e since the beginning of the cost reporting period being dee	med overpayments (42 USC	1395g). OMB NO. 0938-0050			
		EXPIRES 03-31-2022			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-3028 Period: WO AND SETTLEMENT SUMMARY Provided CCN: 15-3028 Period: WO					
I SUNINAKT		12/31/2020 Date/Time Prepared:			
		7/15/2021 11: 42 am			
REPORT STATUS					
 [X] Electronically prepared cost report 	Da	ate: 7/15/2021 Time: 11:42 am			
2. [] Manually prepared cost report					
		tted this cost report			
5. [1]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N]Initial Report for th (3) Settled with Audit (4) Reopened (5) Amended	11. Contrac is Provider CCN 12. [0] I f	ctor's Vendor Code: 4			
1	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provided in the cost report of the cost report and the cost report in th	REPORT STATUS 1. [X] Electronically prepared cost report 2. [] Manually prepared cost report 3. [0] If this is an amended report enter the number of times the provider resubmi 4. [F] Medicare Utilization. Enter "F" for full or "L" for low. 5. [1] Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN nu (4) Reopened			

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REHABILITATION HOSPITAL OF INDIANA (15-3028) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) MARJORIE BASEY

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)
Date

	·		Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	80, 061	-18, 148	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	80, 061	-18, 148	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-3028 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/15/2021 11:42 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 4141 SHORE DRIVE 1.00 PO Box: 1.00 State: IN 2.00 City: INDIANAPOLIS Zip Code: 46254 County: MARION 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)
V | XVIII | XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 REHABILITATION HOSPITAL 153028 26900 5 01/07/1992 Ν 3.00 OF INDIANA Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 Hospital -Based (CMHC) I 17.00 17.00 17. 10 Hospital -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 19.00 Other From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2020 12/31/2020 20.00 21.00 Type of Control (see instructions) 21.00 4 1. 00 3.00 2.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this N N 22 01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.
Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N Ν N 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d pai d days Medi cai d eligible Medi cai d days unpai d paid days el i gi bl e unpai d days 1.00 3.00 4.00 5. 00 6.00 2.00 24.00 If this provider is an IPPS hospital, enter the 0 0 24 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

Health Financial Systems REHABILITATI	ON HOSPITA	L OF INDIAN	NA		In Lie	u of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provi der CC		Period: From 01/ To 12/		Worksh Part I	eet S-2 me Pre	pared:
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	aid 0 ays Med	ther li cai d lays	TZ diii
05 00 16 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1.00	2. 00	3. 00	4.00	5.00		5. 00	05.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	670	141	0			, 192 Date of	Coogn	25. 00
					00	2.		
26.00 Enter your standard geographic classification (not w		at the be	ginning of	the	1			26. 00
cost reporting period. Enter "1" for urban or "2" fo 27.00 Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	age) status r "2" for r	rural. If a	d of the co pplicable,	st	1			27. 00
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status i	n	C			35. 00
					nni ng: 00	Endi 2.		
36.00 Enter applicable beginning and ending dates of SCH s	tatus. Subs	script line	36 for num		00	2.	JU	36. 00
of periods in excess of one and enter subsequent dat 37.00 If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.	es.	•			C)		37. 00
37.01 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f								37. 01
instructions) 38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.								38. 00
					/N 00	Y/ 2.		
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i), (ii), or the mileage	(iii)? En e requireme	ter in colu nts in	ume ımn	N	N.		39.00
or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	er "Y" for			N	N	I	40.00
, , , , , , , , , , , , , , , , , , ,	. (000				V	XVIII	XIX	
Prospective Payment System (PPS)-Capital					1.00	0 2.00	3. 00	
45.00 Does this facility qualify and receive Capital payme	nt for disp	roporti ona	te share in	accordanc	e N	N	N	45. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	•		-		N	N	N	46. 00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital paymen Teaching Hospitals			,		N N	N N	N N	47. 00 48. 00
56.00 Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you	impacted by	CR 11642				N		56.00
GME payment reduction? Enter "Y" for yes or "N" for 57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	period duri r yes or "N th of this Y", complet	ng which ro l" for no i cost repor e Workshee	n column 1. ting period	If column ? Enter "	Y"			57. 00
58.00 If line 56 is yes, did this facility elect cost reim	bursement f	or physici	ans' servic	es as	N			58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 59.00 Are costs claimed on line 100 of Worksheet A? If ye			. Pt I		N			59. 00
57. 30 pile 303 to allinea on Time 100 of Horksheet N. Ti ye	s, comprete	MIGE. D.Z.	NAHE 413. Y/N		heet A ne #	Pass-T Qualifi Crite	cation rion de	37. 00
60.00 Are you claiming nursing and allied health education	(NAHE) cos	ts for	1. 00 N	2.	00	3.	00	60.00
any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in co is "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in col	.85? (see Lumn 1. Lf CR) NAHE MA	column 1	IN					00.00

Health Financial Systems	REHABILITATION HOSPITAL OF INDI	I ANA	In Lieu of	f Form CMS-2552-10

	Financial Systems REHABILITATI TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider C		eri od:	u of Form CMS-2 Worksheet S-2	
				F	rom 01/01/2020 o 12/31/2020	Part I	par
		Y/N	IME	Direct GME	I ME	Direct GME	
		1.00	2. 00	3. 00	4. 00	5. 00	
51. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61
51. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61
1. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61
1. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61
51. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61
61. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61
51. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61
		Pro	gram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2.00	3. 00	4. 00	
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		
						1. 00	1
	ACA Provisions Affecting the Health Resources and Ser						
62. 00 62. 01	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instructions that rotated from a during in this cost reporting period of HRSA THC programmer.)	ctions) a Teachi	ng Health Cer	nter (THC) into		0. 0C 0. 0C	
2 00	Teaching Hospitals that Claim Residents in Nonprovide			not re-	noni od 2 Est	NI NI	٠,
3. 00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple					N Ratio (col.	63
				FTEs Nonprovi der Si te	FTES in Hospital	1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No	onprovi d	der Settinas-	1.00 -This base yea	2.00 ris your cost	3.00 reporting	
54. 00	period that begins on or after July 1, 2009 and before Enter in column 1, if line 63 is yes, or your faciliting the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in column 1 divided by (column 1 + column 2)). (see	re June ty trair n-primar all nor d non-pr n columr	30, 2010. ned residents ry care aprovider rimary care a 3 the ratio	0.00	,		64

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3028 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/15/2021 11:42 am Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ (col. 3 + FTEs FTEs in col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if li is yes, or your facility 0.000000 65.00 0.00 0. 00 if line 63 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col . 1 + col . 2)) FTEs in FTFs Hospi tal Nonprovi der Si te 2. 00 3. 00 1 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 3/(col. 3 +col. 4)) Nonprovi der Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5. 00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 70.00 N Enter "Y" for yes or "N" for no. 71.00 | If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N"

Health Financial Systems In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3028 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/15/2021 11:42 am 1. 00 2.00 3.00 76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for Ν 0 76.00 no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80 00 N 80.00 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 81.00 N "Y" for yes and "N" for no. TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86 00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospital classified under section N 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Ν Υ 90.00 yes or "N" for no in the applicable column. 91.00 is this hospital reimbursed for title V and/or XIX through the cost report either in Ν Ν 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. Ν 93 00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν N applicable column. 0.00 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 95.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 96.00 Ν Ν 96.00 applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 97 00 0 00 97 00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Ν Υ 98.00 stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Υ 98.01 98.01 Ν C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation 98.02 bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 98.03 N N for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of Ν 98.04 outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.05 | Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Ν 98.05 Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ 98.06 Ν Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? N 105 00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106. 00 for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) 107.00 Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Ν 108.00

Health Financial Systems REHABILITATION HOSE	PITAL OF INDIA	NA	In Lie	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co	CN: 15-3028	Peri od: From 01/01/2020 To 12/31/2020	Worksheet S- Part I Date/Time Pro 7/15/2021 11	epared:
	Physi cal	Occupati ona		Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1. 00 N	2. 00 N	3. 00 N	4. 00 N	109.00
				1. 00	
110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no.	If yes,	N N	110.00
			1.00	2.00	+
111.00 f this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.	ost reporting olumn 1 is Y, rticipating ir	period? Enter enter the column 2.	- N		111.00
		1.00	2.00	3.00	+
112.00 Did this hospital participate in the Pennsylvania Rural Hea demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 i in column 2, the date the hospital began participating in t demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable.	period? s "Y", enter he	N			112.00
Miscellaneous Cost Reporting Information	HAIII C	, , , , , , , , , , , , , , , , , , ,			0115 00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, \$2208.1.	B, or E only) 93" percent (includes	N			0 115.00
116.00 Is this facility classified as a referral center? Enter "Y"	for yes or	N			116.00
"N" for no.	rance? Enter	N			117. 00
117.00 Is this facility legally-required to carry malpractice insu			1		118. 00
"Y" for yes or "N" for no. 118.00 s the malpractice insurance a claims-made or occurrence po					
"Y" for yes or "N" for no.		Premi ums	Losses	Insurance	
"Y" for yes or "N" for no. 118.00 s the malpractice insurance a claims-made or occurrence po		Premi ums	Losses 2. 00	Insurance 3.00	

"N" for no.				
117.00 Is this facility legally-required to carry malpractice insurance? Enter	N			117. 00
"Y" for yes or "N" for no. 118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1	1			118.00
if the policy is claim-made. Enter 2 if the policy is occurrence.	'			110.00
it the portey is craim made. Enter 2 if the portey is decarrence.	Premi ums	Losses	Insurance	
		200000	111001 01100	
	1. 00	2. 00	3. 00	
118.01 List amounts of malpractice premiums and paid losses:	67, 396	0		0 118. 01
		1. 00	2. 00	
118.02 Are malpractice premiums and paid losses reported in a cost center other t		N		118. 02
Administrative and General? If yes, submit supporting schedule listing co	ost centers			
and amounts contained therein. 119.00D0 NOT USE THIS LINE				119.00
119.00pb Not use this line 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov	diction in ACA	N	N	120.00
\$3121 and applicable amendments? (see instructions) Enter in column 1, "Y"		IV	IN	120.00
"N" for no. Is this a rural hospital with < 100 beds that qualifies for the				
Hold Harmless provision in ACA §3121 and applicable amendments? (see instr				
Enter in column 2, "Y" for yes or "N" for no.	de trons)			
21.00 Did this facility incur and report costs for high cost implantable devices	s charged to	N		121.00
patients? Enter "Y" for yes or "N" for no.				
122.00 Does the cost report contain healthcare related taxes as defined in §1903((w)(3) of the	N		122. 00
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter				
the Worksheet A line number where these taxes are included.				
Transplant Center Information				
125.00 Does this facility operate a transplant center? Enter "Y" for 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, enter the certif	fication date			126. 00
in column 1 and termination date, if applicable, in column 2.				
127.00 If this is a Medicare certified heart transplant center, enter the certifi	cation date			127. 00
in column 1 and termination date, if applicable, in column 2.				
128.00 If this is a Medicare certified liver transplant center, enter the certifi	cation date			128. 00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certific	sation data in			129. 00
column 1 and termination date, if applicable, in column 2.	cation date in			129.00
130.00 If this is a Medicare certified pancreas transplant center, enter the cert	ti fi cati on			130.00
date in column 1 and termination date, if applicable, in column 2.	tillcation			130.00
131.00 f this is a Medicare certified intestinal transplant center, enter the $c\epsilon$	ertification			131.00
date in column 1 and termination date, if applicable, in column 2.				1.51.00
pacto co. a I did to initiation dato, it apprioudle, iti coi dilli 2.				1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA 132.00 If this is a Medicare certified islet transplant center, ein column 1 and termination date, if applicable, in column 133.00 Removed and reserved 134.00 If this is an organ procurement organization (OPO), enter and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as chapter 10? Enter "Y" for yes or "N" for no in column 1. I' are claimed, enter in column 2 the home office chain number 1.00 2.0	the OPO number i	ication date	To 12	1/01/2020 2/31/2020 1.00	Worksheet S-2 Part I Date/Time Pre 7/15/2021 11:	epared:
in column 1 and termination date, if applicable, in column 133.00 Removed and reserved 134.00 If this is an organ procurement organization (0P0), enter and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as chapter 10? Enter "Y" for yes or "N" for no in column 1. I are claimed, enter in column 2 the home office chain number 1.00 2.0	the OPO number i	ication date	To 12	2/31/2020	Date/Time Pre 7/15/2021 11:	42 am
in column 1 and termination date, if applicable, in column 133.00 Removed and reserved 134.00 If this is an organ procurement organization (0P0), enter and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as chapter 10? Enter "Y" for yes or "N" for no in column 1. I are claimed, enter in column 2 the home office chain number 1.00 2.0	the OPO number i	ication date			7/15/2021 11:	42 am
in column 1 and termination date, if applicable, in column 133.00 Removed and reserved 134.00 If this is an organ procurement organization (0P0), enter and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as chapter 10? Enter "Y" for yes or "N" for no in column 1. I are claimed, enter in column 2 the home office chain number 1.00 2.0	the OPO number i			1.00	2. 00	132.00
in column 1 and termination date, if applicable, in column 133.00 Removed and reserved 134.00 If this is an organ procurement organization (0P0), enter and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as chapter 10? Enter "Y" for yes or "N" for no in column 1. I are claimed, enter in column 2 the home office chain number 1.00	the OPO number i			1.00	2.00	132.00
in column 1 and termination date, if applicable, in column 133.00 Removed and reserved 134.00 If this is an organ procurement organization (0P0), enter and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as chapter 10? Enter "Y" for yes or "N" for no in column 1. I are claimed, enter in column 2 the home office chain number 1.00	the OPO number i					
134.00 If this is an organ procurement organization (OPO), enter and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as chapter 10? Enter "Y" for yes or "N" for no in column 1. I are claimed, enter in column 2 the home office chain number 1.00 2.0	defined in CMS	in column 1		I		
and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as chapter 10? Enter "Y" for yes or "N" for no in column 1. I are claimed, enter in column 2 the home office chain number 1.00 2.0	defined in CMS	in column 1		J		133.00
All Providers 140.00 Are there any related organization or home office costs as chapter 10? Enter "Y" for yes or "N" for no in column 1. I are claimed, enter in column 2 the home office chain number 1.00 2.0						134.00
140.00 Are there any related organization or home office costs as chapter 10? Enter "Y" for yes or "N" for no in column 1. I are claimed, enter in column 2 the home office chain number 1.00 2.0						-
chapter 10? Enter "Y" for yes or "N" for no in column 1. I are claimed, enter in column 2 the home office chain number 1.00 2.0		Pub. 15-1.	$\overline{}$	Υ	15H059	140. 00
1.00 2.0	f yes, and home		s			
	· · · · · · · · · · · · · · · · · · ·	tions)				
		ugh 142 tho	namo an	3.00	of the home	
office and enter the home office contractor name and contr		ugii 145 tile i	ialle all	auui ess	or the nome	
141.00 Name: IU HEALTH Contractor's Name: WI		Contracto	or's Nur	mber: 0810	1	141.00
142.00 Street: 340 W 10TH STREET PO Box:						142.0
143.00 City: INDIANAPOLIS State: II	N	Zip Code:		4620	2	143.0
					1.00	4
144.00 Are provider based physicians' costs included in Worksheet	Δ?				1.00 N	144.00
The soft of provider successful or and sector that also the northenness	,,,					11110
				1. 00	2. 00	1
145.00 If costs for renal services are claimed on Wkst. A, line 7-						145. 00
inpatient services only? Enter "Y" for yes or "N" for no inno, does the dialysis facility include Medicare utilization						
period? Enter "Y" for yes or "N" for no in column 2.	ii ioi tiiis cost	reporting				
146.00 Has the cost allocation methodology changed from the previous	ously filed cos	t report?		N		146. 0
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub.	15-2, chapter	40, §4020) I f	5			
yes, enter the approval date (mm/dd/yyyy) in column 2.						
					1. 00	+
147.00 Was there a change in the statistical basis? Enter "Y" for	yes or "N" for	no.			N N	147.0
148.00 Was there a change in the order of allocation? Enter "Y" for					N	148. 0
149.00 Was there a change to the simplified cost finding method?					N	149. 00
	Part A	Part B		tle V	Title XIX	4
Does this facility contain a provider that qualifies for a	1.00	2.00		3.00 f the Low	4.00	
or charges? Enter "Y" for yes or "N" for no for each compo						
155. 00 Hospi tal	N	N		N	N	ີ່ 155. 0
156.00 Subprovi der - IPF	N	N		N	N	156. 0
157. 00 Subprovi der - I RF 158. 00 SUBPROVI DER	N	N		N	N	157. 0 158. 0
158. 00 S0BPR0VIDER 159. 00 SNF	N	N		N	N	159. 0
160.00 HOME HEALTH AGENCY	N N	N		N	N N	160. 0
161. 00 CMHC		N		N	N	161.0
161. 10 CORF		N		N	N	161. 10
					1.00	4
Multicampus					1. 00	
165.00 s this hospital part of a Multicampus hospital that has on	ne or more campi	uses in diffe	erent CE	3SAs?	N	165. 00
Enter "Y" for yes or "N" for no.						
Name	County		p Code	CBSA	FTE/Campus	4
0	1. 00	2.00	3. 00	4. 00	5. 00	0 166. 00
166.00 f line 165 is yes, for each campus enter the name in column					0.00	J 166. U
0, county in column 1, state in						
column 2, zip code in column 3,						
CBSA in column 4, FTE/Campus in						
ICOLUMN S ICOA INCIPICITANO						
column 5 (see instructions)					1. 00	
jeorumii 3 (see riistructrons)						
Health Information Technology (HIT) incentive in the Ameri			nt Act			
Health Information Technology (HIT) incentive in the Ameri 167.00 sthis provider a meaningful user under §1886(n)? Enter	"Y" for yes or '	"N" for no.			N	
Health Information Technology (HIT) incentive in the Ameri 167.00 Is this provider a meaningful user under §1886(n)? Enter 168.00 If this provider is a CAH (line 105 is "Y") and is a meani	"Y" for yes or ' ngful user (line	"N" for no.		- the	N	
Health Information Technology (HIT) incentive in the Ameri 167.00 Is this provider a meaningful user under §1886(n)? Enter 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningreasonable cost incurred for the HIT assets (see instruction	"Y" for yes or ' ngful user (lind ons)	"N" for no. e 167 is "Y")), enter		N	167. 00 168. 00
Health Information Technology (HIT) incentive in the Ameri 167.00 s this provider a meaningful user under §1886(n)? Enter 168.00 f this provider is a CAH (line 105 is "Y") and is a meanine reasonable cost incurred for the HIT assets (see instructions) 168.01 f this provider is a CAH and is not a meaningful user, do	"Y" for yes or ' ngful user (line ons) es this provide	"N" for no. e 167 is "Y") r qualify for), enter a harc		N	
Health Information Technology (HIT) incentive in the Ameri 167.00 Is this provider a meaningful user under §1886(n)? Enter 168.00 If this provider is a CAH (line 105 is "Y") and is a meaning reasonable cost incurred for the HIT assets (see instruction	"Y" for yes or ' ngful user (lind ons) es this provide " for no. (see i	"N" for no. e 167 is "Y") r qualify for instructions)), enter a harc	dshi p		168. 0

Health Financial Systems	REHABILITATION HOSPI	TAL OF INDIANA	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CCN: 15-3028	Peri od:	Worksheet S-2	2
			From 01/01/2020		
			To 12/31/2020	Date/Time Pre	epared:
				7/15/2021 11:	42 am
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170. 00
period respectively (min day yyyy)					
					-
			1. 00	2. 00	
171.00 If line 167 is "Y", does this prov	vider have any days for indi	ividuals enrolled in	N	(171.00
section 1876 Medicare cost plans r	reported on Wkst. S-3, Pt.	I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in colu	umn 1. If column 1 is yes, e	enter the number of secti	on		
1876 Medicare days in column 2. (s	see instructions)				

HOSPI 1	Financial Systems REHABILITATION HOSPITAL O				u of Form CMS	
	FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Pro	ovider CC	:N: 15-3028	Period: From 01/01/2020 To 12/31/2020	Date/Time Pr	epared:
				Y/N	7/15/2021 11	: 42 am
				1, 00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all	all NO re	enonege Ent			
	mm/dd/yyyy format.	all NO IC	зропзез. Еп	ter arr dates in	trie	
	COMPLETED BY ALL HOSPITALS					
	Provi der Organi zati on and Operati on					
1. 00	Has the provider changed ownership immediately prior to the begin	nning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in column :			s)		
			Y/N	Date	V/I	
			1. 00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare Program yes, enter in column 2 the date of termination and in column 3, "Voluntary or "I" for involuntary.		N			2. 00
3. 00	Is the provider involved in business transactions, including manacontracts, with individuals or entities (e.g., chain home offices or medical supply companies) that are related to the provider or officers, medical staff, management personnel, or members of the of directors through ownership, control, or family and other siminal relationships? (see instructions)	s, drug its board	Y			3.00
	Transfer (add that dationa)		Y/N	Type	Date	
			1.00	2.00	3.00	
	Financial Data and Reports	<u> </u>				
 4.00 5.00 	Column 1: Were the financial statements prepared by a Certified Accountant? Column 2: If yes, enter "A" for Audited, "C" for Com or "R" for Reviewed. Submit complete copy or enter date available column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different f	mpiled, e in from	Y	А		4. 00 5. 00
	those on the filed financial statements? If yes, submit reconcilia	iation.				
				Y/N	Legal Oper.	
	A			1. 00	2. 00	
	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If ye	oc ic th	o providor i	s N	1	6.00
4 00	Tool unit 1. Are costs crarilled for fluisting school? Corullin 2. It yes	25, IS LII	ie provider i	5 11		0.00
6. 00	the Legal operator of the program?			N		
	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instruct	tions				1 7 00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see instruct	tions. r renewed	l durina the	N N		7.00
6. 00 7. 00 8. 00		tions. r renewed	I during the			
7. 00	Are costs claimed for Allied Health Programs? If "Y" see instruct Were nursing school and/or allied health programs approved and/or	r renewed		N		
7. 00 8. 00 9. 00	Are costs claimed for Allied Health Programs? If "Y" see instruct Were nursing school and/or allied health programs approved and/or cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved gradua program in the current cost report? If yes, see instructions.	r renewed	al education	N		8. 00 9. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see instruct Were nursing school and/or allied health programs approved and/or cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved gradua program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renerations.	r renewed	al education	N		8. 00
7. 00 8. 00 9. 00 10. 00	Are costs claimed for Allied Health Programs? If "Y" see instruct Were nursing school and/or allied health programs approved and/or cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved gradua program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renercost reporting period? If yes, see instructions.	r renewed ate medic ewed in t	al education	N Y N		8. 00 9. 00 10. 00
7. 00 8. 00 9. 00	Are costs claimed for Allied Health Programs? If "Y" see instruct Were nursing school and/or allied health programs approved and/or cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved gradua program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or rene cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R is	r renewed ate medic ewed in t	al education	N Y		8. 00 9. 00
7. 00 8. 00 9. 00 10. 00	Are costs claimed for Allied Health Programs? If "Y" see instruct Were nursing school and/or allied health programs approved and/or cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved gradua program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renercost reporting period? If yes, see instructions.	r renewed ate medic ewed in t	al education	N Y N	V/N	8. 00 9. 00 10. 00
7. 00 8. 00 9. 00 10. 00	Are costs claimed for Allied Health Programs? If "Y" see instruct Were nursing school and/or allied health programs approved and/or cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved gradua program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or rene cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R is	r renewed ate medic ewed in t	al education	N Y N	Y/N 1.00	8. 00 9. 00 10. 00
7. 00 8. 00 9. 00 10. 00	Are costs claimed for Allied Health Programs? If "Y" see instruct Were nursing school and/or allied health programs approved and/or cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved gradua program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renercost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in Teaching Program on Worksheet A? If yes, see instructions.	r renewed ate medic ewed in t	al education	N Y N	Y/N 1. 00	8. 00 9. 00 10. 00
7. 00 8. 00 9. 00 10. 00	Are costs claimed for Allied Health Programs? If "Y" see instruct Were nursing school and/or allied health programs approved and/or cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved gradua program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or rene cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in Teaching Program on Worksheet A? If yes, see instructions. Bad Debts	r renewed ate medic ewed in t in an App	al education he current proved	N Y N	1.00	8. 00 9. 00 10. 00 11. 00
7. 00 3. 00 9. 00 10. 00 11. 00	Are costs claimed for Allied Health Programs? If "Y" see instruct Were nursing school and/or allied health programs approved and/or cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved gradua program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renercost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in Teaching Program on Worksheet A? If yes, see instructions. Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see	r renewed ate medic ewed in t in an App	al education he current proved	N Y N N	1. 00 Y	8. 00 9. 00 10. 00 11. 00
7. 00 8. 00 9. 00 10. 00 11. 00	Are costs claimed for Allied Health Programs? If "Y" see instruct Were nursing school and/or allied health programs approved and/or cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved gradua program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or rene cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in Teaching Program on Worksheet A? If yes, see instructions. Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see If line 12 is yes, did the provider's bad debt collection policy of the cost of the	r renewed ate medic ewed in t in an App	al education he current proved	N Y N N	1.00	8. 00 9. 00 10. 00 11. 00
7. 00 3. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Are costs claimed for Allied Health Programs? If "Y" see instruct Were nursing school and/or allied health programs approved and/or cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved gradua program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or rener cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in Teaching Program on Worksheet A? If yes, see instructions. Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see If line 12 is yes, did the provider's bad debt collection policy period? If yes, submit copy.	r renewed ate medic ewed in t in an App instruct change d	he current proved	N Y N N N Cost reporting	1. 00 Y N	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
7. 00 3. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Are costs claimed for Allied Health Programs? If "Y" see instruct Were nursing school and/or allied health programs approved and/or cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved gradua program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or rene cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in Teaching Program on Worksheet A? If yes, see instructions. Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see If line 12 is yes, did the provider's bad debt collection policy of the cost of the	r renewed ate medic ewed in t in an App instruct change d	he current proved	N Y N N N Cost reporting	1. 00 Y	8. 00 9. 00 10. 00 11. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Are costs claimed for Allied Health Programs? If "Y" see instruct Were nursing school and/or allied health programs approved and/or cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved gradua program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renercost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in Teaching Program on Worksheet A? If yes, see instructions. Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see If line 12 is yes, did the provider's bad debt collection policy period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments was	r renewed ate medic ewed in t in an App instruct change d aived? If	ions. luring this of yes, see in	N Y N N N N Scost reporting instructions.	1. 00 Y N	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Are costs claimed for Allied Health Programs? If "Y" see instruct Were nursing school and/or allied health programs approved and/or cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved gradua program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or rener cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in Teaching Program on Worksheet A? If yes, see instructions. Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see If line 12 is yes, did the provider's bad debt collection policy period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments wa Bed Complement	r renewed ate medic ewed in t in an App instruct change d aived? If	ions. luring this of yes, see in	N N N N cost reporting nstructions.	1. 00 Y N	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Are costs claimed for Allied Health Programs? If "Y" see instruct Were nursing school and/or allied health programs approved and/or cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved gradua program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renercost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & Ritteaching Program on Worksheet A? If yes, see instructions. Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see If line 12 is yes, did the provider's bad debt collection policy period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments was Bed Complement Did total beds available change from the prior cost reporting per	r renewed ate medic ewed in t in an App instruct change d aived? If	ions. luring this of yes, see in	N N N N cost reporting nstructions.	1. 00 Y N	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00

	. our bata					
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	Y	04/02/2021	Y	04/02/2021	16.00
	date of the PS&R Report used in columns 2 and 4 .(see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	N I		N		17.00
	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)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					

Health Financial Sy	rstems REHABILITATION HO	SPITAL OF INDIA	INA	Inlie	u of Form CM	S-2552-10
	TAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-3028 F	Period: From 01/01/2020	Worksheet S Part II	5-2
			1	To 12/31/2020	Date/Time P 7/15/2021 1	
			i pti on	Y/N	Y/N	
20 00 If line 16 o	or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00
	for Other? Describe the other adjustments:			IN	IV	20.00
	Y/N Date Y/N 1.00 2.00 3.00					
21.00 Was the cost	report prepared only using the provider's	1.00 N	2.00	3.00 N	4. 00	21.00
	yes, see instructions.					
					1. 00	
	COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS I	HOSPI TALS)			
Capi tal Rela	ted Cost been relifed for Medicare purposes? If yes, se	oo instructions			Υ	22. 00
	s occurred in the Medicare depreciation expense			ng the cost	N N	23. 00
	eriod? If yes, see instructions.		46:4			24.00
	uses and/or amendments to existing leases enter instructions	rea into during	this cost rep	orting period?	N	24.00
25.00 Have there b	een new capitalized leases entered into durinç :	g the cost repo	rting period?	If yes, see	N	25. 00
	subject to Sec. 2314 of DEFRA acquired during	the cost report	ing period? If	yes, see	N	26. 00
27.00 Has the prov	vider's capitalization policy changed during th	ne cost reporti	ng period? If	yes, submit	N	27. 00
copy. Interest Expe	ense					
28.00 Were new Loa	ins, mortgage agreements or letters of credit ϵ	entered into du	ring the cost	reporti ng	N	28. 00
29.00 Did the prov	period? If yes, see instructions. On Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)					
	treated as a funded depreciation account? If yes, see instructions On Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see					
i nstructi ons	i nstructi ons.					
i nstructi ons	j.	ssuance of new	debt? IT yes,		N	31.00
Purchased Sei 32.00 Have changes	rvices s or new agreements occurred in patient care se	ervices furnish	ed through con	tractual	N	32.00
arrangements	with suppliers of services? If yes, see instr	ructi ons.	· ·			
33.00 If line 32 i no, see inst	s yes, were the requirements of Sec. 2135.2 approach to the requirements of Sec. 2135.2 approach to the second sections.	opired pertaini	ng to competit	ive brading? II		33.00
	ed Physicians					
	s furnished at the provider facility under an a instructions.	arrangement wit	h provider-bas	ed physicians?	N	34.00
	s yes, were there new agreements or amended ex luring the cost reporting period? If yes, see i		nts with the p	rovi der-based		35. 00
physici ans a	diring the cost reporting period: 11 yes, see i	nstructions.		Y/N	Date	
Homo Offi oo /	Conto			1. 00	2. 00	
Home Office (36.00 Were home of	fice costs claimed on the cost report?			Υ		36.00
37.00 If line 36 i	s yes, has a home office cost statement been p	orepared by the	home office?	Υ		37.00
38.00 If line 36 i	instructions. s yes, was the fiscal year end of the home of			N		38.00
	? If yes, enter in column 2 the fiscal year er s yes, did the provider render services to oth			Υ		39.00
see instruct 40.00 If line 36 i	ions. s yes, did the provider render services to the	e home office?	If was see	N		40.00
i nstructi ons		o nome office:		IN .		40.00
		1.	00	2.	00	
	Preparer Contact Information					
	rst name, last name and the title/position cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		41.00
respectively 42.00 Enter the em	v. nployer/company name of the cost report	IU HEALTH				42. 00
preparer.				DUTTED		
	elephone number and email address of the cost arer in columns 1 and 2, respectively.	317-962-1093		RUTTER@I UHEALT	H. ORG	43.00

Heal th	Financial Systems REHABI	LITATION HOSE	PITAL OF INDIA	NA	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUEST	ΓΙ ONNAI RE	Provi der Co	CN: 15-3028	Peri od: From 01/01/2020	Worksheet S-2	!
						Date/Time Pre	pared:
			<u>'</u>				
			3.	00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/		DI RECTOR				41.00
	held by the cost report preparer in columns 1,	2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost re	port					42.00
	preparer.						
43.00	Enter the telephone number and email address o						43.00
	report preparer in columns 1 and 2, respective	el y.					

Provi der CCN: 15-3028

| Peri od: | Worksheet S-3 | From 01/01/2020 | Part I | To 12/31/2020 | Date/Time Prepared:

				''	0 12/31/2020	7/15/2021 11:	
	·					I/P Days /	
						0/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Davs	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	91	33, 306	0. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7. 00	Total Adults and Peds. (exclude observation		91	33, 306	0. 00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)		91	33, 306	0. 00	0	14.00
15. 00	CAH visits					0	15. 00
16. 00	SUBPROVIDER - IPF						16.00
17. 00	SUBPROVIDER - IRF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	30.00					24. 10
25. 00	CWHC - CWHC	99. 00				0	25. 00
25. 10	CMHC - CORF	99. 10				0	25. 10
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				o	26. 25
27. 00	Total (sum of lines 14-26)		91			_	27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambulance Trips					_	29. 00
30.00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)		0	0			32.00
32. 01	Total ancillary labor & delivery room			Ĭ			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00
	LTCH site neutral days and discharges						33. 01
	, , , , , , , , , , , , , , , , , , ,	, !		ı	,	,	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-3028

Peri od: Worksheet S-3 From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

7/15/2021 11:42 am I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Title XIX Component Total ALL Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 Hospital Adults & Peds. (columns 5, 6, 7 and 20, 733 6,639 670 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 3,078 4, 333 2.00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4 00 0 4 00 0 5.00 Hospital Adults & Peds. Swing Bed SNF 0 C 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 6,639 670 20, 733 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8 00 8 00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12 00 13.00 NURSERY 13.00 14.00 Total (see instructions) 6,639 670 20, 733 2. 97 365.03 14.00 CAH visits 15.00 15.00 16.00 SUBPROVIDER - IPF 16.00 17.00 SUBPROVIDER - IRF 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 24.00 24.00 24. 10 HOSPICE (non-distinct part) 0 24.10 0.00 CMHC - CMHC 0 0.00 25.00 25, 00 0 25. 10 CMHC - CORF 0 0 0.00 0.00 25.10 RURAL HEALTH CLINIC 26.00 26.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 26 25 0 00 26 25 365.03 27.00 Total (sum of lines 14-26) 2. 97 27.00 28.00 Observation Bed Days 0 0 28.00 29.00 Ambulance Trips 0 29.00 Employee discount days (see instruction) 30 00 O 30.00 0 31.00 Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) 0 32.00 Total ancillary labor & delivery room outpatient days (see instructions) 0 32.01 32.01 33 00 LTCH non-covered days 33 00 33.01 LTCH site neutral days and discharges 33.01

Health Financial Systems REHABILITATION HOSPITAL OF INDIANA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN:

Provider CCN: 15-3028

Peri od: Worksheet S-3 From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: 7/15/2021 11:42 am

						7/15/2021 11:	42 am
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12. 00	13.00	14. 00	Pati ents 15.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00		14.00	1, 283	1.00
1.00	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		O	433	40	1, 203	1.00
2.00	HMO and other (see instructions)			185	264		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	433	40	1, 283	14.00
15.00	CAH vi si ts						15.00
16.00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC	0.00					25.00
25. 10	CMHC - CORF	0.00					25. 10
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29. 00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days			0			33.00
	LTCH site neutral days and discharges			0			33.00
33.01	TETOT SI LE HEULT AT UAYS AND UT SCHALGES	ı İ		ı	ı		JJ. UI

Heal th	Financial Systems REHA	BILITATION HOSPI	TAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CCN: 15-3028		Period: Worksheet A		
					From 01/01/2020 Fo 12/31/2020	Date/Time Pre 7/15/2021 11:	
	Cost Center Description	Sal ari es	0ther		Recl assi fi cat	Reclassi fied	
				+ col. 2)	i ons (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 & FLXT		1, 096, 082	1, 096, 082		1, 096, 082	
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		1, 125, 505	1, 125, 50	5 0	1, 125, 505	2.00
3.00	00300 OTHER CAP REL COSTS	454 440	0	(000 07	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00591 ADMINISTRATIVE AND GENERAL	151, 469	5, 881, 906	6, 033, 37		6, 028, 347	4.00
5. 01 5. 02	00590 OTHER A&G - NON FOUNDATION	4, 209, 078	2, 117, 263 256, 438	6, 326, 34		6, 135, 196	
5. 02 7. 00	00700 OPERATION OF PLANT	748, 029 33, 279	1, 734, 653	1, 004, 46 1, 767, 932		1, 004, 108 1, 767, 570	
8. 00	00800 LAUNDRY & LI NEN SERVI CE	33, 279	1, 734, 033	122, 043		1, 767, 370	1
9. 00	00900 HOUSEKEEPING	316, 943	164, 183	481, 120		479, 087	
10. 00	01000 DI ETARY	65, 405	996, 814	1, 062, 219	· ·	720, 177	
11. 00	01100 CAFETERI A	0	0		341, 874	341, 874	
13.00	01300 NURSING ADMINISTRATION	1, 495, 265	400, 210	1, 895, 475		2, 134, 038	
14.00	01400 CENTRAL SERVICES & SUPPLY	68, 973	100, 986	169, 959		472, 319	
15.00	01500 PHARMACY	603, 661	175, 643	779, 304	-6, 322	772, 982	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	369, 686	127, 830	497, 510	5 0	497, 516	16.00
17. 00	01700 SOCIAL SERVICE	370, 651	78, 670	449, 32		449, 321	17. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	255, 571	255, 57	1 0	255, 571	22.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	7, 679, 307	1, 476, 997	9, 156, 304	-248, 005	8, 908, 299	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	7,074,307	1,470,777	7, 130, 30	-246, 003	0, 700, 277	30.00
50.00	05000 OPERATI NG ROOM	0	0	(0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	138, 788	30, 707	169, 49	-2, 992	166, 503	54.00
60.00	06000 LABORATORY	0	469, 799	469, 799	9 0	469, 799	60.00
65.00	06500 RESPI RATORY THERAPY	481, 812	155, 862	637, 67	-92, 773	544, 901	65.00
66. 00	06600 PHYSI CAL THERAPY	1, 695, 925	371, 113	2, 067, 038		2, 480, 759	
66. 01	06601 PHYSI CAL THERAPY - CARMEL	201, 377	117, 261	318, 638		336, 876	1
67. 00	06700 OCCUPATI ONAL THERAPY	2, 254, 192	261, 214	2, 515, 400		2, 315, 628	1
68.00	06800 SPEECH PATHOLOGY	936, 568	99, 296	1, 035, 86	270, 953	1, 306, 817	1
68. 01	06801 VI SI 0N	1 420 7(0	220 570	1 7/0 2//	144 740	1 (22 570	68. 01
68. 02 69. 00	06802 FAC RESOURCE 06900 ELECTROCARDI OLOGY	1, 429, 768	339, 578	1, 769, 340	-146, 768	1, 622, 578	68. 02 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(164, 151	164, 151	
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(104, 131	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	ő	1, 582, 444	1, 582, 44	4 0	1, 582, 444	
74. 00	07400 RENAL DI ALYSI S	o	0		0	0	1
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	188, 622	59, 870	248, 492	-18, 892	229, 600	
90. 01	09001 SLEEP CENTER	0	0	(0	0	
91.00	09100 EMERGENCY	0	O	(0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
99 00	OTHER REIMBURSABLE COST CENTERS O9900 CMHC	O	٥			0	99.00
	09910 CORF	460, 116	152, 449	612, 56	-612, 565		99. 10
	SPECIAL PURPOSE COST CENTERS						
118.00		23, 898, 914	19, 750, 387	43, 649, 30	-119, 210	43, 530, 091	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	ol		0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFICES	875, 561	545, 927	1, 421, 488		1, 528, 482	1
	07950 FOUNDATION	234, 657	28, 713	263, 370		276, 275	
	07951 PUBLIC RELATIONS	123, 466	270, 303	393, 769		393, 372	1
194. 02	07952 ST. VINCENT - ARU	0	0		0		194. 02
	07953 MUNCIE - ARU	26, 806	15, 217	42, 023	3 0	42, 023	
	07954 RILEY - ARU	0	o	(0	0	194.04
	07955 RETAIL PHARMACY	189, 859	840, 070	1, 029, 929		1, 029, 637	
200.00	TOTAL (SUM OF LINES 118 through 199)	25, 349, 263	21, 450, 617	46, 799, 880	0	46, 799, 880	200.00

Provi der CCN: 15-3028

Peri od: Worksheet A From 01/01/2020 Date/Time Prepared: 7/15/2021 11:42 am

				7/15/2021 11:	
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
			Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-7, 190		1	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	244, 777	1, 370, 282	1	2.00
3.00	00300 OTHER CAP REL COSTS	0	0		3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 071	6, 025, 276		4.00
5. 01	00591 ADMI NI STRATI VE AND GENERAL	2, 860, 859	8, 996, 055		5. 01
5. 02	00590 OTHER A&G - NON FOUNDATION	0	1, 004, 108		5. 02
7.00	00700 OPERATION OF PLANT	-27, 643	1, 739, 927	l control of the cont	7.00
8.00	00800 LAUNDRY & LI NEN SERVI CE	0	122, 043 479, 087		8.00
9.00	00900 HOUSEKEEPI NG	0			9.00
10. 00 11. 00	01000 DI ETARY	141 (10	720, 177 200, 255		11.00
13.00	01100 CAFETERI A	-141, 619			13.00
14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	-365 0	2, 133, 673		14.00
			472, 319		1
15.00	01500 PHARMACY	-20, 517	752, 465		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-25	497, 491		16.00
	01700 SOCIAL SERVICE	0	449, 321		17.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	255, 571		22.00
20 00	O3000 ADULTS & PEDIATRICS	0	8, 908, 299		30.00
30.00	ANCILLARY SERVICE COST CENTERS	U	0, 700, 277		30.00
50. 00	05000 OPERATING ROOM	0	0		50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	166, 503		54.00
60.00	06000 LABORATORY	-37, 553	432, 246	1	60.00
65. 00	06500 RESPI RATORY THERAPY	-57, 555	544, 901		65.00
66. 00	06600 PHYSI CAL THERAPY	0	2, 480, 759	1	66.00
66. 01	06601 PHYSI CAL THERAPY - CARMEL	0	336, 876	1	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	0	2, 315, 628		67.00
68. 00	06800 SPEECH PATHOLOGY	0	1, 306, 817	i e	68.00
68. 01	06801 VI SI ON	0	0,000,017		68. 01
68. 02	06802 FAC RESOURCE	0	1, 622, 578	I .	68. 02
69. 00	06900 ELECTROCARDI OLOGY	0	0		69.00
71. 00		0	164, 151	I .	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 582, 444		73.00
	07400 RENAL DI ALYSI S	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0	229, 600		90.00
90. 01	09001 SLEEP CENTER	0	0		90. 01
91.00		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
99. 10	09910 CORF	0	0		99. 10
	SPECIAL PURPOSE COST CENTERS				
118.00	9 /	2, 867, 653	46, 397, 744		118. 00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	1, 528, 482		192. 00
	07950 FOUNDATI ON	479, 694	755, 969	i e	194. 00
	07951 PUBLIC RELATIONS	0	393, 372		194. 01
	2 07952 ST. VINCENT - ARU	0	0		194. 02
	3 O7953 MUNCI E - ARU	0	42, 023		194. 03
	07954 RI LEY - ARU	0	0		194.04
	507955 RETAIL PHARMACY	0	1, 029, 637		194. 05
200.00	TOTAL (SUM OF LINES 118 through 199)	3, 347, 347	50, 147, 227		200.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-3028 Peri od: Worksheet A-6 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

					7/15/2021 11:42 am
		Increases			77 107 2021 111 12 411
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3.00	4. 00	5. 00	
	A - CAFETERIA				
1.00	CAFETERI A	1100	2 <u>1, 0</u> 54	32 <u>0, 8</u> 20	1. 00
	0		21, 054	320, 820	
	B - NURSING ADMINISTRATION				
1.00	NURSING ADMINISTRATION	1300	18 <u>8, 2</u> 11	0	1.0
	0		188, 211	0	
	C - NCR (CORF)				
1.00	PHYSI CAL THERAPY	66. 00	155, 192	51, 115	1.0
2.00	OCCUPATI ONAL THERAPY	67. 00	185, 371	61, 056	2.0
3.00	SPEECH PATHOLOGY	6800	119, 553	<u> 39, 377</u>	3.0
	0		460, 116	151, 548	
	D - MEDICAL SUPPLIES				
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	341, 907	1.0
2.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	164, 151	2.0
	PATI ENTS				
3.00		0.00	0	О	3.0
4.00		0. 00	0	O	4.0
5.00		0. 00	0	O	5.0
6.00		0. 00	0	O	6.0
7. 00		0.00	o	О	7.0
8. 00		0.00	o	О	8.0
9.00		0.00	o	О	9. (
10.00		0.00	o	О	10.0
11.00		0.00	O	О	11.0
12.00		0.00	O	0	12.0
13. 00		0.00	O	0	13.0
14.00		0.00	o	0	14. (
15. 00		0.00	o	0	15. (
16. 00		0. 00	ō	0	16. (
17. 00		0. 00	o	0	17. (
18. 00		0.00	ol	0	18.0
19. 00		0. 00	ol	0	19. (
20.00		0. 00	ol	0	20.0
21. 00		0. 00	ol	0	21. 0
22. 00		0. 00	ol	0	22.0
			 	506, 058	
	E - THERAPY ADMIN		<u> </u>	555, 555	
1. 00	ADMINISTRATIVE AND GENERAL	5. 01	15, 951	2, 420	1. 0
2. 00	NURSI NG ADMINI STRATI ON	13. 00	59, 832	9, 078	2. 0
3. 00	PHYSI CAL THERAPY	66. 00	183, 956	27, 912	3. 0
4. 00	PHYSICAL THERAPY - CARMEL	66. 01	16, 000	2, 428	4.0
5. 00	SPEECH PATHOLOGY	68. 00	99, 506	15, 098	5.0
6. 00	FOUNDATI ON	194. 00	11, 205	1, 700	6.0
0.00	0		386, 450	_{58,636}	0.0
	F - RTOC ADMIN		300, 430	30, 030	
1. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	123, 502	13, 696	1.0
1.00	0 INTO THE STATE OF THE STATE O		123, 502	13, 696	1.0
500 00	Grand Total: Increases		1, 179, 333	1, 050, 758	500. 0
550.00	pi ana Total. Thereases	ı	1, 177, 555	1,030,730	1 500. 0

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6
From 01/01/2020
To 12/31/2020 Date/Ti me Prepared: Provider CCN: 15-3028

						 7/15/2021 11:42 an
		Decreases				
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10.00	
	A - CAFETERIA					
. 00	DI ETARY	1000	2 <u>1, 0</u> 54	32 <u>0, 8</u> 20		1.0
	0		21, 054	320, 820)	
	B - NURSING ADMINISTRATION					
. 00	ADMI NI STRATI VE AND GENERAL	5. 01	18 <u>8, 2</u> 11	(1.0
	0		188, 211	()	
	C - NCR (CORF)					
. 00	CORF	99. 10	460, 116	151, 548		1.0
. 00		0. 00	0		0	2.0
. 00		000		`	0 0	3.0
	0		460, 116	151, 548	3	
	D - MEDICAL SUPPLIES					
. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	5, 028	1	1.0
00	ADMINISTRATIVE AND GENERAL	5. 01	0	21, 305		2.0
. 00	OTHER A&G - NON FOUNDATION	5. 02	0	359	1	3.0
. 00	OPERATION OF PLANT	7. 00	0	362		4.0
00	HOUSEKEEPI NG	9. 00	0	2, 039	9 0	5.0
00	DI ETARY	10. 00	0	168	0	6.0
00	NURSING ADMINISTRATION	13. 00	0	18, 558	0	7. (
00	CENTRAL SERVICES & SUPPLY	14. 00	0	39, 547	7 0	8.0
.00	PHARMACY	15. 00	0	6, 322	2 0	9. (
0. 00	ADULTS & PEDIATRICS	30. 00	0	248, 005	5 0	10.0
1. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 992	2 0	11. (
2. 00	RESPI RATORY THERAPY	65. 00	0	92, 773	0	12. (
3.00	PHYSI CAL THERAPY	66. 00	O	4, 454	4 0	13.0
4. 00	PHYSICAL THERAPY - CARMEL	66. 01	O	190	o o	14.0
5. 00	OCCUPATI ONAL THERAPY	67. 00	O	1, 119	9 0	15.0
5. 00	SPEECH PATHOLOGY	68. 00	O	2, 581	1 0	16.0
7. 00	FAC RESOURCE	68. 02	O	9, 570	ol ol	17. (
3. 00	CLINIC	90.00	o	18, 892	2 0	18.0
9. 00	CORF	99. 10	O	901	1 0	19. (
0. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	o	30, 204	4 0	20.0
1.00	PUBLIC RELATIONS	194. 01	o	397	7 0	21.0
2. 00	RETAIL PHARMACY	194. 05	O	292	2 0	22.0
				506, 058	3	1
	E - THERAPY ADMIN				· .	
00	OCCUPATI ONAL THERAPY	67. 00	386, 450	58, 636	6 0	1. (
00		0.00	O		o	2.0
00		0.00	O	(3. (
00		0. 00	o	(4. (
00		0.00	o	(5. (
00		0.00	o	(6. (
-		— — — +	386, 450			
	F - RTOC ADMIN		230, .00	23, 300	-	
00	FAC RESOURCE	68. 02	123, 502	13, 696	5 0	1.0
- 0	0	— = = = = +	123, 502	13, 696		'''
00	Grand Total: Decreases	+	1, 179, 333	1, 050, 758		500.0

HIT designated Assets

10.00 Total (line 8 minus line 9)

Reconciling Items

Subtotal (sum of lines 1-7)

7.00

8.00

9.00

7.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-3028 Peri od: Worksheet A-7 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/15/2021 11:42 am Acqui si ti ons Begi nni ng Purchases Disposals and Donati on Total Bal ances Retirements 2.00 3.00 4.00 5.00 1.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2, 506, 638 0 0 1.00 0 370, 910 2.00 Land Improvements 0 2.00 3.00 Buildings and Fixtures 18, 038, 278 733, 543 733, 543 0 3.00 0 4.00 Building Improvements 205, 018 0 4.00 Fi xed Equi pment 2, 265, 857 0 5.00 0 5.00 0 6.00 Movable Equipment 14, 688, 344 337, 655 337, 655 4,869 6.00 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 38, 075, 045 1,071,198 1, 071, 198 4,869 8.00 9.00 Reconciling Items 0 0 9.00 38, 075, 045 1, 071, 198 4, 869 Total (line 8 minus line 9) 1,071,198 10.00 O 10.00 Endi ng Ful I y Bal ance Depreciated Assets 6. 00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2, 506, 638 1.00 2.00 161, 516 Land Improvements 370, 910 2.00 18, 771, 821 3.00 Buildings and Fixtures 882, 803 3.00 4.00 Building Improvements 205, 018 95, 017 4.00 5.00 Fixed Equipment 2, 265, 857 1, 508, 400 5.00 6.00 Movable Equipment 15, 021, 130 7, 254, 108 6.00

39, 141, 374

39, 141, 374

9, 901, 844

9, 901, 844

Health Financial Systems	REHABILITATION HOSPITAL OF INDIANA	In Lie	u of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-3028	Peri od:	Worksheet A-7

Period: WULKSHOOS ...
From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared: 7/15/2021 11: 42 am SUMMARY OF CAPITAL Insurance Cost Center Description Depreciation Interest Taxes (see Lease instructions) (see instructions) 9. 00 10.00 11.00 13.00 12.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP 34, 777 1.00 1.00 756, 031 305, 274 0 2.00 1, 113, 903 -875 0 2.00 1, 869, 934 3.00 Total (sum of lines 1-2) 305, 274 33, 902 0 3.00 SUMMARY OF CAPITAL Other Total (1) Capital-Relat (sum of cols Cost Center Description ed Costs (see 9 through 14) instructions) 14. 00 15. 00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 1, 096, 082 1.00 12, 477 2.00 CAP REL COSTS-MVBLE EQUIP 1, 125, 505 2.00 12, 477 3.00 Total (sum of lines 1-2) 2, 221, 587 3.00

Health Financial Systems	REHABILITATION HOSPITAL OF INDIANA	Ir	In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-3028	Peri od:	Worksheet A-7		

	DI LI IATI ON 1103	TITAL OF THUTA	IIVA	III LI C	u or rorm cm3-2	2332-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7	
				rom 01/01/2020		
				o 12/31/2020		pared:
	COM	DUTATION OF DAT	TLOC	ALLOCATION OF	7/15/2021 11: 4	42 am
	COMPUTATION OF RATIOS			ALLOCATION OF		
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
		200000	(col. 1 -			
			col . 2)			
	1. 00	2, 00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1. 00 CAP REL COSTS-BLDG & FLXT	24, 120, 244	0	24, 120, 244	0. 616234	0	1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	15, 021, 130		15, 021, 130			2.00
3.00 Total (sum of lines 1-2)	39, 141, 374		39, 141, 374			3. 00
100 10tal (cam of 1111co 1 2)		TION OF OTHER (F CAPITAL	0.00
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
μ		Capi tal -Rel at	,			
		ed Costs	through 7)			
	6, 00	7. 00	8.00	9, 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS	<u> </u>		1		
1. 00 CAP REL COSTS-BLDG & FLXT	0	0	(884, 911	0	1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	0	0	ıl c	1, 358, 680	l ol	2.00
3.00 Total (sum of lines 1-2)	0	0		2, 243, 591	ol	3.00
		SL	JMMARY OF CAPI	ΓAL		
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	instructions)	Capi tal -Rel at	(sum of cols.	
		instructions)		ed Costs (see	9 through 14)	
		,		instructions)		
	11. 00	12. 00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	155, 898	34, 777	C	13, 306	1, 088, 892	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	. 0	-875	d	12, 477	1, 370, 282	2.00
3.00 Total (sum of lines 1-2)	155, 898	33, 902		25, 783		3.00
			'			

In Lieu of Form CMS-2552-10 Health Financial Systems REHABILITATION HOSPITAL OF INDIANA ADJUSTMENTS TO EXPENSES Provi der CCN: 15-3028 Peri od: Worksheet A-8 From 01/01/2020 12/31/2020 Date/Time Prepared: 7/15/2021 11:42 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL -149, 376 CAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of 5.00 0.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) 7.00 Tel ephone services (pay -14, 236 OPERATION OF PLANT 7 00 7.00 Α stations excluded) (chapter 8.00 Television and radio service -13, 407 OPERATION OF PLANT 7.00 8.00 Α (chapter 21) 9.00 Parking lot (chapter 21) 9.00 0.00 10.00 Provi der-based physici an 10.00 A-8-2 0 adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 3, 253, 515 12.00 12.00 A-8-1 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 Cafeteria-employees and guests -141, 619 CAFETERI A 11.00 14.00 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical O CENTRAL SERVICES & SUPPLY 16.00 16.00 В 14.00 supplies to other than pati ents 17.00 Sale of drugs to other than В -20, 517 PHARMACY 15.00 17.00 pati ents Sale of medical records and 18.00 -25 MEDICAL RECORDS & LIBRARY R 16.00 18.00 abstracts 19.00 Nursing and allied health 0.00 19.00 0 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 00 ol 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical OPHYSICAL THERAPY 24.00 A-8-3 66.00 therapy costs in excess of limitation (chapter 14) Utilization review 0 *** Cost Center Deleted *** 25.00 25.00 114.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL 1.00 26.00 COSTS-BLDG & FLXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP Non-physician Anesthetist Physicians' assistant 0 *** Cost Center Deleted *** 28.00 19.00 28.00 29 00 0.00 29 00 Adjustment for occupational O OCCUPATIONAL THERAPY 30.00 A-8-3 67.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 OADULTS & PEDIATRICS 30.00 30.99

instructions)

Health Financial Systems
ADJUSTMENTS TO EXPENSES Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/15/2021 11: 42 am Provi der CCN: 15-3028 Peri od: Worksheet A-8

						<u> 7/15/2021 11:</u>	<u>42 am</u>
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					, and the second		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	cost center bescription		AIIIOUITE	Cost Center	LITTE #		
		(2) 1. 00	2.00	2.00	4.00	Ref.	
01.00			2. 00	3.00	4.00	5. 00	04.00
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0. 00	0	32.00
	Depreciation and Interest						
33.00	MI SCELLANEOUS REVENUE	В	-1, 651	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33.00
33. 01	MI SCELLANEOUS REVENUE	В	-56, 327	ADMINISTRATIVE AND GENERAL	5. 01	0	33. 01
33. 02	MI SCELLANEOUS REVENUE	В	-12	NURSING ADMINISTRATION	13. 00	0	33. 02
33. 03	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 03
	(3)						
33. 04	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 04
	(3)						
33. 05	MI SCELLANEOUS REVENUE	В	0	VISION	68. 01	0	33. 05
33. 06	MI SCELLANEOUS REVENUE	В		FAC RESOURCE	68. 02	0	33.06
33. 07	RHI FOUNDATION	A		FOUNDATI ON	194. 00	0	33. 07
33. 08	ADVERTI SI NG	A		DIETARY	10.00	0	33.08
33. 09	ADVERTI SI NG	A		NURSING ADMINISTRATION	13. 00	0	33.09
33. 10	ADVERTI SI NG	A		FAC RESOURCE	68. 02	0	33. 10
33. 10	TAXES	A		ADMINISTRATIVE AND GENERAL	5. 01	0	33. 10
33. 12	TAXES			EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 12
	1 -	A		l I		ŭ	
33. 13		А	14, 182	CAP REL CUSTS-BLDG & FIXT	1.00	14	33.13
00.44			07/	OAD DEL COCTO DI DO O FLVT	4 00	4.4	00.44
	1						
						-	
		A	-353	NURSING ADMINISTRATION		0	
33. 17			0		0. 00	0	33. 17
50.00			3, 347, 347				50.00
	1.5						
	column 6, line 200.)						
33. 13 33. 14 33. 15 33. 16 33. 17 50. 00	BOND ISSUANCE COST AMORTIZATION CARR LATE FEES DONATIONS/CONTRIBUTIONS DONATIONS/CONTRIBUTIONS OTHER ADJUSTMENTS (SPECIFY) (3) TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	A A A	-876 -100	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT ADMINISTRATIVE AND GENERAL NURSING ADMINISTRATION	1. 00 1. 00 5. 01 13. 00 0. 00	14 14 0 0 0	33. 13 33. 14 33. 15 33. 16 33. 17 50. 00

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-3028

Worksheet A-8-1

From 01/01/2020 12/31/2020 Date/Time Prepared:

					7/15/2021 11:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	R CLAIMED HOME	
	OFFICE COSTS:		I			
1. 00		l .	ALLOCATION FROM HO REPORT	128, 880		1. 00
2.00		l .	ALLOCATION FROM HO REPORT	244, 777		2. 00
3.00			ALLOCATION FROM HO REPORT	2, 917, 411	0	3. 00
4.00	5. 01	ADMINISTRATIVE AND GENERAL	RELATED PARTY FEES	11, 283	11, 283	4.00
4. 01	60.00	LABORATORY	ALLOCATION FROM RELATED PART	432, 151	469, 704	4.01
4.02	5. 01	ADMINISTRATIVE AND GENERAL	RELATED PARTY FEES	254, 312	254, 312	4.02
4.03	54. 00	RADI OLOGY-DI AGNOSTI C	RELATED PARTY FEES	3, 021	3, 021	4.03
4.04	0.00			0	0	4.04
4. 05	15. 00	PHARMACY	RELATED PARTY FEES	5, 644	5, 644	4. 05
4.06	192. 00	PHYSICIANS' PRIVATE OFFICES	RELATED PARTY FEES	353, 450	353, 450	4.06
4.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY FEES	137, 410	137, 410	4. 07
4.08	0.00			O	0	4. 08
4.09	0.00			O	O	4. 09
5.00	TOTALS (sum of lines 1-4).			4, 488, 339	1, 234, 824	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.

 Boot pooted to not notice the					
			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
 B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	51. 00 I U HEALTH 51. 00	6.00
7.00	В	49.00 ST. VINCENT 49.00	7. 00
8.00		0.00	8. 00
9. 00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

					10 12/31/2020	7/15/2021 11:	42 am
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
		RED AND ADJUST	ENTS REQUIRED AS A RESULT OF TRANSACTIONS WI	TH RELATED (ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:						
1.00	128, 880	9					1.00
2.00	244, 777	9					2.00
3.00	2, 917, 411	0					3.00
4.00	0	0					4.00
4.01	-37, 553	0					4. 01
4.02	0	0					4. 02
4.03	0	0					4. 03
4.04	0	0					4. 04
4.05	0	0					4. 05
4.06	0	0					4. 06
4.07	0	0					4. 07
4.08	0	0					4. 08
4.09	0	0					4.09
5. 00	3, 253, 515						5. 00

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

	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
-	B. INTERRELATIONSHIP TO RELA	TED 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
	MGMT COMPANY	7.00
8. 00 9. 00		8.00 9.00
9.00		9.00
10. 00 100. 00		10.00
100.00		100.00

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

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Peri od: Worksheet B From 01/01/2020 Part I Provi der CCN: 15-3028

				To		Date/Time Pre	pared:
			CAPI TAL REI	LATED COSTS		77 157 2021 11:	42 alli
	Coot Contor Decement on	Not Evnences	DIDC 0 FLVT	MVBLE EQUIP	EMDL OVEE	Cubtatal	
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	WVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
		0	1.00	2.00	4. 00	4A	
4 00	GENERAL SERVICE COST CENTERS	1 000 000	1 000 000	1			
1. 00 2. 00	OO100 CAP REL COSTS-BLDG & FIXT OO200 CAP REL COSTS-MVBLE EQUIP	1, 088, 892 1, 370, 282	1, 088, 892	1, 370, 282			1.00 2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	6, 025, 276	18, 428		6, 066, 894		4.00
5. 01	00591 ADMINISTRATIVE AND GENERAL	8, 996, 055	33, 284		971, 949	10, 043, 173	5. 01
5. 02 7. 00	00590 OTHER A&G - NON FOUNDATION 00700 OPERATION OF PLANT	1, 004, 108 1, 739, 927	22, 864 14, 111		180, 104 8, 013	1, 235, 848 1, 779, 808	1
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 739, 927	14, 111	i	0,013	1, 779, 808	1
9. 00	00900 HOUSEKEEPI NG	479, 087	9, 202		76, 311	576, 180	9. 00
10.00	01000 DI ETARY	720, 177	38, 157		10, 678	817, 030	1
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	200, 255 2, 133, 673	18, 121 7, 499		5, 069 419, 738	246, 248 2, 570, 347	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	472, 319	9, 380		16, 607	510, 110	
15. 00	01500 PHARMACY	752, 465	4, 637		145, 344	908, 281	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	497, 491 449, 321	12, 372 3, 288		89, 010 89, 242	614, 442 545, 989	1
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	255, 571	3, 200		07, 242	255, 571	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS	·					
30. 00	03000 ADULTS & PEDIATRICS	8, 908, 299	473, 939	596, 416	1, 848, 950	11, 827, 604	30.00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	O	0	O	ol	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	166, 503	6, 210		33, 416	213, 943	54.00
60.00	06000 LABORATORY	432, 246	3, 560		0	440, 286	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	544, 901 2, 480, 759	14, 123 176, 167		116, 006 489, 987	692, 802 3, 368, 605	65. 00 66. 00
66. 01	06601 PHYSI CAL THERAPY - CARMEL	336, 876	0	1	52, 338	389, 214	1
67. 00	06700 OCCUPATI ONAL THERAPY	2, 315, 628	134, 024		494, 330	3, 112, 640	1
68. 00 68. 01	06800 SPEECH PATHOLOGY 06801 VI SI ON	1, 306, 817	27, 145	34, 160	278, 241 0	1, 646, 363 0	68. 00 68. 01
68. 02	06802 FAC RESOURCE	1, 622, 578	4, 128	5, 195	314, 511	1, 946, 412	1
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	164, 151	0	1	0	164, 151	71.00
72. 00 73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 582, 444	0	0	0 0	0 1, 582, 444	72.00 73.00
74.00	07400 RENAL DI ALYSI S	0	0		Ö	0	74.00
00.00	OUTPATIENT SERVICE COST CENTERS	200 (00	2/ 252	45.0(0)	45 445	257, 425	00.00
90.00	09000 CLINIC 09001 SLEEP CENTER	229, 600 0	36, 052 0		45, 415 O	356, 435 0	90. 00 90. 01
91.00	09100 EMERGENCY	o	0		Ö	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
99 00	OTHER REIMBURSABLE COST CENTERS O9900 CMHC	O	0	0	O	0	99. 00
	09910 CORF	o					99. 10
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	46, 397, 744	1, 066, 691	1, 342, 343	5, 685, 259	45, 965, 969]118. 00 I
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	o	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1, 528, 482	19, 020		240, 545	1, 811, 982	192. 00
	07950 FOUNDATION	755, 969	1, 892		59, 196	819, 439	
	07951 PUBLIC RELATIONS 07952 ST. VINCENT - ARU	393, 372 0	1, 289 0	1	29, 727 0	426, 010 0	194.01
194. 03	07953 MUNCIE - ARU	42, 023	Ö	ő	6, 454	48, 477	194. 03
	07954 RILEY - ARU	0	0	0	0		194. 04
194. 05 200. 00	07955 RETAIL PHARMACY Cross Foot Adjustments	1, 029, 637	0	0	45, 713	1, 075, 350 0	194. 05 200. 00
200.00	1 1		О	О	О		201.00
202.00	TOTAL (sum lines 118 through 201)	50, 147, 227	1, 088, 892	1, 370, 282	6, 066, 894	50, 147, 227	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3028

| Peri od: | Worksheet B | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared:

			1	0 12/31/2020	7/15/2021 11:	
Cost Center Description	ADMI NI STRATI V	Subtotal	OTHER A&G -	OPERATION OF	LAUNDRY &	
	E AND GENERAL		NON	PLANT	LINEN SERVICE	
			FOUNDATI ON			
	5. 01	5A. 01	5. 02	7. 00	8. 00	
GENERAL SERVICE COST CENTERS			T			
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	10 042 172					4.00
5. 01 00591 ADMINISTRATIVE AND GENERAL 5. 02 00590 OTHER A&G - NON FOUNDATION	10, 043, 173	1 545 220	1 545 220			5. 01 5. 02
7. 00 00700 OPERATION OF PLANT	309, 491 445, 714	1, 545, 339 2, 225, 522		2, 296, 285	}	7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	30, 563	152, 606		2, 290, 203 0	157, 458	8.00
9. 00 00900 HOUSEKEEPI NG	144, 292	720, 472		21, 127	1	9.00
10. 00 01000 DI ETARY	204, 607	1, 021, 637		87, 602	1	10.00
11. 00 01100 CAFETERI A	61, 667	307, 915			1	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	643, 687	3, 214, 034		17, 216	•	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	127, 746	637, 856		21, 534	•	14.00
15. 00 01500 PHARMACY	227, 459	1, 135, 740		10, 645	•	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	153, 873	768, 315		28, 404	1	16.00
17. 00 01700 SOCI AL SERVI CE	136, 731	682, 720			1	17.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	64, 002	319, 573		0	1	22. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 961, 960	14, 789, 564	470, 244	1, 088, 075	155, 642	30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	53, 577	267, 520		14, 256	1	54.00
60. 00 06000 LABORATORY	110, 260	550, 546		8, 174		60.00
65. 00 06500 RESPI RATORY THERAPY	173, 497	866, 299		32, 423	1	65.00
66. 00 06600 PHYSI CAL THERAPY	843, 593	4, 212, 198		404, 447	1	66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	97, 470	486, 684		0	.,	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	779, 492	3, 892, 132		307, 694	1	67.00
68. 00 06800 SPEECH PATHOLOGY 68. 01 06801 VI SI ON	412, 295	2, 058, 658 0	65, 457 0	62, 321 0	94	68.00
68. 02 06802 FAC RESOURCE	487, 436	2, 433, 848		9, 477	1	68. 01 68. 02
69. 00 06900 ELECTROCARDI OLOGY	467, 430	2, 433, 646	//, 30/	7, 4//	,	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	41, 108	205, 259	6, 526	0	, ,	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	41, 100	203, 237	0, 320	0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	396, 288	1, 978, 732		0	Ö	73.00
74. 00 07400 RENAL DI ALYSI S	0	0		0	Ō	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	89, 261	445, 696	14, 171	82, 769	0	90.00
90. 01 09001 SLEEP CENTER	0	0		0	0	90. 01
91. 00 09100 EMERGENCY	0	0		0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
OTHER REIMBURSABLE COST CENTERS		0				00.00
99. 00 09900 CMHC	0	0			1	
99. 10 09910 CORF SPECI AL PURPOSE COST CENTERS	J U	0	0	0	0	99. 10
118.00 SUBTOTALS (SUM OF LINES 1 through 117	8, 996, 069	44, 918, 865	1, 379, 098	2, 245, 315	157, 458	118 00
NONREI MBURSABLE COST CENTERS) 0, 770, 007	44, 710, 003	1, 377, 070	2, 243, 313	137,430	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	453, 771	2, 265, 753		43, 665		192.00
194. 00 07950 FOUNDATI ON	205, 210	1, 024, 649				194. 00
194. 01 07951 PUBLIC RELATIONS	106, 685	532, 695	16, 938	2, 960	0	194. 01
194. 02 07952 ST. VINCENT - ARU	0	0	0	0	0	194. 02
194. 03 07953 MUNCIE - ARU	12, 140	60, 617	1, 927	0		194. 03
194. 04 07954 RI LEY - ARU	0	0	0	0		194. 04
194.05 07955 RETAIL PHARMACY	269, 298	1, 344, 648	42, 754	0	0	194. 05
200.00 Cross Foot Adjustments		0				200. 00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	10, 043, 173	50, 147, 227	1, 545, 339	2, 296, 285	157, 458	J202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3028

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

7/15/2021 11:42 am Cost Center Description HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL ADMI NI STRATI O SERVICES & Ν **SUPPLY** 9. 00 10.00 11 00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.01 00591 ADMINISTRATIVE AND GENERAL 5.01 00590 OTHER A&G - NON FOUNDATION 5.02 5.02 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 764, 507 9.00 10.00 01000 DI ETARY 29, 436 1, 171, 159 10.00 01100 CAFETERI A 13, 979 373, 286 11.00 11.00 01300 NURSING ADMINISTRATION 5, 785 3, 378, 502 13.00 C 39, 274 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 7, 236 C 2,750 689, 657 14.00 15.00 01500 PHARMACY 3, 577 0 11,871 238, 810 9, 461 15.00 01600 MEDICAL RECORDS & LIBRARY 9, 544 16.00 16.00 0 8.419 169, 372 0 17.00 01700 SOCIAL SERVICE 2, 537 6,309 0 17.00 02200 | &R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 1, 171, 159 136, 327 30.00 365, 619 2, 742, 513 200, 781 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 50.00 05400 RADI OLOGY-DI AGNOSTI C 4.790 54, 864 54.00 0 2.727 4, 449 54.00 60.00 06000 LABORATORY 2,747 0 4,603 Λ 60.00 10, 895 65.00 06500 RESPIRATORY THERAPY 0 8, 597 172, 943 133, 986 65.00 66.00 06600 PHYSI CAL THERAPY 135, 904 0 33, 718 7, 101 66.00 06601 PHYSICAL THERAPY - CARMEL 2, 933 66.01 Ω 0 0 284 66.01 67.00 06700 OCCUPATI ONAL THERAPY 103, 392 C 41, 263 0 8, 268 67.00 06800 SPEECH PATHOLOGY 68.00 20, 941 18, 240 0 4, 198 68.00 06801 VI SI ON 0 0 68.01 0 C 0 68.01 0 06802 FAC RESOURCE 8, 997 68.02 3, 185 C 28, 745 68.02 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 245, 662 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 O 72 00 0 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 0 0 0 73.00 07400 RENAL DIALYSIS 0 0 74.00 74.00 0 OUTPATIENT SERVICE COST CENTERS 90 00 27, 812 14 912 90.00 09000 CLI NI C 0 4.378 0 09001 SLEEP CENTER 90.01 0 0 0 0 90.01 09100 EMERGENCY 0 0 0 91.00 91.00 0 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 0 99.00 0 99.10 09910 CORF 0 0 ol 0 99.10 0 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 747, 379 1, 171, 159 350, 154 3, 378, 502 638, 099 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 17, 261 50, 527 192. 00 14.673 0 0 194. 00 07950 FOUNDATI ON 1, 460 0 3, 343 0 0 194.00 194. 01 07951 PUBLIC RELATIONS 995 2, 528 0 594 194. 01 0 194. 02 07952 ST. VINCENT - ARU 0 0 0 194. 02 0 0 194. 03 07953 MUNCI E - ARU 0 Ω 0 0 0 194 03 194. 04 07954 RILEY - ARU 0 0 0 0 437 194. 04 194. 05 07955 RETAIL PHARMACY 0 0 0 0 194.05 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers \cap 0 201, 00 202.00 TOTAL (sum lines 118 through 201) 373, 286 3, 378, 502 689, 657 202. 00 764, 507 1, 171, 159

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-3028

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

In Lieu of Form CMS-2552-10

7/15/2021 11:42 am INTERNS & **RESI DENTS** Cost Center Description **PHARMACY** MEDI CAL SOCI AL SERVI CES-OTHE Subtotal RECORDS & SERVI CE R PRGM COSTS LI BRARY 15. 00 16.00 17.00 22.00 24.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00591 ADMINISTRATIVE AND GENERAL 5.01 5.01 00590 OTHER A&G - NON FOUNDATION 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 1, 446, 216 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1,008,483 16.00 01700 SOCIAL SERVICE 17.00 0 720, 823 17.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 329, 734 22.00 0 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 1, 008, 483 23, 178, 964 30.00 720, 823 329, 734 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 0 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 357, 112 54.00 06000 LABORATORY 0 60.00 0 0 0 0 0 583, 575 60.00 65 00 06500 RESPIRATORY THERAPY 0 0 0 1, 252, 688 65 00 06600 PHYSI CAL THERAPY 0 0 66.00 0 4, 927, 421 66.00 06601 PHYSI CAL THERAPY - CARMEL 0 0 506, 831 66.01 66.01 06700 OCCUPATI ONAL THERAPY 67.00 0 0 0 0 0 0 4, 476, 648 67.00 06800 SPEECH PATHOLOGY 68 00 Ω 0 2, 229, 909 68 00 68.01 06801 VLSLON 0 0 68.01 06802 FAC RESOURCE 0 0 2, 561, 639 68.02 68.02 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 Ω 457, 447 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 1, 446, 216 3, 487, 864 73.00 07400 RENAL DIALYSIS
OUTPATIENT SERVICE COST CENTERS 74.00 0 0 0 74.00 0 0 90.00 09000 CLI NI C 0 0 0 0 589, 738 90.00 90.01 09001 SLEEP CENTER 0 0 0 0 0 90.01 09100 EMERGENCY 0 91.00 91.00 0 C 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 99.00 09900 CMHC 0 0 0 99.10 09910 CORF O 0 99.10 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 1, 446, 216 1, 008, 483 720, 823 329, 734 44, 609, 836 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 2, 463, 921 192. 00 194. 00 07950 FOUNDATI ON 0 0 0 0 1, 066, 377 194. 00 0 194. 01 07951 PUBLIC RELATIONS 556, 710 194. 01 0 0 0 194. 02 07952 ST. VINCENT - ARU 0 0 0 0 194.02 194. 03 07953 MUNCIE - ARU 0 0 0 0 62, 544 194. 03 0 o 194. 04 07954 RILEY - ARU 0 437 194.04 0 194. 05 07955 RETAIL PHARMACY o 1, 387, 402 194. 05 0 C 0 200.00 Cross Foot Adjustments 0 0 200.00 201.00 Negative Cost Centers 0 201, 00 1,008,483 720, 823 329, 734 50, 147, 227 202. 00 202.00 TOTAL (sum lines 118 through 201) 1, 446, 216

| Peri od: | Worksheet B | From 01/01/2020 | Part | | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-3028

				То	12/31/2020	Date/Time 7/15/2021	
	Cost Center Description	Intern &	Total			77 137 2021	11.42 alli
	'	Resi dents					
		Cost & Post					
		Stepdown					
		Adjustments					
	GENERAL SERVICE COST CENTERS	25. 00	26. 00				
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00591 ADMINISTRATIVE AND GENERAL						5. 01
5.02	00590 OTHER A&G - NON FOUNDATION						5. 02
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13.00
15. 00	01500 PHARMACY						15.00
	01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00	01700 SOCIAL SERVICE						17. 00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD						22.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	-329, 734	22, 849, 230				30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0				50.00
	05400 RADI OLOGY-DI AGNOSTI C	0	357, 112				54.00
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY		583, 575 1, 252, 688				60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY		4, 927, 421				66.00
66. 01	06601 PHYSI CAL THERAPY - CARMEL		506, 831				66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	Ö	4, 476, 648				67.00
68.00	06800 SPEECH PATHOLOGY	0	2, 229, 909				68.00
68. 01	06801 VI SI ON	0	O				68. 01
68. 02	06802 FAC RESOURCE	0	2, 561, 639				68. 02
	06900 ELECTROCARDI OLOGY	0	0				69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	457, 447				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0 407 044				72.00
	07400 RENAL DIALYSIS		3, 487, 864 0				73. 00 74. 00
74.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>				74.00
90.00	09000 CLI NI C	0	589, 738				90.00
90. 01	09001 SLEEP CENTER	0	0				90. 01
91.00	09100 EMERGENCY	0	0				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
00.00	OTHER REIMBURSABLE COST CENTERS						
	09900 CMHC 09910 CORF	0	0				99.00
99. 10	SPECIAL PURPOSE COST CENTERS	UU	U				99. 10
118.00		-329, 734	44, 280, 102				118. 00
	NONREI MBURSABLE COST CENTERS	0277701	11/200/102				110100
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	2, 463, 921				192. 00
	07950 FOUNDATION	0	1, 066, 377				194. 00
	07951 PUBLIC RELATIONS	0	556, 710				194. 01
	07952 ST. VI NCENT - ARU	0	(2.544				194. 02
	07953 MUNCI E - ARU	0	62, 544				194. 03 194. 04
	07954 RI LEY - ARU 07955 RETAI L PHARMACY		437 1, 387, 402				194. 04
200.00			1, 387, 402				200.00
201.00	, ,		o				201.00
202.00		-329, 734	49, 817, 493				202. 00
							•

| Period: | Worksheet B | From 01/01/2020 | Part | I | To | 12/31/2020 | Date/Time | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3028

					To	12/31/2020	Date/Time Pre	pared:
				CAPI TAL REI	ATED COSTS		7/15/2021 11:	42 am
				ON TIME REE	54120 00010			
		Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
			Assigned New				BENEFI TS	
			Capi tal Related Costs				DEPARTMENT	
			0	1. 00	2.00	2A	4. 00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FLXT						1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP		10 400	22 100	41 (10	41 (10	2.00
4. 00 5. 01	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE AND GENERAL	0	18, 428		41, 618	41, 618	4. 00 5. 01
5. 01	1	OTHER A&G - NON FOUNDATION	0	33, 284 22, 864		75, 169 51, 636	6, 669 1, 236	5. 01
7. 00		OPERATION OF PLANT	o	14, 111		31, 868	55	7. 00
8. 00		LAUNDRY & LINEN SERVICE	o	0		0.7000	0	8. 00
9.00	00900	HOUSEKEEPI NG	0	9, 202	11, 580	20, 782	524	9. 00
10.00		DI ETARY	0	38, 157		86, 175	73	10.00
11. 00	1	CAFETERI A	0	18, 121		40, 924	35	11. 00
13.00	1	NURSI NG ADMINISTRATION	0	7, 499		16, 936	2, 880	13.00
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY	0	9, 380 4, 637		21, 184 10, 472	114 997	14. 00 15. 00
		MEDICAL RECORDS & LIBRARY	0	12, 372		27, 941	611	16.00
17. 00	1	SOCIAL SERVICE	ő	3, 288		7, 426	612	17. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		0	0	22. 00
		ENT ROUTINE SERVICE COST CENTERS						
30. 00		ADULTS & PEDIATRICS	0	473, 939	596, 416	1, 070, 355	12, 677	30. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	O	0	0	ol	0	50. 00
54. 00		RADI OLOGY-DI AGNOSTI C	0	6, 210		14, 024	229	54.00
60.00		LABORATORY	o	3, 560		8, 040	0	60.00
65. 00		RESPI RATORY THERAPY	0	14, 123		31, 895	796	65. 00
66.00		PHYSI CAL THERAPY	0	176, 167	221, 692	397, 859	3, 362	66.00
66. 01		PHYSICAL THERAPY - CARMEL	0	0	-	0	359	66. 01
67. 00		OCCUPATI ONAL THERAPY	0	134, 024		302, 682	3, 392	67.00
68. 00		SPEECH PATHOLOGY	0	27, 145		61, 305	1, 909	68.00
68. 01 68. 02	1	VISION FAC RESOURCE	0	0 4, 128		0 9, 323	0 2, 158	68. 01 68. 02
69. 00	1	ELECTROCARDI OLOGY	0	4, 120		7, 323 0	2, 138	69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	ő	0	Ö	Ö	0	71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00		DRUGS CHARGED TO PATIENTS	0	0		O	0	73.00
74. 00		RENAL DIALYSIS	0	0	0	0	0	74.00
00.00		TIENT SERVICE COST CENTERS	O	24 052	4E 240	01 420	212	00.00
90. 00 90. 01		CLINIC SLEEP CENTER	0	36, 052 0		81, 420 0	312 0	90. 00 90. 01
91. 00		EMERGENCY	0	0		0	0	91.00
92.00	1	OBSERVATION BEDS (NON-DISTINCT PART)		_		o	_	92.00
		REIMBURSABLE COST CENTERS						
99. 00	09900		0	0	1	0	0	99.00
99. 10	09910		0	0	0	0	0	99. 10
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 066, 691	1, 342, 343	2, 409, 034	39, 000	118 00
110.00		IMBURSABLE COST CENTERS	<u> </u>	1,000,071	1, 542, 545	2, 407, 004	37,000	110.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	0	19, 020		42, 955		192. 00
	1	FOUNDATI ON	0	1, 892		4, 274		194. 00
	1	PUBLIC RELATIONS	0	1, 289	1	2, 911		194. 01
		ST. VINCENT - ARU MUNCIE - ARU	0	0		0		194. 02 194. 03
		RILEY - ARU		0		0		194. 03 194. 04
		RETAIL PHARMACY		0	0	ol		194. 05
200.00	1	Cross Foot Adjustments				ol		200. 00
201.00		Negative Cost Centers		0	0	О		201. 00
202.00)	TOTAL (sum lines 118 through 201)	0	1, 088, 892	1, 370, 282	2, 459, 174	41, 618	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2020 | Part II | To 12/31/2020 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3028

				11	o 12/31/2020	Date/Time Pre 7/15/2021 11:	
	Cost Center Description	ADMI NI STRATI V	OTHER A&G -	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	42 aiii
	5551 5511151 B5551 P 11 511	E AND GENERAL	NON	PLANT	LINEN SERVICE		
			FOUNDATI ON				
		5. 01	5. 02	7. 00	8. 00	9. 00	
0	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	DO591 ADMINISTRATIVE AND GENERAL	81, 838					5. 01
5.02	00590 OTHER A&G - NON FOUNDATION	2, 522	55, 394				5. 02
7.00	00700 OPERATION OF PLANT	3, 633	2, 537	38, 093			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	249	174	0	423		8. 00
	00900 HOUSEKEEPI NG	1, 176	821		0	23, 653	9. 00
	D1000 DI ETARY	1, 668	1, 165	1, 453	0	911	10.00
11.00	01100 CAFETERI A	503	351	690	0	432	11.00
13.00	01300 NURSING ADMINISTRATION	5, 246	3, 664		0	179	13.00
	01400 CENTRAL SERVICES & SUPPLY	1, 041	727		0	224	14.00
	D1500 PHARMACY	1, 854	1, 295	177	0	111	15. 00
	01600 MEDICAL RECORDS & LIBRARY	1, 254	876		0	295	16.00
	01700 SOCIAL SERVICE	1, 114	778		0	78	17. 00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	522	364	0	0	0	22.00
	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	24, 126	16, 847	18, 052	419	11, 312	30. 00
	ANCILLARY SERVICE COST CENTERS	_	_	_	_1		
	D5000 OPERATING ROOM	0	0		0	0	50.00
1	05400 RADI OLOGY-DI AGNOSTI C	437	305		0	148	
1	06000 LABORATORY	899	628		0	85	60.00
	06500 RESPI RATORY THERAPY	1, 414	988		0	337	65.00
	06600 PHYSI CAL THERAPY	6, 875	4, 802		0	4, 205	66.00
	D6601 PHYSI CAL THERAPY - CARMEL D6700 OCCUPATI ONAL THERAPY	794	555		0	2 100	66. 01 67. 00
	06800 SPEECH PATHOLOGY	6, 353 3, 360	4, 437 2, 347		0	3, 199 648	68.00
	06801 VI SI ON	3, 300	2, 347		0	048	68. 01
	06802 FAC RESOURCE	3, 973	2, 775	_		99	68. 02
	06900 ELECTROCARDI OLOGY	3, 7/3	2,779			0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	335	234		ام	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		o o	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	3, 230	2, 256		l ol	0	73.00
	07400 RENAL DI ALYSI S	0, 200	0		ol	0	74.00
	OUTPATIENT SERVICE COST CENTERS				9		7 11 00
	09000 CLI NI C	727	508	1, 373	0	860	90.00
	09001 SLEEP CENTER	0	0		o	0	90. 01
	09100 EMERGENCY	0	0	0	o	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
C	OTHER REIMBURSABLE COST CENTERS						
99.00	09900 CMHC	0	0	0	0	0	99. 00
99. 10	09910 CORF	0	0	0	0	0	99. 10
5	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	73, 305	49, 434	37, 248	423	23, 123	118. 00
	NONRE I MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	J	·	<u>۱</u>	U	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	3, 698			0		192. 00
	07950 FOUNDATION	1, 672	1, 168		0		194. 00
	07951 PUBLIC RELATIONS	869	607		0		194. 01
	D7952 ST. VI NCENT - ARU	0	0		0		194. 02
	D7953 MUNCIE - ARU	99	69		0		194. 03
	07954 RILEY - ARU	0 105	1 522	_	0		194. 04
	07955 RETAIL PHARMACY	2, 195	1, 533			0	194. 05
200.00	Cross Foot Adjustments		_	_		2	200.00
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118 through 201)	01 020	0 55 204		0 423	23, 653	201.00
202.00	TOTAL (Suill Titles TTO till Ough 201)	81, 838	55, 394	30,093	423	∠ა, ნეა	202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2020 | Part II | To 12/31/2020 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3028

				To	12/31/2020	Date/Time Pre 7/15/2021 11:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	42 aiii
				ADMI NI STRATI O	SERVICES &		
				N	SUPPLY		
		10. 00	11. 00	13.00	14.00	15. 00	
	NERAL SERVICE COST CENTERS						
	100 CAP REL COSTS-BLDG & FIXT						1.00
	200 CAP REL COSTS-MVBLE EQUIP						2.00
1	400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	591 ADMINI STRATI VE AND GENERAL						5. 01
1	590 OTHER A&G - NON FOUNDATION 700 OPERATION OF PLANT						5.02
	800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
1	900 HOUSEKEEPI NG						9.00
	000 DI ETARY	91, 445					10.00
	100 CAFETERI A	0	42, 935				11.00
	300 NURSING ADMINISTRATION	Ö	4, 517				13.00
1	400 CENTRAL SERVICES & SUPPLY	0	316		23, 963		14.00
15. 00 01	500 PHARMACY	0	1, 365	2, 383	329	18, 983	15.00
16. 00 01	600 MEDICAL RECORDS & LIBRARY	0	968	1, 690	0	0	16.00
17. 00 01	700 SOCIAL SERVICE	0	726	0	0	0	17.00
	200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	91, 445	15, 682	27, 363	6, 976	0	30. 00
	CILLARY SERVICE COST CENTERS				ما		F0 00
	OOO OPERATING ROOM	0	0		0	0	50.00
	400 RADI OLOGY-DI AGNOSTI C 000 LABORATORY	0	314 529		155 0	0	54. 00 60. 00
	500 RESPI RATORY THERAPY	0	989		4, 656	0	65.00
1	600 PHYSI CAL THERAPY	0	3, 878		247	0	66.00
	601 PHYSI CAL THERAPY - CARMEL	0	3, 378	l ő	10	0	66.01
	700 OCCUPATI ONAL THERAPY	o	4, 746		287	0	67.00
	800 SPEECH PATHOLOGY	O	2, 098		146	0	68.00
68. 01 06	BO1 VI SI ON	0	0	0	О	0	68. 01
68. 02 06	802 FAC RESOURCE	0	3, 306	0	313	0	68. 02
69. 00 06	900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8, 534	0	71.00
1	200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	300 DRUGS CHARGED TO PATIENTS	0	0		0	18, 983	ł
	400 RENAL DIALYSIS	0	0	0	0	0	74.00
	TPATIENT SERVICE COST CENTERS OOO CLINIC	0	503	O	518	0	90.00
	001 SLEEP CENTER	0	0		0	0	90.00
1	100 EMERGENCY	0	0		0	0	91.00
1	200 OBSERVATION BEDS (NON-DISTINCT PART)	o o	O		Ŭ.	O	92.00
	HER REIMBURSABLE COST CENTERS						72.00
	900 CMHC	0	0	0	0	0	99. 00
99. 10 09	910 CORF	0	0	0	0	0	99. 10
SPI	ECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	91, 445	40, 274	33, 708	22, 171	18, 983	118. 00
	NREIMBURSABLE COST CENTERS						
190. 00 19	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	١	0	0	190. 00
	200 PHYSI CI ANS' PRI VATE OFFI CES	0	1, 985		1, 756		192.00
1	950 FOUNDATION	0	385		0		194.00
	951 PUBLIC RELATIONS	0	291		21		194. 01 194. 02
	952 ST. VINCENT - ARU 953 MUNCIE - ARU	0	0		0		194. 02
1	954 RI LEY - ARU	0	0		15		194. 03
	955 RETAIL PHARMACY	0	0		0		194. 05
200. 00	Cross Foot Adjustments	Ĭ	Ü		Ĭ	Ü	200.00
201. 00	Negative Cost Centers	О	0	o	o	0	201.00
202.00	TOTAL (sum lines 118 through 201)	91, 445	42, 935	33, 708	23, 963	18, 983	
		'		. '	'		

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2020 | Part II | To 12/31/2020 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3028

			10	12/31/2020	Date/Time Pre	
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	INTERNS & RESIDENTS SERVICES-OTHE R PRGM COSTS	Subtotal	Intern & Residents Cost & Post Stepdown	72 diii
	16. 00	17. 00	22.00	24. 00	25. 00	
NERAL SERVICE COST CENTERS						
0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0591 ADMINISTRATIVE AND GENERAL 0590 OTHER A&G - NON FOUNDATION 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING						1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00
1000 CAFETERIA 1300 NURSI NG ADMI NI STRATI ON 1400 CENTRAL SERVI CES & SUPPLY 1500 PHARMACY 1600 MEDI CAL RECORDS & LI BRARY 1700 SOCI AL SERVI CE	34, 106 0 0	·				10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 22. 00
	34, 106	10, 859		1, 340, 219	0	30.00
ICILLARY SERVICE COST CENTERS 5000 OPERATING ROOM 5400 RADIOLOGY-DIAGNOSTIC 6000 LABORATORY 5500 RESPIRATORY THERAPY 5601 PHYSICAL THERAPY 6601 PHYSICAL THERAPY 6601 PHYSICAL THERAPY 6602 PHYSICAL THERAPY 6800 SPEECH PATHOLOGY 8801 VISION FAC RESOURCE 6900 ELECTROCARDIOLOGY 67100 MEDICAL SUPPLIES CHARGED TO PATIENTS 67200 IMPL. DEV. CHARGED TO PATIENTS 67300 DRUGS CHARGED TO PATIENTS 67400 RENAL DIALYSIS 67410 RENAL DIALYSIS 675100 CLINIC 675100 SLEEP CENTER 675100 BSERVATION BEDS (NON-DISTINCT PART) 67510 BSERVATION BEDS (NON-DISTINCT PART)	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 16, 395 10, 317 43, 338 427, 937 2, 059 330, 200 72, 847 0 22, 104 0 9, 103 0 24, 469 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 00 54. 00 60. 00 65. 00 66. 01 67. 00 68. 01 68. 01 68. 02 69. 00 71. 00 72. 00 73. 00 74. 00 90. 01 91. 00 92. 00
9910 CORF	0			0	0	•
SUBTOTALS (SUM OF LINES 1 through 117)	34, 106	10, 859	0	2, 385, 209	0	118. 00
2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2200 PHYSICIANS' PRIVATE OFFICES 2950 FOUNDATION 2951 PUBLIC RELATIONS 2952 ST. VINCENT - ARU 2953 MUNCIE - ARU 2954 RILEY - ARU	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	886 0	0 55, 805 8, 022 4, 983 0 212 15 4, 042 886 0 2, 459, 174	0 0 0 0 0 0 0	190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 200. 00 201. 00 202. 00
	ENERAL SERVICE COST CENTERS 2000 CAP REL COSTS-BLDG & FIXT 2000 CAP REL COSTS-BLDG & FIXT 2000 CAP REL COSTS-MVBLE EQUIP 2000 EMPLOYEE BENEFITS DEPARTMENT 2010 DEMPLOYEE BENEFITS DEPARTMENT 2010 DEMPLOYEE BENEFITS DEPARTMENT 2010 OPERATION OF PLANT 2010 OPERATION OF PLANT 2010 DIETARY 2010 LAUNDRY & LINEN SERVICE 2010 DIETARY 2010 CAFETERIA 2010 NURSING ADMINISTRATION 2010 PHARMACY 2010 PHARMACY 2010 PHARMACY 2010 PHARMACY 2010 PHARMACY 2010 EXERVICES & SUPPLY 2010 EXERVICES OTHER PROM COSTS APPRVD 2010 PHARMACY 2010 LAB SERVICES-OTHER PROM COSTS APPRVD 2010 PHARMACY 2010 PHA	RECORDS & LIBRARY	RECORDS & LI BRARY	INTERNS & RESIDENTS	NEPTICAL RECORDS & SUBJECT SUBJE	MEDICAL SOLIDAR SERVICE SOLIDAR SOLIDAR SERVICE SERV

Provider CCN: 15-3028

Peri od:

201.00

202.00

Part II

From 01/01/2020 Date/Time Prepared: 12/31/2020 7/15/2021 11:42 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 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00591 ADMINISTRATIVE AND GENERAL 5.01 5.01 5.02 00590 OTHER A&G - NON FOUNDATION 5.02 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13 00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15. 00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17 00 17 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 340, 219 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 16, 395 54.00 60. 00 06000 LABORATORY 10, 317 60 00 06500 RESPIRATORY THERAPY 65.00 43, 338 65.00 66. 00 06600 PHYSI CAL THERAPY 427, 937 66.00 66. 01 06601 PHYSI CAL THERAPY - CARMEL 2,059 66.01 06700 OCCUPATI ONAL THERAPY 67 00 330, 200 67.00 68.00 06800 SPEECH PATHOLOGY 72, 847 68.00 06801 VI SI ON 68.01 68.01 06802 FAC RESOURCE 68.02 68.02 22, 104 69 00 06900 ELECTROCARDI OLOGY 0 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 9, 103 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 24, 469 73.00 07400 RENAL DIALYSIS 74.00 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 86, 221 90.00 09001 SLEEP CENTER 90.01 0 90.01 09100 EMERGENCY 91.00 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99 00 99 00 09900 CMHC 0 99.10 09910 CORF 99.10 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 2. 385. 209 118.00 118 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 55, 805 192.00 194. 00 07950 FOUNDATI ON 194.00 8,022 194. 01 07951 PUBLIC RELATIONS 4, 983 194.01 194. 02 07952 ST. VINCENT - ARU 0 194. 02 194. 03 07953 MUNCIE - ARU 212 194. 03 194. 04 07954 RILEY - ARU 194.04 15 194. 05 07955 RETAIL PHARMACY 4,042 194.05 200.00 Cross Foot Adjustments 886 200.00 201.00

2, 459, 174

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: Worksheet B-1 From 01/01/2020 Provider CCN: 15-3028

				T	o 12/31/2020		
		CAPITAL REL	ATED COSTS			7/15/2021 11:	42 am
	Cost Contar Decemintion	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Doognailiatia	ADMI NI STRATI V	
	Cost Center Description	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	n	E AND GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
		1. 00	2. 00	4.00	5A. 01	5. 01	
	BERAL SERVICE COST CENTERS OO CAP REL COSTS-BLDG & FIXT	92, 060					1.00
	COO CAP REL COSTS-MVBLE EQUIP	72,000	92, 060				2.00
	OO EMPLOYEE BENEFITS DEPARTMENT	1, 558				40 104 054	4.00
	91 ADMINISTRATIVE AND GENERAL 90 OTHER A&G - NON FOUNDATION	2, 814 1, 933	l .			40, 104, 054 1, 235, 848	5. 01 5. 02
7. 00 007	OO OPERATION OF PLANT	1, 193	1, 193	33, 279	0	1, 779, 808	7. 00
	300 LAUNDRY & LINEN SERVICE 300 HOUSEKEEPING	0 778	0 778		_	122, 043 576, 180	1
10. 00 010	000 DI ETARY	3, 226	ŀ		0	817, 030	1
	OO CAFETERIA OO NURSING ADMINISTRATION	1, 532	1		0	246, 248	1
	OO CENTRAL SERVICES & SUPPLY	634 793	634 793			2, 570, 347 510, 110	1
	OO PHARMACY	392	392		0	908, 281	
	000 MEDICAL RECORDS & LIBRARY 000 SOCIAL SERVICE	1, 046 278	l .			614, 442 545, 989	1
22. 00 022	100 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	l .				22.00
	ATIENT ROUTINE SERVICE COST CENTERS OO ADULTS & PEDIATRICS	40, 069	40, 069	7, 679, 307	0	11, 827, 604	30.00
	ILLARY SERVICE COST CENTERS	40, 089	40, 069	1, 679, 307	0	11, 627, 604	30.00
	OOO OPERATING ROOM	0	1				
	OO RADI OLOGY-DI AGNOSTI C OO LABORATORY	525 301	525 301	138, 788 0		213, 943 440, 286	1
65. 00 065	000 RESPIRATORY THERAPY	1, 194	ł			692, 802	1
	00 PHYSICAL THERAPY 01 PHYSICAL THERAPY - CARMEL	14, 894	14, 894 0		0	3, 368, 605 389, 214	
	OO OCCUPATIONAL THERAPY	11, 331	11, 331	,	_	3, 112, 640	1
	SPEECH PATHOLOGY	2, 295	2, 295		0	1, 646, 363	1
	001 VISION 002 FAC RESOURCE	349	0 349	0 1, 306, 266	_	0 1, 946, 412	68. 01 68. 02
69. 00 069	000 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	164, 151 0	
	OO DRUGS CHARGED TO PATIENTS	0	0				1
	OO RENAL DIALYSIS	0	0	0	0	0	74. 00
	PATIENT SERVICE COST CENTERS	3, 048	3, 048	188, 622	0	356, 435	90.00
90. 01 090	001 SLEEP CENTER	0	0	0	0	0	90. 01
	OO EMERGENCY OO OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	91. 00 92. 00
	ER REIMBURSABLE COST CENTERS						72.00
99. 00 099		0					99.00
99. 10 099 SPE	CLAL PURPOSE COST CENTERS	0	0	0	0	0	99. 10
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	90, 183	90, 183	23, 612, 738	-10, 043, 173	35, 922, 796	118. 00
	REIMBURSABLE COST CENTERS OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192. 00 192	000 PHYSICIANS' PRIVATE OFFICES	1, 608		999, 063	0	l .	1
	950 FOUNDATION 1951 PUBLIC RELATIONS	160 109					1
	55 PUBLIC RELATIONS 152 ST. VINCENT - ARU	0	l			426, 010 0	194.01
194. 03 079	53 MUNCIE - ARU	0	0	26, 806			194. 03
	954 RILEY - ARU 1955 RETAIL PHARMACY	0	0	0 189, 859	0	0 1, 075, 350	194. 04 194. 05
200. 00	Cross Foot Adjustments			1077007		1,0,0,000	200. 00
201.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	1 000 000	1 270 202	4 044 904		10 042 172	201.00
202. 00	Part I)	1, 088, 892	1, 370, 282	6, 066, 894		10, 043, 173	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	11. 828069	14. 884662			0. 250428	
204. 00	Cost to be allocated (per Wkst. B, Part II)			41, 618		81, 838 	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 001652		0. 002041	205. 00
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Provider CCN: 15-3028

				10	0 12/31/2020	7/15/2021 11:	
	Cost Center Description	Reconciliatio	OTHER A&G -	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		n	NON FOUNDATION	PLANT (SQUARE FEET)	(POUNDS OF	(SQUARE FEET)	
			(ACCUM. COST)	(SQUARE FEET)	LAUNDRY)		
		5A. 02	5. 02	7.00	8. 00	9. 00	
4 00	GENERAL SERVICE COST CENTERS		T				
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 4. 00	OO2OO CAP REL COSTS-MVBLE EQUIP OO4OO EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	00591 ADMINI STRATI VE AND GENERAL						5. 01
5. 02	00590 OTHER A&G - NON FOUNDATION	-1, 545, 339	48, 601, 888	3			5. 02
7. 00	00700 OPERATION OF PLANT	0	2, 225, 522				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	152, 606	0	200, 376		8.00
9. 00	00900 HOUSEKEEPI NG	0	720, 472	778	0	83, 784	9. 00
10.00	01000 DI ETARY	0	1, 021, 637		0	3, 226	
11.00	01100 CAFETERI A	0	307, 915		0	1, 532	
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	3, 214, 034 637, 856		0	634 793	
15. 00	01500 PHARMACY	0	1, 135, 740	•	0	392	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	768, 315	•	0	1, 046	1
17. 00	01700 SOCIAL SERVICE	0	682, 720		0	278	17.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	319, 573	0	0	0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	0	14, 789, 564	40, 069	198, 066	40, 069	30.00
EO 00	ANCILLARY SERVICE COST CENTERS				0	0	FO 00
50. 00 54. 00	05000 OPERATING ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	267, 520		0	0 525	50.00 54.00
60.00	06000 LABORATORY	0	550, 546		0	301	60.00
65. 00	06500 RESPIRATORY THERAPY	0	866, 299		0	1, 194	65.00
66. 00	06600 PHYSI CAL THERAPY	0	4, 212, 198		155	14, 894	1
66. 01	06601 PHYSI CAL THERAPY - CARMEL	0	486, 684	0	1, 851	0	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	0	3, 892, 132	11, 331	185	11, 331	67.00
68. 00	06800 SPEECH PATHOLOGY	0	2, 058, 658		119	2, 295	1
68. 01	06801 VI SI ON	0	0	0	0	0	68. 01
68. 02	06802 FAC RESOURCE	0	2, 433, 848	349	0	349	1
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	205, 259	1 "	0	0	69. 00 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	203, 237		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1, 978, 732	o o	0	Ö	73.00
74.00	07400 RENAL DIALYSIS	0	c	o	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0			0	3, 048	1
90. 01 91. 00	O9001 SLEEP CENTER	0			0	0	90.01
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	_)	U	0	91.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
99. 00	09900 CMHC	0	C	0	0	0	99. 00
99. 10	09910 CORF	0	C	0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS						
118.00	1	-1, 545, 339	43, 373, 526	82, 685	200, 376	81, 907	1118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0					192.00
	07950 FOUNDATION	0	1, 024, 649		0		194.00
	07951 PUBLIC RELATIONS	0	532, 695		0		194. 01
	07952 ST. VINCENT - ARU	0	C	0	0	0	194. 02
	07953 MUNCIE - ARU	0		0	0		194. 03
	07954 RI LEY - ARU	0	1	0	0		194. 04
	07955 RETAIL PHARMACY	0	1, 344, 648	0	0	0	194. 05
200. 00 201. 00	1 1						200. 00 201. 00
201.00			1, 545, 339	2, 296, 285	157, 458	764, 507	
202.00	Part I)		1, 545, 557	2, 290, 203	137, 430	704, 307	202.00
203.00			0. 031796	27. 155046	0. 785813	9. 124737	203.00
204.00			55, 394				204.00
	Part II)						
205.00			0. 001140	0. 450474	0. 002111	0. 282309	205.00
204 00	NAME adjustment amount to be allegated	1					204 00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00							207. 00
	Parts III and IV)	1					

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3028 Peri od: Worksheet B-1 From 01/01/2020 12/31/2020 Date/Time Prepared: 7/15/2021 11:42 am Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI O SERVICES & (MEALS (HOURS PAID) (COSTED SERVED) **SUPPLY** REQUIS.) Ν (DIRECT NURS (COSTED HRS.) REQUIS.) 10.00 11.00 13.00 14.00 15.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00591 ADMINISTRATIVE AND GENERAL 5.01 5.01 00590 OTHER A&G - NON FOUNDATION 5.02 5.02 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 62, 199 10.00 10.00 11.00 01100 CAFETERI A 0 597, 171 11.00 13.00 01300 NURSING ADMINISTRATION 0 62, 829 268, 670 13.00 01400 CENTRAL SERVICES & SUPPLY 0 4, 399 460, 830 14.00 14.00 18, 991 18, 991 01500 PHARMACY 0 100 15.00 6, 322 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 13, 469 13, 469 0 16.00 01700 SOCIAL SERVICE 17.00 0 10,093 0 0 17.00 0 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 62, 199 30.00 03000 ADULTS & PEDIATRICS 218, 094 218, 094 134, 162 0 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 0 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 4, 363 4, 363 2,973 0 54.00 0 60.00 06000 LABORATORY 7, 364 0 60.00 06500 RESPIRATORY THERAPY 0 0 13, 753 13, 753 89 530 65 00 65 00 0 66.00 06600 PHYSI CAL THERAPY 53, 941 0 4,745 0 66.00 06601 PHYSI CAL THERAPY - CARMEL 4, 692 0 190 0 66.01 66.01 06700 OCCUPATI ONAL THERAPY 67.00 00000 66,011 0 5, 525 0 67.00 68 00 06800 SPEECH PATHOLOGY 0 68 00 29, 179 2,805 0 0 68.01 06801 VI SI ON 0 68.01 45, 985 06802 FAC RESOURCE 0 6,012 0 68.02 68.02 69.00 06900 ELECTROCARDI OLOGY C 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 0 164, 151 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 0 100 73.00 07400 RENAL DIALYSIS
OUTPATIENT SERVICE COST CENTERS 0 0 0 0 74.00 74.00 0 90.00 09000 CLI NI C 0 7, 003 0 9, 964 0 90.00 90.01 09001 SLEEP CENTER 0 0 0 0 90.01 09100 EMERGENCY 0 0 91.00 91.00 C 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 99.00 09900 CMHC 0 0 99. 10 99.10 09910 CORF O ol SPECIAL PURPOSE COST CENTERS 118 00 SUBTOTALS (SUM OF LINES 1 through 117) 62, 199 560, 166 268, 670 426, 379 100 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 27,613 0 192.00 33, 762 0 0 0 194.00 194. 00 07950 FOUNDATI ON 5, 348 0 194. 01 07951 PUBLIC RELATIONS 0 4,044 0 194, 01 0 397 194. 02 07952 ST. VINCENT - ARU r 0 0 0 194.02 194. 03 07953 MUNCIE - ARU 0 C 0 0 0 194.03 0 194. 04 07954 RILEY - ARU 0 292 0 194.04 C 194. 05 07955 RETAIL PHARMACY 0 194.05 0 C 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 1, 446, 216 202. 00 Cost to be allocated (per Wkst. B, 3, 378, 502 202.00 1, 171, 159 373, 286 689, 657 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 18.829226 0.625091 12.574913 1. 496554 14, 462. 160000 203. 00 18, 983 204. 00 204.00 Cost to be allocated (per Wkst. B, 91, 445 42, 935 33, 708 23, 963 Part II) 189. 830000 205. 00 205.00 0.071897 Unit cost multiplier (Wkst. B, Part 1.470200 0.125462 0.052000 11) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3028

Peri od:
From 01/01/2020
To 12/31/2020 Date/Ti me Prepared:

7/15/2021 11:42 am INTERNS & **RESI DENTS** MEDI CAL SOCI AL SERVI CES-OTHE Cost Center Description RECORDS & **SERVICE** R PRGM COSTS (ASSI GNED LI BRARY (TOTAL (TOTAL PATIENT DAYS) TIME) PATIENT DAYS) 17. 00 16. 00 22.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00591 ADMINISTRATIVE AND GENERAL 5.01 5.01 5.02 00590 OTHER A&G - NON FOUNDATION 5.02 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 20, 733 16.00 16,00 01700 SOCIAL SERVICE 17.00 20, 733 17.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 100 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 100 30 00 03000 ADULTS & PEDIATRICS 20, 733 20, 733 30 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 0 06000 LABORATORY 0 60 00 60 00 0 0 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 0000000 66.00 06601 PHYSI CAL THERAPY - CARMEL 0 66.01 0 66.01 0 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 06801 VI SI ON 0 68.01 68.01 06802 FAC RESOURCE 0 0 68.02 68.02 06900 ELECTROCARDI OLOGY 0 69 00 C 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 C 07400 RENAL DIALYSIS 0 74.00 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 С 90.01 09001 SLEEP CENTER 0 0 90.01 C 91.00 09100 EMERGENCY 0 C 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 99.00 09900 CMHC 0 0 0 99.10 09910 CORF 0 99.10 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 20, 733 20, 733 100 118.00 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES О 190.00 0 0 192.00 C 194. 00 07950 FOUNDATI ON 0 C 0 194.00 194. 01 07951 PUBLIC RELATIONS 0 0 0 194.01 194. 02 07952 ST. VINCENT - ARU 0 194. 02 0 0 194. 03 07953 MUNCI E - ARU 0 0 0 194.03 194. 04 07954 RILEY - ARU 0 C 0 194.04 194. 05 07955 RETAIL PHARMACY 0 194.05 200.00 Cross Foot Adjustments 200.00 201 00 Negative Cost Centers 201 00 202.00 Cost to be allocated (per Wkst. B, 1,008,483 720, 823 329, 734 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 48.641441 34.766942 3, 297. 340000 203 00 204.00 Cost to be allocated (per Wkst. B, 10,859 204.00 34, 106 886 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 1.645010 0.523754 8.860000 205.00 11) NAHE adjustment amount to be allocated 206.00 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207.00 Parts III and IV)

Health Financial Systems RE	HABILITATION HOS	SPITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/15/2021 11:	
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col . 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ATLENT ROUTINE SERVICE COST CENTERS						
	DO ADULTS & PEDIATRICS	22, 849, 230		22, 849, 230	0	22, 849, 230	30.00
	LLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	0		0	0	0	
	00 RADI OLOGY-DI AGNOSTI C	357, 112		357, 112	0	357, 112	
60.00 0600	DO LABORATORY	583, 575		583, 575	0	583, 575	60.00
65.00 0650	00 RESPI RATORY THERAPY	1, 252, 688	0	1, 252, 688	0	1, 252, 688	65.00
66.00 0660	DO PHYSI CAL THERAPY	4, 927, 421	0	4, 927, 421	0	4, 927, 421	66.00
66. 01 0660	D1 PHYSICAL THERAPY - CARMEL	506, 831	0	506, 831	0	506, 831	66. 01
67.00 0670	OO OCCUPATI ONAL THERAPY	4, 476, 648	0	4, 476, 648	0	4, 476, 648	67.00
68.00 0680	OO SPEECH PATHOLOGY	2, 229, 909	0	2, 229, 909	0	2, 229, 909	68.00
68. 01 0680	D1 VI SI ON	0	0	0	0	0	68. 01
68. 02 0680	D2 FAC RESOURCE	2, 561, 639	0	2, 561, 639	0	2, 561, 639	68. 02
69.00 0690	DO ELECTROCARDI OLOGY	0		0	0	0	69.00
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS	457, 447		457, 447	0	457, 447	71.00
72.00 0720	DO IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	3, 487, 864		3, 487, 864	0	3, 487, 864	73.00
74.00 0740	DO RENAL DIALYSIS	0		0	0	0	74.00
OUTF	PATIENT SERVICE COST CENTERS						
90.00 0900	DO CLINIC	589, 738		589, 738	0	589, 738	90.00
90. 01 0900	D1 SLEEP CENTER	0		0	0	0	90. 01
91.00 0910	DO EMERGENCY	0		0	0	0	91.00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
OTHE	R REIMBURSABLE COST CENTERS						
99. 00 0990	DO CMHC	0		0		0	99. 00
99. 10 0991	IO CORF	0		0		0	99. 10
200.00	Subtotal (see instructions)	44, 280, 102	0	44, 280, 102	o	44, 280, 102	200.00
201.00	Less Observation Beds	0		0			201.00
202. 00	Total (see instructions)	44, 280, 102	0	44, 280, 102	0	44, 280, 102	202.00

Heal th	Financial Systems REHA	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provi der CO	CN: 15-3028	Peri od:	Worksheet C	
					From 01/01/2020 To 12/31/2020		nanad.
					To 12/31/2020	Date/Time Pre 7/15/2021 11:	pareu: 42 am
			Title	XVIII	Hospi tal	PPS	12 0
			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						
	03000 ADULTS & PEDIATRICS	43, 300, 605		43, 300, 60	15		30.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0		0. 000000	0.000000	
	05400 RADI OLOGY-DI AGNOSTI C	1, 728, 098	0	1, 728, 09		0.000000	
	06000 LABORATORY	1, 716, 542	0	1, 716, 54		0.000000	
	06500 RESPI RATORY THERAPY	3, 103, 023	0	3, 103, 02			
	06600 PHYSI CAL THERAPY	12, 174, 904	4, 788, 790			0.000000	
	06601 PHYSI CAL THERAPY - CARMEL	0	1, 332, 580			0.000000	
	06700 OCCUPATI ONAL THERAPY	12, 818, 084	2, 695, 707			0.000000	
	06800 SPEECH PATHOLOGY	10, 007, 127	1, 839, 412	11, 846, 53		0.000000	
	06801 VI SI ON	0	0		0. 000000	0.000000	68. 01
68. 02	06802 FAC RESOURCE	0	669, 268	669, 26	8 3.827524	0.000000	68. 02
69. 00	06900 ELECTROCARDI OLOGY	0	0		0. 000000	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 028, 173	56, 211	2, 084, 38	0. 219464	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0. 000000	0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 639, 504	3, 980, 729	9, 620, 23	0. 362555	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0		0. 000000	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	2, 056, 309	2, 056, 30	0. 286794	0.000000	90.00
	09001 SLEEP CENTER	0	0		0. 000000	0.000000	
91.00	09100 EMERGENCY	0	0		0. 000000	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0. 000000	0.000000	92.00
0	OTHER REIMBURSABLE COST CENTERS						
	09900 CMHC	0	0		0		99. 00
99. 10	09910 CORF	0	0		0		99. 10
200.00	Subtotal (see instructions)	92, 516, 060	17, 419, 006	109, 935, 06	6		200. 00
201.00	Less Observation Beds					l .	201.00
202. 00	Total (see instructions)	92, 516, 060	17, 419, 006	109, 935, 06	6		202. 00

Health Financial Systems	REHABILITATION HOSPI	TAL OF INDIANA	In Lieu	u of Form CMS-2	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3028	Peri od: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prep 7/15/2021 11:4	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Innationt				

			10 12/31/2020	7/15/2021 11:	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
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 206650				54.00
60. 00 06000 LABORATORY	0. 339971				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 403699				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 290469				66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0. 380338				66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0. 288559				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 188233				68. 00
68. 01 06801 VI SI ON	0. 000000				68. 01
68. 02 06802 FAC RESOURCE	3. 827524				68. 02
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 219464				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 362555				73.00
74. 00 07400 RENAL DIALYSIS	0. 000000				74.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 286794				90.00
90. 01 09001 SLEEP CENTER	0. 000000				90. 01
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
99. 00 09900 CMHC					99. 00
99. 10 09910 CORF					99. 10
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

Health Financial Systems	REHABILITATION HOS	SPITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/15/2021 11:	
		Ti tl	e XIX	Hospi tal	PPS	
		·		Costs		
Cost Center Description	Total Cost (from Wkst.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ATIENT ROUTINE SERVICE COST CENTERS						
	00 ADULTS & PEDIATRICS	22, 849, 230		22, 849, 230	0	22, 849, 230	30.00
ANCI	ILLARY SERVICE COST CENTERS						
50.00 0500	OO OPERATING ROOM	0		0	0	0	50.00
54.00 0540	OO RADI OLOGY-DI AGNOSTI C	357, 112		357, 112	0	357, 112	54.00
60.00 0600	00 LABORATORY	583, 575		583, 575	0	583, 575	60.00
65. 00 0650	00 RESPIRATORY THERAPY	1, 252, 688	0	1, 252, 688	0	1, 252, 688	65.00
66. 00 0660	00 PHYSI CAL THERAPY	4, 927, 421	0	4, 927, 421	0	4, 927, 421	66.00
66. 01 0660	01 PHYSICAL THERAPY - CARMEL	506, 831	0	506, 831	0	506, 831	66. 01
67. 00 0670	OO OCCUPATI ONAL THERAPY	4, 476, 648	0	4, 476, 648	0	4, 476, 648	67.00
68. 00 0680	OO SPEECH PATHOLOGY	2, 229, 909	0	2, 229, 909	o	2, 229, 909	68.00
68. 01 0680	01 VI SI ON	0	0	0	O	0	68. 01
68. 02 0680	02 FAC RESOURCE	2, 561, 639	0	2, 561, 639	o	2, 561, 639	68. 02
69.00 0690	00 ELECTROCARDI OLOGY	0		0	0	0	69.00
71.00 0710	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	457, 447		457, 447	0	457, 447	71.00
72.00 0720	00 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73. 00 0730	OO DRUGS CHARGED TO PATIENTS	3, 487, 864		3, 487, 864	o	3, 487, 864	73.00
74.00 0740	00 RENAL DIALYSIS	0		0	o	0	74.00
OUTF	PATIENT SERVICE COST CENTERS	<u>'</u>	•	•			
90.00 0900	OO CLI NI C	589, 738		589, 738	0	589, 738	90.00
90. 01 0900	01 SLEEP CENTER	0		0	0	0	90. 01
91.00 0910	OO EMERGENCY	0		0	0	0	91.00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
OTHE	ER REIMBURSABLE COST CENTERS						
99. 00 0990	DO CMHC	0		0		0	99. 00
99. 10 0991	10 CORF	0		0		0	99. 10
200.00	Subtotal (see instructions)	44, 280, 102	0	44, 280, 102	0	44, 280, 102	200.00
201.00	Less Observation Beds	0		0			201.00
202.00	Total (see instructions)	44, 280, 102	0	44, 280, 102	0	44, 280, 102	202.00

Health Financial Systems REHA	ABILITATION HOSE	PITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO	CN: 15-3028	Peri od:	Worksheet C	
				From 01/01/2020 To 12/31/2020	Part I	
				To 12/31/2020	Date/Time Pre 7/15/2021 11:	pared: 42 am
		Ti tl	e XIX	Hospi tal	PPS	12 0
		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	43, 300, 605		43, 300, 60	15		30.00
ANCILLARY SERVICE COST CENTERS	,					
50.00 05000 OPERATING ROOM	0	0		0. 000000	0. 000000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 728, 098	0	1, 728, 09		0. 000000	54.00
60. 00 06000 LABORATORY	1, 716, 542	0	1, 716, 54		0. 000000	60.00
65. 00 06500 RESPI RATORY THERAPY	3, 103, 023	0	3, 103, 02		0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	12, 174, 904	4, 788, 790			0. 000000	66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	1, 332, 580	1, 332, 58		0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	12, 818, 084	2, 695, 707	15, 513, 79		0.000000	
68. 00 06800 SPEECH PATHOLOGY	10, 007, 127	1, 839, 412	11, 846, 53		0. 000000	
68. 01 06801 VI SI ON	0	0		0. 000000	0.000000	
68. 02 06802 FAC RESOURCE	0	669, 268	669, 26		0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0. 000000	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 028, 173	56, 211	2, 084, 38		0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0. 000000	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 639, 504	3, 980, 729	9, 620, 23		0.000000	
74. 00 07400 RENAL DIALYSIS	0	0		0. 000000	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	2, 056, 309	2, 056, 30		0.000000	90.00
90. 01 09001 SLEEP CENTER	0	0		0. 000000	0. 000000	90. 01
91. 00 09100 EMERGENCY	0	0		0. 000000	0.000000	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0. 000000	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
99. 00 09900 CMHC	0	0		0		99. 00
99. 10 09910 CORF	0	0		0		99. 10
200.00 Subtotal (see instructions)	92, 516, 060	17, 419, 006	109, 935, 06	6		200. 00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	92, 516, 060	17, 419, 006	109, 935, 06	6		202. 00

Health Financial Systems	REHABILITATION HOSP	ITAL OF INDIANA	In Lieu of Form CMS-2552-		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-3028	From 01/01/2020	Date/Time Pre	
		Title XIX	Hospi tal	7/15/2021 11: PPS	42 am_
Cost Center Description	PPS Inpatient	11 21 2 11111			
	Ratio				

		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 206650			54.00
60. 00 06000 LABORATORY	0. 339971			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 403699			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 290469			66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0. 380338			66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0. 288559			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 188233			68. 00
68. 01 06801 VI SI ON	0. 000000			68. 01
68. 02 06802 FAC RESOURCE	3. 827524			68. 02
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 219464			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 362555			73.00
74. 00 07400 RENAL DIALYSIS	0. 000000			74. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 286794			90.00
90. 01 09001 SLEEP CENTER	0. 000000			90. 01
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS				
99. 00 09900 CMHC				99.00
99. 10 09910 CORF				99. 10
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems REHABILITATION FOALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2020 | Part I | To 12/31/2020 | Date/Time Prepared: Provi der CCN: 15-3028

					10 12/31/2020	7/15/2021 11:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost		Capi tal	Operati ng	
		(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
		Part I, col.	Part II col.	Capital Cost		Reduction	
		26)	26)	(col. 1 -		Amount	
				col. 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	NCILLARY SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,		,		T	1
	05000 OPERATING ROOM	0	0		0	0	00.00
	05400 RADI OLOGY-DI AGNOSTI C	357, 112	16, 395			0	0 00
	06000 LABORATORY	583, 575	10, 317			0	60.00
	06500 RESPI RATORY THERAPY	1, 252, 688	43, 338			0	65. 00
	06600 PHYSI CAL THERAPY	4, 927, 421	427, 937			0	66. 00
	06601 PHYSI CAL THERAPY - CARMEL	506, 831	2, 059			0	
	06700 OCCUPATI ONAL THERAPY	4, 476, 648	330, 200			0	07.00
	06800 SPEECH PATHOLOGY	2, 229, 909	72, 847	2, 157, 06	2 0	0	68. 00
	06801 VI SI ON	0	0		0	0	68. 01
	06802 FAC RESOURCE	2, 561, 639	22, 104	2, 539, 53	5 0	0	68. 02
	06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	457, 447	9, 103	448, 34	4 0	0	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	3, 487, 864	24, 469	3, 463, 39	5 0	0	73.00
	07400 RENAL DIALYSIS	0	0		0 0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	589, 738	86, 221	503, 51	7 0	ľ	
	09001 SLEEP CENTER	0	0		0	0	
	09100 EMERGENCY	0	0		0	0	91.00
_	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
	THER REIMBURSABLE COST CENTERS	,				1	
	09900 CMHC	0	0		0	ľ	
	09910 CORF	0	0		0	0	1 , , ,
200.00	Subtotal (sum of lines 50 thru 199)	21, 430, 872	1, 044, 990	20, 385, 88	2 0		200.00
201.00	Less Observation Beds	0	0		0	l	201.00
202. 00	Total (line 200 minus line 201)	21, 430, 872	1, 044, 990	20, 385, 88	2 0] 0	202. 00

In Lieu of Form CMS-2552-10 REHABILITATION HOSPITAL OF INDIANA Provider CCN: 15-3028

Health Financial Systems REHABILITATION H
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2020 | Part II | To | 12/31/2020 | Date/Time Prepared: 7/15/2021 | 11:42 am

						7/15/2021 11:42 am
			Ti tl	e XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges	Outpati ent		
		Capital and	(Worksheet C,	Cost to		
		Operati ng	Part I,	Charge Ratio)	
		Cost	column 8)	(col. 6 /		
		Reduction		col. 7)		
		6. 00	7. 00	8. 00		
	LLARY SERVICE COST CENTERS	1				
	OO OPERATING ROOM	0	0	0. 00000		50.00
	00 RADI OLOGY-DI AGNOSTI C	357, 112				54.00
60.00 0600	00 LABORATORY	583, 575	1, 716, 542	0. 33997	'1	60.00
	00 RESPI RATORY THERAPY	1, 252, 688	3, 103, 023	0. 40369	19	65.00
66.00 0660	00 PHYSI CAL THERAPY	4, 927, 421	16, 963, 694			66.00
66. 01 0660)1 PHYSI CAL THERAPY - CARMEL	506, 831	1, 332, 580	0. 38033	88	66. 01
67.00 0670	OCCUPATIONAL THERAPY	4, 476, 648	15, 513, 791	0. 28855	i9	67.00
68.00 0680	OO SPEECH PATHOLOGY	2, 229, 909	11, 846, 539	0. 18823	13	68. 00
68. 01 0680	D1 VISION	0	0	0. 00000	00	68. 01
68. 02 0680	02 FAC RESOURCE	2, 561, 639	669, 268	3. 82752	24	68. 02
69. 00 0690	00 ELECTROCARDI OLOGY	0	0	0. 00000	00	69.00
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS	457, 447	2, 084, 384	0. 21946	04	71.00
72.00 0720	OO IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000	00	72.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	3, 487, 864	9, 620, 233	0. 36255	55	73.00
74.00 0740	DO RENAL DIALYSIS	0	0	0. 00000	00	74.00
OUTP	PATIENT SERVICE COST CENTERS					
90.00 0900	DO CLINIC	589, 738	2, 056, 309	0. 28679	94	90.00
90. 01 0900	01 SLEEP CENTER	0	0	0. 00000	00	90. 01
91.00 0910	DO EMERGENCY	0	0	0. 00000	00	91.00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0. 00000	00	92.00
OTHE	R REIMBURSABLE COST CENTERS					
99.00 0990	DO CMHC	0	0	0. 00000	00	99. 00
99. 10 0991	O CORF	0	0	0. 00000	00	99. 10
200. 00	Subtotal (sum of lines 50 thru 199)	21, 430, 872	66, 634, 461			200.00
201. 00	Less Observation Beds	0	0			201.00
202. 00	Total (line 200 minus line 201)	21, 430, 872	66, 634, 461			202.00
		•	•	•	•	•

Health Financial Systems REH	ABILITATION HOS	PITAL OF INDIA	NA	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D		
				From 01/01/2020 To 12/31/2020		narod:	
				10 12/31/2020	7/15/2021 11:	42 am	
		Title	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		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	1, 340, 219	0	1, 340, 21	9 20, 733	64. 64	30.00	
200.00 Total (lines 30 through 199)	1, 340, 219		1, 340, 21	9 20, 733		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	6, 639					30.00	
200.00 Total (lines 30 through 199)	6, 639	429, 145				200.00	

Health Financial Systems REHA	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Peri od: From 01/01/2020		
				To 12/31/2020	Date/Time Pre 7/15/2021 11:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	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)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	T	Г	T	-T		
50.00 05000 OPERATING ROOM	0	0	0.00000		0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	16, 395					
60. 00 06000 LABORATORY	10, 317		•		3, 786	
65. 00 06500 RESPIRATORY THERAPY	43, 338					
66. 00 06600 PHYSI CAL THERAPY	427, 937				1	1
66. 01 06601 PHYSI CAL THERAPY - CARMEL	2, 059				0	66. 01
67. 00 06700 0CCUPATI ONAL THERAPY	330, 200	15, 513, 791				
68.00 06800 SPEECH PATHOLOGY	72, 847	11, 846, 539			19, 167	
68. 01 06801 VI SI ON	0	0	0. 00000	0	0	68. 01
68. 02 06802 FAC RESOURCE	22, 104	669, 268			0	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 103	2, 084, 384	0. 00436	7 727, 135	3, 175	71.00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	24, 469	9, 620, 233	0. 00254	3 1, 805, 782	4, 592	73.00
74. 00 07400 RENAL DIALYSIS	0	0	0. 00000	0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	86, 221	2, 056, 309	0. 04193	0	0	
90. 01 09001 SLEEP CENTER	0	0	0.00000		0	90. 01
91. 00 09100 EMERGENCY	0	0	0.00000		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.00000		0	92.00
200.00 Total (lines 50 through 199)	1, 044, 990	66, 634, 461		15, 941, 098	237, 348	200.00

Health Financial Systems REHA	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider Co		Period: From 01/01/2020 Fo 12/31/2020		epared: 42 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown	Nursi ng School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	(0	0	30.00
200.00 Total (lines 30 through 199)	0	0	(0	0	200.00
Cost Center Description	Swing-Bed Adjustment Amount (see	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				1		
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0	20, 733 20, 733		6, 639 6, 639	30. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	1					00.00
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0					30. 00 200. 00

| Peri od: | Worksheet D | From 01/01/2020 | Part IV | To 12/31/2020 | Part IV | Date/Time Prepared: THROUGH COSTS

					10 12/31/2020	7/15/2021 11:	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
	IOLAL ARVA GERVILOE GOOT GENTERO	1. 00	2A	2. 00	3A	3. 00	
	NCILLARY SERVICE COST CENTERS			1	_	_	
	5000 OPERATING ROOM	0	0		0	0	50.00
	5400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
	6000 LABORATORY	0	0		0	0	60.00
	6500 RESPI RATORY THERAPY	0	0		0	0	65.00
	6600 PHYSI CAL THERAPY	0	0		0	0	66.00
	6601 PHYSI CAL THERAPY - CARMEL	0	0		0	0	66. 01
	6700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
	6800 SPEECH PATHOLOGY	0	0		0	0	68. 00
	6801 VI SI ON	0	0		0	0	68. 01
	6802 FAC RESOURCE	0	0		0	0	68. 02
	6900 ELECTROCARDI OLOGY	0	0		0	0	69.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
	7200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
	7300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
	7400 RENAL DIALYSIS	0	0		0 0	0	74. 00
	JTPATIENT SERVICE COST CENTERS 9000 CLINIC			I			00.00
		0	0		0	0	90.00
	9001 SLEEP CENTER 9100 EMERGENCY	0	0		0	0	90. 01
		0	Ü		0	0	91. 00 92. 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)		^		0	1	
200.00	Total (lines 50 through 199)	ı U	0	1	U U	l 0	200. 00

| Peri od: | Worksheet D | From 01/01/2020 | Part IV | To | 12/31/2020 | Date/Time Prepared:
 Heal th Financial
 Systems
 REHABILITATION HOSPITAL OF INDIANA

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 15-3028
 THROUGH COSTS

				0 12/31/2020	7/15/2021 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	_	_	1			
50. 00 05000 OPERATI NG ROOM	0	0	(0	0.000000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(1, 728, 098	1	54.00
60. 00 06000 LABORATORY	0	0	(1, 716, 542		60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	(3, 103, 023	l	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	(16, 963, 694	l	66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	0	(1, 332, 580	l	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(15, 513, 791	l e	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	9	11, 846, 539	l e	
68. 01 06801 VI SI ON	0	0	9	0	0.000000	68. 01
68. 02 06802 FAC RESOURCE	0	0	9	669, 268	l e	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0.000000	69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		2, 084, 384	0.000000	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 (20 222	0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		9, 620, 233		73.00
74. 00 07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	0) 0	0.000000	74. 00
90. 00 O9000 CLINIC		1	1 ,	2, 056, 309	0.000000	90.00
90. 00 09000 CLINIC 90. 01 09001 SLEEP CENTER	0	0		2,056,309	0.00000	90.00
91. 00 09100 SLEEP CENTER 91. 00 09100 EMERGENCY	0	0			0.00000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0.00000	
200.00 Total (lines 50 through 199)				66, 634, 461		200.00
200.00 10tal (111165 30 till ough 179)	1	1	1	00, 034, 401	I	1200.00

Health Financial Systems REHABILITATION HOSPITAL OF INDIANA			In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-3028	Peri od:	Worksheet D

From 01/01/2020 Part IV
To 12/31/2020 Date/Time Prepared: THROUGH COSTS 7/15/2021 11:42 am Title XVIII Hospi tal PPS Cost Center Description Outpati ent I npati ent I npati ent Outpati ent Outpati ent Program Ratio of Cost Program Program Program to Charges Pass-Through Pass-Through Charges Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col . 12) x col. 10) 11.00 9. 00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0.000000 50.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 533, 553 0 0 54.00 06000 LABORATORY 0.000000 629, 921 0 o 0 60.00 60.00 06500 RESPIRATORY THERAPY 0.000000 1, 114, 834 0 65.00 65.00 0 0 06600 PHYSI CAL THERAPY 0.000000 3, 918, 745 66.00 1, 596 0 66.00 66.01 06601 PHYSI CAL THERAPY - CARMEL 0.000000 0 0 66.01 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 4, 094, 052 0 266 67.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 3, 117, 076 0 0 68.00 06801 VI SI ON 68.01 0.000000 0 0 68.01 68.02 06802 FAC RESOURCE 0.000000 0 0 68.02 06900 ELECTROCARDI OLOGY 0 69.00 0.000000 0 69.00 C 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0.000000 0 71.00 727, 135 15, 108 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 73.00 73.00 1, 805, 782 1, 555, 286 07400 RENAL DI ALYSI S 74.00 0.000000 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 000000 0 90.00 622, 657 0 0 0 0 09001 SLEEP CENTER 90.01 0.000000 0 0 90.01 0 91. 00 09100 EMERGENCY 91.00 0.000000 0 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 C 0 0 92.00 Total (lines 50 through 199) 15, 941, 098 2, 194, 913 0 200.00 200.00

Health Financial Systems REHA	ABILITATION HOS	SPITAL OF INDIA	.NA	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	ID VACCINE COST Provider CCN: 15-3028			Peri od:	Worksheet D	
				From 01/01/2020		
				To 12/31/2020		
		Ti +Lo	: XVIII	Hospi tal	7/15/2021 11: PPS	42 alli
		I IIIIE		ноѕрі таі	Costs	
C+ C+ Pi-+i	0+ +-	DDC	Charges	0+		
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services (see inst.)	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(See Trist.)	
	From Worksheet C,	Services (see inst.)	Services Subject To	Services Not		
		I IISt.)	Ded. & Coins.	Subject To Ded. & Coins.		
	Part I, col.		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	0. 000000			0	0	50.00
	1			0	-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 206650	0		0	0	
60. 00 06000 LABORATORY	0. 339971	0		0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 403699			0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 290469	,	47	4 0	464	
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0. 380338	l .		0	0	00.0.
67. 00 06700 OCCUPATI ONAL THERAPY	0. 288559			0	77	
68. 00 06800 SPEECH PATHOLOGY	0. 188233	l .		0	0	
68. 01 06801 VI SI ON	0. 000000	l .		0	0	68. 01
68. 02 06802 FAC RESOURCE	3. 827524	l .		0	0	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			0	0	1 07.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 219464			0	3, 316	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 362555			0	563, 877	
74. 00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 286794			0	178, 574	
90. 01 09001 SLEEP CENTER	0. 000000			0	0	90. 01
91. 00 09100 EMERGENCY	0. 000000	0		0	0	1 / 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Subtotal (see instructions)		2, 194, 913	47	4 0	746, 308	200.00
201.00 Less PBP Clinic Lab. Services-Program				0		201.00
Only Charges					l	
202.00 Net Charges (line 200 - line 201)		2, 194, 913	47	4 0	746, 308	202.00

Peri od: Worksheet D From 01/01/2020 Part V Provider CCN: 15-3028

				To 12/31/2020	Date/Time Pre 7/15/2021 11:	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS	1		1			
50.00 05000 OPERATING ROOM	0	0	ł			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	138	0				66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	0				66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68. 00
68. 01 06801 VI SI ON	0	0				68. 01
68. 02 06802 FAC RESOURCE	0	0				68. 02
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	1			73.00
74. 00 07400 RENAL DIALYSIS	0	0				74. 00
OUTPATIENT SERVICE COST CENTERS	1		T			
90. 00 09000 CLI NI C	0	1	ł			90.00
90. 01 09001 SLEEP CENTER	0	0				90. 01
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	138	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges	100	_				000 00
202.00 Net Charges (line 200 - line 201)	138	0	1			202. 00

Health Financial Systems REH	ABILITATION HOS	PITAL OF INDIA	NA	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2020 To 12/31/2020			
		Ti tl	e XIX	Hospi tal	PPS		
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
	1. 00	2.00	3.00	4.00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00		0.00		
30.00 ADULTS & PEDIATRICS	1, 340, 219	0	1, 340, 21	9 20, 733	64. 64	30.00	
200.00 Total (lines 30 through 199)	1, 340, 219		1, 340, 21	9 20, 733		200.00	
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
	6. 00	7. 00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	670 670		1			30. 00 200. 00	

Health Financial Systems REH	ABILITATION HOS	PITAL OF INDIA	INA	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der C		Period: From 01/01/2020 To 12/31/2020		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0. 00000	0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	16, 395	1, 728, 098	0. 00948	7 58, 704	557	54.00
60. 00 06000 LABORATORY	10, 317	1, 716, 542	0. 00601	0 41, 086	247	60.00
65. 00 06500 RESPIRATORY THERAPY	43, 338	3, 103, 023	0. 01396	6 77, 417	1, 081	65.00
66. 00 06600 PHYSI CAL THERAPY	427, 937	16, 963, 694	0. 02522	7 292, 341	7, 375	66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	2, 059	1, 332, 580	0. 00154	5 0	0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	330, 200	15, 513, 791	0. 02128	4 307, 526	6, 545	67.00
68.00 06800 SPEECH PATHOLOGY	72, 847	11, 846, 539	0. 00614	9 212, 556	1, 307	68.00
68. 01 06801 VI SI ON	0	0	0. 00000	0	0	68. 01
68. 02 06802 FAC RESOURCE	22, 104	669, 268	0. 03302	7 0	0	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 103	2, 084, 384	0. 00436	7 53, 352	233	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	24, 469	9, 620, 233	0. 00254	3 155, 842	396	73.00
74.00 07400 RENAL DIALYSIS	0	l o	0. 00000	0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>					1
90. 00 09000 CLI NI C	86, 221	2, 056, 309	0. 04193	0 0	0	90.00
90. 01 09001 SLEEP CENTER	0	0	0. 00000	0 0	0	90. 01
91. 00 09100 EMERGENCY	0	l 0	0.00000	o o	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 through 199)	1, 044, 990	66, 634, 461	1	1, 198, 824	17, 741	

Health Financial Systems	REHABILITATION HOS	PITAL OF INDIA	INA	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	R PASS THROUGH COS	TS Provider C		Period: From 01/01/2020 To 12/31/2020		
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown	Nursi ng School	Allied Health Post-Stepdowr Adjustments	Allied Health Cost	All Other Medical Education	
	Adjustments				Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0		0 0	0	30. 00 200. 00
Cost Center Description	Swi ng-Bed Adj ustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0	20, 73 20, 73		670 670	30. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0					30. 00 200. 00

| Peri od: | Worksheet D | From 01/01/2020 | Part IV | To 12/31/2020 | Part IV | Date/Time Prepared: THROUGH COSTS

				10 12/31/2020	7/15/2021 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0		0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60. 00 06000 LABORATORY	0	0		0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	0		0	0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
68. 01 06801 VI SI ON	0	0		0	0	68. 01
68. 02 06802 FAC RESOURCE	0	0		0	0	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
74. 00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0	0	90.00
90. 01 09001 SLEEP CENTER	0	0		0	0	90. 01
91. 00 09100 EMERGENCY	0	0		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0	0	200. 00

| Peri od: | Worksheet D | From 01/01/2020 | Part IV | To | 12/31/2020 | Date/Time Prepared:
 Heal th Financial
 Systems
 REHABILITATION HOSPITAL OF INDIANA

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 15-3028
 THROUGH COSTS

				0 12/31/2020	7/15/2021 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and		C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS				_	0.00000	
50. 00 05000 OPERATING ROOM	0	0	0	4 700 000	0. 000000	50.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0		1, 728, 098	0. 000000	54.00
60. 00 06000 LABORATORY	0	0	0	1, 716, 542	0. 000000	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0		3, 103, 023		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		16, 963, 694		66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	0		1, 332, 580		66. 01
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0		15, 513, 791 11, 846, 539		
68. 01 06800 SPEECH PATHOLOGY	0	0		11, 840, 539	0.000000	68. 00 68. 01
68. 02 06802 FAC RESOURCE	0	0		669, 268	0.000000	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0	0		009, 200	0.000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			2, 084, 384	0.000000	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			2,004,304	0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		9, 620, 233		
74. 00 07400 RENAL DI ALYSI S	0	0		7, 020, 233	0. 000000	
OUTPATIENT SERVICE COST CENTERS					0.000000	74.00
90. 00 09000 CLINIC	0	0	0	2, 056, 309	0.000000	90.00
90. 01 09001 SLEEP CENTER	0	0	0	0	0. 000000	
91. 00 09100 EMERGENCY	0	0		0	0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	l o	0	l o	0	0. 000000	
200.00 Total (lines 50 through 199)	Ö	l o	Ö	66, 634, 461		200. 00
	'	•	'			

Health Financial Systems	REHABILITATION HOSPIT	AL OF INDIANA		In Lieu of Form CMS-2552-10
ADDODTI ONMENT OF INDATIENT (OUTDATIENT	ANCILLARY CERVICE OTHER DACC	Drawi don CCN, 1E 2020	Dord od.	Waskahaat D

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Peri od: From 01/01/2020 To 12/31/2020 Worksheet D Part IV Date/Time Prepared: THROUGH COSTS 7/15/2021 11:42 am Title XIX Hospi tal PPS Cost Center Description I npati ent Outpati ent Outpati ent I npati ent Outpati ent Program Ratio of Cost Program Program Program Pass-Through Pass-Through to Charges Charges Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col . 12) x col. 10) 9. 00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0.000000 50 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 58, 704 0 54.00 0 0 0 0 0 0 0 0 0 0 0 06000 LABORATORY 0.000000 41, 086 0 60.00 60.00 0 0 06500 RESPIRATORY THERAPY 0.000000 77, 417 65.00 0 65.00 06600 PHYSI CAL THERAPY 0.000000 66.00 292, 341 0 66.00 66.01 06601 PHYSI CAL THERAPY - CARMEL 0.000000 0 0 66.01 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 307, 526 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 0.000000 212, 556 0 68.00 68.01 06801 VI SI ON 0.000000 0 68.01 68.02 06802 FAC RESOURCE 0.000000 0 0 68.02 06900 ELECTROCARDI OLOGY 0 69.00 0.000000 0 69.00 C 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 71.00 53, 352 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 o 0 73.00 73.00 0.000000 155, 842 07400 RENAL DIALYSIS 74.00 0.000000 0 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 000000 0 0 90.00 0 0 90. 01 09001 SLEEP CENTER 0.000000 0 0 0 0 90.01 0 91. 00 09100 EMERGENCY 91.00 0.000000 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0.000000 C 0 92.00

1, 198, 824

0

0

0 200.00

Total (lines 50 through 199)

200.00

In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-3028 Peri od: Worksheet D From 01/01/2020 To 12/31/2020 Part V Date/Time Prepared: 7/15/2021 11:42 am Title XIX Hospi tal PPS Costs Charges PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Ded. & Coins. Part I, col. 9 (see inst.) (see inst.) 1.00 2.00 3.00 4. 00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0.000000 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 54.00 0. 206650 0 0 06000 LABORATORY 0. 339971 0 60.00 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.403699 0 0 0 0 0 0 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 290469 289, 734 0 66.00 06601 PHYSI CAL THERAPY - CARMEL 0. 380338 3, 745 66.01 0 66.01 67.00 06700 OCCUPATI ONAL THERAPY 0. 288559 216, 815 0 67.00 68.00 06800 SPEECH PATHOLOGY 0. 188233 160, 747 0 68.00 06801 VI SI ON 0.000000 0 68.01 68.01 0 06802 FAC RESOURCE 3.827524 68.02 1, 750 0 68.02 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 219464 0 71.00 71.00 3,010 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 72.00 72 00 0 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0. 362555 0 321, 875 0 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 0. 286794 0 90.00 09000 CLI NI C 109, 399 n 0 0 0 0 0 09001 SLEEP CENTER 0.000000 90.01 90.01 0 0 0 91.00 09100 EMERGENCY 0.000000 0 91.00 92.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 200.00 Subtotal (see instructions) 0 1, 107, 075 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges Net Charges (line 200 - line 201) 0 0 202.00 202.00 0 1, 107, 075

Period: Worksheet D From 01/01/2020 Part V Provider CCN: 15-3028

			1	o 12/31/2020	Date/Time Prepa 7/15/2021 11:42	
		Ti tl	e XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00 06000 LABORATORY	0	0				50.00
65. 00 06500 RESPI RATORY THERAPY	0	0				55.00
66. 00 06600 PHYSI CAL THERAPY	84, 159					66.00
66.01 06601 PHYSI CAL THERAPY - CARMEL	1, 424					66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	62, 564	l .				57. 00
68.00 06800 SPEECH PATHOLOGY	30, 258	0				58. 00
68. 01 06801 VI SI ON	0	0				58. 01
68. 02 06802 FAC RESOURCE	6, 698	0				58. 02
69. 00 06900 ELECTROCARDI OLOGY	0	0				59. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	661	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	116, 697	0				73. 00
74.00 07400 RENAL DIALYSIS	0	0			7	74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	31, 375	0				90.00
90. 01 09001 SLEEP CENTER	0	0				90. 01
91. 00 09100 EMERGENCY	0	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			l ·	92.00
200.00 Subtotal (see instructions)	333, 836	0			20	00.00
201.00 Less PBP Clinic Lab. Services-Program	0				20	01.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	333, 836	0			20	02.00

Health Financial Systems	REHABILITATION HOSPITAL OF INDI	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der (CCN: 15-3028	Peri od: From 01/01/2020	Worksheet D-1
				Date/Time Prepared: 7/15/2021 11:42 am
	Ti tl	e XVIII	Hospi tal	PPS

				7/15/2021 11:	42 am
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
	DADT I ALL DROWNER COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS				-
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	rs ovel udi na nowborn)		20, 733	1.00
2. 00	Inpatient days (including private room days, excluding swing-			20, 733	
3. 00	Private room days (excluding swing-bed and observation bed da		rivate room days		3.00
3.00	do not complete this line.	ys). If you have only pr	Trate room days,	١	3.00
4. 00	Semi-private room days (excluding swing-bed and observation b	ed days)		20, 733	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost		5.00
	reporting period	3 , 3			
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
0.00	reporting period		14 . 6 . 11		0.00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December :	31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (eveluding	s swing bod and	6, 639	9. 00
7. 00	newborn days) (see instructions)	o the Frogram (excruding	g swifig-bed and	0,034	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (includina private m	room davs)	0	10.00
	through December 31 of the cost reporting period (see instruc				
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e				
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	12.00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	ear, enter o on this iii	ie)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	0	1
16. 00	Nursery days (title V or XIX only)			0	1
10.00	SWING BED ADJUSTMENT				10.00
17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 d	of the cost	0.00	17. 00
	reporting period	9			
18.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18.00
	reporting period				
19. 00		s through December 31 of	the cost	0.00	19. 00
20.00	reporting period	£t D 21 -£ -		0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	is after becember 31 of t	.ne cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instruction	(2)		22, 849, 230	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ina period (line		22.00
	5 x line 17)		9	- 1	
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	ng period (line é	0	23.00
	x line 18)				
24.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24. 00
05 00	7 x line 19)				05.00
25. 00] 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		22, 849, 230	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TTTIC 21 IIII TIGS TTTIC 20)		22,017,200	27.00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28. 00
29.00	Private room charges (excluding swing-bed charges)		3.17	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	1
34.00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	1
36.00	Private room cost differential adjustment (line 3 x line 35)	and private room cost di	fforontial (line	22 840 220	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	rierential (IINe	22, 849, 230	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			1
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 102. 07	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			7, 316, 643	1
40.00	Medically necessary private room cost applicable to the Progr	am (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ line 40)		7, 316, 643	41.00

COMPLIT	Financial Systems REHA ATION OF INPATIENT OPERATING COST	BILITATION HOS		CN: 15-3028	Peri od:	u of Form CMS-2 Worksheet D-1	
COMITOT	ATTON OF THEATTEN OF ENATING COST		Trovider c	GN. 13-3020	From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
			Ti tl e	e XVIII	Hospi tal	7/15/2021 11: PPS	42 alli
	Cost Center Description	Total	Total	Average Per		Program Cost	
	· ·	I npati ent	I npati ent	Diem (col.	١ ١	(col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
42.00	NUDCEDY (+: +1 - V o VIV1)	1. 00	2. 00	3.00	4. 00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			4, 495, 133	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)	(see instructi	ons)		11, 811, 776	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst D su	m of Parts I and	429, 145	50.00
30.00	[11]	attent routine	services (110	III WKSt. D, Su	III OI FAILS I AIR	427, 145	30.00
51.00	Pass through costs applicable to Program inp and IV)	atient ancilla	ry services (f	rom Wkst. D,	sum of Parts II	237, 348	51.00
52.00	Total Program excludable cost (sum of lines					666, 493	•
53.00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anest	hetist, and	11, 145, 283	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					1
54.00	Program di scharges					0	54.00
55. 00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	
57. 00	Difference between adjusted inpatient operat	ing cost and to	arget amount (line 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting poriod	anding 1004	undated and a	ompounded by the	0.00	
39.00	market basket	por tring period	ending 1990,	upuateu anu c	onipounded by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, u	odated by the	market basket		0. 00	60.00
61.00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		ts (lines 54 x	60), or 1% o	f the target		
62. 00	Relief payment (see instructions)	i iisti ucti olis)				0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	·					
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	e cost report	ing period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	ner 31 of the	cost renortin	a neriod (See	0	65. 00
03.00	instructions)(title XVIII only)	ts arter becom	oci oi tiic	cost reportin	g perrou (see		05.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
	CAH (see instructions)			6			,,,,,,
67.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs througi	n December 31	or the cost r	eporting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after l	December 31 of	the cost rep	ortina period	0	68.00
	(line 13 x line 20)				3 1		
69. 00	Total title V or XIX swing-bed NF inpatient					0	69.00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				`		70.00
71.00	Adjusted general inpatient routine service c)		71.00
72. 00	Program routine service cost (line 9 x line			_,			72.00
73.00	Medically necessary private room cost applic	able to Program					73. 00
74.00	Total Program general inpatient routine serv			•	Don't II - I		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	worksneet B,	rari II, column		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77. 00	Program capital-related costs (line 9 x line						77. 00
78.00	Inpatient routine service cost (line 74 minu						78.00
79.00	Aggregate charges to beneficiaries for exces				nuc line 70)		79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		vost iimii täti 0	ıı (ııne /a Mi	ilus IIIIe /9)		80.00
82. 00	Inpatient routine service cost limitation (1)				82.00
83.00	Reasonable inpatient routine service costs (* .				83. 00
		structions)					84.00

84.00

85.00

86.00

00 88.00 0 89.00

0 87.00

0.00

Program inpatient ancillary services (see instructions)

Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

84.00

86.00

Health Financial Systems REHA	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od: From 01/01/2020	Worksheet D-1	
				To 12/31/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		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	1, 340, 219	22, 849, 230	0. 05865	5 0	0	90.00
91.00 Nursing School cost	0	22, 849, 230	0.00000	0 0	0	91.00
92.00 Allied health cost	0	22, 849, 230	0.00000	o o	0	92.00
93.00 All other Medical Education	0	22, 849, 230	0. 00000	이 이	0	93.00

Health Financial Systems	REHABILITATION HOSPITAL OF INDIANA IN			u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der C		Peri od: From 01/01/2020	Worksheet D-1
				Date/Time Prepared: 7/15/2021 11:42 am
	Ti tl	e XIX	Hospi tal	PPS

		T: +1 - VIV		7/15/2021 11:	42 am
	Cost Center Description	Title XIX	Hospi tal	PPS	
	cost center bescription			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			20, 733	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		sivata room days	20, 733 0	2. 00 3. 00
3.00	do not complete this line.	iys). Tr you have only pr	ivate room days,	U	3.00
4. 00	Semi-private room days (excluding swing-bed and observation b	ed days)		20, 733	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decembe	er 31 of the cost	0	5.00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roo	um days) through December	31 of the cost	0	7. 00
7.00	reporting period	m days) thi dagii bedember	or or the cost	· ·	7.00
8.00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	670	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private m	coom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		oom days)	O	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	Y only (including privat	a room days)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar y			O	13.00
14.00	Medically necessary private room days applicable to the Progr			0	14.00
15. 00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	cos through Docombor 21 o	of the cost	0.00	17. 00
17.00	reporting period	es through becember 31 to	of the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20.00
	reporting period				
21. 00	Total general inpatient routine service cost (see instruction			22, 849, 230	
22. 00	Swing-bed cost applicable to SNF type services through Decemb 5×1 line 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	na period (line A	0	23. 00
20.00	x line 18)	or or the dest repertir	.g po ou (· ·	20.00
24. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24.00
25 00	7 x line 19)	21 -6		0	25 00
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	j period (iine 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		22, 849, 230	27. 00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	The state of the s			00.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed cr	narges)	0	28. 00 29. 00
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mi	, ,	ctions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.25	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			4 100 ==	00.00
38.00	Adjusted general inpatient routine service cost per diem (see			1, 102. 07	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	*		738, 387 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	•		738, 387	
		•	'	•	

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Peri od:	Worksheet D-1	
					From 01/01/2020 To 12/31/2020	Date/Time Pre 7/15/2021 11:	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)		Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00	2. 00	3. 00	4. 00	5. 00	42.00
12.00	Intensive Care Type Inpatient Hospital Units			1			42.00
13.00	INTENSIVE CARE UNIT						43.00
14.00	CORONARY CARE UNIT						44.00
45. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
46. 00 47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
17.00	Cost Center Description						17.00
						1. 00	
48. 00 49. 00	Program inpatient ancillary service cost (Wks			202)		339, 227	1
+9.00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS	41 till ough 46)	(see mstructi	UIS)		1, 077, 614	49.00
50. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, sun	n of Parts I and	43, 309	50.00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancilla	ry services (f	rom Wkst. D, s	sum of Parts II	17, 741	51.00
52. 00	Total Program excludable cost (sum of lines!	50 and 51)				61, 050	52.00
53. 00	Total Program inpatient operating cost exclude		elated, non-ph	ysician anesth	netist, and	1, 016, 564	53.00
	medical education costs (line 49 minus line !	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					0.00	
6. 00	Target amount (line 54 x line 55)					0	1
57. 00	Difference between adjusted inpatient operati	ing cost and t	arget amount (line 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	ending 1996,	updated and co	mpounded by the	0.00	59. 00
60. 00	Lesser of lines 53/54 or 55 from prior year	cost report, u	pdated by the	market basket		0. 00	60.00
61. 00	If line 53/54 is less than the lower of lines	s 55, 59 or 60	enter the les	ser of 50% of		0	61.00
	which operating costs (line 53) are less that		ts (lines 54 x	: 60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive payment	ent (see instr	uctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	ne cost reporti	ng period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decem	ber 31 of the	cost reporting	neriod (See	0	65. 00
00.00	instructions)(title XVIII only)	10 41 101 2000		oost ropertring	, por rou (000	· ·	00.00
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs throug	h December 31	of the cost re	norting period	0	67. 00
07.00	(line 12 x line 19)	c costs till oug	ii becember 31	or the cost re	por tring perrou	O	07.00
68. 00	Title V or XIX swing-bed NF inpatient routine	e costs after	December 31 of	the cost repo	orting period	0	68. 00
, o oo	(line 13 x line 20)		(1) (7 1)	- (0)		0	(0.00
69. 00	Total title V or XIX swing-bed NF inpatient of PART III - SKILLED NURSING FACILITY, OTHER NU		•			0	69.00
70. 00	Skilled nursing facility/other nursing facili						70.00
71. 00	Adjusted general inpatient routine service co		line 70 ÷ line	2)			71.00
72.00	Program routine service cost (line 9 x line	,	. (11 44 1	05)			72.00
73. 00 74. 00	Medically necessary private room cost application of the program general inpatient routine services.						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	•		•	Part II, column		75.00
	26, line 45)		•		·		
76.00	Per diem capital related costs (line 75 ÷ lin						76.00
77. 00 78. 00	Program capital -related costs (line 9 x line	· · · · · · · · · · · · · · · · · · ·					77. 00 78. 00
78.00 79.00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		provider recor	ds)			79.00
30.00	Total Program routine service costs for compa				nus line 79)		80.00
31. 00	Inpatient routine service cost per diem limi			•	<i></i>		81.00
82.00	Inpatient routine service cost limitation (li	ine 0 v line 8	1)				82.00

Health Financial Systems REHA	ABILITATION HOSPITAL OF INDIANA			In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od: From 01/01/2020	Worksheet D-1	
				To 12/31/2020	Date/Time Prepared: 7/15/2021 11:42 am	
	Ti tle XIX		e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		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	1, 340, 219	22, 849, 230	0. 05865	5 0	0	90.00
91.00 Nursing School cost	0	22, 849, 230	0.00000	0 0	0	91.00
92.00 Allied health cost	0	22, 849, 230	0.00000	o o	0	92.00
93.00 All other Medical Education	0	22, 849, 230	0. 00000	이 이	0	93.00

Health Financial Systems REHABILITATION HOSPITAL OF INDI	ANA	In Lie	u of Form CMS-2	2552-10
	Provi der CCN: 15-3028 P		Worksheet D-3	
		From 01/01/2020 To 12/31/2020		
	e XVIII	Hospi tal	PPS	
Cost Center Description	Ratio of Cos To Charges	t Inpatient Program	Inpatient Program Costs	
		Charges	(col. 1 x col. 2)	
	1.00	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		_		
30. 00 03000 ADULTS & PEDI ATRI CS		13, 822, 618		30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0.00000		0	
54. 00 O5400 RADI OLOGY-DI AGNOSTI C	0. 2066			
60. 00 06000 LABORATORY	0. 3399			
65. 00 O6500 RESPI RATORY THERAPY	0. 4036			
66. 00 06600 PHYSI CAL THERAPY	0. 2904		1, 138, 274	
66. 01 O6601 PHYSI CAL THERAPY - CARMEL	0. 3803		0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0. 2885			
68.00 O6800 SPEECH PATHOLOGY	0. 1882:		586, 737	68. 00
68. 01 06801 VI SI ON	0. 00000		0	
68. 02 06802 FAC RESOURCE	3. 8275		0	
69. 00 06900 ELECTROCARDI OLOGY	0. 00000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 2194		159, 580	1
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS	0. 00000		0	
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 3625		654, 695	1
74. 00 07400 RENAL DI ALYSI S	0. 00000	00 0	0	74.00
OUTPATIENT SERVICE COST CENTERS	_			
90. 00 09000 CLI NI C	0. 2867		0	
90. 01 09001 SLEEP CENTER	0. 00000		0	
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 through 94 and 96 through 98)		15, 941, 098	4, 495, 133	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61))	0		201. 00
202.00 Net charges (line 200 minus line 201)		15, 941, 098	I	202. 00

Health Financial Systems REHABILITATI	ON HOSPITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-3028		Peri od:	Worksheet D-3	
			From 01/01/2020 To 12/31/2020		narod:
			10 12/31/2020	7/15/2021 11:	
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 028, 281		30.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 00000		0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 20665		12, 131	
60. 00 06000 LABORATORY		0. 33997		•	
65. 00 06500 RESPI RATORY THERAPY		0. 40369		31, 253	
66. 00 06600 PHYSI CAL THERAPY		0. 29046		84, 916	
66. 01 06601 PHYSI CAL THERAPY - CARMEL		0. 38033		0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY		0. 28855		88, 739	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 18823	3 212, 556	40, 010	68. 00
68. 01 06801 VI SI 0N		0.00000	0	0	68. 01
68. 02 06802 FAC RESOURCE		3. 82752		0	68. 02
69. 00 06900 ELECTROCARDI OLOGY		0. 00000	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 21946	4 53, 352	11, 709	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 00000	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 36255		56, 501	73.00
74. 00 07400 RENAL DIALYSIS		0. 00000	0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS			_		
90. 00 09000 CLI NI C		0. 28679		0	90.00
90. 01 09001 SLEEP CENTER		0. 00000		0	90. 01
01 00 00100 EMEDCENCY		0 00000		Λ .	01 00

0.000000

0.000000

1, 198, 824 1, 198, 824 0 91.00

0 92.00

339, 227 200. 00 201. 00 202. 00

91. 00 09100 EMERGENCY

92.00 | 09200 | SERVATION BEDS (NON-DISTINCT PART)
200.00 | Total (sum of lines 50 through 94 and 96 through 98)
201.00 | Less PBP Clinic Laboratory Services-Program only charges (line 61)
202.00 | Net charges (line 200 minus line 201)

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2020 Part A Exhi bit 4 To 12/31/2020 Date/Ti me Prepared: 7/15/2021 11: 42 am Provider CCN: 15-3028

							7/15/2021 11:	42 am
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier payments	1. 00	0	0	0	0	0	1.00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	0	0	0		0	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	0	0		0	0	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1.03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to	2. 03	0	0	0		0	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2. 04	0	0		0	0	2. 03
3. 00	instructions) Operating outlier reconciliation	2. 01	0	0	0	0	0	3.00
4. 00	Managed care simulated payments	3. 00	0	0	-1, 332, 380	1, 332, 380	0	4.00
	Indirect Medical Education Adj	ustment						1
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	0	0	0	0	6. 01
	Indirect Medical Education Adj	ustment for the	e Add-on for Se	ection 422 of	the MMA			1
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000		0. 000000		7.00
8. 00	IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	O	0	0	O	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	0	0	9. 01
	Disproportionate Share Adjustm							
10.00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 0000	0. 0000	0. 0000	0. 0000		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	0	0	0	0	0	11.00
11. 01		36.00	0 RD beneficiary	di scharges	0	0	0	11. 01
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0 0	0	0	0	12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47. 00 48. 00	0	0	0	0	0	
15. 00	small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	0	0	0	0	0	15. 00

					XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After	through 4)	
						10/01	,	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
16. 00	Payment for inpatient program	50, 00	0		0.00	1. 00		16.00
10.00		30.00	U	U	U	U	0	10.00
	capital (from Wkst. L, Pt. I,							
	if applicable)		_	_	_	_	_	
17. 00	Special add-on payments for	54. 00	0	0	0	0	0	17. 00
	new technologies							
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from	68. 00	0	0	0	0	0	17. 02
	manufacturers for replaced							
	devices for applicable MS-DRGs							
18. 00	Capital outlier reconciliation		0	^	0	0	0	18. 00
10.00		73.00	U	U	U	U	U	16.00
	adjustment amount (see							
	instructions)			_	_	_	_	
19. 00	SUBTOTAL			0	0	0	0	19.00
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2.00	3. 00	4.00	5. 00	
20.00	Capital DRG other than outlier	1. 00	0	0	0	0	0	20.00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	0	0	0	20. 01
	than outlier		-		_		_	
21. 00	Capital DRG outlier payments	2. 00	0	n	0	0	0	21.00
21. 00	Model 4 BPCI Capital DRG	2. 01	0	0	0	0	0	21.00
21.01		2.01	U	U	U	U	U	21.01
	outlier payments	F 00						
22. 00	Indirect medical education	5. 00	0. 0000	0. 0000	0. 0000	0. 0000		22. 00
	percentage (see instructions)							
23.00	Indirect medical education	6. 00	0	0	0	0	0	23.00
	adjustment (see instructions)							
24.00	Allowable disproportionate	10.00	0.0000	0.0000	0.0000	0.0000		24.00
	share percentage (see							
	instructions)							
25. 00	Di sproporti onate share	11. 00	0	^	0	0	0	25.00
25.00		11.00	U	U	U	U	0	25.00
04 00	adjustment (see instructions)	40.00					_	0, 00
26. 00	Total prospective capital	12. 00	0	0	0	0	0	26. 00
	payments (see instructions)		4.					
		W/S E, Part A	(Amounts to					
		line	E, Part A)					
		0	1.00	2.00	3. 00	4.00	5. 00	
27. 00	Low volume adjustment factor				0.000000	0. 000000		27. 00
28.00	Low volume adjustment	70. 96			0		0	28. 00
	(transfer amount to Wkst. E,						ľ	
	Pt. A, line)							
20.00		70. 97				^	_	20.00
29. 00	Low volume adjustment	/0.9/				0	0	29. 00
	(transfer amount to Wkst. E,							
	Pt. A, line)							
100.00	Transfer low volume		Υ					100.00
	adjustments to Wkst. E, Pt. A.							
			•		•			

 Heal th Financial
 Systems
 REHABILITATION HOSPITAL OF INDIANA

 HOSPITAL
 ACQUIRED
 CONDITION (HAC)
 REDUCTION CALCULATION EXHIBIT 5
 Provider CCN:
 In Lieu of Form CMS-2552-10 Provi der CCN: 15-3028 Peri od: Worksheet E From 01/01/2020 Part A Exhi bit 5 To 12/31/2020 Date/Time Prepared:

				10	12/31/2020	7/15/2021 11:	
			Title		Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1. 00	2.00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	0	0		0	1. 00 1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	0		0	0	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00					2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	0	0		0	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	0		0	0	2. 03
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0	0 3, 111, 690	0 1, 332, 380	0 4, 444, 070	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	6.00
6. 01	IME payment adjustment for managed care (see instructions) Indirect Medical Education Adjustment for the		oction 422 of t	bo MMA	0	0	6. 01
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0.000000	0. 000000		7. 00
8.00	IME adjustment (see instructions)	28. 00	o	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	0	0	8. 01
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	0	0	0 0	0	9. 00 9. 01
	lines 6.01 and 8.01) Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage	33. 00	0. 0000	0. 0000	0. 0000		10. 00
11. 00	(see instructions) Disproportionate share adjustment (see	34. 00	0	0	0	0	11. 00
11. 01	instructions) Uncompensated care payments	36. 00	0	0	0	0	11. 01
12. 00	Additional payment for high percentage of ESI Total ESRD additional payment (see instructions)	46.00	ui scharges 0	0	0	0	12. 00
13. 00	Subtotal (see instructions)	47. 00	0	0	0	0	13.00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	0	0	0	0	14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	0	0	0	0	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	0	0	0	0	
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	0	0	0	0	17. 00 17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	17. 02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	0	0	18.00
19. 00	SUBTOTAL			0	0	0	19. 00

Health Financial Systems	REHABILITATION HOSPI	TAL OF INDIANA	In Lie	u of Form CMS-2552-10
HOSPITAL ACQUIRED CONDITION (HAG	C) REDUCTION CALCULATION EXHIBIT 5	Provi der CCN: 15-3028	Peri od:	Worksheet E

	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider C	CN: 15-3028	Period: From 01/01/2020 To 12/31/2020		t 5 epared:
			Title	: XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from				
			Wkst. L)				
		0	1. 00	2. 00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1. 00	0		0 0	0	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	0		0	0	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
22.00	Indirect medical education percentage (see	5. 00	0.0000	0.000	0. 0000		22.00
	instructions)						
23.00	Indirect medical education adjustment (see	6. 00	0		0	l 0	23.00
	instructions)						
24.00	Allowable disproportionate share percentage	10. 00	0. 0000	0.000	0. 0000		24.00
	(see instructions)				-		
25.00	Disproportionate share adjustment (see	11. 00	0		0	0	25.00
	instructions)		_			_	
26.00	Total prospective capital payments (see	12. 00	0		0	0	26.00
	instructions)		_			_	
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
		,	A)				
		0	1, 00	2.00	3. 00	4. 00	
27. 00		-			0.00		27. 00
28.00	Low volume adjustment prior to October 1	70. 96	1		0	l o	
29.00	Low volume adjustment on or after October 1	70. 97	0		0	ĺ	
30.00	HVBP payment adjustment (see instructions)	70. 93	١			0	
30. 00	HVBP payment adjustment for HSP bonus	70. 90					
30.01	payment (see instructions)	70. 90	٥		٥	٥	30.01
31.00	HRR adjustment (see instructions)	70. 94				0	31.00
31. 00	HRR adjustment for HSP bonus payment (see	70. 94					1
31.01	instructions)	70. 91	0			0	31.01
	Thisti deti ons)					(Amt. to	
						Wkst. E, Pt.	
		0	1. 00	2.00	3. 00	A) 4.00	
22 00	HAC Reduction Program adjustment (see	70. 99	1.00	2.00	0 0		32.00
32.00	instructions)	10.99				l "	32.00
100.00	Transfer HAC Reduction Program adjustment to		N.				100.00
100.00	Wkst. E, Pt. A.	1	N				100.00
	IWKSL. E, Pt. A.	l	I	I	1	I	I

Health Financial Systems	REHABILITATION HOSPIT	AL OF INDIANA	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-3028	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/15/2021 11:42 am

	Ti t	le XVIII	Hospi tal	7/15/2021 11: PPS	42 am_
			noop: tu		
	DART D. HERMON, AND OTHER HEALTH CERVILORS			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			138	1.00
2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)			746, 308	2.00
3. 00	OPPS payments			594, 396	3.00
4.00	Outlier payment (see instructions)			0	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0. 000	5.00
6. 00	Line 2 times line 5			0	6.00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00 0	7. 00 8. 00
9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col.	13 line 200		0	9.00
10.00	Organ acquisitions	15, 11110 200		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			138	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12.00	Ancillary service charges			474	ł
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13)			0 474	13. 00 14. 00
14.00	Customary charges			474	14.00
15. 00	Aggregate amount actually collected from patients liable for payment for	or services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)				
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line	o 10 ovenode Li	no 11) (coo	474 336	ı
19.00	instructions)	s to exceeds it	THE TT) (See	330	19.00
20. 00	Excess of reasonable cost over customary charges (complete only if line	e 11 exceeds li	ne 18) (see	0	20.00
	instructions)		, ,		
21. 00	Lesser of cost or charges (see instructions)			138	ł
22. 00	Interns and residents (see instructions)			0	22.00
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instructions)			0 E04 204	23. 00 24. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			594, 396	24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			95	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for	CAH, see instr	ructions)	123, 316	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the s	sum of lines 22	2 and 23] (see	471, 123	27. 00
	instructions)				
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28. 00 29. 00
30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			471, 123	
31. 00	Primary payer payments			0	31.00
32.00	Subtotal (line 30 minus line 31)			471, 123	•
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34. 00 35. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			66, 383 43, 149	•
36. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)			66, 383	•
37. 00	Subtotal (see instructions)			514, 272	1
38. 00	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			_	39. 50
39. 97	Demonstration payment adjustment amount before sequestration	oo (ooo i notruu	a+! ana)	0	39. 97
39. 98 39. 99	Partial or full credits received from manufacturers for replaced device RECOVERY OF ACCELERATED DEPRECIATION	as (see instruc	Ctrons)	0	39. 98 39. 99
40. 00	Subtotal (see instructions)			514, 272	40.00
40. 01	Sequestration adjustment (see instructions)			3, 394	1
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs				40. 03
41.00	Interim payments			529, 026	1
				_	41.01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42. 00 42. 01
43. 00	Balance due provider/program (see instructions)			-18, 148	1
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44.00	Protested amounts (nonallowable cost report items) in accordance with (CMS Pub. 15-2,	chapter 1,	5, 736	1
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR			_	00.00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90.00
91.00	The rate used to calculate the Time Value of Money			0. 00	
93. 00	Time Value of Money (see instructions)			0.00	93.00
	Total (sum of lines 91 and 93)				94.00

 Heal th
 Financial
 Systems
 REHABILIT

 ANALYSIS
 OF
 PAYMENTS
 TO
 PROVIDERS
 FOR
 SERVICES
 RENDERED
 In Lieu of Form CMS-2552-10 Provi der CCN: 15-3028

			1	0 12/31/2020	7/15/2021 11:	
		Title	· XVIII	Hospi tal	PPS	
		I npati en	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
4 00	I -	1. 00	2.00	3. 00	4. 00	4 00
1. 00 2. 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		10, 642, 470 0		493, 226 0	1. 00 2. 00
3.00	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					3.00
3. 01	ADJUSTMENTS TO PROVIDER		1 0	08/19/2020	35, 800	3.01
3. 02	ADJUSTIMENTS TO TROVIDER			00/17/2020	35, 600	3.02
3. 03			l			3. 03
3. 04			l o		0	3.04
3. 05			Ö		0	
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			0		0	
3. 52			0		0	3. 52
3. 53			0		0	
3. 54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		35, 800	3. 99
4. 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)		10, 642, 470		529, 026	4.00
	TO BE COMPLETED BY CONTRACTOR	T	T		T	
5. 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. 00
	Program to Provider	<u> </u>	•			ĺ
5. 01	TENTATI VE TO PROVI DER		0		0	5.01
5.02			0		0	
5.03			0		0	5.03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	
5. 52	Cultural (com of lines F 01 F 40 minus com of lines		0		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		80, 061		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		18, 148	
7. 00	Total Medicare program liability (see instructions)		10, 722, 531		510, 878	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8.00

Health Financial Systems	REHABILITATION HOSPITAL OF IND	OI ANA	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 15-3028	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part III Date/Time Prepared: 7/15/2021 11:42 am
				DDO

		Title XVIII	Hospi tal	7/15/2021 11:	42 am_
		IT LIE XVIII	поѕрі таі	PP3	
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		<u> </u>		
1.00	Net Federal PPS Payment (see instructions)			10, 049, 890	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0224	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			775, 852	3.00
4.00	Outlier Payments			300, 432	4.00
5. 00	Unweighted intern and resident FTE count in the most recent count to November 15, 2004 (see instructions)	nding on or prior	0. 34	5. 00	
5. 01	Cap increases for the unweighted intern and resident FTE coun program or hospital closure, that would not be counted withou CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0. 00	5. 01
6.00	New Teaching program adjustment. (see instructions)			0.00	6.00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in teaching program" (see instructions)	the new program growth p	period of a "new	2. 97	7. 00
8. 00	Current year's unweighted I&R FTE count for residents within teaching program" (see instructions)			0. 00	8. 00
9. 00	Intern and resident count for IRF PPS medical education adjus	tment (see instructions)		0. 34	9. 00
10. 00	Average Daily Census (see instructions)			56. 647541	
11. 00	Teaching Adjustment Factor (see instructions)			0. 006100	
12.00	Teaching Adjustment (see instructions)			61, 304	
13.00	Total PPS Payment (see instructions)			11, 187, 478	
14.00	Nursing and Allied Health Managed Care payments (see instruct	i on)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)	ruoti ono)		0	15.00
16. 00 17. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		11 107 470	16. 00 17. 00
17.00	Subtotal (see instructions)			11, 187, 478	18.00
19. 00	Primary payer payments Subtotal (line 17 less line 18).			11, 187, 478	
20. 00	Deductibles			40, 744	
21. 00	Subtotal (line 19 minus line 20)			11, 146, 734	
22. 00	Coi nsurance			392, 546	
23. 00	Subtotal (line 21 minus line 22)			10, 754, 188	
24. 00	Allowable bad debts (exclude bad debts for professional servi-	ces) (see instructions)		60, 896	
25. 00	Adjusted reimbursable bad debts (see instructions)	ces) (see Thisti de trons)		39, 582	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		60, 896	
27. 00	Subtotal (sum of lines 23 and 25)	. 401. 51.5)		10, 793, 770	
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 49)		0	28. 00
29. 00	Other pass through costs (see instructions)			0	29.00
30.00	Outlier payments reconciliation			0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	31.50
31. 99	Demonstration payment adjustment amount before sequestration			0	31. 99
32.00	Total amount payable to the provider (see instructions)			10, 793, 770	32.00
32.01	Sequestration adjustment (see instructions)			71, 239	32. 01
32. 02	Demonstration payment adjustment amount after sequestration			0	32. 02
33.00	Interim payments			10, 642, 470	33.00
34.00	Tentative settlement (for contractor use only)			0	34.00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.0	2, 33, and 34)		80, 061	
36. 00	Protested amounts (nonallowable cost report items) in accordal \$115.2	nce with CMS Pub. 15-2,	chapter 1,	195, 412	36. 00
	TO BE COMPLETED BY CONTRACTOR				
50. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			300, 432	50.00
51. 00	Outlier reconciliation adjustment amount (see instructions)			0	51.00
52. 00	The rate used to calculate the Time Value of Money			0. 00	52.00
	Time Value of Money (see instructions)			0	53.00
			'	- 1	

Heal th	Financial Systems REHABILITATION HOSPI	TAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der C		Peri od:	Worksheet E-4	
MEDICA	L EDUCATION COSTS			From 01/01/2020 To 12/31/2020	Date/Time Pre 7/15/2021 11:	
		Title	XVIII	Hospi tal	PPS	12 diii
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	. 0	·	0 .	0. 00	1. 00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CF		(1) (see inst	ructions)	0.00	2. 00 3. 00
3. 00 3. 01	Amount of reduction to Direct GME cap under section 422 of MMDirect GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)		R §413.79 (m)	(see	0. 00 0. 00	
4. 00	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	0. 00	4. 00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instandeding 7/1/2011)		r cost reporti	ng periods	0. 00	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	ts (see ins	tructions for	cost reporting	0. 00	4. 02
5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	line 4 plus	ines 4.01 and	0. 00	5. 00
6. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	r the current	year from your	2. 96	6. 00
7. 00	Enter the lesser of line 5 or line 6		Dri maru Cara	Othor	0. 00	7. 00
			Primary Care 1.00	0ther 2.00	Total 3.00	
8. 00	Weighted FTE count for physicians in an allopathic and osteop	oathi c	0. 0		2. 28	8. 00
9. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherwind multiply line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8 times the line 8 times the result of line 5 divided by the line 8 times times the line 8 times the line 8 times times the line 8 times times the line 8 times times times the line 8 times times times times the line 8 times t		0.0	0. 00	0. 00	9. 00
	6.	built on time				
10.00	Weighted dental and podiatric resident FTE count for the curr	,		0.00		10.00
10. 01 11. 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count	urrent year	0.0	0. 00 0. 00		10. 01 11. 00
12. 00	Total weighted ris count Total weighted resident FTE count for the prior cost reporting [instructions]	ng year (see				12.00
13. 00	Total weighted resident FTE count for the penultimate cost relyear (see instructions)	eporti ng	0.0	0. 00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided	d by 3).	0.0	0.00		14.00
15.00	Adjustment for residents in initial years of new programs		0.0			15.00
15. 01 16. 00	Unweighted adjustment for residents in initial years of new padjustment for residents displaced by program or hospital clo		0.0			15. 01 16. 00
16. 00	Unweighted adjustment for residents displaced by program or h		0.0			16.00
17.00	closure		0.0	0 00		17.00
17. 00 18. 00	Adjusted rolling average FTE count Per resident amount		0.0			17. 00 18. 00
	Approved amount for resident costs		•	0 0	0	
					1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots red	cei ved under 42		20. 00
21 00	Sec. 413.79(c)(4)	uati ana)			2.04	21 00
21. 00 22. 00	Direct GME FTE unweighted resident count over cap (see instru Allowable additional direct GME FTE Resident Count (see instr				2. 96 0. 00	
23. 00	Enter the locality adjustment national average per resident a		instructions)			23. 00
	Multiply line 22 time line 23				0	
	Total direct GME amount (sum of lines 19 and 24)				0	
	Inpatient Managed Care Part A					
			1. 00	2. 00	3. 00	
26. 00	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) (Title XIX - see S-2 Part I	V lino	6, 63	9 3, 078		26. 00
	3. 02, col umn 2)	A, THE				
27. 00 28. 00	Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days		20, 73 0. 32021			27. 00 28. 00
29. 00	Program di rect GME amount		3. 32321	0 0	0	29. 00
29. 01	Percent reduction for MA DGME					29. 01
30.00	Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount			0	0	30. 00 31. 00
51.00	Inct Frogram direct own amount		I	T.	ا	31.00

Hool +b	Financial Systems REHABILITATION HOSPI	TAL OF LNDLANA	In Lio	u of Form CMS-2	DEED 10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-3028	Period:	Worksheet E-4	
	AL EDUCATION COSTS	11001461 0010 10 0020	From 01/01/2020		
			To 12/31/2020	Date/Time Pre 7/15/2021 11:	
		Title XVIII	Hospi tal	PPS	42 alli
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL	E XVIII ONLY (NURSING S	CHOOL AND PARAMED	I CAL	
	EDUCATION COSTS)				
32. 00	, , , , , , , , , , , , , , , , , , , ,	Pt. I, sum of col. 20 a	nd 23, lines 74	0	32.00
22 00	and 94)	l sol 0 sum of lines	74 and 04)	0	33.00
	Renal dialysis and home dialysis total charges (Wkst. C, Pt. Ratio of direct medical education costs to total charges (lir		74 and 94)	0. 000000	
	Medicare outpatient ESRD charges (see instructions)	ie 32 - 111ie 33)		0.000000	1
	Medicare outpatient ESRD direct medical education costs (line	34 v line 35)		0	
30. 00	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII				30.00
	Part A Reasonable Cost	0.121			
37.00	Reasonable cost (see instructions)			11, 811, 776	37. 00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	39.00
40.00	Primary payer payments (see instructions)			0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minu	us line 40)		11, 811, 776	41.00
	Part B Reasonable Cost				
	Reasonable cost (see instructions)			746, 446	1
43. 00	Primary payer payments (see instructions)			0	
44.00	Total Part B reasonable cost (line 42 minus line 43)			746, 446	
	Total reasonable cost (sum of lines 41 and 44)	44 11 45		12, 558, 222	1
	Ratio of Part A reasonable cost to total reasonable cost (lin	,		0. 940561	1
47.00	Ratio of Part B reasonable cost to total reasonable cost (lir ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA			0. 059439	47.00
48 OO	Total program GME payment (line 31)	AR I D		0	48. 00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		0	
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			0	
22.00	1. a. i =	(222 : 1122 2011 0110)		Ü	

	Financial Systems REHABILITATION HOS	PITAL OF INDIA	.NA	In Lie	u of Form CMS-2	2552-10
	E SHEET (If you are nonproprietary and do not maintain	Provi der Co	CN: 15-3028 Pe	riod: om 01/01/2020	Worksheet G	
only)	ype accounting records, complete the General Fund column		To			pared:
J. 1. 37		General Fund	Speci fi c	Endowment	7/15/2021 11: Plant Fund	42 am
		General Fund	Purpose Fund	Fund	Prant Fund	
		1. 00	2.00	3. 00	4. 00	
4 00	CURRENT ASSETS	44 455 0//				1 4 00
1. 00 2. 00	Cash on hand in banks Temporary investments	11, 155, 966 281	0	0	0	1. 00 2. 00
3. 00	Notes receivable	201	0	0	0	3.00
4. 00	Accounts receivable	16, 874, 941	Ö	0	ő	4.00
5.00	Other recei vable	248, 744	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11, 171, 393	0	0	0	6.00
7. 00	Inventory	272, 598		0	0	7.00
8. 00	Prepai d expenses	1, 272, 890	0	0	0	8.00
9. 00 10. 00	Other current assets Due from other funds	0	0	0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	18, 654, 027	0	0	0	11.00
11.00	FIXED ASSETS	10,001,027	<u> </u>			11.00
12.00	Land	1, 904, 164	0	0	0	12.00
13.00	Land improvements	370, 910	0	0	-	13.00
14. 00	Accumulated depreciation	-316, 231	0	0	0	14.00
15.00	Bui I di ngs	23, 012, 087	I	0	0	15.00
16.00	Accumulated depreciation Leasehold improvements	-14, 298, 938		0	0	16.00
17. 00 18. 00	Accumulated depreciation	205, 018 -172, 191	0	0	0	17. 00 18. 00
19. 00	Fi xed equi pment	3, 490, 694		0	0	19.00
20.00	Accumulated depreciation	-2, 017, 736		0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	14, 915, 298		0	0	23.00
24.00	Accumulated depreciation	-12, 650, 409		0	0	24.00
25. 00	Minor equipment depreciable	105, 832		0	0	25.00
26. 00 27. 00	Accumulated depreciation HIT designated Assets	-105, 832	0	0	0	26. 00 27. 00
28. 00	Accumulated depreciation	0	0	0	Ö	28.00
29. 00	Mi nor equi pment-nondepreci abl e	Ö	0	0	-	29.00
30.00	Total fixed assets (sum of lines 12-29)	14, 442, 666	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32. 00 33. 00	Deposits on leases Due from owners/officers	1 114 100	0	0	0	32. 00 33. 00
34. 00	Other assets	1, 116, 198 602, 474	1	0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	1, 718, 672	1	0	ő	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	34, 815, 365		0	0	36.00
	CURRENT LI ABI LI TI ES					
37.00	Accounts payable	3, 742, 786	I	0	0	37.00
38. 00	Salaries, wages, and fees payable	2, 488, 957		0	0	38.00
39. 00 40. 00	Payroll taxes payable Notes and Loans payable (short term)	890, 000	0	0	0	39. 00 40. 00
41. 00	Deferred income	070,000	0	0	0	
42. 00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1, 209, 217		0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	8, 330, 960	0	0	0	45. 00
44 00	LONG TERM LIABILITIES	0	0	0	0	144 00
46. 00 47. 00	Mortgage payable Notes payable	9, 745, 000		0	0	46. 00 47. 00
48. 00	Unsecured Loans	9, 743, 000	0	0	0	48.00
49. 00	Other long term liabilities	0	Ö	0	ő	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9, 745, 000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	18, 075, 960	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	16, 739, 405	1			52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted		0	0		53. 00 54. 00
55.00	Donor created - endowment fund balance - restricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant			Ĭ	0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
50 -:	replacement, and expansion	_,			_	
59.00	Total fund balances (sum of lines 52 thru 58)	16, 739, 405		0	0 0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	34, 815, 365		U		60.00
	1~~/	I	1	ļ	ı	ı

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES REHABILITATION HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 Provider CCN: 15-3028 Peri od: Worksheet G-1 From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/15/2021 11:42 am General Fund Special Purpose Fund Endowment

				opeo.aa	r pose i una	Fund	
		1. 00	2.00	3. 00	4. 00	5. 00	
1. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	1.00	14, 985, 141 1, 754, 265		4.00	5.00	1.00
3.00	Total (sum of line 1 and line 2)		16, 739, 406		0		3.00
4. 00 5. 00	Additions (credit adjustments) (specify)	0		0		0	5.00
6. 00 7. 00		0		0		0	
8. 00 9. 00		0		0		0	8. 00
10.00	Total additions (sum of line 4-9)	o _l	0	0	0	0	10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) ROUNDING	1	16, 739, 406	0	0	0	11. 00 12. 00
13. 00 14. 00		0		0		0	
15. 00 16. 00		0		0		0	15.00
17. 00		0		ő		ő	17.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		16, 739, 405		0		18. 00 19. 00
	sheet (line 11 minus line 18)	Endowment	PI ant	Fund			
		Fund					
		6. 00	7. 00	8. 00			
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0		0			1. 00 2. 00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0	0			3. 00 4. 00
5.00	(speer ry)		0				5.00
6. 00 7. 00			0				6. 00 7. 00
8. 00 9. 00			0				8. 00 9. 00
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0		0			10.00 11.00
12. 00 13. 00	ROUNDI NG		0				12.00
14.00			0				13. 00 14. 00
15. 00 16. 00			0				15. 00 16. 00
17. 00 18. 00	Total deductions (sum of lines 12-17)	0	0	0			17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

 Heal th Financial
 Systems
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 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 Provi der CCN: 15-3028

			0 12/31/2020	7/15/2021 11:	
	Cost Center Description	I npati ent	Outpati ent	Total	12 Cill
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	43, 300, 60	5	43, 300, 605	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF			0	5.00
6.00	Swing bed - NF			0	6.00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSI NG FACI LI TY				8. 00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	43, 300, 60	5	43, 300, 605	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSI VE CARE UNI T				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines			0	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	43, 300, 60	5	43, 300, 605	17. 00
18.00	Ancillary services	49, 215, 45	15, 362, 696	64, 578, 149	18. 00
19.00	Outpati ent servi ces	272, 12	3, 183, 116	3, 455, 240	19.00
20.00	RURAL HEALTH CLINIC		o	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		o	0	21.00
22.00	HOME HEALTH AGENCY				22. 00
23.00	AMBULANCE SERVICES				23. 00
24.00	CMHC		0	0	24.00
24. 10	CORF		o	0	24. 10
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE				26.00
27.00	OTHER (SPECIFY)		o	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27) (transfer column 3 to Wks	t. 92, 788, 18	18, 545, 812	111, 333, 994	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		46, 799, 880		29. 00
30.00	ADD (SPECIFY)				30.00
31.00					31.00
32.00					32.00
33.00					33.00
34.00					34.00
35.00					35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)				37.00
38.00					38. 00
39.00					39. 00
40.00					40.00
41.00					41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tran	sfer	46, 799, 880		43.00
	to Wkst. G-3, line 4)				

Health Financial Systems REHABILITATION HOSPITAL OF INDIANA In Lieu of Form CMS-					
STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-3028	Peri od: From 01/01/2020	Worksheet G-3	
	To 12/31/2020			Date/Time Prepared: 7/15/2021 11:42 am	
				1. 00	
1.00	00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)				1.00
2.00	.00 Less contractual allowances and discounts on patients' accounts			66, 309, 768	2.00
3.00	3.00 Net patient revenues (line 1 minus line 2)				3.00
4.00	.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)				4.00
5.00					5.00
	OTHER I NCOME				
6.00	OO Contributions, donations, bequests, etc				6.00
7. 00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication services			0	8.00
9.00	.00 Revenue from television and radio service			0	9. 00
10. 00	10.00 Purchase discounts			0	10.00
	11.00 Rebates and refunds of expenses				11.00
	12.00 Parking Lot receipts				12.00
13. 00	Revenue from laundry and linen service				13.00

14.00

15.00

20.00

21.00

23.00

24. 50 25. 00

26.00

27.00

0 28.00 1, 754, 265 29.00

0 16.00

0 17.00

0 18.00

0 19.00

0

0 22.00

0

0

2, 064, 160

1, 465, 759 3, 529, 919

1, 754, 265

14.00

16.00

18.00

20.00

21.00

22.00

23.00

26.00

Revenue from meals sold to employees and guests

Revenue from sale of drugs to other than patients

Revenue from sale of medical records and abstracts

Revenue from gifts, flowers, coffee shops, and canteen

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

19.00 Tuition (fees, sale of textbooks, uniforms, etc.)

Revenue from sale of medical and surgical supplies to other than patients

15.00 Revenue from rental of living quarters

Rental of vending machines

Governmental appropriations

Total (line 5 plus line 25)

24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)

Rental of hospital space

24. 00 MI SCELLANEOUS I NCOME

27.00 OTHER EXPENSES (SPECIFY)