·		1
88. 00 08800 RI	URAL HEALTH CLINIC	0	0	0.0000	00	0	88. 00
89. 00 08900 FI	EDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000	00	0	89. 00
90. 00 09000 CI	LINIC	0	0	0.0000	00	0	90.00
91. 00 09100 EI	MERGENCY	0	0	0. 00000	00	0	91.00
OTHER R	EIMBURSABLE COST CENTERS						
98. 00 09850 0 ⁻	THER REIMBURSABLE CC	0	0	0.0000	00	0	98. 00
200. 00 To	otal (lines 50 through 199)	905, 334	21, 296, 645			0	200. 00

Hard the Fire and all Countries	DELIAD HOCD OF	CDEATED INDIAN	1.0	1-11	eu of Form CMS-	2552 10
Heal th Financial Systems PAN APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	REHAB HOSP OF			Period:	Worksheet D	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	33 THROUGH COST	13 Provider C		From 01/01/2022		
				o 12/31/2022	Date/Time Pre	
					5/24/2023 10:	10 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health		
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adj ustments	4.00		2.22		
INDATIONE DOUTING CERVICE COST CENTERS	1A	1. 00	2A	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						20.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0			0	
31. 00 03100 I NTENSI VE CARE UNI T	0	0			0	1
32. 00 03200 CORONARY CARE UNIT	0	0			0	
200.00 Total (lines 30 through 199)	0	T 1 1 0 1	T 1 1 D 11 1) (200. 00
Cost Center Description	Swing-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adjustment Amount (see	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
		1 through 3,				
	4.00	minus col. 4) 5.00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0		13, 412	0.00) 0	30.00
31. 00 03100 NTENSI VE CARE UNI T		0	13,412	0.00		
32. 00 03200 CORONARY CARE UNIT		0	7	0.00		
200.00 Total (lines 30 through 199)		0	13, 412			200.00
Cost Center Description	Inpati ent	0	13,412	4		200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
LAIDATLENT DOUTLAG CEDVI OF COCT CENTEDO	7.00					

30. 00 31. 00 32. 00

200. 00

30. 00 | 03000 | ADULTS & PEDIATRICS | 03100 | O3100 | INTENSIVE CARE UNIT | O3200 | CORONARY CARE UNIT | Total (lines 30 through 199)

Health Financial Systems	PAM REHAB HOSP OF GR	EATER INDIANA	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLAR	Y SERVICE OTHER PASS	Provider CCN: 15-3046	Peri od:	Worksheet D

	H COSTS	RVICE UTHER PAS:	S Provider Co		From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre 5/24/2023 10:	pared: 10 am
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
	[1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	_	-		_1	_	
	05000 OPERATING ROOM	0	0		0	0	50. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	01	54. 00
	06000 LABORATORY	0	0		0	01	60.00
	06500 RESPI RATORY THERAPY	0	0		0	01	65. 00
	06600 PHYSI CAL THERAPY	0	0		0	01	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0		0	01	67. 00
	06800 SPEECH PATHOLOGY	0	0		0	01	68. 00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0	01	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	01	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	01	73. 00
	07400 RENAL DI ALYSI S	0	0		0	01	74. 00
	07500 ASC (NON-DISTINCT PART)	0	0		0	01	75. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	_	1	Г	_1	_	
	08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	01	89. 00
	09000 CLI NI C	0	0		0	01	90. 00
	09100 EMERGENCY	0	0		0 0	0	91. 00
	OTHER REIMBURSABLE COST CENTERS				_1		
	09850 OTHER REIMBURSABLE CC	0	0		0		
200. 00	Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Systems PA	AM REHAB HOSP OF	GREATER INDIA	۱A	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SETHROUGH COSTS	ERVICE OTHER PASS	S Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Pre 5/24/2023 10:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	

			'	12/31/2022	5/24/2023 10:	10 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	1	T	1	T		
50.00 05000 OPERATING ROOM	0	0	(0	0. 000000	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(120, 257	0. 000000	54.00
60. 00 06000 LABORATORY	0	0	(405, 109		60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	(2, 846, 416		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(6, 136, 499		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(4, 895, 541	0. 000000	1
68. 00 06800 SPEECH PATHOLOGY	0	0	(913, 785		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(1, 623, 686		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0. 000000	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	(4, 355, 352	0. 000000	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	(0	0. 000000	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	(0	0. 000000	75. 00
77.00 O7700 ALLOGENEIC STEM CELL ACQUISITION	0	0	(0	0. 000000	77. 00
OUTPATIENT SERVICE COST CENTERS	_		ı	1		
88.00 08800 RURAL HEALTH CLINIC	0	0	(0	0. 000000	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0	0. 000000	89. 00
90. 00 09000 CLI NI C	0	0	(0	0. 000000	90. 00
91. 00 09100 EMERGENCY	0	0	(0	0. 000000	91. 00
OTHER REIMBURSABLE COST CENTERS			ı			
98. 00 09850 OTHER REIMBURSABLE CC	0	0	(0	0. 000000	1
200.00 Total (lines 50 through 199)	0	0	(21, 296, 645		200. 00

	<u> </u>	M REHAB HOSP OF G	_			u of Form CMS-2	2552-10
	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der C		Peri od:	Worksheet D	
THROUG	GH COSTS				From 01/01/2022 To 12/31/2022		nanad.
					To 12/31/2022	Date/Time Pre 5/24/2023 10:	pareu: 10 am
			Ti tl	e XIX	Hospi tal	PPS	TO GIII
	Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	n Charges	Pass-Through	
		(col. 6 ÷ col.	Ü	Costs (col.		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	C)	0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	C)	0	0	54.00
60.00	06000 LABORATORY	0. 000000	C		0 0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	C		0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	C		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	C		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	C		0 0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	C		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	C		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	C		0 0	0	73. 00
74.00	07400 RENAL DI ALYSI S	0. 000000	C		0 0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	C		0 0	0	75. 00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	C		0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	<u> </u>		•			
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	C		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	C		0 0	0	89. 00
00 00	100000 CLINIC	0.000000	_	J			00 00

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88. 00 89. 00 90. 00

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90.00

09000 CLI NI C

98. 00 OTHER REI MBURSABLE COST CENTERS
98. 00 O9850 OTHER REI MBURSABLE CC
200. 00 Total (lines 50 through 199)

91. 00 09100 EMERGENCY

Health Financial Systems	PAM REHAB HOSP OF GR	REATER INDIANA	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3046	Peri od: From 01/01/2022	Worksheet D-1	
			To 12/31/2022	Date/Time Pre 5/24/2023 10:	
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
DADT I ALL DROWLDED COMPONENTS					

		Title XVIII	Hospi tal	PPS	10 diii
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
4 00	I NPATI ENT DAYS			40.440	4 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			13, 412 13, 412	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed day		ate room days,	0	3.00
	do not complete this line.				
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		21 of the cost	13, 412 0	4. 00 5. 00
5.00	reporting period	oli days) trii odgir beceiliber	31 of the cost	O	3.00
6. 00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 31	of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roor	n days) through December 3	1 of the cost	0	7. 00
0.00	reporting period		-6 -1	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December 31	or the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding s	swing-bed and	9, 814	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private roc	om days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		um days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en		uays) arter	U	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	room days)	0	12. 00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Program			0	14. 00
15. 00	Total nursery days (title V or XIX only)	(usgg us	.,	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
	reporting period	9			
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of th	e cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of t	he cost	0. 00	19. 00
20. 00	Medical drate for swing-bed NF services applicable to services reporting period	s after December 31 of the	cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		13, 979, 672	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost reportin	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporting	period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December (31 of the cost reporting r	period (line 8	0	25. 00
	x line 20)	r and and a specific property	(_	
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 13, 979, 672	26. 00 27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	,			
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed char	ges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	: line 28)		0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	•		0.00	32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instructi	ons)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x line	ne 31)		0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost diff	erential (line	13, 979, 672	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			1
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 042. 33	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		10, 229, 427	39. 00
40.00	Medically necessary private room cost applicable to the Program general inpatient routine service cost (line 39)	•		10 229 427	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ ITTIE 40)	I	10, 229, 427	41.00

:OMPUT	Financial Systems PAM ATION OF INPATIENT OPERATING COST	REHAB HOSP OF		CN: 15-3046	Peri od:	wof Form CMS- Worksheet D-1		
70MI 017	WIGHT OF THE ATTEMPT OF ENVIRONMENT OF THE ATTEMPT		Trovider o	on. 10 00 10	From 01/01/2022 To 12/31/2022		epare	
	Coot Contar Decement on	Total		XVIII	Hospi tal	PPS Program Cost		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days		Program Days	Program Cost (col. 3 x col.		
		1.00	2.00	col. 2) 3.00	4. 00	4) 5. 00	\vdash	
2. 00	NURSERY (title V & XIX only)	1.00	2.00	0.00	1. 00	0.00	42.	
	Intensive Care Type Inpatient Hospital Units							
3.00	INTENSIVE CARE UNIT	0				0		
i. 00 5. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	C	0.	00 0	0	44.	
5. 00	SURGICAL INTENSIVE CARE UNIT						46.	
	OTHER SPECIAL CARE (SPECIFY)						47	
	Cost Center Description	·		•				
	D		11 200)			1.00	10	
	Program inpatient ancillary service cost (Wk: Program inpatient cellular therapy acquisition			III lina 10	column 1)	4, 075, 510	1	
	Total Program inpatient costs (sum of lines				, corumir r)	0 14, 304, 937		
	PASS THROUGH COST ADJUSTMENTS	+1 till ough 40. c	71) (See Thisti de	, (1 0113)		14, 304, 737	- 77	
. 00	Pass through costs applicable to Program inpulli)	atient routine	services (from	n Wkst. D, sui	m of Parts I and	2, 000, 093	50	
. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	ry services (fr	rom Wkst. D,	sum of Parts II	657, 632	51	
. 00	Total Program excludable cost (sum of lines!					2, 657, 725		
. 00	Total Program inpatient operating cost exclu		el ated, non-phy	sician anestl	hetist, and	11, 647, 212	53	
	medical education costs (line 49 minus line !	52)					-	
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54	
	7 Target amount per discharge							
. 00								
. 00								
. 00	Bonus payment (see instructions)					0		
. 00	Trended costs (lesser of line 53 ÷ line 54, (or line 55 from	n the cost repo	orting period	ending 1996,	0.00	59	
. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 \div line 54,	or line 55 fro	om prior year o	ost report,	updated by the	0.00	60	
. 00	<pre>market basket) Continuous improvement bonus payment (if line</pre>	53 ± line 54	is loss than t	he lowest of	linge 55 nlue	0	61	
. 00	55.01, or line 59, or line 60, enter the less					0		
	53) are less than expected costs (lines 54 x							
	enter zero. (see instructions)	, ,	3	`	,			
. 00	Relief payment (see instructions)					0		
	Allowable Inpatient cost plus incentive payme	ent (see instru	ıctions)			0	63	
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost report	ing period (See	0	64	
. 00	instructions)(title XVIII only)	ts through bece	siliber 31 of the	cost report	ing period (see		04	
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the o	ost reportin	g period (See	0	65	
	instructions)(title XVIII only)			-> <		_		
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	b)(title XVI	II only); for	0	66	
. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 c	of the cost re	enorting period	0	67	
. 00	(line 12 x line 19)	costs tillougi	i becember or e	ine cost in	eportring perrod		1 0,	
. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	December 31 of	the cost rep	orting period	0	68	
	(line 13 x line 20)					_		
. 00	Total title V or XIX swing-bed NF inpatient					0	69	
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil)		70	
. 00	Adjusted general inpatient routine service of				,		71	
. 00	Program routine service cost (line 9 x line			,			72	
. 00	Medically necessary private room cost application		n (line 14 x li	ne 35)			73	
. 00	Total Program general inpatient routine serv	•					74	
. 00	Capital -related cost allocated to inpatient	routine service	costs (from V	lorksheet B, I	Part II, column		75	
00	26, line 45)	2)					١,,	
. 00	Per diem capital related costs (line 75 ÷ line						76	
. 00	Program capital -related costs (line 9 x line						77	
3. 00 9. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der rocera	le)			78	
). 00	Total Program routine service costs for compa			*	nus line 79)		80	
	Inpatient routine service cost per diem limit			(, ,		81	
	Inpatient routine service cost limitation (I		_			l	1	

Health Financial Systems PAN	1 REHAB HOSP OF	GREATER INDIAN	Α	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		pared: 10 am_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	2, 733, 356	13, 979, 672	0. 19552	4 0	0	90.00
91.00 Nursing Program cost	0	13, 979, 672	0.00000	0 0	0	91.00
92.00 Allied health cost	0	13, 979, 672	0.00000	0	0	92. 00
93.00 All other Medical Education	o	13, 979, 672	0.00000	0 0	0	93. 00

Health Financial Systems	PAM REHAB HOSP OF GREATER INDIANA	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-3046	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Preps/24/2023 10:	
	Title XIX	Hospi tal	PPS	IU alli
Cost Center Description				

		Title XIX	Hospi tal	5/24/2023 10: 1 PPS	10 am
	Cost Center Description	TI LIE XIX	позрі таї		
	DADT I ALL DDOWLDED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				1
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		13, 412	1.00
1	Inpatient days (including private room days, excluding swing-			13, 412	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	ivate room days,	0	3.00
4. 00	Semi-private room days (excluding swing-bed and observation be	ed days)		13, 412	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after December :	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	m davs) through December	31 of the cost	0	7. 00
	reporting period	, .,			
8. 00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	a the Drogram (eveluding	awing had and	0	9.00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swing-bed and	U	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10.00
	through December 31 of the cost reporting period (see instruc				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, en		oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12.00
	through December 31 of the cost reporting period	3 .	,		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra			0	14.00
	Total nursery days (title V or XIX only)	dir (excruding swriig-bed i	uays)	0	15. 00
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20.00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			13, 979, 672	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
ļ	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	r 31 of the cost reporti	ng period (line	0	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)	3			
1	Total swing-bed cost (see instructions)	(1) 04 1 11 0()		0	
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		13, 979, 672	27.00
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		G ,	0	29. 00
1	Semi -pri vate room charges (excluding swing-bed charges)	11 00)		0	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	÷ Tine 28)		0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 min		tions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x line 25)	ne 31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 13, 979, 672	36. 00 37. 00
37.00	27 minus line 36)	and private room cost ur	Tronchital (Title	13, 717, 012	37.00
ļ	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			4 0 40	00.5
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 042. 33 0	38. 00 39. 00
1	Program general innations routing carving cost (line 0 v line				
39. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		0	

)MPUT	Financial Systems PAM ATION OF INPATIENT OPERATING COST		Provi der Co	CN: 15-3046	Peri od: From 01/01/2022	Worksheet D-	-1
					To 12/31/2022		
				e XIX	Hospi tal	PPS	
	Cost Center Description	·	Total Inpatient Days	col . 2)	÷	Program Cost (col. 3 x col 4)	
00	NURSERY (title V & XIX only)	1.00	2.00	3. 00	4. 00	5. 00	42
. 00	Intensive Care Type Inpatient Hospital Units						=
. 00	INTENSIVE CARE UNIT	0	-			1	0 43
. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0.0	00 0	'	0 44
	SURGICAL INTENSIVE CARE UNIT						46
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1. 00	
. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	B, line 200)				0 48
. 01	Program inpatient cellular therapy acquisition	•	•		column 1)	1	0 48
. 00	Total Program inpatient costs (sum of lines A PASS THROUGH COST ADJUSTMENTS	41 through 48.0	01)(see instruc	tions)			0 49
. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sum	of Parts I and	1	0 50
. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II		0 51
. 00	Total Program excludable cost (sum of lines!	50 and 51)					0 52
. 00	Total Program inpatient operating cost exclude		elated, non-phy	sician anesth	netist, and	1	0 53
	medical education costs (line 49 minus line !	52)					_
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					1	0 54
. 00	Target amount per discharge					•	0 55
. 01	Permanent adjustment amount per discharge					0.0	
	Adjustment amount per discharge (contractor					1	00 55
. 00	Target amount (line 54 x sum of lines 55, 55.			ino E4 minus	Lino E2)	1	0 56
. 00							0 58
. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	orting period	endi ng 1996,	0.0	00 59
	updated and compounded by the market basket)	== 0					
. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	om prior year c	cost report, ι	ipdated by the	0.0	00 60
. 00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x	ser of 50% of t	he amount by w	hich operatir	ng costs (line		0 61
	enter zero. (see instructions)	00), 01 1 % 01	the target am	ioditi (TTTIC 50), otherwise		
	Relief payment (see instructions)					1	0 62
	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)				0 63
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reporti	ng period (See	T	0 64
	instructions)(title XVIII only)	Ü		•			
. 00	Medicare swing-bed SNF inpatient routine cosinstructions (title XVIII only)	ts after Decemb	er 31 of the c	ost reporting	period (See		0 65
. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 plus line 6	5)(title XVII	I only); for		0 66
	CAH, see instructions						
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	of the cost re	eporting period		0 67
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after [ecember 31 of	the cost repo	ortina period		0 68
	(line 13 x line 20)				3 1		
. 00	Total title V or XIX swing-bed NF inpatient						0 69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70
. 00	Adjusted general inpatient routine service of						71
. 00	Program routine service cost (line 9 x line						72
	Medically necessary private room cost applications are received to the cost application of the cost applications are received to the cost application of the cost application		•				73
. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient	•			Part II column		74
. 50	26, line 45)	531110 301 VI C	, 20213 (110111 W	.с. колост Б, Т	a. c ii, corumii		′ ັ
. 00	Per diem capital-related costs (line 75 ÷ li						76
	Program capital -related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovider record	ls)		1	78
. 00	Total Program routine service costs for compa	, ,		*.	nus line 79)		80
. 00	Inpatient routine service cost per diem limi	tati on		-	,		81
2 00	Inpatient routine service cost limitation (Li						82

Health Financial Systems PAN	1 REHAB HOSP OF	GREATER INDIAN	Α	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		pared: 10 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	2, 733, 356	13, 979, 672	0. 19552	4 0	0	90.00
91.00 Nursing Program cost	0	13, 979, 672	0.00000	0 0	0	91.00
92.00 Allied health cost	0	13, 979, 672	0.00000	0	0	92. 00
93.00 All other Medical Education	0	13, 979, 672	0. 00000	0 0	О	93. 00

ALLE STATE OF THE	D HOOD OF ODEATED LANDLANA		6.5. 046.4	2550 40
Health Financial Systems PAM REHA INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	B HOSP OF GREATER INDIANA Provider CCN: 15-3046	Period:	eu of Form CMS-2 Worksheet D-3	
INFATIENT ANGIELART SERVICE COST AFFORTIONMENT	Frovider Con. 15-3040	From 01/01/2022		
		To 12/31/2022	Date/Time Pre 5/24/2023 10:	
	Title XVIII	Hospi tal	PPS	
Cost Center Description	Ratio of Cos	r r r r r	Inpati ent	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
			2)	
LABOTT FOR DOUTLAS OFFICE OFFICE	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		15 (10 107		
30. 00 03000 ADULTS & PEDI ATRI CS		15, 642, 187		30.00
31. 00 03100 I NTENSI VE CARE UNI T		0		31. 00
32. 00 03200 CORONARY CARE UNIT		0		32. 00
ANCILLARY SERVICE COST CENTERS	1 0 0000			
50. 00 05000 OPERATING ROOM	0.0000		0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1. 81679			54.00
60. 00 06000 LABORATORY	0. 1997(1
65. 00 06500 RESPI RATORY THERAPY	0. 16254			1
66. 00 06600 PHYSI CAL THERAPY	0. 29078			1
67. 00 06700 OCCUPATI ONAL THERAPY	0. 31320			1
68. 00 06800 SPEECH PATHOLOGY	0. 48139			1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 0474		1	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.00000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 22166		1	
74. 00 07400 RENAL DIALYSIS	0. 00000		0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0. 00000		0	75. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0.00000	00	0	77. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0. 00000		0	00.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 00000	00	0	89. 00
90. 00 09000 CLI NI C	0. 00000		0	90. 00
91. 00 09100 EMERGENCY	0. 00000	00	0	91. 00
OTHER RELABILICARIE COCT CENTERS				1

0.000000

15, 913, 124

15, 913, 124

4, 075, 510 200. 00

0 98.00

201. 00 202. 00

OTHER REIMBURSABLE COST CENTERS

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

98. 00 09850 OTHER REIMBURSABLE CC

200.00

201.00

202.00

Health Financial Systems	PAM REHAB HOSP OF	GREATER INDIA	NA	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C		Period: From 01/01/2022	Worksheet D-3	
					Date/Time Prep 5/24/2023 10:	pared: 10 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
INDATIONE DOUBLING CERVICE COCT CENTERS						

			5/24/2023 10:	io am_
	Title XIX	Hospi tal	PPS	
Cost Center Description	Ratio of Cos	t Inpatient	I npati ent	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
			2)	
	1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS		C)	30. 00
31.00 O3100 INTENSIVE CARE UNIT		C)	31. 00
32. 00 O3200 CORONARY CARE UNIT		C)	32. 00
ANCI LLARY SERVI CE COST CENTERS				
50.00 05000 OPERATI NG ROOM	0.00000		0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1. 81679		0	54.00
60. 00 06000 LABORATORY	0. 19970		0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 1625		0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 29078		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 31320		0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 48139		0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 0474		0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.00000		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 2216		0	73. 00
74. 00 07400 RENAL DI ALYSI S	0.00000		0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0.00000		0	75. 00
77.00 O7700 ALLOGENEIC STEM CELL ACQUISITION	0.0000	00 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0.0000		0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.00000	00	0	89. 00
90. 00 09000 CLI NI C	0.00000	00	0	90. 00
91. 00 09100 EMERGENCY	0.0000	00 0	0	91. 00
OTHER REIMBURSABLE COST CENTERS				
98. 00 09850 OTHER REI MBURSABLE CC	0.00000	00		98. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		(C		200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)	C		201. 00
202.00 Net charges (line 200 minus line 201)		0)	202. 00

Health Financial Systems	PAM REHAB HOSP OF GREATE	ER INDIANA	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pr	rovider CCN: 15-3046	From 01/01/2022	Worksheet E Part B Date/Time Prepared: 5/24/2023 10:10 am
		T1 11 \0.0111		DD0

PART B - MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 OPPS payments	1.00	1. 00
1.00 Medical and other services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instructions)	0 0 0 0 0 0 0 0 0 0	
1.00 Medical and other services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instructions)	0 3	
2.00 Medical and other services reimbursed under OPPS (see instructions)	0 3	
·	0 3	
	0 4	2. 00
4.00 Outlier payment (see instructions)		4. 00
4.01 Outlier reconciliation amount (see instructions)	0 4	4. 01
5.00 Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00 Line 2 times line 5		6. 00
7.00 Sum of lines 3, 4, and 4.01, divided by line 6	1	7.00
8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	1	8. 00 9. 00
10.00 Organ acquisitions	1	9.00
11.00 Total cost (sum of lines 1 and 10) (see instructions)	1	11.00
COMPUTATION OF LESSER OF COST OR CHARGES	•	
Reasonable charges		
12.00 Ancillary service charges		12.00
13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13)		13. 00 14. 00
14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges	0 14	14.00
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basi	is 0 1	15. 00
16.00 Amounts that would have been realized from patients liable for payment for services on a chargebas		16. 00
had such payment been made in accordance with 42 CFR §413.13(e)		
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000)		17. 00
18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see		18. 00 19. 00
instructions)		19.00
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0 20	20. 00
instructions)		
21.00 Lesser of cost or charges (see instructions)	1	21. 00
22.00 Interns and residents (see instructions)	1	22. 00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	1	23. 00 24. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT		24.00
25.00 Deductibles and coinsurance amounts (for CAH, see instructions)	0 2!	25. 00
26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0 20	26. 00
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	e 0 2	27. 00
instructions) 20 00 Direct graduate medical education payments (from Wket E 4 Line E0)	0 28	28. 00
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36)	1	29. 00
30.00 Subtotal (sum of lines 27 through 29)		30. 00
31.00 Primary payer payments	0 3	31. 00
32.00 Subtotal (line 30 minus line 31)	0 32	32. 00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00 Composite rate ESRD (from Wkst. I-5, line 11) 34.00 Allowable bad debts (see instructions)	1	33. 00 34. 00
35.00 Adjusted reimbursable bad debts (see instructions)	1	35. 00
36.00 Allowable bad debts for dual eligible beneficiaries (see instructions)		36. 00
37.00 Subtotal (see instructions)	0 3	37. 00
38.00 MSP-LCC reconciliation amount from PS&R		38. 00
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		39. 00
39.50 Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39.75 N95 respirator payment adjustment amount (see instructions) 39.97 Demonstration payment adjustment amount before sequestration	1	39. 75 39. 97
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)	1	39. 98
39. 99 RECOVERY OF ACCELERATED DEPRECIATION		39. 99
40.00 Subtotal (see instructions)		10. 00
40.01 Sequestration adjustment (see instructions)		10. 01
40.02 Demonstration payment adjustment amount after sequestration		10.02
40.03 Sequestration adjustment-PARHM or CHART pass-throughs 41.00 Interim payments		10. 03 11. 00
41.01 Interim payments-PARHM or CHART	1	11. 01
42.00 Tentative settlement (for contractors use only)		12. 00
42.01 Tentative settlement-PARHM or CHART (for contractor use only)	42	12. 01
43.00 Balance due provider/program (see instructions)		13.00
43. 01 Balance due provider/program-PARHM (see instructions)		13. 01
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0 4	14. 00
TO BE COMPLETED BY CONTRACTOR		
90.00 Original outlier amount (see instructions)	0 90	90. 00
91.00 Outlier reconciliation adjustment amount (see instructions)	0 9	91. 00
92.00 The rate used to calculate the Time Value of Money		92.00
93.00 Time Value of Money (see instructions)		93.00
94.00 Total (sum of lines 91 and 93)	1 0 94	94. 00

Health Financial Systems	PAM REHAB HOSP OF GR	EATER INDIANA	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3046	Peri od:	Worksheet E	
			From 01/01/2022		
			To 12/31/2022	Date/Time Pr	epared:
				5/24/2023 10	: 10 am_
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					0 200. 00

Peri od:

Provider CCN: 15-3046 Worksheet E-1 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/24/2023 10:10 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 18, 131, 431 1. 00 0 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 0 0 3.02 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 0 3.51 0 0 3.52 3.52 3.53 0 0 3.53 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.99 3.50-3.98) 18, 131, 431 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5. 99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 169, 071 0 6.01 6 02 SETTLEMENT TO PROGRAM 0 6.02 7.00 Total Medicare program liability (see instructions) 18, 300, 502 7.00 Contractor NPR Date (Mo/Day/Yr) Number

0

1 00

2 00

8.00

8.00 Name of Contractor

Health Financial Systems	PAM REHAB HOSP OF GREA	ATER INDIANA	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	F	Provider CCN: 1	From 01/01/2022 To 12/31/2022	Worksheet E-3 Part III Date/Time Prepared: 5/24/2023 10:10 am

		Title XVIII	Hospi tal	5/24/2023 10: PPS	10 am
		11110 77111	nospi tui	110	
				1. 00	
1 00	PART III - MEDICARE PART A SERVICES - IRF PPS			10, 200, 020	1 00
1.00	Net Federal PPS Payment (see instructions)			18, 290, 039	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0213	•
3. 00 4. 00	Inpatient Rehabilitation LIP Payments (see instructions) Outlier Payments			356, 656 277, 468	
5.00	Unweighted intern and resident FTE count in the most recent co	est reporting period on	ding on or prior	0.00	1
5.00	to November 15, 2004 (see instructions)	ost reporting period em	uring on or prior	0.00	3.00
5. 01	Cap increases for the unweighted intern and resident FTE count	for residents that were	e displaced by	0.00	5. 01
	program or hospital closure, that would not be counted without	a temporary cap adjusti	ment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
6. 00	New Teaching program adjustment. (see instructions)			0. 00	1
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in t	the new program growth p	eriod of a "new	0.00	7. 00
0.00	teaching program" (see instructions)			0.00	0.00
8. 00	Current year's unweighted I&R FTE count for residents within teaching program" (see instructions)	the new program growth po	eriod of a new	0.00	8. 00
9. 00	Intern and resident count for IRF PPS medical education adjust	ment (see instructions)		0.00	9. 00
10. 00	Average Daily Census (see instructions)	tillerit (see Tristi deti olis)		36. 745205	•
11. 00	Teaching Adjustment Factor (see instructions)			0. 000000	
12. 00	Teaching Adjustment (see instructions)			0	12. 00
	Total PPS Payment (see instructions)			18, 924, 163	1
14.00	Nursing and Allied Health Managed Care payments (see instructi	on)		0	1
15.00		,			15. 00
16.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	16. 00
17.00	Subtotal (see instructions)			18, 924, 163	17. 00
18. 00	Primary payer payments			0	18. 00
19. 00	Subtotal (line 17 less line 18).			18, 924, 163	
20.00	Deducti bl es			274, 836	
21. 00	Subtotal (line 19 minus line 20)			18, 649, 327	1
	Coinsurance			152, 877	1
	Subtotal (line 21 minus line 22)			18, 496, 450	1
	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		57, 817	1
	Adjusted reimbursable bad debts (see instructions)	custions)		37, 581	1
	Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (sum of lines 23 and 25)	uctions)		37, 272 18, 534, 031	1
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ne 49)		10, 334, 031	ı
	Other pass through costs (see instructions)	110 47)		0	ı
30. 00	Outlier payments reconciliation			0	ı
	OTHER ADJUSTMENTS			0	1
31. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	1
31. 98	Recovery of accelerated depreciation.			0	31. 98
31. 99	Demonstration payment adjustment amount before sequestration			0	31. 99
32.00	Total amount payable to the provider (see instructions)			18, 534, 031	32. 00
32. 01	Sequestration adjustment (see instructions)			233, 529	32. 01
32. 02	Demonstration payment adjustment amount after sequestration			0	32. 02
	Interim payments			18, 131, 431	1
34. 00	Tentative settlement (for contractor use only)			0	
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02	•		169, 071	1
36. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, (chapter 1,	0	36. 00
	§115. 2				
EO 00	TO BE COMPLETED BY CONTRACTOR		T	277 440	E0 00
50. 00 51. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4 Outlier reconciliation adjustment amount (see instructions)			277, 468 0	50. 00 51. 00
51.00	The rate used to calculate the Time Value of Money			0.00	
53. 00	Time Value of Money (see instructions)			0.00	1
55. 66	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND	BEGINNING BEFORE THE FNI	O OF THE COVID-19		00.00
99. 00	Teaching Adjustment Factor for the cost reporting period immed			0.000000	99. 00
	Calculated Teaching Adjustment Factor for the current year. (s	3 .	J .,	0. 000000	•
	, J (-	/	'		

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3046	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2023 10:10 am
	Ti tla YIY	Hospi tal	DDC

		Title XIX	Hospi tal	PPS	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1. 00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant programs only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		0		8. 00
9.00	Ancillary service charges		0	0	
10.00	Organ acquisition charges, net of revenue		0		10. 00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		0	0	12. 00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for se	ervices on a charge	0	0	13. 00
	basis				
14. 00	Amounts that would have been realized from patients liable for pa		0	0	14. 00
45.00	a charge basis had such payment been made in accordance with 42 (CFR §413.13(e)			45.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	
16. 00	Total customary charges (see instructions)		0	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete only i	f line 16 exceeds	0	0	17. 00
40.00	line 4) (see instructions)	6.1.		0	40.00
18. 00	Excess of reasonable cost over customary charges (complete only i	T line 4 exceeds line	0	0	18. 00
19. 00	16) (see instructions)		o	0	19. 00
20. 00	Interns and Residents (see instructions)	ti ana)		0	
21. 00	Cost of physicians' services in a teaching hospital (see instructions) of the covered control the losses of line 4 or line 14).	LI OIIS)		0	
21.00	21.00 Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				21.00
22 00	Other than outlier payments	ipreted for 113 provider	0	0	22. 00
23. 00	Outlier payments			0	23.00
24. 00	Program capital payments			Ü	24. 00
	Capital exception payments (see instructions)				25. 00
	Routine and Ancillary service other pass through costs			0	1
27. 00	Subtotal (sum of lines 22 through 26)			0	1
28. 00	Customary charges (title V or XIX PPS covered services only)		l ől	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		l o	0	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		٩		27.00
30. 00	Excess of reasonable cost (from line 18)		ol	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		o	0	
	00 Deductibles		o	0	
33. 00			0	0	
			o	0	34.00
	00 Utilization review		o	· ·	35. 00
	00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		o	0	
	00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	, , , ,		ol	0	
	.00 Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40. 00			o	0	
41. 00				0	
42. 00				0	
43. 00	,			0	
	chapter 1, §115.2	•			
			· '		

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

Provider CCN: 15-3046

Peri od: Worksheet G From 01/01/2022 To 12/31/2022 Date/Time Prepared:

onl y)				10 12/31/2022	5/24/2023 10:	
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3. 00	4.00	
1 00	CURRENT ASSETS	T 50/ 445	.1			4 00
1. 00 2. 00	Cash on hand in banks Temporary investments	-526, 415		0 0		
3.00	Notes receivable				0	
4. 00	Accounts receivable	3, 165, 828		o o	Ö	
5.00	Other recei vable	0		0	0	1
6.00	Allowances for uncollectible notes and accounts receivable	-486, 402	•	0	0	
7. 00	Inventory	52, 236		0	0	
8. 00 9. 00	Prepaid expenses Other current assets	400, 142 -233, 720		0 0	0	
10.00	Due from other funds	-233, 720			· -	
11. 00	Total current assets (sum of lines 1-10)	2, 371, 669	1	o o		
	FIXED ASSETS					
12. 00	Land	0		0	l .	
13.00	Land improvements	0		0	l .	
14. 00 15. 00	Accumulated depreciation Buildings	39, 669, 405		0 0	0	
16. 00	Accumulated depreciation	-1, 966, 999	1		1	1
17. 00		67, 418	1		ĺ	1
18. 00	Accumul ated depreciation	-3, 153	1	0	0	1
19. 00	Fi xed equipment	0	1	0	0	
20. 00	Accumulated depreciation	0	1	0	0	
21. 00	Automobiles and trucks	0		0	0	
22. 00 23. 00	Accumulated depreciation Major movable equipment	520, 417		0 0	0	
	Accumulated depreciation	-44, 176	1		0	1
25. 00	Mi nor equipment depreciable	0	1	0	Ö	1
26. 00	Accumulated depreciation	0) (0	0	26. 00
27. 00	1	0		0	0	
28. 00	Accumulated depreciation	0	1	0		
29. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	38, 242, 912		0 0		
30.00	OTHER ASSETS	30, 242, 712	-	5 0		30.00
31.00	Investments	0) (0	0	31.00
32. 00	Deposits on Leases	0		0		
33. 00	Due from owners/officers	0		0		
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	10, 252, 325 10, 252, 325		0 0	1	
36. 00	Total assets (sum of lines 11, 30, and 35)	50, 866, 906	1		l .	
00.00	CURRENT LI ABI LI TI ES	1 00,000,700	1	5, 0		30.00
37. 00	Accounts payable	812, 742	! (0	0	37. 00
38. 00	1 3	480, 192	•	0	0	
39.00	Payroll taxes payable	10, 033	1	0		
40. 00 41. 00	Notes and loans payable (short term) Deferred income	225, 987	1	0 0	0	
42. 00	Accel erated payments				0	42.00
43. 00		0		0	0	1
	Other current liabilities	375, 464		0		
45. 00	Total current liabilities (sum of lines 37 thru 44)	1, 904, 418	3 (0	0	45. 00
44 00	LONG TERM LIABILITIES	1 0			0	44 00
46. 00 47. 00	Mortgage payable Notes payable		•	0 0	1	
48. 00	Unsecured Loans		l l		l .	
49. 00	Other long term liabilities	39, 192, 331		0		
50.00	Total long term liabilities (sum of lines 46 thru 49)	39, 192, 331		0	•	
51. 00	Total liabilities (sum of lines 45 and 50)	41, 096, 749) (0 0	0	51.00
E2 00	CAPITAL ACCOUNTS	0 770 157	,			1 52 00
52. 00 53. 00	General fund balance Specific purpose fund	9, 770, 157				52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted		`	0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	9, 770, 157	,	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	50, 866, 906		o o	ő	
	59)		1			

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-3046

				'	10 12/31/2022	5/24/2023 10:	
		General	Fund	Special Po	urpose Fund	Endowment Fund	
		1.00			1.00	5.00	
1 00	Fund balances at beginning of period	1.00	2. 00 757, 290	3. 00	4. 00	5. 00	1.00
1. 00 2. 00	Net income (loss) (from Wkst. G-3, line 29)		3, 761, 854			'	2.00
3. 00	Total (sum of line 1 and line 2)		4, 519, 144				3.00
4. 00	Additions (credit adjustments) (specify)	0	4, 317, 144	()	ĺ	
5.00	EQUITY TRANSFER	5, 287, 796		· ·		Ö	
6. 00	Legot I Tromor En	0, 20, , , , 0		(ol .	0	
7. 00				(Ö	
8.00		o		(0	
9.00		o		(0	
10.00	Total additions (sum of line 4-9)		5, 287, 796				10.00
11. 00	Subtotal (line 3 plus line 10)		9, 806, 940				11.00
12.00	Deductions (debit adjustments) (specify)	O		(0	12.00
13.00	PRIOR YEAR CORRECTIONS	36, 783		(0	13.00
14.00		O		(0	14.00
15.00		0		(0	15. 00
16.00		0		(0	16. 00
17. 00		0		(0	
18. 00	Total deductions (sum of lines 12-17)		36, 783)	18. 00
19. 00	Fund balance at end of period per balance		9, 770, 157				19. 00
	sheet (line 11 minus line 18)	Fredrimers Fred	DI+	E d			
		Endowment Fund	PI ant	Funa	-		
		6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0		(D		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0		(3. 00
4.00	Additions (credit adjustments) (specify)		0				4. 00
5.00	EQUITY TRANSFER		0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				8. 00
9.00	T + 1 + 11111 (C + 1 + 1)		O	,			9.00
10.00	Total additions (sum of line 4-9)	0		· ·			10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	U U		(7		11. 00
13. 00	PRIOR YEAR CORRECTIONS		0				13.00
14. 00	FRIOR TEAR CORRECTIONS		0				14. 00
15. 00			0				15. 00
16. 00			0				16.00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0	٩	(18. 00
19. 00	Fund balance at end of period per balance						19.00
	sheet (line 11 minus line 18)	1		`			1
	I SHEET (TITLE IT IIII HUS TITLE 10)		I				

PART PATTERN REVENUES 1.00 2.00 3.00				1	0 12/31/2022	Date/IIme Prep 5/24/2023 10:	
PART I - PATIENT REVENUES		Cost Center Description		Inpati ent	Outpatient		io aiii
PART I - PART BOUTINE SCRIPT BOUTINE SCRIPT SCRIP		3331 331131 33331 1 211 311			_		
General Inpatient Routine Services 1.00 Hospital 21,738,905 1.00 1.00 Hospital 21,738,905 21,738,905 21,738,905 2.00 3		PART I - PATIENT REVENUES				0.00	
SUBPROVIDER - IPF	1.00			21, 738, 905		21, 738, 905	1.00
4. 00 SUBPROVIDER	2.00	SUBPROVIDER - I PF					2.00
5.00 Swing bed - SNF	3.00	SUBPROVI DER - I RF					3.00
SWING Ded NF NO NO NO NO NO NO NO	4.00	SUBPROVI DER					4.00
Swing bed NF SWING PACE	5.00	Swing bed - SNF		0		o	5.00
7. 00 SKILLED MURSING FACILITY 0 0 0 0 0 0 0 0 0	6.00			0		o	6.00
0.00							7.00
10.00 Total general inpatient care services (sum of lines 1-9)	8.00	NURSING FACILITY					8.00
Intensive Care Type Inpatient Hospital Services	9.00	OTHER LONG TERM CARE		0		ol	9.00
Intensive Care Type Inpatient Hospital Services	10.00	Total general inpatient care services (sum of lines 1-9)		21, 738, 905		21, 738, 905	10.00
12.00 CORONARY CARE UNIT							
13. 00 BURN INTENSIVE CARE UNIT 13. 00 14. 00 15. 00 16. 00 17. 00 1	11.00	INTENSIVE CARE UNIT		0		0	11.00
14. 00 SURGICAL INTENSIVE CARE UNIT 14. 00 16. 00	12.00	CORONARY CARE UNIT		0		0	12.00
15. 00	13.00	BURN INTENSIVE CARE UNIT					13.00
Total intensive care type inpatient hospital services (sum of lines 10 and 16) 11-15 17-00 17-00 17-00 17-00 17-00 17-00 18-00 17-00 18-000 18-000	14.00	SURGI CAL INTENSI VE CARE UNIT					14.00
11-15 17-00 17-	15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
17. 00	16.00		lines	0		o	16.00
18. 00 Ancillary services 21, 168, 325 128, 320 21, 296, 645 18. 00 19							
19.00 Outpatient services 0 0 0 19.00	17.00	Total inpatient routine care services (sum of lines 10 and 16)		21, 738, 905		21, 738, 905	17.00
19.00 Outpatient services 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	18.00	Ancillary services		21, 168, 325	128, 320	21, 296, 645	18.00
21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 22.00 100ME HEALTH AGENCY 23.00 22.00 100ME HEALTH AGENCY 23.00 24.00 26.00	19.00	Outpati ent servi ces		0	o		19.00
22. 00 HOME HEALTH AGENCY 0 0 22. 00 23. 00 24. 00 25. 00 0 0 0 0 0 0 0 0 0	20.00	RURAL HEALTH CLINIC		0	o	0	20.00
23. 00 24. 00 CMHC	21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	o	0	21.00
24. 00 CMHC	22.00	HOME HEALTH AGENCY			o	0	22.00
24. 10 CORF 0 0 0 0 24. 10 25. 00 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 25. 00 25. 00 25. 00 0 0 0 25. 00 0 0 0 0 0 25. 00 0 0 0 0 0 0 0 0 0	23.00	AMBULANCE SERVICES					23.00
25. 00 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 25. 00 26. 00 HOSPICE 0 0 0 0 0 0 27. 00 OTHER (SPECIFY) 0 0 0 0 28. 00 G-3, line 1) PART II - OPERATING EXPENSES 29. 00 30. 00 31. 00 31. 00 32. 00 32. 00 33. 00 33. 00 34. 00 35. 00 34. 00 35. 00 35. 00 36. 00 37. 00 37. 00 38. 00 39. 00 39. 00 30. 00 30. 00 30. 00 31. 00 30. 00 32. 00 33. 00 33. 00 0 0 34. 00 0 35. 00 0 36. 00 0 37. 00 0 38. 00 0 39. 00 0 39. 00 0 39. 00 0 39. 00 0 39. 00 0 39. 00 0 39. 00 0 39. 00 39. 00 0 39. 00 30. 00 0 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 43. 00 60 10 60	24.00	CMHC			o	0	24.00
26.00	24. 10	CORF		0	o	0	24. 10
27.00 OTHER (SPECIFY) O O O O O O O O O	25.00	AMBULATORY SURGICAL CENTER (D. P.)		0	o	0	25.00
28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 42, 907, 230 128, 320 43, 035, 550 28.00	26.00	HOSPI CE		0	0	0	26.00
G-3, line 1) PART II - OPERATING EXPENSES 29. 00 30. 00 30. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 35. 00 36. 00 36. 00 37. 00 37. 00 37. 00 38. 00 39. 00 39. 00 39. 00 40. 00 41. 00 42. 00 42. 00 43. 00 Total operating expenses (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 20, 551, 215 43. 00 20. 551, 215 43. 00 20. 551, 215 20. 551	27.00	OTHER (SPECIFY)		0	o	0	27.00
PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY) O 30.00 31.00 32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) O Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer) 29.00 20,551,215 20,551,2	28.00	Total patient revenues (sum of lines 17-27) (transfer column 3	to Wkst.	42, 907, 230	128, 320	43, 035, 550	28.00
29. 00 Operating expenses (per Wkst. A, column 3, line 200) 30. 00 ADD (SPECIFY) 0 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) 43. 00 Total operating expenses (per Wkst. A, column 3, line 200) 29. 00 30. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 29. 00 20, 551, 215 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 20, 551, 215		G-3, line 1)					
30.00 ADD (SPECIFY) 0 30.00 31.00 32.00 32.00 33.00 34.00 35.00 35.00 35.00 35.00 36.00 35.00 36.00 37.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 0 42.00 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 20,551,215 43.00		PART II - OPERATING EXPENSES					
31.00 32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 36.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 0 31.00 32.00 33.00 32.00 33.00 33.00 33.00 33.00 33.00 34.00 35.00 36.00 37.00 36.00 37.00 37.00 38.00 39.00 40.00 41.00 42.00 42.00 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 20,551,215					20, 551, 215		
32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 0 32.00 33.00 33.00 33.00 34.00 35.00 36.00 37.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 0 43.00	30.00	ADD (SPECIFY)		0			30.00
33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 0 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00	31.00			0			31.00
34.00 35.00 36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 20.551, 215 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 43.00	32.00			0			32.00
35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 0 35.00 36.00 37.00 36.00 37.00 37.00 37.00 37.00 37.00 38.00 0 0 0 40.00 41.00 42.00 43.00	33.00			0			33.00
36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 20, 551, 215 43.00				0			
37. 00 DEDUCT (SPECIFY) 0 37. 00 38. 00 39. 00 0 39. 00 0 0 40. 00 0 41. 00 0 42. 00 Total deductions (sum of lines 37-41) 0 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 20, 551, 215 43. 00 20. 551, 215 20. 20. 20. 20. 20. 20. 20. 20. 20. 20.				0			
38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 20,551,215 43.00					0		
39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 20,551,215 43.00		DEDUCT (SPECIFY)		0			
40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 20, 551, 215 43.00				0			
41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 20,551,215 43.00				0			
42.00 Total deductions (sum of lines 37-41) 0 42.00 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 20,551,215 43.00				0			
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 20,551,215 43.00				0			
		·			0		
to Wkst. G-3, line 4)	43. 00		!)(transfer		20, 551, 215		43.00
		TO WKST. G-3, line 4)	I		ı l	I	

Heal th	Health Financial Systems PAM REHAB HOSP OF GREATER INDIANA In Lieu of Form CMS-2552				
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-3046	Peri od:	Worksheet G-3	
			From 01/01/2022 To 12/31/2022	Date/Time Pre	aarad.
			10 12/31/2022	5/24/2023 10:	
				0, 2 1, 2020 10:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	ne 28)		43, 035, 550	1. 00
2.00	Less contractual allowances and discounts on patients' accounts	nts		18, 761, 170	2.00
3.00	Net patient revenues (line 1 minus line 2)			24, 274, 380	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		20, 551, 215	4.00
5.00	Net income from service to patients (line 3 minus line 4)			3, 723, 165	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10. 00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12. 00	Parking lot receipts			0	12.00
13. 00	Revenue from Laundry and Linen service			0	13.00
14. 00	Revenue from meals sold to employees and guests			13, 068	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00	Revenue from sale of medical and surgical supplies to other	than patients		0	16. 00
17. 00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			21	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	OTHER REVENUE			600	24. 00
24. 50	COVI D-19 PHE Fundi ng			25, 000	
25. 00	Total other income (sum of lines 6-24)			38, 689	
	26.00 Total (line 5 plus line 25)			3, 761, 854	
27. 00	OTHER EXPENSES (SPECIFY)			0	27. 00
	28.00 Total other expenses (sum of line 27 and subscripts)			2 741 954	28. 00 29. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)		l	3, 761, 854	∠9. 00