| Health Financial Systems SOUTHERN INDIANA REHAB HOSPITAL In Lieu of Form CMS-2552 | 2-10 |
|---|---------------------------|
| This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED | 0 |
| payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). ONB NO. 0938-0050 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 153037 Period: control Worksheet S | 5 |
| AND SETTLEMENT SUMMARY AND SETTLEMENT SUMMARY 5/27/2015 8:43 au | |
| PART I - COST REPORT STATUS | |
| Provider 1.[X]Electronically filed cost report Date: 5/27/2015 Time: 8:43 | am |
| use only 2.[]Manually submitted cost report 3.[0.1]f this is an amended report enter the number of times the provider resubmitted this cost 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 5. [1]Cost Report Status 6. Date Received: 10. NPR Date: use only (1) As Submitted 7. Contractor No. 11. Contractor's Vendor Code: (2) Settled without Audit 8. [N]Initial Report for this Provider CCN 10. NPR Date: (3) Settled with Audit 9. [N]Final Report for this Provider CCN 10. NPR Date: (4) Reopened (5) Amended 10. NPR Date: | |
| PART II - CERTIFICATION | |
| MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. | |
| CERTIFICATION BY 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 SOUTHERN INDIANA REHAB HOSPITAL (153037) for the cost reporting period beginning O1/01/2014 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. Encryption Information ECR: Date: 5/27/2015 Time: 8:43 am tIwvEig0jJnscVQeaCvm04tDHQ0 warBd0ZIluaTHUS4aySLX04IskshYV :fGROPXizp0JoYjZ PI: Date: 5/27/2015 Time: 8:43 am KvOlK7n6bg7TsJ.V21Aleg510kQhp0 0:rIS0H4CPNwE:y83MUFIDA.yo9AvC RKtd0cJNB70rrSf3 | |
| Title XVIII | |
| Title v Part A Part B HIT Title XIX 1.00 2.00 3.00 4.00 5.00 | <u>- 1997</u> - 1997 - |
| 1.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY | |
| PART 111 * DETTLEMENT SUPPORT | .00 |
| | .00 |
| 3.00 Subprovider - IRF 0 0 0 0 3 | .00 |
| | .00 |
| | 5.00 |
| | 7.00 0.00 |
| | 2.00 |
| 12.00 CMHC I 0 0 12 200.00 Total 0 32,340 -908 0 0 200 | |
| The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. | |
| According to the Paperwork Reduction Act of 1995, no persons are required to 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, navments, medical records or any documents containing sensitive information to the F | 'RA |
| 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 questic or concerns regarding where to submit your documents , please contact 1-800-MEDICARE. | 110 |
| or concerns regularing meter co submite your accompances y product during a contract a set interesting. | |

| | | SOUTHERN IN | | | | N. 152027 | | n Lieu | | rm CMS- | |
|---|--|--|--|--|--|--|--|------------------|------------------|----------------------------|--|
| HUSPI I | AL AND HOSPITAL HEALTH CARE COMPLEX | IDENTIFICATION DA | IA | Provi | der CCI | N: 153037 | Period: From 01/01 To 12/31 | /2014 /2014 | Part I | neet S-2 Time Pre | |
| | 1.00 | 2 | 00 | | 2 00 | | 10 12/31 | | | 2015 8:4 | |
| | Hospital and Hospital Health Care Co | 2. mplex Address: | 00 | | 3.00 | | | 4.00 | | | |
| 1.00 2.00 | Street: 3104 BLACKISTON BOULEVARD City: NEW ALBANY | PO Box: State: I | N 7 | in Code | e: 47150 | Cour | ity: FLOYD | | | | 1.00 |
| 2.00 | | Component Na | me | CCN | CBSA | Provi de | r Date | | | tem (P, | 2.00 |
| | | | N | umber | Number | - Туре | Certified | | , 0, or XVIII | | - |
| | <u> </u> | 1.00 | | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | _ | | |
| 3.00 | Hospital and Hospital-Based Componer Hospital | nt Identification: SOUTHERN INDIANA HOSPITAL | | 53037 | 31140 | 5 | 03/01/200 | 2 N | P | 0 | 3.00 |
| 4.00 5.00 6.00 7.00 8.00 9.00 | Subprovider - IPF Subprovider - IRF Subprovider - (Other) Swing Beds - SNF Swing Beds - NF Hospital-Based SNF | SOUTHERN I NDI ANA HOSPI TAL | REHAB 1 | 55765 | 31140 | | 08/03/200 | 7 N | P | N | 4.00 5.00 6.00 7.00 8.00 9.00 |
| 11.00 12.00 13.00 14.00 15.00 16.00 17.00 | Hospital-Based NF Hospital-Based OLTC Hospital-Based HHA Separately Certified ASC Hospital-Based Hospice Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I Renal Dialysis Other | | | | | | | | | | 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 |
| | | | | | | | From 1.0 | | | 0: | - |
| | Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions) | | | | | | 01/01/ | | | 1/2014 | 20.00 21.00 |
| 22.00 | Inpatient PPS Information Does this facility qualify and is it | currently receiv | ing payme | nts for | r di spro | oporti onat | e N | | | N | 22.00 |
| | share hospital adjustment, in accord for yes or "N" for no. Is this facil | lance with 42 CFR | §412.106? | In co | olumn ['] 1, | , enter "Υ | /" | | | | |
| 22. 01 | amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r | ter "Y" for yes o compensated care res or "N" for no October 1. Enter | or "N" for payments for the p in column | no. for thi ortion 2, "Y" | s cost of the ' for ye | reporting cost es or "N" | | | | N | 22.01 |
| 22. 02 | (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. | ? (see instructione cost reporting | ons) Enter period pr | in col ior to | umn 1, Octobei | "Y" for y r 1. Enter | ves | | | N | 22.02 |
| 22.03 | Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on c hospital contain at least 100 but no | statistical area no for the portic 2, "Y" for yes or or after October 1 ot more than 499 b | ns adopted on of the ""N" for . (see in oeds (as c | by CMS cost re no for structi | S in FY2 eporting the poi ons) Do | 2015? Ente g period rtion of t pes this | er :he | | | N | 22.03 |
| 23.00 | 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per | dicaid days on li f census days, or is cost reporting | nes 24 an 3 if dat period d | e of di ifferer | scharge nt from | e. Is the the metho | od | 3 | | N | 23.00 |
| | | | In-State Medicaid paid days | unpa day | caid ble M aid pa ys | Out-of State ledi cai d ai d days | State Medi cai d el i gi bl e unpai d | Medica HMO da | ys Me | Other edi cai d days | |
| 24.00 | If this provider is an IPPS hospital | , enter the | 1.00 | 2.0 | 00 | 3.00 | 4.00 | 5.00 | 0 | 6.00 C | 24.00 |
| | In this provider is an investious in colum Medicaid eligible unpaid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th | n 1, in-state umn 2, column 3, d days in column it unpaid days in column 6. | 233 | | 53 | 0 | 0 | | 69 | | 25.00 |
| 20.00 | Medicaid paid days in column 1, the Medicaid eligible unpaid days in col out-of-state Medicaid days in column Medicaid eligible unpaid days in col HMO paid and eligible but unpaid days | in-state umn 2, 3, out-of-state umn 4, Medicaid | 233 | | 55 | 0 | 0 | | | | 23.00 |

| | Financial Systems | | | REHAB HOSPI TAL | | Li. | n Lieu | of For | m CMS-2 | 2552-10 |
|---------|---|---|----------------------------|--|--------------------------------|----------------------------------|-----------|---|---------------|----------------|
| HOSPI T | AL AND HOSPITAL HEALTH CARE COMPLEX IDENT | IFICATION DA | TA | Provi der | F | eriod: rom 01/01/ o 12/31/ | | Workshe Part I Date/Ti 5/27/20 | me Pre | pared: |
| | | | | | | Urban/Ru | | Date of | Geogr | - |
| 26.00 | Enter your standard geographic classifica | | | | ginning of the | 1.00 | 1 | 2.0 | 10 | 26.00 |
| 27.00 | cost reporting period. Enter "1" for urba Enter your standard geographic classifica reporting period. Enter in column 1, "1" | ation (not wa for urban or | nge) st "2" f | atus at the en or rural. If a | | | 1 | | | 27.00 |
| 35.00 | enter the effective date of the geographi If this is a sole community hospital (SCH effect in the cost reporting period. | | | | CH status in | | o | | | 35.00 |
| | | | | | | Begi nni 1. 00 | 5 | Endi ı 2. C | | |
| 36.00 | Enter applicable beginning and ending dat | | | Subscript line | 36 for number | | | 2. U | 10 | 36.00 |
| 37.00 | of periods in excess of one and enter sub If this is a Medicare dependent hospital in effect in the cost reporting period. | | | umber of perio | ds MDH status | | o | | | 37.00 |
| 38.00 | Enter applicable beginning and ending dat | | | Subscript line | 38 for number | | | | | 38.00 |
| | of periods in excess of one and enter sub | sequent date | es. | | | Y/N | | Y/I | N | |
| 39.00 | Does this facility qualify for the inpati | ent hosni tal | navme | nt adjustment | for low volume | 1.00 |) | 2. C | | 39.00 |
| 57.00 | hospitals in accordance with 42 CFR §412. or "N" for no. Does the facility meet the CFR 412.101(b)(2)(ii)? Enter in column 2 | 101(b)(2)(ii e mileage rec |)? Ént uireme | er in column 1 nts in accorda | "Y" for yes nce with 42 | | | N | | 37.00 |
| 40.00 | Is this hospital subject to the HAC progr "N" for no in column 1, for discharges pr no in column 2, for discharges on or afte | rior to Octob | per 1. | Enter "Y" for | | N | | N | | 40.00 |
| | | | (366 | | | 1 | V 1.00 | XVIII 2.00 | XI X 3. 00 | |
| 45.00 | Prospective Payment System (PPS)-Capital Does this facility qualify and receive Ca | apital paymer | nt for | di sproporti ona | te share in ac | cordance | N | N | N | 45.00 |
| 46.00 | with 42 CFR Section §412.320? (see instru Is this facility eligible for additional pursuant to 42 CFR §412.348(f)? If yes, c | payment exce | | | | | N | N | Ν | 46.00 |
| | Pt. III. Is this a new hospital under 42 CFR §412. Is the facility electing full federal cap | | | | | | N N | N N | N N | 47.00 48.00 |
| 56 00 | Teaching Hospitals Is this a hospital involved in training r | asidants in | approv | ed CME program | s2 Enter "V" | for ves | N | | | 56.00 |
| | or "N" for no. | | | | | 5 | | | | |
| 57.00 | If line 56 is yes, is this the first cost GME programs trained at this facility? E is "Y" did residents start training in th for yes or "N" for no in column 2. If co | Enter "Y" for ne first mont olumn 2 is "Y | yes o h of t (", com | r "N" for no i his cost repor plete Workshee | n column 1. lf ting period? | Enter "Y" | | | | 57.00 |
| 58.00 | "N", complete Wkst. D, Parts III & IV and If line 56 is yes, did this facility elec defined in CMS Pub. 15-1, § 2148? If yes, | ct cost reimb | ourseme | nt for physici | ans' services | as | | | | 58.00 |
| | Are costs claimed on line 100 of Workshee Are you claiming nursing school and/or al | et A? If yes | s, comp | lete Wkst. D-2 | | , , | N N | | | 59.00 60.00 |
| 00.00 | provider-operated criteria under §413.85? | | for ye | <u>s or "N" for n</u> | o. (see instru | ictions) | | | | 00.00 |
| | | | Y/N | IME | Direct GME | IME | | Di rect | GME | |
| 61 00 | Did your hospital receive FTE slots under | - ACA | 1.00 N | 2.00 | 3.00 | 4.00 | 0.00 | 5. C | | 61.00 |
| | section 5503? Enter "Y" for yes or "N" fo column 1. (see instructions) | or no in | IN | | | | 0.00 | | 0.00 | |
| 61.01 | Enter the average number of unweighted pr FTEs from the hospital's 3 most recent co ending and submitted before March 23, 201 | ost reports | | 0.00 | 0.00 | 0 | | | | 61.01 |
| 61. 02 | instructions) Enter the current year total unweighted p FTE count (excluding OB/GYN, general surg and primary care FTEs added under sectior | gery FTEs, | | 0.00 | 0.00 | b | | | | 61.02 |
| 61.03 | ACA). (see instructions) Enter the base line FTE count for primary and/or general surgery residents, which i | / care s used for | | 0.00 | 0.00 | | | | | 61.03 |
| 61. 04 | determining compliance with the 75% test. instructions) Enter the number of unweighted primary ca surgery allopathic and/or osteopathic FTE | are/or | | 0.00 | 0.00 | þ | | | | 61.04 |
| 61.05 | current cost reporting period. (see instru Enter the difference between the baseline and/or general surgery FTEs and the curre | uctions). e primary ent year's | | 0.00 | 0.00 | þ | | | | 61.05 |
| 61.06 | primary care and/or general surgery FTE c 61.04 minus line 61.03). (see instruction Enter the amount of ACA §5503 award that used for cap relief and/or FTEs that are care or general surgery. (see instruction | ns) is being nonprimary | | 0. 00 | 0. 00 | 5 | | | | 61.06 |

| HOSPITAL AND HOSPITA | AL HEALTH CARE COMPI | EX IDENTIFICATION DA | ATA | Provi der | | eriod: rom 01/01/2014 | Worksheet S-2 Part I | |
|---|---|---|--|--|--|-----------------------------------|---|-------|
| | | | | | | o 12/31/2014 | | |
| | | | Progran | n Name | Program Code | Unweighted IME FTE Count | Unweighted Direct GME FTE Count | |
| | | | 1. (| 00 | 2.00 | 3.00 | 4.00 | |
| specialty, if for each new column 1, the program code, unweighted co FTE unweighte 51.20 Of the FTEs i | any, and the numbe program. (see instr program name, ente enter in column 3, unt and enter in co | uctions) Enter in r in column 2, the the IME FTE lumn 4, direct GME fy each expanded | | | | 0.00 | | 61. 1 |
| residents for instructions) enter in colu 3, the IME FT | each expanded prog Enter in column 1, mn 2, the program c | ram. (see the program name, ode, enter in column and enter in column | | | | | | |
| | | | | | | | 1.00 | 1 |
| | | Ith Resources and Se | | | | | | |
| | | s that your hospital | | this cost | reporting per | iod for which | 0.00 | 62.0 |
| 2.01 Énter the num during in thi | ber of FTE resident s cost reporting pe | funding (see instructs s that rotated from a riod of HRSA THC prog | a Teaching gram. (see | nstructic | | o your hospital | 0.00 | 62.0 |
| 3.00 Has your faci | lity trained reside | sidents in Nonprovid nts in nonprovider so umn 1. If yes, comple | ettings dur | ng this c | instructions) | | N | 63. |
| | | | | | Unweighted | Unweighted | Ratio (col. | |
| | | | | | FTEs Nonprovider Site | FTEs in Hospital | 1/ (col. 1 + col. 2)) | |
| | | | | | 1.00 | 2.00 | 3.00 | |
| | | r FTE Residents in N | | | This base year | r is your cost | reporting | |
| 4.00 Enter in colu in the base y resident FTEs settings. En resident FTEs | mn 1, ifline 63 is ear period, the num attributable to ro ter in column 2 the that trained in yo | uly 1, 2009 and befo yes, or your facili ber of unweighted not tations occurring in number of unweightee ur hospital. Enter in 1 + column 2)). (see | ty trained n-primary ca all nonpro d non-prima n column 3 instruction | residents are vider rycare theratio ns) | 0.00 | | | 64.0 |
| | | Program Name | Program | 1 Code | Unwei ghted FTEs Nonprovi der Si te | Unweighted FTEs in Hospital | Ratio (col. 3/ (col. 3 + col. 4)) | |
| | | 1.00 | 2.0 | 00 | 3.00 | 4.00 | 5.00 | |
| year period, associated wi FTEs for each program in wh residents. En the program c col umn 3, the unweighted pr residents att rotations occ non-provider col umn 4, the unweighted pr resident FTEs your hospital | ur facility ents in the base the program name th primary care primary care ich you trained ter in column 2, ode, enter in number of imary care FTE ributable to urring in all settings. Enter in number of | | | | 0.00 | 0.00 | 0. 000000 | |

| Health Financial Systems | | INDIANA REHAB HOSPI | TAL | In | Li eu | of Form | n CMS-2 | 2552-10 |
|--|---|---|---------------------------------------|------------------------------------|-------|------------------------------|---------|------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE | COMPLEX IDENTIFICATION D | ATA Provide | F | eriod: rom 01/01/2 o 12/31/2 | | Workshe Part I Date/Ti | me Pre | pared: |
| | | | Unwei ghted | Unweighte | | 5/27/20 Ratio | (col. | |
| | | | FTEs Nonprovider | FTEs in Hospital | | 1/ (col col. | | |
| | | | Site | | | | | |
| Section 5504 of the ACA Cur | rent Year FTE Residents i | in Nonprovider Sett | 1.00 ingsEffective 1 | 2.00 for cost re | porti | 3.0 na peri | | |
| beginning on or after July | 1, 2010 | • | | | | 0. | | 44 00 |
| 66.00 Enter in column 1 the numbe FTEs attributable to rotati | | | 0.00 | | 0. 00 | 0. | 000000 | 66.00 |
| Enter in column 2 the numbe FTEs that trained in your h | | | | | | | | |
| (column 1 divided by (colum | <u>n 1 + column 2)). (see ir</u> | nstructions) | | | | | | |
| | Program Name | Program Code | Unweighted FTEs | Unweighte FTEs in | | Ratio 3/ (col | | |
| | | | Nonprovi der | Hospi tal | | col . | | |
| | 1.00 | 2.00 | Site 3.00 | 4.00 | | 5.0 | 0 | |
| 67.00 Enter in column 1, the prog | ram | | 0.00 | | 0. 00 | | | 67.00 |
| name associated with each o your primary care programs | | | | | | | | |
| which you trained residents | | | | | | | | |
| Enter in column 2, the prog code. Enter in column 3, th | | | | | | | | |
| number of unweighted primar care FTE residents attribut | | | | | | | | |
| to rotations occurring in a | | | | | | | | |
| non-provider settings. Ente column 4, the number of | ⁻ in | | | | | | | |
| unweighted primary care | | | | | | | | |
| resident FTEs that trained your hospital. Enter in col | | | | | | | | |
| 5, the ratio of (column 3 | | | | | | | | |
| divided by (column 3 + colu 4)). (see instructions) | | | | | | | | |
| | | | | - | 1.00 | 2.00 | 3.00 | |
| Inpatient Psychiatric Facil 70.00 Is this facility an Inpatie | | (LDE) or doop it of | ontain an LDE aut | | N | | | 70.00 |
| Enter "Y" for yes or "N" f | | (IPF), of does it co | untain an ipp suc | | IN | | | 70.00 |
| 71.00 If line 70 yes: Column 1: D recent cost report filed on | | | | | | | 0 | 71.00 |
| 42 CFR 412.424(d)(1)(iii)(c |)) Column 2: Did this fac | cility train resider | nts in a new teac | hi ng | | | | |
| program in accordance with Column 3: If column 2 is Y, | | | | | | | | |
| reporting period covers the | beginning of the fourth | year, enter 4 in co | olumn 3, or if th | | | | | |
| or subsequent academic year instructions) For cost repo | | | | cost | | | | |
| reporting period covers the teaching program in existen | 0 0 | | cademic year of t | he new | | | | |
| Inpatient Rehabilitation Fa | cility PPS | | | | | | | |
| 75.00 Is this facility an Inpatie subprovider? Enter "Y" for | | ty (IRF), or does it | t contain an IRF | | Y | | | 75.00 |
| 76.00 If line 75 yes: Column 1: D | d the facility have an a | | | | Ν | N | 0 | 76.00 |
| recent cost reporting perio no. Column 2: Did this faci | | | | | | | | |
| CFR 412.424 (d)(1)(iii)(D)? 1, 2, or 3, in column 3. (s | | | | | | | | |
| of the fourth year, enter 4 | in column 3, or if the f | fifth or subsequent | academic years c | of the new | | | | |
| teaching program in existen on or after October 1, 2012 | | | | | | | | |
| any subsequent academic yea | | | | | | | | |
| i nstructi ons) | 5 1 | | | | | | | |
| | | | | I | | | | |
| Long Term Care Hospital DDG | | | | | | 1.0 | 0 | |
| Long Term Care Hospital PPS 80.00 Is this a long term care ho | spital (LTCH)? Enter "Y" | | | | | N | | 80.00 |
| 80.00 Is this a long term care ho 81.00 Is this a LTCH co-located w | spital (LTCH)? Enter "Y" | | | period? Er | nter | | | 80. 00 81. 00 |
| 80.00 Is this a long term care ho 81.00 Is this a LTCH co-located w "Y" for yes and "N" for no. TEFRA Providers | spital (LTCH)? Enter "Y" thin another hospital fo | or part or all of th | he cost reporting | · • | | N | | 81.00 |
| 80.00 Is this a long term care ho 81.00 Is this a LTCH co-located w "Y" for yes and "N" for no. | spital (LTCH)? Enter "Y" thin another hospital fo - 42 CFR Section §413.40(| or part or all of th (f)(1)(i) TEFRA? Er | he cost reporting nter "Y" for yes | or "N" for | | N | | |

| Health Financial Systems SOUTHERN INDIANA | REHAB HOSPI TAL | <u> </u> | ١r | n Lieu | of Form | CMS-2 | 2552-10 |
|--|----------------------------------|----------------------------------|----------------------------------|--------|--|--------|--------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provi der | | eriod: rom 01/01/ o 12/31/ | | Workshee Part I Date/Tim 5/27/201 | ne 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 hospit yes or "N" for no in the applicable column. | al services? E | Enter "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 app | | | N | | Y | | 91.00 |
| 92.00 Are title XIX NF patients occupying title XVIII SNF beds (d instructions) Enter "Y" for yes or "N" for no in the applic | | tion)? (see | | | Ν | | 92.00 |
| 93.00 Does this facility operate an ICF/MR facility for purposes "Y" for yes or "N" for no in the applicable column. | of title V and | d 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 n | no in the | N | | N | | 94.00 |
| 95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye 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 ap Rural Providers | plicable colum | nn. | | 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 | | thod 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 eligi for I &R training programs? Enter "Y" for yes or "N" for n | | | | | | | 107.00 |
| instructions) If yes, the GME elimination would not be on W the program would be cost reimbursed. If yes complete Wkst. | kst. B, Pt. I, D-2, Pt. II. | col. 25 and Column 2: If | | | | | |
| this facility is a CAH, do I&Rs in an approved medical educ CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or 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. | CRNA fee sche | edul e? See 42 | N | | | | 108.00 |
| | Physi cal 1.00 | Occupational 2.00 | Speec 3.00 | | Respira 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. | | | | | | | 109.00 |
| | | 1 | 1 | - | 1.00 |) | |
| 110.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N" | | on project (41 | OA Demo)fo | or | N | | 110.00 |
| The current cost reporting period. Enter in the yes of in | | | | 1.00 | 2.00 | 3.00 | |
| Miscellaneous Cost Reporting Information | | | | | | | |
| 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes o is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, §2208.1. | . If column 2 nt for long te | is "E", enter erm care (inclu | in column des | N | | 0 | 115.00 |
| 116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insu | 2 | | "N" for | N Y | | | 116. 00 117. 00 |
| no. 118.00 Is the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence. | licy? Enter 1 | if the policy | is | 2 | | | 118.00 |
| | | Premiums | Losse | 5 | Insura | nce | |
| | | | | | | | |
| | | 1.00 | 2.00 | | 3.00 | | |
| 118.01 List amounts of malpractice premiums and paid losses: | | 47, 373 | | 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 sche and amounts contained therein. | | | N | | | | 118.02 |
| 119.00 DO NOT USE THIS LINE | | | | | | | 119.00 |
| 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme | n column 1, "Y ualifies for t | (" for yes or the Outpatient | N | | N | | 120.00 |
| Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. | antabl e devi ce | es charged to | N | | | | 121.00 |
| Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f | 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, e | | fication date | | | | | 126.00 |
| in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, en | 2. ter the certif | | | | | | 127.00 |
| in column 1 and termination date, if applicable, in column | 2. | | | | | | |

| alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPL | EX IDENTIFICATION DATA | Provi der | | Period: | Worksheet S- | 2 |
|--|--|--|---|--|--|---|
| | | | | From 01/01/2014 To 12/31/2014 | | |
| | | | | 1.00 | | |
| 8.00 f this is a Medicare certified | iver transplant center | , enter the certi | fication date | 1.00 | 2.00 | 128.0 |
| in column 1 and termination date, | | | | - | | 100 (|
| 9.00 If this is a Medicare certified I column 1 and termination date, if | | | cation date i | n | | 129. (|
| 0.00 If this is a Medicare certified p | • | | rti fi cati on | | | 130. (|
| date in column 1 and termination 1.00 f this is a Medicare certified i | ntestinal transplant c | enter, enter the | certi fi cati on | | | 131. (|
| date in column 1 and termination 2.00 If this is a Medicare certified i | slet transplant center | , enter the certi | fication date | | | 132. |
| in column 1 and termination date, 3.00 f this is a Medicare certified o | | | fication date | | | 133. |
| in column 1 and termination date, 4.00 If this is an organ procurement of | rganization (OPO), ent | | in column 1 | | | 134. |
| and termination date, if applicab All Providers | ne, in corumn 2. | | | | | - |
| 0.00 Are there any related organizatio chapter 10? Enter "Y" for yes or | | | | Y | 18H006 | 140. (|
| are claimed, enter in column 2 th | | J . | | | | |
| <u> </u> | in organization ontor | 2.00 | ough 142 tho r | 3.00 | of the home | |
| office and enter the home office | | | | laille and addi ess | s of the home | |
| 1.00Name: JHSMH INC 2.00Street:250 EAST LIBERTY STREET | Contractor's Name PO Box: | e: CGS SUI TE 500 | Contracto | or's Number: 1510 |)1 | 141. 142. |
| 3. 00 Ci ty: LOUI SVI LLE | State: | KY | Zip Code: | 4020 | 02 | 142. |
| | | | | | 1.00 | - |
| 00 Are provider based physicians' co | sts included in Worksh | eet A? | | | Y | 144. |
| 5.00 If costs for renal services are c | laimed on Worksheet A | ling 71 are the | costs for inp | atient services | N | 145. |
| only? Enter "Y" for yes or "N" fo | | The 74, are the | | | | |
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| only? Enter "Y" for yes or "N" fo 6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i | r no. gy changed from the pr n column 1. (See CMS P | eviously filed co | | 1.00 N | 2.00 | 146. |
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| onl y? Enter "Y" for yes or "N" fo 6.00 Has the cost allocation methodol of Enter "Y" for yes or "N" for no i the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statist 8.00 Was there a change in the order of 9.00 Was there a change to the simplifind no. Does this facility contain a provious or charges? Enter "Y" for yes or 5.00 Hospital 5.00 Subprovider - IPF 7.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in | r no. gy changed from the pr n column 1. (See CMS P column 2. ical basis? Enter "Y" if allocation? Enter "Y ied cost finding metho ider that qualifies fo "N" for no for each co ampus hospital that ha Name 0 | eviously filed co ub. 15-2, § 4020) for yes or "N" fo "for yes or "N" d? Enter "Y" for Part A 1.00 or an exemption fr mponent for Part N N N N S one or more cam County 1.00 | If yes, enter for no. for no. yes or "N" for Part B 2.00 om the applica A and Part B. N N N N N N N N N N N N N | N N N N N N See 42 CFR §41 N N N N N N N N N N N N N N N N N N N | Title XIX 4.00 ver of costs 3.13) N N N N N N N N N N N FTE/Campus 5.00 | 147. 148. 149. |
| onl y? Enter "Y" for yes or "N" fo 6.00 Has the cost allocation methodol of Enter "Y" for yes or "N" for no i the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statist 8.00 Was there a change in the order of 9.00 Was there a change to the simplifind 1.00 Subprovider - 1PF 1.00 Subprovider - 1PF 1.00 SUBPROVIDER 9.00 SNF 1.00 CMHC 1.00 CMHC 1.00 CMHC 5.00 If Line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) | r no. gy changed from the pr n column 1. (See CMS P column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo "N" for no for each co ampus hospital that ha Name 0 T) incentive in the Am r under Section §1886(| eviously filed co ub. 15-2, § 4020) for yes or "N" fo "for yes or "N" fo d? Enter "Y" for Part A 1.00 or an exemption fr mponent for Part N N N N S one or more cam County 1.00 terican Recovery a n)? Enter "Y" fo | If yes, enter r no. for no. yes or "N" for Part B 2.00 om the applica A and Part B. N N N N N N N N N N N N N | N N N N N N N See 42 CFR §41 N N N N N N N N N N N N N N N N N N N | Title XIX 4.00 ver of costs 3.13) N N N N N N N N N N N S TE/Campus 5.00 0.0 | 147. 148. 149. 155. 156. 157. 158. 159. 160. 161. - 165. |

| Health Financial Systems | SOUTHERN | I NDI ANA REHA | B HOSPI TAL | | In Lie | u of Form CMS- | 2552-10 |
|---|------------------|----------------|--------------|-------------|-----------------|----------------|---------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX II | DENTI FI CATI ON | DATA | Provider CC | | Period: | Worksheet S- | 2 |
| | | | | | From 01/01/2014 | | |
| | | | | | To 12/31/2014 | Date/Time Pro | |
| | | | | | | 5/27/2015 8: 4 | 4 <u>2</u> am |
| | | | | | Begi nni ng | Endi ng | |
| | | | | | 1.00 | 2.00 | |
| 170.00 Enter in columns 1 and 2 the EHR begi period respectively (mm/dd/yyyy) | nning date and | d ending date | for the rep | orting | | | 170.00 |
| | | | | | | | |
| | | | | | | 1.00 | |
| 171.00 If line 167 is "Y", does this provide | r have any day | /s for indivi | duals enroll | ed in secti | on 1876 | N | 171.00 |
| Medicare cost plans reported on Wkst. (see instructions) | S-3, Pt. I, I | ine 2, col. | 6? Enter "Y" | for yes ar | nd "N" for no. | | |

| SPLI | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE | STI ONNAI RE Provi | der | | Period: From 01/01/2014 | Worksheet S- Part II | 2 |
|------|---|---|-------------|----------------|----------------------------|-------------------------|---------|
| | | | | | To 12/31/2014 | | epareo |
| | | | | | Y/N | Date | 42 dili |
| | Constal Instruction, Enton V for all VES room | annaa Entar N far all N | NO 50 | ononcoo Ento | 1.00 | 2.00 | _ |
| | General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS | | | | | the | |
| | Provider Organization and Operation Has the provider changed ownership immediate | ly prior to the beginning | q of | the cost | N | | 1. |
| | reporting period? If yes, enter the date of | | | instructions) | | | _ |
| | | | - | Y/N 1.00 | Date 2.00 | V/I 3.00 | |
| | Has the provider terminated participation in | | | N | 2.00 | 0.00 | 2. |
| | yes, enter in column 2 the date of terminatic voluntary or "I" for involuntary. | on and in column 3, "V" t | for | | | | |
| 00 | Is the provider involved in business transac contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel | ., chain home offices, du d to the provider or its | rug | Y | | | 3. |
| | of directors through ownership, control, or | | | | | | |
| | relationships? (see instructions) | | | Y/N | Туре | Date | |
| | | | | 1.00 | 2.00 | 3.00 | |
| | Financial Data and Reports Column 1: Were the financial statements pre | named by a Cartified Dubl | | Y | • | 04 (20 (2015 | |
| | 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 Compile enter date available in | ed, | Ŷ | A | 06/30/2015 | 4. |
| 00 | Are the cost report total expenses and total | revenues different from | | Ν | | | 5. |
| | those on the filed financial statements? If | yes, submit reconciliation | on. | | Y/N | Legal Oper. | |
| | | | | | 1.00 | 2.00 | |
| 00 | Approved Educational Activities Column 1: Are costs claimed for nursing scho | ool? Column 2: If ves i | is th | e provider is | s N | | 6. |
| | the legal operator of the program? | | | | | | 0. |
| | Are costs claimed for Allied Health Programs' Were nursing school and/or allied health prod | | | during the | N N | | 7. |
| 00 | cost reporting period? If yes, see instruction | | neweu | i dui ring the | IN | | 0. |
| 00 | Are costs claimed for Intern-Resident program | ms claimed on the curren | t cos | t report? If | Ν | | 9. |
| 00 | yes, see instructions. Was an Intern-Resident program been initiated | d or renewed in the curre | ent c | ost reporting | N N | | 10. |
| | period? If yes, see instructions. | | | | | | |
| 00 | Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see | | n App | proved | N | | 11. |
| | | | | | | Y/N | |
| _ | Bad Debts | | | | | 1.00 | |
| 00 | Is the provider seeking reimbursement for bac | | | | | Y | 12. |
| 00 | If line 12 is yes, did the provider's bad del period? If yes, submit copy. | bt collection policy char | nge d | luring this co | ost reporting | N | 13. |
| | If line 12 is yes, were patient deductibles a | and/or co-payments waived | d?lf | yes, see ins | structions. | N | 14. |
| | Bed Complement Did total beds available change from the prid | or cost reporting pariod | 2 I F | voc coo inct | ructions | N | 15. |
| 00 | bid total beds available change from the pro | or cost reporting period | <u>, 11</u> | | rt A | Part B | 15. |
| | | Description | | Y/N | Date | Y/N | _ |
| | PS&R Data | 0 | | 1.00 | 2.00 | 3.00 | - |
| | Was the cost report prepared using the PS&R | | | Y | 04/08/2015 | Y | 16. |
| | 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 | | | | | | |
| 00 | instructions) Was the cost report prepared using the PS&R | | | Ν | | N | 17. |
| | 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 | | | | | | |
| 00 | 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments | | | Ν | | N | 18. |
| 00 | rande to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file | | | N | | IN IN | 10. |
| | this cost report? If yes, see instructions. | | | | | | |
| 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 | | | Ν | | N | 19. |
| 00 | instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe | | | Ν | | Ν | 20. |

| Heal th | Financial Systems SO | UTHERN INDIANA | REHAB HOSPI TAI | L | In Lie | u of Form CMS- | 2552-10 |
|---------|--|----------------|-------------------------------------|------------------|-----------------|--------------------------------|----------------|
| | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE | | | CCN: 153037 F | Period: | Worksheet S-2 | |
| | | | | | rom 01/01/2014 | | |
| | | | | 1 | o 12/31/2014 | Date/Time Pre 5/27/2015 8:4 | |
| | | | | 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 | | | N | | N | 21.00 |
| | provider's records? If yes, see | | | | | | |
| | instructions. | | | | | | |
| | | | | | | 1.00 | |
| | COMPLETED BY COST REIMBURSED AND TEFRA HOSPI | TALS ONLY (EXC | EPT CHILDRENS I | HOSPI TALS) | | | |
| ~~ ~~ | Capital Related Cost | | | | | •• | |
| | Have assets been relifed for Medicare purpos | 2 | | | ng the east | N | 22.00 |
| 23.00 | Have changes occurred in the Medicare deprec reporting period? If yes, see instructions. | ration expense | e due to apprais | sars made duri | ng the cost | N | 23.00 |
| 24.00 | Were new leases and/or amendments to existin | a Leases enter | red into durina | this cost rep | ortina period? | N | 24.00 |
| | If yes, see instructions | 9 | · · · · · · · · · · · · · · · · · · | | | | |
| 25.00 | Have there been new capitalized leases enter | ed into during | g the cost repo | rting period? | lfyes, see | N | 25.00 |
| 24 00 | instructions. | | | | | N | 24.00 |
| 26.00 | Were assets subject to Sec.2314 of DEFRA acq instructions. | uirea auring t | ne cost report | ing period? in | yes, see | N | 26.00 |
| 27.00 | Has the provider's capitalization policy cha | naed durina th | ne cost reporti | na period?lf | ves, submit | N | 27.00 |
| | сору. | | | | <i>J</i> , | | |
| | Interest Expense | | | | | | |
| 28.00 | Were new loans, mortgage agreements or lette | rs of credit e | entered into du | ring the cost | reporti ng | N | 28.00 |
| 29.00 | period? If yes, see instructions. Did the provider have a funded depreciation | account and/or | bond funde (D | obt Sorvico Do | corpus Fund) | N | 29.00 |
| 29.00 | treated as a funded depreciation account? If | ves see inst | ructions | ebt Service Re | sei ve Fullu) | N | 29.00 |
| 30.00 | Has existing debt been replaced prior to its | | | debt? If yes, | see | N | 30.00 |
| | instructions. | | 5 | 5 | | | |
| 31.00 | Has debt been recalled before scheduled matu | rity without i | ssuance of new | debt? If yes, | see | N | 31.00 |
| | i nstructi ons. Purchased Servi ces | | | | | | - |
| 32 00 | Have changes or new agreements occurred in p | atient care se | rvices furnish | ed through con | tractual | N | 32.00 |
| 52.00 | arrangements with suppliers of services? If | | | cu through con | | N. | 52.00 |
| 33.00 | If line 32 is yes, were the requirements of | | | ng to competit | ive bidding? If | N | 33.00 |
| | no, see instructions. | | | | | | |
| | Provi der-Based Physi ci ans | | | | | N | 04.00 |
| 34.00 | Are services furnished at the provider facil If yes, see instructions. | ity under an a | arrangement wit | n provider-bas | ed pnysicians? | Y | 34.00 |
| 35.00 | If line 34 is yes, were there new agreements | or amended ex | disting agreeme | nts with the p | rovi der-based | N | 35.00 |
| 00100 | physicians during the cost reporting period? | If yes, see i | nstructions. | nto in the tho p | lottuot bacca | | |
| | | | | | Y/N | Date | |
| | | | | | 1.00 | 2.00 | |
| a | Home Office Costs | | | | | | |
| | Were home office costs claimed on the cost r If line 36 is yes, has a home office cost st | | roparod by the | homo offico? | Y Y | | 36.00 37.00 |
| 37.00 | If yes, see instructions. | atement been p | nepared by the | nome office: | I | | 37.00 |
| 38.00 | If line 36 is yes, was the fiscal year end | of the home of | fice different | from that of | Y | 06/30/2013 | 38.00 |
| | the provider? If yes, enter in column 2 the | fiscal year en | nd of the home | offi ce. | | | |
| 39.00 | If line 36 is yes, did the provider render s | ervices to oth | ner chain compo | nents? If yes, | Y | | 39.00 |
| 40.00 | see instructions. | anylogs to the | home office? | lf voc coo | N | | 40.00 |
| 40.00 | If line 36 is yes, did the provider render s instructions. | ervices to the | | TT yes, see | IN | | 40.00 |
| | | - | | - | | | |
| | | | 1. | 00 | 2. | 00 | |
| 44 00 | Cost Report Preparer Contact Information | | | | | | 44.05 |
| 41.00 | Enter the first name, last name and the title | | BKP LLP | | BKP LLP | | 41.00 |
| | held by the cost report preparer in columns respectively. | r, z, and 3, | | | | | |
| 42.00 | Enter the employer/company name of the cost | report | BKD LLP | | | | 42.00 |
| 00 | preparer. | | | | | | |
| 43.00 | Enter the telephone number and email address | | 502-581-0435 | | LVCOSTREPORTS@ | BKD. COM | 43.00 |
| | report preparer in columns 1 and 2, respecti | vel y. | 1 | | 1 | | |

| HOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE | STI ONNAI RE | Provider CCN: 153037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared 5/27/2015 8:42 am |
|---------|---|----------------|----------------------|---|---|
| | | Part B Date | | | |
| | PS&R Data | 4.00 | | | |
| 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 Report used in columns 2 and 4. (see instructions) | 04/08/2015 | | | 16.0 |
| 17.00 | 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) | | | | 17.0 |
| | 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. 0 |
| 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. | | | | 19.0 |
| 20.00 | If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: | | | | 20.0 |
| 21.00 | Was the cost report prepared only using the provider's records? If yes, see instructions. | | | | 21.0 |
| | | | 3.00 | | |
| | Cost Report Preparer Contact Information | | 0.00 | | |
| 1. 00 | Enter the first name, last name and the title held by the cost report preparer in columns respectively. | | D LLP | | 41. C |
| 2.00 | Enter the employer/company name of the cost | report | | | 42.0 |
| 43.00 | preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respecti | | | | 43.0 |

| OSPI 1 | AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC | AL DATA | Provi der | | Period: From 01/01/2014 To 12/31/2014 | | epar |
|--|--|----------------------------|-------------|-----------------------|---|-------------------------------------|------------------------------------|
| | | | | | | I/P Days / O/P Visits / Trips | |
| | Component | Worksheet A Line Number | No. of Beds | Bed Days Available | CAH Hours | Title V | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| . 00 . 00 . 00 . 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) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider | 30. 00 | 34 | 12, 41 | 0 0.00 | C |) 1 2 3 4 |
| . 00 . 00 . 00 . 00 | Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) | | 34 | 12, 41 | 0 0. 00 | C C C |) 5) 6 |
| . 00 . 00 0. 00 1. 00 2. 00 3. 00 | INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY | | | | | | 8 9 10 11 12 13 |
| 4.00 5.00 6.00 7.00 8.00 | Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER | | 34 | 12, 41 | 0 0.00 | C | |
| 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 | SKI LLED NURSI NG FACI LI TY NURSI NG FACI LI TY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGI CAL CENTER (D. P.) HOSPI CE | 44.00 | 26 | 9, 49 | 0 | С | |
| 4. 10 5. 00 6. 00 6. 25 7. 00 | HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) | 30.00 99.00 88.00 | 60 | | | C C |) 26 26 27 |
| 3.00 9.00 0.00 1.00 2.00 2.01 | Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) | | 0 | | 0 | C |) 28 29 30 31 32 32 |

| OSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC | AL DATA | Provi der | CCN: 153037 | Period: From 01/01/2014 To 12/31/2014 | | pared: |
|--|--------------------|-----------------|-----------------------|---|---------------|--|
| | I/P Days / | ′0/P Visits | / Trips | Full Time | Equi val ents | |
| Component | | Title XIX | Total All Patients | Total Interns & Residents | Payrol I | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| .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) .00 HMO and other (see instructions) .00 HMO IPF Subprovider | 4, 873 188 0 | 233 122 0 | 7, 38 | 34 | | 1.00 2.00 3.00 |
| .00 HMO IRF Subprovider .00 Hospital Adults & Peds. Swing Bed SNF .00 Hospital Adults & Peds. Swing Bed NF | 0 0 | 0 0 | | 0 | | 4.00 5.00 6.00 |
| .00 Total Adults and Peds. (exclude observation beds) (see instructions) | 4, 873 | 233 | 7, 38 | 0 | | 7.00 8.00 |
| .00 I NTENSI VE CARE UNI T .00 CORONARY CARE UNI T 0.00 BURN I NTENSI VE CARE UNI T 1.00 SURGI CAL I NTENSI VE CARE UNI T 2.00 OTHER SPECI AL CARE (SPECI FY) 3.00 NURSERY | | | | | | 9.00 9.00 10.00 11.00 12.00 |
| 4.00 Total (see instructions) 5.00 CAH visits 6.00 SUBPROVIDER - IPF 7.00 SUBPROVIDER - IRF 8.00 SUBPROVIDER | 4, 873 0 | 233 0 | 7, 38 | 34 0.00 0 |) 167.56 | 14.00 15.00 16.00 17.00 18.00 |
| 9.00 SKILLED NURSING FACILITY 0.00 NURSING FACILITY 1.00 OTHER LONG TERM CARE 2.00 HOME HEALTH AGENCY 3.00 AMBULATORY SURGICAL CENTER (D. P.) 4.00 HOSPICE | 5, 437 | 0 | 7,74 | 12 0.00 | 28. 54 | 19.00 20.00 21.00 22.00 23.00 24.00 |
| 4.10 HOSPICE (non-distinct part) 5.00 CMHC - CMHC 6.00 RURAL HEALTH CLINIC 6.25 FEDERALLY QUALIFIED HEALTH CENTER | 0 0 0 | 0 0 0 | | 0 0 0.00 0 0.00 | | |
| 6. 25 FEDERALLY QUALIFIED HEALTH CENTER 7. 00 Total (sum of lines 14-26) 8. 00 Observation Bed Days 9. 00 Ambulance Trips | 0 | 0 | | 0.00 | 0 196. 10 | |
| 9.00 Ambulance frips 0.00 Employee discount days (see instruction) 1.00 Employee discount days - IRF 2.00 Labor & delivery days (see instructions) | 0 | 0 | | 0 0 0 | | 30.00 31.00 32.00 |
| Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days | 0 | | | 0 | | 32.0 33.0 |

| HOSPI | FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC | AL DATA | Provi der | | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Pre 5/27/2015 8:43 | pared: |
|--|---|--------------------------|-----------|-------------|---|--|--|
| | | Full Time Equivalents | | Di se | charges | | |
| | Component | Nonpai d Workers | Title V | Title XVIII | Title XIX | Total All Patients | |
| | | 11.00 | 12.00 | 13.00 | 14.00 | 15.00 | |
| 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) | | 0 | | | 605 | 1.00 |
| 2.00 3.00 4.00 5.00 6.00 | HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF | | | 1 | 0 | | 2.00 3.00 4.00 5.00 6.00 |
| 7.00 8.00 9.00 10.00 11.00 12.00 13.00 | Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY | | | | | | 7.00 8.00 9.00 10.00 11.00 12.00 13.00 |
| 14.00 15.00 16.00 17.00 18.00 | Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER | 0.00 | 0 | 36 | 9 13 | 605 | 14.00 15.00 16.00 17.00 18.00 |
| 19.00 20.00 21.00 22.00 23.00 24.00 24.10 25.00 | AMBULATORY SURGICAL CENTER (D. P.) | 0.00 | | | | | 19.00 20.00 21.00 22.00 23.00 24.00 24.10 25.00 |
| 25.00 26.00 26.25 27.00 28.00 29.00 30.00 31.00 31.00 32.01 | RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days | 0.00 | | | | | 25.00 26.00 27.00 28.00 30.00 31.00 32.00 |

| | Financial Systems SOUTHERN INDIANA | | | | u of Form CMS-2 | |
|------------------|---|---------------|---------------|---|--------------------------------|----------------|
| PRUSPE | CTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider | F | Period: From 01/01/2014 Fo 12/31/2014 | Worksheet S-7 Date/Time Pre | |
| | | | | | 5/27/2015 8:4 | |
| 1.00 | If this facility contains a hospital-based SNF, were all p | atients under | managed care | 1.00 N | 2.00 | 1.00 |
| | or was there no Medicare utilization? Enter "Y" for yes in complete the rest of this worksheet. | | | | | |
| 2.00 | Does this hospital have an agreement under either section swing beds? Enter "Y" for yes or "N" for no in column 1. date (mm/dd/yyyy) in column 2. | | | N | | 2.00 |
| | | Group | SNF Days | Swing Bed SNF Days | Total (sum of col. 2 + 3) | |
| 0.00 | | 1.00 | 2.00 | 3.00 | 4.00 | 2.00 |
| 3.00 4.00 | | RUX RUL | | 0 | 0 | 3.00 4.00 |
| 5.00 6.00 | | RVX RVL | | - | 0 | 5.00 6.00 |
| 7.00 | | RHX | C | - | 0 | 7.00 |
| 8.00 9.00 | | RHL RMX | | - | 0 | 8.00 9.00 |
| 10. 00 11. 00 | | RML RLX | | - | 0 | 10.00 |
| 12.00 | | RUC | 402 | 0 | 402 | 12.00 |
| 13.00 14.00 | | RUB RUA | 668 4, 012 | | | |
| 15.00 | | RVC | 38 | 3 0 | 38 | 15.00 |
| 16.00 17.00 | | RVB RVA | 7 132 | | | 16.00 17.00 |
| 18.00 19.00 | | RHC RHB | | | | 18.00 19.00 |
| 20.00 | | RHA | 36 | 0 | 36 | 20.00 |
| 21.00 22.00 | | RMC RMB | | | 0 | 21.00 22.00 |
| 23.00 24.00 | | RMA RLB | 26 | | | 23.00 24.00 |
| 25.00 | | RLA | C | 0 | 0 | 25.00 |
| 26.00 27.00 | | ES3 ES2 | | | | 26.00 27.00 |
| 28.00 29.00 | | ES1 HE2 | | - | - | 28.00 29.00 |
| 30.00 | | HE1 | C | 0 | 0 | 30.00 |
| 31.00 32.00 | | HD2 HD1 | | | 0 | 31.00 32.00 |
| 33.00 34.00 | | HC2 HC1 | C 5 | - | 05 | 33.00 34.00 |
| 35.00 | | HB2 | 0 | 0 | 0 | 35.00 |
| 36.00 37.00 | | HB1 LE2 | | 6 0 0 0 | 0 | 36.00 37.00 |
| 38.00 39.00 | | LE1 LD2 | | | 0 | 38.00 39.00 |
| 40.00 | | LD1 | 4 | 0 | 4 | 40.00 |
| 41.00 42.00 | | LC2 LC1 | | | 0 | 41.00 42.00 |
| 43.00 44.00 | | LB2 LB1 | 0 | | | 43.00 44.00 |
| 45.00 46.00 | | CE2 CE1 | C | 0 | 0 | 45.00 46.00 |
| 47.00 | | CD2 | C | 0 | 0 | 47.00 |
| 48.00 49.00 | | CD1 CC2 | 9 | | | 48.00 49.00 |
| 50.00 | | CC1 | 2 | 2 0 | 2 | 50.00 |
| 51.00 52.00 | | CB2 CB1 | 4 | 0 | | 51.00 52.00 |
| 53.00 54.00 | | CA2 CA1 | 40 40 | | | 53.00 54.00 |
| 55.00 | | SE3 | c | 0 0 | 0 | 55.00 |
| 56.00 57.00 | | SE2 SE1 | | | 0 | 56.00 57.00 |
| 58.00 59.00 | | SSC SSB | | | | 58.00 59.00 |
| 60.00 | | SSA | C | 0 | 0 | 60.00 |
| 61.00 62.00 | | I B2 I B1 | | | 0 | 61.00 62.00 |
| 63.00 64.00 | | I A2 I A1 | | | | 63.00 64.00 |
| 65.00 | | BB2 | C | 0 | 0 | 65.00 |
| 66.00 67.00 | | BB1 BA2 | | 0 | 0 | 66.00 67.00 |
| 68.00 | | BA1 | с с | 0 | 0 | 68.00 |

| Health Financial Systems SOUTHERN INDIANA | A REHAB HOSPITA | | In Lie | u of Form CMS- | 2552-10 |
|---|--|--|--|--|---------|
| PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provi der | CCN: 153037 | Period: From 01/01/2014 To 12/31/2014 | | epared: |
| | Group | SNF Days | Swing Bed SNF Days | Total (sum of col. 2 + 3) | |
| | 1.00 | 2,00 | 3.00 | 4.00 | |
| 69.00 | PE2 | | 0 0 | 0 | 69.00 |
| 70.00 | PE1 | | 0 0 | 0 | |
| 71.00 | PD2 | | 0 0 | 0 | |
| 72.00 | PD1 | | 0 0 | 0 | |
| 73.00 | PC2 | | 0 0 | 0 | |
| 74.00 | PC1 | | 0 0 | o o | |
| 75.00 | PB2 | | 0 0 | o o | |
| 76.00 | PB1 | | 18 0 | 18 | |
| 77.00 | PA2 | | 0 0 | 0 | |
| 78.00 | PA1 | | 0 0 | 0 | |
| 199.00 | AAA | | 1 0 | - | 199.00 |
| 200. 00 TOTAL | 7003 | 5,4 | 37 0 | | 200.00 |
| | | 5,4 | CBSA at | CBSA on/after | 200.00 |
| | | | Begi nni ng of | October 1 of | |
| | | | Cost | the Cost | |
| | | | Reporting | Reporting | |
| | | | Period | Period (if | |
| | | | | appl i cabl e) | |
| | | | 1.00 | 2.00 | |
| SNF SERVICES | | | | | |
| 201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBS in effect at the beginning of the cost reporting period. E in effect on or after October 1 of the cost reporting peri | Enter in column | 2, the code | 31140 | 31140 | 201.00 |
| | | Expenses | Percentage | Associated with Direct Patient Care and Related | |
| | | 1.00 | 2.00 | Expenses? | |
| A potico publichod in the Ecderal Desister Velver (0. No | 140 August 4 | 1.00 | 2.00 | 3.00 | |
| A notice published in the Federal Register Volume 68, No. payments beginning 10/01/2003. Congress expected this increexpenses. For lines 202 through 207: Enter in column 1 the column 2 the percentage of total expenses for each categor 7, column 3. In column 3, enter "Y" for yes or "N" for no direct patient care and related expenses for each category | ease to be use amount of the y to total SNF if the spending | d for direct expense for revenue from g reflects ir | patient care and each category. E Worksheet G-2, | d related Enter in Part I, line | |
| 202. 00 Staffing | | | 0 0.00 | | 202.00 |
| 203.00 Recruitment | | | 0 0.00 | | 203.00 |
| 204.00 Retention of employees | | | 0 0.00 | | 204.00 |
| 205. 00 Trai ni ng | | | 0 0.00 | | 205.00 |
| 206.00 OTHER (SPECI FY) | | | 0 0.00 | | 206.00 |
| 207.00 Total SNF revenue (Worksheet G-2, Part I, line 7, column 3 | 3) | 2, 706, 1 | 81 | | 207.00 |
| | | | | | |

| | OUTHERN INDIANA R | | | | u of Form CMS-2 | 2552-10 |
|--|-------------------|-------------|---------------|--------------------------------|---|---------|
| RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE | OF EXPENSES | Provi der | | eri od: | Worksheet A | |
| | | | | rom 01/01/2014 o 12/31/2014 | Date/Time Pre 5/27/2015 8:4 | |
| Cost Center Description | Sal ari es | Other | Total (col. 1 | Recl assi fi cat | Recl assi fi ed | |
| | | | + col. 2) | ions (See | Trial Balance | |
| | | | | A-6) | (col. 3 +- | |
| | | | | | col. 4) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 00100 CAP REL COSTS-BLDG & FIXT | | 0 | - | | | 1.00 |
| 2.00 00200 CAP REL COSTS-MVBLE EQUIP | | 0 | | | | 2.00 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT | 93, 640 | 147, 838 | | | | • |
| 5. 00 00500 ADMI NI STRATI VE & GENERAL | 353, 446 | 3, 113, 538 | | | | |
| 6. 00 00600 MAI NTENANCE & REPAI RS | 247, 568 | 474, 127 | | | | • |
| 8.00 00800 LAUNDRY & LINEN SERVICE | 17, 633 | 3, 316 | | | 17, 633 | |
| 9. 00 00900 HOUSEKEEPI NG | 218, 807 | 70, 423 | 289, 230 | -41, 346 | 247, 884 | 9.00 |
| 10. 00 01000 DI ETARY | 274,008 | 483, 716 | 757, 724 | -52, 705 | 705, 019 | 10.00 |
| 14.00 01400 CENTRAL SERVICE & SUPPLY | 33, 982 | 17, 775 | 51, 757 | -12, 945 | 38, 812 | 14.00 |
| 16.00 01600 MEDICAL RECORDS & LIBRARY | 108, 874 | 51, 898 | 160, 772 | -38, 719 | 122, 053 | 16.00 |
| 17.00 01700 SOCIAL SERVICE | 760, 675 | 202, 839 | 963, 514 | -149, 991 | 813, 523 | 17.00 |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 1, 915, 982 | 691, 529 | 2, 607, 511 | -363, 487 | 2, 244, 024 | 30.00 |
| 44.00 04400 SKILLED NURSING FACILITY | 1, 052, 790 | 305, 985 | 1, 358, 775 | -202, 825 | 1, 155, 950 | 44.00 |
| ANCILLARY SERVICE COST CENTERS | | | • | | • | 1 |
| 50.00 05000 OPERATING ROOM | 0 | 7, 476 | | 0 | 7, 476 | 50.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 82, 005 | 82,005 | 0 | 82,005 | 54.00 |
| 60. 00 06000 LABORATORY | 0 | 235, 349 | 235, 349 | 0 | 235, 349 | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 0 | 0 | l c | 0 | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 44, 044 | 363, 045 | 407, 089 | -8, 114 | 398, 975 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 2, 294, 384 | 514, 311 | 2, 808, 695 | -669, 284 | 2, 139, 411 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 1,008,652 | 220, 849 | 1, 229, 501 | -33, 271 | 1, 196, 230 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 598, 973 | 124, 947 | 723, 920 | -38, 962 | 684, 958 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 782 | 782 | 0 | 782 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | l c | 0 | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 222, 150 | 222, 150 | 0 | 222, 150 | 71.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 742, 353 | | | | • |
| 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 255, 859 | 199, 713 | | | | |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | C | 0 | 0 | 88.00 |
| 91. 00 09100 EMERGENCY | 0 | 0 | | | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | Ŭ | 0 | | | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | <u> </u> | | I | | I | 1 |
| 99. 00 09900 CMHC | 0 | 0 | C | 0 | 0 | 99.00 |
| SPECIAL PURPOSE COST CENTERS | | 0 | | | | 1 |
| 118.00 SUBTOTALS (SUM OF LINES 1-117) | 9, 279, 317 | 8, 275, 964 | 17, 555, 281 | -112, 208 | 17, 443, 073 | 118 00 |
| NONREI MBURSABLE COST CENTERS | 7,217,017 | 0,2,0,704 | 17,000,201 | 112,200 | 1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 1 10.00 |
| 194. 00 07950 OTHER NRCC | 0 | 0 | C | 112, 208 | 112, 208 | 194 00 |
| 200.00 TOTAL (SUM OF LINES 118-199) | 9, 279, 317 | 8, 275, 964 | | | | |
| | ,,2,,,317 | 0,2,0,704 | 1 17,000,201 | 0 | 1 17,000,201 | |

| ECLA | SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE | OF EXPENSES | | Provi der | CCN: 153037 | Period: From 01/01/2014 | Worksheet A | |
|----------------|--|--------------|-----|----------------------------|-------------|----------------------------|------------------------------|-------|
| | | | | | | To 12/31/2014 | Date/Time Pr 5/27/2015 8: | |
| | Cost Center Description | Adjustments | Net | Expenses | | | | |
| | | (See A-8) | | For | | | | |
| | | 6.00 | | ocation 7.00 | - | | | |
| | GENERAL SERVICE COST CENTERS | 0.00 | | 7.00 | | | | |
| . 00 | 00100 CAP REL COSTS-BLDG & FLXT | -25, 236 | | 567, 286 | | | | 1. |
| . 00 | 00200 CAP REL COSTS-MVBLE EQUIP | 63, 854 | 1 | 409, 357 | | | | 2. |
| . 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 0 | | 1, 958, 710 | 1 | | | 4. |
| . 00 | 00500 ADMI NI STRATI VE & GENERAL | -774, 790 | 1 | 1, 628, 353 | • | | | 5. |
| . 00 | 00600 MAI NTENANCE & REPAI RS | 0 | | 674, 546 | | | | 6. |
| . 00 | 00800 LAUNDRY & LINEN SERVICE | 0 | | 17,633 | | | | 8. |
| . 00 | 00900 HOUSEKEEPI NG | 0 | | 247,884 | | | | 9. |
| 0.00 | | -3, 546 | | 701, 473 | | | | 10. |
| 4.00 | | 0,010 | | 38, 812 | 1 | | | 14. |
| 4.00 5.00 | | -8, 763 | | 113, 290 | 1 | | | 16. |
| | 01700 SOCIAL SERVICE | 0,703 | | 813, 523 | | | | 17. |
| . 00 | INPATIENT ROUTINE SERVICE COST CENTERS | 0 | | 015, 525 | | | | - ''' |
|). 00 | | -188, 712 | 1 | 2,055,312 | | | | 30. |
| , 00 . 00 | | 0 | | 2, 055, 512 1, 155, 950 | | | | 44. |
| F. UU | ANCI LLARY SERVICE COST CENTERS | 0 | | 1, 155, 950 | | | | 44. |
|). 00 | | -7,055 | 1 | 421 | 1 | | | 50. |
| 1.00 | | -14, 625 | | 67, 380 | | | | 54. |
| +. 00). 00 | | -14, 023 | | 221, 158 | 1 | | | 60. |
| 1.00 | | -14, 191 | | 221, 130 | | | | 64. |
| 4.00 5.00 | | -4, 904 | | 394, 071 | | | | 65. |
| 5.00 5.00 | | -4, 904 | 1 | | | | | 66. |
| | | | 1 | 2,031,412 | | | | 67. |
| 7.00 | | -910 | | 1, 195, 320 | | | | 68. |
| 3.00 | | -3, 960 | 1 | 680, 998 | | | | |
| . 00 | | -525 | | 257 | • | | | 69. |
|). 00 | | 0 | | 0 | | | | 70. |
| 1.00 | | -10, 205 | | 211, 945 | • | | | 71. |
| 3.00 | | 14, 215 | 1 | 756, 568 | • | | | 73. |
| . 00 | | -141, 145 | | 272, 917 | | | | 76. |
| | OUTPATIENT SERVICE COST CENTERS | - | | | 1 | | | |
| 3.00 | | 0 | | 0 | | | | 88. |
| . 00 | | 0 | | 0 | | | | 91. |
| 2. 00 | | | | | | | | 92. |
| | OTHER REIMBURSABLE COST CENTERS | - | | | 1 | | | |
| 9. 00 | | 0 | | 0 | | | | 99. |
| _ | SPECIAL PURPOSE COST CENTERS | | - | | 1 | | | |
| 8.0 | | -1, 228, 497 | 1 | 6, 214, 576 | | | | 118. |
| | NONREI MBURSABLE COST CENTERS | | | | | | | |
| | 007950 OTHER NRCC | 0 | | 112, 208 | | | | 194. |
| 0.0 | 0 TOTAL (SUM OF LINES 118-199) | -1, 228, 497 | 1 | 6, 326, 784 | | | | 200. |

Health Financial Systems RECLASSIFICATIONS

SOUTHERN INDIANA REHAB HOSPITAL Provider CCN: 153037

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2014

| | | | | | To 12/31/2014 Date/Time Pr 5/27/2015 8: | |
|------------------|--|--------------|--------------------|------------------------|--|----------------|
| | | Increases | | | 5/2//2015 6. | |
| | Cost Center | Li ne # | Salary | Other | | |
| | 2.00 | 3.00 | 4.00 | 5.00 | | |
| | A - BENEFITS RECLASS | | • | | | |
| 1.00 | EMPLOYEE BENEFITS DEPARTMENT | 4.00 | 0 | 1, 717, 752 | | 1.00 |
| 2.00 | | 0.00 | 0 | 0 | | 2.00 |
| 3.00 | | 0.00 | 0 | 0 | | 3.00 |
| 4.00 | | 0.00 | 0 | 0 | | 4.00 |
| 5.00 | | 0.00 | 0 | 0 | | 5.00 |
| 6.00 | | 0.00 | 0 | 0 | | 6.00 |
| 7.00 | | 0.00 | 0 | 0 | | 7.00 |
| 8.00 | | 0.00 | 0 | 0 | | 8.00 |
| 9.00 | | 0.00 | 0 | 0 | | 9.00 |
| 10. 00 11. 00 | | 0.00 0.00 | 0 | 0 | | 10.00 11.00 |
| 12.00 | | 0.00 | 0 | 0 | | 12.00 |
| 12.00 | | 0.00 | 0 | 0 | | 12.00 |
| 14.00 | | 0.00 | 0 | 0 | | 14.00 |
| 15.00 | | 0.00 | 0 | 0 | | 15.00 |
| 15.00 | TOTALS — — — — | | — — — o | 1,717,752 | | 15.00 |
| | B - RENT AND LEASE RECLASS | | | 111111102 | | 1 |
| 1.00 | CAP REL COSTS-MVBLE EQUI P | 2.00 | 0 | 151, 750 | | 1.00 |
| 2.00 | | 0.00 | 0 | 0 | | 2.00 |
| 3.00 | | 0.00 | 0 | 0 | | 3.00 |
| 4.00 | | 0.00 | 0 | 0 | | 4.00 |
| 5.00 | | 0.00 | 0 | 0 | | 5.00 |
| 6.00 | | 0.00 | 0 | 0 | | 6.00 |
| 7.00 | | 0.00 | 0 | 0 | | 7.00 |
| 8.00 | | 0.00 | 0 | 0 | | 8.00 |
| 9.00 | | 0.00 | 0 | 0 | | 9.00 |
| 10.00 | | 0.00 | 0 | 0 | | 10.00 |
| 11.00 | | 0.00 | º | 0 | | 11.00 |
| | | | 0 | 151, 750 | | - |
| 1.00 | C - INSURANCE RECLASS CAP REL COSTS-BLDG & FIXT | 1.00 | 0 | 10, 899 | | 1.00 |
| 1.00 | TOTALS | | <u>o</u> | 10, 899 | | 1.00 |
| | D - PUBLIC RELATIONS RECLASS | | Ч | 10, 077 | | - |
| 1.00 | OTHER NRCC | 194.00 | 0 | 112, 208 | | 1.00 |
| | TOTALS | | 0 | 112, 208 | | 1.00 |
| | E - THERAPY ADMINISTRATION RE | CLASS | · · · | | | 1 |
| 1.00 | OCCUPATIONAL THERAPY | 67.00 | 152, 110 | 3, 387 | | 1.00 |
| 2.00 | SPEECH PATHOLOGY | 68.00 | 72, 455 | 1, 614 | | 2.00 |
| | TOTALS | | 224, 565 | 5, 001 | | |
| | F - DEPRECIATION RECLASS | | | | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | 1.00 | 0 | 524, 383 | | 1.00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | | <u>o</u> | 19 <u>3, 753</u> | | 2.00 |
| | | | 0 | 718, 136 | | - |
| 1 00 | G - INTEREST EXPENSE RECLASS | 1 00 | | E7 040 | | 1 00 |
| 1.00 | CAP_REL_COSTS-BLDG_&_FLXT TOTALS | | <u>o</u> | 57,240 | | 1.00 |
| 500 00 | Grand Total: Increases | | 224, 565 | 57, 240 2, 772, 986 | | 500.00 |
| 500.00 | | I | 224, 303 | 2,112,700 | | 1 300. 00 |

| | Financial Systems | SOL | JTHERN INDIANA | REHAB HOSPITA | AL. | | u of Form CMS-2552 | 2-10 |
|--------|------------------------------|--------------|--------------------|------------------------|---------------|----------------------------------|-------------------------|-----------|
| RECLAS | SI FI CATI ONS | | | Provi der | CCN: 153037 | Period: | Worksheet A-6 | |
| | | | | | | From 01/01/2014 To 12/31/2014 | Date/Time Prepar | |
| | | Decreases | | | | | <u>5/27/2015 8:42 a</u> | <u>im</u> |
| | Cost Center | Li ne # | Salary | Other | Wkst. A-7 Ref | - | | |
| | 6.00 | 7.00 | 8.00 | 9,00 | 10,00 | <u> </u> | | |
| | A - BENEFITS RECLASS | | | | | | | |
| 1.00 | ADMINISTRATIVE & GENERAL | 5.00 | 0 | 65, 811 | | 0 | 1 | 1.00 |
| 2.00 | MAINTENANCE & REPAIRS | 6.00 | 0 | 46, 430 | | 0 | 2 | 2.00 |
| 3.00 | LAUNDRY & LINEN SERVICE | 8.00 | 0 | 3, 316 | | 0 | 3 | 3.00 |
| 4.00 | HOUSEKEEPI NG | 9.00 | 0 | 40, 984 | | 0 | 4 | 4.00 |
| 5.00 | DI ETARY | 10.00 | 0 | 51, 167 | | 0 | 5 | 5.00 |
| 6.00 | CENTRAL SERVICE & SUPPLY | 14.00 | 0 | 6, 361 | | 0 | | 6.00 |
| 7.00 | MEDICAL RECORDS & LIBRARY | 16.00 | 0 | 20, 179 | | 0 | | 7.00 |
| 8.00 | SOCI AL SERVI CE | 17.00 | 0 | 142, 590 | | 0 | | 8.00 |
| 9.00 | ADULTS & PEDIATRICS | 30.00 | 0 | 358, 630 | | 0 | | 9.00 |
| 10.00 | SKILLED NURSING FACILITY | 44.00 | 0 | 198, 533 | | 0 | | 0.00 |
| 11.00 | RESPI RATORY THERAPY | 65.00 | 0 | 8, 114 | | 0 | | 1.00 |
| 12.00 | PHYSI CAL THERAPY | 66.00 | 0 | 432, 328 | | 0 | | 2.00 |
| 13.00 | OCCUPATIONAL THERAPY | 67.00 | 0 | 188, 768 | | 0 | | 3.00 |
| 14.00 | SPEECH PATHOLOGY | 68.00 | 0 | 113, 031 | | 0 | | 4.00 |
| 15.00 | PSYCHI ATRI C/PSYCHOLOGI CAL | 76.00 | 0 | 41, 510 | | 0 | 15 | 5.00 |
| | SERVICES | + | — — — _d | 1, 717, 752 | | - | | |
| | B - RENT AND LEASE RECLASS | | U | 1, /17, /52 | | | | |
| 1.00 | EMPLOYEE BENEFITS DEPARTMENT | 4.00 | 0 | 520 | 1 | 0 | 1 | 1.00 |
| 2.00 | ADMI NI STRATI VE & GENERAL | 4.00 5.00 | 0 | 99, 547 | | 0 | | 2.00 |
| 3.00 | MAINTENANCE & REPAIRS | 6.00 | 0 | 719 | | 0 | | 3.00 |
| 4.00 | HOUSEKEEPING | 9.00 | 0 | 362 | | 0 | | 4.00 |
| 5.00 | DI ETARY | 10.00 | 0 | 1, 538 | | 0 | | 5.00 |
| 6.00 | CENTRAL SERVICE & SUPPLY | 14.00 | 0 | 6, 584 | | 0 | | 6.00 |
| 7.00 | MEDICAL RECORDS & LIBRARY | 16.00 | 0 | 18, 540 | | 0 | | 7.00 |
| 8.00 | SOCI AL SERVI CE | 17.00 | 0 | 7, 401 | | 0 | | 8.00 |
| 9.00 | ADULTS & PEDIATRICS | 30, 00 | 0 | 4, 857 | | 0 | | 9.00 |
| 10.00 | SKILLED NURSING FACILITY | 44.00 | 0 | 4, 292 | | 0 | | 0.00 |
| 11.00 | PHYSI CAL THERAPY | 66.00 | 0 | 7, 390 | | 0 | | 1.00 |
| | TOTALS | | | 151, 750 | | 1 | | |
| | C - INSURANCE RECLASS | | · · · · · | | | | | |
| 1.00 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 10, 899 | 1 | 2 | 1 | 1.00 |
| | TOTALS | | 0 | 10, 899 | | | | |
| | D - PUBLIC RELATIONS RECLASS | | | | | | | |
| 1.00 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | <u>112, 2</u> 08 | | 0 | 1 | 1.00 |
| | TOTALS | | 0 | 112, 208 | | | | |
| | E - THERAPY ADMINISTRATION R | | | | 1 | - | | |
| 1.00 | PHYSI CAL THERAPY | 66.00 | 224, 565 | 5, 001 | | 0 | | 1.00 |
| 2.00 | | | 0 | 0 | | <u>o</u> | 2 | 2.00 |
| | TOTALS | | 224, 565 | 5, 001 | | | | |
| | F - DEPRECIATION RECLASS | | -1 | 740.555 | 1 | | | |
| 1.00 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 718, 136 | | 9 | | 1.00 |
| 2.00 | | | 0 | 0 | | 2 | 2 | 2.00 |
| | TOTALS | | 0 | 718, 136 | | | | |
| 1 00 | G - INTEREST EXPENSE RECLASS | E col | | E7 040 | | 1 | | 1 00 |
| 1.00 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 57,240 | | 1 | 1 | 1.00 |
| 500 00 | Grand Total: Decreases | | 224, 565 | 57, 240 2, 772, 986 | | | Enc | 0.00 |
| 500.00 | pi anu Tutat. Deci eases | | 224, 305 | 2, 112, 980 | 1 | | 500 | 5.00 |

| Heal th | Financial Systems SOU | JTHERN INDIANA | REHAB HOSPI TAI | L | In Lie | eu of Form CMS-2 | 2552-10 |
|---------|--|--------------------------|-----------------|-----------------|---|------------------------------|---------|
| | ILIATION OF CAPITAL COSTS CENTERS | | Provi der | | Period: From 01/01/2014 To 12/31/2014 | | |
| | | | | Acqui si ti ons | | | |
| | | Begi nni ng Bal ances | Purchases | Donati on | Total | Disposals and Retirements | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE | T BALANCES | | | | | |
| 1.00 | Land | 425, 000 | 0 | | 0 0 | 0 | 1.00 |
| 2.00 | Land Improvements | 128, 046 | 0 | | 0 0 | 0 | 2.00 |
| 3.00 | Buildings and Fixtures | 14, 812, 387 | 0 | | 0 0 | 0 | 3.00 |
| 4.00 | Building Improvements | 405, 743 | 111, 436 | | 0 111, 436 | 0 | 4.00 |
| 5.00 | Fixed Equipment | 0 | 0 | | 0 0 | 0 | 5.00 |
| 6.00 | Movable Equipment | 4, 894, 836 | 23, 105 | | 0 23, 105 | 0 | 6.00 |
| 7.00 | HIT designated Assets | 0 | 0 | | 0 0 | 0 | 7.00 |
| 8.00 | Subtotal (sum of lines 1-7) | 20, 666, 012 | 134, 541 | | 0 134, 541 | 0 | 8.00 |
| 9.00 | Reconciling Items | 0 | 0 | | 0 0 | 0 | 9.00 |
| 10.00 | Total (line 8 minus line 9) | 20, 666, 012 | 134, 541 | | 0 134, 541 | 0 | 10.00 |
| | | Endi ng | Fully | | | | |
| | | Bal ance | Depreciated | | | | |
| | | | Assets | | | | |
| | | 6.00 | 7.00 | | | | |
| | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE | | | | | | |
| 1.00 | Land | 425, 000 | 0 | | | | 1.00 |
| 2.00 | Land Improvements | 128, 046 | 0 | | | | 2.00 |
| 3.00 | Buildings and Fixtures | 14, 812, 387 | 0 | | | | 3.00 |
| 4.00 | Building Improvements | 517, 179 | 0 | | | | 4.00 |
| 5.00 | Fixed Equipment | 0 | 0 | | | | 5.00 |
| 6.00 | Movable Equipment | 4, 917, 941 | 0 | | | | 6.00 |
| 7.00 | HIT designated Assets | 0 | 0 | | | | 7.00 |
| 8.00 | Subtotal (sum of lines 1-7) | 20, 800, 553 | 0 | | | | 8.00 |
| 9.00 | Reconciling Items | 0 | 0 | | | | 9.00 |
| 10.00 | Total (line 8 minus line 9) | 20, 800, 553 | 0 | | | | 10.00 |

| Heal th | Financial Systems SC | UTHERN INDIANA | REHAB HOSPI TAI | L | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--|-----------------|-----------------|---------------|---|-----------------------------|---------|
| RECONC | CILIATION OF CAPITAL COSTS CENTERS | | Provi der | CCN: 153037 | Period: From 01/01/2014 To 12/31/2014 | | pared: |
| | | | SL | JMMARY OF CAP | I TAL | | |
| | Cost Center Description | Depreciation | Lease | Interest | I nsurance (see i nstructi ons) | Taxes (see instructions) | |
| | | 9.00 | 10.00 | 11.00 | 12.00 | 13.00 | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WOF | KSHEET A, COLU | MN 2, LINES 1 a | and 2 | | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | 0 | 0 | | 0 0 | 0 | 1.00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 0 | 0 | | 0 0 | 0 | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 0 | 0 | | 0 0 | 0 | 3.00 |
| | | SUMMARY C | F CAPI TAL | | | | |
| | Cost Center Description | Other | Total (1) | | | | |
| | | | (sum of cols. | | | | |
| | | | 9 through 14) | | | | |
| | | instructions) | | - | | | |
| | | 14.00 | 15.00 | | | | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WOR | RKSHEET A, COLU | WN 2, LINES 1 a | and 2 | | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | 0 | 0 | | | | 1.00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 0 | 0 | | | | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 0 | 0 | | | | 3.00 |

| Health Financial Systems So | OUTHERN INDIANA | REHAB HOSPI TAI | - | In Lie | u of Form CMS-2 | 552-10 |
|--|-----------------|-----------------|-----------------------|---|-----------------|----------------|
| RECONCILIATION OF CAPITAL COSTS CENTERS | | Provi der | | Period: From 01/01/2014 To 12/31/2014 | | pared: 2 am |
| | COM | PUTATION OF RAT | FI OS | ALLOCATION OF | OTHER CAPITAL | |
| Cost Center Description | Gross Assets | Capi tal i zed | Gross Assets | Ratio (see | Insurance | |
| | | Leases | for Ratio | instructions) | | |
| | | | (col. 1 - | | | |
| | 1.00 | 2.00 | <u>col.2)</u> 3.00 | 4,00 | 5.00 | |
| PART III - RECONCILIATION OF CAPITAL COSTS (| | 2.00 | 3.00 | 4.00 | 5.00 | |
| 1.00 CAP REL COSTS-BLDG & FIXT | 15, 882, 612 | 0 | 15, 882, 61 | 2 0. 763567 | 0 | 1.00 |
| 2.00 CAP REL COSTS-MVBLE EQUIP | 4, 917, 941 | | | | | 2.00 |
| 3.00 Total (sum of lines 1-2) | 20, 800, 553 | | | | | 3.00 |
| | ALLOCA | TION OF OTHER (| CAPITAL | SUMMARY C | F CAPI TAL | |
| Cast Castar Dagariation | Taura | Other | Tatal (avm of | Dennesi etter | | |
| Cost Center Description | Taxes | Capital -Relat | Total (sum of cols. 5 | Depreciation | Lease | |
| | | ed Costs | through 7) | | | |
| | 6, 00 | 7.00 | 8.00 | 9,00 | 10.00 | |
| PART III - RECONCILIATION OF CAPITAL COSTS (| | 1100 | 0.00 | 7100 | 10100 | |
| 1.00 CAP REL COSTS-BLDG & FIXT | 0 | 0 | | 0 499, 147 | 0 | 1.00 |
| 2.00 CAP REL COSTS-MVBLE EQUIP | 0 | 0 | | 0 257,607 | 151, 750 | 2.00 |
| 3.00 Total (sum of lines 1-2) | 0 | 0 | | 0 756, 754 | 151, 750 | 3.00 |
| | | SL | IMMARY OF CAPI | TAL | | |
| Cost Center Description | Interest | Insurance | Taxes (see | Other | Total (2) | |
| | | (see | instructions) | | | |
| | | instructions) | | ed Costs (see | 9 through 14) | |
| | 11.00 | 12.00 | 13.00 | instructions) 14.00 | 15.00 | |
| PART III - RECONCILIATION OF CAPITAL COSTS (| | 12.00 | 13.00 | 14.00 | 15.00 | |
| 1.00 CAP REL COSTS-BLDG & FIXT | 57, 240 | 10, 899 | | 0 0 | 567, 286 | 1.00 |
| 2.00 CAP REL COSTS-MVBLE EQUIP | 0 | | | 0 0 | 409, 357 | 2.00 |
| 3.00 Total (sum of lines 1-2) | 57, 240 | 10, 899 | | 0 0 | 976, 643 | 3.00 |
| | | | | | | |

Health Financial Systems ADJUSTMENTS TO EXPENSES

SOUTHERN INDIANA REHAB HOSPITAL Provider CCN: 153037 Period: In Lieu of Form CMS-2552-10 Worksheet A-8

| ADJUST | MENTS TO EXPENSES | | | | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 Date/Time Pre | pared: |
|----------------|---|--------------------|----------------|---|---|--------------------------------|------------------|
| | | | | Expense Classification or From Which the Amount is | | 5/27/2015 8: 4: | <u>2 am</u> |
| | | | | | | | |
| | Cost Center Description | Basi s/Code (2) | Amount | Cost Center | Line # | Wkst. A-7 Ref. | |
| 1.00 | Investment income - CAP REL | 1.00 | 2.00 0 CAF | 3.00 PREL COSTS-BLDG & FIXT | 4.00 | 5.00 0 | 1.00 |
| 2.00 | COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL | | OCAF | PREL COSTS-MVBLE EQUIP | 2.00 | 0 | 2.00 |
| 3.00 | COSTS-MVBLE EQUIP (chapter 2) Investment income - other | | о | | 0.00 | 0 | 3.00 |
| I. 00 | (chapter 2) Trade, quantity, and time | | о | | 0.00 | 0 | 4.00 |
| 5.00 | discounts (chapter 8) Refunds and rebates of | | о | | 0.00 | 0 | 5.00 |
| . 00 | expenses (chapter 8) Rental of provider space by | | 0 | | 0.00 | 0 | 6.00 |
| 7.00 | suppliers (chapter 8) Telephone services (pay | | 0 | | 0.00 | 0 | 7.00 |
| | stations excluded) (chapter 21) | | , j | | 0.00 | 0 | |
| 3. 00 | Television and radio service (chapter 21) | | о | | 0.00 | 0 | 8.00 |
| 9.00 10.00 | Parking lot (chapter 21) Provider-based physician adjustment | A-8-2 | 0 -148, 343 | | 0.00 | 0 0 | 9. 00 10. 00 |
| 1.00 | Sale of scrap, waste, etc. (chapter 23) | | 0 | | 0.00 | 0 | 11.00 |
| 2.00 | Related organization transactions (chapter 10) | A-8-1 | -634, 954 | | | 0 | 12.00 |
| 3.00 | Laundry and linen service | | 0 | | 0.00 | 0 | |
| 4.00 5.00 | Cafeteria-employees and guests Rental of quarters to employee and others | | 0 0 | | 0.00 0.00 | 0 0 | |
| 6.00 | Sale of medical and surgical supplies to other than | | 0 | | 0.00 | 0 | 16.00 |
| 7.00 | patients Sale of drugs to other than patients | | О | | 0.00 | 0 | 17.00 |
| 8.00 | Sale of medical records and | В | -6, 762 MEE | DI CAL RECORDS & LI BRARY | 16.00 | 0 | 18.00 |
| 19.00 | abstracts Nursing school (tuition, fees, | | О | | 0.00 | 0 | 19.00 |
| | books, etc.) Vending machines | В | -2, 930 DI E | TARY | 10.00 | 0 | |
| | Income from imposition of interest, finance or penalty charges (chapter 21) | | 0 | | 0.00 | 0 | |
| 22.00 | Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments | | 0 | | 0.00 | 0 | 22.00 |
| 23.00 | therapy costs in excess of | A-8-3 | ORES | SPI RATORY THERAPY | 65.00 | | 23.00 |
| 24.00 | therapy costs in excess of | A-8-3 | ОРНУ | SICAL THERAPY | 66.00 | | 24.00 |
| 25.00 | limitation (chapter 14) Utilization review - physicians' compensation | | 0 *** | Cost Center Deleted *** | 114. 00 | | 25.00 |
| 26.00 | (chapter 21) Depreciation - CAP REL | | OCAF | P REL COSTS-BLDG & FIXT | 1.00 | 0 | 26.00 |
| 27.00 | COSTS-BLDG & FIXT Depreciation - CAP REL | | OCAF | P REL COSTS-MVBLE EQUIP | 2.00 | 0 | 27.00 |
| 8. 00 | COSTS-MVBLE EQUIP Non-physician Anesthetist | | 0 * * * | Cost Center Deleted *** | | | 28.00 |
| 29.00 30.00 | therapy costs in excess of | A-8-3 | 0 0000 | CUPATIONAL THERAPY | 0. 00 67. 00 | 0 | 29. 00 30. 00 |
| 30. 99 | limitation (chapter 14) Hospice (non-distinct) (see | | OADL | JLTS & PEDI ATRI CS | 30.00 | | 30. 99 |
| 31. 00 | instructions) Adjustment for speech pathology costs in excess of limitation (chapter 14) | A-8-3 | OSPE | EECH PATHOLOGY | 68.00 | | 31.00 |

| STMENTS | TO | EXPENSES | |
|---------|----|----------|--|

| Health Financial Systems | SOL | UTHERN INDIANA | REHAB HOSPI TAL | In Lieu of Form CMS-2552-10 | | |
|-------------------------------|-------------|----------------|----------------------------|----------------------------------|----------------|--------|
| ADJUSTMENTS TO EXPENSES | | | Provider CCN: 153037 | Peri od: | Worksheet A-8 | |
| | | | | From 01/01/2014 To 12/31/2014 | Date/Time Pre | pared. |
| | | | | | 5/27/2015 8: 4 | 2 am |
| | | | Expense Classification of | | | |
| | | | To/From Which the Amount i | s to be Adjusted | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Cost Center Description | Basi s/Code | Amount | Cost Center | Line # | Wkst. A-7 | |
| | (2) | | | | Ref. | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 32.00 CAH HIT Adjustment for | | 0 | | 0.00 | 0 | 32.00 |
| Depreciation and Interest | | | | | | |
| 33.00 RENTAL INCOME - DIETARY | В | -13, 410 | CAP REL COSTS-BLDG & FIXT | 1.00 | 9 | 33.00 |

| | | U | | 0.00 | 0 | 32.00 |
|--------------------------------|---|---|---|---|--|---|
| Depreciation and Interest | | | | | | |
| RENTAL INCOME - DIETARY | В | -13,410 | CAP REL COSTS-BLDG & FIXT | 1.00 | 9 | 33.00 |
| RENTAL INCOME - ADMIN | В | -11, 826 | CAP REL COSTS-BLDG & FIXT | 1.00 | 9 | 34.00 |
| MISC INCOME - ADMIN | В | -192 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 35.00 |
| MISC INCOME - ST | В | -3,960 | SPEECH PATHOLOGY | 68.00 | 0 | 36.00 |
| MISC INCOME - PT | В | -102, 460 | PHYSI CAL THERAPY | 66.00 | 0 | 37.00 |
| MISC INCOME - PSYCH | В | -540 | PSYCHI ATRI C/PSYCHOLOGI CAL | 76.00 | 0 | 38.00 |
| | | | SERVI CES | | | |
| MISC INCOME - OT | В | -910 | OCCUPATIONAL THERAPY | 67.00 | 0 | 39.00 |
| TELEPHONE SERVICES | А | -28, 122 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 40.00 |
| SCOTT COUNTY ST-BENEFITS | А | -1, 542 | PHYSI CAL THERAPY | 66.00 | 0 | 41.00 |
| SCOTT COUNTY ST MILEAGE | А | -3, 997 | PHYSI CAL THERAPY | 66.00 | 0 | 42.00 |
| TRANSPORTATI ON-BENEFI TS | А | -197 | ADULTS & PEDIATRICS | 30.00 | 0 | 43.00 |
| TRANSPORTATI ON | А | -187, 856 | ADULTS & PEDIATRICS | 30.00 | 0 | 44.00 |
| CIVIC ACTIVITIES/COMMUNITY | А | -79,880 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 45.00 |
| BENEFI T | | | | | | |
| DI ETARY I NSTRUCTI ONS | В | -616 | DI ETARY | 10.00 | 0 | 46.00 |
| TOTAL (sum of lines 1 thru 49) | | -1, 228, 497 | , | | | 50.00 |
| (Transfer to Worksheet A, | | | | | | |
| column 6, line 200.) | | | | | | |
| | Depreciation and Interest RENTAL INCOME - DIETARY RENTAL INCOME - ADMIN MISC INCOME - ADMIN MISC INCOME - ST MISC INCOME - PT MISC INCOME - PT MISC INCOME - OT TELEPHONE SERVICES SCOTT COUNTY ST-BENEFITS SCOTT COUNTY ST MILEAGE TRANSPORTATION-BENEFITS TRANSPORTATION-BENEFITS TRANSPORTATION CIVIC ACTIVITIES/COMMUNITY BENEFIT DIETARY INSTRUCTIONS TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, | Depreciation and InterestRENTAL INCOME - DIETARYBRENTAL INCOME - ADMINBMISC INCOME - ADMINBMISC INCOME - STBMISC INCOME - PTBMISC INCOME - OTBMISC INCOME - OTCSCOTT COUNTY ST-BENEFITSASCOTT COUNTY ST MILEAGEATRANSPORTATIONACIVIC ACTIVITIES/COMMUNITYABUEFFITDIETARY INSTRUCTIONSDIETARY INSTRUCTIONSBTOTAL (sum of Lines 1 thru 49)(Transfer to Worksheet A, | Depreciation and Interest RENTAL INCOME - DIETARYB-13,410RENTAL INCOME - ADMINB-11,820MISC INCOME - ADMINB-192MISC INCOME - STB-3,960MISC INCOME - PTB-102,460MISC INCOME - PTB-28,122SCOTT COUNTY ST-BENEFITSA-1,542SCOTT COUNTY ST MILEAGEA-1,542CIVIC ACTIVITIES/COMMUNITYA-187,856CIVIC ACTIVITIES/COMMUNITYA-79,880BENEFITDIETARY INSTRUCTIONSB-616TOTAL (sum of lines 1 thru 49)-1,228,497 | Depreciation and Interest RENTAL INCOME - DIETARYB-13,410 CAP REL COSTS-BLDG & FIXTRENTAL INCOME - ADMINB-11,826 CAP REL COSTS-BLDG & FIXTMISC INCOME - ADMINB-192 ADMINISTRATIVE & GENERALMISC INCOME - STB-3,960 SPEECH PATHOLOGYMISC INCOME - PTB-102,460 PHYSICAL THERAPYMISC INCOME - OTB-540 PSYCHIATRIC/PSYCHOLOGICAL SERVICESMISC INCOME - OTB-28,122 ADMINISTRATIVE & GENERALSCOTT COUNTY ST-BENEFITSA-1,542 PHYSICAL THERAPYSCOTT COUNTY ST MILEAGEA-3,997 PHYSICAL THERAPYTRANSPORTATION-BENEFITSA-197 ADULTS & PEDIATRICSTRANSPORTATIONA-187,856 ADULTS & PEDIATRICSCIVIC ACTIVITIES/COMMUNITYA-79,880 ADMINISTRATIVE & GENERALBENEFITDIETARY INSTRUCTIONSB-616 DIETARYTOTAL (sum of Lines 1 thru 49)-1,228,497 | Depreciation and Interest RENTAL INCOME - DIETARYB-13,410 CAP REL COSTS-BLDG & FIXT1.00RENTAL INCOME - ADMINB-11,826 CAP REL COSTS-BLDG & FIXT1.00MISC INCOME - ADMINB-192 ADMINISTRATIVE & GENERAL5.00MISC INCOME - STB-3,960 SPEECH PATHOLOGY68.00MISC INCOME - PTB-102,460 PHYSICAL THERAPY66.00MISC INCOME - PTB-102,460 PHYSICAL THERAPY66.00MISC INCOME - OTB-910 OCCUPATIONAL THERAPY67.00SCOTT COUNTY ST-BENEFITSA-28,122 ADMINISTRATIVE & GENERAL5.00SCOTT COUNTY ST-BENEFITSA-1,542 PHYSICAL THERAPY66.00SCOTT COUNTY ST MILEAGEA-3,997 PHYSICAL THERAPY66.00TRANSPORTATION-BENEFITSA-197 ADULTS & PEDIATRICS30.00TRANSPORTATIONA-187,856 ADULTS & PEDIATRICS30.00CIVIC ACTIVITIES/COMMUNITYA-79,880 ADMINISTRATIVE & GENERAL5.00BENEFITDIETARY INSTRUCTIONSB-616 DIETARY10.00TOTAL (sum of Lines 1 thru 49)-1,228,497-1,228,49710.00 | Depreciation and Interest RENTAL INCOME - DIETARYB-13,410 CAP REL COSTS-BLDG & FIXT1.00RENTAL INCOME - ADMINB-13,240 CAP REL COSTS-BLDG & FIXT1.009MISC INCOME - ADMINB-192 ADMIN STRATIVE & GENERAL5.0000MISC INCOME - STB-3,960 SPEECH PATHOLOGY68.0000MISC INCOME - PTB-102,460 PHYSI CAL THERAPY66.0000MISC INCOME - PSYCHB-540 PSYCHIATRIC/PSYCHOLOGI CAL76.0000MISC INCOME - OTB-910 OCCUPATIONAL THERAPY67.0000TELEPHONE SERVICESA-28,122 ADMINISTRATIVE & GENERAL5.0000SCOTT COUNTY ST-BENEFITSA-1,542 PHYSI CAL THERAPY66.0000SCOTT COUNTY ST-BENEFITSA-187,856 ADULTS & PEDI ATRICS30.0000RANSPORTATION-BENEFITSA-187,856 ADULTS & PEDI ATRICS30.0000CIVIC ACTIVITIES/COMMUNITYA-79,880 ADMINISTRATIVE & GENERAL5.0000DI ETARY INSTRUCTIONSB-616 DI ETARY10.000OTAL (sum of lines 1 thru 49)-1,228,497-1,228,4970.0000 |

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

(2) basis of adjustment (see first definition).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

| Heal th | Financial Systems | SOUTHERN INDIAN | A REHAB HOSPITAL | In Lie | eu of Form CMS- | 2552-10 |
|------------------|---|-------------------------------|------------------------------|---|-----------------|---------|
| STATEM OFFICE | ENT OF COSTS OF SERVICES FROM COSTS | RELATED ORGANIZATIONS AND HO | | Period: From 01/01/2014 To 12/31/2014 | | epared: |
| | Line No. | Cost Center | Expense Items | Amount of Allowable Cost | Amount | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | A. COSTS INCURRED AND ADJUST OFFICE COSTS: | MENTS REQUIRED AS A RESULT OF | TRANSACTIONS WITH RELATED C | RGANI ZATI ONS OF | R CLAIMED HOME | |
| 1.00 | | ADMINISTRATIVE & GENERAL | FLOYD - A&G | 7,200 | | 1.00 |
| 2.00 | | OPERATING ROOM | FLOYD - OR | 1, 279 | | 2.00 |
| 3.00 | | RADI OLOGY-DI AGNOSTI C | FLOYD - X-RAY | 50, 914 | | 3.00 |
| 4.00 | | RADI OLOGY-DI AGNOSTI C | FLOYD - CT | 774 | | 4.00 |
| 4.01 | | LABORATORY | FLOYD - LAB | 411 | 842 | 4.01 |
| 4.02 | | RESPI RATORY THERAPY | FLOYD - RESPIRATORY THERAPY | 54 | | 4.02 |
| 4.03 | | SPEECH PATHOLOGY | FLOYD - SPEECH THERAPY | 5, 502 | | 4.03 |
| 4.04 | | ELECTROCARDI OLOGY | FLOYD - EKG | 257 | | 4.04 |
| 4.05 | | | FLOYD - MEDICAL SUPPLIES | 889 | | 4.05 |
| 4.06 | | DRUGS CHARGED TO PATIENTS | FLOYD - PHARMACY | 340, 808 | | 4.06 |
| 4.07 | | ADULTS & PEDIATRICS | FLOYD - ER | 876 | | 4.07 |
| 4.08 | | ADMINISTRATIVE & GENERAL | CLARK - ADMIN AND GENERAL | 15, 942 | | 4.08 |
| 4.09 | | MEDICAL RECORDS & LIBRARY | CLARK - HIM | 22, 215 | | 4.09 |
| 4.10 | | RADI OLOGY-DI AGNOSTI C | CLARK - RADIO DIAGNOSTICS | 945 | | 4.10 |
| 4.11 | | LABORATORY | CLARK - LAB ADMINISTRATION | 210, 479 | | 4.11 |
| 4.12 | | RESPI RATORY THERAPY | CLARK - RESPIRATORY THERAPY | 323, 171 | | 4.12 |
| 4.13 | | MEDICAL SUPPLIES CHARGED TO | CLARK - SUPPLY & DISTRIBUTIC | | | 4.13 |
| 4.14 | | DRUGS CHARGED TO PATIENTS | CLARK - IV THERAPY/PHARMACY | 119, 081 | | 4.14 |
| 4.15 | | ADULTS & PEDIATRICS | CLARK - EMERGENCY ROOM | 0 | , . | 4.15 |
| 4.16 | | ADMINISTRATIVE & GENERAL | KYONE | 545, 204 | | 4.16 |
| 4.17 | | CAP REL COSTS-MVBLE EQUIP | KYONE | 63, 854 | 0 | 4.17 |
| 4.18 | 0.00 | | | 0 | 0 | 4.18 |
| 4.19 | 0.00 | | | 0 | 0 | 4.19 |
| 5.00 | TOTALS (sum of lines 1-4). | | | 1, 825, 829 | 2, 460, 783 | 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.

| 1100 | | | | | i oi tino parti | |
|------|------------|------|---------------|------------------------------|-----------------|---|
| | | | | Related Organization(s) and/ | or Home Office | |
| | | | | | | |
| | | | | | | |
| | | | | | | L |
| | Symbol (1) | Name | Percentage of | Name | Percentage of | |
| | | | Ownership | | 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 | 0. 00 KENTUCKYONE 33. 34 | 6.00 |
|----------|-------------------------|---------------------------|--------|
| 7.00 | В | 0.00 CLARK MEMORIAL 33.33 | 7.00 |
| 8.00 | В | 0.00 FLOYD MEMORIAL 33.33 | 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 |
| lr | 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 organizati on.

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

| Health Financial Systems | SOUTHERN INDIANA REHA | AB HOSPITAL | In Lieu | u of Form CMS-2552-10 |
|---|------------------------|----------------------|----------------------------|-----------------------|
| STATEMENT OF COSTS OF SERVICES FROM RELATED OFFICE COSTS | ORGANIZATIONS AND HOME | Provider CCN: 153037 | Period: From 01/01/2014 | Worksheet A-8-1 |
| | | | To 12/31/2014 | Date/Time Prepared: |

| $\begin{tabular}{ c c c c c c c c c c c c c c c c c c c$ | | | | | 10 12/31/2014 | 5/27/2015 8:42 am |
|--|----------------|----------------|-------------------------------------|-------------------------|--------------------|-------------------|
| (co) / 4 minus col. 5)* 7.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 1.00 0 0 2.00 2.00 -7.055 0 3.00 3.00 -8.049 0 4.00 4.01 -431 0 4.02 4.02 -37 0 4.02 4.03 0 0 4.03 4.04 -525 0 4.05 4.05 118 0 4.06 4.06 -23.699 0 4.06 4.05 118 0 4.06 4.06 -23.699 0 4.06 4.07 -583 0 4.08 4.09 -2.001 0 4.08 4.10 -13 0 4.08 4.10 4.11 4.12 -4.867 0 4.14 37.914 0 4.13 4.14 4.17 63.854 | Net | Wkst. A-7 Ref. | | · · · · | | |
| col. 5)* col. 5)* col. 5)* col. 5)* col. 7.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME 1.00 2.00 -7,055 0 3.00 3.00 -8,049 0 3.00 4.01 -431 0 4.01 4.02 -37 0 4.02 4.03 0 0 4.02 4.04 -525 0 4.04 4.05 118 0 4.02 4.06 -23,699 0 4.02 4.09 -2,001 0 4.02 4.11 -13 0 4.02 4.12 -4,867 0 4.03 4.11 -13,760 0 4.03 4.11 -76 0 4.12 4.13 -10,323 0 4.12 4.14 -674,800 9 4.16 4.15 -76 0 4.16 4.16 -6 | Adjustments | | | | | |
| 6.00 7.00 A. COSTS I NURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME 1.00 0.00 -7,055 0 2.00 2.00 -7,055 0 3.00 4.00 -6,563 0 4.00 4.01 -431 0 4.02 4.02 -37 0 4.02 4.03 0 0 4.03 4.05 118 0 4.05 4.06 -23,699 0 4.06 4.09 -2,001 0 4.02 4.08 15,942 0 4.08 4.09 -2,001 0 4.04 1.11 -13,760 0 4.11 4.12 -4,867 0 4.12 4.14 37,914 0 4.12 4.14 37,914 0 4.12 4.14 37,914 0 4.12 4.18 0 0 4.18 4. | (col. 4 minus | | | | | |
| A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 0 0 0 2.00 -7,055 0 2.00 2.00 3.00 -8,049 0 4.00 | | | | | | |
| $\begin{array}{ c c c c c c c c c c c c c c c c c c c$ | | | | | | |
| $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$ | A. COSTS INCUR | RED AND ADJUST | MENTS REQUIRED AS A RESULT OF TRANS | SACTIONS WITH RELATED C | ORGANI ZATI ONS OR | CLAIMED HOME |
| $ \begin{array}{cccccccccccccccccccccccccccccccccccc$ | OFFICE COSTS: | | | | | |
| $ \begin{array}{cccccccccccccccccccccccccccccccccccc$ | - | - | | | | |
| $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$ | | | | | | |
| $ \begin{array}{cccccccccccccccccccccccccccccccccccc$ | | | | | | |
| $ \begin{array}{cccccccccccccccccccccccccccccccccccc$ | | 0 | | | | |
| $ \begin{array}{cccccccccccccccccccccccccccccccccccc$ | | 0 | | | | |
| $ \begin{array}{cccccccccccccccccccccccccccccccccccc$ | -37 | 0 | | | | |
| $ \begin{array}{cccccccccccccccccccccccccccccccccccc$ | - | 0 | | | | |
| $ \begin{array}{cccccccccccccccccccccccccccccccccccc$ | | | | | | |
| $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$ | | | | | | |
| $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$ | | | | | | |
| $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$ | | | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| 4. 12 -4, 867 0 4. 12 4. 13 -10, 323 0 4. 13 4. 14 37, 914 0 4. 14 4. 15 -76 0 4. 15 4. 16 -674, 800 9 4. 16 4. 17 63, 854 9 4. 18 4. 18 0 0 4. 18 4. 19 0 0 4. 19 | | | | | | |
| 4.13 -10,323 0 4.13 4.14 37,914 0 4.14 4.15 -76 0 4.15 4.16 -674,800 9 4.16 4.17 63,854 9 4.17 4.18 0 0 4.18 4.19 0 0 4.19 | | | | | | |
| 4.14 37,914 0 4.14 4.15 -76 0 4.15 4.16 -674,800 9 4.16 4.17 63,854 9 4.17 4.18 0 0 4.18 4.19 0 0 4.19 | | | | | | |
| 4.15 -76 0 4.15 4.16 -674,800 9 4.16 4.17 63,854 9 4.17 4.18 0 0 4.18 4.19 0 0 4.19 | | | | | | |
| 4. 16 -674, 800 9 4. 16 4. 17 63, 854 9 4. 17 4. 18 0 0 4. 18 4. 19 0 0 4. 19 | | | | | | |
| 4.17 63,854 9 4.17 4.18 0 0 4.18 4.19 0 0 4.19 | | | | | | |
| 4.18 0 0 4.19 0 0 | | | | | | |
| 4.19 0 0 4.19 | 63, 854 | 9 | | | | |
| | 0 | 0 | | | | |
| 5.00 -634,954 5.00 | 0 | 0 | | | | |
| * The empirity on Lines 1.4 (and subcerints as engraphicate) are transferred in detail to Warksheet A column (Lines as | | | | | | |

* 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.

| been posted to norkaneet n, | conditions i difference allocated and be indicated in condition parts | |
|----------------------------------|---|--|
| Related Organization(s) | | |
| and/or Home Office | | |
| | | |
| | | |
| Type of Business | | |
| 51 | | |
| 6, 00 | | |
| | TED ORGANIZATION(S) AND/OR HOME OFFICE: | |
| B. INTERRELATIONSHIP TO RELA | ED 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 | HOME OFFICE | 6.00 |
|-------------------|----------------|--------|
| 7.00 | SHARED SVCS JV | 7.00 |
| 8.00 | SHARED SVCS JV | 8.00 |
| 9.00 | | 9.00 |
| 10.00 | | 10.00 |
| 10. 00 100. 00 | | 100.00 |

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

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

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

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

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

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

| Heal th | Fir | nanci a | | SVS | ter | ms | |
|-----------|-----|---------|------------|--------|----------|-----|------|
| neur th | | iunci c | | 595 | LCI | 113 | |
| D D D U D | | | D 1 | 11 (01 | <u>.</u> | | |

SOUTHERN INDIANA REHAB HOSPITAL In Lieu of Form CMS-2552-10

| PROVI DE | R BASED PHYSIC | I AN ADJUSTMENT | | Provi der | | Period: | Worksheet A-8 | 3-2 |
|---------------|----------------|------------------------------|----------------|-----------------------|-----------------|---------------------------------------|------------------|---------------|
| | | | | | | From 01/01/2014 To 12/31/2014 | | norod. |
| | | | | | | 10 12/31/2014 | 5/27/2015 8:4 | 12 am |
| | Wkst. A Line # | Cost Center/Physician | Total | Professi onal | Provi der | RCE Amount | Physi ci an/Prov | |
| | | Identifier | Remunerati on | Component | Component | | ider Component | |
| | | | | - | | | Hours | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | 7.00 | |
| 1.00 | | ADMI NI STRATI VE & GENERAL | 7, 738 | | | | | |
| 2.00 | | PSYCHI ATRI C/PSYCHOLOGI CAL | 140, 605 | 140, 605 | C | 138, 700 | 0 | 2.00 |
| | | SERVICES | | | | | | |
| 3.00 | 0.00 | | 0 | | | - | | 3.00 |
| 4.00 | 0. 00 0. 00 | | 0 | | | - | - | 4.00 |
| 5.00 | | | 0 | - | | - | 0 | 5.00 |
| 6.00 | 0. 00 0. 00 | | 0 | 0 | | 0 | 0 | 6.00 |
| 7.00 8.00 | 0.00 | | | 0 | | 0 | 0 | 7.00 8.00 |
| 8.00 9.00 | 0.00 | | | | | 0 | 0 | 8.00 9.00 |
| 9.00 10.00 | 0.00 | | 0 | | | 0 | 0 | 9.00 10.00 |
| 200.00 | 0.00 | | 148, 343 | Ŭ Ŭ | | e e e e e e e e e e e e e e e e e e e | - | 200.00 |
| | Wkst. A Line # | Cost Center/Physician | Unadjusted RCE | | Cost of | Provi der | Physician Cost | 200.00 |
| | WRSt. A LINC # | I denti fi er | | Unadjusted RCE | | Component | of Malpractice | |
| | | ruonti i roi | Li ili c | Limit | Conti nui ng | Share of col. | Insurance | |
| | | | | | Education | 12 | | |
| | 1.00 | 2.00 | 8.00 | 9.00 | 12.00 | 13.00 | 14.00 | |
| 1.00 | 5.00 | ADMI NI STRATI VE & GENERAL | 0 | 0 | C | 0 | 0 | 1.00 |
| 2.00 | 76.00 | PSYCHI ATRI C/PSYCHOLOGI CAL | 0 | 0 | C | 0 | 0 | 2.00 |
| | | SERVICES | | | | | | |
| 3.00 | 0.00 | | 0 | 0 | C | - | | 3.00 |
| 4.00 | 0.00 | | 0 | 0 | C | - | | 4.00 |
| 5.00 | 0.00 | | 0 | 0 | - | - | | |
| 6.00 | 0.00 | | 0 | 0 | C | | 0 | 6.00 |
| 7.00 | 0.00 | | 0 | 0 | C | 0 | 0 | 7.00 |
| 8.00 | 0.00 | | 0 | 0 | C | 0 | 0 | 8.00 |
| 9.00 | 0.00 | | 0 | 0 | | l i | 0 | 9.00 |
| 10.00 | 0.00 | | 0 | - | - | - | | |
| 200.00 | Wkst. A Line # | Cost Center/Physician | Provi der | 0 | RCE | - | 0 | 200.00 |
| | WKSL A LINE # | I denti fi er | Component | Adjusted RCE Limit | Di sal l owance | Adjustment | | |
| | | ruentinei | Share of col. | | DISATIOWATICE | | | |
| | | | 14 | | | | | |
| | 1.00 | 2.00 | 15.00 | 16.00 | 17.00 | 18.00 | | |
| 1.00 | | ADMI NI STRATI VE & GENERAL | 0 | | | | | 1.00 |
| 2.00 | 76.00 | PSYCHI ATRI C/PSYCHOLOGI CAL | 0 | 0 | C | 140,605 | | 2.00 |
| | | SERVI CES | | | | | | |
| 3.00 | 0.00 | | 0 | 0 | C | 0 | | 3.00 |
| 4.00 | 0.00 | | 0 | | C | 0 | | 4.00 |
| 5.00 | 0.00 | | 0 | 0 | C | 0 | | 5.00 |
| 6.00 | 0.00 | | 0 | 0 | C | - | | 6.00 |
| 7.00 | 0.00 | | 0 | | | - | | 7.00 |
| 8.00 | 0.00 | | 0 | 0 | - | - | | 8.00 |
| 9.00 | 0.00 | | 0 | | | | | 9.00 |
| 10.00 | 0.00 | | 0 | | | | | 10.00 |
| 200.00 | | | 0 | 0 | C | 148, 343 | | 200.00 |
| | | | | | | | | |

| Heal th | Financial Systems SO | UTHERN INDIANA | REHAB HOSPI TAI | _ | In Lie | u of Form CMS-: | 2552-10 |
|---------|--|--|-----------------|-------------|---|---|---------|
| | LOCATION - GENERAL SERVICE COSTS | | Provi der | CCN: 153037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Pre 5/27/2015 8:4 | pared: |
| | | | CAPI TAL REI | ATED COSTS | | 0/2//2010 0.1 | |
| | Cost Center Description | Net Expenses for Cost Allocation (from Wkst A | BLDG & FIXT | MVBLE EQUIP | EMPLOYEE BENEFI TS DEPARTMENT | Subtotal | |
| | | col. 7) | 1.00 | | 1.00 | | |
| | | 0 | 1.00 | 2.00 | 4.00 | 4A | |
| | GENERAL SERVICE COST CENTERS | F(7,00) | F (7, 00 (| | | | 1 |
| | 00100 CAP REL COSTS-BLDG & FIXT | 567, 286 | 567, 286 | | | | 1.00 |
| | 00200 CAP REL COSTS-MVBLE EQUIP | 409, 357 | | 409, 35 | | | 2.00 |
| | 00400 EMPLOYEE BENEFITS DEPARTMENT | 1, 958, 710 | 0 | | 0 1, 958, 710 | | 4.00 |
| | 00500 ADMI NI STRATI VE & GENERAL | 1, 628, 353 | 189, 675 | 136, 87 | | 2, 030, 265 | • |
| | 00600 MAINTENANCE & REPAIRS | 674, 546 | 0 | | 0 52, 790 | 727, 336 | |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 17, 633 | 0 | | 0 3, 760 | 21, 393 | 8.00 |
| 9.00 | 00900 HOUSEKEEPI NG | 247, 884 | 0 | | 0 46, 657 | 294, 541 | 9.00 |
| 10.00 | 01000 DI ETARY | 701, 473 | 36, 984 | 26, 68 | 8 58, 428 | 823, 573 | 10.00 |
| | 01400 CENTRAL SERVICE & SUPPLY | 38, 812 | 0 | | 0 7,246 | 46,058 | 14.00 |
| | 01600 MEDI CAL RECORDS & LI BRARY | 113, 290 | 0 | | 0 23, 216 | 136, 506 | |
| | 01700 SOCI AL SERVI CE | 813, 523 | 0 | | 0 162, 203 | 975, 726 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | 010, 020 | 0 | I | 102,200 | 710,720 | 17.00 |
| | 03000 ADULTS & PEDI ATRI CS | 2,055,312 | 61, 640 | 44, 48 | 408, 554 | 2, 569, 986 | 30.00 |
| | 04400 SKILLED NURSING FACILITY | 1, 155, 950 | 69, 419 | | | 1, 499, 954 | |
| | ANCI LLARY SERVICE COST CENTERS | 1,133,930 | 07,417 | 50,03 | 5 224,472 | 1,477,704 | 44.00 |
| | 05000 OPERATING ROOM | 421 | 0 | | 0 0 | 421 | 50.00 |
| | | | | | | | |
| | 05400 RADI OLOGY-DI AGNOSTI C | 67, 380 | 2,085 | | | 70, 970 | |
| | 06000 LABORATORY | 221, 158 | 1, 540 | | | 223, 809 | |
| | 06400 I NTRAVENOUS THERAPY | 0 | 0 | | 0 0 | 0 | |
| | 06500 RESPI RATORY THERAPY | 394, 071 | 869 | 62 | | 404, 959 | |
| | 06600 PHYSI CAL THERAPY | 2, 031, 412 | 111, 923 | | | 2,665,460 | |
| | 06700 OCCUPATI ONAL THERAPY | 1, 195, 320 | 83, 058 | 59, 93 | 5 247, 515 | 1, 585, 828 | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 680, 998 | 5, 299 | 3, 82 | 4 143, 172 | 833, 293 | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 257 | 0 | | 0 0 | 257 | 69.00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 0 0 | 0 | 70.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 211, 945 | 0 | | 0 0 | 211, 945 | 71.00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 756, 568 | 1, 422 | 1, 02 | 6 0 | 759, 016 | |
| | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 272, 917 | 3, 372 | 2, 43 | | 333, 280 | • |
| | OUTPATIENT SERVICE COST CENTERS | , | -, | | | | 1 |
| | 08800 RURAL HEALTH CLINIC | 0 | 0 | | 0 0 | 0 | 88.00 |
| | 09100 EMERGENCY | 0 | 0 | | 0 0 | 0 | |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | Ŭ | 0 | | 0 | 0 | |
| | OTHER REIMBURSABLE COST CENTERS | | | | | 0 | 72.00 |
| | | | 0 | | | 0 | 00.00 |
| | 09900 CMHC | 0 | 0 | | 0 0 | 0 | 99.00 |
| | SPECIAL PURPOSE COST CENTERS | 44.044.574 | E (7. 00 (| 100.05 | | 44 044 534 | 1 |
| 118.00 | SUBTOTALS (SUM OF LINES 1-117) | 16, 214, 576 | 567, 286 | 409, 35 | 7 1, 958, 710 | 16, 214, 576 | 118.00 |
| | NONREI MBURSABLE COST CENTERS | 1 | | 1 | | | |
| | 07950 OTHER NRCC | 112, 208 | 0 | | 0 0 | 112, 208 | |
| 200.00 | Cross Foot Adjustments | | | | | | 200.00 |
| 201.00 | Negative Cost Centers | | 0 | | 0 0 | | 201.00 |
| 202.00 | TOTAL (sum lines 118-201) | 16, 326, 784 | 567, 286 | 409, 35 | 7 1, 958, 710 | 16, 326, 784 | 202.00 |
| | | · | | | · | | |

| Heal th | Financial Systems SC | OUTHERN INDIANA | REHAB HOSPITA | L | In Lie | u of Form CMS-: | 2552-10 |
|--------------|--|-----------------|---------------|--------------|-----------------|--------------------------------|---------|
| | ALLOCATION - GENERAL SERVICE COSTS | | | CCN: 153037 | Peri od: | Worksheet B | |
| | | | | | From 01/01/2014 | Part I | |
| | | | | | To 12/31/2014 | Date/Time Pre 5/27/2015 8:4 | epared: |
| | Cost Center Description | | MAINTENANCE & | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | |
| | cost center bescription | E & GENERAL | REPAIRS | LINEN SERVIC | | DILIARI | |
| | | 5.00 | 6.00 | 8.00 | 9.00 | 10.00 | |
| | GENERAL SERVICE COST CENTERS | 5.00 | 0.00 | 0.00 | 7.00 | 10.00 | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2.00 | 00200 CAP REL COSTS-MUBLE EQUIP | | | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 4.00 5.00 | 00500 ADMINI STRATI VE & GENERAL | 2,030,265 | | | | | 5.00 |
| 6.00 | 00600 MAINTENANCE & REPAIRS | 103, 290 | | | | | 6.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 3, 038 | | | 01 | | 8.00 |
| 8.00 9.00 | 00900 HOUSEKEEPING | 41, 828 | | | | | 9.00 |
| | 01000 DI ETARY | | - | | | 1 052 010 | |
| 10.00 | | 116, 956 | | | | 1, 053, 918 | |
| 14.00 | 01400 CENTRAL SERVICE & SUPPLY | 6, 541 | 0 | | 0 0 | 0 | |
| 16.00 | 01600 MEDI CAL RECORDS & LI BRARY | 19, 385 | | | 0 1, 317 | 0 | 16.00 |
| 17.00 | | 138, 564 | 0 | 1 | 0 2,823 | 0 | 17.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | 364, 966 | | | | 504, 837 | 30.00 |
| 44.00 | 04400 SKILLED NURSING FACILITY | 213, 010 | 152, 700 | 6, 10 | 0 8 | 549, 081 | 44.00 |
| | ANCI LLARY SERVICE COST CENTERS | | | 1 | | | |
| 50.00 | 05000 OPERATING ROOM | 60 | | | 0 0 | 0 | 50.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 10, 079 | | | 0 690 | 0 | 54.00 |
| 60.00 | 06000 LABORATORY | 31, 783 | 3, 388 | | 0 0 | 0 | 60.00 |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 0 | | | 0 0 | 0 | 64.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 57, 509 | | | 0 1, 798 | 0 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 378, 526 | 246, 195 | | | 0 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 225, 205 | 182, 702 | 1, 30 | 0 14, 470 | 0 | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 118, 337 | 11, 657 | | 0 2,488 | 0 | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 36 | 0 | | 0 0 | 0 | 69.00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 0 0 | 0 | 70.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 30, 099 | 0 | | 0 0 | 0 | 71.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 107, 789 | 3, 127 | | 0 460 | 0 | 73.00 |
| 76.00 | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 47, 329 | 7, 418 | | 0 4, 768 | 0 | 76.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | · | | | 1 |
| 88.00 | 08800 RURAL HEALTH CLINIC | 0 | 0 | | 0 0 | 0 | 88.00 |
| 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 |
| 99.00 | 09900 CMHC | 0 | 0 | | 0 0 | 0 | 99.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | 4 | | 1 |
| 118.00 | | 2,014,330 | 830, 626 | 24, 43 | 31 337, 102 | 1, 053, 918 | 1118.00 |
| | NONREI MBURSABLE COST CENTERS | | | | 1 | | |
| 194.00 | DO7950 OTHER NRCC | 15, 935 | 0 | | 0 0 | 0 | 194.00 |
| 200.00 | | | ĺ | | | 0 | 200.00 |
| 201.00 | | 0 | 0 | | 0 0 | 0 | 201.00 |
| 202.00 | 5 | 2,030,265 | 830, 626 | 24, 43 | 31 337, 102 | 1, 053, 918 | |
| | | _,, 200 | , 020 | | | .,,,,,, | |

| Heal th | Financial Systems SO | UTHERN I NDI ANA | REHAE | B HOSPI TAL | | | In Lieu | u of Form CMS-: | 2552-10 |
|---------|--|-----------------------|-------|-------------|---------------------|----|---------------|-----------------------|----------|
| | LLOCATION - GENERAL SERVICE COSTS | - | | | CCN: 153037 | Pe | eri od: | Worksheet B | |
| | | | | | | Fr | om 01/01/2014 | Part I | |
| | | | | | | To | 12/31/2014 | Date/Time Pre | |
| | Cast Castas Description | CENTRAL | | DICAL | COCI AI | | Cultatetel | 5/27/2015 8:4 | 2 am |
| | Cost Center Description | CENTRAL SERVI CE & | | DICAL | SOCI AL SERVI CE | | Subtotal | Intern & Residents | |
| | | SUPPLY | | BRARY | SERVICE | | | Cost & Post | |
| | | JUPPLI | LI | DRAKT | | | | Stepdown | |
| | | | | | | | | Adjustments | |
| | | 14.00 | 1 | 6.00 | 17.00 | | 24.00 | 25.00 | |
| | GENERAL SERVICE COST CENTERS | 14.00 | | 0.00 | 17.00 | | 24.00 | 23.00 | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | | | | | | | | 1.00 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | | | 4.00 |
| 5.00 | 00500 ADMI NI STRATI VE & GENERAL | | | | | | | | 5.00 |
| 6.00 | 00600 MAI NTENANCE & REPAI RS | | | | | | | | 6.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | | | | | | | | 8.00 |
| 9,00 | 00900 HOUSEKEEPI NG | | | | | | | | 9.00 |
| 10.00 | 01000 DI ETARY | | | | | | | | 10.00 |
| | 01400 CENTRAL SERVICE & SUPPLY | 52, 599 | | | | | | | 14.00 |
| | 01600 MEDICAL RECORDS & LIBRARY | 02,077 | | 157, 208 | | | | | 16.00 |
| | 01700 SOCIAL SERVICE | 0 | | 07,200 | | 13 | | | 17.00 |
| 17.00 | INPATIENT ROUTINE SERVICE COST CENTERS | U 01 | | 0 | 1, 1, 1, 1, | 10 | 1 | | 17.00 |
| 30.00 | 03000 ADULTS & PEDIATRICS | 0 | | 76, 744 | 545, 3 | 37 | 4, 436, 808 | 0 | 30.00 |
| 44.00 | 04400 SKILLED NURSING FACILITY | 0 | | 80, 464 | | | 3, 073, 093 | 0 | 44.00 |
| | ANCILLARY SERVICE COST CENTERS | г — т | | | | | · · · · | | |
| 50.00 | 05000 OPERATING ROOM | 0 | | 0 | | 0 | 481 | 0 | 50.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0 | | 0 | | 0 | 86, 325 | 0 | 54.00 |
| 60.00 | 06000 LABORATORY | 0 | | 0 | | 0 | 258, 980 | 0 | 60.00 |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 0 | | 0 | | 0 | 0 | 0 | 64.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0 | | 0 | | 0 | 466, 177 | 0 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0 | | 0 | | 0 | 3, 343, 374 | 0 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0 | | 0 | | 0 | 2,009,505 | 0 | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0 | | 0 | | 0 | 965, 775 | 0 | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | | 0 | | 0 | 293 | 0 | 69.00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 0 | | 0 | | 0 | 0 | 0 | 70.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 52, 599 | | 0 | | 0 | 294, 643 | 0 | 71.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | | 0 | | 0 | 870, 392 | 0 | 73.00 |
| 76.00 | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | | 0 | | 0 | 392, 795 | 0 | 76.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| | 08800 RURAL HEALTH CLINIC | 0 | | 0 | | 0 | 0 | 0 | |
| | 09100 EMERGENCY | 0 | | 0 | | 0 | 0 | 0 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | | 0 | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | II | | | | | | | |
| 99.00 | 09900 CMHC | 0 | | 0 | | 0 | 0 | 0 | 99.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | - | |
| 118.00 | | 52, 599 | | 157, 208 | 1, 117, 1 | 13 | 16, 198, 641 | 0 | 118.00 |
| | NONREI MBURSABLE COST CENTERS | | | | 1 | - | 100.110 | | 1.0.4.00 |
| | 07950 OTHER NRCC | 0 | | 0 | | 0 | 128, 143 | | 194.00 |
| 200.00 | 5 | _ | | ~ | | | 0 | | 200.00 |
| 201.00 | 5 | 0 50 500 | | 157 200 | 1 117 1 | 12 | 16 226 704 | | 201.00 |
| 202.00 | TOTAL (sum lines 118-201) | 52, 599 | | 157, 208 | 1, 117, 1 | 13 | 16, 326, 784 | 0 | 202.00 |
| | | | | | | | | | |

Health Financial Systems

| SOUTHERN | I NDI ANA | REHAB | HOSPI TAL |
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In Lieu of Form CMS-2552-10

| Cost Center Description Total 26.00 In 00 00100 CAP REL COSTS - BLDG & FI XT 2.00 00200 CAP REL COSTS - MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINI STRATI VE & GENERAL | 1.00 2.00 4.00 5.00 6.00 |
|---|--------------------------------------|
| GENERAL SERVI CE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FI XT 2.00 00200 CAP REL COSTS-MVBLE EQUI P 4.00 00400 EMPLOYEE BENEFI TS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL | 2.00 4.00 5.00 6.00 |
| 1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUI P 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMI NI STRATI VE & GENERAL | 2.00 4.00 5.00 6.00 |
| 2. 0000200CAP REL COSTS-MVBLE EQUI P4. 0000400EMPLOYEE BENEFI TS DEPARTMENT5. 0000500ADMI NI STRATI VE & GENERAL | 2.00 4.00 5.00 6.00 |
| 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL | 4.00 5.00 6.00 |
| 5. 00 00500 ADMINI STRATI VE & GENERAL | 5.00 6.00 |
| | 6.00 |
| | |
| 6. 00 00600 MAI NTENANCE & REPAI RS | |
| 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG | 8.00 9.00 |
| 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY | 10.00 |
| 14. 00 01400 CENTRAL SERVICE & SUPPLY | 14.00 |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY | 16.00 |
| 17. 00 01700 SOCIAL SERVICE | 17.00 |
| INPATIENT ROUTINE SERVICE COST CENTERS | - 17.00 |
| 30. 00 03000 ADULTS & PEDIATRICS 4, 436, 808 | 30.00 |
| | 44.00 |
| 44. 00 04400 SKILLED NURSING FACILITY 3, 073, 093 ANCILLARY SERVICE COST CENTERS | 44.00 |
| 50. 00 05000 OPERATING ROOM 481 | 50.00 |
| 54. 00 05400 RADI 0LOGY-DI AGNOSTI C 86, 325 | 54.00 |
| 60. 00 06000 LABORATORY 258, 980 | 60.00 |
| 64. 00 06400 I NTRAVENOUS THERAPY 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY 466, 177 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY 3, 343, 374 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY 2, 009, 505 | 67.00 |
| | 68.00 |
| 68. 00 06800 SPEECH PATHOLOGY 965, 775 69. 00 06900 ELECTROCARDI OLOGY 293 | 69.00 |
| 70. 00 07000 ELECTROEARDI OLOGY 293 | 70.00 |
| 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 294, 643 | 70.00 |
| | 73.00 |
| 73. 00 07300 DRUGS CHARGED TO PATI ENTS 870, 392 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 392, 795 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | - 70.00 |
| 88. 00 08800 RURAL HEALTH CLINIC 0 | 88.00 |
| 91. 00 09100 EMERGENCY 0 | 91.00 |
| 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | _ 72.00 |
| 99. 00 09900 CMHC 0 | 99.00 |
| SPECIAL PURPOSE COST CENTERS | _ **.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1-117) 16, 198, 641 | 118.00 |
| NONREI MBURSABLE COST CENTERS | |
| 194. 00 07950 OTHER NRCC 128, 143 | 194.00 |
| 200.00 Cross Foot Adjustments 0 | 200.00 |
| 201.00 Negative Cost Centers 0 | 200.00 |
| 202.00 TOTAL (sum lines 118-201) 16, 326, 784 | 201.00 |
| | |

| | Financial Systems SC TION OF CAPITAL RELATED COSTS | OUTHERN INDIANA | | | eriod: | u of Form CMS-: Worksheet B | 2552- |
|---------|---|-----------------|--------------|-------------|----------------|--------------------------------|-------|
| 00A | TION OF CAPITAL RELATED COSTS | | FIOVICEI | | rom 01/01/2014 | Part II | |
| | | | | T | | Date/Time Pre | |
| | | | CAPI TAL REL | ATED COSTS | | 5/27/2015 8:4 | 12 am |
| | | | CAPITAL REL | LATED CUSTS | | | |
| | Cost Center Description | Di rectl y | BLDG & FIXT | MVBLE EQUIP | Subtotal | EMPLOYEE | |
| | | Assigned New | 5250 a 11/11 | | oubrotai | BENEFITS | |
| | | Capi tal | | | | DEPARTMENT | |
| | | Related Costs | | | | | |
| | | 0 | 1.00 | 2.00 | 2A | 4.00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1.0 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2.0 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 0 | | 0 | 0 | 0 | 4.0 |
| 5.00 | 00500 ADMI NI STRATI VE & GENERAL | 0 | 189, 675 | 136, 870 | 326, 545 | 0 | 5.0 |
| 5.00 | 00600 MAI NTENANCE & REPAI RS | 0 | 0 | 0 | 0 | 0 | 6.0 |
| 3. 00 | 00800 LAUNDRY & LINEN SERVICE | 0 | 0 | 0 | 0 | 0 | |
| 9.00 | 00900 HOUSEKEEPI NG | 0 | 0 | 0 | 0 | 0 | 9.0 |
| 0.00 | 01000 DI ETARY | 0 | 36, 984 | 26, 688 | 63, 672 | 0 | 10.0 |
| | 01400 CENTRAL SERVICE & SUPPLY | 0 | 0 | 0 | 0 | 0 | 14.0 |
| 6.00 | 01600 MEDICAL RECORDS & LIBRARY | 0 | 0 | 0 | 0 | 0 | 16.0 |
| 7.00 | 01700 SOCIAL SERVICE | 0 | 0 | 0 | 0 | 0 | 17.0 |
| ľ | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | 0 | | 44, 480 | 106, 120 | 0 | |
| 4.00 | 04400 SKILLED NURSING FACILITY | 0 | 69, 419 | 50, 093 | 119, 512 | 0 | 44.0 |
| ľ | ANCILLARY SERVICE COST CENTERS | 1 | | | 1 | | |
| 50.00 | 05000 OPERATING ROOM | 0 | - | 0 | 0 | 0 | |
| 4.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0 | | 1, 505 | 3, 590 | 0 | |
| 0.00 | 06000 LABORATORY | 0 | ., | 1, 111 | 2, 651 | 0 | |
| 4.00 | 06400 I NTRAVENOUS THERAPY | 0 | 0 | 0 | 0 | 0 | |
| 5.00 | 06500 RESPI RATORY THERAPY | 0 | 869 | 627 | 1, 496 | 0 | |
| | 06600 PHYSI CAL THERAPY | 0 | 111, 923 | 80, 765 | 192, 688 | 0 | |
| | 06700 OCCUPATI ONAL THERAPY | 0 | | 59, 935 | 142, 993 | 0 | |
| 8.00 | 06800 SPEECH PATHOLOGY | 0 | 5, 299 | 3, 824 | 9, 123 | 0 | |
| | 06900 ELECTROCARDI OLOGY | 0 | 0 | 0 | 0 | 0 | |
| | 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | 0 | 0 | 0 | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | 1 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0 | ., .== | 1, 026 | 2, 448 | 0 | |
| 6.00 | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | 3, 372 | 2, 433 | 5, 805 | 0 | 76. |
| | OUTPATIENT SERVICE COST CENTERS | | | 0 | | | |
| | 08800 RURAL HEALTH CLINIC | 0 | | 0 | 0 | 0 | |
| | 09100 EMERGENCY | 0 | 0 | 0 | 0 | 0 | |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | 0 | | 92.0 |
| | OTHER REIMBURSABLE COST CENTERS | 0 | 0 | 0 | 0 | 0 | |
| 9.00 | SPECIAL PURPOSE COST CENTERS | 0 | 0 | 0 | U | 0 | 99.0 |
|) | | 0 | 567, 286 | 409, 357 | 976, 643 | 0 | 118. |
| 10 00 | NONREIMBURSABLE COST CENTERS | 0 | 507,280 | 409, 357 | 970, 043 | 0 | 1110. |
| 18. 00 | | - | 0 | 0 | 0 | 0 | 194. |
| | | ∩ | | | | | |
| 94.00 | 07950 OTHER NRCC | 0 | 0 | 0 | - | 0 | |
| 200. 00 | 07950 OTHER NRCC Cross Foot Adjustments | 0 | 0 | 0 | 0 | | 200. |
| 94.00 | 07950 OTHER NRCC Cross Foot Adjustments Negative Cost Centers | 0 | 0 | 0 | - | 0 | |

| Heal th | Financial Systems SC | OUTHERN INDIANA | REHAB HOSPI TAI | _ | In Lie | u of Form CMS-: | 2552-10 |
|---------|--|------------------|-----------------|--------------|-----------------|--------------------------------|---------|
| | TION OF CAPITAL RELATED COSTS | | Provi der | CCN: 153037 | Peri od: | Worksheet B | |
| | | | | | From 01/01/2014 | Part II | |
| | | | | | To 12/31/2014 | Date/Time Pre 5/27/2015 8:4 | epared: |
| | Cost Center Description | ADMI NI STRATI V | MAINTENANCE & | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | |
| | | E & GENERAL | REPAI RS | LINEN SERVIC | | 51217.00 | |
| | | 5.00 | 6.00 | 8.00 | 9.00 | 10.00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5.00 | 00500 ADMINI STRATI VE & GENERAL | 326, 545 | | | | | 5.00 |
| 6.00 | 00600 MAI NTENANCE & REPAI RS | 16, 613 | 16, 613 | | | | 6.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 489 | 0 | 48 | 39 | | 8.00 |
| 9.00 | 00900 HOUSEKEEPI NG | 6, 728 | 0 | - | 5 6,743 | | 9.00 |
| 10.00 | 01000 DI ETARY | 18, 811 | 1, 627 | - | 5 626 | 84, 751 | 10.00 |
| 14.00 | 01400 CENTRAL SERVICE & SUPPLY | 1,052 | 0 | | 0 0 | 0 | 14.00 |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | 3, 118 | 0 | | 0 26 | 0 | 16.00 |
| 17.00 | 01700 SOCIAL SERVICE | 22, 287 | 0 | | 0 56 | 0 | 17.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | 1 |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | 58, 701 | 2, 712 | 24 | 4, 545 | 40, 597 | 30.00 |
| 44.00 | 04400 SKILLED NURSING FACILITY | 34, 260 | 3, 054 | 12 | 22 0 | 44, 154 | 44.00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | 1 |
| 50.00 | 05000 OPERATING ROOM | 10 | 0 | | 0 0 | 0 | 50.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 1, 621 | 92 | | 0 14 | 0 | 54.00 |
| 60.00 | 06000 LABORATORY | 5, 112 | 68 | | 0 0 | 0 | 60.00 |
| 64.00 | 06400 INTRAVENOUS THERAPY | 0 | 0 | | 0 0 | 0 | 64.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 9, 250 | 38 | | 0 36 | 0 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 60, 879 | 4, 924 | | 997 | 0 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 36, 222 | 3, 654 | | 289 | 0 | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 19, 033 | 233 | | 0 50 | 0 | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 6 | 0 | | 0 0 | 0 | 69.00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 0 0 | 0 | 70.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 4, 841 | 0 | | 0 0 | 0 | 71.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 17, 337 | 63 | | 0 9 | 0 | 73.00 |
| 76.00 | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 7,612 | 148 | | 0 95 | 0 | 76.00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 | 08800 RURAL HEALTH CLINIC | 0 | 0 | | 0 0 | 0 | 88.00 |
| 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 | | | | | | |
| 99.00 | 09900 CMHC | 0 | 0 | | 0 0 | 0 | 99.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 118.00 | | 323, 982 | 16, 613 | 48 | 6, 743 | 84, 751 | 118.00 |
| | NONREI MBURSABLE COST CENTERS | | | | | | |
| | 07950 OTHER NRCC | 2, 563 | 0 | | 0 0 | 0 | 194.00 |
| 200.00 | | | | | | | 200.00 |
| 201.00 | 5 | 0 | 0 | | 0 0 | | 201.00 |
| 202.00 | TOTAL (sum lines 118-201) | 326, 545 | 16, 613 | 48 | 6, 743 | 84, 751 | 202.00 |
| | | | | | | | |

| Heal th | Financial Systems SOU | UTHERN INDIANA | REHAB HOSPI TAI | L | In Lie | u of Form CMS-: | 2552-10 |
|---|---|---------------------------------|-----------------------------------|---------------------|---|---|---|
| ALLOCA | TION OF CAPITAL RELATED COSTS | | Provi der | CCN: 153037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Pre 5/27/2015 8:4 | |
| | Cost Center Description | CENTRAL SERVI CE & SUPPLY | MEDI CAL RECORDS & LI BRARY | SOCI AL SERVI CE | Subtotal | Intern & Residents Cost & Post Stepdown Adjustments | |
| | | 14.00 | 16.00 | 17.00 | 24.00 | 25.00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 2.00 4.00 5.00 6.00 | 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS | | | | | | 1.00 2.00 4.00 5.00 6.00 |
| 8.00 9.00 10.00 14.00 16.00 | 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01400 CENTRAL SERVI CE & SUPPLY 01600 MEDI CAL RECORDS & LI BRARY | 1, 052 0 | 3, 144 | | | | 8.00 9.00 10.00 14.00 16.00 |
| 17.00 | 01700 SOCIAL SERVICE | 0 | 3, 144 | 22, 34 | 12 | | 17.00 |
| 17.00 | INPATIENT ROUTINE SERVICE COST CENTERS | UU | 0 | 22, 32 | 1.5 | | 17.00 |
| 30.00 | 03000 ADULTS & PEDIATRICS | 0 | 1, 535 | 10, 90 | 225, 361 | 0 | 30.00 |
| 44.00 | 04400 SKILLED NURSING FACILITY | 0 | 1, 609 | | | 0 | |
| 44.00 | ANCI LLARY SERVICE COST CENTERS | 0 | 1,007 | 11, 4 | 214, 147 | 0 | 44.00 |
| 50.00 | 05000 OPERATING ROOM | 0 | 0 | 1 | 0 10 | 0 | 50.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | 0 5, 317 | 0 | |
| 60.00 | 06000 LABORATORY | 0 | 0 | | 0 7,831 | 0 | |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 0 | 0 | | 0 7,031 | 0 | |
| 65.00 | 06500 RESPIRATORY THERAPY | 0 | 0 | | 0 10, 820 | 0 | |
| 66,00 | 06600 PHYSI CAL THERAPY | 0 | 0 | | .0,020 | 0 | |
| | | 0 | 0 | | | 0 | |
| 67.00 | 06700 OCCUPATIONAL THERAPY | 0 | 0 | | | - | |
| 68.00 | 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 28, 439 | 0 | |
| 69.00 | | 0 | 0 | | | 0 | |
| | 07000 ELECTROENCEPHALOGRAPHY | | 0 | | | 0 | |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 1, 052 | 0 | | 0 5, 893 | 0 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 19,857 | 0 | |
| 76.00 | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | 0 | | 0 13, 660 | 0 | 76.00 |
| 00.00 | OUTPATIENT SERVICE COST CENTERS | | | 1 | | | |
| 88.00 | 08800 RURAL HEALTH CLINIC | 0 | 0 | | 0 0 | 0 | |
| 91.00 | 09100 EMERGENCY | 0 | 0 | | 0 0 | 0 | |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS | | | | | 0 | 92.00 |
| 99.00 | 09900 CMHC SPECIAL PURPOSE COST CENTERS | 0 | 0 | | 0 0 | 0 | 99.00 |
| 118.00 | | 1, 052 | 3, 144 | 22, 34 | 974, 080 | 0 | 118.00 |
| 110.00 | NONREIMBURSABLE COST CENTERS | 1, 002 | 5, 144 | 22, 3 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 0 | 1 10.00 |
| 194 00 | 07950 OTHER NRCC | 0 | 0 | | 0 2, 563 | 0 | 194.00 |
| 200.00 | | | 0 | | 0 2, 303 | | 200.00 |
| 200.00 | 5 | | 0 | | | | 200.00 |
| 201.00 | 5 | 1, 052 | 3, 144 | 22, 34 | 976, 643 | | 201.00 |
| 202.00 | | 1,002 | 5, 144 | 1 22, 32 | , , , , , , , , , , , , , , , , , , , | 0 | 1202.00 |

Health Financial Systems

| SOUTHERN | I NDI ANA | REHAB | HOSPI TAL |
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In Lieu of Form CMS-2552-10

| | | JUTHERN TNDIANA F | | In Lieu of Form CMS- | -2552-10 |
|---------------|--|-------------------|----------------------|--|------------------|
| ALLOCA | TTION OF CAPITAL RELATED COSTS | | Provider CCN: 153037 | Peri od: Worksheet B From 01/01/2014 Part II To 12/31/2014 Date/Time Pri 5/27/2015 | epared: 42 am |
| | 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 |
| 5.00 | 00500 ADMI NI STRATI VE & GENERAL | | | | 5.00 |
| 6.00 | 00600 MAINTENANCE & REPAIRS | | | | 6.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | | | | 8.00 |
| 9.00 | 00900 HOUSEKEEPI NG | | | | 9.00 |
| 10.00 | 01000 DI ETARY | | | | 10.00 |
| 14.00 | 01400 CENTRAL SERVICE & SUPPLY | | | | 14.00 |
| 16.00 | 01600 MEDI CAL RECORDS & LI BRARY | | | | 16.00 |
| | 01700 SOCI AL SERVI CE | | | | 17.00 |
| 17.00 | INPATIENT ROUTINE SERVICE COST CENTERS | 1 | | | - 17.00 |
| 30.00 | 03000 ADULTS & PEDIATRICS | 225, 361 | | | 30.00 |
| 44.00 | 04400 SKI LLED NURSI NG FACI LI TY | 214, 147 | | | 44.00 |
| 44.00 | ANCI LLARY SERVICE COST CENTERS | 214,147 | | | |
| 50.00 | 05000 OPERATING ROOM | 10 | | | 50.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 5, 317 | | | 54.00 |
| 60.00 | 06000 LABORATORY | 7, 831 | | | 60.00 |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 7,031 | | | 64.00 |
| 65.00 | 06500 RESPIRATORY THERAPY | 10, 820 | | | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 259, 555 | | | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 183, 184 | | | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 28, 439 | | | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 20, 439 | | | 69.00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 0 | | | 70.00 |
| 70.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 5, 893 | | | 71.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 19, 857 | | | 73.00 |
| | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 13, 660 | | | 76.00 |
| 70.00 | OUTPATIENT SERVICE COST CENTERS | 13,000 | | | /0.00 |
| 88.00 | 08800 RURAL HEALTH CLINIC | 0 | | | 88.00 |
| 91.00 | 09100 EMERGENCY | 0 | | | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | | | 92.00 |
| 72.00 | OTHER REIMBURSABLE COST CENTERS | | | | 92.00 |
| 99.00 | 09900 CMHC | 0 | | | 99.00 |
| <i>77</i> .00 | SPECIAL PURPOSE COST CENTERS | 0 | | | 77.00 |
| 118.00 | | 974, 080 | | | 118.00 |
| 110.00 | NONREI MBURSABLE COST CENTERS | 774,000 | | | |
| 10/ 00 | 07950 OTHER NRCC | 2, 563 | | | 194.00 |
| 200.00 | | 2, 303 | | | 200.00 |
| 200.00 | | 0 | | | 200.00 |
| 201.00 | 5 | 976, 643 | | | 201.00 |
| 202.00 | | 770,043 | | | 1202.00 |
| | | | | | |

| OST A | LLOCATION - STATISTICAL BASIS | | Provid | der | | Period: | Worksheet B-1 | |
|--------|--|--|-------------|-----|----------------------|-----------------|--------------------------------|------|
| 001 // | | | 110010 | | 1 | From 01/01/2014 | | |
| | | | | | - | To 12/31/2014 | Date/Time Pre 5/27/2015 8:4 | |
| | | CAPI TAL REI | LATED COSTS | | | | 0/2//2013 0.4 | |
| | | | | | | | | |
| | Cost Center Description | BLDG & FIXT | MVBLE EQUI | | EMPLOYEE | Reconciliatio | | |
| | | (SQUARE FEET) | (SQUARE FEI | EI) | BENEFITS | n | E & GENERAL | |
| | | | | | DEPARTMENT (GROSS | | (ACCUM. COST) | |
| | | | | | SALARI ES) | | | |
| | | 1.00 | 2.00 | | 4.00 | 5A | 5.00 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | |
| | 00100 CAP REL COSTS-BLDG & FIXT | 71, 831 | | | | | | 1. |
| . 00 | 00200 CAP REL COSTS-MVBLE EQUIP | | 71, | 831 | | | | 2. |
| . 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 0 | | 0 | 9, 185, 67 | | | 4. |
| . 00 | 00500 ADMINI STRATI VE & GENERAL | 24, 017 | 24, | 017 | 353, 440 | | 14, 296, 519 | |
| . 00 | 00600 MAINTENANCE & REPAIRS | 0 | | 0 | 247, 568 | | 727, 336 | |
| . 00 | 00800 LAUNDRY & LINEN SERVICE | 0 | | 0 | 17,633 | | 21, 393 | |
| . 00 | 00900 HOUSEKEEPI NG | 0 | | 0 | 218, 80 | | 294, 541 | |
| | 01000 DI ETARY | 4, 683 | 4, | 683 | 274,008 | | 823, 573 | |
| | 01400 CENTRAL SERVICE & SUPPLY | 0 | | 0 | 33, 982 | | 46, 058 | |
| | 01600 MEDICAL RECORDS & LIBRARY | 0 | | 0 | 108, 874 | | 136, 506 | |
| 7.00 | 01700 SOCI AL SERVI CE | 0 | | 0 | 760, 67 | 5 0 | 975, 726 | 17 |
| 0 00 | INPATIENT ROUTINE SERVICE COST CENTERS | 7.005 | | 005 | 1 015 000 | | 0.5(0.00) | 1 |
| | 03000 ADULTS & PEDIATRICS | 7,805 | | 805 | 1, 915, 982 | | 2, 569, 986 | |
| | 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS | 8, 790 | 8, | 790 | 1, 052, 790 | 0 0 | 1, 499, 954 | 44 |
| | 05000 OPERATING ROOM | 0 | 1 | 0 | | 0 0 | 421 | 50 |
| | 05400 RADI OLOGY-DI AGNOSTI C | 264 | | 264 | | 0 0 | 70, 970 | |
| | 06000 LABORATORY | 195 | | 195 | | 0 0 | 223, 809 | |
| | 06400 INTRAVENOUS THERAPY | 0 | | 195 | (| - | 223, 809 | |
| | 06500 RESPIRATORY THERAPY | 110 | | 110 | 44, 044 | 0 | 404, 959 | |
| | 06600 PHYSI CAL THERAPY | 14, 172 | | 172 | 2, 069, 819 | | 2, 665, 460 | |
| | 06700 OCCUPATI ONAL THERAPY | 10, 517 | | 517 | 1, 160, 762 | | 1, 585, 828 | |
| | 06800 SPEECH PATHOLOGY | 671 | | 671 | 671, 428 | | 833, 293 | |
| | 06900 ELECTROCARDI OLOGY | 0/1 | | 0/1 | 071, 420 | | 257 | |
| | 07000 ELECTROENCEPHALOGRAPHY | 0 | | o | (| - | 237 | |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | | o | (| - | 211, 945 | |
| | 07300 DRUGS CHARGED TO PATIENTS | 180 | | 180 | | 0 0 | 759, 016 | |
| | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 427 | | 427 | 255, 859 | | 333, 280 | |
| | OUTPATIENT SERVICE COST CENTERS | | 1 | | , | · | | |
| | 08800 RURAL HEALTH CLINIC | 0 | | 0 | (| 0 0 | 0 | 88 |
| | 09100 EMERGENCY | 0 | | 0 | (| 0 0 | 0 | 91 |
| 2.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | | 92 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| | 09900 CMHC | 0 | | 0 | (| 0 0 | 0 | 99 |
| | SPECIAL PURPOSE COST CENTERS | 1 | | | | | | 4 |
| 18.00 | SUBTOTALS (SUM OF LINES 1-117) | 71, 831 | 71, | 831 | 9, 185, 67 | 7 -2, 030, 265 | 14, 184, 311 | 118 |
| | NONREI MBURSABLE COST CENTERS | 0 | 1 | 0 | | | 110.000 | |
| | 07950 OTHER NRCC | 0 | | 0 | (| 0 0 | 112,200 | |
| 00.00 | 3 | | | | | | | 200. |
| 01.00 | Negative Cost Centers | - (- , - | | | 4 959 74 | | | 201 |
| 02.00 | Cost to be allocated (per Wkst. B, | 567, 286 | 409, | 357 | 1, 958, 710 | U | 2, 030, 265 | 202 |
| 00.00 | Part I) | 7 0075 | | | 0 010 | _ | 0.1.00 | 000 |
| 03.00 | Unit cost multiplier (Wkst. B, Part I) | 7. 897509 | 5. 698 | 890 | 0. 21323 | | 0. 142011 | |
| 04.00 | Cost to be allocated (per Wkst. B, | | | | (| J | 326, 545 | 204 |
| | Part II) Unit cost multiplier (Wkst. B, Part | | | | | | | 0.05 |
| 05.00 | | | | | 0.00000 | | 0. 022841 | |

| Heal th | Financial Systems S0 | UTHERN INDIANA | REHAB HOSPI TAI | L | In Lie | u of Form CMS- | 2552-10 |
|---------|--|----------------|-----------------|---------------|-----------------|----------------|---------|
| | LLOCATION - STATISTICAL BASIS | | Provi der | CCN: 153037 | Peri od: | Worksheet B-1 | |
| | | | | | From 01/01/2014 | | |
| | | | | | To 12/31/2014 | | |
| | | | | | | 5/27/2015 8:4 | 2 am |
| | Cost Center Description | MAINTENANCE & | LAUNDRY & | HOUSEKEEPI NG | | CENTRAL | |
| | | REPAIRS | LINEN SERVICE | | (MEALS | SERVICE & | |
| | | (SQUARE FEET) | (POUNDS OF | SERVI CE) | SERVED) | SUPPLY | |
| | | | LAUNDRY) | | | (COSTED | |
| | | (00 | 0.00 | 0.00 | 10.00 | REQUIS.) | |
| | GENERAL SERVICE COST CENTERS | 6.00 | 8.00 | 9.00 | 10.00 | 14.00 | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5.00 | 00500 ADMI NI STRATI VE & GENERAL | | | | | | 5.00 |
| 6,00 | 00600 MAI NTENANCE & REPAI RS | 47, 814 | | | | | 6.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 0 | 46, 732 | | | | 8.00 |
| 9.00 | 00900 HOUSEKEEPI NG | 0 | 1, 402 | | 15 | | 9.00 |
| | 01000 DI ETARY | Ŭ | | | | | 10.00 |
| | | 4, 683 | 1, 402 | | | 100 | |
| | 01400 CENTRAL SERVICE & SUPPLY | 0 | 0 | | 0 0 | 100 | |
| | 01600 MEDICAL RECORDS & LIBRARY | 0 | 0 | - | | 0 | |
| 17.00 | 01700 SOCI AL SERVI CE | 0 | 0 | 67 | 5 0 | 0 | 17.00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| | 03000 ADULTS & PEDIATRICS | 7, 805 | 23, 366 | | | 0 | |
| 44.00 | 04400 SKILLED NURSING FACILITY | 8, 790 | 11, 683 | | 0 25, 739 | 0 | 44.00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATING ROOM | 0 | 0 |) | 0 0 | 0 | 50.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 264 | 0 | 16 | 5 0 | 0 | 54.00 |
| 60.00 | 06000 LABORATORY | 195 | 0 | | 0 0 | 0 | 60.00 |
| 64.00 | 06400 INTRAVENOUS THERAPY | 0 | l o | | 0 0 | 0 | 64.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 110 | 0 | 43 | 0 0 | 0 | 1 |
| | 06600 PHYSI CAL THERAPY | 14, 172 | 6, 393 | | | 0 | 1 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 10, 517 | 2, 486 | | | 0 | 1 |
| | 06800 SPEECH PATHOLOGY | 671 | 0 | 59 | | 0 | |
| | 06900 ELECTROCARDI OLOGY | 0,1 | 0 | 1 | 0 0 | 0 | |
| | 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 0 0 | 0 | 1 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 0 | 100 | 1 |
| | 07300 DRUGS CHARGED TO PATIENTS | 180 | | 11 | | 0 | 1 |
| 76.00 | 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 427 | 0 | | | 0 | 1 |
| 76.00 | | 427 | 0 | 1, 14 | 0 0 | 0 | /0.00 |
| ~~~~~ | OUTPATIENT SERVICE COST CENTERS | | | 1 | | | |
| 88.00 | 08800 RURAL HEALTH CLINIC | 0 | 0 | | 0 0 | 0 | 1 |
| | 09100 EMERGENCY | 0 | 0 | | 0 0 | 0 | |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | 1 | | 1 | | | |
| 99.00 | 09900 CMHC | 0 | 0 | | 0 0 | 0 | 99.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 118.00 | | 47, 814 | 46, 732 | 80, 60 | 49, 404 | 100 | 118.00 |
| | NONREIMBURSABLE COST CENTERS | | | | | | |
| 194.00 | 07950 OTHER NRCC | 0 | 0 | | 0 0 | 0 | 194.00 |
| 200.00 | Cross Foot Adjustments | | | | | | 200.00 |
| 201.00 | Negative Cost Centers | | | | | | 201.00 |
| 202.00 | | 830, 626 | 24, 431 | 337, 10 | 1, 053, 918 | 52 599 | 202.00 |
| 202.00 | Part I) | 0007020 | 2.17.101 | | 1,000,710 | 02,077 | 202100 |
| 203.00 | | 17. 372025 | 0. 522790 | 4. 18214 | 8 21. 332645 | 525. 990000 | 203.00 |
| 203.00 | | 16, 613 | 489 | | | | 204.00 |
| 204.00 | Part II) | 10,013 | 407 | 0,74 | .5 04,751 | 1, 032 | 204.00 |
| 205.00 | | 0. 347451 | 0. 010464 | 0. 08365 | 5 1. 715468 | 10. 520000 | 205 00 |
| 200.00 | | 0. 347431 | 0.010404 | 0.00303 | 1.713400 | 10. 020000 | 200.00 |
| | | I | I | I | 1 | | 1 |

| Health Financial Systems SO | UTHERN INDIANA | REHAB HOSPITAL | | In Lieu of Form CM | MS-2552-10 |
|--|----------------|----------------|-------------|-------------------------|------------|
| COST ALLOCATION - STATISTICAL BASIS | | | CCN: 153037 | Period: Worksheet | |
| | | | | From 01/01/2014 | |
| | | | | To 12/31/2014 Date/Time | |
| Cost Center Description | MEDI CAL | SOCIAL | | 5/27/2015 | 8:42 am |
| cost center bescription | RECORDS & | SERVI CE | | | |
| | LIBRARY | (TOTAL | | | |
| | | · · · | | | |
| | | PATIENT DAYS) | | | |
| | PATIENT DAYS) | 17.00 | | | |
| | 16.00 | 17.00 | | | |
| GENERAL SERVICE COST CENTERS | 1 | | | | 1 00 |
| 1.00 00100 CAP REL COSTS-BLDG & FIXT | | | | | 1.00 |
| 2.00 00200 CAP REL COSTS-MVBLE EQUIP | | | | | 2.00 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | 4.00 |
| 5. 00 00500 ADMI NI STRATI VE & GENERAL | | | | | 5.00 |
| 6.00 00600 MAINTENANCE & REPAIRS | | | | | 6.00 |
| 8.00 00800 LAUNDRY & LINEN SERVICE | | | | | 8.00 |
| 9. 00 00900 HOUSEKEEPI NG | | | | | 9.00 |
| 10. 00 01000 DI ETARY | | | | | 10.00 |
| 14.00 01400 CENTRAL SERVICE & SUPPLY | | | | | 14.00 |
| 16.00 01600 MEDICAL RECORDS & LIBRARY | 15, 126 | | | | 16.00 |
| 17.00 01700 SOCIAL SERVICE | 0 | 15, 126 | | | 17.00 |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 7, 384 | 7, 384 | | | 30.00 |
| 44.00 04400 SKILLED NURSING FACILITY | 7, 742 | 7,742 | | | 44.00 |
| ANCI LLARY SERVICE COST CENTERS | ., | ., | | | |
| 50. 00 05000 OPERATING ROOM | 0 | 0 | | | 50.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | | 54.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | | | 60.00 |
| 64. 00 06400 I NTRAVENOUS THERAPY | 0 | 0 | | | 64.00 |
| | 0 | 0 | | | 65.00 |
| | 0 | | | | |
| 66.00 06600 PHYSI CAL THERAPY | а С | 0 | | | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | | 71.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | | 73.00 |
| 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | 0 | | | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | | | 88.00 |
| 91.00 09100 EMERGENCY | 0 | 0 | | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | |
| 99.00 09900 CMHC | 0 | 0 | | | 99.00 |
| SPECIAL PURPOSE COST CENTERS | | | | | |
| 118.00 SUBTOTALS (SUM OF LINES 1-117) | 15, 126 | 15, 126 | | | 118.00 |
| NONREI MBURSABLE COST CENTERS | | | | | |
| 194. 00 07950 OTHER NRCC | 0 | 0 | | | 194.00 |
| 200.00 Cross Foot Adjustments | | 0 | | | 200.00 |
| 201.00 Negative Cost Centers | | | | | 200.00 |
| 202.00 Cost to be allocated (per Wkst. B, | 157, 208 | 1 117 110 | | | 201.00 |
| Part I) | 157,208 | 1, 117, 113 | | | 202.00 |
| 203.00 Unit cost multiplier (Wkst. B, Part I) | 10. 393230 | 73. 853828 | | | 203.00 |
| | 1 | | | | |
| | 3, 144 | 22, 343 | | | 204.00 |
| Part II) 205.00 Unit cost multiplier (Wkst. B, Part | 0. 207854 | 1. 477125 | | | 205.00 |
| 205.00 Unit cost multiplier (Wkst. B, Part | 0. 207854 | 1.4//125 | | | 205.00 |
| | I | 1 | | | I |

| Health Financial Systems | SC | OUTHERN INDIANA | REHAB HOSPI TA | _ | In Lie | u of Form CMS-: | 2552-10 |
|---------------------------------|---------------------|---------------------------------------|-----------------------|-------------|---|-----------------|---------|
| COMPUTATION OF RATIO OF COSTS | TO CHARGES | | | | Period: From 01/01/2014 To 12/31/2014 | 5/27/2015 8:4 | |
| | | 1 | Titl | e XVIII | Hospi tal | PPS | |
| | | | | | Costs | | |
| Cost Center Descri | i pti on | (from Wkst. B, Part I, col. 26) | Therapy Limit Adj. | Total Costs | Di sal I owance | Total Costs | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| INPATIENT ROUTINE SERVI | CE COST CENTERS | | | | | | |
| 30.00 03000 ADULTS & PEDIATRI | CS | 4, 436, 808 | | 4, 436, 80 | 0 8 | 4, 436, 808 | 30.00 |
| 44.00 04400 SKILLED NURSING FA | ACILITY | 3, 073, 093 | | 3, 073, 09 | 03 0 | 3, 073, 093 | 44.00 |
| ANCILLARY SERVICE COST | CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | | 481 | | 48 | 31 0 | 481 | 50.00 |
| 54.00 05400 RADI OLOGY-DI AGNOS | TIC | 86, 325 | | 86, 32 | 25 0 | 86, 325 | 54.00 |
| 60.00 06000 LABORATORY | | 258, 980 | | 258, 98 | 30 0 | 258, 980 | 60.00 |
| 64.00 06400 INTRAVENOUS THERA | PY | 0 | | | 0 0 | 0 | 64.00 |
| 65.00 06500 RESPI RATORY THERA | PY | 466, 177 | 0 | 466, 17 | 7 0 | 466, 177 | 65.00 |
| 66.00 06600 PHYSI CAL THERAPY | | 3, 343, 374 | 0 | 3, 343, 37 | 74 0 | 3, 343, 374 | 66.00 |
| 67.00 06700 OCCUPATIONAL THER | APY | 2,009,505 | 0 | 2,009,50 | 05 0 | 2,009,505 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | | 965, 775 | 0 | 965, 77 | 75 0 | 965, 775 | 68.00 |
| 69.00 06900 ELECTROCARDI OLOGY | | 293 | | 29 | 03 0 | 293 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGI | RAPHY | 0 | | | 0 0 | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES (| CHARGED TO PATIENTS | 294, 643 | | 294, 64 | 3 0 | 294, 643 | 71.00 |
| 73.00 07300 DRUGS CHARGED TO I | PATI ENTS | 870, 392 | | 870, 39 | 02 0 | 870, 392 | 73.00 |
| 76.00 03550 PSYCHI ATRI C/PSYCH | OLOGI CAL SERVI CES | 392, 795 | | 392, 79 | 95 0 | 392, 795 | 76.00 |
| OUTPATIENT SERVICE COST | CENTERS | · | | | | | 1 |
| 88.00 08800 RURAL HEALTH CLIN | IC | 0 | | | 0 0 | 0 | 88.00 |
| 91.00 09100 EMERGENCY | | 0 | | | 0 0 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS | (NON-DISTINCT PART) | 0 | | | 0 | 0 | 92.00 |
| OTHER REIMBURSABLE COST | CENTERS | | | | | | 1 |
| 99.00 09900 CMHC | | 0 | | | 0 | 0 | 99.00 |
| 200.00 Subtotal (see ins | tructions) | 16, 198, 641 | 0 | 16, 198, 64 | 1 0 | 16, 198, 641 | 200.00 |
| 201.00 Less Observation I | | 0 | | | 0 | 0 | 201.00 |
| 202.00 Total (see instru | ctions) | 16, 198, 641 | C | 16, 198, 64 | 1 0 | 16, 198, 641 | 202.00 |
| | | | • | | | | |

| Health Financial Systems S | OUTHERN INDIANA | REHAB HOSPI TAI | | In Lie | u of Form CMS- | 2552-10 |
|--|-----------------|-----------------|-------------|---|--------------------------------|------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provi der | | Period: From 01/01/2014 To 12/31/2014 | Date/Time Pre 5/27/2015 8:4 | epared: 12 am |
| | | Ti tl | e XVIII | Hospi tal | PPS | |
| | | Charges | | | | |
| Cost Center Description | I npati ent | Outpati ent | Total (col. | 6 Cost or Other | TEFRA | |
| | | | + col. 7) | Ratio | I npati ent | |
| | | | | | Ratio | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 03000 ADULTS & PEDIATRICS | 12, 098, 902 | | 12, 098, 90 | 2 | | 30.00 |
| 44.00 04400 SKILLED NURSING FACILITY | 2, 706, 181 | | 2, 706, 18 | 1 | | 44.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 101, 322 | 0 | 101, 32 | 2 0.004747 | 0. 000000 | 50.00 |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 207, 612 | 0 | 207, 61 | 2 0. 415800 | 0.00000 | 54.00 |
| 60. 00 06000 LABORATORY | 2, 038, 307 | 2, 026 | 2, 040, 33 | 3 0. 126930 | 0. 000000 | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 0 | 0 | | 0 0. 000000 | 0. 000000 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 2, 158, 289 | 393, 024 | 2, 551, 31 | 3 0. 182720 | 0. 000000 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 8, 816, 125 | 9, 129, 017 | 17, 945, 14 | 2 0. 186311 | 0. 000000 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 7, 419, 211 | 2, 245, 508 | 9, 664, 71 | 9 0. 207922 | 0. 000000 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 2, 564, 920 | 2, 036, 715 | 4, 601, 63 | 5 0. 209876 | 0. 000000 | 68.00 |
| 69.00 06900 ELECTROCARDI OLOGY | 2, 841 | 0 | 2,84 | 0. 103133 | 0.00000 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 0 0.000000 | 0.00000 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 876, 809 | 637 | 877,44 | 6 0. 335796 | 0.00000 | 71.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 3, 255, 411 | 91 | 3, 255, 50 | 2 0. 267360 | 0.00000 | 73.00 |
| 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 197, 151 | 1, 499, 750 | 1, 696, 90 | 0. 231478 | 0. 000000 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | 1 |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | | 0 | | 88.00 |
| 91.00 09100 EMERGENCY | 0 | 0 | | 0 0.000000 | 0.00000 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | 0 0.000000 | 0. 000000 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | · · · | | • | | | |
| 99.00 09900 CMHC | 0 | 0 | | 0 | | 99.00 |
| 200.00 Subtotal (see instructions) | 42, 443, 081 | 15, 306, 768 | 57, 749, 84 | 9 | | 200.00 |
| 201.00 Less Observation Beds | | | | | | 201.00 |
| 202.00 Total (see instructions) | 42, 443, 081 | 15, 306, 768 | 57, 749, 84 | 9 | | 202.00 |
| | | | | 1 | | |

| j | SOUTHERN INDIANA RE | | | u of Form CMS- | 2552-10 |
|--|---------------------------------|----------------------|---|---|------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider CCN: 153037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Pre 5/27/2015 8:4 | epared: 42 am |
| | | Title XVIII | Hospi tal | PPS | |
| Cost Center Description | PPS Inpatient Ratio 11.00 | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | · · · | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | | | | | 30.00 |
| 44.00 04400 SKILLED NURSING FACILITY | | | | | 44.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | |
| 50.00 05000 OPERATING ROOM | 0. 004747 | | | | 50.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 415800 | | | | 54.00 |
| 60. 00 06000 LABORATORY | 0. 126930 | | | | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 0. 000000 | | | | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 182720 | | | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 186311 | | | | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0. 207922 | | | | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0. 209876 | | | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 103133 | | | | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0. 000000 | | | | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 335796 | | | | 71.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 267360 | | | | 73.00 |
| 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0. 231478 | | | | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | | | | | 88.00 |
| 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 |
| 200.00 Subtotal (see instructions) | | | | | 200.00 |
| 201.00 Less Observation Beds | | | | | 201.00 |
| 202.00 Total (see instructions) | | | | | 202.00 |

| Health Financial Systems Si | OUTHERN INDIANA | REHAB HOSPI TA | L | In Lie | u of Form CMS-: | 2552-10 |
|--|---|-----------------------|-------------|---|---|---------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provi der | CCN: 153037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Pre 5/27/2015 8:4 | |
| | _ | Tit | le XIX | Hospi tal | Cost | |
| | | | | Costs | | |
| Cost Center Description | Total Cost (from Wkst. B, Part I, col. 26) | Therapy Limit Adj. | Total Costs | RCE Di sal I owance | Total Costs | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 4, 436, 808 | | 4, 436, 80 | 0 8 | 4, 436, 808 | 30.00 |
| 44.00 04400 SKILLED NURSING FACILITY | 3, 073, 093 | | 3, 073, 09 | 03 0 | 3, 073, 093 | 44.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 481 | | 48 | 31 0 | 481 | 50.00 |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 86, 325 | | 86, 32 | 25 0 | 86, 325 | 54.00 |
| 60. 00 06000 LABORATORY | 258, 980 | | 258, 98 | 30 0 | 258, 980 | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 0 | | | 0 0 | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 466, 177 | 0 | 466, 17 | 7 0 | 466, 177 | 65.00 |
| 66.00 06600 PHYSI CAL THERAPY | 3, 343, 374 | 0 | 3, 343, 37 | 4 0 | 3, 343, 374 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 2, 009, 505 | 0 | 2, 009, 50 | 05 0 | 2,009,505 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 965, 775 | 0 | 965, 77 | 75 0 | 965, 775 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 293 | | 29 | 03 0 | 293 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0 | | | 0 0 | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 294, 643 | | 294, 64 | 3 0 | 294, 643 | 71.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 870, 392 | | 870, 39 | 02 0 | 870, 392 | 73.00 |
| 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 392, 795 | | 392, 79 | 95 0 | 392, 795 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | | | 0 0 | 0 | 88.00 |
| 91.00 09100 EMERGENCY | 0 | | | 0 0 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | | | 0 | 0 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | |] |
| 99.00 09900 CMHC | 0 | | | 0 | 0 | 99.00 |
| 200.00 Subtotal (see instructions) | 16, 198, 641 | 0 | 16, 198, 64 | 1 0 | 16, 198, 641 | |
| 201.00 Less Observation Beds | 0 | | | 0 | 0 | 201.00 |
| 202.00 Total (see instructions) | 16, 198, 641 | o | 16, 198, 64 | 1 0 | 16, 198, 641 | 202.00 |

| Health Financial Systems So | OUTHERN INDIANA | REHAB HOSPI TAL | - | In Lie | u of Form CMS- | 2552-10 |
|--|-----------------|-----------------|-------------|---|----------------|------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | | | Period: From 01/01/2014 To 12/31/2014 | | epared: 42 am |
| | | | le XIX | Hospi tal | Cost | |
| | | Charges | | | | |
| Cost Center Description | I npati ent | Outpati ent | | 6 Cost or Other | TEFRA | |
| | | | + col. 7) | Ratio | Inpatient | |
| | | | | | Ratio | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 12, 098, 902 | | 12, 098, 90 | 2 | | 30.00 |
| 44.00 04400 SKILLED NURSING FACILITY | 2, 706, 181 | | 2, 706, 18 | 1 | | 44.00 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 101, 322 | 0 | 101, 32 | 2 0.004747 | 0.00000 | 50.00 |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 207, 612 | 0 | 207, 61 | 2 0. 415800 | 0.00000 | 54.00 |
| 60. 00 06000 LABORATORY | 2, 038, 307 | 2, 026 | 2, 040, 33 | 3 0. 126930 | 0. 000000 | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 0 | 0 | | 0 0. 000000 | 0. 000000 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 2, 158, 289 | 393, 024 | 2, 551, 31 | 3 0. 182720 | 0. 000000 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 8, 816, 125 | 9, 129, 017 | 17, 945, 14 | 2 0. 186311 | 0. 000000 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 7, 419, 211 | 2, 245, 508 | 9, 664, 71 | 9 0. 207922 | 0.00000 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 2, 564, 920 | 2,036,715 | 4, 601, 63 | 5 0. 209876 | 0.00000 | 68.00 |
| 69.00 06900 ELECTROCARDI OLOGY | 2, 841 | 0 | 2,84 | 0. 103133 | 0. 000000 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 0 0.000000 | 0. 000000 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 876, 809 | 637 | 877, 44 | 6 0. 335796 | 0. 000000 | 71.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 3, 255, 411 | 91 | 3, 255, 50 | 2 0. 267360 | 0. 000000 | 73.00 |
| 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 197, 151 | 1, 499, 750 | 1, 696, 90 | 0. 231478 | 0. 000000 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | · · · · | | | | | 1 |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | | 0 0.000000 | 0.00000 | 88.00 |
| 91.00 09100 EMERGENCY | 0 | 0 | | 0 0.000000 | 0.00000 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | 0 0.000000 | 0.00000 | |
| OTHER REIMBURSABLE COST CENTERS | - | | | | | |
| 99.00 09900 CMHC | 0 | 0 | | 0 | | 99.00 |
| 200.00 Subtotal (see instructions) | 42, 443, 081 | 15, 306, 768 | | - | | 200.00 |
| 201.00 Less Observation Beds | ,,, | ,, | | | | 201.00 |
| 202.00 Total (see instructions) | 42, 443, 081 | 15, 306, 768 | 57, 749, 84 | 9 | | 202.00 |
| | ,,, | , 000, 700 | | - 1 | 1 | |

| Heal th Financial | | SOUTHERN INDIANA R | | | of Form CMS-2 | 552- |
|-------------------|-----------------------------------|--------------------|----------------------|---|---|-------|
| COMPUTATION OF RA | ATLO OF COSTS TO CHARGES | | Provider CCN: 153037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prep 5/27/2015 8:42 | |
| | | | Title XIX | Hospi tal | Cost | |
| Cost | Center Description | PPS Inpatient | | | | |
| | | Ratio | | | | |
| | | 11.00 | | | | |
| | ROUTINE SERVICE COST CENTERS | | | | | |
| | IS & PEDIATRICS | | | | | 30. C |
| | ED NURSING FACILITY | | | | | 44.(|
| | SERVICE COST CENTERS | | | | | |
| 50.00 05000 0PER/ | ATING ROOM | 0. 000000 | | | | 50.0 |
| |)LOGY-DI AGNOSTI C | 0. 000000 | | | | 54. |
| 0.00 06000 LABO | | 0. 000000 | | | | 60. |
| | AVENOUS THERAPY | 0. 000000 | | | | 64. |
| | RATORY THERAPY | 0. 000000 | | | | 65. |
| | CAL THERAPY | 0. 000000 | | | | 66. |
| | PATIONAL THERAPY | 0. 000000 | | | | 67. |
| 8.00 06800 SPEE | CH PATHOLOGY | 0. 000000 | | | | 68. |
| 9.00 06900 ELEC | FROCARDI OLOGY | 0. 000000 | | | | 69. |
| 0.00 07000 ELEC | FROENCEPHALOGRAPHY | 0. 000000 | | | | 70. |
| 1.00 07100 MEDI | CAL SUPPLIES CHARGED TO PATIEN | ITS 0. 000000 | | | | 71. |
| 3.00 07300 DRUG | S CHARGED TO PATIENTS | 0. 000000 | | | | 73. |
| 6.00 03550 PSYCI | H ATRI C/PSYCHOLOGI CAL SERVI CES | 0. 000000 | | | | 76. |
| OUTPATI ENT | SERVICE COST CENTERS | | | | | |
| 8. 00 08800 RURAI | _ HEALTH CLINIC | 0. 000000 | | | | 88. |
| 09100 EMER | GENCY | 0. 000000 | | | | 91. |
| 2.00 09200 0BSEI | RVATION BEDS (NON-DISTINCT PAR | CT) 0. 000000 | | | | 92. |
| OTHER REIM | BURSABLE COST CENTERS | | | | | |
| 9.00 09900 CMHC | | | | | | 99. |
| 200.00 Subto | otal (see instructions) | | | | | 200. |
| 01.00 Less | Observation Beds | | | | 2 | 201. |
| 202.00 Total | (see instructions) | | | | | 202. |

| Health Financial Systems SC | UTHERN INDIANA | REHAB HOSPI TAI | L | In Lie | u of Form CMS- | 2552-10 |
|--|----------------|-----------------|--------------|----------------------------------|----------------|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL | COSTS | Provi der | CCN: 153037 | Period: | Worksheet D | |
| | | | | From 01/01/2014 To 12/31/2014 | | pared: |
| | | | | | 5/27/2015 8:4 | 2 am |
| | | | e XVIII | Hospi tal | PPS | |
| Cost Center Description | Capi tal | Swing Bed | Reduced | Total Patient | Per Diem | |
| | Related Cost | Adjustment | Capi tal | Days | (col. 3 / | |
| | (from Wkst. | | Related Cost | t | col. 4) | |
| | B, Part II, | | (col. 1 - | | | |
| | col. 26) | | col. 2) | | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 ADULTS & PEDIATRICS | 225, 361 | 0 | 225, 36 | 51 7, 384 | 30. 52 | 30.00 |
| 44.00 SKILLED NURSING FACILITY | 214, 147 | | 214, 14 | 17 7, 742 | 27.66 | 44.00 |
| 200.00 Total (lines 30-199) | 439, 508 | | 439, 50 | 08 15, 126 | | 200.00 |
| Cost Center Description | I npati ent | I npati ent | | | | |
| | Program days | Program | | | | |
| | | Capital Cost | | | | |
| | | (col. 5 x | | | | |
| | | col. 6) | | | | |
| | 6.00 | 7.00 | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 ADULTS & PEDIATRICS | 4, 873 | 148, 724 | | | | 30.00 |
| 44.00 SKILLED NURSING FACILITY | 5, 437 | 150, 387 | | | | 44.00 |
| 200.00 Total (lines 30-199) | 10, 310 | 299, 111 | | | | 200.00 |

| Health Financial Systems SO | UTHERN INDIANA | REHAB HOSPI TAI | L | In Lie | u of Form CMS-2 | 2552-10 |
|---|----------------|-----------------|------------|---|---|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT/ | AL COSTS | Provi der | | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Pre | |
| | | Ti +1 | e XVIII | Hospi tal | 5/27/2015 8:4 PPS | 2 am |
| Cost Center Description | Capi tal | Total Charges | | | Capital Costs | |
| cost center bescription | Related Cost | (from Wkst. | to Charges | Program | (column 3 x | |
| | (from Wkst. | C, Part I, | (col. 1 ÷ | Charges | column 4) | |
| | B, Part II, | col. 8) | col. 2) | charges | | |
| | col. 26) | | | | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCILLARY SERVICE COST CENTERS | | • | • | | | |
| 50. 00 05000 OPERATI NG ROOM | 10 | 101, 322 | 0.00009 | 9 42, 799 | 4 | 50.00 |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 5, 317 | 207, 612 | 0. 02561 | 0 81, 019 | 2, 075 | 54.00 |
| 60. 00 06000 LABORATORY | 7, 831 | 2, 040, 333 | 0. 00383 | 8 711, 831 | 2, 732 | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 0 | 0 | 0. 00000 | 0 0 | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 10, 820 | 2, 551, 313 | 0.00424 | 1 705, 673 | 2, 993 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 259, 555 | 17, 945, 142 | 0. 01446 | 4 2, 973, 109 | 43, 003 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 183, 184 | 9, 664, 719 | 0. 01895 | 4 2, 685, 643 | 50, 904 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 28, 439 | 4, 601, 635 | 0. 00618 | 0 1, 259, 417 | 7, 783 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 6 | 2, 841 | 0. 00211 | 2 845 | 2 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | 0. 00000 | 0 0 | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 5, 893 | 877, 446 | 0. 00671 | 6 334, 430 | 2, 246 | 71.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 19, 857 | 3, 255, 502 | 0. 00610 | 0 1, 205, 060 | 7, 351 | 73.00 |
| 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 13, 660 | 1, 696, 901 | 0.00805 | 0 2, 526 | 20 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | 0. 00000 | 0 0 | 0 | 88.00 |
| 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) | 534, 572 | 42, 944, 766 | | 10, 002, 352 | 119, 113 | 200.00 |

| Health Financial Systems SC | OUTHERN INDIANA | REHAB HOSPI TA | L | In Lie | eu of Form CMS-: | 2552-10 |
|--|-----------------|----------------|--------------|---|------------------|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P | ASS THROUGH COS | STS Provi der | | Period: From 01/01/2014 To 12/31/2014 | | |
| | | | e XVIII | Hospi tal | PPS | |
| Cost Center Description | Nursi ng | Allied Health | All Other | Swi ng-Bed | Total Costs | |
| | School | Cost | Medi cal | Adjustment | (sum of cols. | |
| | | | Educati on | Amount (see | 1 through 3, | |
| | | | Cost | instructions) | minus col. 4) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 0 | (|) | 0 0 | 0 | 30.00 |
| 44.00 04400 SKILLED NURSING FACILITY | 0 | 0 | | 0 | 0 | 44.00 |
| 200.00 Total (lines 30-199) | 0 | 0 | | 0 | 0 | 200.00 |
| Cost Center Description | Total Patient | Per Diem | I npati ent | I npati ent | | |
| | Days | (col. 5 ÷ | Program Days | s Program | | |
| | - | col. 6) | | 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 & PEDIATRICS | 7, 384 | 0.00 | 4,87 | 3 0 | | 30.00 |
| 44.00 04400 SKILLED NURSING FACILITY | 7,742 | 0.00 | 5,43 | i7 0 | | 44.00 |
| 200.00 Total (lines 30-199) | 15, 126 | | 10, 31 | 0 0 | | 200.00 |

| Health Financial Systems SC | OUTHERN INDIANA REI | HAB HOSPITAL | _ | In Lie | u of Form CMS-2 | 2552-10 |
|--|---------------------|--------------|--------------|----------------------------------|-----------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE | RVICE OTHER PASS | Provi der | CCN: 153037 | Period: | Worksheet D | |
| THROUGH COSTS | | | | From 01/01/2014 To 12/31/2014 | | narod |
| | | | | 10 12/31/2014 | 5/27/2015 8: 4 | |
| | | Titl | e XVIII | Hospi tal | PPS | |
| Cost Center Description | Non Physician | | Allied Healt | | Total Cost | |
| | Anesthetist | School | | Medi cal | (sum of col 1 | |
| | Cost | | | Educati on | through col. | |
| | | | | Cost | 4) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCI LLARY SERVICE COST CENTERS | L | | 1 | | | |
| 50.00 05000 OPERATING ROOM | 0 | 0 | | 0 0 | 0 | 50.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | 0 0 | 0 | 54.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | | 0 0 | 0 | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 0 | 0 | | 0 0 | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 0 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 0 | 0 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 0 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 0 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 0 | 0 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 0 0 | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 0 | 0 | 71.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 0 | 0 | 73.00 |
| 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | 0 | | 0 0 | 0 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | 1 1 | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | | 0 0 | 0 | 88.00 |
| 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 SC | UTHERN INDIANA | REHAB HOSPI TAI | L | In Lie | u of Form CMS-2 | 2552-10 |
|--|-----------------|-----------------|---------------|----------------------------------|--------------------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE | RVICE OTHER PAS | S Provi der | | Period: | Worksheet D | |
| THROUGH COSTS | | | | From 01/01/2014 To 12/31/2014 | | norod. |
| | | | | 10 12/31/2014 | Date/Time Pre 5/27/2015 8:4 | |
| | | Ti tl | e XVIII | Hospi tal | PPS | 2 411 |
| Cost Center Description | Total | Total Charges | Ratio of Cost | 0utpatient | Inpati ent | |
| | Outpati ent | (from Wkst. | to Charges | Ratio of Cost | Program | |
| | Cost (sum of | C, Part I, | (col. 5 ÷ | to Charges | Charges | |
| | col. 2, 3 and | col. 8) | col. 7) | (col. 6 ÷ | | |
| | 4) | | | col. 7) | | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| ANCILLARY SERVICE COST CENTERS | 1 | - | 1 | -1 | | |
| 50.00 05000 OPERATING ROOM | 0 | 101, 322 | | | | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 207, 612 | | | | • |
| 60. 00 06000 LABORATORY | 0 | 2, 040, 333 | | | 711, 831 | • |
| 64.00 06400 INTRAVENOUS THERAPY | 0 | 0 | 0.00000 | | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 2, 551, 313 | 0.00000 | 0 0. 000000 | 705, 673 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 17, 945, 142 | | | 2, 973, 109 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | 9, 664, 719 | 0.00000 | 0 0. 000000 | 2, 685, 643 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 4, 601, 635 | 0.00000 | 0 0. 000000 | 1, 259, 417 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 2, 841 | 0.00000 | 0 0. 000000 | 845 | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | 0.00000 | 0 0. 000000 | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 877, 446 | 0.00000 | 0 0. 000000 | 334, 430 | 71.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 3, 255, 502 | 0.00000 | 0 0. 000000 | 1, 205, 060 | 73.00 |
| 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | 1, 696, 901 | 0.00000 | 0 0. 000000 | 2, 526 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | 0.00000 | 0 0. 000000 | 0 | 88.00 |
| 91.00 09100 EMERGENCY | 0 | 0 | 0.00000 | 0 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 | 42, 944, 766 | | | 10, 002, 352 | 200.00 |

| Health Financial Systems SC | OUTHERN INDIANA | REHAB HOSPI TAI | _ | In Lie | u of Form CMS- | 2552-10 |
|--|-----------------|-----------------|-------------|----------------------------------|----------------|------------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE | RVICE OTHER PAS | S Provi der | CCN: 153037 | Period: | Worksheet D | |
| THROUGH COSTS | | | | From 01/01/2014 To 12/31/2014 | | oporod. |
| | | | | To 12/31/2014 | 5/27/2015 8:4 | apareu: 42 am |
| | | Ti tl | e XVIII | Hospi tal | PPS | |
| Cost Center Description | Inpatient | Outpati ent | Outpati ent | | 1 | |
| | Program | Program | Program | | | |
| | Pass-Through | Charges | Pass-Throug | h | | |
| | Costs (col. 8 | Ũ | Costs (col. | 9 | | |
| | x col. 10) | | x col. 12) | | | |
| | 11.00 | 12.00 | 13.00 | | | |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 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 |
| 64.00 06400 INTRAVENOUS THERAPY | 0 | 0 | | 0 | | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 28, 758 | | 0 | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 2, 499 | | 0 | | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 | | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 | | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 0 | | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 | | 71.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 | | 73.00 |
| 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | 331, 181 | | 0 | | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | | 0 | | 88.00 |
| 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 | 362, 438 | | 0 | | 200.00 |
| | | | | | | |

| Health Financial Systems | SOUTHERN INDIANA | REHAB HOSPITA | L | In Lie | u of Form CMS-2 | 2552-10 |
|--|------------------|---------------|---------------|---|-----------------|---------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES | AND VACCINE COST | Provi der | | Period: From 01/01/2014 To 12/31/2014 | | |
| | | Titl | e XVIII | Hospi tal | PPS | |
| | | | Charges | | Costs | |
| Cost Center Description | Cost to | PPS | Cost | Cost | PPS Services | |
| | Charge Ratio | Reimbursed | Reimbursed | Reimbursed | (see inst.) | |
| | From | Services (see | Servi ces | Services Not | | |
| | Worksheet C, | inst.) | Subject To | Subject To | | |
| | Part I, col. | | Ded. & Coins. | Ded. & Coins. | | |
| | 9 | | (see inst.) | (see inst.) | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCILLARY SERVICE COST CENTERS | | 1 | | | | |
| 50.00 05000 OPERATING ROOM | 0. 004747 | | | 0 0 | 0 | 50.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 415800 | | | 0 0 | 0 | 54.00 |
| 60. 00 06000 LABORATORY | 0. 126930 | | | 0 0 | 0 | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 0. 000000 | | | 0 0 | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 182720 | | | 0 0 | 5, 255 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 186311 | | | 0 0 | 466 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0. 207922 | | | 0 0 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0. 209876 | | | 0 0 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 103133 | 0 | | 0 0 | 0 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0. 000000 | 0 | | 0 0 | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | S 0. 335796 | 0 | | 0 0 | 0 | 71.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 267360 | | | 0 0 | 0 | 73.00 |
| 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0. 231478 | 331, 181 | | 0 0 | 76, 661 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0. 000000 | | | | 0 | 88.00 |
| 91.00 09100 EMERGENCY | 0. 000000 | | | 0 0 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0. 000000 | | | 0 0 | 0 | 92.00 |
| 200.00 Subtotal (see instructions) | | 362, 438 | | 0 0 | 82, 382 | 200.00 |
| 201.00 Less PBP Clinic Lab. Services-Progra | am | | | 0 0 | 1 | 201.00 |
| Only Charges | | | | | 1 | |
| 202.00 Net Charges (line 200 +/- line 201) | | 362, 438 | | 0 0 | 82, 382 | 202.00 |

| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CN: 153037 Period: From 01/01/2014 To 12/31/2014 Worksheet D Part V Date/Time Prepared: 5/7/2015 8:42 am Cost Title XVIII Hospital PPS Cost Center Description Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) Form 01/01/2014 (see inst.) Form 01/01/2014 (see inst.) Form 01/01/2014 (see inst.) 50.00 05000 (DPERATING ROOM 0000 (LARORATORY 6.00 0 0 0 50.00 66.00< | Health Financial Systems SO | UTHERN I NDI ANA | REHAB HOSPITAL | | In Lieu | u of Form CMS- | 2552-10 |
|--|---|------------------|----------------|---------|----------------------------------|--|---------|
| Cost Center Description Cost Services Reimbursed Subject To Ded. & Coins. Cost Cost Subject To Ded. & Coins. Cost Subject To Ded. & Coins. ANCILLARY SERVICE COST CENTERS Subject To Ded. & Coins. Subject To Ded. & Coins. Subject To Ded. & Coins. 6.00 05000 (DPERATING ROOM 0 0 0 50.00 50.00 05000 (DPERATING ROOM 0 0 0 50.00 6.000 ALBORATORY 0 0 0 60.00 54.00 64.00 06400 INTRAVENUS THERAPY 0 0 0 66.00 66.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 66.00 66.00 66.00 06700 CUCPATIONAL THERAPY 0 0 0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 | APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | O VACCINE COST | | | From 01/01/2014 To 12/31/2014 | Part V Date/Time Pre 5/27/2015 8:4 | |
| Cost Center Description Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) Cost Reimbursed Subject To Ded. & Coins. (see inst.) ANCILLARY SERVICE COST CENTERS 0 0 50:00 05000 OPERATING ROOM 054:00 0 0 50:00 05000 OPERATING ROOM 054:00 0 0 6:00 7:00 6:00 7:00 50:00 05000 OPERATING ROOM 0:00 0 0 6:00 0 0 0 6:00 0 0 0 6:00 0 0 0 6:00 0 0 0 6:00 0 0 0 6:00 0 0 0 6:00 0 0 0 6:00 0 0 0 6:00 0 0 0 6:00 0 0 0 6:00 0 0 0 6:00 0 0 0 0 0 0 | | | | e XVIII | Hospi tal | PPS | |
| Reimbursed Subject To bed. & Coins. (see inst.) Reimbursed Subject To bed. & Coins. (see inst.) Reimbursed Subject To bed. & Coins. (see inst.) ANCILLARY SERVICE COST CENTERS 0 0 0 05000 [0PERATING R00M 0 0 0 6.00 7.00 0 0 50.00 7.00 0 0 0 0 60.00 6.00 0 0 0 0 60.00 60.00 6.00 0 0 0 0 0 60.00 60.00 6.00 0 0 0 0 0 0 60.00 6.00 0 0 0 0 0 60.00 66.00 60.00 0 0 0 0 0 66.00 66.00 67.00 0 0 0 0 67.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 71.00 71.00 73.00 73.00 < | | | | | | | |
| ANCI LLARY SERVICE COST CENTERS Services Not Subject To Sub | Cost Center Description | | | | | | |
| Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. (see inst.) ANCI LLARY SERVICE COST CENTERS 6.00 7.00 ANCI OSCOOL OPERATI NG ROOM 0 0 6.00 7.00 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 60.00 0 0 60.00 60.00 64.00 OKANOTRY 0 0 60.00 65.00 065000 RESPI RATORY THERAPY 0 0 66.00 66.00 066000 PHYSI CAL THERAPY 0 0 66.00 66.00 066000 SPEECH PATHOLOGY 0 0 66.00 67.00 06400 INTRAVALORAPHY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 73.00 73.00 03550 PSYCHI ATRIC/PSYCHOLOGI CAL SERVICES 0 0 73.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> | | | | | | | |
| Ded. & Coins. (see inst.) Ded. & Coins. (see inst.) ANCILLARY SERVICE COST CENTERS 50.00 05000 0PERATING ROM 0 0 6.00 0 0 0 0 0 60.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 0 60.00 06000 LABORATORY 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<> | | | | | | | |
| ANCI LLARY SERVICE COST CENTERS 50.00 05000 0PERATI NG ROM 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 60.00 LABORATORY 0 0 64.00 64.00 06400 INTRAVENOUS THERAPY 0 0 65.00 06500 RESPI RATORY THERAPY 0 0 65.00 06500 RESPI RATORY THERAPY 0 0 66.00 06700 0COPATI ONAL THERAPY 0 0 65.00 06500 RESPI RATORY THERAPY 0 0 65.00 66.00 06700 0COPATI ONAL THERAPY 0 0 66.00 67.00 06700 0COPATI ONAL THERAPY 0 0 68.00 69.00 06000 ELECTROCRADI OLOGY 0 0 68.00 69.00 07000 ELECTROCRADI OLOGY 0 0 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 73.00 < | | | | | | | |
| ANCI LLARY SERVICE COST CENTERS 50.00 OPERATI NG ROOM 0 0 50.00 0 50.00 0 50.00 0 50.00 0 50.00 0 50.00 0 50.00 0 0 50.00 0 50.00 0 0 0 0 54.00 60.00 65.00 0.0500 RESPI RATORY THERAPY 0 0 0 65.00 0.6000 PHYSI CAL THERAPY 0 0 0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 68.00 68.00 69.00 60.00 67.00 69.00 70.00 70.00 70.00 71.00 70.00 | | | | | | | |
| ANCI LLARY SERVICE COST CENTERS 50.00 05000 (PERATI NG ROOM 0 0 50.00 54.00 05400 (RADI OLOGY-DI AGNOSTI C 0 0 54.00 60.00 06000 LABORATORY 0 0 64.00 64.00 06400 (INTRAVENOUS THERAPY 0 0 64.00 65.00 06500 (RESPI RATORY THERAPY 0 0 65.00 65.00 06500 (RESPI RATORY THERAPY 0 0 66.00 66.00 06600 [PHYSI CAL THERAPY 0 0 66.00 67.00 06700 [CCUPATI ONAL THERAPY 0 0 67.00 68.00 06800 [SPECH PATHOLOGY 0 0 68.00 69.00 00 0 0 68.00 69.00 07000 ELECTROCARDI OLOGY 0 0 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 73.00 70.00 00 00 0 73.00 73.00 73.00 70.00 00 | | | | | | | |
| 50.00 OS000 OPERATI NG ROOM 0 0 50.00 54.00 OS400 RADI 0L0GY-DI AGNOSTI C 0 0 64.00 60.00 LABORATORY 0 0 60.00 60.00 64.00 O6400 INTRAVENOUS THERAPY 0 0 64.00 65.00 O6500 RESPI RATORY THERAPY 0 0 65.00 66.00 O6600 PHYSI CAL THERAPY 0 0 65.00 66.00 O6600 PHYSI CAL THERAPY 0 0 66.00 67.00 OCOD CCUPATI ONAL THERAPY 0 0 67.00 68.00 OECUPATI ONAL THERAPY 0 0 68.00 68.00 69.00 CCUPATI ONAL THERAPY 0 0 68.00 69.00 70.00 DO100 ELECTROCARDI OLOGY 0 0 70.00 70.00 71.00 OT300 DRUGS CHARGED TO PATI ENTS 0 0 71.00 73.00 73.00 OUTPATI ENT SERVI CE COST CENTERS 0 0 91.00 91.00 91.00 <td>ANCILLADY SEDVICE COST CENTERS</td> <td>6.00</td> <td>7.00</td> <td></td> <td></td> <td></td> <td>_</td> | ANCILLADY SEDVICE COST CENTERS | 6.00 | 7.00 | | | | _ |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 60.00 LABORATORY 0 0 60.00 60.00 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 ELECTROCARDI OLOGY 0 0 68.00 69.00 70.00 OTIOC REDICARDI OLOGY 0 0 70.00 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 73.00 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 73.00 73.00 74.00 08800 RURAL HEALTH CLINIC 0 0 91.00 91.00 92.00 092000 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 | | 0 | 0 | | | | 50.00 |
| 60.00 06000 LABORATORY 0 0 60.00 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 65.00 66.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 67.00 68.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 69.00 70.00 70.00 OTODO ELECTROCARDENCEPHALOGRAPHY 0 0 70.00 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 08800 RURAL HEALTH CLINIC 0 0 91.00 91.00 92.00 09100 EMERGENCY 0 0 0 91.00 92.00 200.00 <t< td=""><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></t<> | | 0 | 0 | | | | |
| 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 68.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 73.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES 0 0 73.00 76.00 08800 RURAL HEALTH CLINIC 0 0 91.00 91.00 09100 EMERGENCY 0 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DI STINCT PART) 0 0 200.00 <t< td=""><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></t<> | | 0 | 0 | | | | |
| 65.00 06500 RESPI RATORY THERAPY 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 67.00 69.00 06900 ELECTROCARDI OLOGY 0 0 68.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 73.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES 0 0 73.00 76.00 08800 RURAL HEALTH CLINIC 0 0 91.00 91.00 9200 OBSERVATION BEDS (NON-DI STI NCT PART) 0 0 92.00 200.00 Subtotal (see instructions) 0 0 200.00 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 <t< td=""><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></t<> | | 0 | 0 | | | | |
| 66.00 06600 PHYSI CAL THERAPY 0 0 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 69.00 69.00 69.00 69.00 69.00 69.00 70.00 70.00 70.00 70.00 71.00 70.00 71.00 70.00 71.00 71.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 | | 0 | 0 | | | | |
| 67.00 06700 0CCUPATIONAL THERAPY 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 71.00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 0 76.00 00TPATIENT SERVICE COST CENTERS 0 0 0 76.00 71.00 91.00 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 0 76.00 71.00 72.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 91.00 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 200.00 200.00 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 < | | | 0 | | | | |
| 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 0 76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 0 76.00 76.00 04100 09100 EMERGENCY 0 0 76.00 71.00 91.00 09100 EMERGENCY 0 0 91.00 92.00 200.00 Subtotal (see instructions) 0 0 200.00 200.00 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.0 | | | 0 | | | | |
| 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 73.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 76.00 0UTPATI ENT SERVI CE COST CENTERS 0 0 0 76.00 76.00 09100 EMERGENCY 0 0 0 91.00 92.00 9200 08SERVATI ON BEDS (NON-DI STI NCT PART) 0 0 92.00 92.00 92.00 92.00 200.00 200.00 200.00 201.00 | | | 0 | | | | |
| 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 73.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 76.00 00100 03500 RURAL HEALTH CLINIC 0 0 76.00 09100 EMERGENCY 0 0 91.00 92.00 9200 085ERVATI ON BEDS (NON-DI STI NCT PART) 0 0 92.00 92.00 92.00 0 200.00 200.00 201.00 <td< td=""><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></td<> | | 0 | 0 | | | | |
| 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 76.00 03550 PSYCHIATRIC/PSYCHOLOGI CAL SERVICES 0 0 76.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 76.00 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 91.00 09100 EMERGENCY 0 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 200.00 Subtotal (see instructions) 0 0 200.00 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 201.00 | | 0 | 0 | | | | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 76.00 76.00 76.00 76.00 76.00 76.00 70.00 <th70.00< th=""> <th70.00< th=""> 70.00</th70.00<></th70.00<> | | 0 | 0 | | | | |
| 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 76.00 OUTPATI ENT SERVI CE COST CENTERS 0 0 0 88.00 91.00 90100 EMERGENCY 0 0 91.00 91.00 91.00 91.00 92.00 058ERVATI ON BEDS (NON-DI STI NCT PART) 0 0 92.00 92.00 200.00 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 201.00 201.00 201.00 0 201.00 0 201.00 0 201.00 0 </td <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td> | | 0 | 0 | | | | |
| OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 91.00 09100 EMERGENCY 0 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 200.00 Subtotal (see instructions) 0 0 200.00 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 201.00 | | 0 | o | | | | |
| 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) 0 0 200.00 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 201.00 | | | | | | | 1 |
| 92.00092000BSERVATION BEDS (NON-DISTINCT PART)0092.00200.00Subtotal (see instructions)00200.00201.00Less PBP Clinic Lab. Services-Program00201.000nl y Charges0000 | | 0 | 0 | | | | 88.00 |
| 200.00Subtotal (see instructions)00200.00201.00Less PBP Clinic Lab. Services-Program00201.000nl y Charges0000 | 91.00 09100 EMERGENCY | 0 | 0 | | | | 91.00 |
| 201.00 Less PBP Clinic Lab. Services-Program 0 0nly Charges 0 | 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | | | 92.00 |
| Only Charges | 200.00 Subtotal (see instructions) | 0 | 0 | | | | 200.00 |
| Only Charges | 201.00 Less PBP Clinic Lab. Services-Program | 0 | | | | | 201.00 |
| 202.00 Net Charges (line 200 +/- line 201) 0 0 202.00 | | | | | | | |
| | 202.00 Net Charges (line 200 +/- line 201) | 0 | 0 | | | | 202.00 |

| Health Financial Systems SC | OUTHERN INDIANA F | REHAB HOSPI TAL | - | In Lie | u of Form CMS-2 | 2552-10 |
|--|-------------------|-----------------|---------------|-----------------|--------------------------------|--------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE | RVICE OTHER PASS | Provi der | CCN: 153037 | Period: | Worksheet D | |
| THROUGH COSTS | | Component | - CCN. 155745 | From 01/01/2014 | | norod. |
| | | component | CCN: 155765 | To 12/31/2014 | Date/Time Pre 5/27/2015 8:4 | |
| | | Titl | e XVIII | Skilled Nursing | PPS | <u> 2 um</u> |
| | | | | Facility | | |
| Cost Center Description | Non Physician | Nursi ng | Allied Healt | | Total Cost | |
| | Anesthetist | School | | Medi cal | (sum of col 1 | |
| | Cost | | | Educati on | through col. | |
| | | | | Cost | 4) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 0 | 0 | | 0 0 | 0 | 50.00 |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | 0 0 | 0 | 54.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | | 0 0 | 0 | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 0 | 0 | | 0 0 | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 0 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 0 | 0 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 0 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 0 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 0 | 0 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 0 0 | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 0 | 0 | 71.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 0 | 0 | 73.00 |
| 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | 0 | | 0 0 | 0 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | T T | | [| | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | | 0 0 | 0 | 88.00 |
| 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 SC | UTHERN INDIANA | REHAB HOSPI TAI | L | In Lie | u of Form CMS-2 | 2552-10 |
|--|-----------------|-----------------|---------------|----------------------------------|--------------------------|----------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE | RVICE OTHER PAS | S Provi der | | Period: | Worksheet D | |
| THROUGH COSTS | | Component | | From 01/01/2014 To 12/31/2014 | Part IV Date/Time Pre | narod |
| | | component | L CON. 155705 | 10 12/31/2014 | 5/27/2015 8:4 | 2 am |
| | | Titl | e XVIII | Skilled Nursing | PPS | |
| | | | | Facility | | |
| Cost Center Description | Total | Total Charges | | | Inpati ent | |
| | Outpati ent | (from Wkst. | to Charges | Ratio of Cost | Program | |
| | Cost (sum of | C, Part I, | (col. 5 ÷ | to Charges | Charges | |
| | col. 2, 3 and | col. 8) | col. 7) | (col. 6 ÷ | | |
| | 4) | 7.00 | 0.00 | col. 7) | 10.00 | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| ANCI LLARY SERVI CE COST CENTERS | 0 | 101, 322 | 0.00000 | 0 0.00000 | 26, 991 | 50.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 207, 612 | | | 28, 991 43, 471 | 50.00 54.00 |
| 60. 00 06000 LABORATORY | 0 | 2, 040, 333 | | | 537, 725 | 60.00 |
| 64. 00 06400 I NTRAVENOUS THERAPY | 0 | 2,040,333 | 0.00000 | | 557,725 | 64.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 0 | 2, 551, 313 | | | 673, 876 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 17, 945, 142 | 1 | | 3, 060, 861 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0 | 9, 664, 719 | | | 2, 271, 648 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0 | 4, 601, 635 | | | 406, 478 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 2, 841 | | | 739 | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | 2,011 | 0, 00000 | | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 877, 446 | 0, 00000 | | 252, 681 | 71.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 3, 255, 502 | | | 1, 126, 510 | 73.00 |
| 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | 1, 696, 901 | 0.00000 | 0.000000 | 10, 408 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | 0.00000 | 0 0. 000000 | 0 | 88.00 |
| 91.00 09100 EMERGENCY | 0 | 0 | 0.00000 | 0 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 | 42, 944, 766 | | | 8, 411, 388 | 200.00 |
| | | | | | | |

| Health Financial Systems SC | OUTHERN INDIANA | REHAB HOSPI TA | L | In Lie | u of Form CMS- | 2552-10 |
|--|------------------|----------------|---------------|----------------------------------|--------------------------------|----------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE | RVICE OTHER PASS | S Provi der | CCN: 153037 | Peri od: | Worksheet D | |
| THROUGH COSTS | | Component | + CON. 1557/5 | From 01/01/2014 To 12/31/2014 | Part IV | anorod. |
| | | componen | t CCN: 155765 | To 12/31/2014 | Date/Time Pro 5/27/2015 8:4 | 42 am |
| | | Ti tl | e XVIII | Skilled Nursing | | |
| | | | | Facility | | |
| Cost Center Description | Inpatient | 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 | | | 1 | | | |
| 50. 00 05000 OPERATING ROOM | 0 | 0 |) | 0 | | 50.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 |) | 0 | | 54.00 |
| | 0 | 0 |) | 0 | | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 0 | 0 | 2 | 0 | | 64.00 65.00 |
| 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 | | 65.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 | | 67.00 |
| 68. 00 106800 SPEECH PATHOLOGY | 0 | 0 | | 0 | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 | | 69.00 |
| 70. 00 07000 ELECTROEARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 0 | | 70.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 | | 71.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 | | 73.00 |
| 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0 | 0 | | 0 | | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | 1 01 | | | 0 | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | | 0 | | 88.00 |
| 91. 00 09100 EMERGENCY | 0 | Ő | | 0 | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | 0 | | 92.00 |
| 200.00 Total (lines 50-199) | 0 | 0 | | 0 | | 200.00 |
| | | | | 1 | | |

| Health Financial Systems SO | UTHERN INDIANA | REHAB HOSPI TAL | L | In Lie | u of Form CMS-2 | 2552-10 |
|---|----------------|-----------------|--------------|---|-----------------|---------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | O VACCINE COST | | CCN: 153037 | Period: From 01/01/2014 To 12/31/2014 | | |
| | | Tit | le XIX | Hospi tal | Cost | |
| | | | Charges | | Costs | |
| Cost Center Description | Cost to | PPS | Cost | Cost | PPS Services | |
| | Charge Ratio | Reimbursed | Reimbursed | Rei mbursed | (see inst.) | |
| | From | Services (see | Servi ces | Services Not | | |
| | Worksheet C, | inst.) | Subject To | Subject To | | |
| | Part I, col. | | Ded. & Coins | | | |
| | 9 | | (see inst.) | (see inst.) | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCI LLARY SERVICE COST CENTERS | | I | | | | |
| 50.00 05000 OPERATING ROOM | 0. 004747 | | | 0 0 | 0 | 50.00 |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 0. 415800 | | | 0 0 | 0 | 54.00 |
| 60. 00 06000 LABORATORY | 0. 126930 | | | 0 0 | 0 | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 0. 000000 | 0 | | 0 0 | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 182720 | 0 | | 0 0 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 186311 | 0 | 277, 42 | 28 0 | 0 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0. 207922 | 0 | 166, 3 | 76 0 | 0 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0. 209876 | 0 | 103, 23 | 34 0 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 103133 | 0 | | 0 0 | 0 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0. 000000 | 0 | | 0 0 | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 335796 | 0 | | 0 0 | 0 | 71.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 267360 | 0 | | 0 0 | 0 | 73.00 |
| 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 0. 231478 | 0 | 41, 52 | 28 0 | 0 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | • | • | · | | 1 |
| 88.00 08800 RURAL HEALTH CLINIC | 0. 000000 | | | | 0 | 88.00 |
| 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 | 0 | 588, 50 | 6 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 | 588, 50 | 66 0 | 0 | 202.00 |

| Health Financial Systems SO | UTHERN INDIANA | REHAB HOSPI TAL | - | In Lieu | u of Form CMS- | 2552-10 |
|---|----------------|-----------------|-------------|---|----------------|---------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI | D VACCINE COST | | CCN: 153037 | Period: From 01/01/2014 To 12/31/2014 | 5/27/2015 8:4 | |
| | | | le XIX | Hospi tal | Cost | |
| | Cos | sts | | | | |
| Cost Center Description | Cost | Cost | | | | |
| | Reimbursed | Reimbursed | | | | |
| | Servi ces | Services Not | | | | |
| | Subject To | Subject To | | | | |
| | Ded. & Coins. | Ded. & Coins. | | | | |
| | (see inst.) | (see inst.) | | | | |
| | 6.00 | 7.00 | | | | |
| ANCI LLARY SERVICE COST CENTERS | | | | | | |
| 50.00 05000 OPERATING ROOM | 0 | 0 | | | | 50.00 |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | | | 54.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | | | | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | 0 | 0 | | | | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 51, 688 | | | | | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 34, 593 | | | | | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 21, 666 | 0 | | | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | | | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | | | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | | | 71.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | | | 73.00 |
| 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | 9, 613 | 0 | | | | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | 0 | 0 | | | | 88.00 |
| 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) | 117, 560 | 0 | | | | 200.00 |
| 201.00 Less PBP Clinic Lab. Services-Program | 0 | | | | | 201.00 |
| Only Charges | | | | | | |
| 202.00 Net Charges (line 200 +/- line 201) | 117, 560 | 0 | | | | 202.00 |

| | Financial Systems SOUTHERN INDIANA REHAB ATION OF INPATIENT OPERATING COST | Provider CCN: 153037 | Period: From 01/01/2014 | u of Form CMS-2 Worksheet D-1 | |
|--------------|--|-----------------------|----------------------------|----------------------------------|------|
| | | | To 12/31/2014 | 5/27/2015 8:4 | |
| | Cost Center Description | Title XVIII | Hospi tal | PPS | |
| | | | | 1.00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | | |
| . 00 | Inpatient days (including private room days and swing-bed days, | | | 7, 384 | |
| . 00 . 00 | Inpatient days (including private room days, excluding swing-bed Private room days (excluding swing-bed and observation bed days) | | rivato room dave | 7, 384 0 | 2.0 |
| . 00 | do not complete this line. | . Ti you have only p | rivate room days, | 0 | 3.0 |
| . 00 | Semi-private room days (excluding swing-bed and observation bed | | 21 -6 +6 | 7, 384 | |
| 00 | Total swing-bed SNF type inpatient days (including private room reporting period | days) through Decemb | er 31 of the cost | 0 | 5.0 |
| 00 | Total swing-bed SNF type inpatient days (including private room | days) after December | 31 of the cost | 0 | 6. |
| 00 | reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room c | lavs) through Decembe | r 31 of the cost | 0 | 7. |
| | reporting period | 5 / 0 | | - | |
| 00 | Total swing-bed NF type inpatient days (including private room c reporting period (if calendar year, enter 0 on this line) | lays) after December | 31 of the cost | 0 | 8. |
| 00 | Total inpatient days including private room days applicable to t | he Program (excludin | g swing-bed and | 4, 873 | 9. |
| 00 | newborn days) | (including private | | 0 | 10 |
| . 00 | Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction | | room uays) | 0 | 10. |
| . 00 | Swing-bed SNF type inpatient days applicable to title XVIII only | (including private | room days) after | 0 | 11. |
| 2.00 | December 31 of the cost reporting period (if calendar year, enter Swing-bed NF type inpatient days applicable to titles V or XIX of | | te room days) | 0 | 12. |
| | through December 31 of the cost reporting period | 5 (51 | 5 / | | |
| 8.00 | Swing-bed NF type inpatient days applicable to titles V or XIX c after December 31 of the cost reporting period (if calendar year | | | 0 | 13. |
| . 00 | Medically necessary private room days applicable to the Program | | | 0 | 14. |
| . 00 | Total nursery days (title V or XIX only) | | - | 0 | |
| o. 00 | Nursery days (title V or XIX only) SWING BED ADJUSTMENT | | | 0 | 16. |
| . 00 | Medicare rate for swing-bed SNF services applicable to services | through December 31 | of the cost | 0.00 | 17. |
| 8. 00 | reporting period Medicare rate for swing-bed SNF services applicable to services | after December 31 of | the cost | 0.00 | 18. |
| . 00 | reporting period Medicaid rate for swing-bed NF services applicable to services t | hrough December 31 o | f the cost | 0.00 | 19. |
| | reporting period | 0 | | | |
| 0. 00 | Medicaid rate for swing-bed NF services applicable to services a reporting period | alter December 31 of | the cost | 0.00 | 20. |
| . 00 | Total general inpatient routine service cost (see instructions) | | | 4, 436, 808 | |
| 2.00 | Swing-bed cost applicable to SNF type services through December 5×1 ine 17) | 31 of the cost repor | ting period (line | 0 | 22. |
| 8. 00 | Swing-bed cost applicable to SNF type services after December 31 | of the cost reporti | ng period (line 6 | 0 | 23. |
| I. 00 | x line 18) Swing-bed cost applicable to NF type services through December 3 | 31 of the cost report | ing period (line | 0 | 24. |
| | 7 x line 19) | | 0 1 1 | _ | |
| 5.00 | Swing-bed cost applicable to NF type services after December 31 x line 20) | of the cost reportin | g period (line 8 | 0 | 25. |
| 5.00 | Total swing-bed cost (see instructions) | | | 0 | 26. |
| 7.00 | General inpatient routine service cost net of swing-bed cost (li PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | ne 21 minus line 26) | | 4, 436, 808 | 27. |
| 8. 00 | General inpatient routine service charges (excluding swing-bed a | and observation bed c | harges) | 0 | 28. |
| 9.00 | Private room charges (excluding swing-bed charges) | | | 0 | |
| 0.00 | Semi-private room charges (excluding swing-bed charges) | (mag. 20) | | 0 | |
| . 00 . 00 | General inpatient routine service cost/charge ratio (line 27 ÷ l Average private room per diem charge (line 29 ÷ line 3) | The 28) | | 0. 000000 0. 00 | |
| . 00 | Average semi-private room per diem charge (line 20 ÷ line 3) | | | 0.00 | |
| 00 | Average per diem private room charge differential (line 32 minus | s line 33)(see instru | ctions) | 0.00 | |
| . 00 | Average per diem private room cost differential (line 34 x line | | | 0.00 | |
| . 00 | Private room cost differential adjustment (line 3 x line 35) | , | | 0 | |
| . 00 | General inpatient routine service cost net of swing-bed cost and | l private room cost d | ifferential (line | | |
| | 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST | | | | |
| 8.00 | Adjusted general inpatient routine service cost per diem (see in | - | | 600.87 | |
| | Program general inpatient routine service cost (line 9 x line 38 | () | | 2, 928, 040 | 1.39 |
| 9.00 0.00 | Medically necessary private room cost applicable to the Program | - | | 2, 720, 010 | |

| MPUTATION OF INPATIENT OPERATING | | SOUTHERN INDIANA | | CCN: 153037 | Peri od: | u of Form CMS- Worksheet D- | |
|--|-----------------|------------------|------------------|------------------------|----------------------------------|--------------------------------|--------------|
| | | | | | From 01/01/2014 To 12/31/2014 | Date/Time Pr | epar |
| | | | | | | 5/27/2015 8: | |
| Cost Center Description | 1 | Total | Ti ti Total | e XVIII Average Per | Hospital Program Days | PPS Program Cost | |
| | | Inpatient | Inpatient | Diem (col. | | (col. 3 x | |
| | | Cost | Days | ÷ col. 2) | | col. 4) | |
| 00 NURSERY (title V & XIX only) | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 42 |
| Intensive Care Type Inpatien | | ts | | | | | 42 |
| 00 INTENSIVE CARE UNIT | • | | | | | | 43 |
| 00 CORONARY CARE UNIT | | | | | | | 44 |
| 00 BURN INTENSIVE CARE UNIT 00 SURGICAL INTENSIVE CARE UNIT | | | | | | | 45 |
| 00 OTHER SPECIAL CARE (SPECIFY) | | | | | | | 40 |
| Cost Center Description | | | 1 | • | | | |
| 00 Program inpatient ancillary | convice cost () | Wkat D 2 col | 2 Line 200) | | | 1.00 | 2 48 |
| 00 Total Program inpatient cost | • | | | ons) | | 4, 993, 030 | |
| PASS THROUGH COST ADJUSTMENT | | o in through io) | (000 111011 4011 | 0110) | | 1, 7, 6, 660 | |
| 00 Pass through costs applicabl | e to Program i | npatient routine | services (fro | om Wkst. D, su | m of Parts I and | 148, 724 | 4 5C |
| 00 Pass through costs applicabl | a to Program in | nnationt ancilla | ry corvince (f | From Wkst D | sum of Darte II | 119, 113 | 3 51 |
| and IV) | | | iy services (I | IJIII WASL. D, | Juni VI Fails II | 117,113 | 1 21 |
| 00 Total Program excludable cos | | | | | | 267, 837 | |
| .00 Total Program inpatient oper | | | elated, non-ph | nysician anest | hetist, and | 4, 725, 193 | 3 53 |
| medical education costs (lin TARGET AMOUNT AND LIMIT COMP | | e 52) | | | | | 1 |
| 00 Program di scharges | | | | | | | 54 |
| 00 Target amount per discharge | | | | | | 0.00 | |
| 00 Target amount (line 54 x lin 00 Difference between adjusted | , | ating agat and t | arget emount (| line E(minue | Line E2) | | 0 56 0 57 |
| 00 Bonus payment (see instructi | | ating cost and t | arget anount (| | TTHE 55) | | D 57 D 58 |
| 00 Lesser of Lines 53/54 or 55 | | reporting period | endi ng 1996, | updated and c | ompounded by the | | |
| market basket | | | | | | | |
| .00 Lesser of lines 53/54 or 55 .00 If line 53/54 is less than t | | | | | | 0.00 | 0 60 0 61 |
| which operating costs (line | | | | | | (| |
| amount (line 56), otherwise | | | | | <u>j</u> | | |
| 00 Relief payment (see instruct | | | | | | |) 62 |
| 00 Allowable Inpatient cost plu PROGRAM INPATIENT ROUTINE SW | | yment (see Instr | uctions) | | | l | 0 63 |
| .00 Medicare swing-bed SNF inpat | | osts through Dec | ember 31 of th | ne cost report | ing period (See | (| 5 64 |
| instructions)(title XVIII or | ll y) | - | | | | | |
| .00 Medicare swing-bed SNF inpat instructions)(title XVIII or | | osts after Decem | ber 31 of the | cost reportin | g period (See | (| D 65 |
| 00 Total Medicare swing-bed SNF | | tine costs (line | 64 plus line | 65)(title XVI | II onlv). For | (| 5 66 |
| CAH (see instructions) | | | | | - | | |
| 00 Title V or XIX swing-bed NF | inpatient rout | ine costs throug | h December 31 | of the cost r | eporting period | (|) 67 |
| (line 12 x line 19) OO Title V or XIX swing-bed NF | inpatient routi | ine costs after | December 31 of | the cost rep | orting period | ſ | 3 68 |
| (line 13 x line 20) | inputiont rout | | | 110 0031 100 | or tring period | | |
| 00 Total title V or XIX swing-b | | | | | | (| 5 69 |
| PART III - SKILLED NURSING F .00 Skilled nursing facility/oth | | | | | | | 70 |
| 00 Adjusted general inpatient r | | | | | | | 71 |
| 00 Program routine service cost | (line 9 x line | e 71) | | | | | 72 |
| 00 Medically necessary private | | U U | • | | | | 73 |
| 00 Total Program general inpati 00 Capital-related cost allocat | | • | | | Part II column | | 74 |
| 26, line 45) | | | 5 55515 (110) | | | | |
| 00 Per diem capital-related cos | • | , | | | | | 76 |
| 00 Program capital -related cost00 Inpatient routine service co | | | | | | | 77 |
| 00 Aggregate charges to benefic | • | , | provi der recor | ds) | | | 79 |
| 00 Total Program routine service | | • | • | | nus line 79) | | 80 |
| 00 Inpatient routine service co | • | | | | | | 8 |
| 00 Inpatient routine service co 00 Reasonable inpatient routine | | • | | | | | 82 |
| .00 Program inpatient ancillary | | | 113) | | | | 84 |
| 00 Utilization review - physici | | | ons) | | | | 85 |
| 00 Total Program inpatient oper | | | | | | | 86 |
| PART IV - COMPUTATION OF OBS 00 Total observation bed days (| | | | | | (| 5 87 |
| 00 Adjusted general inpatient r | | | ÷line 2) | | | 0.00 | |
| | | • | | | | | 2 89 |

| Health Financial Systems SC | UTHERN INDIANA | REHAB HOSPI TAL | - | In Lie | u of Form CMS-2 | 2552-10 |
|---|----------------|-----------------|------------|----------------------------------|-----------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der | | Period: | Worksheet D-1 | |
| | | | | From 01/01/2014 To 12/31/2014 | | pared: 2 am |
| | | Titl | e XVIII | Hospi tal | PPS | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observati on | |
| | | (from line | column 2 | Observati on | Bed Pass | |
| | | 27) | | Bed Cost | Through Cost | |
| | | | | (from line | (col. 3 x | |
| | | | | 89) | 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 | 225, 361 | 4, 436, 808 | 0. 05079 | 3 0 | 0 | 90.00 |
| 91.00 Nursing School cost | 0 | 4, 436, 808 | 0.0000 | 0 0 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 4, 436, 808 | 0.0000 | 0 0 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 4, 436, 808 | 0.00000 | 0 0 | 0 | 93.00 |

| | | Provider CCN: 153037 Component CCN: 155765 Title XVIII | Period: From 01/01/2014 To 12/31/2014 Skilled Nursing Facility | Worksheet D-1 Date/Time Pre 5/27/2015 8:4 PPS | pared: |
|--------------|--|--|--|--|--------------|
| | Cost Center Description | | Facility | 1.00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | 1.00 | |
| . 00 | INPATIENT DAYS Inpatient days (including private room days and swing-bed days, | oveluding newborn) | | 7, 742 | 1.00 |
| . 00 | Inpatient days (including private room days, excluding swing-bed | | | 7,742 | 2.00 |
| . 00 | Private room days (excluding swing-bed and observation bed days) | . If you have only pr | rivate room days, | 0 | 3.00 |
| . 00 | do not complete this line. Semi-private room days (excluding swing-bed and observation bed | dave) | | 7, 742 | 4.0 |
| . 00 | Total swing-bed SNF type inpatient days (including private room | | er 31 of the cost | 7, 742 | 5.0 |
| | reporting period | 5, 6 | | - | |
| . 00 | Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line) | days) after December | 31 of the cost | 0 | 6.0 |
| . 00 | Total swing-bed NF type inpatient days (including private room d | lays) through December | - 31 of the cost | 0 | 7.0 |
| | reporting period | | | | |
| . 00 | Total swing-bed NF type inpatient days (including private room d reporting period (if calendar year, enter 0 on this line) | lays) after December . | 31 OF THE COST | 0 | 8.00 |
| . 00 | Total inpatient days including private room days applicable to t | he Program (excluding | g swing-bed and | 5, 437 | 9.00 |
| 0 00 | newborn days) | (including private) | and dave) | 0 | 10.0 |
| 0.00 | Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instructio | | oom days) | 0 | 10.0 |
| 1.00 | Swing-bed SNF type inpatient days applicable to title XVIII only | íncluding private i | room days) after | 0 | 11.0 |
| 2.00 | December 31 of the cost reporting period (if calendar year, ente Swing-bed NF type inpatient days applicable to titles V or XIX o | | te room days) | 0 | 12.0 |
| 2.00 | through December 31 of the cost reporting period | | | 0 | 12.0 |
| 3.00 | Swing-bed NF type inpatient days applicable to titles V or XIX o | | | 0 | 13.0 |
| 4.00 | after December 31 of the cost reporting period (if calendar year Medically necessary private room days applicable to the Program | | | 0 | 14.0 |
| 5.00 | Total nursery days (title V or XIX only) | | | 0 | 15.0 |
| 6.00 | Nursery days (title V or XIX only) SWING BED ADJUSTMENT | | | 0 | 16.0 |
| 7.00 | Medicare rate for swing-bed SNF services applicable to services | through December 31 d | of the cost | 0.00 | 17.0 |
| 0 00 | reporting period | | | 0.00 | 10.0 |
| 8.00 | Medicare rate for swing-bed SNF services applicable to services reporting period | after December 31 of | the cost | 0.00 | 18.0 |
| 9.00 | Medicaid rate for swing-bed NF services applicable to services t | hrough December 31 of | f the cost | 0.00 | 19.0 |
| 0. 00 | reporting period Medicaid rate for swing-bed NF services applicable to services a | fter December 31 of t | the cost | 0.00 | 20.0 |
| 0.00 | reporting period | | | | |
| 1.00 | Total general inpatient routine service cost (see instructions) | 21 of the east report | ting pariod (lind | 3, 073, 093 0 | |
| 2.00 | Swing-bed cost applicable to SNF type services through December 5 x line 17) | 31 OF the cost report | ung period (ine | 0 | 22.0 |
| 3.00 | Swing-bed cost applicable to SNF type services after December 31 | of the cost reportin | ng period (line 6 | 0 | 23.0 |
| 4.00 | x line 18) Swing-bed cost applicable to NF type services through December 3 | 1 of the cost reporti | na period (line | 0 | 24.0 |
| 1.00 | 7 x line 19) | | | 0 | 21.0 |
| 5.00 | Swing-bed cost applicable to NF type services after December 31 x line 20) | of the cost reporting | g period (line 8 | 0 | 25.0 |
| 6.00 | Total swing-bed cost (see instructions) | | | 0 | 26.0 |
| 7.00 | General inpatient routine service cost net of swing-bed cost (li | ne 21 minus line 26) | | 3, 073, 093 | 27.0 |
| 8.00 | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed a | nd observation bed ch | arges) | 0 | 28.0 |
| 9.00 | Private room charges (excluding swing-bed charges) | | la ges) | 0 | 29.0 |
| 0.00 | Semi-private room charges (excluding swing-bed charges) | | | 0 | |
| 1.00 2.00 | General inpatient routine service cost/charge ratio (line 27 ÷ l Average private room per diem charge (line 29 ÷ line 3) | ine 28) | | 0.000000 | |
| 3.00 | Average semi-private room per diem charge (line 30 ÷ line 4) | | | 0.00 | |
| 4.00 | Average per diem private room charge differential (line 32 minus | , , | ctions) | 0.00 | |
| 5.00 6.00 | Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) | 31) | | 0.00 | 35.0 36.0 |
| 7.00 | General inpatient routine service cost net of swing-bed cost and | private room cost di | fferential (line | 3, 073, 093 | |
| | 27 minus line 36) | | | | - |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST | MENTS | | | |
| 8.00 | Adjusted general inpatient routine service cost per diem (see in | | | | 38.0 |
| 9.00 | Program general inpatient routine service cost (line 9 x line 38 | | | | 39.0 40.0 |
| 0.00 | Medically necessary private room cost applicable to the Program | | | | |

| ealth Financial Sys OMPUTATION OF INPA | TIENT OPERATING COST | | REHAB HOSPITA Provider | CCN: 153037 | Peri od: | u of Form CMS-: Worksheet D-1 | |
|---|--|-------------------|---------------------------|--|----------------------------------|----------------------------------|------------|
| | | | Componen | t CCN: 155765 | From 01/01/2014 To 12/31/2014 | | |
| | | | Titl | e XVIII | Skilled Nursing | | |
| Cost Co | nter Description | Total | Total | Average Der | Facility | Program Cost | |
| cost ce | inter bescription | Inpatient Cost | Inpati ent Days | Average Per Diem (col. ÷ col. 2) | 0 5 | (col. 3 x col. 4) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 2.00 NURSERY (titl | | | | | | | 42. |
| | e Type Inpatient Hospital Units | | 1 | 1 | | | 1 40 |
| 3.00 INTENSIVE CAR 4.00 CORONARY CAR | | | | | | | 43. 44. |
| 5. 00 BURN INTENSI | | | | | | | 45. |
| | ENSIVE CARE UNIT | | | | | | 46. |
| 7.00 OTHER SPECIAL | · / | | | | | | 47. |
| Cost Ce | nter Description | | | | | 1.00 | |
| 3 00 Program inpat | ient ancillary service cost (Wk | st D-3 col | 3 Line 200) | | | 1.00 | 48. |
| | n inpatient costs (sum of lines 4 | | | ons) | | | 49. |
| | COST ADJUSTMENTS | <u> </u> | | | | | |
| , v | costs applicable to Program inpa | atient routine | services (fro | m Wkst. D, su | um of Parts I and | | 50. |
|) 1.00 Pass through | costs applicable to Program inpa | atient ancilla | IN SERVICES (F | rom Wkst D | sum of Parts II | | 51. |
| and IV) | | | | . om mkot. D, | cam or runto il | | 51. |
| 2.00 Total Program | n excludable cost (sum of lines ! | | | | | | 52. |
| | n inpatient operating cost exclud | | elated, non-ph | ysi ci an anest | hetist, and | | 53. |
| | Ation costs (line 49 minus line 1 AND LIMIT COMPUTATION | 52) | | | | | - |
| 4.00 Program di sch | | | | | | | 54. |
| | per di scharge | | | | | | 55. |
| | : (line 54 x line 55) | | | | | | 56. |
| | etween adjusted inpatient operati | ing cost and t | arget amount (| line 56 minus | s line 53) | | 57. |
| | : (see instructions) nes 53/54 or 55 from the cost rep | porting period | ending 1996 | undated and c | compounded by the | | 58. 59. |
| market basket | | por tring period | r enuring 1990, | | Sompounded by the | - | 37. |
| | nes 53/54 or 55 from prior year o | | | | | | 60. |
| | lis less than the lower of line | | | | | | 61. |
| | ng costs (line 53) are less than 56), otherwise enter zero (see i | | sts (lines 54 x | 60), or 1% c | of the target | | |
| | it (see instructions) | | | | | | 62. |
| 3.00 Allowable Inp | patient cost plus incentive payme | ent (see instr | ructions) | | | | 63. |
| | I ENT ROUTI NE SWI NG BED COST | | | | | | 1 |
| | ng-bed SNF inpatient routine cos (title XVIII only) | ts through Dec | emper 31 of th | e cost report | ing period (See | | 64. |
| | ng-bed SNF inpatient routine cos | ts after Decem | ber 31 of the | cost reportir | ng period (See | | 65. |
| | (title XVIII only) | | | • | 51 (| | |
| | re swing-bed SNF inpatient routin | ne costs (line | e 64 plus line | 65)(title XVI | ll only). For | | 66. |
| CAH (see inst 7 00 Title V or XI | ructions) X swing-bed NF inpatient routing | e costs throug | h December 31 | of the cost r | eporting period | | 67. |
| (line 12 x li | 5 | | IT December 51 | of the cost i | epor tring period | | 07. |
| | X swing-bed NF inpatient routine | e costs after | December 31 of | the cost rep | orting period | | 68. |
| (line 13 x li | | | | - (0) | | | |
| | / or XIX swing-bed NF inpatient ILLED NURSING FACILITY, OTHER NU | | | | | | 69. |
| | ng facility/other nursing facili | | | | | 3, 073, 093 | 70. |
| 1.00 Adjusted gene | eral inpatient routine service co | ost per diem (| | | | 396.94 | 71. |
| U U | ne service cost (line 9 x line | | - (1) | | | 2, 158, 163 | |
| | cessary private room cost applica n general inpatient routine servi | 0 | | | | 0 2, 158, 163 | |
| 5 | ed cost allocated to inpatient | | | | Part II. column | 2, 158, 163 | |
| 26, line 45) | | | (1.5) | | | | |
| | tal-related costs (line 75 ÷ lin | | | | | 0.00 | |
| 5 1 | al-related costs (line 9 x line: tine service cost (line 74 minu: | , | | | | 0 | |
| | arges to beneficiaries for excess | | provi den recor | ds) | | 0 | |
|). 00 Total Program | n routine service costs for compa | arison to the | • | | nus line 79) | 0 | |
| | itine service cost per diem limi | | | | | 0.00 | |
| | utine service cost limitation (li | | | | | 0 | |
| | npatient routine service costs (: ient ancillary services (see in: | | 115) | | | 2, 158, 163 1, 726, 013 | |
| | review - physician compensation | | ons) | | | 1, 720, 013 | |
| 6.00 Total Program | n inpatient operating costs (sum | of lines 83 t | hrough 85) | | | 3, 884, 176 | |
| | PUTATION OF OBSERVATION BED PASS | | | | | | |
| | ntion bed days (see instructions) eral inpatient routine cost per (| | $\pm \text{line 2}$ | | | 0 00 | 87. 88. |
| 8.00 Adjusted gene | παι πηρατισητισυτηθείουδι ρθΓ (| | | | | 0.00 | 1 00. |

| Health Financial Systems SC | UTHERN INDIANA | REHAB HOSPITA | L | In Lie | u of Form CMS-2 | 2552-10 |
|---|----------------|---------------|---------------|----------------------------------|-----------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der | CCN: 153037 | Period: | Worksheet D-1 | |
| | | Componen | t CCN: 155765 | From 01/01/2014 To 12/31/2014 | | |
| | | Ti tl | e XVIII | Skilled Nursing | PPS | |
| | | | | Facility | | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observati on | |
| | | (from line | column 2 | Observati on | Bed Pass | |
| | | 27) | | Bed Cost | Through Cost | |
| | | | | (from line | (col. 3 x | |
| | | | | 89) | 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 | 0 | C | 0.0000 | 0 00 | 0 | 90.00 |
| 91.00 Nursing School cost | 0 | C | 0.0000 | 0 00 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | C | 0.0000 | 0 00 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | с | 0.0000 | 0 00 | 0 | 93.00 |

| OMPUT | ATION OF INPATIENT OPERATING COST | vider CCN: 153037 | Period: From 01/01/2014 | Worksheet D-1 | |
|--------------|--|--------------------|----------------------------|--|----------|
| | | Title XIX | To 12/31/2014 | Date/Time Pre 5/27/2015 8:4 Cost | |
| | Cost Center Description | | Hospi tal | | |
| | PART I - ALL PROVIDER COMPONENTS | | | 1.00 | |
| 00 | INPATIENT DAYS | | | 7 204 | |
| 00 00 | Inpatient days (including private room days and swing-bed days, exc Inpatient days (including private room days, excluding swing-bed an | | | 7, 384 7, 384 | 1. 2. |
| 00 | Private room days (excluding swing-bed and observation bed days). I | | rivate room days, | 0 | 3. |
| 00 | do not complete this line. Semi-private room days (excluding swing-bed and observation bed day | e) | | 7, 384 | 4. |
| 00 | Total swing-bed SNF type inpatient days (including private room day | | er 31 of the cost | 0 | 5. |
| 00 | reporting period Total swing-bed SNF type inpatient days (including private room day | s) after December | 31 of the cost | 0 | 6. |
| 00 | reporting period (if calendar year, enter 0 on this line) | s) al tel December | ST OF THE COST | 0 | 0. |
| 00 | Total swing-bed NF type inpatient days (including private room days |) through Decembe | r 31 of the cost | 0 | 7. |
| 00 | reporting period Total swing-bed NF type inpatient days (including private room 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 the newborn days) | Program (excluding | g swing-bed and | 233 | 9. |
| 0. 00 | Swing-bed SNF type inpatient days applicable to title XVIII only (i | ncluding private | room days) | 0 | 10. |
| . 00 | through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (i | ncluding private | room davs) after | 0 | 11. |
| | December 31 of the cost reporting period (if calendar year, enter O | on this line) | 5 / | | |
| 2.00 | Swing-bed NF type inpatient days applicable to titles V or XIX only through December 31 of the cost reporting period | (including priva | te room days) | 0 | 12 |
| 8.00 | Swing-bed NF type inpatient days applicable to titles V or XIX only | | | 0 | 13. |
| . 00 | after December 31 of the cost reporting period (if calendar year, e Medically necessary private room days applicable to the Program (ex | | | 0 | 14 |
| . 00 | Total nursery days (title V or XIX only) | cruaring swing-bea | uays) | 0 | 15 |
| . 00 | Nursery days (title V or XIX only) | | | 0 | 16 |
| . 00 | SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services thr | ough December 31 | of the cost | 0.00 | 17 |
| | reporting period | | | 0.00 | 10 |
| . 00 | Medicare rate for swing-bed SNF services applicable to services aft reporting period | er December 31 of | the cost | 0.00 | 18 |
| . 00 | Medicaid rate for swing-bed NF services applicable to services thro | ugh December 31 o | f the cost | 0.00 | 19 |
| 0. 00 | reporting period Medicaid rate for swing-bed NF services applicable to services afte | r December 31 of | the cost | 0.00 | 20 |
| | reporting period | | | | |
| . 00 | Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 | of the cost repor | ting period (line | 4, 436, 808 0 | 21 |
| | 5 x line 17) | | 3 T (| - | |
| . 00 | Swing-bed cost applicable to SNF type services after December 31 of x line 18) | the cost reportion | ng period (line 6 | 0 | 23 |
| . 00 | Swing-bed cost applicable to NF type services through December 31 o | f the cost report | ng period (line | 0 | 24 |
| . 00 | 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of | the cost reporting | a poriod (line 9 | 0 | 25 |
| . 00 | x line 20) | the cost reporting | g period (inne 8 | 0 | 25 |
| . 00 | Total swing-bed cost (see instructions) | 21 minus Line 24) | | 0 | |
| . 00 | General inpatient routine service cost net of swing-bed cost (line PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | 21 minus fine 20) | | 4, 436, 808 | 27 |
| . 00 | General inpatient routine service charges (excluding swing-bed and | observation bed c | narges) | 0 | 28 |
| . 00 . 00 | Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) | | | 0 | 29 30 |
| . 00 | General inpatient routine service cost/charge ratio (line 27 ÷ line | 28) | | 0.000000 | |
| . 00 | Average private room per diem charge (line 29 ÷ line 3) | | | 0.00 | |
| . 00 | Average semi-private room per diem charge (line 30 ÷ line 4) | no 22)/ ' · · · | ati ana) | 0.00 | |
| . 00 . 00 | Average per diem private room charge differential (line 32 minus li Average per diem private room cost differential (line 34 x line 31) | <i>,</i> , , | strons) | 0.00 0.00 | 34 35 |
| . 00 | Private room cost differential adjustment (line 3 x line 35) | | | 0.00 | 35 |
| . 00 | General inpatient routine service cost net of swing-bed cost and pr | ivate room cost d | fferential (line | 4, 436, 808 | |
| | 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMEN | TS | | | |
| . 00 | Adjusted general inpatient routine service cost per diem (see instr | | | 600.87 | |
| . 00 | Program general inpatient routine service cost (line 9 x line 38) | no 14 v 1: 05 | | 140, 003 | |
|). 00 | Medically necessary private room cost applicable to the Program (li | ne 14 x IIne 35) | | 0 | 40 41 |

| VIPUI | ATION OF INPATIENT OPERATING COST | | Provi dei | - CCN: 153037 | Period: From 01/01/2014 | Worksheet D- | 1 |
|--------------|---|--------------------|--------------------|---------------------------|----------------------------|------------------------------|--------------|
| | | | | | To 12/31/2014 | Date/Time Pr 5/27/2015 8: | |
| | | 1 | | tle XIX | Hospi tal | Cost | 42 0 |
| | Cost Center Description | Total Inpatient | Total Inpatient | Average Per Diem (col. | Program Days | Program Cost (col. 3 x | |
| | | Cost | Days | ÷ col . 2) | | col. 4) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 00 | NURSERY (title V & XIX only) | | | | | | 42 |
| 00 | Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT | | 1 | | | | 43 |
| . 00 | CORONARY CARE UNIT | | | | | | 44 |
| | BURN INTENSIVE CARE UNIT | | | | | | 45 |
| | SURGICAL INTENSIVE CARE UNIT | | | | | | 46 |
| 00 | OTHER SPECIAL CARE (SPECIFY) Cost Center Description | | | | | | 47 |
| | cost center bescription | | | | | 1.00 | + |
| . 00 | Program inpatient ancillary service cost (Wk | st. D-3, col. | 3, line 200) | | | 112, 501 | 1 48 |
| 00 | Total Program inpatient costs (sum of lines | 41 through 48) | (see instruct | i ons) | | 252, 504 | 1 49 |
| 00 | PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program ing | ationt routing | oorviooo (fr | am Wkat D av | m of Dorto L ond | | 50 |
| . 00 | (111) | atient routine | services (II | UNI WKSL. D, SU | m of Parts F and | i (| 50 |
| . 00 | Pass through costs applicable to Program inp | atient ancilla | ry services (| from Wkst. D, | sum of Parts II | (| 51 |
| o - | and IV) | | | | | | |
| . 00 . 00 | Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu | | alated non a | hveician anast | batist and | |) 52) 53 |
| . 00 | medical education costs (line 49 minus line | | erateu, non-p | nysi crair anest | netist, dilu | l l | 1 33 |
| | TARGET AMOUNT AND LIMIT COMPUTATION | | | | | | |
| | Program di scharges | | | | | (| |
| . 00 . 00 | Target amount per discharge Target amount (line 54 x line 55) | | | | | 0.00 |) 55) 56 |
| | Difference between adjusted inpatient operat | ing cost and t | arget amount | (line 56 minus | line 53) | |) 57 |
| 00 | Bonus payment (see instructions) | ing observation e | angot amount | | | | 5 |
| 00 | Lesser of lines 53/54 or 55 from the cost re | eporting period | endi ng 1996, | updated and c | ompounded by the | 0.00 | 59 |
| 00 | market basket | aget report | ndated by the | markat backat | | 0.00 | |
| . 00 . 00 | Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line | | | | | |) 60) 61 |
| . 00 | which operating costs (line 53) are less that | | | | | | |
| | amount (line 56), otherwise enter zero (see | instructions) | | | Ū. | | |
| | Relief payment (see instructions) | | | | | |) 62 |
| . 00 | Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST | ient (see instr | uctions) | | | (|) 63 |
| . 00 | Medicare swing-bed SNF inpatient routine cos | sts through Dec | ember 31 of t | he cost report | ing period (See | (| 64 |
| | instructions)(title XVIII only) | - | | | | | |
| . 00 | Medicare swing-bed SNF inpatient routine cos | sts after Decem | ber 31 of the | cost reportin | g period (See | (|) 65 |
| . 00 | instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi | ne costs (line | 64 plus line | 65)(title XVI | ll only) For | (| 66 |
| | CAH (see instructions) | | | | | | |
| . 00 | Title V or XIX swing-bed NF inpatient routin | ne costs throug | h December 31 | of the cost r | eporting period | (|) 67 |
| 00 | (line 12 x line 19) Title V or VLX swing had NE inputient routin | o coste ofter | December 21 e | f the cost ron | orting pariod | (| 68 |
| . 00 | Title V or XIX swing-bed NF inpatient routir (line 13 x line 20) | | December 31 0 | i the cost rep | or tring period | (| 68 |
| . 00 | Total title V or XIX swing-bed NF inpatient | routine costs | (line 67 + li | ne 68) | | (|) 69 |
| ~ ~ | PART III - SKILLED NURSING FACILITY, OTHER N | | | | | | 1 |
| . 00 . 00 | Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of | | | | | | 70 |
| . 00 | Program routine service cost (line 9 x line | | THE /0 ÷ TH | 6 2) | | | 72 |
| | Medically necessary private room cost applic | | m (line 14 x | line 35) | | | 73 |
| 00 | Total Program general inpatient routine serv | • | | | 5 | | 74 |
| . 00 | Capital-related cost allocated to inpatient 26, line 45) | routine servic | e costs (from | Worksheet B, | Part II, column | | 75 |
| . 00 | Per diem capital-related costs (line 75 ÷ li | ne 2) | | | | | 76 |
| 00 | Program capital-related costs (line 9 x line | , | | | | | 7 |
| 00 | Inpatient routine service cost (line 74 minu | | | | | | 78 |
| | Aggregate charges to beneficiaries for exces | • | • | | nue lino 70) | | 79 |
| 00 00 | Total Program routine service costs for comp Inpatient routine service cost per diem limi | | | | 1103 IIIC /7) | | 80 |
| 00 | Inpatient routine service cost limitation (I | | 1) | | | | 82 |
| 00 | Reasonable inpatient routine service costs (| see instructio | | | | | 83 |
| 00 | Program inpatient ancillary services (see in | | | | | | 84 |
| 00 00 | Utilization review - physician compensation Total Program inpatient operating costs (sum | | | | | | 85 |
| . 00 | PART IV - COMPUTATION OF OBSERVATION BED PAS | | | | | | |
| | | | | | | (| 0 87 |
| . 00 | Total observation bed days (see instructions Adjusted general inpatient routine cost per | | | | | 0.00 | |

| Health Financial Systems SC | UTHERN INDIANA | REHAB HOSPI TAL | _ | In Lie | u of Form CMS-2 | 2552-10 |
|---|----------------|-----------------|-------------|----------------------------------|-----------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der | CCN: 153037 | Period: | Worksheet D-1 | |
| | | | | From 01/01/2014 To 12/31/2014 | | pared: 2 am |
| | | Tit | le XIX | Hospi tal | Cost | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observati on | |
| | | (from line | column 2 | Observati on | Bed Pass | |
| | | 27) | | Bed Cost | Through Cost | |
| | | | | (from line | (col. 3 x | |
| | | | | 89) | 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 | 225, 361 | 4, 436, 808 | 0. 05079 | 93 0 | 0 | 90.00 |
| 91.00 Nursing School cost | 0 | 4, 436, 808 | 0.0000 | 0 0 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 4, 436, 808 | 0. 00000 | 0 0 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 4, 436, 808 | 0.0000 | 0 0 | 0 | 93.00 |

| Health Financial Systems SO | UTHERN INDIANA REHAB HOSPITAL | L | In Lie | u of Form CMS-2 | 2552-10 |
|--|-------------------------------|--------------|----------------------------------|-----------------|--------------------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provi der | | Period: | Worksheet D-3 | |
| | | | From 01/01/2014 To 12/31/2014 | Date/Time Pre | pared [.] |
| | | | 10 12/01/2011 | 5/27/2015 8:4 | |
| | Ti tl | e XVIII | Hospi tal | PPS | |
| Cost Center Description | | Ratio of Cos | | Inpati ent | |
| | | To Charges | U U | Program Costs | |
| | | | Charges | (col. 1 x | |
| | | 1.00 | 0.00 | <u>col. 2)</u> | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | 1.00 | 2.00 | 3.00 | |
| 30. 00 03000 ADULTS & PEDIATRICS | | 1 | 7 000 407 | | 30,00 |
| ANCI LLARY SERVICE COST CENTERS | | | 7, 988, 687 | | 30.00 |
| 50. 00 05000 OPERATING ROOM | | 0.00474 | 42, 799 | 203 | 50.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | | 0. 41580 | | 33, 688 | |
| 60. 00 06000 LABORATORY | | 0. 12693 | | 90, 353 | |
| 64. 00 06400 I NTRAVENOUS THERAPY | | 0.00000 | | 0,000 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | | 0. 18272 | | 128, 941 | |
| 66. 00 06600 PHYSI CAL THERAPY | | 0. 18631 | | 553, 923 | |
| 67.00 06700 OCCUPATI ONAL THERAPY | | 0. 20792 | | 558, 404 | |
| 68.00 06800 SPEECH PATHOLOGY | | 0. 20987 | | 264, 321 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | | 0. 10313 | 3 845 | 87 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | | 0. 00000 | 0 0 | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0. 33579 | 6 334, 430 | 112, 300 | 71.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | | 0. 26736 | | 322, 185 | 73.00 |
| 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | | 0. 23147 | 8 2, 526 | 585 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | |
| 88.00 08800 RURAL HEALTH CLINIC | | 0.00000 | | 0 | 88.00 |
| 91.00 09100 EMERGENCY | | 0.00000 | | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 0.00000 | | 0 | 92.00 |
| 200.00 Total (sum of lines 50-94 and 96-98) | | | 10, 002, 352 | 2,064,990 | |
| 201.00 Less PBP Clinic Laboratory Services-Pro | ogram only charges (line 61) | | 0 | | 201.00 |
| 202.00 Net Charges (line 200 minus line 201) | | 1 | 10, 002, 352 | | 202.00 |

| Health Financial Systems SOUTHERN INDIANA REHA | B HOSPI TAI | _ | In Lie | u of Form CMS-: | 2552-10 |
|---|-------------|---------------|----------------------------------|-----------------------|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provi der | CCN: 153037 | Period: | Worksheet D-3 | |
| | Component | t CCN: 155765 | From 01/01/2014 To 12/31/2014 | Date/Time Pre | pared. |
| | • | | | 5/27/2015 8:4 | |
| | Titl | e XVIII | Skilled Nursing | PPS | |
| | | | Facility | | |
| Cost Center Description | | Ratio of Cos | | Inpatient | |
| | | To Charges | Program | Program Costs | |
| | | | Charges | (col. 1 x | |
| | | 1.00 | 2.00 | <u>col.2)</u> 3.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | 1.00 | 2.00 | 3.00 | |
| 30. 00 03000 ADULTS & PEDIATRICS | | | 0 | | 30.00 |
| ANCI LLARY SERVICE COST CENTERS | | | | | 00100 |
| 50.00 05000 OPERATING ROOM | | 0.0047 | 47 26, 991 | 128 | 50.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | | 0. 4158 | 43, 471 | 18, 075 | 54.00 |
| 60. 00 06000 LABORATORY | | 0. 1269 | 30 537, 725 | 68, 253 | 60.00 |
| 64.00 06400 INTRAVENOUS THERAPY | | 0.0000 | 0 00 | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | | 0. 1827 | 20 673, 876 | 123, 131 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | | 0. 1863 | 3, 060, 861 | 570, 272 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | | 0. 2079 | 22 2, 271, 648 | 472, 326 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | | 0. 2098 | 76 406, 478 | 85, 310 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | | 0. 1031 | 33 739 | 76 | |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | | 0.0000 | | 0 | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0. 3357 | 96 252, 681 | 84, 849 | 71.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | | 0. 2673 | | | • |
| 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES | | 0. 2314 | 78 10, 408 | 2, 409 | 76.00 |
| OUTPATIENT SERVICE COST CENTERS | | 1 | - | | |
| 88.00 08800 RURAL HEALTH CLINIC | | 0.0000 | | 0 | 00.00 |
| 91. 00 09100 EMERGENCY | | 0.0000 | | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 0.0000 | | 0 | 12.00 |
| 200.00 Total (sum of lines 50-94 and 96-98) | | | 8, 411, 388 | 1, 726, 013 | |
| 201.00 Less PBP Clinic Laboratory Services-Program only charges (| (line 61) | | 0 | | 201.00 |
| 202.00 Net Charges (line 200 minus line 201) | | I | 8, 411, 388 | | 202.00 |

| Health Financial Systems SOUTHERN INDIANA REHAB | HOSPI TAI | L | In Lie | u of Form CMS-2 | 2552-10 |
|--|-----------|--------------|----------------------------------|-----------------|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provi der | CCN: 153037 | Peri od: | Worksheet D-3 | |
| | | | From 01/01/2014 To 12/31/2014 | Date/Time Pre | narod |
| | | | 10 12/31/2014 | 5/27/2015 8:4 | |
| | Ti t | le XIX | Hospi tal | Cost | |
| Cost Center Description | | Ratio of Cos | t Inpatient | I npati ent | |
| | | To Charges | Program | Program Costs | |
| | | | Charges | (col. 1 x | |
| | | | | col. 2) | |
| | | 1.00 | 2.00 | 3.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | 1 | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | | | 411, 095 | | 30.00 |
| ANCI LLARY SERVI CE COST CENTERS | | | | | |
| 50.00 ODERATING ROOM | | 0.0047 | | 18 | |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | | 0.4158 | | 2, 122 | |
| 60. 00 06000 LABORATORY | | 0. 12693 | | 3, 431 | |
| 64.00 06400 INTRAVENOUS THERAPY | | 0.0000 | | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | | 0. 1827 | | 5,838 | |
| 66. 00 O6600 PHYSI CAL THERAPY | | 0. 1863 | | 26, 529 | |
| 67.00 06700 OCCUPATI ONAL THERAPY | | 0. 2079 | | 29, 165 | |
| 68. 00 06800 SPEECH PATHOLOGY | | 0. 2098 | | 14, 540 | |
| 69. 00 06900 ELECTROCARDI OLOGY | | 0. 10313 | | 0 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | | 0.0000 | | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | 0.3357 | | 7,266 | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | | 0. 2673 | | 22,039 | |
| 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS | | 0. 2314 | 78 6, 710 | 1, 553 | 76.00 |
| 88.00 08800 RURAL HEALTH CLINIC | | 0.0000 | 0 | 0 | 88.00 |
| 91. 00 09100 EMERGENCY | | 0.0000 | | 0 | 91.00 |
| 91.00 09100 EMERGENCE 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 0.0000 | | 0 | 91.00 |
| 200.00 Total (sum of lines 50-94 and 96-98) | | 0.0000 | 530, 505 | 112, 501 | |
| 201.00 Less PBP Clinic Laboratory Services-Program only charges (I | ing 61) | | 550, 505 | | 200.00 |
| 202.00 Net Charges (line 200 minus line 201) | | | 530, 505 | | 201.00 |
| 202.00 [Net charges (The 200 influs The 201) | | 1 | 530, 505 | | 202.00 |

| LCUL | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 153037 | Period: From 01/01/2014 | Worksheet E Part B | |
|------------|--|------------------------|----------------------------|-----------------------|------|
| | | | To 12/31/2014 | Date/Time Pre | |
| | | Title XVIII | Hospi tal | 5/27/2015 8:4 PPS | 2 am |
| | | | | | |
| | PART B - MEDI CAL AND OTHER HEALTH SERVI CES | | | 1.00 | |
| 00 | Medical and other services (see instructions) | | | 0 | 1. |
| 00 | Medical and other services reimbursed under OPPS (see instruct | i ons) | | 82, 382 | |
| 00 | PPS payments | | | 61, 691 | |
| 00 00 | Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instruc | tions) | | 0 0.000 | |
| 00 | Line 2 times line 5 | | | 0 | |
| 00 | Sum of line 3 plus line 4 divided by line 6 | | | 0.00 | |
| 00 | Transitional corridor payment (see instructions) | V 12 1: 200 | | 0 | |
| 00 . 00 | Ancillary service other pass through costs from Wkst. D, Pt. I Organ acquisitions | V, COL. 13, TINE 200 | | 0 | |
| | Total cost (sum of lines 1 and 10) (see instructions) | | | 0 | |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | - | |
| . 00 | Reasonable charges Ancillary service charges | | | 0 | 1 12 |
| | Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, c | ol. 4) | | 0 | |
| | Total reasonable charges (sum of lines 12 and 13) | , | | 0 | 14 |
| | Customary charges | | | | |
| | Aggregate amount actually collected from patients liable for p Amounts that would have been realized from patients liable for | 5 | U U | 0 | 15 |
| . 00 | had such payment been made in accordance with 42 CFR §413.13(e | | on a chargebasi's | 0 | |
| . 00 | Ratio of line 15 to line 16 (not to exceed 1.000000) | , | | 0.000000 | 17 |
| | Total customary charges (see instructions) | | | 0 | |
| . 00 | Excess of customary charges over reasonable cost (complete onl | y if line 18 exceeds l | ine 11) (see | 0 | 19 |
| . 00 | instructions) Excess of reasonable cost over customary charges (complete on | vifline 11 exceeds l | ine 18) (see | 0 | 20 |
| . 00 | instructions) | | | 0 | 2 |
| | Lesser of cost or charges (line 11 minus line 20) (for CAH see | instructions) | | 0 | |
| | Interns and residents (see instructions) | | | 0 | |
| | Cost of physicians' services in a teaching hospital (see instr Total prospective payment (sum of lines 3, 4, 8 and 9) | uctions) | | 0 61, 691 | 23 |
| . 00 | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | 01,071 | 2- |
| | Deductibles and coinsurance (for CAH, see instructions) | | | 0 | |
| | Deductibles and Coinsurance relating to amount on line 24 (for | | | 12, 478 | |
| . 00 | Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) p CAH, see instructions) | Tus the sum of Times 2 | 2 and 23} (Tor | 49, 213 | 27 |
| . 00 | Direct graduate medical education payments (from Wkst. E-4, li | ne 50) | | 0 | 28 |
| | ESRD direct medical education costs (from Wkst. E-4, line 36) | | | 0 | 29 |
| | Subtotal (sum of lines 27 through 29) | | | 49, 213 | |
| | Primary payer payments Subtotal (line 30 minus line 31) | | | 0 49, 213 | |
| | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC | FS) | | 49,213 | 32 |
| | Composite rate ESRD (from Wkst. I-5, line 11) | / | | 0 | 33 |
| | Allowable bad debts (see instructions) | | | 503 | |
| | Adjusted reimbursable bad debts (see instructions) | | | 327 | |
| | Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) | uctions) | | 0 49, 540 | 36 |
| | MSP-LCC reconciliation amount from PS&R | | | 49, 540 | 38 |
| | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 | |
| | Pioneer ACO demonstration payment adjustment (see instructions | | | 0 | |
| | Partial or full credits received from manufacturers for replac | ed devices (see instru | ctions) | 0 | |
| | RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) | | | 0 49, 540 | |
| | Sequestration adjustment (see instructions) | | | 49, 540 | |
| | Interim payments | | | 49, 457 | |
| | Tentative settlement (for contractors use only) | | | 0 | |
| | Balance due provider/program (see instructions) | | abanti 1 | -908 | |
| . 00 | Protested amounts (nonallowable cost report items) in accordan §115.2 | ce with CMS Pub. 15-2, | cnapter 1, | 0 | 44 |
| | TO BE COMPLETED BY CONTRACTOR | | | | |
| | Original outlier amount (see instructions) | | | | 90 |
| | Outlier reconciliation adjustment amount (see instructions) | | | 0 | |
| | The rate used to calculate the Time Value of Money Time Value of Money (see instructions) | | | 0.00 | |
| | Total (sum of lines 91 and 93) | | | | 94 |

| ANALY | SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provi der | F | Period: From 01/01/2014 To 12/31/2014 | | |
|--------------|--|------------|-------------|---|--------------------|-------------------|
| | | | e XVIII | Hospi tal | PPS | |
| | | I npati en | t Part A | Par | 't B | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | |
| 1.00 | Total interim payments paid to provider | | 6, 497, 859 |) | 48, 317 | 1.00 |
| 2.00 | Interim payments payable on individual bills, either | | C |) | 0 | 2.00 |
| | submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, | | | | | |
| | write "NONE" or enter a zero | | | | | |
| 3.00 | List separately each retroactive lump sum adjustment | | | | | 3.00 |
| | amount based on subsequent revision of the interim rate | | | | | |
| | for the cost reporting period. Also show date of each | | | | | |
| | payment. If none, write "NONE" or enter a zero. (1) | | | | | |
| 3. 01 | Program to Provider ADJUSTMENTS TO PROVIDER | 12/16/2014 | 2, 351 | 12/16/2014 | 1, 140 | 3. 01 |
| 3.01 | ADJUSTMENTS TO PROVIDER | 08/05/2014 | 14, 757 | | 1, 140 | 3.02 |
| 3.02 | | 00/03/2014 | (| | Ő | 3.03 |
| 3.04 | | | C | | 0 | 3.04 |
| 3.05 | | | C |) | 0 | 3.05 |
| | Provider to Program | | | 1 | | |
| 3.50 | ADJUSTMENTS TO PROGRAM | | 0 | | 0 | 3.50 |
| 3.51 3.52 | | | C | | 0 | 3.51 3.52 |
| 3.52 3.53 | | | C | | 0 | 3.52 |
| 3.54 | | | C | | Ő | 3.54 |
| 3.99 | Subtotal (sum of lines 3.01–3.49 minus sum of lines | | 17, 108 | 3 | 1, 140 | 3.99 |
| | 3. 50-3. 98) | | | | | |
| 4.00 | Total interim payments (sum of lines 1, 2, and 3.99) | | 6, 514, 967 | 7 | 49, 457 | 4.00 |
| | (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) | | | | | |
| | TO BE COMPLETED BY CONTRACTOR | <u> </u> | | 1 | | |
| 5.00 | List separately each tentative settlement payment after | | | | | 5.00 |
| | desk review. Also show date of each payment. If none, | | | | | |
| | write "NONE" or enter a zero. (1) | | | | | |
| 5. 01 | Program to Provider TENTATIVE TO PROVIDER | | C | | 0 | 5. 0 ⁻ |
| 5.02 | | | 0 | | 0 | 5.02 |
| 5.03 | | | C | | 0 | 5.03 |
| | Provider to Program | 11 | | | | |
| 5.50 | TENTATI VE TO PROGRAM | | C | | 0 | 5.50 |
| 5.51 | | | 0 | | 0 | 5.5 |
| 5.52 5.99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines | | (| | 0 | 5.52 5.99 |
| J. 77 | 5. 50-5. 98) | | (| | 0 | J. 71 |
| 6.00 | Determined net settlement amount (balance due) based on | | | | | 6.00 |
| | the cost report. (1) | | | | | |
| 6.01 | SETTLEMENT TO PROVIDER | | 32, 340 | | 0 | 6.01 |
| 6.02 | SETTLEMENT TO PROGRAM | | |) | 908 | 6.02 |
| 7.00 | Total Medicare program liability (see instructions) | | 6, 547, 307 | Contractor | 48,549 NPR Date | 7.00 |
| | | | | Number | (Mo/Day/Yr) | |
| | | C | | 1.00 | 2.00 | |

| ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | | | CCN: 153037 CCN: 155765 | Period: From 01/01/2014 To 12/31/2014 | | epare |
|---|--|------------|----------------------------|---|-------------|---------|
| | | Ti tl | e XVIII | Skilled Nursing | | 42 alli |
| | | I npati en | t Part A | Facility Pai | rt B | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| 00 | | 1.00 | 2.00 | 3.00 | 4.00 | |
| 00 00 | Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero | | 2, 298, 6 | 0 | C C | |
| 00 | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | 3. |
| 01 | ADJUSTMENTS TO PROVIDER | | | 0 | C | 3. |
| 02 | | | | 0 | C | |
| 03 | | | | 0 | C |) 3. |
| 04 | | | | 0 | C | |
| 05 | Describer to Descrean | | | 0 | C |) 3 |
| 50 | Provider to Program ADJUSTMENTS TO PROGRAM | | | 0 | C | 3 |
| 50 51 | | | | 0 | | |
| 52 | | | | 0 | 0 | |
| 53 | | | | 0 | C |) 3 |
| 54 | | | | 0 | C | |
| 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) | | | 0 | C | |
| 00 | Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) | | 2, 298, 6 | 19 | C | 0 4 |
| | TO BE COMPLETED BY CONTRACTOR | | | | | |
| 00 | List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | | | | | 5 |
| | Program to Provider | | | | | |
| 01 | TENTATI VE TO PROVI DER | | | 0 | C | |
| 02 | | | | 0 | C | |
| 03 | Provider to Program | | | 0 | C |) 5 |
| 50 | TENTATI VE TO PROGRAM | | | 0 | C | 5 |
| 50 51 52 | | | | 0 | |) 5 |
| 99 | Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98) | | | 0 | C C | |
| 00 | Determined net settlement amount (balance due) based on the cost report. (1) | | | | | 6 |
| 01 | SETTLEMENT TO PROVIDER | | | 0 | C | |
| 02 | SETTLEMENT TO PROGRAM | | 2 200 (| 0 | C | |
| 00 | Total Medicare program liability (see instructions) | | 2, 298, 6 | Contractor | NPR Date |) 7 |
| | | | | Number | (Mo/Day/Yr) | |
| | | (|) | 1.00 | 2.00 | |

| ALCUL | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 153037 | Period: From 01/01/2014 To 12/31/2014 | | pare |
|-------|--|--------------------------|---|------------------|------------|
| | | Title XVIII | Hospi tal | PPS | 2 0111 |
| | | | | | |
| | | | | 1.00 | |
| | PART III - MEDICARE PART A SERVICES - IRF PPS | | | | |
| . 00 | Net Federal PPS Payment (see instructions) | | | 6, 563, 784 | 1. |
| . 00 | Medicare SSI ratio (IRF PPS only) (see instructions) | | | 0. 0396 | 2. |
| 00 | Inpatient Rehabilitation LIP Payments (see instructions) | | | 177, 879 | 3. |
| 00 | Outlier Payments | | | 17,664 | 4. |
| 00 | Unweighted intern and resident FTE count in the most recent of to November 15, 2004 (see instructions) | cost reporting period e | naing on or prior | 0.00 | 5. |
| . 01 | Cap increases for the unweighted intern and resident FTE cour program or hospital closure, that would not be counted without CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) | | | 0.00 | 5. |
| 00 | New Teaching program adjustment. (see instructions) | | | 0.00 | 6. |
| 00 | Current year's unweighted FTE count of I&R excluding FTEs in | the new program growth | period of a "new | 0.00 | |
| 00 | teaching program" (see instructions) | the new program growth | | 0100 | |
| 00 | Current year's unweighted L&R FTE count for residents within teaching program" (see instructions) | the new program growth | period of a "new | 0.00 | 8 |
| 00 | Intern and resident count for IRF PPS medical education adjus | stment (see instructions |) | 0.00 | |
| | Average Daily Census (see instructions) | | | 20. 230137 | |
| | Teaching Adjustment Factor (see instructions) | | | 0.000000 | |
| | Teaching Adjustment (see instructions) | | | 0 | 12 |
| | Total PPS Payment (see instructions) | h:) | | 6, 759, 327 | 13 |
| | Nursing and Allied Health Managed Care payments (see instruct | tion) | | 0 | 14 |
| | Organ acquisition (DO NOT USE THIS LINE) | tructione) | | 0 | 15 |
| | Cost of physicians' services in a teaching hospital (see inst Subtotal (see instructions) | tructions) | | 0 6, 759, 327 | 16 17 |
| | Primary payer payments | | | 19,053 | |
| | Subtotal (line 17 less line 18). | | | 6, 740, 274 | |
| | Deducti bl es | | | 37,600 | |
| | Subtotal (line 19 minus line 20) | | | 6, 702, 674 | |
| | Coinsurance | | | 26, 752 | |
| | Subtotal (line 21 minus line 22) | | | 6, 675, 922 | |
| | Allowable bad debts (exclude bad debts for professional servi | ces) (see instructions) | | 7, 698 | |
| | Adjusted reimbursable bad debts (see instructions) | , , | | 5,004 | 25 |
| . 00 | Allowable bad debts for dual eligible beneficiaries (see inst | tructions) | | 0 | 26 |
| . 00 | Subtotal (sum of lines 23 and 25) | | | 6, 680, 926 | 27 |
| . 00 | Direct graduate medical education payments (from Wkst. E-4, I | ine 49) | | 0 | 28 |
| . 00 | Other pass through costs (see instructions) | | | 0 | 29 |
| | Outlier payments reconciliation | | | 0 | 30 |
| | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 | 31 |
| | Pioneer ACO demonstration payment adjustment (see instruction | าร) | | 0 | 31 |
| | Recovery of Accel erated Depreciation | | | 0 | |
| | Total amount payable to the provider (see instructions) | | | 6, 680, 926 | |
| . 01 | Sequestration adjustment (see instructions) | | | 133, 619 | |
| | Interim payments | | | 6, 514, 967 | |
| | Tentative settlement (for contractor use only) Balance due provider/program line 32 minus lines 32.01, 33 ar | ad 34 | | 32, 340 | 34 |
| | Protested amounts (nonallowable cost report items) in accorda §115.2 | | chapter 1, | 32, 340 0 | |
| | TO BE COMPLETED BY CONTRACTOR | | | | 1 |
| | Original outlier amount from Wkst. E-3, Pt. III, line 4 | | | 17, 664 | |
| | Outlier reconciliation adjustment amount (see instructions) | | | 0 | 51 |
| | The rate used to calculate the Time Value of Money | | | 0.00 | 52 |

| alth Financial Systems ALCULATION OF REIMBURSEMENT SETT | | DI ANA REHAB HOSPI TAL | | u of Form CMS-2 | |
|--|------------------------------|---------------------------------|----------------------------|--------------------------|-------|
| ALCULATION OF REIMBURSEMENT SETT | | Provider CCN: 153037 | Period: From 01/01/2014 | Worksheet E-3 Part VI | i i |
| | | Component CCN: 155765 | | Date/Time Pre | parec |
| | | | | 5/27/2015 8:4 | 2 am |
| | | Title XVIII | Skilled Nursing | PPS | |
| | | | Facility | | |
| | | | | | |
| | | | | 1.00 | |
| PART VI - CALCULATION OF RE | IMBURSEMENT SETTLEMEMENT - | ALL OTHER HEALTH SERVICES FOR | ITTLE XVIII PART | A PPS SNF | |
| PROSPECTIVE PAYMENT AMOUNT | (SEE LINSTRUCTIONS) | | | | - |
| 00 Resource Utilization Group | · / | | | 2, 467, 738 | 1 1.0 |
| 00 Routine service other pass | | | | 2,407,738 | |
| 00 Ancillary service other pass | | | | 0 | |
| 00 Subtotal (sum of lines 1 th | | | | 2, 467, 738 | |
| COMPUTATION OF NET COST OF | | | | 2, 107, 700 | 1 |
| | | accine costs are included in li | ne 1 of W/S E. | | 15. |
| Part B. This line is now sl | | | | | |
| 00 Deductible | | | | 0 | 6. |
| 00 Coi nsurance | | | | 122, 208 | 7. |
| 00 Allowable bad debts (see in | nstructions) | | | 0 | 8. |
| 00 Reimbursable bad debts for | | s (see instructions) | | 0 | 9. |
|).00 Adjusted reimbursable bad (| debts (see instructions) | | | 0 | 10. |
| 1.00 Utilization review | | | | 0 | 1 |
| 2.00 Subtotal (sum of lines 4, ! | | lines 10 and 11)(see instructi | ons) | 2, 345, 530 | |
| 3.00 Inpatient primary payer pay | | | | 0 | |
| 1.00 OTHER ADJUSTMENTS (SEE INS | | | | 0 | 1 |
| 4.50 Pioneer ACO demonstration | | tructions) | | 0 | 1 |
| 4.99 Recovery of Accelerated De | preciation | | | 0 | 1 |
| 5.00 Subtotal (see instructions | | | | 2, 345, 530 | |
| 5.01 Sequestration adjustment (| see instructions) | | | 46, 911 | |
| 5.00 Interim payments | | | | 2, 298, 619 | |
| 7.00 Tentative settlement (for a | | | | 0 | 1 |
| 3 00 IBalance due provider/progr | am (line 15 minus lines 15.0 | 01, 16, and 17) | | 0 | 1 |
| 9.00 Protested amounts (nonallow | | | | 0 | 19. |

| _CUL | ATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 153037 | Period: From 01/01/2014 To 12/31/2014 | | pared |
|----------|---|------------------------|---|---------------|------------|
| | | Title XIX | Hospi tal | Cost | |
| | | | Inpatient | Outpati ent | |
| | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV | | | 2.00 | |
| | COMPUTATION OF NET COST OF COVERED SERVICES | ICES FOR TITLES V OR A | ALA SERVICES | | - |
| 00 | Inpatient hospital/SNF/NF services | | 252, 504 | | 1 1.0 |
| 00 | Medical and other services | | 202,001 | 117, 560 | |
| 00 | Organ acquisition (certified transplant centers only) | | 0 | , | 3.0 |
| 00 | Subtotal (sum of lines 1, 2 and 3) | | 252, 504 | 117, 560 | 4.0 |
| 00 | Inpatient primary payer payments | | 0 | | 5.0 |
| 00 | Outpatient primary payer payments | | | 0 | 6.0 |
| 00 | Subtotal (line 4 less sum of lines 5 and 6) | | 252, 504 | 117, 560 | 7.0 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | | - |
| 00 | Reasonable Charges Routine service charges | | 0 | | 8.0 |
| 00 | Ancillary service charges | | 530, 505 | 588, 566 | |
| | Organ acquisition charges, net of revenue | | 0 | 555, 566 | 10. |
| | Incentive from target amount computation | | 0 | | 11. |
| 00 | Total reasonable charges (sum of lines 8 through 11) | | 530, 505 | 588, 566 | 12. |
| | CUSTOMARY CHARGES | | | | |
| 00 | Amount actually collected from patients liable for payment for | services on a charge | 0 | 0 | 13. |
| 00 | basis Amounts that would have been realized from patients liable for | | on 0 | 0 | 14. |
| | a charge basis had such payment been made in accordance with 42 | CFR §413.13(e) | | | |
| | Ratio of line 13 to line 14 (not to exceed 1.000000) | | 0.000000 | 0.000000 | |
| 00 | Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only | if line 14 exceeds | 530, 505 | 588, 566 | |
| 00 | line 4) (see instructions) | IT THE TO exceeds | 278, 001 | 471,006 | 17. |
| 00 | Excess of reasonable cost over customary charges (complete only 16) (see instructions) | if line 4 exceeds lin | ne 0 | 0 | 18. |
| 00 | Interns and Residents (see instructions) | | 0 | 0 | 19. |
| | Cost of physicians' services in a teaching hospital (see instru | ctions) | 0 | 0 | 20. |
| 00 | Cost of covered services (enter the lesser of line 4 or line 16 |) | 252, 504 | 117, 560 | 21. |
| | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c | ompleted for PPS provi | i ders. | | |
| | Other than outlier payments | | 0 | 0 | |
| | Outlier payments | | 0 | 0 | |
| 00 | Program capital payments | | 0 | | 24. |
| | Capital exception payments (see instructions) Routine and Ancillary service other pass through costs | | 0 | 0 | |
| | Subtotal (sum of lines 22 through 26) | | 0 | 0 | |
| | Customary charges (title V or XIX PPS covered services only) | | 0 | 0 | 28. |
| 00 | Titles V or XIX (sum of lines 21 and 27) | | 252, 504 | 117, 560 | |
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | , | 1 |
| 00 | Excess of reasonable cost (from line 18) | | 0 | 0 | 30. |
| 00 | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) | | 252, 504 | 117, 560 | 31. |
| 00 | Deducti bl es | | 0 | 0 | |
| | Coinsurance | | 0 | 0 | |
| | Allowable bad debts (see instructions) | | 0 | 0 | |
| | Utilization review | 22) | 252 504 | 117 540 | 35. |
| 00 00 | Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | <i>33)</i> | 252, 504 | 117, 560 0 | 36. 37. |
| | Subtotal (line 36 ± 1 ine 37) | | 252, 504 | 117, 560 | |
| | Direct graduate medical education payments (from Wkst. E-4) | | 232, 304 | 117, 300 | 39. |
| | Total amount payable to the provider (sum of lines 38 and 39) | | 252, 504 | 117, 560 | |
| | Interim payments | | 252, 504 | 117, 560 | |
| | Balance due provider/program (line 40 minus line 41) | | 0 | 0 | 1 |
| | Protested amounts (nonallowable cost report items) in accordance | e with CMS Pub 15-2. | 0 | 0 | 43. |

| nα-τ | E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column on | | | eriod: rom 01/01/2014 | Worksheet G | |
|----------|---|---------------------------|--------------------------|--------------------------|--------------------------------|------|
| | | | | | Date/Time Pre 5/27/2015 8:4 | |
| | | General Fund | Specific Purpose Fund | Endowment Fund | Plant Fund | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | |
| 00 | CURRENT ASSETS Cash on hand in banks | 2, 571, 302 | 0 | 0 | 0 | 1. |
| 00 | Temporary investments | 0 | 0 | 0 | 0 | |
| 00 | Notes receivable | 0 | 0 | 0 | 0 | |
| 00 | Accounts receivable | 14, 011, 764 | 0 | 0 | 0 | |
| 00 | Other receivable | 296, 410 | | 0 | 0 | |
| 00 00 | Allowances for uncollectible notes and accounts receivable Inventory | -10, 863, 900 | 0 | 0 | 0 | |
| 00 | Prepai d expenses | 107, 663 | - | 0 | 0 | |
| | Other current assets | 107, 488 | | 0 | 0 | |
| | Due from other funds | 0 | 0 | 0 | 0 | |
| | Total current assets (sum of lines 1-10) FIXED ASSETS | 6, 230, 727 | 0 | 0 | 0 | 11 |
| | Land | 425,000 | 0 | 0 | 0 | 12 |
| | Land improvements | 128, 046 | | 0 | 0 | |
| | Accumulated depreciation | -126, 189 | 0 | 0 | 0 | |
| | Buildings | 14, 812, 387 | 0 | 0 | 0 | |
| | Accumulated depreciation Leasehold improvements | -11, 751, 907 517, 179 | 0 | 0 | 0 | |
| | Accumulated depreciation | -375, 958 | - | 0 | 0 | |
| | Fixed equipment | 0 | 0 | 0 | 0 | |
| | Accumulated depreciation | 0 | 0 | 0 | 0 | |
| | Automobiles and trucks | 0 | 0 | 0 | 0 | |
| | Accumulated depreciation Major movable equipment | 4, 917, 941 | 0 | 0 | 0 | |
| | Accumulated depreciation | -4, 528, 838 | | 0 | 0 | |
| | Minor equipment depreciable | 0 | 0 | 0 | 0 | |
| | Accumulated depreciation | 0 | 0 | 0 | 0 | |
| | HIT designated Assets | 0 | 0 | 0 | 0 | |
| | Accumulated depreciation | 0 | 0 | 0 | 0 | |
| | Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29) | 4, 017, 661 | 0 | 0 | 0 | |
| | OTHER ASSETS | | - | - | | |
| | Investments | 0 | | 0 | 0 | |
| | Deposits on Leases | 0 | 0 | 0 | 0 | |
| | Due from owners/officers Other assets | 27, 513 | | 0 | 0 | |
| | Total other assets (sum of lines 31-34) | 27, 513 | | 0 | 0 | |
| | Total assets (sum of lines 11, 30, and 35) | 10, 275, 901 | 0 | 0 | 0 | 36 |
| | CURRENT LIABILITIES | [| | | | |
| | Accounts payable Salaries, wages, and fees payable | 256, 593 | | 0 | 0 | |
| | Payrol I taxes payable | 879, 652 0 | 0 | 0 | 0 | |
| | Notes and Loans payable (short term) | 600,000 | | 0 | 0 | |
| 00 | Deferred income | 152, 454 | 0 | 0 | 0 | 41 |
| | Accel erated payments | 0 | | | | 42 |
| | Due to other funds Other current liabilities | 491, 945 334, 759 | | 0 | 0 | |
| . 00 | Total current liabilities (sum of lines 37 thru 44) | 2, 715, 403 | | 0 | 0 | |
| | LONG TERM LIABILITIES | | | - | | |
| | Mortgage payable | 0 | | 0 | 0 | |
| | Notes payable | 0 | 0 | 0 | 0 | |
| | Unsecured Loans Other Long term Liabilities | 0 647, 409 | 0 | 0 | 0 | |
| | Total long term liabilities (sum of lines 46 thru 49 | 647, 409 | | 0 | 0 | |
| | Total liabilites (sum of lines 45 and 50) | 3, 362, 812 | | 0 | 0 | |
| | CAPI TAL ACCOUNTS | | | | | |
| | General fund balance | 6, 913, 089 | | | | 52 |
| | Specific purpose fund Donor created - endowment fund balance - restricted | | 0 | 0 | | 53 |
| | Donor created - endowment fund balance - restricted | | | 0 | | 55 |
| | Governing body created - endowment fund balance | | | 0 0 | | 56 |
| 00 | Plant fund balance - invested in plant | | | | 0 | |
| 00 | Plant fund balance - reserve for plant improvement, | | | | 0 | 58 |
| | replacement, and expansion Total fund balances (sum of lines 52 thru 58) | 6, 913, 089 | 0 | ~ | 0 | 59 |
| . 00 | | 0 413 089 | | () | 0 | 1 34 |

| | | JTHERN INDIANA F | | | Davaland | | u of Form CMS | | 552-10 |
|---|---|---|---|-------------|--|--|-------------------|---|---|
| STATE | MENT OF CHANGES IN FUND BALANCES | | | CCN: 153037 | | : 01/01/2014 2/31/2014 | | rep | oared: 2 am |
| | | General | Fund | Speci al | Purpose | e Fund | Endowment Fund | | |
| | | 1.00 | 2.00 | 3.00 | | 4.00 | 5.00 | - | |
| $\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ \end{array}$ | | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 2, 615, 923 -702, 834 6, 913, 089 0 6, 913, 089 0 6, 913, 089 0 6, 913, 089 | | 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 0 0 | $\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$ |
| | sheet (line 11 minus line 18) | Endowment Fund | PI ant | Fund | | | | | |
| | | 6.00 | 7.00 | 8.00 | | | - | | |
| 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 | Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) | 0 | 0 0 0 0 | | 0 | | | | 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 |
| 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 | Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING Total deductions (sum of lines 12-17) | 0 0 | 0 0 0 0 0 0 0 | | 0 0 | | | | 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 |
| | . , | 0 0 | 0 | | 0 0 | | | | |

| 5/27/2 Cost Center Description Inpati ent Outpati ent Tot Outpati ent Routi ne Services General Inpati ent Routi ne Services 100 1.00 2.00 3.00 SubBPROVI DER - IPF 12,098,902 12,098,902 12,0 SubPROVI DER - IPF 0 SubPROVI DER - IPF 3.00 SUBPROVI DER - IPF 4.00 SUBPROVI DER - IRF 0 11.00 10 11.00 10 11.00 10 11.00 10 11 0 <th< th=""><th>& II me Prep 15 8:42 al</th><th>1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00</th></th<> | & II me Prep 15 8:42 al | 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 |
|--|------------------------------------|--|
| Cost Center DescriptionInpatientOutpatientTotPART 1 - PATIENT REVENUESGeneral Inpatient Routine ServicesGeneral Inpatient Routine Services1.00Hospital2.00SUBPROVIDER - IPF3.00SUBPROVIDER - IRF4.00SUBPROVIDER5.00Swing bed - SNF6.00Swing bed - SNF7.00SKILLED NURSING FACILITY8.00NURSING FACILITY9.00OTHER LONG TERM CARE10.00Total general inpatient care services (sum of lines 1-9)14, 805, 08314, 80511.00INTENSIVE CARE UNIT12.00CORONARY CARE UNIT13.00BURN INTENSIVE CARE UNIT14.00SUGICAL INTENSIVE CARE UNIT15.00OTHER SPECIAL CARE (SPECIFY)16.00Total intensive care type inpatient hospital services (sum of lines16.00Total intensive care type inpatient hospital services (sum of lines | 0 98, 902 0 0 006, 181 | 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 |
| PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospital 2.00 SUBPROVIDER - IPF 3.00 SUBPROVIDER - IRF 4.00 SUBPROVIDER 5.00 Swing bed - SNF 0 0 7.00 SKILLED NURSING FACILITY 8.00 NURSING FACILITY 9.00 OTHER LONG TERM CARE 10.00 Total general inpatient care services (sum of lines 1-9) 14,805,083 14,8 11.00 INTENSIVE CARE UNIT 12.00 CORONARY CARE UNIT 13.00 BURN INTENSIVE CARE UNIT 14.00 SURGICAL INTENSIVE CARE UNIT 15.00 OTHER SPECIAL CARE (SPECIFY) 16.00 Total intensive care type inpatient hospital services (sum of lines | 98, 902 0 0 06, 181 | $\begin{array}{c} 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ \end{array}$ |
| General Inpatient Routine Services1.00Hospital12,098,90212,02.00SUBPROVI DER - IPF12,098,90212,03.00SUBPROVI DER - IRF012,004.00SUBPROVI DER012,005.00Swing bed - SNF006.00Swing bed - NF007.00SKI LLED NURSI NG FACI LI TY2,706,1812,78.00NURSI NG FACI LI TY2,706,1812,79.00OTHER LONG TERM CARE14,805,08314,810.00Total general inpatient care services (sum of lines 1-9)14,805,08314,811.00INTENSI VE CARE UNI T12.00CORONARY CARE UNI T14,805,08314,812.00CORONARY CARE UNI T500OTHER SPECI AL CARE (SPECI FY)16.00Total intensive care type inpatient hospital services (sum of lines0 | 0 0 06, 181 | $\begin{array}{c} 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ \end{array}$ |
| 1.00Hospital12,098,90212,02.00SUBPROVIDER - IPF18,0012,098,90212,03.00SUBPROVIDER - IRF010,004.00SUBPROVIDER005.00Swing bed - SNF006.00Swing bed - NF007.00SKILLED NURSI NG FACILITY2,706,1812,78.00NURSI NG FACILITY2,706,1812,79.00OTHER LONG TERM CARE14,805,08314,810.00Total general inpatient care services (sum of lines 1-9)14,805,08314,811.00INTENSI VE CARE UNI T12.00012.00CORONARY CARE UNI T13.00BURN INTENSI VE CARE UNI T14.0014.00SURGI CAL INTENSI VE CARE UNI T15.000015.00OTHER SPECI AL CARE (SPECI FY)16.00Total intensive care type inpatient hospital services (sum of lines0 | 0 0 06, 181 | $\begin{array}{c} 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ \end{array}$ |
| 2.00SUBPROVIDER - IPF3.00SUBPROVIDER - IRF4.00SUBPROVIDER5.00Swing bed - SNF0Swing bed - NF0SKILLED NURSING FACILITY2.00NURSING FACILITY2.00OTHER LONG TERM CARE10.00Total general inpatient care services (sum of lines 1-9)14,805,08314,805,08311.00INTENSIVE CARE UNIT12.00CORONARY CARE UNIT13.00BURN INTENSIVE CARE UNIT14.00SURGICAL INTENSIVE CARE UNIT15.00OTHER SPECIAL CARE (SPECIFY)16.00Total intensive care type inpatient hospital services (sum of lines0OTHER SPECIAL CARE (SPECIFY)16.00Total intensive care type inpatient hospital services (sum of lines | 0 0 06, 181 | $\begin{array}{c} 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ \end{array}$ |
| 3.00 SUBPROVIDER - IRF 4.00 SUBPROVIDER 5.00 Swing bed - SNF 0 Swing bed - NF 0 Swing bed - NF 0 SkiLLED NURSING FACILITY 2, 706, 181 2, 70 8.00 NURSING FACILITY 9.00 OTHER LONG TERM CARE 10.00 Total general inpatient care services (sum of lines 1-9) 14, 805, 083 14, 80 11.00 INTENSI VE CARE UNIT 12.00 CORONARY CARE UNIT 13.00 BURN INTENSI VE CARE UNIT 14.00 SUBRICAL INTENSI VE CARE UNIT 15.00 OTHER SPECIAL CARE (SPECI FY) 16.00 Total intensive care type inpatient hospital services (sum of lines | 0 06, 181 | 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 |
| 4.00SUBPROVIDER05.00Swing bed - SNF06.00Swing bed - NF07.00SKILLED NURSING FACILITY2,706,1818.00NURSING FACILITY2,706,1819.00OTHER LONG TERM CARE14,805,08310.00Total general inpatient care services (sum of lines 1-9)14,805,08311.00INTENSI VE CARE UNI T12.00CORONARY CARE UNI T13.00BURN INTENSI VE CARE UNI T14.00SURGICAL INTENSI VE CARE UNI T15.00OTHER SPECI AL CARE (SPECI FY)16.00Total intensive care type inpatient hospital services (sum of lines0OTHER SPECI AL CARE (SPECI FY)16.00Total intensive care type inpatient hospital services (sum of lines | 0 06, 181 | 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 |
| 5.00 Swing bed - SNF 0 6.00 Swing bed - NF 0 7.00 SKILLED NURSING FACILITY 2,706,181 8.00 NURSING FACILITY 2,706,181 9.00 OTHER LONG TERM CARE 14,805,083 10.00 Total general inpatient care services (sum of lines 1-9) 14,805,083 11.00 INTENSIVE CARE UNIT 14,805,083 12.00 CORONARY CARE UNIT 14,805,083 13.00 BURN INTENSIVE CARE UNIT 14,000 14.00 SURGICAL INTENSIVE CARE UNIT 14,000 15.00 OTHER SPECIAL CARE (SPECIFY) 16.00 16.00 Total intensive care type inpatient hospital services (sum of lines 0 | 0 06, 181 | 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 |
| 6.00Swing bed - NF07.00SKILLED NURSING FACILITY2,706,1818.00NURSING FACILITY2,706,1819.00OTHER LONG TERM CARE210.00Total general inpatient care services (sum of lines 1-9)14,805,08311.00INTENSI VE CARE UNI T12.00CORNARY CARE UNI T13.00BURN INTENSI VE CARE UNI T14.00SURGI CAL INTENSI VE CARE UNI T15.00OTHER SPECI AL CARE (SPECI FY)16.00Total intensive care type inpatient hospital services (sum of lines | 0 06, 181 | 6.00 7.00 8.00 9.00 10.00 11.00 12.00 |
| 7.00SKILLED NURSING FACILITY2,706,1812,78.00NURSING FACILITY2,706,1812,79.00OTHER LONG TERM CARE14,805,08314,810.00Total general inpatient care services (sum of lines 1-9)14,805,08314,811.00INTENSI VE CARE UNI T11,001000000000000000000000000000000000000 | 06, 181 | 7.00 8.00 9.00 10.00 11.00 12.00 |
| 8.00 NURSING FACILITY 9.00 OTHER LONG TERM CARE 10.00 Total general inpatient care services (sum of lines 1-9) 14,805,083 11.00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSI VE CARE UNI T 12.00 CORONARY CARE UNI T 13.00 BURN INTENSI VE CARE UNI T 14.00 SURGICAL INTENSI VE CARE UNI T 15.00 OTHER SPECI AL CARE (SPECI FY) 16.00 Total intensive care type inpatient hospital services (sum of lines | | 8.00 9.00 10.00 11.00 12.00 |
| 9.00 OTHER LONG TERM CARE 14,805,083 14,805,083 10.00 Total general inpatient care services (sum of lines 1-9) 14,805,083 14,805,083 11.00 INTENSI VE CARE UNIT 14,805,083 14,805,083 11.00 INTENSI VE CARE UNIT 14,805,083 14,805,083 12.00 CORONARY CARE UNIT 12,00 0 0 BURN INTENSI VE CARE UNIT 13,00 BURN INTENSI VE CARE UNIT 14.00 SURGI CAL INTENSI VE CARE UNIT 15,00 0 15.00 OTHER SPECI AL CARE (SPECI FY) 16,00 Total intensive care type inpatient hospital services (sum of lines 0 | <u>05, 083</u> | 9.00 10.00 11.00 12.00 |
| 10.00Total general inpatient care services (sum of lines 1-9)14,805,08314,805,083Intensive Care Type Inpatient Hospital Services11.00INTENSI VE CARE UNIT12.00CORONARY CARE UNIT13.00BURN INTENSI VE CARE UNIT14.00SURGI CAL INTENSI VE CARE UNIT15.00OTHER SPECI AL CARE (SPECI FY)16.00Total intensive care type inpatient hospital services (sum of lines0 | 05, 083 | 10.00 11.00 12.00 |
| Intensive Care Type Inpati ent Hospital Services 11.00 INTENSIVE CARE UNIT 12.00 CORONARY CARE UNIT 13.00 BURN INTENSIVE CARE UNIT 14.00 SURGICAL INTENSIVE CARE UNIT 15.00 OTHER SPECIAL CARE (SPECIFY) 16.00 Total intensive care type inpatient hospital services (sum of lines | | 11. 00 12. 00 |
| 11. 00 INTENSIVE CARE UNIT 12. 00 CORONARY CARE UNIT 13. 00 BURN INTENSIVE CARE UNIT 14. 00 SURGICAL INTENSIVE CARE UNIT 15. 00 OTHER SPECIAL CARE (SPECIFY) 16. 00 Total intensive care type inpatient hospital services (sum of lines 0 | | 12.00 |
| 12.00CORONARY CARE UNIT13.00BURN INTENSIVE CARE UNIT14.00SURGICAL INTENSIVE CARE UNIT15.00OTHER SPECIAL CARE (SPECIFY)16.00Total intensive care type inpatient hospital services (sum of lines | | 12.00 |
| 13.00BURN INTENSIVE CARE UNIT14.00SURGICAL INTENSIVE CARE UNIT15.00OTHER SPECIAL CARE (SPECIFY)16.00Total intensive care type inpatient hospital services (sum of lines | | |
| 14.00SURGI CAL INTENSIVE CARE UNIT15.00OTHER SPECIAL CARE (SPECIFY)16.00Total intensive care type inpatient hospital services (sum of lines0 | | |
| 15.00OTHER SPECIAL CARE (SPECIFY)16.00Total intensive care type inpatient hospital services (sum of lines0 | | 14.00 |
| | | 15.00 |
| | 0 | 16.00 |
| 11-15) | | |
| | 05, 083 | 17.00 |
| 18.00 Anci I I ary services 27, 637, 998 15, 306, 768 42, 9 | 44, 766 | 18.00 |
| 19.00 Outpatient services 0 0 | 0 | 19.00 |
| 20.00 RURAL HEALTH CLINIC 0 0 | 0 | 20.00 |
| 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 | 0 | 21.00 |
| 22. OO HOME HEALTH AGENCY | | 22.00 |
| 23. 00 AMBULANCE SERVICES | | 23.00 |
| | 0 | 24.00 |
| 25. 00 AMBULATORY SURGI CAL CENTER (D. P.) | | 25.00 |
| 26. 00 HOSPI CE 27. 00 OTHER (DI ETARY) 616 0 | 616 | 26.00 27.00 |
| | 50, 465 | 27.00 |
| G-3, Line 1) | 50, 405 | 20.00 |
| PART II - OPERATING EXPENSES | | |
| 29.00 Operating expenses (per Wkst. A, column 3, line 200) 17,555,281 | | 29.00 |
| 30. 00 ADD (SPECI FY) 0 | | 30.00 |
| 31.00 | | 31.00 |
| 32.00 | | 32.00 |
| 33.00 | | 33.00 |
| 34.00 | | 34.00 |
| 35.00 0 | | 35.00 |
| 36.00 Total additions (sum of lines 30-35) 0 | | 36.00 |
| 37. 00 DEDUCT (SPECIFY) 0 | | 37.00 |
| 38.00 0 | | 38.00 |
| 39.00 | | 39.00 |
| 40.00 | | 40.00 |
| | | 41.00 |
| 42.00 Total deductions (sum of lines 37-41) 0 42.00 Total expensions (sum of lines 30 and 26 minus line 42) (transfer | | 42.00 |
| 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 17,555,281 to Wkst. G-3, line 4) | | 43.00 |
| | I | |

| Heal th | Financial Systems SOUTHERN INDIANA REH. | AB HOSPITAL | In Lieu | u of Form CMS-2 | 2552-10 |
|---------|--|----------------------|---|---|---------|
| STATEN | ENT OF REVENUES AND EXPENSES | Provider CCN: 153037 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-3 Date/Time Pre 5/27/2015 8:4 | pared: |
| | | | | | |
| | | | | 1.00 | |
| 1.00 | Total patient revenues (from Wkst. G-2, Part I, column 3, line | | | 57, 750, 465 | 1.00 |
| 2.00 | Less contractual allowances and discounts on patients' account | S | | 41, 071, 822 | 2.00 |
| 3.00 | Net patient revenues (line 1 minus line 2) | | | 16, 678, 643 | |
| 4.00 | Less total operating expenses (from Wkst. G-2, Part II, line 4 | 3) | | 17, 555, 281 | 4.00 |
| 5.00 | Net income from service to patients (line 3 minus line 4) | | | -876, 638 | 5.00 |
| | OTHER INCOME | | 1 | | |
| 6.00 | Contributions, donations, bequests, etc | | | 0 | 6.00 |
| 7.00 | Income from investments | | | 30, 814 | 7.00 |
| 8.00 | Revenues from telephone and other miscellaneous communication | servi ces | | 0 | 8.00 |
| 9.00 | Revenue from television and radio service | | | 0 | 9.00 |
| 10.00 | Purchase di scounts | | | 0 | 10.00 |
| 11.00 | Rebates and refunds of expenses | | | 0 | 11.00 |
| 12.00 | Parking lot receipts | | | 0 | 12.00 |
| 13.00 | Revenue from Laundry and Linen service | | | 0 | 13.00 |
| 14.00 | Revenue from meals sold to employees and guests | | | 0 | 14.00 |
| | Revenue from rental of living quarters | | | 0 | |
| 16.00 | Revenue from sale of medical and surgical supplies to other th | an patients | | 0 | |
| | Revenue from sale of drugs to other than patients | | | 0 | |
| | Revenue from sale of medical records and abstracts | | | 0 | |
| | Tuition (fees, sale of textbooks, uniforms, etc.) | | | 0 | |
| | Revenue from gifts, flowers, coffee shops, and canteen | | | 0 | 20.00 |
| | Rental of vending machines | | | 2, 930 | |
| 22.00 | Rental of hospital space | | | 0 | 22.00 |
| 23.00 | Governmental appropriations | | | 0 | 23.00 |
| 24.00 | OTHER (IDENTIFIED ON TB) | | | 140, 060 | |
| | Total other income (sum of lines 6-24) | | | 173, 804 | |
| | Total (line 5 plus line 25) | | | -702, 834 | |
| | ROUNDING | | | 0 | 27.00 |
| | 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) | | | -702, 834 | 29.00 |