				u of Form CMS-2552-10		
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Failu	re to report can resu	lt in all interim	FORM APPROVED	
payments made	since the beginning of the cost	t reporting period being d	eemed overpayments (4	2 USC 1395g).	OMB NO. 0938-0050	
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COS SUMMARY	ST REPORT CERTIFICATION	Provider CCN: 153028	From 01/01/2014	Worksheet S Parts I-III Date/Time Prepared: 5/28/2015 10:23 am	
PART I - COST	REPORT STATUS					
Provi der	1. [ X ] Electronically filed c	ost report		Date: 5/28/20	15 Time: 10:23 am	
use only	2. [ ] Manually submitted cos	t report				
	3. [ 0 ]If this is an amended report enter the number of times the provider resubmitted this cost report 4. [ F ]Medicare Utilization. Enter "F" for full or "L" for low.					
Contractor use only	5. [ 1 ]Cost Report Status 6 (1) As Submitted 7 (2) Settled without Audit 8 (3) Settled with Audit 9 (4) Reopened (5) Amended	. Contractor No.	this Provider CCN 12.			
PART II - CERTIFICATION						
UL OBERREATUTAT						

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 OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

## CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REHABILITATION HOSPITAL OF INDIANA (153028) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 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.

(Si gned)	

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

Date

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-20, 970	30, 594	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
12.00	CMHCI	0		0		0	12.00
200.00	Total	0	-20, 970	30, 594	0	0	200.00

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

-	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX I	REHABILITATI DENTIFICATION DA				N: 153028	Peri o			of For Norkshe		2552-10
							From	01/01/	/2014   I /2014   I	Part I Date/Ti 5/28/20	me Pre	pared:
	1.00		00		3.00				4.00	5720720	10 10.	
1 00	Hospital and Hospital Health Care Con											1 00
1.00 2.00	Street: 4141 SHORE DRIVE City: INDIANAPOLIS	PO Box: State: I	N 7	ip Code	e: 46254	4 Cou	unty: MAI	RION				1.00 2.00
		Component Na		CCN	CBSA		- Y	ate		nt Syste		
			N	lumber	Numbe	r Type	e Cert	ified		0, or		
		1.00		2.00	3.00	4.00	) 5	00	V 6.00	XVIII 7.00	XI X 8.00	
	Hospital and Hospital-Based Componen	t Identification:										
3.00		REHABILITATION H	OSPI TAL 1	53028	26900	D 5	01/0	7/1992	N	P	Р	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00 8.00	Swing Beds – SNF Swing Beds – NF											7.00 8.00
9.00	Hospital -Based SNF											9.00
	Hospital-Based NF											10.00
11. 00 12. 00	Hospi tal -Based OLTC Hospi tal -Based HHA											11.00 12.00
	Separately Certified ASC											13.00
	Hospital-Based Hospice											14.00
	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC											15.00 16.00
17.00	Hospital-Based (CMHC) I											17.00
17.10	Hospital-Based (CORF) I											17.10
18.00 19.00	Renal Dialysis											18.00 19.00
19.00	other							From	:	То	:	19.00
	1							1.00		2.0		
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						0.	1/01/2	014 4	12/31/	2014	20. 00 21. 00
22.00	Inpatient PPS Information Does this facility qualify and is it	currently receiv	/ing paymer	nts for	di spro	oporti ona	te	N		N		22.00
	share hospital adjustment, in accorda for yes or "N" for no. Is this facili	ance with 42 CFR ity subject to 42	§412.106? 2 CFR Secti	In co ion §41	lumn <sup>1</sup> ,	, enter "	Y"					
22. 01	amendment hospital?) In column 2, en Did this hospital receive interim und				s cost	roportin	a	Ν		Ν		22. 01
22.01	period? Enter in column 1, "Y" for ye	•				•	y	IN		IN		22.01
	reporting period occurring prior to (											
	for no for the portion of the cost re (see instructions)	eporting period o	occurring o	on or a	fter Oc	ctober 1.						
22. 02	Is this a newly merged hospital that	requires final u	uncompensat	ted car	e payme	ents to b	e	Ν		Ν		22.02
	determined at cost report settlement											
	or "N" for no, for the portion of the in column 2, "Y" for yes or "N" for r											
	or after October 1.			0031 1	cpor tri	ng period						
22.03	Did this hospital receive a geographi							Ν		Ν		22. 03
	of the OMB standards for delineating in column 1, "Y" for yes or "N" for r						er					
	prior to October 1. Enter in column 2	2, "Y" for yes or	"N" for r	no for	the poi	rtion of	the					
	cost reporting period occurring on or						i + h					
	hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3,			Junteu		or dance w						
23.00	Which method is used to determine Med	dicaid days on li	nes 24 and						2	Ν		23.00
	1, enter 1 if date of admission, 2 in method of identifying the days in thi											
	used in the prior cost reporting peri											
			In-State			Out-of	Out-c		ledicai		ther	
			Medicaid paid days			State Medicaid	Stat Medi ca		HMO day		i cai d ays	
			,	unpa	nid p	baid days	eligit	le			5-	
			1.00	day		2.00	unpai		E 00		00	
24.00	If this provider is an IPPS hospital,	enter the	1.00	2.0	0	3.00 C	4.00	0	5.00	0	. 00	24.00
00	in-state Medicaid paid days in column	n 1, in-state		-	Ĩ			Ĩ			0	
	Medicaid eligible unpaid days in colu											
	out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpaid											
	4, Medicaid HMO paid and eligible bu	t unpaid days in										
25.00	column 5, and other Medicaid days in			2	640	~			~	20		25.00
∠5.00	If this provider is an IRF, enter the Medicaid paid days in column 1, the i		742	∠	642	C		0	2	20		25.00
	Medicaid eligible unpaid days in colu	umn 2,										
	out-of-state Medicaid days in column											
	Medicaid eligible unpaid days in colu HMO paid and eligible but unpaid days											
	, , <u>,</u>				1			1				

From 01/01/2014         Part 1         Into 12/31/2014         Part 1         Part 1         Part	ION HOSPITAL OF INDIANA         In Lieu of Form CMS-2552-10		
2.00         Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.         1.00         2.00           cost reporting period. Enter "1" for urban or "2" for rural.         If a policable.         1         1           cost reporting period. Enter "1" for urban or "2" for rural.         If a policable.         1         1           cost reporting period.         Enter "1" for urban or "2" for rural.         If a policable.         1         0           36.00         Inter applicable beginning and ending dates of SUI status.         Subscript I ine 36 for number of periods.         8         0         2.00           36.00         Inter applicable beginning and ending dates of SUI status.         Subscript I ine 36 for number of periods.         1         0         2.00           37.00         If this is a kedicare dependent hospital.         0.00         1         0         2.00           38.00         Obees this facility qualify for the inpatient hospital payment adjustment for ice volume hospitals in accordance with 42 GR \$412.1010(2)(1)(1)" Enter in colum.         N         N         N           39.00         Dees this facility qualify for the inpatient hospital payment adjustment for ice volume hospital subject to the IAC program reduction adjustment for ice volume hospital subject to the IAC program reduction adjustment for ice volume hospital subject to the IAC preductions)         N <td>From 01/01/2014 Part I</td> <td>ITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA</td> <td>HOSPI 7</td>	From 01/01/2014 Part I	ITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	HOSPI 7
20.00       Enter your standard geographic classification (not wage) status at the beginning of the cost for profile periods. Enter "'' for yous or "'' for the of the geographic classification (not wage) status at the end of the cost for the density of the status at the end of the cost for the effect in the of the geographic reclassification (not wage) status at the end of the geographic classification (not wage) status at the end of the geographic classification (not wage) status at the end of the geographic classification (not wage) status at the end of the geographic classification (not wage) status at the end of the cost for end of the geographic reclassification in column 2.       Image: Control of the cost reporting period.         36.00       Deter applicable beginning and ending dates of SCI status. Subscript Line 36 for number of periods line access of one and enter subsequent dates.       Image: Control of the geographic classification (DN) and the status status at the ending dates of DN status in effect in the cost reporting period.       Image: Control of the geographic classification (DN) and the status at the ending dates of DN status in eacerdance with 42 CR 5412.01(bl) (2(11))? Entor in close on Image: Control on the cost of the cost of "N" for no line column 1, for discharges prior to dotober 1. Enter "Y" for yes or "N" for no line column 1, for discharges prior to dotober 1. Enter "Y" for yes or "N" for no line column 1, for discharges and or after 0 between the discreption of the cost of the cost of "N" for no line column 2. For discharges and or after 0 between the discreption on line of the cost	Urban/Rural S Date of Geogr		
27.00       Enter your ständard geographic classification (not wage) status at the end of the cost incoment in column 1.1" for prizand in register in column 1.1" for prizand in register the diffective date of the geographic reclassification in column 2.       1         28.00       Enter applicable beginning and ending dates of SCH status. Subscript Line 36 for number of periods UBH status. In effect in the cost reporting period.       1       0       2.00         28.00       Enter applicable beginning and ending dates of SCH status. Subscript Line 36 for number of periods UBH status. Subscript Line 36 for number of periods UBH status. Subscript Line 36 for number of periods in access of one and enter subsequent dates.       1.00       2.00         39.00       Does this facility qualify for the inpatient hospital payment adjusteen (For low volume N to reverse or 'N' for or use on 'N' for one. See instructions)       N       N       N         30.00       Fitter applicable beginning and ending 2.11 (St 12) (St 12	rage) status at the beginning of the 1 26.00		26.00
35.00       [If this is a sole community hospital (SO), enter the number of periods SOI status in effect in the cost reporting period.       Beginning.       Finding.         20.00       Exter applicable beginning and ending dates of SOI status. Subscript line 36 for number of periods MDI status.       0       2.00         37.00       If this is a Modicare dependent hospital (MD), enter the number of periods MDI status.       0       0         38.00       Distribution ing and ending dates of MDI status.       0       0       0         39.00       Does this facility qualify for the inpatient hospital payment adjustment for low volume in the cost reporting period.       N       N         39.00       Does this facility qualify for the langt ent hospital gayment adjustment for low volume in the optical subject to the HAC program reduction adjustment? Enter 'T' for yes or 'N' for proyes or 'N' for proyes or 'N' for noi. Csee instructions)       N       N         40.00       Is this hospital subject to the HAC program reduction adjustment? Enter 'T' for yes or 'N' for noi in column 1.0'' for yes or 'N' for inc in column 1.0'' for yes or 'N' for noi in column 1.0'' for yes or 'N' for noi in column 1.0'' for yes or 'N' for noi in column 1.0'' for yes or 'N' for noi in column 1.0'' for yes or 'N' for noi in column 1.0'' for yes or 'N' for noi in column 1.0'' for yes or 'N' for noi in column 1.0'' for yes or 'N' for noi in column 1.0'' for yes or 'N' for noi in column 1.0'' for yes or 'N' for noi.       N         10.00       Statis facility adjustment for disproportionate share in accordance N N       N	rage) status at the end of the cost 1 27.00 r "2" for rural. If applicable,	0 Enter your standard geographic classification (not wage reporting period. Enter in column 1, "1" for urban or "	27.00
Solo         Enter applicable beginning and ending dates of SCI status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.         1.00         2.00           38.00         In effect in the cost reporting period.         where the number of periods NDH status         0		00 If this is a sole community hospital (SCH), enter the r	35.00
36.00 Enter applicable beginning and ending dates of SCH status. Subscript I line 36 for number of periods in excess of one and enter subsequent dates.       0         37.00 [F this is a Medicare dependent hospital (MOH), enter the number of periods MOH status in effect in the cost reporting period.       0         38.00 [Enter applicable beginning and ending dates of MOH status. Subscript I line 38 for number of periods in excess of one and enter subsequent dates.       V/N       V/N         39.00 Does this facility quality for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR \$412.101(b) (2) (11)? Enter in column 1 'Y' for yes or 'N' for no. (see instructions)       N       N         30.00 [Is this hospital subject to the MC pergam reduction adjustment? Enter 'Y' for yes or 'N' for no in colum 1. for discharges prior to 0ctober 1. (see instructions)       N       N         30.00 [Is this facility quality and receive Capital       payment? Enter '' for yes or 'N' for no.       N       N         45.00 [Does this facility eligible for additional payment exception for extraordinary circumstances parsamit to 42 CFR \$412.348(7)? If yes, complete Wesht. L. Pt. I through N       N       N         47.00 [Is this a new hespital under 42 CFR \$412.300 PS capital? Enter 'Y' for yes or 'N' for no.       N       N       N         47.00 [It in this has a shoppital       interiming residents in approved (ME pergamas? Enter 'Y' for yes or 'N' for no.       N       N         47.00 [It into is has pay ital       inter' '' for yes or 'N' for no.			
37. 00       If this is a Medicare dependent hospital (WH), enter the number of periods MDH status of periods in excess of one and enter subsequent dates.       V/N       V/N         38. 00       Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.       V/N       V/N         39. 00       Does this facility quality for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 6412.101(b) (2) (1)? Enter in column 1 'Y' for yes or or 'N' for no. loos the facility meet the mileage requirements in accordance with 42 CFR 412.101(b) (2) (1)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)       N       N         100       Does this facility quality and receive Capital payment for disproportionate share in accordance with 42 CFR Section 9412.320? (See instructions)       N       N       N         100       Jose this facility eligible for additional payment for disproportionate share in accordance with 42 CFR Section 9412.320? (See instructions)       N       N       N         40. 00       Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 541.348(?)? If yes, completer Wist. L, Pt. I Imorgh       N       N         40. 00       Is this facility eligible for additional payment? Enter 'Y' for yes or 'N' for no.       N       N         41. 00       CFR 541.348(?)? If yes, completer Wist. L, Pt. I Imorgh       N       N         42. 00       Is this facil	tatus. Subscript line 36 for number 36.00		36.00
or periods in excess of one and enter subsequent dates.         Y/N         Y/N           20.00         Does this facility qualify for the inpatient hospital payment adjustment for low volume         N           0.01         String accordance with 42 CFR §412.101(b)(2)(11)? Enter in column 1 'Y' for yes or 'N' for no. (see Instructions)         N           0.02         In column 2, for all scharges on or after October 1. Enter 'Y' for yes or 'N' for no in column 1, for all scharges on or after October 1. See Instructions)         N         N           0.01         Is this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR §412.300 (PS capital 2000) (See Instructions)         V         V/III           40.00         Is this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR §412.348(f)? If yes, complete Wkst. L. P. III and Wkst. L-1, Pt. I through Pt. III.         N         N           40.00         Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.         N         N           41.00         Is this a new hospital under 42 CFR §412.300 PPS capital payment? Enter 'Y' for yes or 'N' for no.         N         N           42.00         Is this a new hospital under 42 CFR §412.201 (Period and any which we have have any for the column 1. If column 1.         N         N           43.00         Is this a new hospital under 42 CFR §412.300 PPS capital Pereor 'N' for no.         N         N		00 If this is a Medicare dependent hospital (MDH), enter 1	37.00
V/N         V/N         V/N         V/N           30.00         Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(11)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(11)? Enter in column 2 'Y' for yes or 'N' for no. (See Instructions)         N         N           40.00         Is this hospital subject to the MA program reduction adjustment? Enter 'Y' for yes or 'N' for 'No in column 2, for discharges on or after October 1. (See Instructions)         N         N         N           50.00         Dest his facility qualify and receive Capital payment to A2 CFR \$412.300? (See Instructions)         N         N         N           60.01         Is facility qualify and receive Capital pursuant to A2 CFR \$412.348(f)? If yes, complete Mkst L, Pt. II and Mkst L, Pt. I through pursuant to A2 CFR \$412.348(f)? If yes, complete Mkst L, Pt. II and Mkst L, Pt. I through pursuant to A2 CFR \$412.348(f)? If yes, complete Mkst L, Pt. II and Mkst L, Pt. I through pursuant to A2 CFR \$412.348(f)? If yes, complete Mkst L, Pt. II and Mkst L, Pt. I through pursuant to A2 CFR \$412.348(f)? If yes, complete Mkst L, Pt. II through pursuant to A2 CFR \$412.348(f)? If yes, complete Mkst L, Pt. II through pursuant to A2 CFR \$412.348(f)? If yes, complete Mkst L, Pt. III and Mkst L, I, Pt. I through pursuant to A2 CFR \$412.348(f)? If yes, complete Mkst L, Pt. III and Mkst L, I, Pt. III and Kst L, Pt. III and Kst			38.00
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 5412.101(b) (2) (1)? Entor in column 1.17* for yess or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b) (2) (1)? Entor in column 2.1* for yess or "N" for no. See Instructions)       N       N         40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "V" for yess or "N" for no. In column 1. for discharges prior to October 1. Enter "V" for yess or "N" for no. To discharges prior to October 1. Enter "V" for yess or "N" for no.       N       N         45.00 Dees this facility qualify and receive Capital       V       XVIIII       1.00       2.00         46.00 Is this a not halfa 220° (see instructions)       N       N       N       N         47.00 Is this a now hospital would dot dot for extraord nary circumstances       N       N       N       N         47.00 Is this a now hospital involved in training residents in approved GME programs? Enter "Y" for yess or "N" for no.       N       N       N         47.00 Is this a hospital survolved in training residents in approved GME programs? Enter "Y" for yess or "N" for no.       N       N       N         48.00 Is the facility event complete Wstt. L-2.Pt. II and Wst. L-1, Pt. I	Y/N Y/N	bi perious in excess of one and enter subsequent dates.	
CFR 412.101(b)(2)(1)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)       N       N         ALO 01 st his hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges prior to October 1. Enter "Y" for yes or "N" for no.       N       N         Prospective Payment System (PPS)-Capital       V XVIII       1.00 2.00 1       2.00 1         Brospective Payment System (PPS)-Capital       N       N       N       N         6.00 Is this facility qualify and receive Capital payment for disproportionate share in accordance with facility Get additional payment texception for extraordinary circumstances pursuant to 42 CFR \$412.300 (See instructions)       N <td< td=""><td>I payment adjustment for low volume N N 39.00 i)? Enter in column 1 "Y" for yes</td><td>hospitals in accordance with 42 CFR §412.101(b)(2)(ii)</td><td>39.00</td></td<>	I payment adjustment for low volume N N 39.00 i)? Enter in column 1 "Y" for yes	hospitals in accordance with 42 CFR §412.101(b)(2)(ii)	39.00
V         XVIII           Prospective Payment System (PPS)-Capital         1.00         2.00           Column 1         5.00         Does this Facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 5412.3207 (see instructions)         N         N           Column 1         1.00         2.00         1         N         N           Model State         1.01         2.02         1         N         N           Model State         1.01         2.02         1         1.00         2.00         1           Model State         1.01         2.02         1         1.00         2.00         1           Model State         1.01         2.02         1.01         1.00         2.00         1           Model State         1.02         2.02         1.01         1.00         1.01         1.00         2.00         1           Model State         1.00         1.01         1.02         1.00         1.01         1.00         1.01         1.00         1.01         1.00         1.01         1.00         1.01         1.00         1.01         1.00         1.01         1.00         1.01         1.00         1.00         1.01         1.00 <t< td=""><td>or "N" for no. (see instructions) n adjustment? Enter "Y" for yes or N N 40.00 ber 1. Enter "Y" for yes or "N" for</td><td>CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or Is this hospital subject to the HAC program reduction a "N" for no in column 1, for discharges prior to October</td><td>40. 00</td></t<>	or "N" for no. (see instructions) n adjustment? Enter "Y" for yes or N N 40.00 ber 1. Enter "Y" for yes or "N" for	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or Is this hospital subject to the HAC program reduction a "N" for no in column 1, for discharges prior to October	40. 00
Prospective Payment System (PPS)-capital           65.00         Does this Facility qualify, and raceive (Capital payment for disproportionate share in accordance with 42 (FR Section 5412, 3207 (see instructions)         N         N           46.00         Is this facility qualify, and raceive (Capital payment exception for extraordinary circumstances pursuant to 42 (FR §412, 348(f)?) If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.         N         N           47.00         Is this a new hospital under 42 CFR §412, 300 PPS capital? Enter "Y for yes or "N" for no.         N         N           48.00         Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.         N         N           56.00         If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1         Start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1         Start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no.         N           9.00         Are so this facility elect cost reinbursement for physicians' services as defined in CMS pub. 15-1, \$ 21487 If yes, complete Wkst. D-2, Pt. I.         N         N           60.00         Direct Wkst. D. Parts III & IV and D-2, Pt. IV, if applicable.         N         N         N           80.00         M line 56 is yes, did this facility elect cost reinbursement for phys	V XVIII XIX	no in column 2, for discharges on or after October 1. (	
with 42 CFR Section \$412.320? (see instructions)       N       N         46.00       Is this Facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR \$412.308(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.       N       N         47.00       Is this a new hospital under 42 CFR \$412.300 PPS capital? Enter "Y for yes or "N" for no.       N       N       N         48.00       Is this a new hospital under 42 CFR \$412.300 PPS capital? Enter "Y for yes or "N" for no.       N       N       N         56.00       Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "N" for no in colum 1. If column 1 is "N" for no in colum 1. If column 1 is "N" for no in colum 1. If column 1 is "N" complete Wkst. D. Parts III & IV and D-2, Pt. II, if applicable.       N       N         50.00       Are casts claimed at this facility elect cost reimbursement for physiclans' services as defined in CMS Pub. 15-1, § 21487 If yes, complete Wkst. D-5.       N       N         50.00       Are casts claimed on line 100 of Worksheet A? If Py ses, complete Wkst. D-2, Pt. I.       N       N         61.00       Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. Geo instructions)       Direct GME       IME       Direct GME         61.00       Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in colum 1. Geo instructions)	1.00 2.00 3.00	Prospective Payment System (PPS)-Capital	
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.       N         47.00 Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no. Teaching Hospitals       N       N         56.00 Is this a new hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.       N       N         57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1.       If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.       N         58.00 If line 56 is yes, did this facility elect cost reporting period? Enter "V" for yes or "N" for no in colum 1.       N       N         58.00 If line 56 is yes, did this facility elect cost rephyticals: "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.       N       N         59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.       N       N         60.00 Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under \$413.85? Enter "Y" for yes or "N" for no in column 1. (see instructions)       Direct GME       IME       Direct GME         61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)       N       0.00       0.00         61.01 Enter the average number of unweighted primary care instructions)       <		with 42 CFR Section §412.320? (see instructions)	
48.00       Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.       N       N         56.00       Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.       Y       Y         56.00       Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.       Y       Y         56.00       In the 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2.       N         56.00       If line 56 is yes, idid this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 21487 If yes, complete Wkst. D-2, Pt. I.       N       N         59.00       Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.852 Enter "Y" for yes or "N" for no in column 1. (see instructions)       N       0.00       0.00         61.00       Did your hospital receive FTE slots under ACA section 55037 Enter "Y" for yes or "N" for no in column 1. (see instructions)       N       0.00       0.00       0.00         61.00       Did your hospital receive for March 23, 2010. (see instructions)       N       0.00       0.00       0.00       0.00       0.00       0.00       0	eption for extraordinary circumstances N N N 46.00 t. L, Pt. III and Wkst. L-1, Pt. I through 46.00	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst.	40.00
56.00       Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.       Y         57.00       If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1. If column 1. If column 2. If column 2 is "W, complete Wrst. D. Provider E4. If column 2 is "W, complete Wrst. D. Provider E4. If column 2 is "N", complete Wrst. D. For physicians' services as N         58.00       If line 56 is yes, did this facility elect cost reinbursement for physicians' services as N         60.00       If line 56 is yes, did this facility elect cost reinbursement for physicians' services as N         61.00       Are costs claimed on line 100 of Worksheet A7 If yes, complete Wkst. D-2. Pt. I.       N         61.00       Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)       N         61.00       Did your hospital' receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)       N       0.00         61.01       Enter the averge number of unweighted primary care FTEs from the hospital's 3 most recent cost reports and primary care FTEs added under section 5503 of ACA). (see instructions)       N       0.00       0.00         61.02       Enter the current year total unweighted primary care fTE count (excluding 0B/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)       N       0.00		00 Is the facility electing full federal capital payment?	
57.00       If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wst. D, Parts III & IV and D-2, Pt. II, if applicable.       N         58.00       If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wst. D-5.       N       N         59.00       Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.       N       N         60.00       Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.82? Enter "Y" for yes or "N" for no. in column 1. (see instructions)       N       IME       Direct GME         61.00       Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)       N       0.00       0.00         61.02       Enter the average number of unweighted primary care ending and submitted before March 23, 2010. (see instructions)       0.00       0.00       0.00         61.02       Enter the current year total unweighted primary care and primary care FTEs added under section 5503 of ACA). (see instructions)       0.00       0.00       0.00       0.00       0.00	approved GME programs? Enter "Y" for yes Y 56.00	00 Is this a hospital involved in training residents in ap	56.00
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.       N         58.00       If line 56 is yes, did this facility elect cost reimbursement for physiclans' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-2, Pt. I.       N         59.00       Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.       N         60.00       Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)       N         61.00       Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)       N       0.00         61.01       Enter the average number of unweighted primary care FTE stors under ACA section solution the before March 23, 2010. (see instructions)       N       0.00       0.00         61.02       Enter the current year total unweighted primary care And primary care FTE sudded under section 5503 of ACA). (see instructions)       0.00       0.00       0.00         61.03       Enter the current year total unweighted primary care And primary care FTE sudded under section 5503 of ACA). (see instructions)       0.00       0.00       0.00         61.03       Enter the base line FTE count for primary care And primary care And primary care FTE sudded under section 5503 of ACA). (see instructions)       0.00       0.00       0.00         61.03       Enter the base line FTE count fo	r yes or "N" for no in column 1. If column 1 th of this cost reporting period? Enter "Y"	00 If line 56 is yes, is this the first cost reporting per GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first month	57.00
defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5.       N         59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.       N         60.00 Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)       N         60.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)       Direct GME       IME       Direct GME         61.01 Enter the average number of unweighted primary care ending and submitted before March 23, 2010. (see instructions)       0.00       0.00       0.00       0.00         61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GVN, general surgery FTEs, and primary care FTE sadded under section 5503 of ACA). (see instructions)       0.00       0.00       0.00         61.03 Enter the base line FTE count for primary care instructions)       0.00       0.00       0.00       0.00         61.04 Enter the number of unweighted primary care instructions)       0.00       0.00       0.00       0.00         61.03 Enter the base line FTE count for primary care instructions)       0.00       0.00       0.00       0.00         61.04 Enter the number of unweighted primary care instructions)       0.00       0.00       0.00       0.00         61.03 Enter the base line FTE count for primary care instr	I, if applicable.	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II,	58.00
provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)IMEDirect GMEIMEV/NIMEDirect GMEIMEDirect GME1.002.003.004.005.0061.00Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)0.000.0061.01Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports entructions)0.000.000.0061.02Enter the current year total unweighted primary care FTE count (excluding 0B/GYN, general surgery FTEs, and primary care FTE added under section 5503 of ACA). (see instructions)0.000.000.0061.03Enter the base line FTE count for primary care instructions)0.000.000.000.0061.04Enter the number of unweighted primary care/or surgery all opathic and/or osteopathic FTEs in the current year's0.000.000.0061.05Enter the difference between the baseline primary care/or and/or general surgery FTEs and the current year's0.000.000.00			59.00
Y/NIMEDirect GMEIMEDirect GMEIMEDirect GMEIMEDirect GME61.00Di your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)N0.000.0061.01Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)N0.000.0061.02Enter the current year total unweighted primary care FTE count (excluding 0B/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)0.000.000.0061.03Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)0.000.000.0061.04Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).0.000.000.0061.05Enter the difference between the baseline primary and/or general surgery FTEs and the current year's0.000.000.00			60.00
61.00Did your hospital receive FTE slots under ACAN0.00section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)0.000.0061.01Enter the average number of unweighted primary care ending and submitted before March 23, 2010. (see instructions)0.000.0061.02Enter the current year total unweighted primary care FTE count (excluding 0B/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)0.000.0061.03Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)0.000.0061.04Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).0.000.0061.05Enter the difference between the baseline primary and/or general surgery FTEs and the current year's0.000.00			
section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)61.01Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)0.000.0061.02Enter the current year total unweighted primary care FTE count (excluding 0B/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)0.000.0061.03Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)0.000.0061.04Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).0.000.0061.05Enter the difference between the baseline primary 	1.00 2.00 3.00 4.00 5.00	-	
61.01Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)0.000.0061.02Enter the current year total unweighted primary care FTE count (excluding 0B/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)0.000.0061.03Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)0.000.0061.04Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).0.000.0061.05Enter the difference between the baseline primary and/or general surgery FTEs and the current year's0.000.00	N 0.00 0.00 61.00	section 5503? Enter "Y" for yes or "N" for no in	61.00
61.02Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)0.000.0061.03Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)0.000.0061.04Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).0.000.0061.05Enter the difference between the baseline primary and/or general surgery FTEs and the current year's0.000.00	0.00 0.00 61.01	11 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see	61.01
ACA). (see instructions)61.03Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)61.04Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).61.05Enter the difference between the baseline primary and/or general surgery FTEs and the current year's	0.00 0.00 61.02	2 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,	61. 02
instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's 0.00 0.00	0.00 0.00 61.03	ACA). (see instructions) 33 Enter the base line FTE count for primary care and/or general surgery residents, which is used for	61. 03
current cost reporting period. (see instructions).61.05Enter the difference between the baseline primary and/or general surgery FTEs and the current year's0.00	0.00 0.00 61.04	instructions) 04 Enter the number of unweighted primary care/or	61. 04
		current cost reporting period. (see instructions). 5 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's	61.05
61.04 minus line 61.03). (see instructions)61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		61.04 minus line 61.03). (see instructions) 6 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary	61.06

HOSPI TAL AN	D HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA	Provi der		eriod: rom 01/01/2014 o 12/31/2014	Worksheet S-2 Part I Date/Time Pre 5/28/2015 10:	pared:
			Program	n Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. (	00	2.00	3.00	4.00	
speci for e colum progr unwei FTE u 1.20 Of th progr resid instr enter 3, th	e FTEs in line 61.05, speci alty, if any, and the numbe ach new program. (see instr in 1, the program name, ente am code, enter in column 3, ghted count and enter in co nweighted count. e FTEs in line 61.05, speci am specialty, if any, and t lents for each expanded prog uctions) Enter in column 1, in column 2, the program c e IME FTE unweighted count rect GME FTE unweighted count	r of FTE residents uctions) Enter in r in column 2, the the IME FTE Jumn 4, direct GME fy each expanded he number of FTE ram. (see the program name, ode, enter in column and enter in column				0.00		61. 1
I, ui	reet ome the annergined cod				1			
							1.00	
	rovisions Affecting the Hea the number of FTE resident					od for which	0.00	42 0
	hospital received HRSA PCRE			this cost	reporting peri	od for which	0.00	62.00
2.01 Énter durin	the number of FTE resident g in this cost reporting pe	s that rotated from a riod of HRSA THC prog	a Teaching H gram. (see i			your hospital	0.00	62. 0 <sup>.</sup>
3.00 Has y	<u>ing Hospitals that Claim Re</u> our facility trained reside for yes or "N" for no in col	nts in nonprovider se	ettings duri		instructions)		N	63.00
					Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					1.00	2.00	3.00	1
	on 5504 of the ACA Base Yea				This base year	is your cost r	eporting	
4.00 Enter in th resid setti resid	d that begins on or after J in column 1, if line 63 is e base year period, the num ent FTEs attributable to ro ngs. Enter in column 2 the ent FTEs that trained in yo olumn 1 divided by (column	yes, or your facilit ber of unweighted non tations occurring in number of unweighted ur hospital. Enter in 1 + column 2)). (see	ty trained r p-primary ca all nonprov non-primar column 3 t instruction	residents re rider ry care he ratio rs)	0. OC			
		Program Name	Program	n Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
1		1.00	2. (	00	3.00	4.00	5.00	
is ye train year assoc FTEs progr resid the p colum unwei resid rotat non-p colum	in column 1, if line 63 s, or your facility ed residents in the base period, the program name iated with primary care for each primary care am in which you trained ents. Enter in column 2, rogram code, enter in n 3, the number of ghted primary care FTE ents attributable to ions occurring in all rovider settings. Enter in n 4, the number of ghted primary care ent FTEs that trained in				0. 00	0.00	0. 000000	

	Financial Systems AL AND HOSPITAL HEALTH CARE COMP		ION HOSPITAL			l Peri od:	n Lieu	u of For Workshe		
позетт	AL AND HUSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA		1 OVI dei	1	From 01/01, To 12/31,		Part I Date/Ti	me Pre	pared:
					Unwei ghted	Unwei gh		5/28/20 Ratio (c		14 am
					FTEs Nonprovi der	FTES Hospit		(col. 1 2)		
					Si te 1.00	2.00	)	3. 0	00	
	Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider	Setti ng						
66.00	Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit	nber of unweighted non-primary care resident       0.00         ations occurring in all nonprovider settings.       0.00         nber of unweighted non-primary care resident       0.00         ^ hospital. Enter in column 3 the ratio of       0.00         umn 1 + column 2)). (see instructions)       0.00						0.	000000	66.00
		Program Name	Program	Code	Unweighted	Unwei gh		Ratio (c		
					FTEs Nonprovider Site	FTEs i Hospi t		(col. 3 4)		
(7.00	Fatos in column 1, the average	1.00	2.00		3.00	4.00		5.0		(7.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				O. C		0.00	0.	000000	87.00
							1.00	2.00	3.00	
70. 00	Inpatient Psychiatric Facility P Is this facility an Inpatient Ps	ychiatric Facility (I	PF), or does	it conta	ain an IPF sub	provi der?	N			70.00
71.00	Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th		oproved GME t	eachi ng 🏻	program in the	e most			0	71.00
	recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, ente reporting period covers the begi or subsequent academic years of instructions) For cost reporting reporting period covers the begi	lumn 2: Did this faci R 412.424 (d)(1)(iii) r 1, 2, or 3, in colu nning of the fourth y the new teaching prog periods beginning or nning of the sixth or	lity train r (D)? Enter " umn 3. (see i year, enter 4 gram in exist n or after Oc any subsequ	esidents Y" for ye nstructio in colur ence, en tober 1, ent acade	in a new teac es or "N" for ons) If this c nn 3, or if th ter 5. (see 2012, if this	ching no. cost ne fifth s cost				
	teaching program in existence, e Inpatient Rehabilitation Facilit	y PPS								
	Is this facility an Inpatient Re subprovider? Enter "Y" for yes	and "N" for no.					Y			75.00
76.00						Y	N	0	76.00	
								1. 0	00	
80.00	Long Term Care Hospital PPS Is this a long term care hospita	( TCH)? Enter "V"	for ves and	"N" for r	10			N		80.00
	Is this a LTCH co-located within "Y" for yes and "N" for no.					ŋ period? E	nter	N		81.00
	TEFRA Providers Is this a new hospital under 42 Did this facility establish a ne \$413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider (	(excluded uni				no.	N		85. 00 86. 00

Health Financial Systems REHABILITATION HOS				n Lie	u of Form		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der		eriod: rom 01/01/ o 12/31/		Workshee Part I Date/Tim 5/28/201	e Pre	pared:
		·	V		XI X		
Title V and XIX Services			1.00		2.00		
90.00 Does this facility have title V and/or XIX inpatient hospita yes or "N" for no in the applicable column.	al services? Ei	nter "Y" for	N		Y		90.00
91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the appl			N		N		91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (du instructions) Enter "Y" for yes or "N" for no in the applica	ual certificati				N		92.00
93.00 Does this facility operate an ICF/MR facility for purposes of "Y" for yes or "N" for no in the applicable column.		XIX? Enter	N		N		93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for no	o in the	N		N		94.00
95.00  If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			N	0. 00	Ν	0.00	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	olicable colum	n		0.00	-	0.00	97.00
$105.00$ Does this hospital qualify as a Critical Access Hospital (C/ $106.00$ ] If this facility qualifies as a CAH, has it elected the all $\cdot$		hod of payment	N				105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If this facility qualifies as a CAH, is it eligit							107.00
for I &R training programs? Enter "Y" for yes or "N" for no instructions) If yes, the GME elimination would not be on WI the program would be cost reimbursed. If yes complete Wkst. this facility is a CAH, do I&Rs in an approved medical educa CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or '	kst. B, Pt. I, D-2, Pt. II. ( ation program <sup>-</sup>	col. 25 and Column 2: If train in the					
instructions) 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N				108.00
	Physi cal 1.00	Occupational 2.00	Speec 3.00		Respi ra 4.00		
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		N		109. 00
			1		1 00		
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (410	A Demo)fo	r	1.00 N		110. 00
				1.00	) 2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2.	If column 2 i	is "E", enter i	n column	N		0	115.00
3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provided Pub. 15-1, §2208.1.	rs) based on th	he definition i					
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insur no.	rance? Enter "	Y" for yes or '		N Y			116.00 117.00
118.00 Is the mal practice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 i			1			118.00
		Premi ums	Losse	S	Insurar	nce	
		1.00	2.00		3.00		
118.01 List amounts of malpractice premiums and paid losses:		74, 490		0		0	118.01
			1.00		2.00		
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scher and amounts contained therein.			N				118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold	d Harmless pro	vision in ACA	N		N		119. 00 120. 00
§3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment for the formation of the f	he Outpatient						
Enter in column 2, "Y" for yes or "N" for no. 121.00Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable devices	s charged to	N				121.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N"	for no. If	N				125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en		fication date					126. 00
in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, en-	ter the certifi	ication date					127. 00
in column 1 and termination date, if applicable, in column 2	∠.		1				1

Health Financial Systems	REHABILITATION HOS			In Lie	eu of Form CMS-	-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	CIDENTIFICATION DATA	Provi der		eriod: rom 01/01/2014	Worksheet S-2 Part I	2		
				0 12/31/2014	Date/Time Pre			
					5/28/2015 10:			
128.00 If this is a Medicare certified li	or transplant contor on	tor the cortifi	cation data	1.00	2.00	128.00		
in column 1 and termination date,			cation date			120.00		
129.00 If this is a Medicare certified lu column 1 and termination date, if		er the certific	ation date in			129.00		
130.00 If this is a Medicare certified pa	ncreas transplant center,		i fi cati on			130. 00		
date in column 1 and termination d 131.00 If this is a Medicare certified in	testinal transplant cente	r, enter the ce	erti ficati on			131.00		
date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified islet transplant center, enter the certification date								
in column 1 and termination date, if applicable, in column 2. 133.00 If this is a Medicare certified other transplant center, enter the certification date								
in column 1 and termination date,	f applicable, in column	2.				133.00		
134.00 If this is an organ procurement or and termination date, if applicabl		ne UPU number i	n column I			134.00		
All Providers 140.00 Are there any related organization	or home office costs as	defined in CMS	Pub 15-1	Y	15H059	140.00		
chapter 10? Enter "Y" for yes or "	N" for no in column 1. If	yes, and home	office costs	1	131103 7	140.00		
are claimed, enter in column 2 the 1.00	home office chain number		i ons)	3.00				
If this facility is part of a chai			ugh 143 the na		of the			
home office and enter the home off				-l - Number 001(	21	1.4.1 .00		
141.00Name: IU HEALTH 142.00Street: 340 W 10TH STREET	Contractor's Name: WF PO Box:	25	Contractor	r's Number: 0810	)	141.00 142.00		
143.00 City: INDIANAPOLIS	State: II	N	Zip Code:	4620	)2	143.00		
					1.00	-		
144.00 Are provider based physicians' cos					N	144.00		
145.00 If costs for renal services are cl only? Enter "Y" for yes or "N" for		e 74, are the c	costs for inpa	tient services	N	145.00		
146.00 Has the cost allocation methodolog	, changed from the previo	usly filed cost	report?	1.00 N	2.00	146.00		
Enter "Y" for yes or "N" for no in				14		140.00		
the approval date (mm/dd/yyyy) in 147.00Was there a change in the statisti		vec or "N" for	20	N		147.00		
148.00 Was there a change in the order of				N		147.00		
149.00 Was there a change to the simplifi	ed cost finding method? E	nter "Y" for ye	es or "N" for	N		149.00		
no.		Part A	Part B	Title V	Title XIX			
Does this facility contain a provi	don that qualifier for an	1.00	2.00	3.00	4.00	_		
or charges? Enter "Y" for yes or "								
155.00Hospi tal		N	N	N	N	155.00		
156.00 Subprovider - IPF 157.00 Subprovider - IRF		N	N N	N N	N N	156.00		
158. 00 SUBPROVI DER						158.00		
159. 00 SNF		N	N	Ν	Ν	159.00		
160.00HOME HEALTH AGENCY 161.00CMHC		N	N N	N N	N N	160.00		
161. 10 CORF			N	N	N	161.10		
<sup>1</sup>					1.00	_		
Mul ti campus					1.00			
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	npus hospital that has on	e or more campu	ises in differ	ent CBSAs?	N	165.00		
	Name	County		Code CBSA	FTE/Campus			
166.00 If line 165 is yes, for each	0	1.00	2.00 3.	. 00 4. 00	5.00	0 166. 00		
campus enter the name in column					0.0			
0, county in column 1, state in								
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in								
column 5 (see instructions)								
					1.00	-		
Heal th Information Technology (HIT	) incentive in the Americ	an Recovery and	d Reinvestment	Act		4/7.05		
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10	under Section §1886(n)? 5 is "Y") and is a meaning	Enter "Y" for aful user (line	yes or "N" fo 167 is "Y")	r no. enter the	N	167.00 0168.00		
reasonable cost incurred for the H				SILCE LIG				
169.00 If this provider is a meaningful u		is not a CAH (	[line 105 is "	N"), enter the	0.0	0169.00		
transition factor. (see instructio	13/				I	1		

Health Financial Systems	u of Form CMS-	2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CCN: 153028	Period:	Worksheet S-2	2	
		From 01/01/2014 To 12/31/2014		narod		
		10 12/31/2014	5/28/2015 10:	14 am		
	Begi nni ng 1. 00					
	2.00					
170.00 Enter in columns 1 and 2 the EHR begi period respectively (mm/dd/yyyy)		170.00				
				1.00		
171.00 If line 167 is "Y", does this provide Medicare cost plans reported on Wkst.	N	171.00				
(see instructions)						

	2	ABILITATION HOSPITAL OF IN	In Lieu of Form CMS-255			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE Provi d		Period: From 01/01/2014 To 12/31/2014		epared:
				Y/N	Date	
	Constal Instruction, Entor V for all VES room	oncoc Entor N for all NO	rochoncoc Ento	1.00	2.00	-
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format.	onses. Enter N for all No	responses. Ente	r an uates in	the	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation			•	1	1
1.00	Has the provider changed ownership immediatel reporting period? If yes, enter the date of t	y prior to the beginning the change in column 2 (s	of the cost ee instructions)	N		1.00
	Treporting period: Triges, enter the date of t	the change in corumn 2. (3	Y/N	Date	V/I	
	1		1.00	2.00	3.00	
2.00	Has the provider terminated participation in yes, enter in column 2 the date of terminatic voluntary or "I" for involuntary.		r N			2.00
3.00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or f	, chain home offices, dru d to the provider or its , or members of the board	g			3.00
	relationships? (see instructions)					
			Y/N	Туре	Date	
	Cincucial Data and Demonts		1.00	2.00	3.00	_
4.00	Financial Data and Reports Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr	Audited, "C" for Compiled enter date available in		A		4.00
5.00	Are the cost report total expenses and total		N			5.00
	those on the filed financial statements? If y	yes, submit reconciliation		Y/N	Legal Oper.	
				1.00	2.00	
6.00	Approved Educational Activities Column 1: Are costs claimed for nursing scho the legal operator of the program?	ool?Column 2: If yes, is	the provider is	N		6.00
7.00	Are costs claimed for Allied Health Programs?	? If "Y" see instructions.		Ν		7.00
8.00	Were nursing school and/or allied health prog		wed during the	Ν		8.00
9.00	cost reporting period? If yes, see instruction Are costs claimed for Intern-Resident program		cost report? If	Y		9.00
7.00	yes, see instructions.					7.00
10.00	Was an Intern-Resident program been initiated	d or renewed in the curren	t cost reporting	Ν		10.00
11.00	period? If yes, see instructions. Are GME cost directly assigned to cost center	rs other than I & R in an	Approved	Ν		11.00
11.00	Teaching Program on Worksheet A? If yes, see		Approved	IN IN		11.00
					Y/N	
	Bad Debts				1.00	
12.00	Is the provider seeking reimbursement for bac	d debts? If ves, see instr	uctions.		Y	12.00
	If line 12 is yes, did the provider's bad deb			st reporting	N	13.00
4.4.00	period? If yes, submit copy.					11.00
14.00	If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments waived?	TT yes, see ths	tructions.	N	14.00
15.00	Did total beds available change from the price	or cost reporting period?	lf yes, see inst	ructions.	N	15.00
				nrt A	Part B	
		Description O	Y/N 1.00	Date 2.00	Y/N 3.00	
	PS&R Data		1.00	2.00		
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R		Y	04/18/2015	Y	16.00
17.00	Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records		N		N	17.00
18. 00	for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments		N		N	18.00
10.00	made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file		IN			
19. 00	this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see		N		N	19.00
20. 00	instructions.		N		N	20.00

Heal th	Financial Systems REHA	BILITATION HOS	SPITAL OF INDIA	NA	In Lie	eu of Form CMS-	2552-10		
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		eriod:	Worksheet S-2	2		
					rom 01/01/2014 o 12/31/2014		oparad.		
				1	0 12/31/2014	5/28/2015 10:			
				Par	rt A	Part B			
		Descr	iption	Y/N	Date	Y/N			
		(	0	1.00	2.00	3.00			
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 HOSPIT	ALS ONLY (EXCE	EPT CHILDRENS H	IOSPI TALS)			_		
	Capital Related Cost					I	_		
	Have assets been relifed for Medicare purpose	<b>J</b> .					22.00		
23.00	Have changes occurred in the Medicare depreci reporting period? If yes, see instructions.	ation expense	due to apprais	ais made durin	g the cost		23.00		
24.00	Were new leases and/or amendments to existing	n leases enter	ed into during	this cost reno	rting period?		24.00		
24.00	If yes, see instructions		cu into during	1113 0031 1000	ring period:		24.00		
25.00	Have there been new capitalized leases entere instructions.	ed into during	the cost repor	ting period? I	f yes, see		25. 00		
26.00	Were assets subject to Sec.2314 of DEFRA acqu	uired during th	he cost reporti	ng period? If	yes, see		26.00		
	instructions.	-		-					
27.00	Has the provider's capitalization policy char	nged during the	e cost reportin	ng period? If y	es, submit		27.00		
	copy. Interest Expense								
28.00	Were new Loans, mortgage agreements or letter	rs of credit er	ntered into dur	ing the cost r	enortina		28.00		
20.00	period? If yes, see instructions.			The cost i	cpor tring		20.00		
29.00	Did the provider have a funded depreciation a	account and/or	bond funds (De	bt Service Res	erve Fund)		29.00		
	treated as a funded depreciation account? If	yes, see instr	ructions						
30.00	Has existing debt been replaced prior to its	scheduled matu	urity with new	debt? If yes,	see		30.00		
	instructions.		6						
31.00	Has debt been recalled before scheduled matur instructions.	rity without is	ssuance of new	debt? If yes,	see		31.00		
	Purchased Services								
32.00	Have changes or new agreements occurred in pa	atient care ser	rvi ces furni she	d through cont	ractual		32.00		
	arrangements with suppliers of services? If			5					
33.00	If line 32 is yes, were the requirements of S	Sec. 2135.2 app	plied pertainin	ng to competiti	ve bidding? If		33.00		
	no, see instructions.								
04.00	Provi der-Based Physi ci ans				<u> </u>		1		
34.00	Are services furnished at the provider facili If yes, see instructions.	ty under an ar	rrangement with	n provider-base	d physicians?		34.00		
35 00	If line 34 is yes, were there new agreements	or amended exi	istina aareemen	ts with the nr	ovi der-based		35.00		
00.00	physicians during the cost reporting period?				orraor based		00.00		
					Y/N	Date			
-					1.00	2.00			
	Home Office Costs				1	L	_		
	Were home office costs claimed on the cost re	•					36.00		
37.00	If line 36 is yes, has a home office cost sta If yes, see instructions.	atement been pr	repared by the	nome office?			37.00		
38.00	If line 36 is yes, was the fiscal year end o	of the home of	fice different	from that of			38.00		
00.00	the provider? If yes, enter in column 2 the f						00.00		
39.00	If line 36 is yes, did the provider render se						39.00		
	see instructions.								
40.00	If line 36 is yes, did the provider render se	ervices to the	home office?	lf yes, see			40.00		
	instructions.								
	1.00 2.00								
	Cost Report Preparer Contact Information								
	held by the cost report preparer in columns î						41.00		
	respecti vel y.								
42.00	Enter the employer/company name of the cost r	report	IU HEALTH				42.00		
10.00	preparer.		047 0/0 1005				40.00		
43.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv		317-962-1093		RUTTER@I UHEALT	H. ORG	43.00		

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provider C	CN: 153028	From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared 5/28/2015 10:14 am
		Part B				
		Date				
		4.00				
	PS&R Data					
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	04/18/2015				16. C
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					17. C
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					18. C
9.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.					19. C
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:					20. C
	Was the cost report prepared only using the provider's records? If yes, see instructions.					21.0
					_	
			3.0	0		
1. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		IANAGER			41. C
	Enter the employer/company name of the cost r preparer.	report				42. C
	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv					43. C

OSPI T	Financial Systems REHA AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	BILITATION HOS AL DATA		CCN: 153028		ri od:	u of Form CM Worksheet S		
					Fr To	om 01/01/2014 12/31/2014	Part I Date/Time P 5/28/2015 1		
							I/P Days / 0		
	Component	Worksheet A	No. of Beds	Bed Days		CAH Hours	<u>Visits / Tri</u> Title V	ps	
	component	Line Number	No. of Dous	Avai I abl e		or an inour s	intro v		
		1.00	2.00	3.00		4.00	5.00		
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	91	33, 2	15	0.00		0	1.0
	8 exclude Swing Bed, Observation Bed and								
	Hospice days) (see instructions for col. 2								
~~	for the portion of LDP room available beds)								~ ~ ~
. 00 . 00	HMO and other (see instructions) HMO IPF Subprovider								2.0 3.0
. 00	HMO IPF Subprovider HMO IRF Subprovider								4.0
. 00	Hospital Adults & Peds. Swing Bed SNF							0	4. C
. 00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF							o	6.0
. 00	Total Adults and Peds. (exclude observation		9'	33, 2	15	0.00		0	7.0
	beds) (see instructions)					0.00		Ŭ	,
. 00	INTENSIVE CARE UNIT								8. (
. 00	CORONARY CARE UNI T								9. (
0. 00	BURN INTENSIVE CARE UNIT								10.
1.00	SURGICAL INTENSIVE CARE UNIT								11.
2.00	OTHER SPECIAL CARE (SPECIFY)								12.
3.00	NURSERY								13.0
4.00	Total (see instructions)		91	33, 2	15	0.00		0	14.0
5.00	CAH visits							0	15.0
6.00 7.00	SUBPROVIDER – IPF SUBPROVIDER – IRF								16. 17.
7.00 8.00	SUBPROVIDER - TRF								17.
9.00	SKILLED NURSING FACILITY								10. 19.
0.00	NURSING FACILITY								20.
1.00	OTHER LONG TERM CARE								21.
2.00	HOME HEALTH AGENCY								22.
3.00	AMBULATORY SURGICAL CENTER (D. P.)								23.
4.00	HOSPI CE								24.
1. 10	HOSPICE (non-distinct part)	30. 00							24.
5.00	СМНС – СМНС	99.00						0	25.
. 10	CMHC - CORF	99. 10						0	25.
b. 00	RURAL HEALTH CLINIC								26.
5.25	FEDERALLY QUALIFIED HEALTH CENTER								26.
7.00	Total (sum of lines 14-26)		91					0	27.
3.00 9.00	Observation Bed Days Ambulance Trips							U	28. 29.
9.00 0.00	Employee discount days (see instruction)								29. 30.
1.00	Employee discount days (see fisting for the second se								30. 31.
2.00	Labor & delivery days (see instructions)		(	0	0				32.
2.00	Total ancillary labor & delivery room			1					32. (
	outpatient days (see instructions)								52.1
3.00	LTCH non-covered days								33.

10SPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC			CCN: 153028		eriod: com 01/01/2014 o 12/31/2014	Worksheet S-3 Part I Date/Time Pre 5/28/2015 10:	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients		Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7, 278	844	18, 89	94			1.00
2.00	HMO and other (see instructions)	1, 856	760					2.00
3.00	HMO I PF Subprovi der	0	0					3.00
4.00	HMO IRF Subprovider	0	0		0			4.00
5.00 5.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	0	0		0			5.00 6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	7, 278	844	18, 89	94			7.00
3. 00	INTENSI VE CARE UNI T							8.00
9.00	CORONARY CARE UNIT							9.00
0.00	BURN INTENSIVE CARE UNIT							10.00
1.00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13.00
14.00	Total (see instructions)	7, 278	844	18, 89	94	3.14	268.82	
15.00	CAH visits	0	0		0			15.00
16.00 17.00	SUBPROVI DER – I PF SUBPROVI DER – I RF							16.00 17.00
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
2.00	HOME HEALTH AGENCY							22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPICE							24.00
24. 10	HOSPICE (non-distinct part)	0	0		0			24.10
25.00	CMHC - CMHC	0	0		0	0.00	0.00	•
25.10	CMHC - CORF	0	0		0	0.00	0.00	•
26.00	RURAL HEALTH CLINIC							26.00
26.25 27.00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)					3.14	268.82	26.2
28.00	Observation Bed Days		0		0	5.14	200.02	27.00
9.00	Ambul ance Trips	0	0		0			29.00
0.00	Employee discount days (see instruction)	0			0			30.00
31.00	Employee discount days - IRF				0			31.00
32.00	Labor & delivery days (see instructions)	0	0		0			32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)				0			32. 01
33.00	LTCH non-covered days	0						33.00

CAL DATA	Provi der	CCN: 153028	Period: From 01/01/2014 To 12/31/2014		
Full Time Equivalents		Di s	charges		
Nonpai d	Title V	Title XVIII	Title XIX	Total All	
Workers				Pati ents	
		13.00			
d	0	5	20 0	1, 213	1. 2. 3. 3. 4. 5. 6. 7. 10. 11. 12. 13. 14. 15. 14. 15. 14. 15. 14. 20. 21. 22. 23. 24. 25. 24. 25. 24. 25. 31. 24. 25. 24. 25. 26. 27. 27. 28. 29. 20. 21. 22. 23. 24. 25. 24. 25. 26. 27. 27. 27. 27. 27. 27. 27. 27
	Full Time           Equivalents           Nonpaid           Workers           11.00           d           0           0           0           0           0.00           0.00	Full Time         Equivalents           Nonpaid         Title V           Workers         11.00           11.00         12.00           d         0           0         0           0         0           0         0           0         0	Full Time         Disc           Equivalents         Disc           Nonpaid         Title V           11.00         12.00           11.00         12.00           0         51           0         51           0         0           0         51           0         0           0         0           0         0           0         0           0         0           0         0	Full Time Equivalents         Discharges           Nonpaid         Title V         Title XVIII           11.00         12.00         13.00         14.00           Id         0         510         78           0.00         0         510         78           0.00         0         510         78	Full 1 Time Equivalents         Discharges           Nonpaid         Title V         Title XVIII         Total All Patients           11.00         12.00         13.00         14.00         15.00           d         0         510         78         1,213           0         510         78         1,213           0         0         510         78         1,213           0         0         510         78         1,213           0         0         510         78         1,213

LASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provi der		Period:	Worksheet A
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/28/2015 10:
Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	1 Reclassificati ons (See A-6)	Reclassified Trial Balance
					(col. 3 +-
					col. 4)
	1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS	1 1	4 000 /50	1 000 / 5		1 000 (50
00100 CAP REL COSTS-BLDG & FIXT		1,030,653			
00200 CAP REL COSTS-MVBLE EQUI P		843, 900			843, 900
00300 OTHER CAP REL COSTS	101.070	0		0 0	0
00400 EMPLOYEE BENEFITS DEPARTMENT	194, 272	4, 985, 904			5, 171, 284
1 00591 ADMINI STRATI VE AND GENERAL	2, 420, 220	2, 221, 282	4, 641, 50		4, 497, 943
2 00590 OTHER A&G - NON FOUNDATION	848, 922	313, 514			1, 162, 434
00700 OPERATION OF PLANT	365, 297	1,023,329			1, 391, 413
00800 LAUNDRY & LINEN SERVICE	0	112, 909			112, 909
00900 HOUSEKEEPI NG	256, 202	158, 935			413, 887
01000 DI ETARY	59, 204	978, 753			
01100 CAFETERI A	0	0		0 334, 010	334, 010
01300 NURSING ADMINISTRATION	1, 096, 208	141, 588			1, 371, 711
00 01400 CENTRAL SERVICES & SUPPLY	67, 411	37, 033			
DO 01500 PHARMACY	385, 397	148, 066		3 1, 723	535, 186
00 01600 MEDI CAL RECORDS & LI BRARY	277, 307	134, 210	411, 51	7 -4	411, 513
DO 01700 SOCIAL SERVICE	281, 436	110, 332	391, 76	0 8	391, 768
00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	217, 205	217, 20	05 0	217, 205
INPATIENT ROUTINE SERVICE COST CENTERS			_		
03000 ADULTS & PEDIATRICS	5, 628, 838	1, 170, 995	6, 799, 83	3 -317, 361	6, 482, 472
ANCI LLARY SERVI CE COST CENTERS			_		
DO 05000 OPERATING ROOM	0	0		0 0	0
05400 RADI OLOGY-DI AGNOSTI C	57,444	35, 755	93, 19	-3, 939	89, 260
DO 06000 LABORATORY	0	408, 230	408, 23	-406	407, 824
00 06500 RESPI RATORY THERAPY	324, 670	139, 034	463, 70	-41, 238	422, 466
00 06600 PHYSI CAL THERAPY	1, 485, 326	284, 908	1, 770, 23	4 156, 105	1, 926, 339
01 06601 PHYSI CAL THERAPY - CARMEL	294, 078	141, 715	435, 79	-2, 539	433, 254
00 06700 OCCUPATI ONAL THERAPY	1, 282, 075	158, 211	1, 440, 28	6 256, 923	1, 697, 209
00 06800 SPEECH PATHOLOGY	478, 882	63, 319	542, 20	176, 985	719, 186
D1 06801 VI SI ON	146, 313	27, 381	173, 69	4 -1, 259	172, 435
02 06802 FAC RESOURCE	383, 172	80, 613	463, 78	-6, 296	457, 489
00 06900 ELECTROCARDI OLOGY	0	0		0 0	0
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 191, 699	191, 699
00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0
00 07300 DRUGS CHARGED TO PATIENTS	0	1, 536, 789	1, 536, 78	9 0	1, 536, 789
00 07400 RENAL DIALYSIS	0	0		0 0	0
00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	482,027	112, 335	594, 36	2 -11, 463	582, 899
OUTPATIENT SERVICE COST CENTERS					
09000 CLINIC	169, 488	55, 100	224, 58	8 -25, 827	198, 761
01 09001 SLEEP CENTER	0	0		0 0	0
00 09100 EMERGENCY	0	0		0 0	0
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		-		-	-
OTHER REIMBURSABLE COST CENTERS					
00 09900 CMHC	0	0		0 0	0
10 09910 CORF	398, 496	202, 186			0
SPECIAL PURPOSE COST CENTERS	570, 470	202,100	000,00	000, 002	0
00 SUBTOTALS (SUM OF LINES 1-117)	17, 382, 685	16, 874, 184	34, 256, 86	9 0	34, 256, 869
NONREI MBURSABLE COST CENTERS	17, 302, 003	10, 074, 104	57,200,00	0	57,230,009
00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0
. 00 19000 GFFT, FLOWER, COFFEE SHOP & CANTEEN	0				
		654, 574			654, 574
00 07950 FOUNDATION	56, 130	11, 493			67, 623
01 07951 PUBLIC RELATIONS 00 TOTAL (SUM OF LINES 118-199)	205, 740	90, 922			296, 662 35, 275, 728
101 101AL (SUM OF LINES 118-199)	17, 644, 555	17, 631, 173	35, 275, 72	8 0	1 35 275 728

Heal th Financial	Systems		REHAB	BILITATION HOSPITAL	_ OF INDIANA		I
RECLASSI FI CATI ON	I AND ADJUSTMENTS	OF TRIAL	BALANCE OF	EXPENSES	Provider CCN	153028	Peri od:

In Lieu of Form CMS-2552-10 Worksheet A

					From 01/01/2014 To 12/31/2014	Date/Time Pre 5/28/2015 10:	pared:
	Cost Center Description	Adjustments	Net Expenses				
		(See A-8)	For Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS	07.450		1			1
	00100 CAP REL COSTS-BLDG & FIXT	97, 453		1			1.00
	00200 CAP REL COSTS-MVBLE EQUIP	105, 307		1			2.00
	00300 OTHER CAP REL COSTS	0	C	•			3.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	-6, 059		1			4.00
	00591 ADMINISTRATIVE AND GENERAL	1, 636, 430		•			5.0
	00590 OTHER A&G - NON FOUNDATION	-1, 182, 297		1			5.0
	00700 OPERATION OF PLANT	-15, 117		•			7.0
	00800 LAUNDRY & LINEN SERVICE	0					8.0
	00900 HOUSEKEEPI NG	0		1			9.0
	D1000 DI ETARY	0	703, 609	1			10.0
	01100 CAFETERI A	-118, 514					11.0
	01300 NURSING ADMINISTRATION	0	1, 371, 711				13.0
	01400 CENTRAL SERVICES & SUPPLY	-6, 263	343, 099				14.0
	01500 PHARMACY	-6, 640	528, 546				15.0
6.00 0	01600 MEDICAL RECORDS & LIBRARY	-800	410, 713	5			16.0
7.00 0	01700 SOCIAL SERVICE	0		8			17.0
2.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	217, 205				22.0
	NPATIENT ROUTINE SERVICE COST CENTERS	r	1				
	03000 ADULTS & PEDI ATRI CS	0	6, 482, 472				30.0
	NCILLARY SERVICE COST CENTERS	1		1			
	05000 OPERATI NG ROOM	0	-	1			50.0
	05400 RADI OLOGY-DI AGNOSTI C	-183		1			54.0
	06000 LABORATORY	-69, 589	338, 235				60.00
	06500 RESPI RATORY THERAPY	0		1			65.0
	06600 PHYSI CAL THERAPY	0		•			66.0
	06601 PHYSI CAL THERAPY – CARMEL	-1, 584					66.0
	06700 OCCUPATI ONAL THERAPY	0		1			67.0
	06800 SPEECH PATHOLOGY	0	,				68.0
	06801 VI SI ON	-3, 705	168, 730				68.0
	06802 FAC RESOURCE	-107	457, 382	2			68.0
	06900 ELECTROCARDI OLOGY	0					69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	191, 699				71.0
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C				72.0
	07300 DRUGS CHARGED TO PATIENTS	0	1, 536, 789				73.0
	07400 RENAL DIALYSIS	0	C				74.00
6.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	-2, 550	580, 349				76.0
	DUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	-7, 520	191, 241				90.0
	09001 SLEEP CENTER	0	C	1			90.0
	09100 EMERGENCY	0	C				91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.0
	THER REIMBURSABLE COST CENTERS		1	1			
	09900 CMHC	0					99.00
	09910 CORF	0	C				99.10
-	SPECIAL PURPOSE COST CENTERS	· · · · · · ·		T			
18.00	SUBTOTALS (SUM OF LINES 1-117)	418, 262	34, 675, 131				118.00
	IONREI MBURSABLE COST CENTERS	1	1	1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190. 0
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	001/071				192. 0
	07950 FOUNDATI ON	750, 596		1			194.0
	07951 PUBLIC RELATIONS	0	296, 662	•			194. 01
200.00	TOTAL (SUM OF LINES 118-199)	1, 168, 858	36, 444, 586	1			200.00

CLAS	SI FI CATI ONS			Provider CCN: 153	D28 Peri od: From 01/01/2014 To 12/31/2014	Worksheet A-6 Date/Time Prepar 5/28/2015 10:14
		Increases				0,20,2010 10111
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A – CAFETERIA					
00	CAFETERIA	11.00	19, 058	314, 952		
	TOTALS		19,058	314, 952		
	B - NURSING ADMINISTRATION	I				
00	NURSING ADMINISTRATION	13.00	143, 161	0		
	TOTALS		143, 161			
	C - NCR (CORF)	I		- <u>+</u>		
00	PHYSI CAL THERAPY	66,00	108, 549	54, 874		
00	OCCUPATI ONAL THERAPY	67.00	171, 277	86, 585		
00	SPEECH PATHOLOGY	68.00	118, 670	59, 990		
	TOTALS		398, 496	201, 449		
	D - MEDI CAL SUPPLI ES		· .	· .		
00	CENTRAL SERVICES & SUPPLY	14.00	0	436, 617		
00	PHARMACY	15.00	0	1, 723		
00		0.00	0	0		
00		0.00	0	0		
00		0.00	0	0		
00		0.00	0	0		
00		0.00	0	0		
00		0.00	0	0		
00		0.00	0	0		
0. 00		0.00	0	0		1
. 00		0.00	0	0		1
. 00		0.00	0	0		1
. 00		0.00	0	0		1
. 00		0.00	0	0		1
. 00		0.00	0	0		1
. 00		0.00	0	0		1
. 00		0.00	0	0		1
. 00		0.00	0	0		1
00 .		0.00	o	0		1
. 00		0.00	0	0		2
. 00		0.00	0	0		2
	TOTALS		0	438, 340		
	E - BILLABLE MEDICAL SUPPLIES					
00	MEDICAL SUPPLIES CHARGED TO	71.00	0	191, 699		
	PATI ENTS					
	TOTALS		0	191, 699		
	F - GAS EXPENSE					
00	OPERATION_OF_PLANT	7.00	0	<u>3, 3</u> 65		
	TOTALS		0	3, 365		
0 00	Grand Total: Increases		560, 715	1, 149, 805		50

ECLAS	SI FI CATI ONS			Provi der	- CCN: 153028	Period: From 01/01/2014 To 12/31/2014	Worksheet A- Date/Time Pr 5/28/2015 10	repare
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	A – CAFETERIA							
00	DI ETARY	10.00	19, 058	314, 952	-	0		1.
	TOTALS		19, 058	314, 952				
	B - NURSING ADMINISTRATION		<u>.</u>					
00	ADMI NI STRATI VE AND GENERAL	5.01	143, 161	0	)	0		1.
	TOTALS	T	143, 161	0	)	7		
	C - NCR (CORF)		<u>.</u>					
00	CORF	99.10	398, 496	201, 449	)	0		1.
00		0.00	0	0		o		2.
00		0.00	0	0		o		3.
	TOTALS		398, 496	201, 449	)	7		
	D - MEDI CAL SUPPLI ES		· · ·	· ·		1		
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8, 892		0		1
00	ADMI NI STRATI VE AND GENERAL	5.01	0	398		o		2
00	OTHER A&G - NON FOUNDATION	5.02	0	2		o		3
00	OPERATION OF PLANT	7.00	0	578		o		4
00	HOUSEKEEPING	9.00	0	1, 250		o		5
00	DI ETARY	10.00	0	338		o		6
00	NURSING ADMINISTRATION	13.00	0	9, 246		o		7
00	MEDICAL RECORDS & LIBRARY	16.00	0	4		o		8
00	ADULTS & PEDIATRICS	30.00	0	317, 361		o		9
0. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	3, 939		o		10
1.00	LABORATORY	60.00	0	406		o		11
2.00	RESPI RATORY THERAPY	65.00	0	41, 238		o		12
3.00	PHYSICAL THERAPY	66.00	0	3, 953		o		13
1.00	PHYSICAL THERAPY - CARMEL	66.01	0	2, 539		o		14
5.00	OCCUPATI ONAL THERAPY	67.00	0	939		o		15
5.00	SPEECH PATHOLOGY	68.00	0	1, 675		o		16
7.00	VI SI ON	68.01	0	1, 259		o		17
3. 00	FAC RESOURCE	68.02	0	6, 296		o		18
9. 00	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	76.00	0	11, 463		0		19
D. 00	CLINIC	90.00	О	25, 827		0		20
1.00	CORF	99.10	0	737		0		21
	TOTALS			438, 340		1		
	E - BILLABLE MEDICAL SUPPLIES							1
00	CENTRAL SERVICES & SUPPLY	14.00	0	191, 699		0		1
	TOTALS			191, 699		1		1
	F - GAS EXPENSE			, 0,,,				
00	PHYSI CAL THERAPY	66.00	0	3, 365		0		1
	TOTALS		<del>_</del>	3, 365		1		1
00 00	Grand Total: Decreases		560, 715	1, 149, 805		1		500

Heal th	Fi nanci al	Sys	stems		
RECONC	I LI ATI ON	OF C	API TAL	COSTS	CENTERS

## REHABILITATION HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 Provider CCN: 153028 Period: From 01/01/2014 Worksheet A-7

2.00         Land Improvements         3.00, 081         6,600         0         6,600         0         2.00           3.00         Buildings and Fixtures         14,590,869         363,379         0         3.63,379         0         3.00         0 <t< th=""><th></th><th></th><th></th><th></th><th></th><th>From 01/01/2014 To 12/31/2014</th><th></th><th>pared: <u>14 am</u></th></t<>						From 01/01/2014 To 12/31/2014		pared: <u>14 am</u>
Bai ances         Retirements           1.00         2.00         3.00         4.00         5.00           1.00         2.506,638         0         0         0         0         1.00           2.00         Land         2,506,638         0         0         0         0         1.00           2.00         Land Improvements         300,081         6,600         0         6,600         0         0         1.00           3.00         Buil ding and Fixtures         14,590,869         363,379         0         363,379         0         3.00         4.00           5.00         Fixed Equipment         2,042,475         4.373         0         4.373         0         5.00         6.00         0					Acqui si ti ons			
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         0			Begi nni ng	Purchases	Donati on	Total		
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         0         0         0         0         1.00           1.00         Land         mprovements         2,506,638         0         0         6,600         0         2.00           3.00         Buildings and Fixtures         14,590,869         363,379         0         363,379         0         3.00           4.00         Building Improvements         95,017         0         0         0         4.00           5.00         Fixed Equipment         2,042,475         4,373         0         4,373         0         5.00           6.00         Movable Equipment         10,687,958         817,080         0         800         817,080         0         6.00           7.00         HIT designated Assets         0								
1.00       Land       2,506,638       0				2.00	3.00	4.00	5.00	
2.00         Land Improvements         300,081         6,600         0         6,600         0         2.00           3.00         Buildings and Fixtures         14,590,869         363,379         0         363,379         0         3.00           4.00         Building Improvements         95,017         0         0         0         4.00           5.00         Fixed Equipment         2,042,475         4,373         0         4,373         0         5.00           6.00         Movable Equipment         10,687,958         817,080         0         817,080         0         7.00           7.00         HI designated Assets         0         0         0         0         0         7.00           8.00         Subtotal (sum of lines 1-7)         30,223,038         1,191,432         0         1,191,432         0         8.00           9.00         Reconciling Items         0         0         0         0         0         0         9.00           10.00         Total (line 8 minus line 9)         30,223,038         1,191,432         0         1,191,432         0         10.00           10.00         Land         Ending Balance         Full y         Depreciated         <		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET					1	
3.00       Buildings and Fixtures       14,590,869       363,379       0       363,379       0       3.00         4.00       Building Improvements       95,017       0       0       0       0       4.00         5.00       Fixed Equipment       2,042,475       4,373       0       4,373       0       6.00         6.00       Movable Equipment       10,687,958       817,080       0       817,080       0       6.00         7.00       HIT designated Assets       0       0       0       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       30,223,038       1,191,432       0       1,191,432       0       8.00         9.00       Reconciling Items       0		Land	2, 506, 638			0 0		1.00
4.00       Building Improvements       95,017       0       0       0       0       4.00         5.00       Fixed Equipment       2,042,475       4,373       0       4,373       0       5.00         6.00       Movable Equipment       10,687,958       817,080       0	2.00	Land Improvements	300, 081					2.00
5.00       Fixed Equipment       2,042,475       4,373       0       4,373       0       5.00         6.00       Movable Equipment       10,687,958       817,080       0 <td>3.00</td> <td>Buildings and Fixtures</td> <td>14, 590, 869</td> <td>363, 379</td> <td></td> <td>0 363, 379</td> <td>0</td> <td>3.00</td>	3.00	Buildings and Fixtures	14, 590, 869	363, 379		0 363, 379	0	3.00
6.00       Movable Equipment       10,687,958       817,080       0       817,080       0       6.00         7.00       HIT designated Assets       0       0       0       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       30,223,038       1,191,432       0       1,191,432       0       8.00         9.00       Reconcil ing I tems       0       0       0       0       0       9.00         10.00       Total (line 8 minus line 9)       30,223,038       1,191,432       0       1,191,432       0       10.00         9.00       Reconcil ing I tems       0       0       0       0       0       0       9.00         10.00       Total (line 8 minus line 9)       30,223,038       1,191,432       0       1,191,432       0       10.00         PART 1 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         1.00       Land       2,506,638       0       2.00       2.00       14,954,248       0       2.00       3.00         3.00       Buil ding and Fixtures       14,954,248       0       3.00       4.00       5.00         5.00       Fixed Equipment       2,046,848       0       5.00       6.0	4.00	Building Improvements	95, 017			0 0	0	4.00
7.00       HIT designated Assets       0       0       0       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       30,223,038       1,191,432       0       1,191,432       0       8.00         9.00       Reconciling Items       0 <td>5.00</td> <td>Fixed Equipment</td> <td>2, 042, 475</td> <td>4, 373</td> <td></td> <td>0 4, 373</td> <td>0</td> <td>5.00</td>	5.00	Fixed Equipment	2, 042, 475	4, 373		0 4, 373	0	5.00
8.00       Subtotal (sum of lines 1-7)       30,223,038       1,191,432       0       1,191,432       0       8.00         9.00       Reconciling ltems       0 <td< td=""><td>6.00</td><td>Movable Equipment</td><td>10, 687, 958</td><td>817, 080</td><td></td><td>0 817, 080</td><td>0</td><td>6.00</td></td<>	6.00	Movable Equipment	10, 687, 958	817, 080		0 817, 080	0	6.00
9.00       Reconciling Items       0       0       0       0       0       0       9.00         10.00       Total (line 8 minus line 9)       30,223,038       1,191,432       0       1,191,432       0       10.00         Image: the state of t	7.00		0	0		0 0	0	7.00
9.00       Reconciling Items       0       0       0       0       0       0       9.00         10.00       Total (line 8 minus line 9)       30,223,038       1,191,432       0       1,191,432       0       10.00         Image: the state of t	8.00	Subtotal (sum of lines 1-7)	30, 223, 038	1, 191, 432		0 1, 191, 432	0	8.00
Ending Balance         Fully Depreciated Assets           6.00         7.00           PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         1.00           Land         2,506,638         0           2.00         Land Improvements         306,681         0           3.00         Buildings and Fixtures         14,954,248         0         3.00           4.00         Building Improvements         95,017         0         4.00           5.00         Fixed Equipment         2,046,848         0         5.00           6.00         Movable Equipment         11,505,038         0         6.00           7.00         HI designated Assets         0         0         7.00           8.00         Subtotal (sum of Lines 1-7)         31,414,470         0         8.00	9.00		0	0		0 0	0	9.00
Ending Balance         Fully Depreciated Assets           6.00         7.00           PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         1.00           Land         2,506,638         0           2.00         Land Improvements         306,681         0           3.00         Buildings and Fixtures         14,954,248         0         3.00           4.00         Building Improvements         95,017         0         4.00           5.00         Fixed Equipment         2,046,848         0         5.00           6.00         Movable Equipment         11,505,038         0         6.00           7.00         HI designated Assets         0         0         7.00           8.00         Subtotal (sum of Lines 1-7)         31,414,470         0         8.00	10.00	Total (line 8 minus line 9)	30, 223, 038	1, 191, 432		0 1, 191, 432	0	10.00
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         -			Endi ng Bal ance					
6.00         7.00           PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         1.00           Land         2,506,638         0           2.00         Land Improvements         306,681         0           3.00         Buildings and Fixtures         14,954,248         0         3.00           4.00         Building Improvements         95,017         0         4.00           5.00         Fixed Equipment         2,046,848         0         5.00           6.00         Movable Equipment         0         0         6.00           8.00         Subtotal (sum of lines 1-7)         31,414,470         0         8.00           9.00         Reconciling Items         0         0         9.00								
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES           1.00         Land         2, 506, 638         0         1.00           2.00         Land Improvements         306, 681         0         2.00           3.00         Buildings and Fixtures         14, 954, 248         0         3.00           4.00         Building Improvements         95,017         0         4.00           5.00         Fixed Equipment         2, 046, 848         0         5.00           6.00         Movable Equipment         11, 505, 038         0         6.00           7.00         HIT designated Assets         0         0         7.00           8.00         Subtotal (sum of lines 1-7)         31, 414, 470         0         8.00           9.00         Reconciling Items         0         0         9.00								
1.00       Land       2,506,638       0       1.00         2.00       Land Improvements       306,681       0       2.00         3.00       Buildings and Fixtures       14,954,248       0       3.00         4.00       Building Improvements       95,017       0       4.00         5.00       Fixed Equipment       2,046,848       0       5.00         6.00       Movable Equipment       11,505,038       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       31,414,470       0       8.00         9.00       Reconciling Items       0       0       9.00				7.00				
2.00       Land Improvements       306,681       0       2.00         3.00       Buildings and Fixtures       14,954,248       0       3.00         4.00       Building Improvements       95,017       0       4.00         5.00       Fixed Equipment       2,046,848       0       5.00         6.00       Movable Equipment       11,505,038       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       31,414,470       0       8.00         9.00       Reconciling Items       0       0       9.00								
3.00       Buildings and Fixtures       14,954,248       0       3.00         4.00       Building Improvements       95,017       0       4.00         5.00       Fixed Equipment       2,046,848       0       5.00         6.00       Movable Equipment       11,505,038       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       31,414,470       0       8.00         9.00       Reconciling Items       0       0       9.00	1.00	Land	2, 506, 638	0				1.00
4.00       Building Improvements       95,017       0       4.00         5.00       Fixed Equipment       2,046,848       0       5.00         6.00       Movable Equipment       11,505,038       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       31,414,470       0       8.00         9.00       Reconciling Items       0       0       9.00		Land Improvements		0				2.00
5.00       Fixed Equipment       2,046,848       0       5.00         6.00       Movable Equipment       11,505,038       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       31,414,470       0       8.00         9.00       Reconciling Items       0       0       9.00			14, 954, 248	0				3.00
6.00       Movable Equipment       11,505,038       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       31,414,470       0       8.00         9.00       Reconciling Items       0       0       9.00	4.00	Building Improvements	95, 017	0				4.00
7.00         HIT designated Assets         0         0         7.00           8.00         Subtotal (sum of lines 1-7)         31,414,470         0         8.00         8.00         9.00	5.00	Fixed Equipment	2, 046, 848	0				5.00
8.00         Subtotal (sum of lines 1-7)         31,414,470         0         8.00           9.00         Reconciling Items         0         0         9.00			11, 505, 038	0				6.00
9.00 Reconciling Items 0 0 9.00	7.00		0	0				7.00
	8.00	Subtotal (sum of lines 1-7)	31, 414, 470	0				8.00
10.00  Total (line 8 minus line 9)   31,414,470   0   10.00	9.00	Reconciling Items	0	0				9.00
	10.00	Total (line 8 minus line 9)	31, 414, 470	0				10.00

Heal th	Financial Systems REH/	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	eu of Form CMS-2	2552-10
RECONC	LIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014		
						5/28/2015 10:	14 am
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
	<b>T</b>	9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2	-		
1.00	CAP REL COSTS-BLDG & FIXT	565, 871	0	427, 69			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	813, 963			0 4, 590	0	2.00
3.00	Total (sum of lines 1-2)	1, 379, 834		427, 69	1 41, 681	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 030, 653				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	25, 347	843, 900				2.00
3.00	Total (sum of lines 1-2)	25, 347	1, 874, 553				3.00

	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 153028 P	eri od:	Worksheet A-7	2552-
2001			11001 dei		rom 01/01/2014		
					o 12/31/2014		pare
						5/28/2015 10:1	14 ai
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col.	· · ·		
				2)			
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS					
. 00	CAP REL COSTS-BLDG & FIXT	19, 909, 432	0	19, 909, 432	0. 633766	0	1.
. 00	CAP REL COSTS-MVBLE EQUIP	11, 505, 038	0	11, 505, 038	0. 366234	0	2.
. 00	Total (sum of lines 1-2)	31, 414, 470		31, 414, 470		0	3.
			TION OF OTHER (		SUMMARY C	E CAPITAL	0.
		1220011			000000000000		
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel ate				
			d Costs	through 7)			
		6,00	7.00	8,00	9,00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS					
. 00	CAP REL COSTS-BLDG & FIXT	0	0	0	672, 439	0	1.
. 00	CAP REL COSTS-MVBLE FOULP	0	0	0	919, 270	0	2.
. 00	Total (sum of lines 1-2)	0	0		1, 591, 709		3.
			SI	JMMARY OF CAPIT			0.
		Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	Cost Center Description	Interest	I IISUI AIICE (SEE				
	Cost Center Description	Interest					
	Cost Center Description	Thterest			Capi tal -Rel ate	of cols. 9	
	Cost Center Description	Interest			Capital-Relate d Costs (see		
	Cost Center Description	11.00			Capi tal -Rel ate	of cols. 9	
	·	11.00	instructions)	instructions)	Capi tal -Rel ate d Costs (see instructions)	of cols. 9 through 14)	
00	PART III - RECONCILIATION OF CAPITAL COSTS	11.00 CENTERS	instructions)	instructions)	Capi tal -Rel ate d Costs (see i nstructi ons) 14.00	of cols. 9 through 14) 15.00	1
. 00	·	11.00	i nstructi ons) 12.00 37,091	instructions)	Capital-Relate d Costs (see instructions) 14.00 0	of col s. 9 through 14) 15.00 1, 128, 106	1.

	Financial Systems	REHA	BILITATION HOSPI	TAL OF INDIANA	In Lie	u of Form CMS-2	
ADJUST	MENTS TO EXPENSES			Provider CCN: 153028	Period: From 01/01/2014 To 12/31/2014		
				Evenence Classification a		5/28/2015 10:	
			Т	Expense Classification o D/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2.00	3.00	4.00	5. 00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-9, 115 CA	AP REL COSTS-BLDG & FIXT	1.00	11	1.
2.00	Investment income - CAP REL		0 CA	AP REL COSTS-MVBLE EQUIP	2.00	0	2.
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.
	(chapter 2)		0				
. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.
5.00	Refunds and rebates of		0		0.00	0	5.
. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.
	suppliers (chapter 8)		0				
. 00	Telephone services (pay stations excluded) (chapter 21)	A	-15, 1170F	PERATION OF PLANT	7.00	0	7.
. 00	Television and radio service	A	-23, 389 AI	MINISTRATIVE AND GENERAL	5.01	0	8.
. 00	(chapter 21) Parking lot (chapter 21)		о		0.00	0	9.
0. 00	Provider-based physician	A-8-2	О			0	10.
1.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.
2.00	(chapter 23) Related organization	A-8-1	1, 838, 163			0	12.
	transactions (chapter 10)				0.00		10
3.00 4.00	Laundry and linen service Cafeteria-employees and guests	В	-118, 514CA	AFETERI A	0.00 11.00		
5.00	Rental of quarters to employee		0		0.00		
6. 00	and others Sale of medical and surgical supplies to other than	В	-6, 263 CE	ENTRAL SERVICES & SUPPLY	14.00	0	16.
7.00		В	-5, 722 Pł	IARMACY	15.00	0	17.
8. 00	patients Sale of medical records and	В	- 800 ME	EDI CAL RECORDS & LI BRARY	16.00	0	18
9.00	abstracts Nursing school (tuition, fees,		0		0.00	0	19
	books, etc.)						
D. 00 1. 00	Vending machines Income from imposition of		0		0.00		
	interest, finance or penalty charges (chapter 21)						
2.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22
	repay Medicare overpayments						
3.00	Adjustment for respiratory therapy costs in excess of	A-8-3	ORE	SPIRATORY THERAPY	65.00		23
	limitation (chapter 14)						
4.00	Adjustment for physical therapy costs in excess of	A-8-3	OPF	IYSI CAL THERAPY	66.00		24
- 00	limitation (chapter 14)				111.00		
5.00	Utilization review - physicians' compensation		0^*	** Cost Center Deleted ***	114.00		25.
( 00	(chapter 21)				1 00		24
6. 00	Depreciation - CAP REL COSTS-BLDG & FIXT			AP REL COSTS-BLDG & FIXT	1.00	0	26.
7.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		OCA	AP REL COSTS-MVBLE EQUIP	2.00	0	27
8.00	Non-physician Anesthetist		0 **	* Cost Center Deleted ***	19.00		28.
9.00			0		0.00		
0. 00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		CCUPATI ONAL THERAPY	67.00		30.
0. 99	Hospice (non-distinct) (see		ΟΑΙ	DULTS & PEDIATRICS	30.00		30
1. 00	instructions) Adjustment for speech	A-8-3	0.54	PEECH PATHOLOGY	68.00		31
	pathology costs in excess of						
2.00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.
	Depreciation and Interest		F 000-				
33.00	MI SCELLANEOUS EMPLOYEE BENEFITS REV	В	-5, 982 EN	MPLOYEE BENEFITS DEPARTMEN	IT 4.00	0	33.

Heal th	Financial Systems	REHA	BILITATION HOS	PITAL OF INDIANA	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 01/01/2014 To 12/31/2014		narod
					10 12/31/2014	5/28/2015 10:	
				Expense Classification or	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Coot Conton Decemination		A	Cast Castar	1.5.00.0.1		
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
33.01	MI SCELLANEOUS REVENUE	B		ADMI NI STRATI VE AND GENERAL	4.00		33.01
33.01	MI SCELLANEOUS REVENUE	В		OTHER A&G - NON FOUNDATION	5.01		
33.02	MI SCELLANEOUS RADI OLOGY	B		RADI OLOGY-DI AGNOSTI C	54.00		33.02
33.03	REVENUE	в	- 103	KADI OLOGI - DI AGNOSTI C	54.00	0	33.03
33.04	MI SCELLANEOUS PT-CARMEL	В	_1 584	PHYSICAL THERAPY - CARMEL	66.01	0	33.04
00.01	REVENUE	U	1,001		00.01		00.01
33.05	MISCELLANEOUS VISION REVENUE	В	-3.705	VISION	68.01	0	33.05
33.06	MI SCELLANEOUS FAC RESOURCE	В	-107	FAC RESOURCE	68.02	0	
	REVENUE						
33.07	MI SCELLANEOUS PSYCHOLOGY	В	-2, 550	PSYCHI ATRI C/PSYCHOLOGI CAL	76.00	0	33.07
	REVENUE			SERVI CES			
33.08	MI SCELLANEOUS CLINIC REVENUE	В		CLINIC	90.00		00.00
33.09	RHI FOUNDATION	A		FOUNDATI ON	194.00	0	
33. 10	DONATI ONS	A		ADMI NI STRATI VE AND GENERAL	5.01	0	001.10
33. 11	ADVERTI SI NG	A		EMPLOYEE BENEFITS DEPARTMEN			33. 11
33. 12	ADVERTI SI NG	A		ADMINISTRATIVE AND GENERAL	5.01		00112
33.13	TAXES	A		ADMINISTRATIVE AND GENERAL	5.01	0	
33.14	TAXES	A		PHARMACY	15.00	0	00.11
50.00	TOTAL (sum of lines 1 thru 49)		1, 168, 858				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

(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.

Heal th	Financial Systems	REHABILITATION HC	SPITAL OF INDIANA	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 153028	Period: From 01/01/2014	Worksheet A-8	8-1
OFFICE				To 12/31/2014		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOCATION FROM HO REPORT	106, 568	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	ALLOCATION FROM HO REPORT	105, 307	0	2.00
3.00	5. 01	ADMINISTRATIVE AND GENERAL	ALLOCATION FROM HO REPORT	1, 942, 955	247,078	3.00
4.00	30.00	ADULTS & PEDIATRICS	ALLOCATION FROM HO REPORT	10, 490	10, 490	4.00
4.01	60.00	LABORATORY	ALLOCATION FROM HO REPORT	338, 085	407, 674	4.01
5.00	TOTALS (sum of lines 1-4).			2, 503, 405	665, 242	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/or Home Office						
Symbol (1)	Name	Percentage of	Name	Percentage of					
		Ownershi p		Ownershi p					
1.00	2.00	3.00	4.00	5.00					
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:									

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

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

6.00	В	51.00 U HEALTH 51.00	6.00
7.00	В	49.00 ST. VI NCENT 49.00	7.00
8.00		0.00 0.00	8.00
9.00		0.00 0.00	9.00
10.00		0.00 0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization. F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Health Financial Systems	REHABILITATION HOSPITA	L OF INDIANA	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FRO OFFICE COSTS	M RELATED ORGANIZATIONS AND HOME	Provider CCN: 153028	From 01/01/2014	Worksheet A-8-1 Date/Time Prepared:

							5/28/2015 10:	14 am
	Net	Wkst. A-7 Ref.						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6.00	7.00						
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS	S A RESULT OF TRANS	ACTIONS WITH RELATED C	RGANIZATIONS OR CL	_AI MED	
	HOME OFFICE CO	STS:						
1.00	106, 568	9						1.00
2.00	105, 307	9						2.00
3.00	1, 695, 877	0						3.00
4.00	0	0						4.00
4.01	-69, 589	0						4.01
5.00	1, 838, 163							5.00

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

1105 1101	been posted to worksheet A,	columns i and/of 2, the amount arrowable should be rindicated in column 4 of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE	

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

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

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

i ci ilibui	Schert under trete Aviri.		
6.00	HOME OFFICE		6.00
7.00	MGMT COMPANY		7.00
8.00			8.00
9.00			9.00
10. 00 100. 00			10.00
100.00		1	00.00
<i></i>			

(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.

JUST ALLUCA	ATION – GENERAL SERVICE COSTS		Provi der	CCN: 153028	Peri od:	Worksheet B	
					From 01/01/2014 To 12/31/2014	Part I Date/Time Pre	
				ATED COSTS		5/28/2015 10:	<u>14</u> a
			CAPI TAL REL	LATED CUSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost			BENEFI TS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)	1.00				-
	RAL SERVICE COST CENTERS	0	1.00	2.00	4.00	4A	
	0 CAP REL COSTS-BLDG & FIXT	1, 128, 106	1, 128, 106				1 1
	O CAP REL COSTS-MVBLE EQUIP	949, 207	1, 120, 100	949, 20	70		2
	O EMPLOYEE BENEFITS DEPARTMENT	5, 165, 225	19, 366				4
	ADMINISTRATIVE AND GENERAL	6, 134, 373	36, 333			6, 879, 932	
	O OTHER A&G - NON FOUNDATION	-19, 863	7, 831	6, 58		247, 570	
	O OPERATION OF PLANT	1, 376, 296	10, 317	8, 68		1, 504, 167	
00 0080	O LAUNDRY & LINEN SERVICE	112, 909	0		0 0	112, 909	
00 0090	O HOUSEKEEPI NG	413, 887	9, 671	8, 13	76, 358	508, 053	9
. 00  0100	DO DI ETARY	703, 609	40, 099	33, 74	11, 965	789, 413	10
. 00 0110	O CAFETERIA	215, 496	19, 043	16, 02	5, 680	256, 242	11
	O NURSI NG ADMI NI STRATI ON	1, 371, 711	7, 881	6, 63		1, 755, 605	
	0 CENTRAL SERVICES & SUPPLY	343, 099	9, 857	8, 29		381, 341	14
	O PHARMACY	528, 546	4, 873	4, 10	00 114, 864	652, 383	15
	0 MEDICAL RECORDS & LIBRARY	410, 713	13, 002			517, 304	
	0 SOCIAL SERVICE	391, 768			83, 879	482, 011	
	0 I&R SERVICES-OTHER PRGM COSTS APPRVD	217, 205	1, 243	1, 04	16 0	219, 494	22
	TI ENT ROUTI NE SERVI CE COST CENTERS						4
	0 ADULTS & PEDIATRICS	6, 482, 472	498, 053	419, 07	1, 677, 621	9, 077, 217	30
	LLARY SERVICE COST CENTERS		0			0	1
	0 OPERATING ROOM	0	0		0 0	110 215	
	0 RADI OLOGY-DI AGNOSTI C	89,077	6, 526			118, 215	
	00 LABORATORY 00 RESPI RATORY THERAPY	338, 235	3, 741	3, 14		345, 124	
	0 PHYSI CAL THERAPY	422, 466 1, 926, 339	14, 841 182, 509	12, 48 153, 56		546, 560 2, 737, 453	
	1 PHYSICAL THERAPY - CARMEL	431, 670	182, 509		0 87,647	519, 317	
	O OCCUPATIONAL THERAPY	1, 697, 209	-	120, 99		2, 395, 166	
	O SPEECH PATHOLOGY	719, 186	32, 703	27, 51		957, 500	
	1 VISION	168, 730	02,700	27,01	0 43,607	212, 337	
	2 FAC RESOURCE	457, 382	6, 936	5, 83		584, 355	
	0 ELECTROCARDI OLOGY	0	0, 100	0,00	0 0	001,000	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	191, 699	0		0 0	191, 699	
	O IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
	O DRUGS CHARGED TO PATIENTS	1, 536, 789	0		0 0	1, 536, 789	7:
. 00 0740	O RENAL DI ALYSI S	0	0		0 0	0	74
. 00 0355	0 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	580, 349	7, 794	6, 55	58 143, 663	738, 364	76
	ATIENT SERVICE COST CENTERS						
	DO CLINIC	191, 241	36, 644	30, 83	32 50, 514	309, 231	
	1 SLEEP CENTER	0	0		0 0		90
	DO EMERGENCY	0	0		0 0	0	
. 00 0920	0 OBSERVATION BEDS (NON-DISTINCT PART)					0	92
	R REIMBURSABLE COST CENTERS						4
	O CMHC	0			0 0	0	
. 10 0991		0	0		0 0	0	99
	AL PURPOSE COST CENTERS	24 475 104	1 11/ 504	020 4/	0 E 100 000	24 575 754	1110
8.00	SUBTOTALS (SUM OF LINES 1-117) EIMBURSABLE COST CENTERS	34, 675, 131	1, 116, 521	939, 46	5, 122, 838	34, 575, 751	1118
	OGIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190
	0 PHYSICIANS' PRIVATE OFFICES	654, 574	9, 596		-	672, 244	
	O FOUNDATION	818, 219				838, 610	
	1 PUBLIC RELATIONS	296, 662	1, 989	1,0/	0 61, 319	357, 981	
4.010795 0.00	Cross Foot Adjustments	290, 002	0		01,319		200
1.00	Negative Cost Centers		^		0 0		200
02.00	TOTAL (sum lines 118-201)	36, 444, 586	1, 128, 106	949, 20			
2.001	TOTAL (SUM TIMES TID-ZUT)	1 30, 444, 300	1, 120, 100	1 747, ZU	5, 200, 860	50, 444, 500	12U.

COST AL	Financial Systems REI LOCATION - GENERAL SERVICE COSTS	HABILITATION HOSPI		CCN: 153028	Period: From 01/01/2014 Fo 12/31/2014		epared:
	Cost Center Description	ADMI NI STRATI VE	Subtotal	OTHER A&G -	OPERATION OF	LAUNDRY &	
		AND GENERAL 5.01	5A. 01	NON FOUNDATION 5.02	N PLANT 7.00	LINEN SERVICE 8.00	
0	GENERAL SERVICE COST CENTERS	5.01	5A. 01	5.02	7.00	0.00	
	DO100 CAP REL COSTS-BLDG & FIXT						1.00
	DO200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	20591 ADMINI STRATI VE AND GENERAL	6, 879, 932					5.01
	DO590 OTHER A&G - NON FOUNDATION	57, 612	305, 182	305, 182	2		5. 02
	DO700 OPERATION OF PLANT	350, 032	1, 854, 199				7.00
	DOBOO LAUNDRY & LINEN SERVICE	26, 275	139, 184				
	20900 HOUSEKEEPING	118, 228	626, 281				
	DIGO DI ETARY						
		183, 703	973, 116				
	D1100 CAFETERIA	59, 630	315, 872				
	01300 NURSING ADMINISTRATION	408, 543	2, 164, 148			0	
	01400 CENTRAL SERVICES & SUPPLY	88, 741	470, 082				
	D1500 PHARMACY	151, 815	804, 198			C	
	01600 MEDICAL RECORDS & LIBRARY	120, 381	637, 685	5, 385	5 23, 060	0	16.00
7.00	D1700 SOCIAL SERVICE	112, 168	594, 179	5, 018	6, 129	C	17.00
2.00	D2200 I&R SERVICES-OTHER PRGM COSTS APPRVD	51, 078	270, 572	2, 285	5 2, 205	0	22.00
Ī	NPATIENT ROUTINE SERVICE COST CENTERS						
0.00	03000 ADULTS & PEDI ATRI CS	2, 112, 339	11, 189, 556	94, 48	1 883, 361	138, 245	30.00
4	ANCI LLARY SERVI CE COST CENTERS						
	D5000 OPERATI NG ROOM	0	0	(	0 0	C	50.00
	05400 RADI OLOGY-DI AGNOSTI C	27, 510	145, 725	1, 23	1 11, 574	C	
	D6000 LABORATORY	80, 313	425, 437				
	06500 RESPI RATORY THERAPY	127, 189	673, 749			C C	
	D6600 PHYSI CAL THERAPY	637, 027	3, 374, 480			102	
	D6601 PHYSI CAL THERAPY - CARMEL	120, 849	640, 166				
	06700 OCCUPATI ONAL THERAPY					160	
		557, 374	2,952,540				
	06800 SPEECH PATHOLOGY	222, 818	1, 180, 318			111	
	D6801 VI SI ON	49, 413	261, 750			-	
	D6802 FAC RESOURCE	135, 984	720, 339				
	06900 ELECTROCARDI OLOGY	0	C		-	-	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	44, 610	236, 309	1, 996	6 0	C	
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0 0	0	
3.00 0	D7300 DRUGS CHARGED TO PATIENTS	357, 623	1, 894, 412	15, 998	3 0	0	73.00
4.00 0	07400 RENAL DIALYSIS	0	C	(	0 0	C	74.00
6.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	171, 823	910, 187	7,68	7 13, 823	C	76.00
C	DUTPATIENT SERVICE COST CENTERS						
0.00	09000 CLINIC	71, 961	381, 192	3, 219	9 64, 992	C	90.00
	09001 SLEEP CENTER	0	0		0 0		90.01
	D9100 EMERGENCY	0	0		0 0		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		Ő				92.00
	THER REIMBURSABLE COST CENTERS		0	1			/2.00
	D9900 CMHC	0	0		0 0	C	99.00
	09910 CORF			1			99.10
	SPECIAL PURPOSE COST CENTERS	0	0	<u>'</u>	0 0	0	99.10
		( 445 020	24 140 050	205 72	1 040 011	140.050	1110 00
18.00	SUBTOTALS (SUM OF LINES 1-117)	6, 445, 039	34, 140, 858	285, 72	7 1, 849, 311	140, 359	1118.00
-	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	156, 437	828, 681				192.00
	07950 FOUNDATI ON	195, 151	1, 033, 761				194.00
94.01	07951 PUBLIC RELATIONS	83, 305	441, 286	3, 72	7 0	0	194.01
00.00	Cross Foot Adjustments		C				200.00
01.00	Negative Cost Centers	0	0	(	0 0	0	201.00
							202.00

COST A	Financial Systems REH		Provi der	CCN: 153028	Peri od:	Worksheet B	2552-10
2001 7					From 01/01/2014 To 12/31/2014	Part I Date/Time Pre 5/28/2015 10:	pared: 14 am
	Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00591 ADMINISTRATIVE AND GENERAL						5.01
5.02	00590 OTHER A&G - NON FOUNDATION						5. 02
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG	648, 722					9.00
10.00	01000 DI ETARY	24, 903	1,077,358				10.00
11.00		11, 826	0	364, 14			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	4, 894	0	26, 36		500 774	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	6, 121	0	3, 11		500, 771	
15.00	01500 PHARMACY	3,026	0	7, 19		0	
16.00	01600 MEDICAL RECORDS & LIBRARY	8,074	0	8, 56		5	16.00
17.00	01700 SOCIAL SERVICE	2, 146	0	7,87		0	
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	772	0		0 0	0	22.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	309, 308	1,077,358	155, 78	1, 905, 052	10/ 110	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	309, 300	1,077,300	155,76	1, 905, 052	186, 119	30.00
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 053	0	1, 63		4, 716	•
60.00	06000 LABORATORY	2, 324	0	1, 0.	0 0	4, 710	
65.00	06500 RESPIRATORY THERAPY	9, 217	0	8, 98	-	33, 535	•
66.00	06600 PHYSI CAL THERAPY	113, 344	0	41, 13		4, 408	
66.01	06601 PHYSI CAL THERAPY - CARMEL	0	0	7, 17		3, 032	
67.00	06700 OCCUPATI ONAL THERAPY	89, 306	0	36, 42		946	
68.00	06800 SPEECH PATHOLOGY	20, 310	0	15, 14		1, 496	
68.01	06801 VI SI ON	0	0	3, 37		1, 523	•
68.02	06802 FAC RESOURCE	4, 307	0	12,60		7, 536	
69.00	06900 ELECTROCARDI OLOGY	0	0	,	0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	229, 489	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0		0 0	0	74.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	4, 840	0	9, 87	2 0	13, 723	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	22, 757	0	5, 64	15 0	13, 757	90.00
90. 01	09001 SLEEP CENTER	0	0		0 0	0	90.01
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	1 1		-			
	09900 CMHC	0	0		0 0	0	
99. 10	09910 CORF	0	0		0 0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
118.00		641, 528	1,077,358	350, 89	2, 227, 659	500, 771	118.00
	NONREI MBURSABLE COST CENTERS	1			-		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	5, 959	0		0 0		192.00
	07950 FOUNDATI ON	1, 235	0	8, 99			194.00
	07951 PUBLI C RELATI ONS	0	0	4, 25	62 0	0	194.01
200.00							200.00
201.00		0	1 077 050				201.00
202.00	TOTAL (sum lines 118-201)	648, 722	1,077,358	364, 14	2, 227, 659	500, 771	1202.00

OST ALLOCATION - GENERAL SERVICE COSTS		PITAL OF INDIA Provider		Peri od:	u of Form CMS-: Worksheet B	<u></u>
		11 off der	1	rom 01/01/2014	Part I	
				To 12/31/2014	Date/Time Pre 5/28/2015 10:	pared
				INTERNS &	0/20/2010 10.	
				RESI DENTS		
Cost Center Description	PHARMACY	MEDICAL	SOCIAL SERVICI	SERVI CES-OTHER	Subtotal	
		RECORDS &		PRGM COSTS		
	15.00	LI BRARY 16.00	17.00	22.00	24.00	
GENERAL SERVICE COST CENTERS	13.00	10.00	17.00	22.00	24.00	
00 00100 CAP REL COSTS-BLDG & FIXT						1. (
00200 CAP REL COSTS-MVBLE EQUIP						2.0
00400 EMPLOYEE BENEFITS DEPARTMENT						4. (
01 00591 ADMI NI STRATI VE AND GENERAL						5.0
00590 OTHER A&G - NON FOUNDATION						5.0
DO  00700 0PERATION OF PLANT DO  00800 LAUNDRY & LINEN SERVICE						7.0
00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING						9.0
. 00 01000 DI ETARY						10.0
00 01100 CAFETERI A						11. (
00 01300 NURSING ADMINISTRATION						13.0
00 01400 CENTRAL SERVICES & SUPPLY						14. (
00 01500 PHARMACY	917, 842					15. (
00 01600 MEDI CAL RECORDS & LI BRARY	0	787, 531	1			16. (
00 01700 SOCIAL SERVICE	0	(	615, 343			17. (
00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0		) (	275, 834		22. (
INPATIENT ROUTINE SERVICE COST CENTERS		707 504	(45.04)	075 004	47 (47 074	
00 03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	0	787, 531	615, 343	3 275, 834	17, 617, 974	30. (
00 05000 OPERATI NG ROOM	0	(			0	50. (
00 05400 RADI OLOGY-DI AGNOSTI C	0	(			188, 870	
00 06000 LABORATORY	0	(			438, 476	
00 06500 RESPIRATORY THERAPY	0	(			867, 426	
00 06600 PHYSI CAL THERAPY	0	(		0 0	3, 885, 670	
. 01 06601 PHYSI CAL THERAPY - CARMEL	0	(		0 0	657, 519	66. (
. 00 06700 OCCUPATI ONAL THERAPY	0	(		-	3, 359, 366	
. 00 06800 SPEECH PATHOLOGY	0	(		, i	1, 285, 348	
. 01 06801 VI SI ON	0	(		, i	268, 857	
02 06802 FAC RESOURCE	0	(		-	763, 167	
00 06900 ELECTROCARDI OLOGY 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	(		, i	0	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(		, v	467, 794 0	
00 07300 DRUGS CHARGED TO PATIENTS	917, 842	(		, i	2, 828, 252	
00 07400 RENAL DIALYSIS	0	(		-	0 27 0207 202	
00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C		0	960, 132	
OUTPATIENT SERVICE COST CENTERS	-					
00 09000 CLINIC	0	(			491, 562	
. 01 09001 SLEEP CENTER	0	(	0 (		0	
00 09100 EMERGENCY	0	(		0	0	
00 09200 0BSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. (
00 09900 CMHC	0	(		0	0	99. (
10 09910 CORF	0	(			0	
SPECIAL PURPOSE COST CENTERS	<u> </u>		- <b>I</b>	- <u> </u>	0	1
B. 00 SUBTOTALS (SUM OF LINES 1-117)	917, 842	787, 531	615, 343	3 275, 834	34, 080, 413	]118. (
NONREI MBURSABLE COST CENTERS						4
0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	(	) (	-		190. (
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	(		, i	858, 658	
4. 00 07950 FOUNDATI ON	0	(		2 0	1, 056, 250	
4. 01 07951 PUBLIC RELATIONS	0	(		0	449, 265	
0.00 Cross Foot Adjustments		,				200. 0
1.00 Negative Cost Centers 2.00 TOTAL (sum lines 118-201)	0 917, 842	787, 531	/ ( 			201.0
	917,042	101,03	615, 343	3 275, 834	30, 444, 380	1202.1

OST ALLC	nancial Systems RE DCATION - GENERAL SERVICE COSTS		Provider (	CN: 153028	Peri od:	u of Form CMS-2 Worksheet B	
					From 01/01/2014 To 12/31/2014	Part I Date/Time Prep	
	Cost Center Description	Intern &	Total		1	5/28/2015 10:1	14 ai
	····	Residents Cost					
		& Post					
		Stepdown					
		Adjustments					
0.5		25.00	26.00				
	NERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT	1					1
	200 CAP REL COSTS-BLDG & FIXT						1. 2.
	400 EMPLOYEE BENEFITS DEPARTMENT						
	591 ADMI NI STRATI VE AND GENERAL						4. 5.
	590 OTHER A&G - NON FOUNDATION						5.
	700 OPERATION OF PLANT						7.
	800 LAUNDRY & LINEN SERVICE						8.
	900 HOUSEKEEPI NG						9.
	000 DI ETARY						10.
	100 CAFETERI A						11.
	300 NURSING ADMINISTRATION						13.
	400 CENTRAL SERVICES & SUPPLY						14.
	500 PHARMACY						15.
5.00 01	600 MEDI CAL RECORDS & LI BRARY						16.
7.00 01	700 SOCIAL SERVICE						17.
2.00 02	200 I &R SERVICES-OTHER PRGM COSTS APPRVD						22.
I N	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	-275, 834	17, 342, 140				30.
	CILLARY SERVICE COST CENTERS						
	000 OPERATING ROOM	0	0				50.
	400 RADI OLOGY-DI AGNOSTI C	0	188, 870			1	54.
	000 LABORATORY	0	438, 476				60.
	500 RESPI RATORY THERAPY	0	867, 426				65.
	600 PHYSI CAL THERAPY	0	3, 885, 670				66
	601 PHYSI CAL THERAPY - CARMEL	0	657, 519				66
	700 OCCUPATIONAL THERAPY	0	3, 359, 366				67
	800 SPEECH PATHOLOGY	0	1, 285, 348				68 68
	801 VI SI ON 802 FAC RESOURCE	0	268, 857 763, 167				68
	900 ELECTROCARDI OLOGY	0	/03, 10/				69
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	467, 794				71
	200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72
	300 DRUGS CHARGED TO PATIENTS	0	2, 828, 252				73
	400 RENAL DI ALYSI S	0	0				74
	550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	960, 132				76
OU	TPATIENT SERVICE COST CENTERS						
. 00 09	000 CLINIC	0	491, 562				90
	001 SLEEP CENTER	0	О				90
. 00 09	100 EMERGENCY	0	О				91
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92
	HER REIMBURSABLE COST CENTERS	1 1					
	900 CMHC	0	0				99
		0	0				99
	ECIAL PURPOSE COST CENTERS	275 024	22 004 570				110
8.00	SUBTOTALS (SUM OF LINES 1-117)	-275, 834	33, 804, 579			1	118
	NREIMBURSABLE COST CENTERS		0				100
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 200 PHYSICIANS' PRIVATE OFFICES	0					190
	950 FOUNDATION	0	858,658				192 194
	950 POUNDATION 951 PUBLIC RELATIONS	0	1, 056, 250 449, 265				194 194
4.0107 0.00	Cross Foot Adjustments	0	449, 265				200
	USS TOUL AUJUSTINETILS	0	U				
01.00	Negative Cost Centers	0				·	201.

	Financial Systems REH TION OF CAPITAL RELATED COSTS	ABILITATION HOS		CCN: 153028	Peri od: From 01/01/2014 To 12/31/2014	u of Form CMS- Worksheet B Part II Date/Time Pre	epared:
			CAPITAL REI	LATED COSTS		5/28/2015 10:	14 am
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	9 Subtotal	EMPLOYEE BENEFITS 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 EQUIP		10.0//	1/ 0/			2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00591 ADMINISTRATIVE AND GENERAL	0	19, 366 36, 333			35, 661 4, 654	
5.01	00590 OTHER A&G - NON FOUNDATION	0	7, 831			1, 735	
7.02	00700 OPERATION OF PLANT	0	10, 317			747	
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0 0	0	
9.00	00900 HOUSEKEEPI NG	0	9, 671		-	524	
10.00	01000 DI ETARY	0	40, 099			82	
	01100 CAFETERI A	0	19, 043			39	
	01300 NURSI NG ADMI NI STRATI ON	0	7, 881			2, 533	13.00
	01400 CENTRAL SERVICES & SUPPLY	0	9, 857	8, 2		138	14.00
	01500 PHARMACY	0	4, 873	4, 10	0 8, 973	788	15.00
	01600 MEDICAL RECORDS & LIBRARY	0	13, 002			567	
	01700 SOCIAL SERVICE	0	3, 456			575	
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	1, 243	1, 04	46 2, 289	0	22.00
~ ~ ~	INPATIENT ROUTINE SERVICE COST CENTERS		100.050	440.0	24 047 404	11 100	
30.00	03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS	0	498, 053	419, 0	71 917, 124	11, 498	30.00
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	6, 526		-	117	
60.00	06000 LABORATORY	0	3, 741			0	
65.00	06500 RESPI RATORY THERAPY	0	14, 841			664	
	06600 PHYSI CAL THERAPY	0	182, 509			3, 258	
66. 01	06601 PHYSI CAL THERAPY - CARMEL	0	0		0 0	601	66.01
67.00	06700 OCCUPATI ONAL THERAPY	0	143, 802	120, 9	98 264, 800	2, 971	67.00
68.00	06800 SPEECH PATHOLOGY	0	32, 703	27, 5	17 60, 220	1, 221	
68. 01	06801 VI SI ON	0	0		0 0	299	
68. 02	06802 FAC RESOURCE	0	6, 936	5, 8		783	
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		0 0	0	
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	7, 794		-	985	
, 0. 00	OUTPATIENT SERVICE COST CENTERS	0	1, 194	0, 5	14, 332	700	1 / 0. 00
90.00	09000 CLINIC	0	36, 644	30, 8	32 67, 476	346	90.00
	09001 SLEEP CENTER	0	0		0 0	0+0	
	09100 EMERGENCY	0	0		0 0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS						
99.00	09900 CMHC	0	0		0 0	0	99.00
99. 10	09910 CORF	0	0		0 0	0	99.10
	SPECIAL PURPOSE COST CENTERS	1	-				
118.00		0	1, 116, 521	939, 4	60 2, 055, 981	35, 125	118.00
	NONREI MBURSABLE COST CENTERS			1			1.05 -
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		U 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	9, 596				192.00
		0	1, 989	1, 6			194.00
194.01 200.00	07951 PUBLIC RELATIONS Cross Foot Adjustments	0	0		0 0	421	194. 01 200. 00
200.00	· · · · · · · · · · · · · · · · · · ·		^		0	^	200.00
							IZUL. UL

	Financial Systems REH TION OF CAPITAL RELATED COSTS	ABILITATION HOSP			eriod:	u of Form CMS-2 Worksheet B	2552-10
ALLUCA	TION OF CAPITAL RELATED COSTS		FIOVICE	F	rom 01/01/2014 o 12/31/2014	Part II Date/Time Pre 5/28/2015 10:	
	Cost Center Description	ADMI NI STRATI VE	OTHER A&G -	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	·		ION FOUNDATI ON	PLANT	LINEN SERVICE		
		5.01	5.02	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS				I I		1
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	71 550					4.00
5.01	00591 ADMI NI STRATI VE AND GENERAL	71, 558	15 700				5.01
5.02 7.00	00590 OTHER A&G - NON FOUNDATION	599	15, 730	24 102			5.02
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	3, 640 273	807	24, 192 0	334		8.00
8.00 9.00	00900 HOUSEKEEPING	1, 229	61 272	222	534 0	20, 055	
10.00	01000 DI ETARY	1, 229	423	920	-	20, 055	1
11.00	01100 CAFETERI A	620	423	437	0	366	1
13.00	01300 NURSI NG ADMI NI STRATI ON	4, 249	941	181	0	151	
14.00	01400 CENTRAL SERVICES & SUPPLY	4, 249	204	226	-	189	
15.00	01500 PHARMACY	1, 579	350	112	0	94	
16.00	01600 MEDICAL RECORDS & LI BRARY	1, 252	277	298	-	250	
17.00	01700 SOCIAL SERVICE	1, 166	258	79		66	
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	531	118	29		24	
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	551	110	21	0	24	22.00
30.00	03000 ADULTS & PEDIATRICS	21, 980	4, 880	11, 428	330	9, 561	30.00
00.00	ANCI LLARY SERVICE COST CENTERS	21,700	1,000	11, 120	000	7,001	00.00
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	286	63	150		125	
60.00	06000 LABORATORY	835	185	86		72	
65.00	06500 RESPI RATORY THERAPY	1, 323	293	341	0	285	
66.00	06600 PHYSI CAL THERAPY	6,625	1, 468	4, 188	0	3, 504	66.00
66. 01	06601 PHYSI CAL THERAPY - CARMEL	1, 257	278	0	4	0	66. 01
57.00	06700 OCCUPATIONAL THERAPY	5, 796	1, 284	3, 300	0	2, 761	67.00
68.00	06800 SPEECH PATHOLOGY	2, 317	513	750	0	628	68.00
68. 01	06801 VI SI ON	514	114	0	0	0	68. 01
68. 02	06802 FAC RESOURCE	1, 414	313	159	0	133	68. 02
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	464	103	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 719	824	0	0	0	73.00
74.00	07400 RENAL DI ALYSI S	0	0	0	-	0	
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 787	396	179	0	150	76.00
	OUTPATIENT SERVICE COST CENTERS	1			1 1		4
90.00	09000 CLINIC	748	166	841	0	704	
90.01	09001 SLEEP CENTER	0	0	0		0	
91.00	09100 EMERGENCY	0	0	0	0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
~ ~ ~	OTHER REIMBURSABLE COST CENTERS						
99.00	09900 CMHC	0	0	0		0	
99.10	09910 CORF	0	0	0	0	0	99. 10
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	67,036	14, 728	23, 926	334	10 022	118.00
116.00	NONREI MBURSABLE COST CENTERS	07,030	14, 720	23, 920	534	19, 033	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	1, 627	360	220			190.00
			450	46			192.00
92.00	07950 FOUNDATION	.) (1)01					11/7.00
192.00 194.00	07950 FOUNDATION	2,029					
192.00 194.00 194.01	07951 PUBLIC RELATIONS	2, 029 866	192	0		0	194. 01
192.00 194.00	07951 PUBLIC RELATIONS Cross Foot Adjustments				0	0	194. 01 200. 00 201. 00

ALLOCA	TI ON OF CAPI TAL RELATED COSTS		Provi der	F	eriod: rom 01/01/2014 o 12/31/2014	Worksheet B Part II Date/Time Pre 5/28/2015 10:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
	F	10.00	11.00	13.00	14.00	15.00	
1 00	GENERAL SERVICE COST CENTERS				I		1 1 00
15. 00 16. 00 17. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00591 ADMINI STRATI VE AND GENERAL 00590 OTHER A&G - NON FOUNDATI ON 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	77, 944 0 0 0 0 0 0 0	36, 665 2, 655 314 725 863 793 0	25, 222 0 996 1, 186 0 0	20, 145 0 0	13, 617 0 0	16.00 17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			-	-		
30.00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	77, 944	15, 684	21, 569	7, 487	0	30.00
71.00 72.00 73.00	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06601 PHYSI CAL THERAPY 06601 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06801 VI SI ON 06802 FAC RESOURCE 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS		0 164 0 905 4, 142 722 3, 668 1, 525 340 1, 269 0 0 0 0 0 0	0 226 0 1,245 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	190 20	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 54.\ 00\\ 60.\ 00\\ 65.\ 00\\ 66.\ 01\\ 67.\ 00\\ 68.\ 00\\ 68.\ 01\\ 68.\ 02\\ 69.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ \end{array}$
74.00	07400 RENAL DI ALYSI S	0	0 994	0	0	0	
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS		994	0	552	0	76.00
90. 00 90. 01 91. 00 92. 00	09000 CLINIC 09001 SLEEP CENTER 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0	568 0 0	000000000000000000000000000000000000000	0	0 0 0	90.01
99 00	OTHER REIMBURSABLE COST CENTERS 09900 CMHC	0	0	0	0	0	99.00
	09910 CORF SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	99. 00 99. 10
118.00		77, 944	35, 331	25, 222	20, 145	13, 617	118.00
192.00 194.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 FOUNDATION 07951 PUBLIC RELATIONS Cross Foot Adjustments	0 0 0	0 0 906 428	0		0 0 0	190.00 192.00 194.00 194.01 200.00 201.00

LLOCATION O	cial Systems REH. F CAPITAL RELATED COSTS	ABILITATION HOS		CCN: 153028	Peri od:	u of Form CMS- Worksheet B	
					From 01/01/2014 To 12/31/2014	Part II Date/Time Pre	epare
						5/28/2015 10:	14 8
				INTERNS &			
				RESI DENTS			
	Cost Center Description	MEDI CAL	SOCIAL SERVICE			Intern &	
		RECORDS &		PRGM COSTS		Residents Cost	
		LI BRARY				& Post	
						Stepdown Adjustments	
		16.00	17.00	22.00	24.00	25.00	-
GENERA	L SERVICE COST CENTERS						
00 00100	CAP REL COSTS-BLDG & FIXT						1
00 00200	CAP REL COSTS-MVBLE EQUIP						2
00 00400	EMPLOYEE BENEFITS DEPARTMENT						4
01 00591	ADMINISTRATIVE AND GENERAL						5
02 00590	OTHER A&G - NON FOUNDATION						5
00 00700	OPERATION OF PLANT						7
00800	LAUNDRY & LINEN SERVICE						8
00 00900	HOUSEKEEPING						9
. 00 01000	DI ETARY						10
. 00 01100	CAFETERIA						11
. 00 01300	NURSI NG ADMI NI STRATI ON						13
. 00 01400	CENTRAL SERVICES & SUPPLY						14
. 00 01500	PHARMACY						15
. 00 01600	MEDICAL RECORDS & LIBRARY	28, 635					16
	SOCIAL SERVICE	0	9, 301				17
	I&R SERVICES-OTHER PRGM COSTS APPRVD	0			91		22
	ENT ROUTINE SERVICE COST CENTERS	-	-				
	ADULTS & PEDIATRICS	28, 635	9, 301		1, 137, 421	0	J 30
ANCI LL	ARY SERVICE COST CENTERS		· · · ·				
. 00 05000	OPERATING ROOM	0	C	)	0	0	50
. 00 05400	RADI OLOGY-DI AGNOSTI C	0	C		13, 338	0	54
. 00 06000	LABORATORY	0	C		8, 087	0	60
. 00 06500	RESPI RATORY THERAPY	0	C		33, 734	0	65
. 00 06600	PHYSI CAL THERAPY	0	C	)	359, 437	0	66
. 01 06601	PHYSICAL THERAPY - CARMEL	0	C	)	2, 984	0	66
. 00 06700	OCCUPATI ONAL THERAPY	0	C	)	284, 618	0	67
. 00 06800	SPEECH PATHOLOGY	0	C	)	67, 234	0	68
. 01 06801	VISION	0	C		1, 328	0	68
. 02 06802	FAC RESOURCE	0	C		17, 146	0	68
. 00 06900	ELECTROCARDI OLOGY	0	C		0	0	69
. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		9, 800	0	71
. 00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	C		0	0	72
. 00 07300	DRUGS CHARGED TO PATIENTS	0	C		18, 160	0	73
	RENAL DIALYSIS	0	C		0	0	
	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			19, 395	0	
	IENT SERVICE COST CENTERS						
. 00 09000	CLINIC	0	C	)	71, 402	0	90
	SLEEP CENTER	0	C		0	0	
.00 09100		0	C		0	0	
	OBSERVATION BEDS (NON-DISTINCT PART)					0	
	REIMBURSABLE COST CENTERS						
. 00 09900	СМНС	0	C	)	0	0	99
. 10 09910	CORF	0	C		0	0	99
	L PURPOSE COST CENTERS						
8.00	SUBTOTALS (SUM OF LINES 1-117)	28, 635	9, 301	L	0 2, 044, 084	0	118
	MBURSABLE COST CENTERS			1			
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C		0		190
	PHYSICIANS' PRIVATE OFFICES	0	C		20, 061		192
	FOUNDATION	0	C		7, 246		194
	PUBLIC RELATIONS	0	C		1, 907		194
	Cross Foot Adjustments			2, 9	91 2, 991		200
	Negative Cost Centers	0	C		0 1, 024		201
2.00	TOTAL (sum lines 118-201)	28, 635	9, 301	2, 9	91 2, 077, 313		202

Heal th	Financi	al Syste	ms
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In Lieu of Form CMS-2552-10

	FINANCIAL SYSTEMS REHA	ABILITATION HOSPI	Provi der CCN: 153028	In Lieu of Form CMS           Period:         Worksheet B           From 01/01/2014         Part II           To         12/31/2014           Date/Time Pr           5/28/2015	repared:
	Cost Center Description	Total 26.00			
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00591 ADMINISTRATIVE AND GENERAL				5.01
5.02	00590 OTHER A&G - NON FOUNDATION				5.02
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPI NG				9.00
10.00	01000 DI ETARY				10.00
11.00	01100 CAFETERI A				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON				13.00
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				17.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD				22.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · ·			
30.00	03000 ADULTS & PEDI ATRI CS	1, 137, 421			30.00
	ANCI LLARY SERVICE COST CENTERS	· · · · · ·			
50.00	05000 OPERATING ROOM	0			50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	13, 338			54.00
60.00	06000 LABORATORY	8, 087			60.00
65.00	06500 RESPI RATORY THERAPY	33, 734			65.00
66.00	06600 PHYSI CAL THERAPY	359, 437			66.00
66. 01	06601 PHYSI CAL THERAPY - CARMEL	2, 984			66.01
67.00	06700 OCCUPATI ONAL THERAPY	284, 618			67.00
68.00	06800 SPEECH PATHOLOGY	67, 234			68.00
68. 01	06801 VI SI ON	1, 328			68.01
68. 02	06802 FAC RESOURCE	17, 146			68.02
69.00	06900 ELECTROCARDI OLOGY	0			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 800			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	18, 160			73.00
74.00	07400 RENAL DI ALYSI S	0			74.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	19, 395			76.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	71, 402			90.00
90. 01	09001 SLEEP CENTER	0			90.01
91.00	09100 EMERGENCY	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS				
99.00	09900 CMHC	0			99.00
99.10	09910 CORF	0			99.10
	SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	2, 044, 084			118.00
	NONREI MBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	20, 061			192.00
	07950 FOUNDATI ON	7, 246			194.00
194.01	07951 PUBLIC RELATIONS	1, 907			194.01
200.00	Cross Foot Adjustments	2, 991			200.00
		1 004			1
201.00	Negative Cost Centers	1, 024			201.00

Heal th Financial	Systems	
COST ALLOCATION	- STATI STI CAL	BASI S

 REHABILITATION HOSPITAL OF INDIANA
 In Lieu of Form CMS-2552-10

 Provider CCN: 153028
 Period: From 01/01/2014
 Worksheet B-1

CUST ALLUCATION - STA	ATTSTICAL BASIS		Provi der		From 01/01/2014	WORKSneet B-I	
					To 12/31/2014	Date/Time Pre	
						5/28/2015 10:	14 am
		CAPITAL REL	LATED CUSTS				
Cost Cen	ter Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconci I i ati on	ADMI NI STRATI VE	
		(SQUARE FEET)	(SQUARE FEET)	BENEFI TS		AND GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
		1.00	2.00	SALARIES) 4.00	5A. 01	5. 01	
GENERAL SERVIC	F COST CENTERS	1.00	2.00	4.00	JA. 01	5.01	
	COSTS-BLDG & FIXT	90, 757					1.00
2.00 00200 CAP REL (	COSTS-MVBLE EQUIP		90, 757				2.00
	BENEFITS DEPARTMENT	1, 558					4.00
	RATIVE AND GENERAL	2, 923					5.01
5. 02 00590 OTHER A&C 7. 00 00700 OPERATI 0	G - NON FOUNDATION	630 830				247, 570	5.02
	LINEN SERVICE	830	830			1, 504, 167 112, 909	7.00 8.00
9.00 00900 HOUSEKEEF		778	778		-	508, 053	1
10.00 01000 DI ETARY		3, 226				789, 413	
11.00 01100 CAFETERI	<i>4</i>	1, 532	1, 532	19, 058	3 0	256, 242	11.00
13.00 01300 NURSI NG A		634	634			1, 755, 605	1
	SERVICES & SUPPLY	793	793			381, 341	1
15.00 01500 PHARMACY		392	392			652, 383	1
16.00 01600 MEDICAL F 17.00 01700 SOCIAL SE	RECORDS & LI BRARY	1, 046 278				517, 304 482, 011	1
1 1	CES-OTHER PRGM COSTS APPRVD	100	100				1
	INE SERVICE COST CENTERS	100	100		<u> </u>	217,171	22.00
30.00 03000 ADULTS &		40, 069	40, 069	5, 628, 838	3 0	9, 077, 217	30.00
	I CE COST CENTERS	1		1	1	1	
50.00 05000 OPERATI NO		0	0		-		
54.00 05400 RADI OLOG		525	525		1 0	118, 215	
60. 00 06000 LABORATOR 65. 00 06500 RESPI RATO		301 1, 194	301 1, 194			345, 124 546, 560	
66. 00 06600 PHYSI CAL		14, 683	14, 683			2, 737, 453	1
	THERAPY - CARMEL	0	0			519, 317	1
67.00 06700 0CCUPATI	ONAL THERAPY	11, 569	11, 569			2, 395, 166	1
68.00 06800 SPEECH PA	ATHOLOGY	2, 631	2, 631	597, 552	2 0	957, 500	68.00
68.01 06801 VI SI ON		0	0	110,010		212, 337	1
68.02 06802 FAC RESOL		558	558	383, 172	2 0	584, 355	1
69.00 06900 ELECTROC/ 71.00 07100 MEDI CAL S	SUPPLIES CHARGED TO PATIENTS	0				0 191, 699	69.00 71.00
1 1	V. CHARGED TO PATIENTS	0				0	1
	ARGED TO PATIENTS	0	0		0 0	1, 536, 789	
74.00 07400 RENAL DI		0	0		0 0		1
	RIC/PSYCHOLOGICAL SERVICES	627	627	482, 027	7 0	738, 364	76.00
	VICE COST CENTERS				-		
90.00 09000 CLINIC 90.01 09001 SLEEP CE		2, 948	2, 948	169, 488	3 0		90.00
91.00 09100 EMERGENC		0	0			0	90. 01 91. 00
1 1	ON BEDS (NON-DISTINCT PART)	0				0	92.00
	ABLE COST CENTERS	1		1			/2:00
99.00 09900 CMHC		0	0	(	0 0	0	99.00
99.10 09910 CORF		0	0	(	0 0	0	99.10
SPECIAL PURPOS							
	S (SUM OF LINES 1-117)	89, 825	89, 825	17, 188, 413	3 -6, 879, 932	27, 695, 819	118.00
NONREI MBURSABL	DWER, COFFEE SHOP & CANTEEN	0	0		0	0	190.00
192. 00 19200 PHYSI CI AI	-	772	-				
194. 00 07950 FOUNDATI		160			0 0	838, 610	
194.01 07951 PUBLIC R		0	0	205, 740		357, 981	
	ot Adjustments						200. 00
Ű	Cost Centers						201.00
	be allocated (per Wkst. B,	1, 128, 106	949, 207	5, 200, 886		6, 879, 932	202.00
203.00 Part I) Unit cost	t multiplier (Wkst. B, Part I)	12. 429961	10. 458775	0. 298040		0. 232708	203 00
	be allocated (per Wkst. B, Part I)	12.429901	10. 400//0	35, 66			203.00
Part II)						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
205.00 Unit cost	t multiplier (Wkst. B, Part			0. 002044	1	0. 002420	205.00
)				I		I	I

ST AL	LOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
					To 12/31/2014	Date/Time Pre	par
	Cost Center Description	Reconciliation	OTHER A&G - NON FOUNDATION (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LINEN SERVICE	5/28/2015 10: HOUSEKEEPING (SQUARE FEET)	14
		5A. 02	5. 02	7.00	8.00	9.00	-
C	GENERAL SERVICE COST CENTERS	0/11/02	0.02	1.00	0100	7100	
00	DO100 CAP REL COSTS-BLDG & FIXT						1 '
	DO200 CAP REL COSTS-MVBLE EQUIP						
0 0	DO400 EMPLOYEE BENEFITS DEPARTMENT						
	DO591 ADMINISTRATIVE AND GENERAL						
	DO590 OTHER A&G - NON FOUNDATION	-305, 182					
	00700 OPERATION OF PLANT	C	.,				
	DO800 LAUNDRY & LINEN SERVICE	C	1077101		0 222, 003		
	00900 HOUSEKEEPI NG	0	626, 281			84, 038	
	D1000 DI ETARY	0	973, 116			3, 226	
			315, 872			1, 532	
	01300 NURSI NG ADMI NI STRATI ON		2, 164, 148			634	
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY		470, 082 804, 198			793 392	
	D1600 MEDICAL RECORDS & LIBRARY				-	392 1, 046	
	D1700 SOCIAL SERVICE					278	
	D2200 I &R SERVICES-OTHER PRGM COSTS APPRVD					100	
	NPATIENT ROUTINE SERVICE COST CENTERS		210, 312		<u> </u>	100	2
	03000 ADULTS & PEDI ATRI CS	C	11, 189, 556	40, 06	9 218, 659	40, 069	3
	ANCI LLARY SERVICE COST CENTERS		,,,	1 10,00	210,007	10/00/	
	D5000 OPERATING ROOM	C	) C	)	0 0	0	15
00 0	05400 RADI OLOGY-DI AGNOSTI C	C	145, 725	52	5 0	525	5
	06000 LABORATORY	C	425, 437		1 0	301	6
00 0	06500 RESPI RATORY THERAPY	C				1, 194	6
00 0	06600 PHYSI CAL THERAPY	C	3, 374, 480	14, 68	3 161	14, 683	6
01 0	06601 PHYSI CAL THERAPY - CARMEL	C	640, 166		0 2, 754	0	6
00 0	06700 OCCUPATI ONAL THERAPY	C	2, 952, 540	11, 56	9 253	11, 569	6
00 0	D6800 SPEECH PATHOLOGY	C	1, 180, 318	2,63	1 176	2, 631	6
01 0	06801 VI SI ON	C	261, 750		0 0	0	6
02 0	06802 FAC RESOURCE	C	720, 339	55	8 0	558	6
	06900 ELECTROCARDI OLOGY	C	) C		0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	236, 309		0 0	0	1
	D7200 IMPL. DEV. CHARGED TO PATIENTS	C			0 0	0	
	D7300 DRUGS CHARGED TO PATIENTS	C	1,0,1,112		0 0	0	1 .
	07400 RENAL DI ALYSI S	C	-		0 0	0	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	C	910, 187	62	7 0	627	7
- H	DUTPATIENT SERVICE COST CENTERS	C	201 102	2.04	8 0	2.040	1.
	09001 SLEEP CENTER				0 0	2, 948 0	
	D9100 EMERGENCY		-		0 0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	0	9
	THER REIMBURSABLE COST CENTERS			I			ť
	09900 CMHC	C			0 0	0	9
	09910 CORF				0 0	0	
	SPECIAL PURPOSE COST CENTERS		<u> </u>		<u> </u>		
. 00	SUBTOTALS (SUM OF LINES 1-117)	-305, 182	33, 835, 676	83, 88	4 222, 003	83, 106	11
Γ	NONREIMBURSABLE COST CENTERS						
. 00 1	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	) C		0 0	0	19
	19200 PHYSI CLANS' PRI VATE OFFI CES	C				772	
	D7950 FOUNDATI ON	C	.,			160	
	07951 PUBLIC RELATIONS	C	441, 286		0 0	0	19
. 00	Cross Foot Adjustments						20
. 00	Negative Cost Centers						20
. 00	Cost to be allocated (per Wkst. B,		305, 182	1, 869, 85	8 140, 359	648, 722	20
00	Part I)		0.000445	22 04/05	0 ( 22222	7 740000	2
. 00	Unit cost multiplier (Wkst. B, Part I)		0.008445			7. 719389	
. 00	Cost to be allocated (per Wkst. B,		16, 754	24, 19	2 334	20, 055	204
. 00	Part II)		0.000435	0 20522	0 001504	0 220442	201
	Unit cost multiplier (Wkst. B, Part	1	0. 000435	0. 28522	9 0. 001504	0. 238642	120

		ABILITATION HOS				u of Form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
					To 12/31/2014	Date/Time Pre 5/28/2015 10:	
	Cost Center Description	DIETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
		(MEALS SERVED)	(HOURS PAID)	ADMI NI STRATI O	N SERVICES & SUPPLY	(COSTED REQUIS.)	
				(DI RECT NURS.	(COSTED	RECORD. )	
		10.00	11.00	HRS. )	REQUIS.)	45.00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	15.00	
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
5.01 5.02	00591 ADMINISTRATIVE AND GENERAL 00590 OTHER A&G - NON FOUNDATION						5.01
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG	54 400					9.00
	01000 DI ETARY 01100 CAFETERI A	56, 682 0	437, 697				10.00
	01300 NURSING ADMINISTRATION	0	437, 697 31, 689		0		13.00
	01400 CENTRAL SERVICES & SUPPLY	0	3, 744		0 418, 309		14.00
	01500 PHARMACY	0	8, 649	8, 64	9 0	100	15.00
	01600 MEDICAL RECORDS & LIBRARY	0	10, 297			0	
	01700 SOCIAL SERVICE 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	9, 461 0		0 0 0 0	0	
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0		0 0	0	22.00
30.00	03000 ADULTS & PEDI ATRI CS	56, 682	187, 259	187, 25	9 155, 471	0	30.00
	ANCI LLARY SERVI CE COST CENTERS	1 1			1 1		
	05000 OPERATING ROOM	0	0		0 0	0	
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	1, 960	1, 96	0 3, 939 0 406	0	
	06500 RESPI RATORY THERAPY	0	10, 805	10, 80		0	
66.00	06600 PHYSI CAL THERAPY	0	49, 446		0 3, 682	0	66.00
	06601 PHYSI CAL THERAPY - CARMEL	0	8, 623		0 2, 533	0	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	43, 787		0 790 0 1.250	0	
	06801 VI SI ON	0	18, 201 4, 055		0 1, 250 0 1, 272	0	
	06802 FAC RESOURCE	0	15, 145		0 6, 295	0	
	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 191, 699	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0 0 0	0 100	
	07400 RENAL DI ALYSI S	0	0		0 0	0	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	11, 866		0 11, 463	0	
	OUTPATIENT SERVICE COST CENTERS	-1		1			
	09000 CLINIC 09001 SLEEP CENTER	0	6, 785		0 11, 492 0 0	0	
	09100 EMERGENCY	0	0		0 0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		Ū.			0	92.00
	OTHER REIMBURSABLE COST CENTERS	1					
	09900 CMHC	0	0		0 0		99.00
99.10	09910 CORF SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	99.10
118.00		56, 682	421, 772	218, 97	0 418, 309	100	118.00
	NONREI MBURSABLE COST CENTERS		,				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	07950 FOUNDATI ON 07951 PUBLI C RELATI ONS	0	10, 814 5, 111				194.00 194.01
200.00			5, 111			0	200.00
201.00	Negative Cost Centers						201.00
202.00		1, 077, 358	364, 141	2, 227, 65	9 500, 771	917, 842	202.00
202.00	Part I)	10 007057	0 001040	10 17005	2 1 107100	0 170 40000	202 00
203.00 204.00		19. 007057 77, 944	0. 831948 36, 665			9, 178. 420000 13. 617	203.00
207.00	Part II)	, , , , , + 4	50, 005	20,22	20, 143	15, 017	207.00
205.00		1. 375110	0. 083768	0. 11518	5 0. 048158	136. 170000	205 00
205.00		1. 373110	0.003700	0. 11510	0.040130	130. 170000	200.00

	Financial Systems REH. LOCATION - STATISTICAL BASIS	ADILIIAIIUN HUS	PITAL OF INDIAN Provider	IA CCN: 153028	In Lieu of Fo Period: Worksh	neet B-1
					From 01/01/2014	
					To 12/31/2014 Date/T 5/28/2	ime Prepare 2015 10:14 a
				INTERNS &		
				RESI DENTS		
	Cost Center Description		SOCIAL SERVICE		R	
		RECORDS &		PRGM COSTS		
			(PATIENT DAYS)	(ASSI GNED		
		(PATIENT DAYS) 16.00	17.00	TI ME)	_	
0	GENERAL SERVICE COST CENTERS	10.00	17.00	22.00		
	DO100 CAP REL COSTS-BLDG & FIXT					1
	DO200 CAP REL COSTS-MVBLE EQUIP					2
	00400 EMPLOYEE BENEFITS DEPARTMENT					4
	00591 ADMINISTRATIVE AND GENERAL					5
	DO590 OTHER A&G - NON FOUNDATION					5
	DO700 OPERATION OF PLANT					7
0 0	DO800 LAUNDRY & LINEN SERVICE					8
0 0	DO900 HOUSEKEEPI NG					9
00	D1000 DI ETARY					10
00 0	D1100 CAFETERI A					11
	01300 NURSING ADMINISTRATION					13
	01400 CENTRAL SERVICES & SUPPLY					14
	D1500 PHARMACY					15
	01600 MEDI CAL RECORDS & LI BRARY	18, 894				16
	D1700 SOCIAL SERVICE	0	18, 894			17
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	10	00	22
	INPATIENT ROUTINE SERVICE COST CENTERS	10.004	1.001			
	03000 ADULTS & PEDIATRICS	18, 894	18, 894	10	00	30
	ANCI LLARY SERVICE COST CENTERS	0	0			
	05000 OPERATING ROOM	0	0		0	50
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	54
	06000 LABORATORY 06500 RESPI RATORY THERAPY	0	0		0	60
	D6600 PHYSI CAL THERAPY	0	0		0	66
	D6601 PHYSICAL THERAPY - CARMEL	0	0		0	66
	06700 OCCUPATI ONAL THERAPY		0		0	67
	D6800 SPEECH PATHOLOGY	0	0		0	68
	06801 VI SI ON	0	0		0	68
	06802 FAC RESOURCE	0	0		0	68
	06900 ELECTROCARDI OLOGY	0	0		0	69
00 0	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0	71
00 0	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	72
00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	73
00	07400 RENAL DIALYSIS	0	0		0	74
00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	76
	DUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C	0	0		0	90
	D9001 SLEEP CENTER	0	0		0	90
	D9100 EMERGENCY	0	0		0	91
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92
	OTHER REIMBURSABLE COST CENTERS				-	
	09900 CMHC	0	0		0	99
	09910 CORF	0	0		0	99
	SPECIAL PURPOSE COST CENTERS					
. 00	SUBTOTALS (SUM OF LINES 1-117)	18, 894	18, 894	10	00	118
	NONREI MBURSABLE COST CENTERS	0				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	192
	07950 FOUNDATI ON 07951 PUBLI C RELATI ONS	0	0		0	194 194
		0	0			
. 00	Cross Foot Adjustments					200
. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	707 501	£1E 343	275, 83		201 202
. 00	Part I)	787, 531	615, 343	275,83	24	202
. 00	Unit cost multiplier (Wkst. B, Part I)	41. 681539	32. 568170	2, 758. 34000	00	203
1. 00	Cost to be allocated (per Wkst. B, Part I)	41. 681539 28, 635		2, 758. 34000		203
	Part II)	20,035	9, 301	2, 95		204
5. 00	Unit cost multiplier (Wkst. B, Part	1. 515560	0. 492273	29.91000	00	205
		1. 515500	5. 772275	27. 71000		203

COMPUTATION OF RATIO OF COSTS TO CHARGES			CCN: 153028	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/28/2015 10:	
		Titl	e XVIII	Hospi tal	PPS	_
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)			Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	17, 342, 140	)	17, 342, 14	10 0	17, 342, 140	30.00
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	C	1		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	188, 870		188, 87		188, 870	54.00
60. 00 06000 LABORATORY	438, 476		438, 47		438, 476	60.00
65. 00 06500 RESPI RATORY THERAPY	867, 426		867, 42		867, 426	
66. 00 06600 PHYSI CAL THERAPY	3, 885, 670		3, 885, 67		3, 885, 670	
66.01 06601 PHYSI CAL THERAPY - CARMEL	657, 519		657, 51		657, 519	
67.00 06700 OCCUPATI ONAL THERAPY	3, 359, 366		3, 359, 36		3, 359, 366	67.00
68.00 06800 SPEECH PATHOLOGY	1, 285, 348		1, 285, 34		1, 285, 348	
68. 01 06801 VI SI ON	268, 857		268, 85		268, 857	
68. 02 06802 FAC RESOURCE	763, 167	0	763, 16	57 0	763, 167	68.02
69. 00 06900 ELECTROCARDI OLOGY	C			0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	467, 794	-	467, 79	04 0	467, 794	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	C			0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 828, 252	2	2, 828, 25	52 0	2, 828, 252	
74.00 07400 RENAL DIALYSIS	C			0 0	0	74. OC
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	960, 132	2	960, 13	32 0	960, 132	76.00
OUTPATIENT SERVICE COST CENTERS				-		
90. 00 09000 CLINIC	491, 562	2	491, 56		491, 562	90.00
90. 01 09001 SLEEP CENTER	C			0 0	0	90.01
91.00 09100 EMERGENCY	C			0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REI MBURSABLE COST CENTERS			1			
99.00 09900 CMHC	C			0	0	99.00
99. 10 09910 CORF				0	0	99.10
200.00 Subtotal (see instructions)	33, 804, 579	0	33, 804, 57	0 0	33, 804, 579	
201.00 Less Observation Beds				0		201.00
202.00  Total (see instructions)	33, 804, 579	2 O	33, 804, 57	0 0	33, 804, 579	202.00

Health Financial Systems         REH           COMPUTATION OF RATIO OF COSTS TO CHARGES	IABI LI TATI ON HOSI	Provi der	CCN: 153028	Period: From 01/01/2014 To 12/31/2014	u of Form CMS- Worksheet C Part I Date/Time Pre 5/28/2015 10:	epared:
			e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	30, 516, 302		30, 516, 30	02		30.00
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0.000000	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	928, 148	0	928, 14		0. 000000	
60. 00 06000 LABORATORY	1, 124, 787	123			0.00000	
65. 00 06500 RESPI RATORY THERAPY	2, 426, 561	506			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	9, 071, 362	4, 167, 613			0. 000000	
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	1, 544, 340			0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	9, 275, 540	2,045,241			0. 000000	
68.00 06800 SPEECH PATHOLOGY	5, 858, 720	1, 068, 020			0. 000000	
68. 01 06801 VI SI ON	263, 400	499, 336			0.00000	
68. 02 06802 FAC RESOURCE	0	415, 023			0.00000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0. 000000	0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 151, 643	158, 581	1, 310, 2		0.00000	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0. 000000	0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 632, 075	3, 378, 996	9, 011, 0		0.00000	
74.00 07400 RENAL DIALYSIS	0	0		0 0. 000000	0.00000	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	232, 636	377, 558	610, 19	94 1. 573486	0. 000000	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	5, 129	1, 687, 810	1, 692, 9			
90. 01 09001 SLEEP CENTER	0	0		0 0.000000	0.00000	
91.00 09100 EMERGENCY	0	0		0 0.000000	0.00000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1	0 0.00000	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS				0		00.00
99. 00 09900 CMHC	0	0		0		99.00
99. 10 09910 CORF	0	0	01.000	0		99.10
200.00 Subtotal (see instructions)	66, 486, 303	15, 343, 147	81, 829, 4	50		200.00
201.00 Less Observation Beds		45 040 117	01.000	- 0		201.00
202.00 Total (see instructions)	66, 486, 303	15, 343, 147	81, 829, 4	50		202.00

Health Financial Systems REH	ABILITATION HOSPITA	AL OF INDIANA	In Lieu	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 153028	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pro 5/28/2015 10:	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	1				_
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCILLARY SERVICE COST CENTERS					_
50.00 05000 OPERATI NG ROOM	0. 000000				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 203491				54.00
60. 00 06000 LABORATORY	0. 389788				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 357397				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 293502				66.00
66.01 06601 PHYSI CAL THERAPY - CARMEL	0. 425761				66.01
67.00 06700 OCCUPATI ONAL THERAPY	0. 296743				67.00
68.00 06800 SPEECH PATHOLOGY	0. 185563				68.00
68. 01 06801 VI SI ON	0. 352490				68.01
68. 02 06802 FAC RESOURCE	1.838855				68.02
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 357034				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 313864				73.00
74.00 07400 RENAL DIALYSIS	0. 000000				74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1. 573486				76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 290360				90.00
90.01 09001 SLEEP CENTER	0. 000000				90.01
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS	-				
99.00 09900 CMHC					99.00
99. 10 09910 CORF					99.10
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

COMPUTATI ON	N OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 153028	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/28/2015 10:	
			Tit	le XIX	Hospi tal	PPS	-
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)			Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	TI ENT ROUTI NE SERVI CE COST CENTERS	1	•				
	0 ADULTS & PEDIATRICS	17, 342, 140		17, 342, 14	40 0	17, 342, 140	30.00
	LLARY SERVICE COST CENTERS	1	1	1			-
	O OPERATING ROOM	0		100.0	0 0	0	
	0 RADI OLOGY-DI AGNOSTI C	188, 870		188, 8		188, 870	•
		438, 476		438, 4		438, 476	60.00
	0 RESPI RATORY THERAPY 0 PHYSI CAL THERAPY	867, 426		867, 42		867, 426	
	1 PHYSICAL THERAPY 1 PHYSICAL THERAPY - CARMEL	3, 885, 670 657, 519		3, 885, 6 657, 5		3, 885, 670 657, 519	
	0 OCCUPATIONAL THERAPY	3, 359, 366		3, 359, 3		3, 359, 366	
	0 SPEECH PATHOLOGY	1, 285, 348		1, 285, 3		1, 285, 348	
	1 VI SI ON	268, 857		268, 8		268, 857	•
	2 FAC RESOURCE	763, 167		763, 10		763, 167	68.02
	0 ELECTROCARDI OLOGY	, 00, 107	Ű	, , , , , , , , , , , , , , , , , , , ,	0 0	0	69.00
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS	467, 794		467, 79	94 0	467, 794	
	O I MPL. DEV. CHARGED TO PATIENTS	0			0 0	0	
	O DRUGS CHARGED TO PATIENTS	2, 828, 252		2, 828, 2	52 0	2, 828, 252	73.00
74.00 0740	O RENAL DI ALYSI S	0			0 0	0	74.00
76.00 0355	0 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	960, 132		960, 13	32 0	960, 132	76.00
	ATIENT SERVICE COST CENTERS						
90.00 0900		491, 562		491, 5	52 0	491, 562	90.00
	1 SLEEP CENTER	0			0 0	0	90.01
	O EMERGENCY	0			0 0	0	91.00
	O OBSERVATION BEDS (NON-DISTINCT PART)	0	)		0	0	92.00
	R REIMBURSABLE COST CENTERS	1	1	1			
	O CMHC	0			0	0	99.00
	0 CORF	0			0	0	99.10
200.00	Subtotal (see instructions)	33, 804, 579	0	33, 804, 5	79 0	33, 804, 579	
201.00	Less Observation Beds	0			0		201.00
202.00	Total (see instructions)	33, 804, 579	0	33, 804, 5	79 0	33, 804, 579	202.0

Health Financial Systems REH COMPUTATION OF RATIO OF COSTS TO CHARGES	ABILITATION HOSI	Provi der	CCN: 153028	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/28/2015 10:	epared:
			le XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	lotal (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	30, 516, 302		30, 516, 30	02		30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 0. 000000	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	928, 148	0			0.00000	
60. 00 06000 LABORATORY	1, 124, 787	123	1, 124, 9			
65. 00 06500 RESPI RATORY THERAPY	2, 426, 561	506				
66. 00 06600 PHYSI CAL THERAPY	9, 071, 362	4, 167, 613	13, 238, 9			
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	1, 544, 340	1, 544, 3	40 0. 425761	0.00000	
67.00 06700 OCCUPATI ONAL THERAPY	9, 275, 540	2, 045, 241	11, 320, 7		0.00000	
68.00 06800 SPEECH PATHOLOGY	5, 858, 720	1, 068, 020	6, 926, 7		0.00000	
68. 01 06801 VI SI ON	263, 400	499, 336	762, 73		0.00000	
68. 02 06802 FAC RESOURCE	0	415, 023	415, 02		0.00000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0.000000	0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 151, 643	158, 581	1, 310, 2	0. 357034	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0.000000	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 632, 075	3, 378, 996	9, 011, 0	0. 313864	0.00000	73.00
74. 00 07400 RENAL DI ALYSI S	0	0		0 0.000000	0.00000	74.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	232, 636	377, 558	610, 19	94 1. 573486	0.00000	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	5, 129	1, 687, 810	1, 692, 9	39 0. 290360	0. 000000	90.00
90. 01 09001 SLEEP CENTER	0	0		0 0.000000	0.00000	
91.00 09100 EMERGENCY	0	0		0 0.000000	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0.000000	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						1
99.00 09900 CMHC	0	0		0		99.00
99. 10 09910 CORF	0	0		0		99.10
200.00 Subtotal (see instructions)	66, 486, 303	15, 343, 147	81, 829, 4	50		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	66, 486, 303	15, 343, 147	81, 829, 4	50		202.00

In Lieu of Form CMS-2552-10

Health Financial Systems REHA	ABILITATION HUSPIT	AL OF INDIANA	In Lieu	J OT FORM CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 153028	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pro 5/28/2015 10	
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM	0.000000				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 203491				54.00
60. 00 06000 LABORATORY	0. 389788				60.00
65. 00 06500 RESPI RATORY THERAPY	0.357397				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 293502				66.00
66.01 06601 PHYSI CAL THERAPY - CARMEL	0. 425761				66.01
67.00 06700 OCCUPATI ONAL THERAPY	0. 296743				67.00
68.00 06800 SPEECH PATHOLOGY	0. 185563				68.00
68. 01 06801 VI SI ON	0. 352490				68.01
68. 02 06802 FAC RESOURCE	1.838855				68.02
69.00 06900 ELECTROCARDI OLOGY	0.000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 357034				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 313864				73.00
74.00 07400 RENAL DI ALYSI S	0. 000000				74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1. 573486				76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 290360				90.00
90. 01 09001 SLEEP CENTER	0. 000000				90.01
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
99.00 09900 CMHC					99.00
99. 10 09910 CORF					99.10
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems REH	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provi der		Period: From 01/01/2014 To 12/31/2014	Date/Time Pre	
		Ti t	le XIX	Hospi tal	5/28/2015 10: PPS	14 dili
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
oost oontor bescription		(Wkst. B, Part			Reduction	
	I, col. 26)		Cost (col. 1		Amount	
	.,		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		•				
50. 00 05000 OPERATI NG ROOM	0	C	)	0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	188, 870	13, 338	175, 53	32 0	0	54.00
60. 00 06000 LABORATORY	438, 476	8, 087	430, 38	39 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	867, 426	33, 734	833, 69	02 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 885, 670	359, 437	3, 526, 23	33 0	0	66.00
66.01 06601 PHYSICAL THERAPY - CARMEL	657, 519	2, 984	654, 53	35 0	0	66.01
67.00 06700 OCCUPATI ONAL THERAPY	3, 359, 366	284, 618	3, 074, 74	18 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1, 285, 348	67, 234	1, 218, 11	4 0	0	68.00
68. 01 06801 VI SI ON	268, 857	1, 328	267, 52	29 0	0	68.01
68. 02 06802 FAC RESOURCE	763, 167	17, 146	746, 02	21 0	0	68.02
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	467, 794	9, 800	457, 99	04 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	2, 828, 252	18, 160	2, 810, 09	02 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	960, 132	19, 395	940, 73	37 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	491, 562	71, 402	420, 16	0 0	0	
90. 01 09001 SLEEP CENTER	0	0		0 0	0	
91. 00 09100 EMERGENCY	0	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
OTHER REI MBURSABLE COST CENTERS			1			
99.00 09900 CMHC	0	0		0 0	0	
99. 10 09910 CORF	0	0		0 0	0	
200.00 Subtotal (sum of lines 50 thru 199)	16, 462, 439	906, 663	15, 555, 77	6 0		200.00
201.00 Less Observation Beds	0	0		0 0		201.00
202.00  Total (line 200 minus line 201)	16, 462, 439	906, 663	15, 555, 77	0	0	202.00

Health Financial Systems REF	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R. REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF		CCN: 153028	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part II Date/Time Pre 5/28/2015 10:	
			le XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges				
	Capital and	(Worksheet C,				
	Operating Cost			6		
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS	1					
50.00 05000 OPERATI NG ROOM	0	-				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	188, 870					54.00
60. 00 06000 LABORATORY	438, 476					60.00
65. 00 06500 RESPI RATORY THERAPY	867, 426	2, 427, 067	0. 35739	97		65.00
66. 00 06600 PHYSI CAL THERAPY	3, 885, 670	13, 238, 975	0. 29350	)2		66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	657, 519	1, 544, 340	0. 42576	51		66. 01
67.00 06700 OCCUPATI ONAL THERAPY	3, 359, 366	11, 320, 781	0. 29674	13		67.00
68.00 06800 SPEECH PATHOLOGY	1, 285, 348	6, 926, 740	0. 1855	53		68.00
68. 01 06801 VI SI ON	268, 857	762, 736	0. 35249	90		68.01
68. 02 06802 FAC RESOURCE	763, 167	415, 023	1.8388	55		68.02
69.00 06900 ELECTROCARDI OLOGY	0	0	0.0000	00		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	467, 794	1, 310, 224	0. 35703	34		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.0000	00		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 828, 252	9, 011, 071	0. 31386	54		73.00
74.00 07400 RENAL DIALYSIS	0	0	0.0000	00		74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	960, 132	610, 194	1.57348	36		76.00
OUTPATIENT SERVICE COST CENTERS	·					
90. 00 09000 CLINIC	491, 562	1, 692, 939	0. 2903	50		90.00
90. 01 09001 SLEEP CENTER	0	C	0.0000	00		90.01
91.00 09100 EMERGENCY	0	0	0.0000	00		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	c c	0.0000	00		92.00
OTHER REIMBURSABLE COST CENTERS						
99, 00 09900 CMHC	0	C	0.0000	00		99.00
99. 10 09910 CORF	0	c c	0.0000			99.10
200.00 Subtotal (sum of lines 50 thru 199)	16, 462, 439	51, 313, 148				200.00
201.00 Less Observation Beds	0					201.00
202.00 Total (line 200 minus line 201)	16, 462, 439	51, 313, 148				202.00

Health Financial Systems RE	HABILITATION HOS	PITAL OF INDIA	In Lie	eu of Form CMS-:	2552-10	
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Period:	Worksheet D	
				From 01/01/2014 To 12/31/2014		pared: 14 am
		Ti tl	e XVIII	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	1, 137, 421	C	1, 137, 42	1 18, 894	60.20	30.00
200.00 Total (lines 30-199)	1, 137, 421		1, 137, 42	1 18, 894		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	7,278	438, 136				30.00
200.00 Total (lines 30-199)	7, 278	438, 136				200.00

Health Financial Systems REH.	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS			Period: From 01/01/2014 To 12/31/2014	5/28/2015 10:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1		1			
50.00 05000 OPERATI NG ROOM	0	0	0.00000		0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	13, 338				4, 716	
60. 00 06000 LABORATORY	8, 087					
65. 00 06500 RESPI RATORY THERAPY	33, 734					
66. 00 06600 PHYSI CAL THERAPY	359, 437					
66. 01 06601 PHYSI CAL THERAPY - CARMEL	2, 984				0	66. 01
67.00 06700 OCCUPATI ONAL THERAPY	284, 618					
68.00 06800 SPEECH PATHOLOGY	67, 234				19, 501	68.00
68. 01 06801 VI SI ON	1, 328				0	68.01
68. 02 06802 FAC RESOURCE	17, 146	415, 023			0	68.02
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 800	1, 310, 224	0.00748	566, 650	4, 239	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	18, 160	9, 011, 071	0. 00201	5 2, 295, 011	4, 624	73.00
74. 00 07400 RENAL DI ALYSI S	0	0	0.00000	0 0	0	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	19, 395	610, 194	0. 03178	5 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	71, 402	1, 692, 939	0. 04217	6 0	0	90.00
90. 01 09001 SLEEP CENTER	0	0	0. 00000	0 0	0	90.01
91.00 09100 EMERGENCY	0	0	0.00000	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0. 00000	0 0	0	92.00
200.00 Total (lines 50-199)	906, 663	51, 313, 148		13, 641, 718	235, 767	200. 00

Health Financial Systems REH.	inancial Systems REHABILITATION HOSPITAL OF INDIANA In Lieu of Form CMS-25						
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS	Provi der	CCN: 153028	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/28/2015 10:	
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School		Cost	All Other Medical Education Co		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00		2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDIATRICS 200. 00 Total (lines 30-199)	0		0		0 0 0	0	30.00 200.00
Cost Center Description	Total Patient Days	5 ÷	col . 6)	Inpatient Program Day	Pass-Through Cost (col. 7 x col. 8)		
	6.00		7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS	1						4
30. 00 03000 ADULTS & PEDI ATRI CS	18, 894		0.00				30.00
200.00   Total (lines 30-199)	18, 894			7, 2	78 0		200. 00

Health Financial Systems REH	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	6 Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2014 To 12/31/2014		narod
				10 12/31/2014	5/28/2015 10:	14 am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	5	
	1.00				4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		0	1	0	0	
	0	0		0 0	0	50.00 54.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	0		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
66. 01 06601 PHYSICAL THERAPY	0	0		0 0	0	66.00
67. 00 06700 OCCUPATIONAL THERAPY	0	0		0 0	0	67.00
68. 00 106800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
68. 01 06801 VI SI ON	0	0			0	68.01
68. 02 06802 FAC RESOURCE	0	0			0	68.02
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	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 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	)	0 0	0	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	)	0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	)	0 0	0	90.00
90. 01 09001 SLEEP CENTER	0	0	)	0 0	0	90.01
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
200.00 Total (lines 50-199)	0	0		0 0	0	200. 00

Health Financial Systems REH,	REHABILITATION HOSPITAL OF INDIANA In Lieu of Form CMS-255						
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	5 Provi der		Peri od:	Worksheet D		
THROUGH COSTS				From 01/01/2014	Part IV		
				To 12/31/2014	Date/Time Pre 5/28/2015 10:		
		Ti tl	e XVIII	Hospi tal	PPS		
Cost Center Description		Total Charges		t Outpatient	Inpati ent		
		(from Wkst. C,		Ratio of Cost	Program		
	Cost (sum of	Part I, col.	(col. 5 ÷ col		Charges		
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.			
	4)			7)			
	6.00	7.00	8.00	9.00	10.00		
ANCI LLARY SERVI CE COST CENTERS	,						
50.00 05000 OPERATI NG ROOM	0	0	0.00000		0	50.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	928, 148			328, 181	54.00	
60. 00 06000 LABORATORY	0	1, 124, 910				60.00	
65. 00 06500 RESPI RATORY THERAPY	0	2, 427, 067				65.00	
66. 00 06600 PHYSI CAL THERAPY	0	13, 238, 975			3, 588, 514	66.00	
66.01 06601 PHYSI CAL THERAPY - CARMEL	0	1, 544, 340			0	66. 01	
67.00 06700 OCCUPATI ONAL THERAPY	0	11, 320, 781	0.00000		3, 638, 993	67.00	
68.00 06800 SPEECH PATHOLOGY	0	6, 926, 740			2, 009, 125	68.00	
68. 01 06801 VI SI ON	0	762, 736	0.00000	0 0.000000	0	68.01	
68. 02 06802 FAC RESOURCE	0	415, 023	0.00000	0 0.000000	0	68.02	
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000	0 0.000000	0	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 310, 224	0.00000	0 0.000000	566, 650	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000	0.000000	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	9, 011, 071	0.00000	0.000000	2, 295, 011	73.00	
74.00 07400 RENAL DIALYSIS	0	0	0.00000	0.000000	0	74.00	
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	610, 194	0.00000	0.000000	0	76.00	
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0	1, 692, 939	0.00000	0.000000	0	90.00	
90. 01 09001 SLEEP CENTER	0	0	0.00000	0.000000	0	90.01	
91.00 09100 EMERGENCY	0	0	0.00000	0.000000	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.00000	0 0.000000	0	92.00	
200.00 Total (lines 50-199)	0	51, 313, 148			13, 641, 718	200. 00	

Health Financial Systems REH	ABILITATION HOSE	PITAL OF INDIA	NA	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS		CCN: 153028	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/28/2015 10:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS						
50.00 O5000 OPERATING ROOM	0	0		0		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
60. 00 06000 LABORATORY	0	0		0		60.00
65. 00 06500 RESPI RATORY THERAPY	0	412		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
66.01 06601 PHYSICAL THERAPY - CARMEL	0	0		0		66.01
67.00 06700 OCCUPATI ONAL THERAPY	0	201		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0		68.00
68. 01 06801 VI SI ON	0	0		0		68.01
68. 02 06802 FAC RESOURCE	0	0		0		68.02
69. 00 06900 ELECTROCARDI OLOGY	0	0		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23, 995		0		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 514, 806		0		73.00
74.00 07400 RENAL DIALYSIS	0	0		0		74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0		76.00
OUTPATIENT SERVICE COST CENTERS	· · ·		•			1
90. 00 09000 CLINIC	0	407, 062		0		90.00
90. 01 09001 SLEEP CENTER	0	0		0		90.01
91.00 09100 EMERGENCY	0	0		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0		92.00
200.00 Total (lines 50-199)	0	1,946,476		0		200.00

Health Financial Systems REH	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 153028	Peri od:	Worksheet D	
				From 01/01/2014 To 12/31/2014		narod
				10 12/31/2014	5/28/2015 10:	14 am
		Ti tl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			L			
50.00 05000 OPERATING ROOM	0. 000000			0 0	0	00.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 203491	0		0 0	0	
60. 00 06000 LABORATORY	0. 389788			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 357397			0 0	147	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 293502			0 0	0	
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0. 425761	0		0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 296743			0 0	60	
68.00 06800 SPEECH PATHOLOGY	0. 185563			0 0	0	
68. 01 06801 VI SI ON	0. 352490			0 0	0	00.0.
68. 02 06802 FAC RESOURCE	1. 838855			0 0	0	68.02
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 357034			0 0	8, 567	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 313864			0 0	475, 443	73.00
74.00 07400 RENAL DIALYSIS	0. 000000			0 0	0	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1. 573486	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 290360	407, 062		0 0	118, 195	90.00
90. 01 09001 SLEEP CENTER	0. 000000	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Subtotal (see instructions)		1, 946, 476		0 0	602, 412	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		1, 946, 476		0 0	602, 412	202.00

Health Financial Systems REI	HABILITATION HOS	ABILITATION HOSPITAL OF INDIANA			In Lieu of Form CMS-2552-1		
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	Provi der	CCN: 153028	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pre 5/28/2015 10:		
		Ti tl	e XVIII	Hospi tal	PPS		
	Co	sts					
Cost Center Description	Cost Reimbursed	Cost Reimbursed					
	Servi ces	Services Not					
	Subject To	Subject To					
	Ded. & Coins.	Ded. & Coins.					
	(see inst.)	(see inst.)					
	6.00	7.00					
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	C	0				50.00	
54.00 05400 RADI OLOGY-DI AGNOSTI C	C	0				54.00	
60. 00 06000 LABORATORY	C	0				60.00	
65. 00 06500 RESPI RATORY THERAPY	C	0				65.00	
66. 00 06600 PHYSI CAL THERAPY	C	0				66.00	
66. 01 06601 PHYSI CAL THERAPY - CARMEL	C	0				66. 01	
67.00 06700 OCCUPATI ONAL THERAPY	C	0				67.00	
68.00 06800 SPEECH PATHOLOGY	C	0				68.00	
68. 01 06801 VI SI ON	C	0				68.01	
68. 02 06802 FAC RESOURCE	C	0				68.02	
69. 00 06900 ELECTROCARDI OLOGY	C	0				69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0				71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	0				72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	C	0				73.00	
74.00 07400 RENAL DIALYSIS	C	0	•			74.00	
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	C	0	)			76.00	
OUTPATIENT SERVICE COST CENTERS	1	1	1				
90. 00 09000 CLINIC	C	0				90.00	
90. 01 09001 SLEEP CENTER	C	C				90.01	
91.00 09100 EMERGENCY	C	0				91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	0				92.00	
200.00 Subtotal (see instructions)	C	0				200.00	
201.00 Less PBP Clinic Lab. Services-Program	C					201.00	
Only Charges							
202.00 Net Charges (line 200 +/- line 201)	C	C	0			202.00	

Health Financial Systems RE	EHABILITATION HOSPITAL OF INDIANA In Lieu of Form CM					
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	Provi der	rovider CCN: 153028 Period: From 01/01/2014 To 12/31/2014			pared: 14 am	
		Ti	tle XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col 2)	Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4,00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
30.00 ADULTS & PEDIATRICS	1, 137, 421		0 1, 137, 42	18, 894	60.20	30.00
200.00 Total (lines 30-199)	1, 137, 421		1, 137, 42	18, 894		200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 200.00 Total (lines 30-199)	844 844					30. 00 200. 00

Health Financial Systems REH.	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	NL COSTS			Period: From 01/01/2014 To 12/31/2014	5/28/2015 10:	pared: 14 am
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		-	1			
50.00 05000 OPERATING ROOM	0	0	0.00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	13, 338				939	54.00
60. 00 06000 LABORATORY	8, 087	1, 124, 910	0.00718	9 58, 961	424	60.00
65. 00 06500 RESPI RATORY THERAPY	33, 734	2, 427, 067	0. 01389	9 149, 320	2, 075	65.00
66. 00 06600 PHYSI CAL THERAPY	359, 437	13, 238, 975	0. 02715	0 524, 078	14, 229	66.00
66.01 06601 PHYSICAL THERAPY - CARMEL	2, 984	1, 544, 340	0. 00193	2 0	0	66. 01
67.00 06700 OCCUPATI ONAL THERAPY	284, 618	11, 320, 781	0. 02514	1 564, 353	14, 188	67.00
68.00 06800 SPEECH PATHOLOGY	67, 234	6, 926, 740	0.00970	6 404, 243	3, 924	68.00
68. 01 06801 VI SI ON	1, 328	762, 736	0. 00174	1 12,000	21	68. 01
68.02 06802 FAC RESOURCE	17, 146	415, 023	0. 04131	3 0	0	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,800	1, 310, 224	0. 00748	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	18, 160	9, 011, 071	0. 00201	5 345, 187	696	73.00
74.00 07400 RENAL DIALYSIS	0	0	0. 00000	0 0	0	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	19, 395	610, 194	0. 03178	5 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	71, 402	1, 692, 939	0.04217	6 4,032	170	90.00
90. 01 09001 SLEEP CENTER	0	0	0. 00000	0 0	0	90.01
91.00 09100 EMERGENCY	0	0	0. 00000	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0. 00000	0 0	0	92.00
200.00   Total (lines 50-199)	906, 663	51, 313, 148		2, 127, 487	36, 666	200. 00

Health Financial Systems REHABILITATION HOSPITAL OF INDIANA In Lieu of Form CMS-2552							2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS		CCN: 153028	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/28/2015 10:	
			-	le XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	ALLI	ed Health	All Other	Swi ng-Bed	Total Costs	
			Cost	Medi cal	Adjustment	(sum of cols.	
				Education Cos	st Amount (see	1 through 3,	
					instructions)	minus col. 4)	
	1.00		2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS	0		0		0 0	0	30.00
200.00 Total (lines 30-199)	0		0		0	0	200.00
Cost Center Description	Total Patient	Per D	iem (col.	Inpati ent	Inpati ent		
	Days	5 ÷	col. 6)	Program Days	s Program		
			· · · ·		Pass-Through		
					Cost (col. 7 x		
					col. 8)		
	6.00		7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS	18, 894		0.00	84	14 0		30.00
200.00   Total (lines 30-199)	18, 894			84	14 0		200. 00

Health Financial Systems REF	HABILITATION HOS	PITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider	CCN: 153028	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2014 To 12/31/2014		narad
				10 12/31/2014	5/28/2015 10:	14 am
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 O5000 OPERATING ROOM	0	0		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	0		0 0	0	66.01
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
68. 01 06801 VI SI ON	0	C		0 0	0	68.01
68.02 06802 FAC RESOURCE	0	C		0 0	0	68.02
69.00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	C		0 0	0	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	C		0 0	0	90.00
90. 01 09001 SLEEP CENTER	0	C		0 0	0	90.01
91.00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
200.00   Total (lines 50-199)	0	0		0 0	0	200.00

Health Financial Systems REH.	REHABILITATION HOSPITAL OF INDIANA In Lieu of Form CMS-25					
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2014		
				To 12/31/2014	Date/Time Pre 5/28/2015 10:	
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cost	0utpati ent	Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	r		1	- F		
50.00 05000 OPERATI NG ROOM	0	0	0.00000		0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	928, 148	0.00000	0 0.000000	65, 313	54.00
60. 00 06000 LABORATORY	0	1, 124, 910	0.00000	0 0.000000	58, 961	60.00
65. 00 06500 RESPI RATORY THERAPY	0	2, 427, 067	0.00000	0.000000	149, 320	65.00
66. 00 06600 PHYSI CAL THERAPY	0	13, 238, 975	0.00000	0.000000	524, 078	66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	1, 544, 340	0.00000	0.000000	0	66.01
67.00 06700 OCCUPATI ONAL THERAPY	0	11, 320, 781	0.00000	0. 000000	564, 353	67.00
68.00 06800 SPEECH PATHOLOGY	0	6, 926, 740	0.00000	0. 000000	404, 243	68.00
68. 01 06801 VI SI ON	0	762, 736	0. 00000	0.000000	12, 000	68.01
68. 02 06802 FAC RESOURCE	0	415, 023	0. 00000	0.000000	0	68.02
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000	0.000000	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 310, 224	0. 00000	0.000000	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	9, 011, 071	0.00000	0.000000	345, 187	73.00
74.00 07400 RENAL DI ALYSI S	0	0	0.00000	0.000000	0	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	610, 194	0.00000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	1, 692, 939	0.00000	0.000000	4,032	90.00
90. 01 09001 SLEEP CENTER	0	0	0.00000	0.000000	0	90.01
91.00 09100 EMERGENCY	0	0	0. 00000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.00000		0	92.00
200.00 Total (lines 50-199)	0	51, 313, 148			2, 127, 487	200. 00

Health Financial Systems REH	IABILITATION HOSF	PITAL OF INDIA	NA	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS		CCN: 153028	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/28/2015 10:	
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS			1	1		_
50.00 05000 OPERATI NG ROOM	0	0		0		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
60. 00 06000 LABORATORY	0	0		0		60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	0		0		66. 01
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0		68.00
68. 01 06801 VI SI ON	0	0		0		68.01
68. 02 06802 FAC RESOURCE	0	0		0		68.02
69. 00 06900 ELECTROCARDI OLOGY	0	0		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0		73.00
74.00 07400 RENAL DIALYSIS	0	0		0		74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0		76.00
OUTPATIENT SERVICE COST CENTERS	· · ·					
90. 00 09000 CLINIC	0	0	I	0		90.00
90.01 09001 SLEEP CENTER	0	0		0		90.01
91.00 09100 EMERGENCY	0	0		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0		92.00
200.00 Total (lines 50-199)	0	0	1	0		200. 00

Health Financial Systems REH	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 153028	Peri od:	Worksheet D	
				From 01/01/2014 To 12/31/2014		norod.
				To 12/31/2014	Date/Time Pre 5/28/2015 10:	14 am
		Tit	le XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	0		0 0	0	00.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 203491	0		0 0	0	01100
60. 00 06000 LABORATORY	0. 389788	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 357397	0		0 0	0	
66.00 06600 PHYSI CAL THERAPY	0. 293502	0	217, 54		0	
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0. 425761	0	13, 84		0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 296743		98, 41		0	071.00
68.00 06800 SPEECH PATHOLOGY	0. 185563		48, 66		0	00.00
68. 01 06801 VI SI ON	0. 352490		62, 45		0	
68. 02 06802 FAC RESOURCE	1. 838855		3, 74	5 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 357034			0 0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 313864		426, 40	06 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1. 573486	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 290360	0	230, 25	69 0	0	90.00
90. 01 09001 SLEEP CENTER	0. 000000	0		0 0	0	90.01
91.00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Subtotal (see instructions)		0	1, 101, 33	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0	1, 101, 33	0	0	202.00

Health Financial Systems RE	EHABILITATION HOS	SPITAL OF INDIA	NA	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provi der	CCN: 153028	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pro 5/28/2015 103	
		Tit	le XIX	Hospi tal	PPS	
	Co	sts				
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
ANCI LLARY SERVICE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0	1			54.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPIRATORY THERAPY						65.00
66. 00 06600 PHYSI CAL THERAPY	63, 849					66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	5, 894					66.01
67. 00 06700 OCCUPATI ONAL THERAPY	29, 205					67.00
68. 00 06800 SPEECH PATHOLOGY	9,030					68.00
68. 01 06801 VI SI ON	22,014					68.01
68. 02 06802 FAC RESOURCE	6, 887					68.02
69. 00 06900 ELECTROCARDI OLOGY	0	0	)			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	)			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	133, 833	0				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				76.00
OUTPATIENT SERVICE COST CENTERS	·	·				
90. 00 09000 CLINIC	66, 858	0	)			90.00
90. 01 09001 SLEEP CENTER	0	0				90.01
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	337, 570	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	337, 570	0				202.00

In Lieu of Form CMS-2552-10

	Financial Systems REHABILITATION HOSPIT	AL OF INDIANA	In Lie	u of Form CMS-2	2552
) MPUT	ATION OF INPATIENT OPERATING COST	OST Provider CCN: 153028			
			From 01/01/2014 To 12/31/2014	Date/Time Pre	pare
			10 12/31/2014	5/28/2015 10:	14 a
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
,				1.00	
	PART I - ALL PROVIDER COMPONENTS				-
00	Inpatient days (including private room days and swing-bed days	excluding newborn)		18, 894	1
00	Inpatient days (including private room days, excluding swing-b			18, 894	2
	Private room days (excluding swing-bed and observation bed day		rivate room days,	0	3
	do not complete this line.				
	Semi-private room days (excluding swing-bed and observation be			18, 894	4
00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	er 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private roo	m dave) after December	21 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	ni days) arter becember	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private room	n davs) through December	~ 31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable to	o the Program (excluding	g swing-bed and	7, 278	9
0. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII on	ly (including private )	com dave)	0	10
. 00	through December 31 of the cost reporting period (see instruct		com days)	0	
1.00	Swing-bed SNF type inpatient days applicable to title XVIII on		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, en	nter 0 on this line)	3		
2.00	Swing-bed NF type inpatient days applicable to titles V or XIX	( only (including privat	te room days)	0	12
	through December 31 of the cost reporting period	/ I / I I I I			
3. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13
. 00	Medically necessary private room days applicable to the Progra			0	14
	Total nursery days (title V or XIX only)	(over during owing bod	uujo)	0	15
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 d	of the cost	0.00	17
	reporting period				
3. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	118
9.00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	f the cost	0.00	19
	reporting period	through becchiber of o		0.00	'
0. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	the cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instructions			17, 342, 140	
2. 00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	er 31 of the cost report	ting period (line	0	22
3. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportion	na period (line 6	0	23
5.00	x line 18)			Ű	20
4.00	Swing-bed cost applicable to NF type services through December	- 31 of the cost reporti	ng period (line	0	24
	7 x line 19)				
5.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	g period (line 8	0	25
4 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)		17, 342, 140	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			17, 342, 140	2
3. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	narges)	0	28
	Private room charges (excluding swing-bed charges)		0	0	29
	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 ÷	- line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	us line 22) (coo instru	stions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x lin		50015/	0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	36
		and private room cost di	fferential (line	17, 342, 140	
5.00	General inpatient routine service cost net of swing-bed cost a				1
6. 00					
. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	•			
5. 00 7. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
o. 00 7. 00 8. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see	ISTMENTS instructions)		917.86	
5. 00 7. 00 8. 00 9. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS instructions) 38)		917. 86 6, 680, 185 0	

Heal th	Financial Systems REH	ABILITATION HOS	PITAL OF INDI	ANA	In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
					From 01/01/2014 To 12/31/2014		pared:
						5/28/2015 10:	14 am
	Cost Center Description	Total	Total	le XVIII Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription			sDiem (col. 1		(col. 3 x col.	
				col . 2)		4)	
42.00	NUDCEDY (+; +Lo V & VIV only)	1.00	2.00	3.00	4.00	5.00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT						43.00
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.00 46.00
	OTHER SPECIAL CARE (SPECIFY)						48.00
	Cost Center Description						171.00
10.00						1.00	10.00
	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		3, 944, 702 10, 624, 887	48.00 49.00
47.00	PASS THROUGH COST ADJUSTMENTS		See matruet	01137		10, 024, 007	47.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	438, 136	50.00
51.00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancillar	y services (f	rom Wkst. D, s	um of Parts II	235, 767	51.00
E2 00	and IV)	FO and F1)				(72.002	E2 00
52.00 53.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non-ph	vsician anesth	etist and	673, 903 9, 950, 984	52.00 53.00
00100	medical education costs (line 49 minus line	5 1	natoa, non ph	jor of all allos th	otrot, and	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	TARGET AMOUNT AND LIMIT COMPUTATION					-	
	Program discharges Target amount per discharge					0.00	54.00 55.00
	Target amount (line 54 x line 55)					0.00	56.00
	Difference between adjusted inpatient operat	ing cost and ta	irget amount (	line 56 minus	line 53)	0	57.00
	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost remarket basket	eporting period	ending 1996,	updated and co	mpounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the	market basket		0.00	60.00
61.00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		is (lines 54 x	60), or 1% of	the target		
62.00	Relief payment (see instructions)					0	62.00
	Allowable Inpatient cost plus incentive paym	nent (see instru	ictions)			0	63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST	to through Door	mbar 21 of th	a agat raparti	ng pariod (Cao	0	4 00
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts through Dece		e cost reporti	ng period (see	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the	cost reporting	period (See	0	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no ocoto (lino	(1 plug ling	(E) (+; +  o V)/		0	66.00
00.00	CAH (see instructions)	ne costs (inte	64 prus rine	os)(title xvii	i oniy). Foi	0	00.00
67.00	Title V or XIX swing-bed NF inpatient routir (line 12 x line 19)	ne costs through	December 31	of the cost re	porting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost repo	rting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + lin	e 68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N					I	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	5		• •			70.00 71.00
	Program routine service cost (line 9 x line		The 70 ÷ The	2)			72.00
73.00	Medically necessary private room cost applic		n (line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine serv	•					74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (Trom	WORKSneet B, P	art II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77.00	Program capital-related costs (line 9 x line						77.00
78.00 79.00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	rovi der recor	de)			78.00 79.00
80.00	Total Program routine service costs for comp				us line 79)		80.00
81.00	Inpatient routine service cost per diem limi				-		81.00
82.00	Inpatient routine service cost limitation (I		· .				82.00
83.00 84.00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		13)				83.00 84.00
	Utilization review - physician compensation		ons)				85.00
86.00	Total Program inpatient operating costs (sum		rough 85)				86.00
87.00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					0	87.00
88.00	Adjusted general inpatient routine cost per		line 2)			0.00	
89.00	Observation bed cost (line 87 x line 88) (se	e instructions)				0	89.00

Health Financial Systems REH.	ABILITATION HOS	SPITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
				To 12/31/2014	Date/Time Pre 5/28/2015 10:	pared: 14 am
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 137, 421	17, 342, 140	0.06558	7 0	0	90.00
91.00 Nursing School cost	0	17, 342, 140	0.00000	0 0	0	91.00
92.00 Allied health cost	0	17, 342, 140	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	17, 342, 140	0. 00000	0 0	0	93.00

In Lieu of Form CMS-2552-10

Health Financial Systems REH, COMPUTATION OF INPATIENT OPERATING COST	ABILITATION HOSPITA	Provider CCN: 153028	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2014 To 12/31/2014	Date/Time Pre 5/28/2015 10:	
		Title XIX	Hospi tal	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS				1.00	
I NPATI ENT DAYS					1
1.00 Inpatient days (including private room days				18, 894	
<ol> <li>Inpatient days (including private room days,</li> <li>Private room days (excluding swing-bed and o</li> </ol>			ivate room days,	18, 894 0	2.00 3.00
do not complete this line. 4.00 Semi-private room days (excluding swing-bed	and observation ber	(aven t		18, 894	4.00
5.00 Total swing-bed SNF type inpatient days (inc reporting period			er 31 of the cost	0	
6.00 Total swing-bed SNF type inpatient days (inc reporting period (if calendar year, enter 0		n days) after December	31 of the cost	0	6.00
7.00 Total swing-bed NF type inpatient days (incl reporting period	0.1			0	7.00
8.00 Total swing-bed NF type inpatient days (incl reporting period (if calendar year, enter 0	uding private room on this line)	days) after December 3	1 of the cost	0	8.00
9.00 Total inpatient days including private room newborn days)	5 11			844	
10.00 Swing-bed SNF type inpatient days applicable through December 31 of the cost reporting pe	eriod (see instructi	ons)	5, 1	0	
11.00 Swing-bed SNF type inpatient days applicable December 31 of the cost reporting period (if	cal endar year, ent	er 0 on this line)	5,7	0	
12.00 Swing-bed NF type inpatient days applicable through December 31 of the cost reporting pe	eri od	<u> </u>	5 -	0	
<ul> <li>13.00 Swing-bed NF type inpatient days applicable after December 31 of the cost reporting peri</li> <li>14.00 Medically necessary private room days applic</li> </ul>	od (if calendar yea	ar, enter O on this lir	ne)	0	
15.00 Total nursery days (title V or XIX only)		r (excluding swing-bed	uays)	0	
16.00 Nursery days (title V or XIX only)				0	
SWING BED ADJUSTMENT					
17.00 Medicare rate for swing-bed SNF services app reporting period	olicable to services	s through December 31 c	of the cost	0.00	17.00
18.00 Medicare rate for swing-bed SNF services app reporting period	licable to services	after December 31 of	the cost	0.00	18.00
19.00 Medicaid rate for swing-bed NF services appl reporting period	icable to services	through December 31 of	f the cost	0.00	19.00
20.00 Medicaid rate for swing-bed NF services appl reporting period	icable to services	after December 31 of t	he cost	0.00	20.00
21.00 Total general inpatient routine service cost 22.00 Swing-bed cost applicable to SNF type servic			ing period (line	17, 342, 140 0	1
23.00 Swing-bed cost applicable to SNF type servic x line 18)	es after December 3	31 of the cost reportin	ng period (line 6	0	23.00
24.00 Swing-bed cost applicable to NF type service 7 x line 19)	es through December	31 of the cost reporti	ng period (line	0	24.00
25.00 Swing-bed cost applicable to NF type service x line 20)	es after December 31	of the cost reporting	period (line 8	0	25.00
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net o	of swing-bed cost (I	ine 21 minus line 26)		0 17, 342, 140	
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			·		
28.00 General inpatient routine service charges (e		and observation bed ch	narges)	0	
29.00 Private room charges (excluding swing-bed ch 30.00 Semi-private room charges (excluding swing-b	0,			0	
31.00 General inpatient routine service cost/charg		line 28)		0.000000	
32.00 Average private room per diem charge (line 2	,			0.00	32.00
33.00 Average semi-private room per diem charge (I				0.00	
34.00 Average per diem private room charge differe			ctions)	0.00	
<ul> <li>35.00 Average per diem private room cost different</li> <li>36.00 Private room cost differential adjustment (I</li> </ul>		: 31)		0.00	1
87.00 General inpatient routine service cost net o 27 minus line 36)		nd private room cost di	fferential (line	17, 342, 140	
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS	THROUGH COST AD US	TMENTS			-
38.00 Adjusted general inpatient routine service c				917.86	38.00
39.00 Program general inpatient routine service co	ost (line 9 x line 3	38)		774, 674	39.00
40.00 Medically necessary private room cost applic				0	•
41.00  Total Program general inpatient routine serv	vice cost (line 39 +	- IINE 40)		774, 674	41.00

Heal th	Financial Systems REH	ABILITATION HOSPI	TAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		eriod:	Worksheet D-1	
					rom 01/01/2014 o 12/31/2014	Date/Time Pre	oared <sup>.</sup>
						5/28/2015 10:	
				le XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient CostIn	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
		inpatrent costin	ipatient bays		•	4)	
		1.00	2.00	3.00	4.00	5.00	
	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43.00
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			599, 682	48.00
49.00	Total Program inpatient costs (sum of lines	41 through 48)(se	ee instructio	ns)		1, 374, 356	49.00
F0 00	PASS THROUGH COST ADJUSTMENTS			Whet D arm	of Doute Loud	50,000	F0 00
50.00	Pass through costs applicable to Program inp	atient routine se	ervices (from	WKST. D, SUM	or Parts I and	50, 809	50.00
51.00	Pass through costs applicable to Program inp and IV)	oatient ancillary	services (fr	om Wkst. D, su	m of Parts II	36, 666	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				87, 475	52.00
	Total Program inpatient operating cost exclu	uding capital rela	ated, non-phy	sician anesthe	tist, and	1, 286, 881	
	medical education costs (line 49 minus line	52)					
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge						55.00
	Target amount (line 54 x line 55)					0	56.00
	Difference between adjusted inpatient operat	ing cost and targ	get amount (I	ine 56 minus l	ine 53)	0	57.00
58.00 59.00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting pariod or	ding 100/	ndated and com	nounded by the	0.00	58.00 59.00
39.00	market basket	eportring perrod er	iui iig 1990, u	puateu anu com	pounded by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	60.00
61.00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		(TINES 54 X	60), or 1% or	the target		
62.00	Relief payment (see instructions)					0	62.00
	Allowable Inpatient cost plus incentive paym	nent (see instruct	tions)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Decemb	per 31 of the	cost reportir	g period (See	0	64.00
	instructions)(title XVIII only)						
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after December	r 31 of the c	ost reporting	period (See	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	4 plus line 6	5)(title XVIII	only). For	0	66.00
	CAH (see instructions)	,			<u> </u>		
67.00	Title V or XIX swing-bed NF inpatient routir (line 12 x line 19)	ne costs through [	December 31 o	f the cost rep	orting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routir (line 13 x line 20)	ne costs after Dec	cember 31 of	the cost repor	ting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line	68)		0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N						70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of						70. 00 71. 00
	Program routine service cost (line 9 x line			2)			72.00
73.00	Medically necessary private room cost applic	able to Program (	(line 14 x li	ne 35)			73.00
74.00	Total Program general inpatient routine serv	•					74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine service o	COSTS (Trom W	orksneet B, Pa	rt II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77.00	Program capital-related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 minu	,		- >			78.00
79.00 80.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			· .	sline 79)		79.00 80.00
81.00	Inpatient routine service cost per diem limi				5 TTTC 77)		81.00
82.00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (	•	)				83.00
84.00 85.00	Program inpatient ancillary services (see in Utilization review - physician compensation		5)				84.00 85.00
	Total Program inpatient operating costs (sur	•	· · · · · · · · · · · · · · · · · · ·				86.00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	~ /				
	Total observation bed days (see instructions		ino 2)			0	87.00
88.00 89.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se						88. 00 89. 00

Health Financial Systems REH.	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
				To 12/31/2014	Date/Time Pre 5/28/2015 10:	pared: 14 am
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 137, 421	17, 342, 140	0. 06558	7 0	0	90.00
91.00 Nursing School cost	0	17, 342, 140	0.00000	0 0	0	91.00
92.00 Allied health cost	0	17, 342, 140	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	17, 342, 140	0. 00000	0 0	0	93.00

Health Financial Systems			CCN: 153028	Period:	u of Form CMS- Worksheet D-3	
ThirATTENT ANOTELART SERVICE COS	ATTORTONMENT	riovider	0011. 100020	From 01/01/2014	WOLKSHEET D 5	,
				To 12/31/2014		
					5/28/2015 10:	14 am
		liti	e XVIII	Hospi tal	PPS	
Cost Center Descrip	tion		Ratio of Cos		Inpati ent	
			To Charges	Program Charges	Program Costs (col. 1 x col.	
				charges	2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE	COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS				11, 692, 292		30. 00
ANCILLARY SERVICE COST CE	NTERS					
50.00 05000 OPERATING ROOM			0.0000	0 00	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI	C		0. 2034	91 328, 181	66, 782	54.00
60. 00 06000 LABORATORY			0. 3897		181, 240	60.00
65. 00 06500 RESPI RATORY THERAPY			0.3573		268, 145	65.00
66.00 06600 PHYSI CAL THERAPY			0. 29350	3, 588, 514	1, 053, 236	66.00
66. 01 06601 PHYSI CAL THERAPY -			0. 4257		0	
67.00 06700 OCCUPATIONAL THERAP	Y		0. 2967			
68.00 06800 SPEECH PATHOLOGY			0. 1855		372, 819	
68. 01 06801 VI SI ON			0. 3524		0	
68.02 06802 FAC RESOURCE			1.8388		0	00.02
69.00 06900 ELECTROCARDI OLOGY			0.0000		0	
71.00 07100 MEDICAL SUPPLIES CH			0. 3570			
72.00 07200 I MPL. DEV. CHARGED			0.0000		0	
73.00 07300 DRUGS CHARGED TO PA	TIENTS		0. 3138		720, 321	
74.00 07400 RENAL DIALYSIS			0.0000		0	
76.00 03550 PSYCHI ATRI C/PSYCHOL			1. 5734	36 0	0	76.00
OUTPATIENT SERVICE COST C	ENTERS		0.0000	(0)		
90. 00 09000 CLINIC			0. 2903		0	1
90. 01 09001 SLEEP CENTER			0.0000		0	
91.00 09100 EMERGENCY	ON DISTINCT DADT)		0.0000		, o	1 / 00
92.00 09200 OBSERVATION BEDS (N			0.0000		0	
200.00 Total (sum of lines	50-94 and 96-98) pratory Services-Program only cha	proof (line (1)		13, 641, 718	3, 944, 702	
		arges (inne of)		12 441 710		201.00
202.00 Net Charges (line 2	ou minus line 201)		I	13, 641, 718	I	202.00

Health Financial Systems REHABILITATION HOSPITAL	OF INDIA	NA	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 153028	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Pre 5/28/2015 10:	epared:
	Ti t	le XIX	Hospi tal	PPS	<u> </u>
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			1, 862, 454		30.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0.0000			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2034			
60. 00 06000 LABORATORY		0. 3897			
65. 00 06500 RESPI RATORY THERAPY		0. 3573			
66. 00 06600 PHYSI CAL THERAPY		0. 2935			
66. 01 06601 PHYSI CAL THERAPY - CARMEL		0. 4257			
67.00 06700 OCCUPATI ONAL THERAPY		0. 2967			
68.00 06800 SPEECH PATHOLOGY		0. 1855			
68. 01 06801 VI SI ON		0. 3524			
68. 02 06802 FAC RESOURCE		1. 8388		C	
69. 00 06900 ELECTROCARDI OLOGY		0.0000		C	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3570		C	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0.0000		C	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3138			
74. 00 07400 RENAL DIALYSIS		0.0000		C	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		1. 5734	86 0	C	76.00
OUTPATIENT SERVICE COST CENTERS		0.0000			
90. 00 09000 CLINIC		0. 2903			
90. 01 09001 SLEEP CENTER		0.0000		C	
91.00 09100 EMERGENCY		0.0000		C	/ / / 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0.0000		C	
200.00 Total (sum of lines 50-94 and 96-98)			2, 127, 487	599, 682	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (I	ıne 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			2, 127, 487		202.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 153028	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Pre 5/28/2015 10:	
		Title XVIII	Hospi tal	PPS	1 <del>-</del> u
				1.00	-
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
	Medical and other services (see instructions)			0	1
00	Medical and other services reimbursed under OPPS (see instructi	ons)		602, 412	
00 00	PPS payments Outlier payment (see instructions)			497, 369 0	
00	Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instruct	ions)		0.000	
00	Line 2 times line 5			0.000	
00	Sum of line 3 plus line 4 divided by line 6			0.00	
00	Transitional corridor payment (see instructions)			0	
00	Ancillary service other pass through costs from Wkst. D, Pt. IN	7, col. 13, line 200		0	
	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0	
	COMPUTATION OF LESSER OF COST OR CHARGES			0	1
	Reasonabl e charges				
	Ancillary service charges				12
	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co Total reasonable charges (sum of lines 12 and 13)	)I. 4)		0	
. 00	Customary charges			0	1 14
. 00	Aggregate amount actually collected from patients liable for pa	ayment for services on	a charge basis	0	15
. 00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16
00	had such payment been made in accordance with 42 CFR §413.13(e)	1		0,000000	1 1 7
	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 0	
	Excess of customary charges over reasonable cost (complete only	/ifline 18 exceeds li	ne 11) (see	0	
	instructions)				
. 00	Excess of reasonable cost over customary charges (complete only	/ifline 11 exceeds li	ne 18) (see	0	20
00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		0	21
	Interns and residents (see instructions)	Thisti uctions)		0	
	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	
. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			497, 369	24
- 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	25
	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	CAH see instructions)		100, 702	
	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl			396, 667	
	CAH, see instructions)				
	Direct graduate medical education payments (from Wkst. E-4, lir	ne 50)		7, 582	
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 404, 249	29
	Primary payer payments			404, 249	
	Subtotal (line 30 minus line 31)			404, 214	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			36, 361 23, 635	
	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		36, 361	
	Subtotal (see instructions)	,		427, 849	
	MSP-LCC reconciliation amount from PS&R			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replace		tions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	
	Subtotal (see instructions)			427, 849	
	Sequestration adjustment (see instructions)			8, 557	
	Interim payments			388, 698	
	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0 30, 594	
	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2	chapter 1.	30, 594	
	§115. 2		·		]
	TO BE COMPLETED BY CONTRACTOR				Ι.
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0.00	
	Time Value of Money (see instructions)				93
	Total (sum of lines 91 and 93)				94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provi der	Provider CCN: 153028		Worksheet E-1 4 Part I 4 Date/Time Pre 5/28/2015 10:	pare
		Ti tl	e XVIII	Hospi tal	PPS	
		Inpatien	t Part A		nrt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		9, 740, 7	12	388, 698	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
~~	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	<u>I</u>				
)1	ADJUSTMENTS TO PROVIDER			0	0	3
)2				0	0	3
03				0	0	3
)4				0	0	3
)5				0	0	3
	Provider to Program			-	1	
0	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99)		9, 740, 7	12	388, 698	4
	(transfer to Wkst. E or Wkst. E-3, line and column as		7,740,7	12	300, 070	
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	1				
0	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
)1	TENTATI VE TO PROVIDER			0	0	5
)2 )3				0	0	5
/5	Provider to Program			0	0	
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
9	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6
	the cost report. (1)				20 504	
)1	SETTLEMENT TO PROVIDER			0	30, 594	6
)2	SETTLEMENT TO PROGRAM		20, 9		410, 202	6
00	Total Medicare program liability (see instructions)		9, 719, 7	42 Contractor	419,292 NPR Date	7
				Number	(Mo/Day/Yr)	
		(	)	1.00	2.00	
	Name of Contractor		-	1.00	2.00	8

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 153028	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part III Date/Time Prep 5/28/2015 10:	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
1.00	Net Federal PPS Payment (see instructions)			9, 170, 954	1. OC
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0397	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			348, 496	3.00
4.00	Outlier Payments			412, 837	4.00
5.00	Unweighted intern and resident FTE count in the most recent co to November 15, 2004 (see instructions)	ost reporting period en	ding on or prior	0.34	5.00
5. 01	Cap increases for the unweighted intern and resident FTE count program or hospital closure, that would not be counted without CFR $\frac{12}{2}$ (22(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	5. 01
5.00	New Teaching program adjustment. (see instructions)			0.00	6. OC
7.00	Current year's unweighted FTE count of I&R excluding FTEs in t	he new program growth p	eriod of a "new	3.14	7. OC
3. 00	teaching program" (see instructions) Current year's unweighted I&R FTE count for residents within t	he new program growth p	eriod of a "new	0.00	8.00
9.00	teaching program" (see instructions) Intern and resident count for IRF PPS medical education adjust	mont (coo instructions)		0.34	9.00
10.00	,			51. 764384	
	Teaching Adjustment Factor (see instructions)			0. 006675	
12.00	Teaching Adjustment (see instructions)			61, 216	
13.00				9, 993, 503	
14.00	Nursing and Allied Health Managed Care payments (see instructi	on)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)				15.00
16.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	16.00
17.00	, , ,			9, 993, 503	
18.00				25, 576	
19.00				9, 967, 927	19.00
20.00				60, 672	
21.00	· · ·			9, 907, 255	
22.00 23.00				184, 440 9, 722, 815	
24.00		cos) (soo instructions)		9, 722, 815	
25.00				61, 870	
26.00		ructions)		95, 185	
	Subtotal (sum of lines 23 and 25)	dottono)		9, 784, 685	
28.00	Direct graduate medical education payments (from Wkst. E-4, li	ne 49)		133, 419	28.00
29.00				0	29.00
30.00				0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	31.50
31.99	Recovery of Accelerated Depreciation			0	31.99
32.00				9, 918, 104	32.00
32.01	Sequestration adjustment (see instructions)			198, 362	
33.00				9, 740, 712	
34.00	Tentative settlement (for contractor use only)	1.24		0	
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and			-20, 970	
36.00	Protested amounts (nonallowable cost report items) in accordar §115.2	ice with CMS Pub. 15-2,	cnapter 1,	520, 910	36.00
-0.00	TO BE COMPLETED BY CONTRACTOR			410 007	E0.01
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			412, 837	50.00
51.00 52.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0	51.00
12 (11)	The face used to calculate the time value of Money			0.001	52.00

DIKLUI	Financial Systems REHABILITATION HOSPITA GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT		CCN: 153028	Period:	u of Form CMS-2 Worksheet E-4	
/IEDI CA	L EDUCATION COSTS			From 01/01/2014 To 12/31/2014	Date/Time Pre	
		Title	e XVIII	Hospi tal	5/28/2015 10: PPS	14 dili
					1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
1.00	Unweighted resident FTE count for allopathic and osteopathic pr	courams for	cost reporti	na periods	0.00	1 1.0
. 00	ending on or before December 31, 1996.	ograms ror	cost reporti	ng periods	0.00	
. 00	Unweighted FTE resident cap add-on for new programs per 42 CFR	413.79(e)(1	) (see instr	uctions)	0.00	2.0
. 00	Amount of reduction to Direct GME cap under section 422 of MMA				0.00	3.0
. 01	Direct GME cap reduction amount under ACA §5503 in accordance w	vith 42 CFR	§413.79 (m).	(see	0.00	3. (
	instructions for cost reporting periods straddling 7/1/2011)					
. 00	Adjustment (plus or minus) to the FTE cap for allopathic and os	steopathic p	programs due	to a Medicare	3.14	4.0
01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	ations for	aget report	na noni odo	0.00	
. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instrustraddling 7/1/2011)	ICTIONS TOP	cost reporti	ng perious	0.00	4.0
4. 02	ACA Section 5506 number of additional direct GME FTE cap slots	(see instr	cuctions for	cost reporting	0.00	4.0
1. 02	periods straddling 7/1/2011)	(300 1131		cost reporting	0.00	7.0
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus	s or minus l	ine 4 plus l	ines 4.01 and	3.14	5.0
	4.02 plus applicable subscripts		·			
6.00	Unweighted resident FTE count for allopathic and osteopathic pr	ograms for	the current	year from your	3.14	6.0
	records (see instructions)					
7.00	Enter the lesser of line 5 or line 6		Drimory Care	Othor	3.14	7.0
		F	Primary Care 1.00	0ther 2.00	Total 3.00	
3.00	Weighted FTE count for physicians in an allopathic and osteopat	hic	0.0		3.03	8.0
. 00	program for the current year.		0.0	5.05	5.05	0.0
9.00	If line 6 is less than 5 enter the amount from line 8, otherwis	se	0.0	0 3.03	3.03	9. (
	multiply line 8 times the result of line 5 divided by the amoun	nt on line				
	6.					
10.00	Weighted dental and podiatric resident FTE count for the curren	nt year		0.00		10.0
11.00	Total weighted FTE count		0.0			11. (
2.00	Total weighted resident FTE count for the prior cost reporting	year (see	0.0	0 2.92		12. (
13.00	instructions) Total weighted resident FTE count for the penultimate cost repo	orting	0.0	0 3.49		13. (
13.00	year (see instructions)	Ji ti ng	0.0	0 3.49		13.0
14.00	Rolling average FTE count (sum of lines 11 through 13 divided b	ov 3).	0.0	0 3.15		14. (
		5	0.0			15.0
16.00	Adjustment for residents displaced by program or hospital closu	ire	0.0	0.00		16.0
17.00	Adjusted rolling average FTE count		0.0	0 3.15		17.0
	Per resident amount		95, 329. 3			18. (
19.00	Approved amount for resident costs			0 300, 287	300, 287	19. (
					1.00	
0 00	Additional unweighted allopathic and osteopathic direct GME FTE	rocidont a	an clote roo	aived under 12	1.00	20.0
20.00	Sec. 413.79(c)(4)		ap siots iec	ei veu unuer 42	0.00	20.0
21.00	Direct GME FTE unweighted resident count over cap (see instruct	ions)			0.00	21. (
22.00	Allowable additional direct GME FTE Resident Count (see instruc				0.00	
23.00	Enter the locally adjustment national average per resident amou		structions)		0.00	23.
24.00	Multiply line 22 time line 23				0	24.
	Total direct GME amount (sum of lines 19 and 24)				300, 287	25.0
25.00		1	npatient Par	t Managed care		
25.00		-	A	2.00	2.00	
25.00			1.00	2.00	3.00	
25.00						
	COMPUTATION OF PROGRAM PATIENT LOAD	I	רר ד	Q 1 0EZ		26 1
26. 00	Inpatient Days (see instructions)		7, 27			
26. 00 27. 00	Inpatient Days (see instructions) Total Inpatient Days (see instructions)		18, 89	4 18, 894		27.0
26. 00 27. 00 28. 00	Inpatient Days (see instructions) Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days		18, 89 0. 38520	4 18, 894 2 0. 098232		26. 0 27. 0 28. 0 29. 0
26. 00 27. 00	Inpatient Days (see instructions) Total Inpatient Days (see instructions)		18, 89	4 18, 894 2 0. 098232		27.0

Health Financial Systems	REHABILITATION HOSPIT	AL OF INDIANA	In Lie	u of Form CMS-2	2552-10	
DIRECT GRADUATE MEDICAL EDUCATION (G	ME) & ESRD OUTPATIENT DIRECT	Provider CCN: 153028	Peri od:	Worksheet E-4		
MEDICAL EDUCATION COSTS			From 01/01/2014 To 12/31/2014	Date/Time Pre	arad	
			10 12/31/2014	5/28/2015 10:		
	PPS					
				1.00		
DIRECT MEDICAL EDUCATION COSTS	5 FOR ESRD COMPOSITE RATE - TITLE	XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL		
EDUCATION COSTS)						
	education costs (from Wkst. B, P	rt. I, sum of col. 20 an	d 23, lines 74	0	32.00	
and 94)						
	sis total charges (Wkst. C, Pt. I		74 and 94)	-		
	tion costs to total charges (line	e 32 ÷ line 33)		0.000000	34.00 35.00	
	0	36.00				
	RE REASONABLE COST - TITLE XVIII	UNLY				
Part A Reasonable Cost 37.00 Reasonable cost (see instructi	202)			10, 624, 887	37.00	
	D-4, Pt. III, col. 1, line 69)			10, 624, 887	37.00	
	n a teaching hospital (see instr	suctions)		0	39.00	
1 5	5 1 1	uctions)		25, 576		
Part B Reasonable Cost	sum of Triffes 37 thiough 37 minus	s i i i i i i i i i i i i i i i i i i i		10, 599, 311	41.00	
42.00 Reasonable cost (see instructi	ons)			602, 412	42.00	
43.00 Primary payer payments (see in	·			35	43.00	
44.00 Total Part B reasonable cost (				602, 377	44.00	
45.00 Total reasonable cost (sum of				11, 201, 688		
	st to total reasonable cost (line			0. 946224 0. 053776	47.00	
ALLOCATION OF MEDICARE DIRECT	GME COSTS BETWEEN PART A AND PAR	ТВ				
48.00 Total program GME payment (lir	ie 31)			141, 001	48.00	
49.00 Part A Medicare GME payment (I	ine 46 x 48) (title XVIII only)	(see instructions)		133, 419	49.00	
50.00 Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)					50.00	

	Financial Systems         REHABILITATION HOS           E SHEET (If you are nonproprietary and do not maintain         Not state of the state of th	Provi der	CCN: 153028	Period:	u of Form CMS-2 Worksheet G	
ind-1	ype accounting records, complete the General Fund column onl	y)		From 01/01/2014 To 12/31/2014	Date/Time Pre	
		General Fund	Speci fi c	Endowment Fund	5/28/2015 10: Plant Fund	14 8
		1.00	Purpose Fund		4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	7, 560, 858	(	0 0	0	1
00	Temporary investments	0		0 0	0	2
00	Notes receivable	0		0 0	0	
00	Accounts receivable	17, 417, 690 474, 933		0	0	4
00 00	Other receivable Allowances for uncollectible notes and accounts receivable	-11, 288, 131			0	
00	Inventory	267, 659		0 0	0	
00	Prepaid expenses	494, 585		0 0	0	6
00	Other current assets	21, 614		0 0	0	9
. 00	Due from other funds	0		0 0	0	10
. 00	Total current assets (sum of lines 1-10)	14, 949, 208		0 0	0	11
. 00	FI XED ASSETS	2, 506, 638		0 0	0	1 12
. 00	Land improvements	306, 681			0	13
. 00	Accumulated depreciation	-180, 416		0	0	14
. 00	Bui I di ngs	14, 954, 248	(	0 0	0	15
. 00	Accumulated depreciation	-10, 633, 883		o o	0	16
. 00	Leasehold improvements	95, 017		0 0	0	17
3.00	Accumulated depreciation	-79, 674		0 0	0	18
9.00	Fixed equipment	2,046,848		0 0	0	19
0.00	Accumulated depreciation Automobiles and trucks	-1, 758, 987			0	20
2.00	Accumulated depreciation				0	22
3.00	Major movable equipment	11, 399, 206		0	0	23
1.00	Accumulated depreciation	-7,007,496		0	0	24
. 00	Minor equipment depreciable	105, 832	(	o o	0	25
. 00	Accumulated depreciation	-105, 832	(	0 0	0	26
7.00	HIT designated Assets	0		0 0	0	27
3. 00	Accumulated depreciation	0		0 0	0	28
9.00	Minor equipment-nondepreciable	0			0	29
0. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	11, 648, 182		0 0	0	30
. 00	Investments	2, 082, 294		0 0	0	3.
2.00	Deposits on Leases	0		0 0	0	32
. 00	Due from owners/officers	0	(	0 0	0	33
. 00	Other assets	339, 932	(	0 0	0	34
5.00	Total other assets (sum of lines 31-34)	2, 422, 226		0 0	0	35
b. 00	Total assets (sum of lines 11, 30, and 35)	29, 019, 616		0 0	0	36
. 00	CURRENT LI ABI LI TI ES	752, 026		0 0	0	37
3.00	Accounts payable Salaries, wages, and fees payable	2, 380, 697			0	
9.00	Payrol I taxes payable	2, 300, 077		0	0	
. 00		637, 538		0	0	
. 00	Deferred income	0	(	o o	0	41
2.00	Accelerated payments	0				42
8. 00	Due to other funds	0	(	0 0	0	
1.00	Other current liabilities	501, 273		0 0	0	44
5.00	Total current liabilities (sum of lines 37 thru 44)	4, 271, 534	(	0 0	0	45
5. 00	LONG TERM LIABILITIES Mortgage payable	17, 396, 478		0 0	0	46
7.00	Notes payable	0		0 0	0	
3.00	Unsecured Loans	0		o o	0	
9.00	Other long term liabilities	0		0 0	0	
. 00	Total long term liabilities (sum of lines 46 thru 49	17, 396, 478		0 0	0	50
. 00	Total liabilites (sum of lines 45 and 50)	21, 668, 012		0 0	0	5
00	CAPITAL ACCOUNTS	7 251 /04		1		-
. 00	General fund balance Specific purpose fund	7, 351, 604				52
. 00	Donor created - endowment fund balance - restricted			0		54
. 00	Donor created - endowment fund balance - unrestricted			0		5!
. 00	Governing body created - endowment fund balance			0		56
7.00	Plant fund balance - invested in plant				0	
3. 00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					
9.00	Total fund balances (sum of lines 52 thru 58)	7, 351, 604		0 0	0	
). 00	Total liabilities and fund balances (sum of lines 51 and	29, 019, 616		O	0	60

General 1.00 0 0 0 0 0 0 0 0 0 0 0 0		3.00	4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Date/Ti me Prej 5/28/2015 10: Endowment Fund 5.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14 am 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
1.00	2.00 6,082,925 1,268,686 7,351,611	3.00	4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
0	6, 082, 925 1, 268, 686 7, 351, 611 0			0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
0	6, 082, 925 1, 268, 686 7, 351, 611 0			0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
0			0 0 0	0	12.00 13.00 14.00 15.00
0 0 Endowment Fund	7 7, 351, 604 Pl ant				16. 00 17. 00 18. 00 19. 00
6.00	7.00	8.00			1.00
0	0 0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
0 0	0 0 0 0 0 0		0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
	6.00 0 0 0 0	Endowment Fund Plant  6.00 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Endowment Fund PI ant Fund 6.00 7.00 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0         0

	Financial Systems REHABILITATION HOSPIT		CCN: 153028	Pρ	ri od:	Worksheet G-2	2552-10
STATEN	LINE OF FAITENT REVENUES AND OFERATING EAFENSES	FIOVICE	CCN. 155028		om 01/01/2014	Parts I & II Date/Time Pre 5/28/2015 10:	pared:
	Cost Center Description		I npati ent		Outpatient	Total	
			1.00		2.00	3.00	
	PART I – PATIENT REVENUES						-
	General Inpatient Routine Services						
1.00	Hospital		30, 516, 3	02		30, 516, 302	
2.00	SUBPROVIDER - IPF						2.00
3.00 4.00	SUBPROVI DER – I RF SUBPROVI DER						3.00
4.00 5.00	Swing bed - SNF			0		0	
6.00	Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY			0		0	7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		30, 516, 3	02		30, 516, 302	10.00
	Intensive Care Type Inpatient Hospital Services						
11.00	INTENSIVE CARE UNIT						11.00
12.00	CORONARY CARE UNI T						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL INTENSI VE CARE UNI T						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines		0		0	16.00
17.00	11-15) Total inpatient routine care services (sum of lines 10 and 16)		30, 516, 3	02		30, 516, 302	17.00
17.00	Ancillary services		35, 964, 8		13, 655, 337	49, 620, 209	
19.00	Outpati ent services		5, 1		1, 687, 810	1, 692, 939	
20.00	RURAL HEALTH CLINIC		0,1	0	0	0	
	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
	HOME HEALTH AGENCY						22.00
23.00	AMBULANCE SERVICES						23.00
24.00	СМНС				0	0	24.00
24. 10				0	0	0	
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPI CE						26.00
27.00	OTHER (SPECIFY)	+- 111+	( 10( )	0	15 242 147	01 000 450	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 G-3, line 1)	to wkst.	66, 486, 3	03	15, 343, 147	81, 829, 450	28.00
	PART II - OPERATING EXPENSES						1
29.00	Operating expenses (per Wkst. A, column 3, line 200)				35, 275, 728		29.00
30.00	ADD (SPECIFY)			0			30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECI FY)			0			37.00
38.00				0			38.00
39.00				0			39.00
40.00				0 0			40.00
41.00 42.00	Total deductions (sum of lines 37-41)			U	0		41.00
	Total operating expenses (sum of lines 29 and 36 minus line 42				9		42.00
43.00	LIGTAL OPERATING EXPENSES (SUM OF LIDES 29 and 36 minus Line 4	))(transter			35, 275, 728		

Health Financial Systems REHABILITATION HOSPITAL OF INDIANA	In Lieu of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 153028 Period:	Worksheet G-3
From 01/01 To 12/31	1/2014 1/2014 Date/Time Prepared: 5/28/2015 10:14 am
	1.00
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	81, 829, 450 1.00
2.00 Less contractual allowances and discounts on patients' accounts	46, 872, 276 2.00
3.00 Net patient revenues (line 1 minus line 2)	34, 957, 174 3. 00
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)	35, 275, 728 4. 00
5.00 Net income from service to patients (line 3 minus line 4) OTHER INCOME	-318, 554 5.00
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 services	0 8.00
9.00 Revenue from television and radio service	0 9.00
10.00 Purchase di scounts	0 10.00
11.00 Rebates and refunds of expenses	0 11.00
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 quests	0 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	0 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 MISCELLANEOUS INCOME	1, 587, 240 24. 00
25.00 Total other income (sum of lines 6-24)	1, 587, 240 25. 00
26.00 Total (line 5 plus line 25)	1, 268, 686 26. 00
27.00 OTHER EXPENSES (SPECIFY)	0 27.00
28.00 Total other expenses (sum of line 27 and subscripts)	0 28.00
29.00 Net income (or loss) for the period (line 26 minus line 28)	1, 268, 686 29. 00