Health Financial Systems REHABILITATION HOSPITAL OF INDIANA In Lieu of	of Form CMS-2552-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FO	ORM APPROVED
payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OM	MB NO. 0938-0050
EX	XPIRES 03-31-2022
	orksheet S
	arts I-III ate/Time Prepared:
	/27/2022 7:34 am
PART I - COST REPORT STATUS	
Provider 1. [X] Electronically prepared cost report Date: 5/27/2022	Time: 7:34 am
use only 2. [] Manually prepared cost report	
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost	t report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.	
Contractor5. [1] Cost Report Status6. Date Received:10. NPR Date:Use only(1) As Submitted7. Contractor No.11. Contractor's Vendor O	Codo: 1
use only (1) As Submitted 7. Contractor No. (11. Contractor's Vendor C (2) Settled without Audit 8. [N]Initial Report for this Provider CCN 12. [0]If line 5, colum	umn 1 is 4: Enter
(3) Settled with Audit 9. [N] Final Report for this Provider CCN number of times	
(4) Reopened	
(5) Amended	
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S) MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINA	
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS	
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINA	
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 accompa	
electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet a	
Statement of Revenue and Expenses prepared by REHABILITATION HOSPITAL OF INDIANA (15-3028) for the cos	
reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, report and statement are true, correct, complete and prepared from the books and records of the provider	
accordance with applicable instructions, except as noted. I further certify that I am familiar with the	
regulations regarding the provision of health care services, and that the services identified in this co	
report were provided in compliance with such laws and regulations.	

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

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	179, 622	-589	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
12.00	CMHCI	0		0		0	12.00
200.00	Total	0	179, 622	-589	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.

	FAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provi d	er CCN	N: 15-3028	Period: From 01/0		Workshe Part I		
						To 12/3	1/2021	Date/Ti 5/27/20		
	1.00	2.00		3.00			4.00			-
00	Hospital and Hospital Health Care Con Street: 4141 SHORE DRIVE	PO Box:								1.
00	City: INDIANAPOLIS	State: IN	Zip Cod	e: 462	54 Cou	nty: MARION				2.
		Component Name	CCN	CBS				ent Syst		
			Number	Numb	er Type	Certifie		, 0, or	· ·	-
		1.00	2.00	3.0	4.00	5.00	V 6. 00	XVIII 7.00	XIX 8.00	-
	Hospital and Hospital-Based Componen		2:00	0.0		0100		/ // 00	1 01 00	
00		REHABILITATION HOSPITAL	153028	2690	00 5	01/07/199	2 N	P	P	3
0	Subprovider - IPF	OF INDIANA								4
00	Subprovider - IRF									5
0	Subprovider - (Other)									6
0	Swing Beds - SNF									7
0 0	Swing Beds - NF Hospital-Based SNF									8
00										10
00										11
00	Hospital-Based HHA									12
	Separately Certified ASC Hospital-Based Hospice									13
	Hospital-Based Health Clinic - RHC									15
	Hospital-Based Health Clinic - FQHC									16
	Hospital-Based (CMHC) I									17
	Hospital-Based (CORF) I Renal Dialysis									17
	0ther									19
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00	Cost Departing Desied (mm (dd (uuuu))					1.0		2.0		20
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					01/01/		12/31,	/2021	20
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					1.00	20	\cap	3 (00	
					1.00	2.0	10	5.0		-
00	Inpatient PPS Information	currently receiving pay	ments for					5.0		22
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	TION HOSPITA			_	In Lie	1		2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	IATA I	Provider CC	N: 15-3028	Period: From 01/0 To 12/3	01/2021 1/2021	Part Date/	heet S-2 I Time Pre 2022 7:3	epared:
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medi cai d pai d days	Out-of State Medi cai d el i gi bl e unpai d	Medi ca HMO da	aid ays M	Other edi cai d days	
24.00 If this provider is an IPPS hospital, enter the	1.00	2.00	3.00	4.00	5.00)	6.00	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. 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 	653	207		35	4,	, 494	· · · ·	25. 00
HMO paid and eligible but unpaid days in column 5.				Urban/R	Rural S	Date o	of Geogr	
26.00 Enter your standard geographic classification (not w	vane) status	at the bee	inning of t	1.			. 00	26.00
20.00 Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassif	or rural. vage) status or "2" for r	at the end ural. If ap	l of the cos		1			27.00
35.00 If this is a sole community hospital (SCH), enter th			CH status ir	n	C	þ		35.00
effect in the cost reporting period.				Begi n			di ng:	
36.00 Enter applicable beginning and ending dates of SCH s	status. Subs	cript line	36 for numb	1. Der	00	2	. 00	36.00
of periods in excess of one and enter subsequent dat 37.00 f this is a Medicare dependent hospital (MDH), ente	tes.	•			C			37.00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f	the MDH tran	sitional pa	yment in		_			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 center subsequent dates. 								38.00
				Y/			Y/N . 00	-
39.00 Does this facility qualify for the inpatient hospita 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 or "N" for no. (see instructions)), (ii), or the mileage ii)? Enter	(iii)? Ent requiremen in column 2	er in colum nts in ? "Y" for ye	ime N in es			N	39.00
40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ober 1. Ente	r "Y" for y			l		N	40.00
					V	XVII 2.00		-
Prospective Payment System (PPS)-Capital				· ·				
 45.00 Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception 	·	•			N N	N N	N N	45.00
pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS	·		·	5	N	N	N	47.00
48.00 Is the facility electing full federal capital paymer Teaching Hospitals					N	N	N	48.00
56.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the respons was involved in training residents in approved GME p year, and are you are impacted by CR 11642 (or appli Enter "Y" for yes; otherwise, enter "N" for no in co	se to column programs in cable CRs) plumn 2.	1 is "Y", the prior y MA direct G	or if this vear or penu GME payment	hospital Iltimate reduction?		N		56.00
57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mor 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	or yes or "N oth of this 'Y", complet I, if appli	" for no in cost report e Worksheet cable.	n column 1. ing period? E-4. If co	lf column 'Enter "Y olumn 2 is				57.00
58.00 fline 56 is yes, did this facility elect cost reim	nbursement f	or physicia	ins' servi ce	es as	N			58.00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	COMDIEIE w	51. 0-5						

			PITAL OF INDIA			eu of Form CMS-2	
HUSPII	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	IA	Provider CC		eriod: rom 01/01/2021 o 12/31/2021	Worksheet S-2 Part I Date/Time Pre	pared:
				NAHE 413.85 Y/N	Worksheet A Line #	5/27/2022 7:3 Pass-Through Qualification Criterion Code	
				1.00	2.00		
60.00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C	85? (s umn 1.	see If column 1	1.00 N	2.00	3.00	60.00
	adjustement? Enter "Y" for yes or "N" for no in colu		I ME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61.00
61. 01	column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61.01
61. 02	instructions) 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						61. 02
61.03	ACA). (see instructions) 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						61.03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.04
61. 05	current cost reporting period. (see instructions). 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						61.05
61.06	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)						61.06
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
(1.10	Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	(1 10
	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				0. 00		61. 10
	instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
						1.00	
	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a	trai nec ti ons)	in this cost	reporting peri			62. 00 62. 01
62. 01	during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	iram. (s	<u>see instructio</u>		your nospital	0.00	02.01
63.00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co	67. (see instru	uctions)	N N	63.00
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No			1.00 This base year	2.00 is your cost r	3.00 reporting	
64.00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non 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 of (column 1 divided by (column 1 + column 2)). (see	y trair i-primar all nor l non-pr i columr	ned residents ry care nprovider rimary care n 3 the ratio	0. 00	0. 00	0. 000000	64.00

	EX IDENTIFICATION DA	IA Provider (Fr	eriod: com 01/01/2021	Worksheet S-2 Part I	
			Tc	12/31/2021	Date/Time Pre 5/27/2022 7:3	pared 4 am
	Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
_	1.00	2.00	Si te 3. 00	4.00	5.00	-
.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00		65.0
is yes, or your facility 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 2, column						
divided by (column 3 + column 4)). (see instructions)						
			Unweighted	Unweighted FTEs in	Ratio (col. 1/	/
			FTEs Nonprovider	Hospital	(col. 1 + col. 2))	
			Si te	•		
		Negerie des Cattin	1.00	2.00	3.00	
Section 5504 of the ACA Current Y beginning on or after July 1, 201		i Nonprovider Settin	igsErrective to	r cost reporti	ng periods	
FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	nweighted non-primar I. Enter in column 3	ry care resident 3 the ratio of	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	1
.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column			0.00	0. 00	0. 000000	
4)). (see instructions)				1.0	0 2.00 3.00	
4)). (see instructions)				1.0	2.00 3.00	
Inpatient Psychiatric Facility PP						70.
Inpatient Psychiatric Facility PP 00 Is this facility an Inpatient Psy		PF), or does it con	tain an IPF subp	rovider? N		
Inpatient Psychiatric Facility PP Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic (see instructions)	chiatric Facility (1 the facility have ar fore November 15, 2C umn 2: Did this faci : 412.424 (d)(1)(iii) ate which program ye	n approved GME teachi D04? Enter "Y" for lity train residents)(D)? Enter "Y" for	ing program in t yes or "N" for n s in a new teach yes or "N" for n	he most o. (see ing o.	0	71.
 Inpatient Psychiatric Facility PP Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic 	chiatric Facility (I the facility have ar fore November 15, 20 umn 2: Did this faci : 412.424 (d)(1)(iii) ate which program ye <u>PPS</u> abilitation Facility	n approved GME teachi D04? Enter "Y" for y lity train residents (D)? Enter "Y" for y ear began during this	ing program in t yes or "N" for n s in a new teach yes or "N" for n s cost reporting	he most o. (see ing o.	0	71. (

	Financial Systems REHABILITATION HOS				eu of Form CMS	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet S- Part I Date/Time Pr 5/27/2022 7:	repared:
					1.00	_
	Long Term Care Hospital PPS					
	Is this a long term care hospital (LTCH)? Enter "Y" for yes Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no.			g period? Enter	N N	80.00 81.00
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)		,		N	85.00
86.00	Did this facility establish a new Other subprovider (exclude \$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	ed unit) under	42 CFR Sectio	on		86.00
87.00	Is this hospital an extended neoplastic disease care hospita 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	al classified	under section		N	87.00
				V 1.00	XI X 2.00	_
	Title V and XIX Services			1.00	2.00	
90.00	Does this facility have title V and/or XIX inpatient hospita	al services? E	nter "Y" for	N	Y	90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through			N	N	91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the appl Are title XIX NF patients occupying title XVIII SNF beds (du				N	92.00
93.00	instructions) Enter "Y" for yes or "N" for no in the applica Does this facility operate an ICF/IID facility for purposes		d XIX? Enter	N	N	93.00
	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes,			N	N	94.00
	applicable column.					
	If line 94 is "Y", enter the reduction percentage in the apploes title V or XIX reduce operating cost? Enter "Y" for yes			0. 00 N	0.00 N	95.00 96.00
97.00	applicable column. If line 96 is "Y", enter the reduction percentage in the app	olicable colum	n.	0.00	0.00	97.00
	Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y"	Y	98.00			
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti			Ν	Y	98. 01
98. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o			N	Y	98. 02
98. 03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a cri- reimbursed 101% of inpatient services cost? Enter "Y" for ye	tical access h	ospital (CAH)	N	N	98.03
98. 04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in	reimbursed 10	1% of	N	N	98.04
	in column 2 for title XIX.					
98.05	Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in a column 2 for title XIX.			N ר	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			N	Y	98.06
	Rural Providers					
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all	-inclusive met	hod of paymen [.]	t N		105.00 106.00
	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for co		1 5			107.00
107.00	training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do Japproved medical education program in the CAH's excluded II	n 1. (see ins you train I&R	tructions) s in an			107.00
108.00	Enter "Y" for yes or "N" for no in column 2. (see instructions of the second se	ions)		N		108.00
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	r			Deeni netem	
		Physi cal 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	<u></u>
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N	109.00
					1.00	_
110.00	Did this hospital participate in the Rural Community Hospita				N	110.00
	Demonstration)for the current cost reporting period? Enter ' complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	"Y" for yes or	"N" for no. I	f yes,		

Bealth Financial Systems REHABILITATION HOSPI OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC		Period:	eu of Form CMS Worksheet S-	
			From 01/01/202 To 12/31/202		
			1.00	2.00	_
1.00 If this facility qualifies as a CAH, did it participate in th Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	t reporting p umn 1 is Y, e icipating in	eriod? Enter enter the column 2.	N	2.00	111.
		1.00	2.00	3.00	_
12.00 Did this hospital participate in the Pennsylvania Rural Healt demonstration for any portion of the current cost reporting p Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceas participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	eriod? "Y", enter	N			112.
5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93 for short term hospital or "98" percent for long term care (i psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) " percent ncludes) based on	N			0115.
6.00 Is this facility classified as a referral center? Enter "Y" for "N" for no.	3	Ν			116.
 7.00 Is this facility legally-required to carry malpractice insura "Y" for yes or "N" for no. 8.00 Is the malpractice insurance a claims-made or occurrence policity 		N	1		117.
if the policy is claim-made. Enter 2 if the policy is occurre	2	Premi ums	Losses	Insurance	
8.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	3.00 0	0 118.
			1.00	2.00	_
3.02 Are malpractice premiums and paid losses reported in a cost c Administrative and General? If yes, submit supporting schedu and amounts contained therein.			N	2.00	118.
DO DO NOT USE THIS LINE DO IS this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA \$3121 and applicable amendment Eath of the page of the second sec	column 1, "Y" lifies for th	for yes or ne Outpatient		Ν	119. 120.
Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implan	table devices	charged to	N		121.
patients? Enter "Y" for yes or "N" for no. 2.00Does the cost report contain healthcare related taxes as defi	ned in §1903(w)(3) of the	N		122.
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information	is "Y", enter	in column 2			
5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	yes and "N"	for no. If	N		125.
0.00 If this is a Medicare certified kidney transplant center, ent	er the certif	ication date			126.
in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, ente	r the certifi	cation date			127.
in column 1 and termination date, if applicable, in column 2. 0.00 f this is a Medicare certified liver transplant center, ente	r the certifi	cation date			128.
			n		120.
in column 1 and termination date, if applicable, in column 2.	the contifie		"		
in column 1 and termination date, if applicable, in column 2. 000 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.					
in column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.	nter the cert				130.
 in column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified pancreas transplant center, e date in column 1 and termination date, if applicable, in colu. 00 If this is a Medicare certified intestinal transplant center, 	nter the cert mn 2. enter the ce	i fi cati on			
 in column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified pancreas transplant center, e date in column 1 and termination date, if applicable, in colum. 00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colu 00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colu 00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in colum 2. 	nter the cert mn 2. enter the ce mn 2.	i fi cati on erti fi cati on			131. 132.
 in column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, e date in column 1 and termination date, if applicable, in colum 1.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colum 2. 0.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colum 2. 0.00 If this is a Medicare certified islet transplant center, ente in column 1 and termination date, if applicable, in colum 2. 0.00 Removed and reserved 0.00 If this is an organ procurement organization (OPO), enter the and termination date, in column 2. 	nter the cert mn 2. enter the ce mn 2. r the certifi	ification ertification cation date			130. 131. 132. 133. 134.
 in column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, e date in column 1 and termination date, if applicable, in colum 1. 1.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colum 2. 0.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colum 2. 0.00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in colum 2. 0.00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2. 0.00 If this is an organ procurement organization (OPO), enter the 	nter the cert mn 2. enter the ce mn 2. r the certifi OPO number i	ification ertification cation date n column 1	Y	15H059	131. 132. 133.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	REHABILITATION X IDENTIFICATION DATA		Provider CC			riod: om 01/01/	2021	u of Form CMS- Worksheet S-2 Part I Date/Time Pre 5/27/2022 7:3	2 epared:
1.00		2.00				3. (
If this facility is part of a chain home office and enter the home of					he nam	e and add	ress (of the	
141. 00 Name: IU HEALTH	Contractor's Nam				actor'	s Number:	0810	1	141.00
42.00 Street: 340 W 10TH STREET	PO Box:								142.00
143.00 City: INDIANAPOLIS	State:	IN		Zip(Code:		46202	2	143.00
							ŀ	1.00	-
144.00 Are provider based physicians' cos	sts included in Worksh	neet A?						N	144.00
									_
145.00 If costs for renal services are cl	aimed on Wkst A lin	0 74 7	are the costs	for		1.00		2.00	145.00
inpatient services only? Enter "Y" no, does the dialysis facility in period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in	'for yes or "N" for n clude Medicare utiliza for no in column 2. ay changed from the pr	no in co ntion fo reviousl	olumn 1. lf c or this cost y filed cost	column 1 i reporting report?	9	N			146. 00
yes, enter the approval date (mm/c		ub. 15		, 34020,	,				
								1.00	
47.00 Was there a change in the statisti								N	147.0
148.00Was there a change in the order of 149.00Was there a change to the simplifi					for r	`		N N	148. 0 149. 0
	ea cost finding metho		Part A	Part		Title	V	Title XIX	149.0
			1.00	2.00		3.00	-	4.00	-
Does this facility contain a prov									
or charges? Enter "Y" for yes or ' 155.00Hospital	N FOR NO FOR each co	mponen	N N	and Part N	B. (Si	<u>ee 42 CFR</u> N	9413.	. 13) N	155. 0
56. 00 Subprovi der – IPF			N	N		N		N	156.0
57.00 Subprovider - IRF			N	N		Ν		Ν	157.0
58. 00 SUBPROVI DER									158.0
59.00 SNF 60.00 HOME HEALTH AGENCY			N N	N N		N N		N N	159. 0 160. 0
161. 00 CMHC			IN	N N		N		N	161. 0
161. 10 CORF				N		N		N	161.1
								1.00	
Multicampus 165.00 Is this hospital part of a Multica	ampus hospital that ha	is one c	or more campu	ıses in di	fferer	nt CBSAs?		N	165. 0
Enter "Y" for yes or "N" for no.	Name		County	State	Zip (Code CB	SA	FTE/Campus	
	0		1.00	2.00	3.0		00	5.00	
166.00 If line 165 is yes, for each campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	0 166. 0
							-	1.00	1
Health Information Technology (HI 167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10	under §1886(n)? Ent	er "Y"	for yes or "	N" for no	Э.			N	167. 0 168. 0
reasonable cost incurred for the H	HT assets (see instru	ictions))						
68.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)?						hardshi p			168. 0
exception under §413.70(a)(b)(11) 69.00 If this provider is a meaningful u						'), enter	the	0.0	0169.0
transition factor. (see instruction									
					-	Begi nni 1. 00	ng	Endi ng 2. 00	-
70.00 Enter in columns 1 and 2 the EHR H	beginning date and end	ling dat	te for the re	eporting		1.00		2.00	170. 0
					-	1.00		2.00	-
171.00 fline 167 is "Y", does this prov section 1876 Medicare cost plans n "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3, umn 1. If column 1 is	Pt. I,	line 2, col	. 6? Ente		N			0171.0

	Financial Systems REHABILITATION HOS	SPITAL OF INDIA	ANA .	In Lie	u of Form CMS-	
HOSPI TAI	L AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-3028	Period: From 01/01/2021 To 12/31/2021		epared:
				Y/N	5/27/2022 7:3 Date	<u>34 am</u>
				1.00	2.00	
	eneral Instruction: Enter Y for all YES responses. Enter N	N for all NO re	esponses. Ente	r all dates in 1	the	
	m/dd/yyyy format. :OMPLETED BY ALL HOSPITALS					-
P	Provider Organization and Operation					
I.00 F	las the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.00
r	reporting period? If yes, enter the date of the change in o	column 2. (see	Instructions)	Date	V/I	
			1.00	2.00	3.00	+
	las the provider terminated participation in the Medicare F		N			2.00
	yes, enter in column 2 the date of termination and in colur voluntary or "I" for involuntary.	nn 3, "V" for				
	is the provider involved in business transactions, includir	na management	Y			3.00
c	contracts, with individuals or entities (e.g., chain home o	offices, drug				
	or medical supply companies) that are related to the provid					
	officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe					
	relationships? (see instructions)					
			Y/N	Туре	Date	
F	inancial Data and Reports		1.00	2.00	3.00	
. 00 0	Column 1: Were the financial statements prepared by a Cert	tified Public	Y	A		4.00
A	Accountant? Column 2: If yes, enter "A" for Audited, "C" 1	for Compiled,				
	or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	ailable in				
	Are the cost report total expenses and total revenues diffe	erent from	N			5.00
	those on the filed financial statements? If yes, submit red					
				Y/N 1.00	Legal Oper. 2.00	
Δ	pproved Educational Activities			1.00	2.00	
. 00 0	Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	s the provider	· N		6.00
	s the legal operator of the program?					
	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		wed during the	N N		7.00
	cost reporting period? If yes, see instructions.		wed during the			0.00
. 00 A	Are costs claimed for Interns and Residents in an approved		cal education	Y		9.00
	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o		the current	N		10.00
	cost reporting period? If yes, see instructions.			IN		10.00
1.00 A	Are GME cost directly assigned to cost centers other than I	l & R in an App	proved	Ν		11.00
]	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1.00	-
	ad Debts					
	s the provider seeking reimbursement for bad debts? If yes				Y	12.00
	fline 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.	boilcy change of	buring this co	ist reporting	N	13.00
1.	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? I	fyes, see ins	tructions.	Ν	14.00
	Bed Complement		· · ·		•	1 45 00
5.00 [L	Did total beds available change from the prior cost reporti		<u>yes, see inst</u> rt A		n N	15.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	VS&R Data	Y	04/01/2022	Y	04/01/2022	14 00
	Nas the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	T	04/01/2022	т	04/01/2022	16.00
	date of the PS&R Report used in columns 2 and 4 .(see					
	nstructions)	N		N		17.00
	Nas the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	IN		IN		17.00
	either column 1 or 3 is yes, enter the paid-through date					
	n columns 2 and 4. (see instructions)					10.00
	fline 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18.00
	but are not included on the PS&R Report used to file this					
c	cost report? If yes, see instructions.					
	fline 16 or 17 is yes, were adjustments made to PS&R	N		N		19.00
	Report data for corrections of other PS&R Report nformation? If yes, see instructions.					
11	mormation: II yes, see mistiluctions.	1	1	1	I	1

Health Financial Systems

REHABILITATION HOSPITAL OF	I NDI ANA
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	Financial Systems REHABILITATION HO	SPITAL OF INDIA	NA	In Lie	eu of Form Cl	MS-2552-
OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 01/01/2021 To 12/31/2021		
				10 12/31/2021	5/27/2022	
		Descr	iption	Y/N	Y/N	
			0	1.00	3.00	
. 00	If line 16 or 17 is yes, were adjustments made to PS&R			Ν	N	20. (
	Report data for Other? Describe the other adjustments:	Y/N	Dete	Y/N	Data	_
		1.00	Date 2.00	3.00	Date 4.00	
. 00	Was the cost report prepared only using the provider's	1.00	2.00	<u> </u>	4.00	21.0
1.00	records? If yes, see instructions.	IN		IN		21.1
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	IOSPI TALS)		1.00	
	Capital Related Cost					
. 00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			Y	22.
. 00	Have changes occurred in the Medicare depreciation expense	due to apprais	als made duri	ng the cost	N	23.
. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter	od into during	this sect ran	anting pariod2	N	24.
. 00	If yes, see instructions	eu mito during	this cost rep	or tring period?	IN IN	24.
. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	lfyes, see	N	25.
. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost reporti	ng period? If	yes, see	N	26.
. 00	instructions. Has the provider's capitalization policy changed during th	e cost reportir	ng period?lf	yes, submit	N	27.
	copy. Interest Expense			-		_
. 00	Were new loans, mortgage agreements or letters of credit e	ntered into dur	ing the cost	reporting	N	28.
. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or				N	29.
	treated as a funded depreciation account? If yes, see inst	ructions				
. 00	Has existing debt been replaced prior to its scheduled mat instructions.	urity with new	debt? If yes,	see	N	30.
. 00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes,	see	N	31.
	Purchased Services				1	
. 00	Have changes or new agreements occurred in patient care se		ed through con	tractual	N	32.
. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competit	ive bidding? If		33.
	no, see instructions. Provider-Based Physicians					
00	Are services furnished at the provider facility under an a	rrangement with	nrovi der-bas	ed physicians?	N	34.
. 00	If yes, see instructions.				11	54.
00	If line 34 is yes, were there new agreements or amended ex	isting agreemer	nts with the p	rovi der-based		35.
	physicians during the cost reporting period? If yes, see i		···· ··· ··· ··· -			
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
	Were home office costs claimed on the cost report?			Y		36.
00	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	repared by the	home office?	Y		37.
00	If line 36 is yes, was the fiscal year end of the home of			Ν		38.
00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth			Y		39.
00	see instructions. If line 36 is yes, did the provider render services to the	home office?	lfyes, see	N		40.
	instructions.		-			
		1.	00	2.	00	
	Cost Report Preparer Contact Information					
00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		41.
	respectivel y.					
		LUL UEAL TU	1		42.	
. 00	Enter the employer/company name of the cost report preparer.	IU HEALTH				4Z.

Health Financial Systems R	REHABILITATION HOSP	PITAL OF INDIANA	In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provider CCN: 15-3028	Period:	Worksheet S-2	
			From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/27/2022 7:3	pared: 4 am
		3.00			
Cost Report Preparer Contact Information					
41.00 Enter the first name, last name and the ti	tle/position D	DI RECTOR			41.00
held by the cost report preparer in columr	ns 1, 2, and 3,				
respecti vel y.					
42.00 Enter the employer/company name of the cos	st report				42.00
preparer.					
43.00 Enter the telephone number and email addre	ess of the cost				43.00
report preparer in columns 1 and 2, respec	cti vel y.				

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-3028	Period: From 01/01/2021	Worksheet S-3 Part I	naradi
					To 12/31/2021	5/27/2022 7:3	
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e	CAH Hours	Title V	
	1	1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	30. 00	91	33, 2	15 0.00	0	2.00
3.00 4.00	HMO I PF Subprovi der HMO I RF Subprovi der						3.00 4.00
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	5.00 6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		91	33, 2	15 0.00		7.00
8.00 9.00 10.00 11.00 12.00 13.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						8.00 9.00 10.00 11.00 12.00 13.00
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY		91	33, 2	15 0.00	0	14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00
23.00 24.00 24.10 25.00 25.10 26.00	AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC CMHC - CORF RURAL HEALTH CLINIC	30. 00 99. 00 99. 10				0	23. 0 24. 0 24. 1 25. 0 25. 1 26. 0
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	89. 00	91 0		0	0	20. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 00
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges						33. 00 33. 0 [.]

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part I Date/Time Pre 5/27/2022 7:3	pared:
	I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
 .00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) .00 HMO and other (see instructions) .00 HMO IPF Subprovider .00 HMO IRF Subprovider .00 Hospital Adults & Peds. Swing Bed SNF .00 Hospital Adults & Peds. Swing Bed NF .00 Hospital Adults and Peds. (exclude observation beds) (see instructions) .00 INTENSIVE CARE UNIT .00 BURN INTENSIVE CARE UNIT .00 SURGICAL INTENSIVE CARE UNIT .00 OTHER SPECIAL CARE (SPECIFY) .00 NURSERY 	5, 600 3, 793 0 0 0 5, 600	653 4, 736 0 0 0 0 653	19, 79 19, 79	7 0 0 7		1.0 2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 11.0 12.0 13.0
 4.00 Total (see instructions) 5.00 CAH visits 6.00 SUBPROVIDER - IPF 7.00 SUBPROVIDER - IRF 8.00 SUBPROVIDER 9.00 SKILLED NURSING FACILITY 0.00 NURSING FACILITY 1.00 OTHER LONG TERM CARE 2.00 HOME HEALTH AGENCY 3.00 AMBULATORY SURGICAL CENTER (D. P.) 4.00 HOSPICE (non-distinct part) 	5,600 0	653 0		7 2.84	346. 31	14. 0 15. 0 16. 0 17. 0 18. 0 20. 0 21. 0 22. 0 23. 0 24. 0 24. 1
5. 00 CMHC - CMHC 5. 10 CMHC - CORF	0 0	0 0		0 0.00 0 0.00		25. 0 25. 1
 6. 00 RURAL HEALTH CLINIC 6. 25 FEDERALLY QUALIFIED HEALTH CENTER 7. 00 Total (sum of lines 14-26) 8. 00 Observation Bed Days 9. 00 Ambulance Trips 0. 00 Employee discount days (see instruction) 1. 00 Employee discount days - IRF 2. 01 Labor & delivery days (see instructions) 2. 01 Total ancillary labor & delivery room outpatient days (see instructions) 	0 0 0	0 0 0		0 0.00 2.84 0 0 0 0 0		
outpatient days (see instructions) 3.00 LTCH non-covered days 3.01 LTCH site neutral days and discharges	0 0					3:

HOSPI TAL A	ND HOSPITAL HEALTH CARE COMPLEX STATISTIC/	AL DATA	Provider CO	CN: 15-3028	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part I Date/Time Pre 5/27/2022 7:3	pared:
		Full Time		Di s	charges		
	Component	Equi val ents Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
8 e Hos, for 2.00 HMO 3.00 HMO 4.00 HMO 5.00 HOS 6.00 HOS 6.00 HOS 7.00 Fot. bed BOO 11.00 SUR 12.00 OTH 13.00 NUR 14.00 Tot. 15.00 CAH 16.00 SUB 17.00 SUB 19.00 SUB 20.00 NUR 21.00 OTH 22.00 AMB 24.00 HOS 25.10 CMH 25.00 <t< td=""><td>pital Adults & Peds. (columns 5, 6, 7 and xclude Swing Bed, Observation Bed and pice days) (see instructions for col. 2 the portion of LDP room available beds) and other (see instructions) IPF Subprovider pital Adults & Peds. Swing Bed SNF pital Adults & Peds. Swing Bed SNF al Adults and Peds. (exclude observation s) (see instructions) ENSIVE CARE UNIT ONARY CARE UNIT ONARY CARE UNIT GICAL INTENSIVE CARE UNIT ER SPECIAL CARE (SPECIFY) SERY al (see instructions) visits PROVIDER - IRF PROVIDER - IRF PROVIDER - IRF PROVIDER LLED NURSING FACILITY SING FACILITY ER LONG TERM CARE E HEALTH AGENCY ULATORY SURGICAL CENTER (D.P.) PICE PICE (non-distinct part) C - CMHC C - CORF AL HEALTH CLINIC ERALLY QUALIFIED HEALTH CENTER al (sce instructions) uiance Trips loyee discount days (see instruction) loyee discount days - IRF or & delivery days (see instructions) a ancillary labor & delivery room</td><td>0. 00 0. 00 0. 00 0. 00 0. 00 0. 00</td><td>0</td><td>41</td><td>09 48 56 335 0 0 09 48</td><td>1, 431</td><td>1. 0 2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0 12. 0 13. 0 14. 0 15. 0 16. 0 17. 0 18. 0 20. 0 21. 0 22. 0 23. 0 24. 0 24. 10 25. 11 25. 0 24. 0 24. 10 25. 11 26. 0 24. 0 24. 0 24. 0 24. 0 25. 11 26. 0 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0 32. 0 32. 0 32. 0 32. 0 32. 0 32. 0 32. 0 32. 0 33. 0</td></t<>	pital Adults & Peds. (columns 5, 6, 7 and xclude Swing Bed, Observation Bed and pice days) (see instructions for col. 2 the portion of LDP room available beds) and other (see instructions) IPF Subprovider pital Adults & Peds. Swing Bed SNF pital Adults & Peds. Swing Bed SNF al Adults and Peds. (exclude observation s) (see instructions) ENSIVE CARE UNIT ONARY CARE UNIT ONARY CARE UNIT GICAL INTENSIVE CARE UNIT ER SPECIAL CARE (SPECIFY) SERY al (see instructions) visits PROVIDER - IRF PROVIDER - IRF PROVIDER - IRF PROVIDER LLED NURSING FACILITY SING FACILITY ER LONG TERM CARE E HEALTH AGENCY ULATORY SURGICAL CENTER (D.P.) PICE PICE (non-distinct part) C - CMHC C - CORF AL HEALTH CLINIC ERALLY QUALIFIED HEALTH CENTER al (sce instructions) uiance Trips loyee discount days (see instruction) loyee discount days - IRF or & delivery days (see instructions) a ancillary labor & delivery room	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	0	41	09 48 56 335 0 0 09 48	1, 431	1. 0 2. 0 3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0 12. 0 13. 0 14. 0 15. 0 16. 0 17. 0 18. 0 20. 0 21. 0 22. 0 23. 0 24. 0 24. 10 25. 11 25. 0 24. 0 24. 10 25. 11 26. 0 24. 0 24. 0 24. 0 24. 0 25. 11 26. 0 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0 32. 0 32. 0 32. 0 32. 0 32. 0 32. 0 32. 0 32. 0 33. 0
33. 00 LTC	H site neutral days and discharges				0		33. C

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXI ENGES	Provider CC	N. 15 5020	Peri od:	Worksheet A	
					From 01/01/2021		
					To 12/31/2021	Date/Time Prep 5/27/2022 7:34	
	Cost Center Description	Sal ari es	Other	Total (col.	1 Reclassi ficati	Reclassi fi ed	
	·			+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS		1, 102, 399	1, 102, 39	9 0	1, 102, 399	1.00
	00200 CAP REL COSTS-BEDG & FIXT		925, 215	925, 21		925, 215	2.00
	00300 OTHER CAP REL COSTS		920, 210	920, 21	0 0	925, 215	3.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	202, 018	6, 349, 659	6, 551, 67	-	6, 550, 793	4.00
	00591 ADMI NI STRATI VE AND GENERAL	3, 434, 040	1, 958, 005	5, 392, 04		5, 197, 105	5.01
	00590 OTHER A&G - NON FOUNDATION	810, 836	287, 763	1, 098, 59		1, 097, 927	5.02
	00700 OPERATION OF PLANT	35, 238	1, 788, 309	1, 823, 54		1, 820, 432	7.00
	00800 LAUNDRY & LINEN SERVICE	0	116, 051	116, 05		116, 051	8.00
	00900 HOUSEKEEPI NG	329, 576	164, 028	493, 60		493, 592	9.00
	01000 DI ETARY	55, 179	1, 039, 883	1, 095, 06		742, 525	
	01100 CAFETERI A	00, 177	1,007,000	1,070,00	0 352, 482	352, 482	
	01300 NURSI NG ADMI NI STRATI ON	1, 547, 683	234, 153	1, 781, 83		2,033,332	
	01400 CENTRAL SERVICES & SUPPLY	70, 689	285, 458	356, 14		567, 340	
	01500 PHARMACY	596, 977	152, 349	749, 32		740, 896	
	01600 MEDICAL RECORDS & LIBRARY	383, 942	126, 754	510, 69		510, 696	
	01700 SOCIAL SERVICE	435, 340	246, 070	681, 41		679, 209	17.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	186, 387	186, 38		186, 387	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS		100,007	100,00		100,007	22.00
	03000 ADULTS & PEDIATRICS	7, 881, 824	1, 510, 174	9, 391, 99	-183, 293	9, 208, 705	30.00
	ANCI LLARY SERVI CE COST CENTERS					, ,	
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	132, 890	35, 458	168, 34	8 -2,096	166, 252	54.00
60.00	06000 LABORATORY	0	458, 343	458, 34	3 0	458, 343	60.00
65.00	06500 RESPI RATORY THERAPY	514, 098	157, 529	671, 62	-92, 280	579, 347	65.00
66.00	06600 PHYSI CAL THERAPY	1, 624, 813	306, 033	1, 930, 84	6 441, 867	2, 372, 713	66.00
66.01	06601 PHYSICAL THERAPY - CARMEL	261, 724	122, 472	384, 19	6 20, 858	405, 054	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	2, 123, 985	243, 434	2, 367, 41	9 -101, 863	2, 265, 556	67.00
68.00 (06800 SPEECH PATHOLOGY	893, 440	79, 557	972, 99	7 291, 526	1, 264, 523	68.00
68.01 (06801 VI SI ON	0	0		0 0	0	68.01
68.02	06802 FAC RESOURCE	1, 339, 278	306, 378	1, 645, 65	6 -151, 932	1, 493, 724	68.02
	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 172, 839	172, 839	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 744, 354	1, 744, 35		1, 744, 354	
	07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
	DUTPATIENT SERVICE COST CENTERS	205 5(2)	(4 770	270.22	2 24.047	245 477	
	09000 CLINIC	205, 563	64, 770	270, 33		245, 466	1
	09001 SLEEP CENTER	0	0		0 0	0	90.01
	09100 EMERGENCY	0	0		0 0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	99.00
	09910 CORF	585, 507	157, 885	743, 39		0	
	SPECIAL PURPOSE COST CENTERS	565, 507	157,005	743, 37	- 143, 372	0	99.10
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	23, 464, 640	20, 148, 870	43, 613, 51	0 -120, 253	43, 493, 257	118 00
	VONREI MBURSABLE COST CENTERS	207 10 17 0 10	2011101010	10/010/01	120,200	10/ 170/ 207	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	841, 415	537, 620	1, 379, 03	5 115, 029	1, 494, 064	
	07950 FOUNDATION	230, 144	75, 816	305, 96		311, 330	
	07951 PUBLIC RELATIONS	150, 582	301, 782	452, 36		452, 274	
	07952 ST. VINCENT - ARU	0	0		0 0		194.02
	07953 MUNCIE - ARU	o	0		0 0		194.03
	07954 RILEY - ARU	o	0		0 0		194.04
	07955 RETAIL PHARMACY	232, 570	1, 024, 090	1, 256, 66	-56	1, 256, 604	194.05
		24, 919, 351	22, 088, 178				200.00

ECLASSI F	ICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-3028	Peri od:	Worksheet	A
					From 01/01/2021 To 12/31/2021	Date/Ti me	Prenare
					10 12/01/2021	5/27/2022	7:34 an
	Cost Center Description	Adjustments	Net Expenses				
		(See A-8) 6.00	For Allocation 7.00				
GEN	NERAL SERVICE COST CENTERS	0.00	7.00				_
	100 CAP REL COSTS-BLDG & FIXT	237, 242	1, 339, 641				1
	200 CAP REL COSTS-BEDG & TTXT	301,845					2
	300 OTHER CAP REL COSTS	301, 845	1, 227, 000				3
	400 EMPLOYEE BENEFITS DEPARTMENT	-					4
	591 ADMI NI STRATI VE AND GENERAL	-1,863					
	590 OTHER A&G - NON FOUNDATION	3, 473, 609	8, 670, 714				5
		0	1,097,927				5
	700 OPERATION OF PLANT	-25,053	1, 795, 379				7
	800 LAUNDRY & LINEN SERVICE	0	116, 051				8
	900 HOUSEKEEPI NG	0	493, 592				9
	000 DI ETARY	0	742, 525				10
	100 CAFETERI A	-160, 133					11
	300 NURSI NG ADMI NI STRATI ON	-341	2, 032, 991				13
	400 CENTRAL SERVICES & SUPPLY	0	567, 340				14
	500 PHARMACY	-41, 604	699, 292				15
	600 MEDI CAL RECORDS & LI BRARY	-43	510, 653				16
00 01	700 SOCI AL SERVI CE	0	679, 209				17
00 022	200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	186, 387				22
I NF	PATIENT ROUTINE SERVICE COST CENTERS						
00 030	000 ADULTS & PEDIATRICS	0	9, 208, 705				30
ANC	CILLARY SERVICE COST CENTERS						
00 050	000 OPERATING ROOM	0	0				50
00 054	400 RADI OLOGY-DI AGNOSTI C	0	166, 252				54
00 060	000 LABORATORY	-4,062	454, 281				60
00 06!	500 RESPI RATORY THERAPY	0	579, 347				65
	600 PHYSI CAL THERAPY	0	2, 372, 713				66
01 060	601 PHYSI CAL THERAPY - CARMEL	0	405, 054				66
	700 OCCUPATI ONAL THERAPY	0	2, 265, 556				67
	800 SPEECH PATHOLOGY	0	1, 264, 523				68
	801 VI SI ON	0	0				68
	802 FAC RESOURCE	0	1, 493, 724				68
	900 ELECTROCARDI OLOGY	0	0				69
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	172, 839				71
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72
	300 DRUGS CHARGED TO PATIENTS	0	1, 744, 354				73
	400 RENAL DI ALYSI S	0	1, 744, 334				74
	TPATIENT SERVICE COST CENTERS	0	0				/4
	000 CLINIC	0	245, 466				90
	001 SLEEP CENTER 100 EMERGENCY	0	0				90
		0	0				
	200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	HER REIMBURSABLE COST CENTERS		0				
	900 CMHC	0	0				99
	910 CORF	0	0				99
-	ECIAL PURPOSE COST CENTERS	0 770 507	17 070 054				
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 779, 597	47, 272, 854				118
	NREI MBURSABLE COST CENTERS						
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190
	200 PHYSI CLANS' PRI VATE OFFI CES	0					192
	950 FOUNDATI ON	629, 053	940, 383				194
	951 PUBLIC RELATIONS	0	452, 274				194
	952 ST. VINCENT – ARU	0	0				194
	953 MUNCLE – ARU	0	0				194
i. 04 07،	954 RILEY - ARU	0	0				194
4. 05 07°	955 RETAIL PHARMACY	0	1, 256, 604				194
0. 00	TOTAL (SUM OF LINES 118 through 199)	4, 408, 650	51, 416, 179				200

ASSI FI CATI ONS				Provider CCN:	15-3028	Period: From 01/01/2021 To 12/31/2021	Worksheet A-6 Date/Time Prep
							5/27/2022 7:34
		Increases		0.11			
Cost Ce		Line #	Salary	Other			
	0	3.00	4.00	5.00			
A - CAFETERIA		11 00	17 7(2)	334, 720			
CAFETERI A	+	<u>11.00</u>	1 <u>7, 7</u> 62 17, 762	<u>334, 720</u> 334, 720			
B - NURSING ADMI			17,702	334, 720			
NURSING ADMINIS		13.00	205, 322	0			
			205, 322	- <u> </u>			
C - NCR (CORF)			205, 522	0			
PHYSICAL THERAPY	/	66.00	198, 902	53, 241			
OCCUPATIONAL THE		67.00	235, 777	63, 112			
SPEECH PATHOLOG		68.00	150, 828	40, 373			
0	<u> </u>		585, 507	156, 726			
D - MEDICAL SUPP	PLI ES	I	,,,,	,.=0			
CENTRAL SERVICES		14.00	0	281, 988			
MEDICAL SUPPLIES	S CHARGED TO	71.00	0	172, 839			
PATI ENTS							
		0.00	0	0			
		0.00	0	0			
		0.00	0	0			
		0.00	0	0			
		0.00	0	0			
		0.00	0	0			
		0.00	0	0			
0		0.00	0	0			
0		0.00	0	0			
0		0.00	0	0			
0		0.00	0	0			
0		0.00	0	0			
0		0.00	0	0			
0		0.00 0.00	0	0			
0		0.00	0	0			
0		0.00	0	0			
0		0.00	0	0			
0		0.00	o	0			
0		0.00	o	0			
0		0,00	o	0			
0		0,00	o	0			
° – – – –	- — — +		_	454, 827			
E - THERAPY ADMI	IN		-				
ADMI NI STRATI VE		5.01	12, 434	1, 814			
NURSING ADMINIST	TRATI ON	13.00	51, 486	7, 512			
PHYSICAL THERAPY	Y	66.00	168, 035	24, 516			
PHYSICAL THERAPY	Y - CARMEL	66. 01	18, 544	2, 706			
SPEECH PATHOLOGY	Y	68.00	88, 311	12, 885			
FOUNDATI ON		194.00	7, 395	1, 079			
0			346, 205	50, 512			
F - RTOC ADMIN							
PHYSICIANS' PRIV	ATE OFFICES	192.00	125, 719	20, 051			
			125, 719	20, 051			

CLASS	SI FI CATI ONS			Provider (CCN: 15-3028	Period: From 01/01/2021	Worksheet A-6	
						To 12/31/2021	Date/Time Prep 5/27/2022 7:34	
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Re	f.		
	6.00	7.00	8.00	9.00	10.00			
	A - CAFETERIA				1			
00	DI ETARY	<u>10.</u> 00	1 <u>7, 7</u> 62	33 <u>4, 7</u> 20		Q		1
	0		17, 762	334, 720				
	B - NURSING ADMINISTRATION		i		1			
00	ADMI NI STRATI VE AND GENERAL	5.01	205, 322	0		Q		1
	0		205, 322	C				
	C - NCR (CORF)				i .			
	CORF	99.10	585, 507	156, 726		0		1
00		0.00	0	C		0		2
00		0.00	0	0		Q		3
	0		585, 507	156, 726				
	D - MEDICAL SUPPLIES				1			
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	884		0		1
	ADMI NI STRATI VE AND GENERAL	5.01	0	3, 866		0		2
00	OTHER A&G - NON FOUNDATION	5.02	0	672		0		3
	OPERATION OF PLANT	7.00	0	3, 115		0		4
00	HOUSEKEEPING	9.00	0	12		0		5
00	DI ETARY	10.00	0	55		0		6
00	NURSING ADMINISTRATION	13.00	0	12, 824		0		7
00	CENTRAL SERVICES & SUPPLY	14.00	0	70, 795		0		8
00	PHARMACY	15.00	0	8,430		0		9
. 00	SOCIAL SERVICE	17.00	0	2, 201		0		10
. 00	ADULTS & PEDIATRICS	30.00	0	183, 293		0		11
. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	2,096		0		12
. 00	RESPI RATORY THERAPY	65.00	0	92, 280		0		13
. 00	PHYSI CAL THERAPY	66.00	0	2, 827		0		14
. 00	PHYSICAL THERAPY - CARMEL	66.01	0	392		0		15
	OCCUPATI ONAL THERAPY	67.00	0	4,035		0		16
. 00	SPEECH PATHOLOGY	68.00	0	871		0		17
. 00	FAC RESOURCE	68.02	0	6, 162		0		18
	CLINIC	90.00	0	24, 867		0		19
00	CORF	99.10	0	1, 159		0		20
. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0	30, 741		0		21
. 00	FOUNDATI ON	194.00	0	3, 104		0		22
. 00	PUBLIC RELATIONS	194.01	0	90		0		23
.00	RETAIL PHARMACY	194.05	0	56		0		24
		+	<u>_</u>	454, 827		7		
	E - THERAPY ADMIN		-					
00	OCCUPATI ONAL THERAPY	67.00	346, 205	50, 512		0		1
00		0.00	0	C		0		2
00		0.00	o	C		0		3
00		0.00	o	C		0		4
00		0.00	o	C		0		5
00		0.00	ō	0		0		6
-			346, 205	50, 512		1		0
	F - RTOC ADMIN		2.2, 200	, 012	1	I		
00	FAC RESOURCE	68.02	125, 719	20, 051		0		1
			125, 719	20,051	<u>├──</u> ── ──	-		
	Grand Total: Decreases		1, 280, 515	1, 016, 836				500

REHABILITATION HOSPITAL OF INDIANA Provider CCN: 15-3028 Period:

In Lieu of Form CMS-2552-10 Worksheet A-7

RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-3028		riod: om 01/01/2021 12/31/2021	Worksheet A-7 Part I Date/Time Pre 5/27/2022 7:3	oared: 4 am
				Acqui si ti or	าร			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
	1	1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	2, 506, 638			0	0	0	1.00
2.00	Land Improvements	370, 910			0	0	0	2.00
3.00	Buildings and Fixtures	18, 771, 821	2,041,688		0	2, 041, 688	0	3.00
4.00	Building Improvements	205, 018	0		0	0	0	4.00
5.00	Fixed Equipment	2, 265, 857	0		0	0	0	5.00
6.00	Movable Equipment	15, 021, 130	276, 020		0	276, 020	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	39, 141, 374	2, 317, 708		0	2, 317, 708	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	39, 141, 374	2, 317, 708		0	2, 317, 708	0	10.00
		Endi ng Bal ance	Fully					
		_	Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	2, 506, 638	0					1.00
2.00	Land Improvements	370, 910	12, 468, 076					2.00
3.00	Buildings and Fixtures	20, 813, 509	1, 713, 448					3.00
4.00	Building Improvements	205, 018	10, 791, 467					4.00
5.00	Fixed Equipment	2, 265, 857	105, 832					5.00
6.00	Movable Equipment	15, 297, 150	187, 578					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	41, 459, 082	25, 266, 401					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	41, 459, 082	25, 266, 401					10.00

Heal th	Financial Systems REH	ABILITATION HOS	PITAL OF INDIA	ANA	In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2021 To 12/31/2021		pared:
			S	UMMARY OF CAPI	ΓAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	815, 916	(252, 191	34, 292	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	910, 303	(0 0	3, 349	0	2.00
3.00	Total (sum of lines 1-2)	1, 726, 219	(252, 191	37, 641	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum	n			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	-				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 102, 399	7			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11, 563	925, 215	5			2.00
3.00	Total (sum of lines 1-2)	11, 563	2, 027, 614	4			3.00

	Financial Systems		PITAL OF INDIA		Period:	u of Form CMS-2 Worksheet A-7	
LCON	CIEFATION OF CAFITAL COSTS CENTERS		FIOVIDEI CO		From 01/01/2021	Part III	
					To 12/31/2021	Date/Time Prep	pared:
						5/27/2022 7:34	<u>4 am</u>
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col			
				2)			
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS	5 CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	26, 161, 932	0	26, 161, 93	2 0. 631030	0	1.0
2.00	CAP REL COSTS-MVBLE EQUIP	15, 297, 150	0	15, 297, 15	0 0. 368970	0	2.0
3.00	Total (sum of lines 1-2)	41, 459, 082	0	41, 459, 08	2 1.000000	0	3.0
		ALLOCA	TION OF OTHER O	CAPI TAL	SUMMARY O	F CAPITAL	
			1				
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel ate				
			d Costs	through 7)			
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS	S CENTERS	1	r	-1		
. 00	CAP REL COSTS-BLDG & FIXT	0	, o		0 1, 063, 898	0	1.0
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 1, 212, 148		2.0
3.00	Total (sum of lines 1-2)	0	0		0 2, 276, 046	0	3.0
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)				
					d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS	5 CENTERS					
I. 00	CAP REL COSTS-BLDG & FIXT	227, 920	34, 292		0 13, 531	1, 339, 641	1.0
2.00	CAP REL COSTS-MVBLE EQUIP	0	3, 349		0 11, 563	1, 227, 060	2.0
3.00	Total (sum of lines 1-2)	227, 920	37, 641		0 25, 094	2, 566, 701	3.0

REHABILITATION HOSPITAL OF INDIANA

	Financial Systems	REHA	BILITATION HOS	SPITAL OF INDIANA		u of Form CMS-2	2552-10
ADJUSTI	MENTS TO EXPENSES			Provider CCN: 15-3028	Period: From 01/01/2021 To 12/31/2021	Worksheet A-8 Date/Time Prep 5/27/2022 7:34	
				Expense Classification o To/From Which the Amount is			<u>+ ani</u>
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	-	1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-24, 271	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	О	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	o	4.00
	discounts (chapter 8)		0				5.00
5.00	Refunds and rebates of expenses (chapter 8)		U		0.00		
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-11, 192	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service	A	-13, 861	OPERATION OF PLANT	7.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			0	10.00
11.00	Sale of scrap, waste, etc.		0		0.00	0	11.00
	(chapter 23) Related organization transactions (chapter 10)	A-8-1	4, 080, 786				12.00
	Laundry and linen service Cafeteria-employees and guests	в	0 -160 133	CAFETERI A	0.00		13.00 14.00
	Rental of quarters to employee		00, 135		0.00		15.00
16. 00	and others Sale of medical and surgical supplies to other than	В	O	CENTRAL SERVICES & SUPPLY	14.00	0	16.00
17.00	patients Sale of drugs to other than	В	-41, 604	PHARMACY	15.00	0	17.00
18.00	patients Sale of medical records and	В	-43	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	abstracts Nursing and allied health		0		0.00	о	19.00
	education (tuition, fees, books, etc.)						
	Vending machines		0		0.00		20.00
21.00	Income from imposition of interest, finance or penalty		0		0.00	0	21.00
22 00	charges (chapter 21) Interest expense on Medicare		O		0.00	0	22.00
22.00	overpayments and borrowings to		0		0.00	U	22.00
23.00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	о	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	О	27.00
	COSTS-MVBLE EQUIP Non-physician Anesthetist			*** Cost Center Deleted ***			28.00
	Physicians' assistant		0		0.00		
	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	O	OCCUPATI ONAL THERAPY	67.00		30. 00
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00

	Firenzial Custome	DELLA			1 1		0000 10
	Financial Systems	KEHA	BILITATION HUS	PITAL OF INDIANA		eu of Form CMS-2	
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2021		
					To 12/31/2021	Date/Time Pre 5/27/2022 7:3	
				Expanse Classification of	Workchoot A	<u>372172022</u> 1. 3	4 аш
				Expense Classification of			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MI SCELLANEOUS REVENUE	В	-60, 244	ADMINISTRATIVE AND GENERAL	5.01	0	33.01
33.07	RHI FOUNDATION	A	629, 053	FOUNDATI ON	194.00	0	33.07
33.08	ADVERTI SI NG	A	-544	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	33.08
33.09	ADVERTI SI NG	A	-168	ADMINI STRATI VE AND GENERAL	5.01	0	33.09
33.10	ADVERTI SI NG	A	-341	NURSING ADMINISTRATION	13.00	0	33.10
33.13	BOND ISSUANCE COST	A		CAP REL COSTS-BLDG & FIXT	1.00		
001.10	AMORTI ZATI ON CARR		,				
33.14	LATE FEES	А	451	CAP REL COSTS-BLDG & FIXT	1.00	14	33.14
	DONATI ONS/CONTRI BUTI ONS	1					•
33.15		A		ADMINISTRATIVE AND GENERAL	5.01	0	33.15
50.00	TOTAL (sum of lines 1 thru 49)		4, 408, 650				50.00
	(Transfer to Worksheet A,						
		1		1	1	1	1

(Iransfer to Worksheet A, column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1. (2) Basis for adjustment (see instructions).

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

Heal th	Financial Systems	REHABILITATION HC	SPITAL OF INDIANA	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 01/01/2021 To 12/31/2021	Date/Time Pre	pared.
				10 12/01/2021	5/27/2022 7:3	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
	1.00	2.00	2.00	4.00	5	
				4.00	5.00	
	HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS UR	CLAIMED	
1.00		CAP REL COSTS-BLDG & FIXT	ALLOCATION FROM HO REPORT	247, 982	0	1.00
2.00			ALLOCATION FROM HO REPORT	301,845	0	2.00
3.00		ADMINI STRATI VE AND GENERAL	ALLOCATION FROM HO REPORT	3, 535, 021	0 0	3.00
4.00		ADMINISTRATIVE AND GENERAL	RELATED PARTY FEES	8, 883	8, 883	4.00
4.01	60.00	LABORATORY	ALLOCATION FROM RELATED PART	452, 489	456, 551	4.01
4.02	5. 01	ADMINISTRATIVE AND GENERAL	RELATED PARTY FEES	192, 777	192, 777	4.02
4.03	54.00	RADI OLOGY-DI AGNOSTI C	RELATED PARTY FEES	1, 380	1, 380	4.03
4.04	0.00			0	0	4.04
4.05	15.00	PHARMACY	RELATED PARTY FEES	5,068	5, 068	4.05
4.06	192.00	PHYSICIANS' PRIVATE OFFICES	RELATED PARTY FEES	343, 210	343, 210	4.06
4.07		EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY FEES	25, 901	25, 901	4.07
4.08	0.00			0	0	4.08
4.09	0.00			0	0	4.09
5.00	TOTALS (sum of lines 1-4).			5, 114, 556	1, 033, 770	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

				Related Organization(s) and	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	

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

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

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

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

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

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

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

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

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

						5/27/2022 7:34	am
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6.00	7.00					
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED O	RGANIZATIONS OR CI	_AI MED	
	HOME OFFICE CO	STS:					
1.00	247, 982	9					1.00
2.00	301, 845	9					2.00
3.00	3, 535, 021	0					3.00
4.00	0	0					4.00
4.01	-4, 062	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	4, 080, 786						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	nus i	iot been posted to norkaneet A,	cordinas r ana/or 2, the amount arrowable should be mareated in cordinary or this part.	
Type of Busi ness 6.00		Related Organization(s)		
6.00		and/or Home Office		
6.00				
6.00				
		Type of Business		
		6.00		
D. INTERRELATIONSHIP TO RELATED ORGANIZATION(3) AND/OR HOWE OFFICE.		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

reriibui	Sement under title Aviii.	
6.00	HOME OFFICE	6.00
7.00	MGMT COMPANY	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00
(1) 11		

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

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

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

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

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

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

		ABILITATION HOS			In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/27/2022 7:3	pared: 4 am
			CAPI TAL REL	ATED COSTS		572172022 7.5	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		<u>col.7)</u>	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 339, 641	1, 339, 641				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 227, 060		1, 227, 06			2.00
4.00	00400 EMPLOYEE BENEFI TS DEPARTMENT	6, 548, 930		20, 76		0 (12 (10	4.00
5. 01 5. 02	00591 ADMINISTRATIVE AND GENERAL 00590 OTHER A&G - NON FOUNDATION	8, 670, 714 1, 097, 927	40, 949 28, 129	37, 50 25, 76		9, 613, 619 1, 368, 079	5. 01 5. 02
5.02 7.00	00700 OPERATION OF PLANT	1, 795, 379	17, 360	15, 90		1, 838, 038	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	116,051	0		0 0	116, 051	8.00
9.00	00900 HOUSEKEEPI NG	493, 592	11, 321	10, 37	0 87, 901	603, 184	9.00
10.00	01000 DI ETARY	742, 525	46, 944	42, 99		842, 447	10.00
11.00	01100 CAFETERI A	192, 349	22, 293	20, 42		239, 799	11.00
13.00	01300 NURSING ADMINISTRATION	2, 032, 991	9, 226			2, 531, 944	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	567, 340		10, 57		608, 303	
15.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	699, 292	5, 704 15, 221	5, 22		869, 441	15.00
16.00 17.00	01700 SOCIAL SERVICE	510, 653 679, 209	4, 045	13, 94 3, 70		642, 217 803, 069	16.00 17.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	186, 387	4,043		0 0	186, 387	1
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	100,007			0	100,007	22.00
30.00	03000 ADULTS & PEDIATRICS	9, 208, 705	583, 078	534, 07	5 2, 102, 170	12, 428, 028	30.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	0	50,00
54.00	05400 RADI OLOGY-DI AGNOSTI C	166, 252	7, 640			216, 333	
60.00	06000 LABORATORY	454, 281	4, 380	4, 01		462, 673	
65.00	06500 RESPI RATORY THERAPY	579, 347	17, 375	15, 91		749, 752	
66.00	06600 PHYSI CAL THERAPY	2, 372, 713	217, 040	198, 80	1 531, 220	3, 319, 774	66.00
66. 01	06601 PHYSI CAL THERAPY - CARMEL	405, 054	0		0 74, 750	479, 804	•
67.00	06700 OCCUPATI ONAL THERAPY	2, 265, 556	164, 858	151, 00		3, 118, 453	
68.00	06800 SPEECH PATHOLOGY	1, 264, 523	33, 120	30, 33		1, 630, 050	
68. 01 68. 02	06801 VI SI ON 06802 FAC RESOURCE	1, 493, 724	5, 064	4, 63	0 0 8 323, 668	1, 827, 094	68. 01 68. 02
69.02	06900 ELECTROCARDI OLOGY	1,475,724	0		0 323,000	1, 027, 094	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	172, 839	0		0 0	172, 839	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		o o	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 744, 354	0		0 0	1, 744, 354	
74.00	07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
00.00		245 477	44.254	10 (2	7 54.00/	205 272	00.00
90. 00 90. 01	09000 CLINIC 09001 SLEEP CENTER	245, 466 0	44, 354 0		7 54,826 0 0	385, 273 0	1
	09100 EMERGENCY	0			0 0	0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
	OTHER REIMBURSABLE COST CENTERS	•			-		1
99.00	09900 CMHC	0	0		0 0	0	
99.10	09910 CORF	0	0		00	0	99.10
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	47, 272, 854	1, 312, 313	1, 202, 02	8 6, 168, 879	46, 797, 005	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 1, 494, 064	0 23, 414				190.00
	07950 FOUNDATION	940, 383	23, 414 2, 328	21, 44 2, 13		1, 796, 868 1, 008, 198	
	07951 PUBLIC RELATIONS	452, 274	1, 586			495, 475	
	07952 ST. VINCENT - ARU	0	0		0 0		194.02
	07953 MUNCIE – ARU	0	0		0 0		194.03
	07954 RILEY - ARU	0	0		o o		194.04
	07955 RETAIL PHARMACY	1, 256, 604	0		0 62, 029	1, 318, 633	
200.00							200.00
201.00 202.00		51, 416, 179	0 1, 339, 641	1, 227, 06	0 0 0 6, 592, 368		201.00
202.00		1 01, 110, 177	1, 007, 041	1, 227, 00	5, 572, 300	51, 110, 177	1202.00

Heal th Financial	Systems	
AGAT ALL GAATLAN	OFNERAL	050

REHABILITATION HOSPITAL OF INDIANA

COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part I Date/Time Pre 5/27/2022 7:3	pared: 4 am
	Cost Center Description	ADMI NI STRATI VE	Subtotal	OTHER A&G -	OPERATION OF	LAUNDRY &	
		AND GENERAL 5.01	5A. 01	NON FOUNDATION 5.02	PLANT 7.00	LINEN SERVICE 8.00	
	GENERAL SERVICE COST CENTERS	0.01	0/11/01	0102	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0100	
1.00 2.00 4.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 2.00 4.00
5.01	00591 ADMI NI STRATI VE AND GENERAL	9, 613, 619					5.01
5.02	00590 OTHER A&G - NON FOUNDATION	314, 627	1, 682, 706				5. 02
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	422, 706	2, 260, 744		2, 337, 234	147 540	7.00
8.00 9.00	00900 HOUSEKEEPING	26, 689 138, 718	142, 740 741, 902		21, 503	147, 569 0	8.00 9.00
10.00	01000 DI ETARY	193, 743	1, 036, 190			0	10.00
11.00	01100 CAFETERI A	55, 148	294, 947	9, 979	42, 343	0	11.00
13.00	01300 NURSING ADMINISTRATION	582, 289	3, 114, 233		17, 523	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	139, 896	748, 199			0	14.00
15.00	01500 PHARMACY	199, 951	1,069,392		10, 835	0	15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	147, 695 184, 687	789, 912 987, 756			0	16.00 17.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	42, 865	229, 252		7,004	0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS	,		.,	-		
30. 00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	2, 858, 154	15, 286, 182	517, 214	1, 107, 479		30.00
50.00	05000 OPERATING ROOM	0	0		-	0	50.00
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	49, 752 106, 404	266, 085 569, 077		14, 511 8, 319	0	54.00 60.00
65.00	06500 RESPIRATORY THERAPY	172, 426	922, 178		33, 001	0	65.00
66.00	06600 PHYSI CAL THERAPY	763, 472	4, 083, 246		412, 240	141	66.00
66. 01	06601 PHYSI CAL THERAPY - CARMEL	110, 344	590, 148		0	2, 130	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	717, 172	3, 835, 625		313, 126	168	67.00
68.00	06800 SPEECH PATHOLOGY	374, 874	2,004,924		62, 907	107	68.00
68. 01 68. 02	06801 VI SI ON 06802 FAC RESOURCE	420, 190	0 2, 247, 284	0 76, 035	0 9, 618	0	68.01 68.02
69.02	06900 ELECTROCARDI OLOGY	420, 190	2, 247, 204	10,035	9,018	0	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	39, 749	212, 588	7, 193	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	401, 161	2, 145, 515	72, 591	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
00.00		00.404	472 077	16 022	04 245	0	00.00
90. 00 90. 01	09000 CLINIC 09001 SLEEP CENTER	88, 604 0	473, 877 0		84, 245 0	0	90.00 90.01
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						
99.00	09900 CMHC	0	0		0	0	99.00
99. 10	09910 CORF SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	99.10
118.00		8, 551, 316	45, 734, 702	1, 490, 479	2, 285, 327	147, 569	110 00
110.00	NONREI MBURSABLE COST CENTERS	0, 331, 310	43,734,702	1,490,479	2,200,327	147, 309	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	413, 238	2, 210, 106	74, 777	44, 472	0	192.00
	07950 FOUNDATI ON	231, 862	1, 240, 060				194.00
	07951 PUBLIC RELATIONS	113, 948	609, 423	20, 619	3, 013		194.01
	07952 ST. VINCENT – ARU 07953 MUNCIE – ARU	0	0	0	0		194.02 194.03
	07953 MUNCIE - ARU 07954 RILEY - ARU	0	0		0		194.03
	07955 RETAIL PHARMACY	303, 255	1, 621, 888	54, 875	0		194.04
200.00		000,200	0	0.,070	Ŭ	0	200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	9, 613, 619	51, 416, 179	1, 682, 706	2, 337, 234	147, 569	1

	cial Systems REHA ION - GENERAL SERVICE COSTS	ABILITATION HOSP	Provider CC	N: 15-3028 F	Period: From 01/01/2021	u of Form CMS-2 Worksheet B Part I	
					0 12/31/2021	Date/Time Pre 5/27/2022 7:3	pared
. (Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL	
		9.00	10.00	11.00	13.00	14.00	
	L SERVICE COST CENTERS						
	CAP REL COSTS-BLDG & FIXT						1.0
	CAP REL COSTS-MVBLE EQUIP						2.0
	EMPLOYEE BENEFITS DEPARTMENT						4.0
	ADMINISTRATIVE AND GENERAL						5.0
	OTHER A&G - NON FOUNDATION						5.0
00 00700	OPERATION OF PLANT						7.0
	LAUNDRY & LINEN SERVICE						8.0
00 00900 1	HOUSEKEEPING	788, 507					9.0
0.00 01000 0	DI ETARY	30, 360	1, 190, 772				10.0
. 00 01100	CAFETERIA	14, 418	0	361, 687	7		11. (
. 00 01300 1	NURSING ADMINISTRATION	5, 967	0	38, 414	3, 281, 504		13.0
. 00 01400	CENTRAL SERVICES & SUPPLY	7, 463	0	2, 801	0	805, 696	14.0
. 00 01500 1	PHARMACY	3, 689	0	12, 359	252, 746	15, 438	15.0
. 00 01600 1	MEDICAL RECORDS & LIBRARY	9, 844	0	8, 252	168, 758	0	16.0
. 00 01700	SOCIAL SERVICE	2, 616	0	6, 277	0	4, 031	17.0
. 00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	C	0 0	0	22.0
I NPATI	ENT ROUTINE SERVICE COST CENTERS						
. 00 03000	ADULTS & PEDIATRICS	377, 097	1, 190, 772	128, 505	2, 627, 983	191, 781	30.0
ANCI LL	ARY SERVICE COST CENTERS						
. 00 05000	OPERATING ROOM	0	0	C	0 0	0	50.0
. 00 05400 1	RADI OLOGY-DI AGNOSTI C	4, 941	0	2, 669	54, 581	3, 838	54.0
. 00 06000	LABORATORY	2, 833	0	4, 631	0	0	60.0
00 06500 1	RESPI RATORY THERAPY	11, 237	0	8, 676	5 177, 436	163, 208	65.0
00 06600 1	PHYSI CAL THERAPY	140, 368	0	33, 294	l 0	5, 633	66.0
. 01 06601 1	PHYSICAL THERAPY - CARMEL	0	0	3, 675	5 0	718	66.0
00 06700	OCCUPATIONAL THERAPY	106, 619	0	39, 225	5 0	7,863	67.0
00 06800	SPEECH PATHOLOGY	21, 420	0	17, 498	3 0	2, 141	68.0
01 06801	VISION	0	0	C	0 0	0	68.0
. 02 06802	FAC RESOURCE	3, 275	0	27, 145	5 0	7,034	68.0
. 00 06900 1	ELECTROCARDI OLOGY	0	0	C	0 0	0	69.0
. 00 07100 1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0 0	316, 515	71.0
. 00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0 0	0	72.0
. 00 07300 1	DRUGS CHARGED TO PATIENTS	0	0	C	0 0	0	73.0
00 07400 1	RENAL DIALYSIS	0	0	C	0 0	0	74.0
OUTPAT	IENT SERVICE COST CENTERS						
00 09000	CLINIC	28, 685	0	4, 875	5 0	21, 528	90.0
	SLEEP CENTER	0	0	C		0	90. (
00 09100	EMERGENCY	0	0	C	0 0	0	91. (
	OBSERVATION BEDS (NON-DISTINCT PART)						92. (
-	REIMBURSABLE COST CENTERS	· · · · ·					
00 09900		0	0	C		0	
10 09910		0	0	C	0 0	0	99. ⁻
	L PURPOSE COST CENTERS						
	SUBTOTALS (SUM OF LINES 1 through 117)	770, 832	1, 190, 772	338, 296	3, 281, 504	739, 728	118. (
	MBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C			190. (
	PHYSI CLANS' PRI VATE OFFI CES	15, 143	0	16, 406		60, 022	
	FOUNDATION	1, 506	0	3, 720		5, 684	
	PUBLIC RELATIONS	1, 026	0	3, 265			194. (
	ST. VINCENT - ARU	0	0	C			194. (
	MUNCIE – ARU	0	0	C	0		194. (
	RILEY - ARU	0	0	C	0		194. (
	RETAIL PHARMACY	0	0	C	0		194. (
	Cross Foot Adjustments						200. (
. 00	Negative Cost Centers	0	0	C	0		201. (
2.00	TOTAL (sum lines 118 through 201)	788, 507	1, 190, 772	361, 687	3, 281, 504	805, 696	1202 (

In Lieu of Form CMS-2552-10 Worksheet B

COST ALLOCATION - GENERA	AL SERVICE CUSIS		Provider C	F	rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre 5/27/2022 7:3	pared: 34 am
Cost Center	Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS	Subtotal	
		15.00	16.00	17.00	22.00	24.00	
GENERAL SERVICE C				1	<u>г</u>		4
1.00 00100 CAP REL COS							1.00
2.00 00200 CAP REL COS 4.00 00400 EMPLOYEE BEI							2.00
4. 00 00400 EMPLOYEE BEI 5. 01 00591 ADMI NI STRAT							4.00 5.01
5. 02 00590 OTHER A&G -							5.01
7.00 00700 OPERATION 0							7.00
8.00 00800 LAUNDRY & L							8.00
9.00 00900 HOUSEKEEPI N							9.00
10. 00 01000 DI ETARY							10.00
11.00 01100 CAFETERIA							11.00
13.00 01300 NURSING ADM	I NI STRATI ON						13.00
14.00 01400 CENTRAL SER	VICES & SUPPLY						14.00
15.00 01500 PHARMACY		1, 400, 641					15.00
16.00 01600 MEDICAL REC		0	1,032,403				16.00
17.00 01700 SOCIAL SERV		0	0				17.00
	S-OTHER PRGM COSTS APPRVD	0	0	0 0	237, 009		22.00
	SERVICE COST CENTERS	ol	1 022 402	1 041 704	227.000	22 002 222	20.00
30. 00 03000 ADULTS & PEI ANCI LLARY SERVICE		0	1, 032, 403	1, 041, 784	237, 009	23, 883, 232	30.00
50.00 05000 OPERATING R		0	0	0	o	0	50.00
54. 00 05400 RADI OLOGY-D		0	0			355, 628	
60. 00 06000 LABORATORY	TAGINOSTI C	0	0		0	604, 114	
65. 00 06500 RESPI RATORY	THERAPY	o	0	0	0	1, 346, 937	1
66.00 06600 PHYSI CAL TH		0	0	0	0	4, 813, 075	1
66. 01 06601 PHYSI CAL TH	ERAPY - CARMEL	0	0	0 0	0	616, 638	1
67.00 06700 OCCUPATI ONA	L THERAPY	0	0	0	0	4, 432, 401	67.00
68.00 06800 SPEECH PATH	OLOGY	0	0	0 0	0	2, 176, 832	68.00
68. 01 06801 VI SI ON		0	0	0	0	0	
68.02 06802 FAC RESOURC		0	0	0	0	2, 370, 391	1
69.00 06900 ELECTROCARD		0	0	0	0	0	
	PLIES CHARGED TO PATIENTS	0	0	0	0	536, 296	1
1 1	CHARGED TO PATIENTS	1 400 (41	0		0	0	
73. 00 07300 DRUGS CHARG 74. 00 07400 RENAL DI ALY		1, 400, 641 0	0			3, 618, 747 0	1
OUTPATIENT SERVIC		<u> </u>	0	<u>/</u> 0	0	0	74.00
90. 00 09000 CLINIC		0	0	0	0	629, 243	90.00
90. 01 09001 SLEEP CENTER	R	Ő	0			0277210	1
91.00 09100 EMERGENCY		0	0			0	1
92.00 09200 OBSERVATI ON	BEDS (NON-DISTINCT PART)						92.00
OTHER REI MBURSABL	E COST CENTERS						
99. 00 09900 CMHC		0	0			0	
99. 10 09910 CORF		0	0	00	0	0	99.10
SPECIAL PURPOSE C							4
	SUM OF LINES 1 through 117)	1, 400, 641	1,032,403	1, 041, 784	237, 009	45, 383, 534	118.00
NONREI MBURSABLE C							100.00
190. 00 19000 GTFT, FLOWE	R, COFFEE SHOP & CANTEEN	0	0			2, 420, 926	190.00
192. 00 19200 PHTSI CLANS 194. 00 07950 FOUNDATI ON	PRIVATE OFFICES	0	0			2, 420, 920 1, 297, 348	
194. 01 07951 PUBLIC RELA	TLONS	0	0		-	637, 511	
194. 02 07952 ST. VI NCENT		0	0		-		194.02
194. 03 07953 MUNCI E - ARI		0	0		0		194.03
194. 04 07954 RI LEY - ARU		o	0	0	0	97	194.04
194.0507955 RETAIL PHAR		Ō	0	0	0	1, 676, 763	
200.00 Cross Foot					0	0	200.00
201.00 Negative Cos		o	0	0	0		201.00
202.00 TOTAL (sum	lines 118 through 201)	1, 400, 641	1,032,403	1, 041, 784	237, 009	51, 416, 179	202.00

COST AI	LLOCATION - GENERAL SERVICE COSTS		Provi der CCI	N: 15-3028	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/27/2022 7:3-	pared: 4 am
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total 26.00				
	GENERAL SERVICE COST CENTERS	20.00	20.00				
	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
	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
	01100 CAFETERIA						11.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15. OC
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
17.00	01700 SOCIAL SERVICE						17.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD						22.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	-237,009	23, 646, 223				30.00
	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	0	0				50.00
	05400 RADI OLOGY-DI AGNOSTI C	0	355, 628				50.00 54.00
	06000 LABORATORY	0	604, 114				60.00
	06500 RESPIRATORY THERAPY	0	1, 346, 937				65. 00
	06600 PHYSI CAL THERAPY	0	4, 813, 075				66. OC
66.01	06601 PHYSI CAL THERAPY - CARMEL	0	616, 638				66. 01
	06700 OCCUPATI ONAL THERAPY	0	4, 432, 401				67.00
	06800 SPEECH PATHOLOGY	0	2, 176, 832				68.00
	06801 VI SI ON	0	0				68.01
	06802 FAC RESOURCE	0	2, 370, 391				68.02
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0 536, 296				69.00 71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	530, 290				72.00
	07300 DRUGS CHARGED TO PATIENTS	0	3, 618, 747				73.00
	07400 RENAL DI ALYSI S	0	0				74. OC
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	629, 243				90.00
	09001 SLEEP CENTER	0	0				90.01
	09100 EMERGENCY	0	0				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
	OTHER REIMBURSABLE COST CENTERS	0	0				99.00
	09910 CORF	0	0				99.10
	SPECIAL PURPOSE COST CENTERS	U					, , , , , , , , , , , , , , , , , , , ,
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-237,009	45, 146, 525				118. OC
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	2, 420, 926				192.00
	07950 FOUNDATI ON	0	1, 297, 348				194.00
	07951 PUBLIC RELATIONS	0	637, 511				194.01
	07952 ST. VINCENT – ARU 07953 MUNCIE – ARU	0	0				194. 02 194. 03
	07953 MUNCLE - ARU 07954 RILEY - ARU	0	97				194.03
	07955 RETAIL PHARMACY	0	1, 676, 763				194.04
200.00	Cross Foot Adjustments	0	0				200.00
201.00	5	0	0				201.00
202.00		-237, 009	51, 179, 170				202.00

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		OF C		PELATED	C

REHABILITATION HOSPITAL OF INDIANA

lealth Fina	incial Systems REH/	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provider CO		eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part II Date/Time Pre	
				ATED COSTS		5/27/2022 7:3	<u>4 am</u>
				LATED COSTS			
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
GENE	RAL SERVICE COST CENTERS	0	1.00	2.00	20	4.00	
	O CAP REL COSTS-BLDG & FIXT						1.00
	O CAP REL COSTS-MVBLE EQUIP						2.00
	O EMPLOYEE BENEFITS DEPARTMENT	0	22, 672	20, 766	43, 438	43, 438	4.00
5.01 0059	1 ADMINISTRATIVE AND GENERAL	0	40, 949	37, 508	78, 457	5, 695	5.01
5.02 0059	O OTHER A&G - NON FOUNDATION	0	28, 129	25, 765	53, 894	1, 425	5.02
7.00 0070	O OPERATION OF PLANT	0	17, 360	15, 901	33, 261	62	7.00
8.00 0080	O LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00 0090	0 HOUSEKEEPI NG	0	11, 321	10, 370	21, 691	579	9.00
10.00 0100	0 DI ETARY	0	46, 944	42, 999	89, 943	66	10.00
	O CAFETERI A	0	22, 293	20, 420	42, 713	31	11.00
	O NURSI NG ADMI NI STRATI ON	0	9, 226		17, 677	3, 170	
	0 CENTRAL SERVICES & SUPPLY	0	11, 540	10, 570	22, 110	124	
	O PHARMACY	0	5, 704	5, 225	10, 929	1, 049	•
	0 MEDI CAL RECORDS & LI BRARY	0	15, 221	13, 942	29, 163	675	•
	O SOCIAL SERVICE	0	4,045		7, 750	765	•
	0 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
	TI ENT_ROUTI NE_SERVI CE_COST_CENTERS 0 ADULTS & PEDI ATRI CS	0	583, 078	534, 075	1, 117, 153	13, 858	30.00
	LLARY SERVICE COST CENTERS	0	505,070	554,075	1, 117, 155	15,000	30.00
	O OPERATING ROOM	0	0	0	0	0	50.00
	0 RADI OLOGY-DI AGNOSTI C	0	7, 640	-	14, 638	233	
	0 LABORATORY	0	4, 380		8, 392	0	60.00
	0 RESPI RATORY THERAPY	0	17, 375		33, 290	903	
	0 PHYSI CAL THERAPY	0	217, 040	198, 801	415, 841	3, 500	66.00
66.01 0660	1 PHYSICAL THERAPY - CARMEL	0	0	0	0	492	66.01
67.00 0670	O OCCUPATI ONAL THERAPY	0	164, 858	151, 003	315, 861	3, 538	67.00
	O SPEECH PATHOLOGY	0	33, 120	30, 337	63, 457	1, 990	68.00
	1 VI SI ON	0	0	0	0	0	68.01
	2 FAC RESOURCE	0	5, 064	4, 638	9, 702	2, 132	
	0 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
	O MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
	O IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	O DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	ORENAL DIALYSIS	0	0	0	0	0	74.00
	ATIENT SERVICE COST CENTERS	0	44, 354	40, 627	84, 981	361	90.00
	1 SLEEP CENTER	0		40, 027	04, 701	0	90.00
	0 EMERGENCY	0		0	0	0	91.00
	O OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
	R REIMBURSABLE COST CENTERS						1
99.00 0990		0	0	0	0	0	99.00
	0 CORF	0		0	0	0	
SPEC	I AL PURPOSE COST CENTERS		*	•			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 312, 313	1, 202, 028	2, 514, 341	40, 648	118.00
	EIMBURSABLE COST CENTERS	1	1				
	OGIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0		190.00
	0 PHYSI CLANS' PRI VATE OFFI CES	0	23, 414		44, 860		192.00
	O FOUNDATI ON	0	2, 328		4, 461		194.00
	1 PUBLIC RELATIONS	0	1, 586		3, 039		194.01
	2 ST. VINCENT - ARU	0	0	0	0		194.02
	3 MUNCIE - ARU	0	0	0	0		194.03
	4 RILEY - ARU 5 RETAIL PHARMACY	0		0	0		194.04 194.05
200.00	Cross Foot Adjustments	0		0	0	409	200.00
200.00	Negative Cost Centers		_	_	0	0	200.00
201.00	TOTAL (sum lines 118 through 201)	0	1, 339, 641	1, 227, 060	2, 566, 701		201.00
		. 0	1,007,041	1, 227, 000	2, 500, 701	1 75, 750	1-02.00

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		CADI	TAI	DEL ATEL	

REHABILITATION HOSPITAL OF INDIANA

ALLOCA	TION OF CAPITAL RELATED COSTS	1	Provider CO	F		Worksheet B Part II Date/Time Pre 5/27/2022 7:3	pared: 4 am
	Cost Center Description	ADMI NI STRATI VE AND GENERAL	OTHER A&G - NON FOUNDATION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5. 01	5. 02	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	1	1	1	1		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	04.450					4.00
5.01	00591 ADMI NI STRATI VE AND GENERAL	84, 152					5.01
5.02 7.00	00590 OTHER A&G - NON FOUNDATION 00700 OPERATION OF PLANT	2, 754 3, 700					5.02 7.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	234		39, 664	401		8.00
9.00	00900 HOUSEKEEPING	1, 214		365	401	24, 716	9.00
9.00 10.00	01000 DI ETARY	1, 214			0	24,710	1
11.00	01100 CAFETERI A	483		719	0	452	
13.00	01300 NURSI NG ADMI NI STRATI ON	5,097		297	0	187	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 225		372	0	234	
15.00	01500 PHARMACY	1, 750		184	0	116	
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 293		491	o	309	
17.00	01700 SOCIAL SERVICE	1, 617		130	0	82	17.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	375		0	0	0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	25, 021	17, 839	18, 794	395	11, 819	30.00
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	435		246	0	155	1
60.00	06000 LABORATORY	931		141	0	89	60.00
65.00	06500 RESPIRATORY THERAPY	1, 509		560	0	352	65.00
66.00	06600 PHYSI CAL THERAPY	6, 683		6, 996	0	4,400	1
66.01	06601 PHYSI CAL THERAPY - CARMEL	966		0	6	0	66.01
67.00	06700 OCCUPATI ONAL THERAPY	6, 277		5, 314	ō	3, 342	67.00
68.00	06800 SPEECH PATHOLOGY	3, 281		1, 068	0	671	68.00
68.01	06801 VI SI ON	0	0	0	0	0	68.01
68.02	06802 FAC RESOURCE	3, 678	2, 625	163	0	103	68.02
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	348	248	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 511		0	0	0	73.00
74.00	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS	1	1				
90.00	09000 CLINIC	776		1, 430	0	899	90.00
90.01	09001 SLEEP CENTER	0		0	0	0	90.01
91.00 92.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
99, 00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	99.00
	09910 CORF		0	0	0	0	99.00
99. IU	SPECIAL PURPOSE COST CENTERS	0	0	0	U	0	99.10
118.00		74, 854	51, 438	38, 783	401	24 162	118.00
110.00	NONREI MBURSABLE COST CENTERS	74,004	51,430	50,703	101	24, 102	110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	3, 617	2, 581	755	o		192.00
	07950 FOUNDATI ON	2,030			o		194.00
	07951 PUBLIC RELATIONS	997		51	o		194.01
	07952 ST. VINCENT - ARU	0	0	0	0		194.02
	07953 MUNCIE – ARU	0	0	0	0	0	194.03
	07954 RILEY - ARU	0	0	0	0		194.04
194.05	07955 RETAIL PHARMACY	2, 654	1, 894	0	0		194.05
200.00							200.00
			0		0	0	201.00
201.00		0 84, 152	-	-	401		201.00

00 C 00 C 00 C 01 C 02 C 00 C 5.00 C 5.00 C 2.00 C 0.00 C 0.00 C	Cost Center Description GENERAL SERVICE COST CENTERS D0100 CAP REL COSTS-BLDG & FIXT D0200 CAP REL COSTS-MVBLE EQUIP D0400 EMPLOYEE BENEFITS DEPARTMENT D0591 ADMINISTRATIVE AND GENERAL D0590 OTHER A&G - NON FOUNDATION D0590 OTHER A&G - NON FOUNDATION D0700 OPERATION OF PLANT D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DI ETARY D1100 CAFETERIA D1100 CAFETERIA D1200 HARMACY D1600 MEDICAL RECORDS & LIBRARY D1700 SOCIAL SERVICE D2200 I & SERVICES-OTHER PRGM COSTS APPRVD NPATIENT ROUTINE SERVICE COST CENTERS D3000 ADULTS & PEDIATRICS	DI ETARY 10. 00 95, 380 0 0 0 0 0 0 0 0 0 0 0 0 0	CAFETERI A 11. 00 44, 742 4, 752 346 1, 529 1, 021 777	34, 817 0	25, 285 484	Date/Ti me Preg 5/27/2022 7: 34 PHARMACY 15. 00 19, 972	4 am 1. (2. (4. (5. (5. (7. (8. (9. (10. (11. (13. (14. (14. (14. (14. (14. (14. (14. (14. (15. (14. (14. (14. (15. (14.
00 C 00 C 00 C 01 C 02 C 00 C 0 C 0 C 0 C	ENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00591 ADMINISTRATIVE AND GENERAL 00590 OTHER A&G - NON FOUNDATION 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 11000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 11400 CENTRAL SERVICES & SUPPLY 11500 PHARMACY 10600 MEDICAL RECORDS & LIBRARY 11700 SOCIAL SERVICE 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD NPATLENT ROUTINE SERVICE COST CENTERS	10.00 95,380 0 0 0 0 0	11.00 44,742 4,752 346 1,529 1,021	ADMI NI STRATI ON 13. 00 34, 817 0 2, 682	SERVI CES & SUPPLY 14.00 25, 285	15.00	2. 0 4. 0 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0
00 C 00 C 00 C 01 C 02 C 00 C 0 C 0 C 0 C	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00591 ADMINISTRATIVE AND GENERAL 00590 OTHER A&G - NON FOUNDATION 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING - - 01000 DI ETARY - - 01100 CAFETERIA - - - 01100 CAFETERIA - - - 011400 CENTRAL SERVICES & SUPPLY - 01500 PHARMACY - - - 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE - - 01200 I & SERVI CES-OTHER PRGM COSTS APPRVD 01700 SOCI AL SERVI CES-OTHER PRGM COSTS APP	95, 380 0 0 0 0 0 0	44, 742 4, 752 346 1, 529 1, 021	34, 817 0 2, 682	14. 00 25, 285		2. 0 4. 0 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0
00 C 00 C 00 C 01 C 02 C 00 C 0 C 0 C 0 C	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00591 ADMINISTRATIVE AND GENERAL 00590 OTHER A&G - NON FOUNDATION 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING - - 01000 DI ETARY - - 01100 CAFETERIA - - - 01100 CAFETERIA - - - 011400 CENTRAL SERVICES & SUPPLY - 01500 PHARMACY - - - 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE - - 01200 I & SERVI CES-OTHER PRGM COSTS APPRVD 01700 SOCI AL SERVI CES-OTHER PRGM COSTS APP	0 0 0 0 0	4, 752 346 1, 529 1, 021	34, 817 0 2, 682		10 072	2. 0 4. 0 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0
00 C 00 C 01 C 02 C 00 C	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00591 ADMI NI STRATI VE AND GENERAL 00590 OTHER A&G - NON FOUNDATI ON 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 011000 DI ETARY 011000 CAFETERI A 013000 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 02200 I & SERVI CES-OTHER PRGM COSTS APPRVD NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 0 0 0 0	4, 752 346 1, 529 1, 021	34, 817 0 2, 682		10 072	2. 0 4. 0 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0
00 C 01 C 02 C 00 C	00400 EMPLOYEE BENEFITS DEPARTMENT 00591 ADMINISTRATIVE AND GENERAL 00590 OTHER A&G - NON FOUNDATION 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 011000 DIETARY 011000 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD NPATIENT ROUTINE SERVICE COST CENTERS	0 0 0 0 0	4, 752 346 1, 529 1, 021	34, 817 0 2, 682		10 072	4. 0 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0
01 C 02 C 00 C	00591 ADMI NI STRATI VE AND GENERAL 00590 OTHER A&G - NON FOUNDATI ON 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 011000 DI ETARY 011000 CAFETERI A 013000 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 0 0 0 0	4, 752 346 1, 529 1, 021	34, 817 0 2, 682		10 072	5. 0 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0 14. 0
02 C 00 C	00590 OTHER A&G - NON FOUNDATION 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01400 CENTRAL SERVICES & SUPPLY 01400 MEDICAL RECORDS & LIBRARY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD NPATIENT ROUTINE SERVICE COST CENTERS	0 0 0 0 0	4, 752 346 1, 529 1, 021	34, 817 0 2, 682		10 072	5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 13. 0
00 C 1.00 C 3.00 C 5.00 C 5.00 C 5.00 C 2.00 C 0.00 C	00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01400 CENTRAL SERVI CES & SUPPLY 01600 MEDI CAL RECORDS & LI BRARY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 0 0 0 0	4, 752 346 1, 529 1, 021	34, 817 0 2, 682		10 072	7.0 8.0 9.0 10.0 11.0 13.0 14.0
00 C 00 C 00 C 00 C 1.00 C 3.00 C 4.00 C 5.00 C 6.00 C 7.00 C 2.00 C D.00 C	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 02200 I & SERVI CES-OTHER PRGM COSTS APPRVD 01701 ENT ROUTI NE SERVI CE COST CENTERS	0 0 0 0 0	4, 752 346 1, 529 1, 021	34, 817 0 2, 682		10 072	8. 0 9. 0 10. 0 11. 0 13. 0 14. 0
00 C 0.00 C 1.00 C 3.00 C 4.00 C 5.00 C 6.00 C 2.00 C 2.00 C 0.00 C 0.00 C	00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02200 I & SERVICES-OTHER PRGM COSTS APPRVD NPATIENT ROUTINE SERVICE COST CENTERS	0 0 0 0 0	4, 752 346 1, 529 1, 021	34, 817 0 2, 682		10 072	9.0 10.0 11.0 13.0 14.0
D. 00 C 1. 00 C 3. 00 C 4. 00 C 5. 00 C 6. 00 C 7. 00 C 2. 00 C D. 00 C	D1000 DI ETARY D1100 CAFETERI A D1300 NURSI NG ADMI NI STRATI ON D1400 CENTRAL SERVI CES & SUPPLY D1500 PHARMACY D1600 MEDI CAL RECORDS & LI BRARY D1700 SOCI AL SERVI CE D2200 I & SERVI CES-OTHER PRGM COSTS APPRVD NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 0 0 0 0	4, 752 346 1, 529 1, 021	34, 817 0 2, 682		10 072	10.0 11.0 13.0 14.0
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3.00 C 4.00 C 5.00 C 6.00 C 7.00 C 2.00 C 0.00 C	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 01701 ENT ROUTI NE SERVI CE COST CENTERS		4, 752 346 1, 529 1, 021	34, 817 0 2, 682		10 072	13.0 14.0
4.00 C 5.00 C 5.00 C 5.00 C 7.00 C 2.00 C 0.00 C	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 02200 I & SERVI CES-OTHER PRGM COSTS APPRVD NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 0 0 0 0	346 1, 529 1, 021	0 2, 682		10 072	14.0
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7.00 C 2.00 C 0.00 C	01700 SOCI AL SERVI CE 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD NPATI ENT ROUTI NE SERVI CE COST CENTERS	000			o	19, 972	
2.00 C I D.00 C A	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	111	1, 791	126	0	
D. 00 C	NPATIENT ROUTINE SERVICE COST CENTERS	U	0		0	0	
D. 00 C			0	0	U	0	22.0
A		95, 380	15, 896	27, 882	6, 019	0	30.0
-	NCI LLARY SERVICE COST CENTERS	95, 500	15, 070	27,002	0,019	0	30.0
	05000 OPERATI NG ROOM	0	0	0	0	0	50.0
	05400 RADI OLOGY-DI AGNOSTI C	0	330		120	0	54.0
	06000 LABORATORY	0	573		0	0	60.0
	06500 RESPI RATORY THERAPY	0	1,073		5, 122	0	65.0
	06600 PHYSI CAL THERAPY	0	4, 119		177	0	66.0
	06601 PHYSI CAL THERAPY - CARMEL	0	455		23	0	66.0
	06700 OCCUPATI ONAL THERAPY	0	4, 852	0	247	0	67.0
	06800 SPEECH PATHOLOGY	0	2, 165	0	67	0	68.0
	06801 VI SI ON	0	0	0	0	0	68.0
3. 02 0	06802 FAC RESOURCE	o	3, 358	0	221	0	68.0
	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	9, 933	0	71.0
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.0
3.00 0	7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	19, 972	73.0
4.00 0	07400 RENAL DIALYSIS	0	0	0	0	0	74.0
С	DUTPATIENT SERVICE COST CENTERS						
D. OO 🛛 🖸	09000 CLINIC	0	603	0	676	0	90.0
D. 01 0	09001 SLEEP CENTER	0	0	0	0	0	90.0
	09100 EMERGENCY	0	0	0	0	0	91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.0
	THER REIMBURSABLE COST CENTERS						
	09900 CMHC	0	0		0	0	
	09910 CORF	0	0	0	0	0	99.1
	PECIAL PURPOSE COST CENTERS	05 000	14 6 12	04.017	00.015	40.072	110 .
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	95, 380	41, 849	34, 817	23, 215	19, 972	118.0
	IONREI MBURSABLE COST CENTERS		0	0			190. 0
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9200 PHYSI CLANS' PRI VATE OFFI CES	0	2, 029	-	0 1, 884		190. (192. (
	07950 FOUNDATION	0	2, 029 460		1, 884		192. (194. (
	07951 PUBLIC RELATIONS	0	400		5		194. (194. (
	07951 PUBLIC RELATIONS 07952 ST. VINCENT - ARU	0	404		5		194. (194. (
	07952 ST. VINCENT - ARU 07953 MUNCLE - ARU	0	0	0	0		194. (194. (
	07953 MUNCIE - ARU 07954 RILEY - ARU	0	0	0	2		194. (194. (
	07955 RETAIL PHARMACY	0	0	0	3 0		194. (
0.00	Cross Foot Adjustments	0	0	0	0		200. 0
0.00	Negative Cost Centers	_	^	_	~		200.0
02.00	TOTAL (sum lines 118 through 201)	95, 380	44, 742	34, 817	25, 285		

Health Fina	inci al	Syste	ems	
ALLOCATI ON	OF CA	PI TAL	RELATED	С

ALLDCATION OF CARITAL RELATED COSTS Provider COX: 15-302	Heal th	Financial Systems REHA	BILITATION HOS	SPITAL OF INDIA	NA	In Lie	eu of Form CMS-	2552-10
Cost Center Description MEDICAL REDICAL NUCLEAR SOCIAL SERVICE SERVICES-OTHER SERVICES OF ALL SERVICES AND ALL SERVICES OF ALL SERVIC						Period: From 01/01/2021	Worksheet B	
Light Cost Center Description BUD COL BECOMES A LUBBOW SOLIAL SINUC FREE PREMICES 10 UTF PREMICES 10							Date/Time Pre	epared: 34 am
UP 10 22 00 24.00 24.00 10 00100 CAP REL COSTS BLG & FIAT 1.00 1.00 1.00 10 00100 CAP REL COSTS BLG & FIAT 1.00 1.00 1.00 10 00100 CAP REL COSTS BLG & FIAT 1.00 1.00 1.00 10 0010 CAP REL COSTS BLG & FIAT 1.00 1.00 1.00 10 0010 CAP REL COSTS CAN FOUNDATION 7.00 7.00 7.00 7.00 10.00 00000 CHARLON STRATURE AND CENERAL 9.00 9.		Cost Center Description	RECORDS &	SOCI AL SERVI CE	RESI DENTS SERVI CES-OTHI	ER Subtotal	Residents Cost	
ENFRAN SERVICE COST CENTERS 1.00 17.00 22.00 24.00 25.00 1.00 00100 (AP REL COSTS BLIGS & FIXT 2.00 1.00								
1.00 00100 CAP REL COSTS-BLG & FIXT			16.00	17.00	22.00	24.00		
2: 00 00200 CAP BEL COSTS -MVBLE COUTP 2. 00 00: 00400 ENLYCEE BALE COSTS -MVBLE COUTP 4. 00 00: 00500 ENLYCEE BALE COSTS -MVBLE COUTP 5. 01 00: 00500 ENLYCEE BALE COSTS -MVBLE COUTP 5. 02 00: 00500 ENLYCE BALE COSTS -MVBLE COUTP 7. 00 00: 00000 ENLER AGE - NUN SERVICE 8. 00 00: 00000 ENLER AGE - NUN SERVICE 8. 00 00: 00000 ENLER AGE - NUN SERVICE 8. 00 00: 00000 ENLER AGE - NUN SERVICE 11. 00 10: 00 10000 EFERATE. SERVICES & SUPPLY 14. 00 10: 00 01300 RUNES NG - ADM IN STRATION 14. 00 11: 00 11000 ETERATE. SERVICE COST S ADPOND 0 13. 00 00: 01500 PLANARCY 35. 666 12. 401 1. 398, 123 0 00: 01500 PLANARCY 0 0 0 0 0 0 00: 000 SOL ALL SERVICE COST CONTERS 35. 666 12. 401 1. 398, 123 0 0 00: 000 OLL ADULTS A PEDIALTORST ADPOND 0 0 0 0 0 0 00: 0000 OLL ADULTS A PEDIALTORST ADPOND <	1 00			1	1			1 00
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b. 01 00071 ADM IN STRATUCE AND CENERAL 5. 01 5. 02 00500 OTERE AG. > NON FOUNDATION 5. 02 7. 00 00700 OPERATION 0F FLANT 5. 00 8. 00 00600 (ANDROY & LINN STRATUCE 7. 00 9. 00 00900 HOUSSEKEEN ING 10. 00 10. 00 01100 (CALFEIRIA A 11. 00 11. 00 01100 (CALFEIRIA A 01. 01 11. 00 0100 (CALFEIRIA A 01. 01 11. 00 0100 (CALFEIRIA A 01. 01 11. 00 0100 (CALFEIRIA A 01. 01 11. 00 00 0 01. 00 11. 00 00								1
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54.00 05400 RADIOLOGY-DIASURSTIC 0 17.047 54.00 66.00 66000 ABORATORY 0 0 10.791 66.00 66.00 06500 RESPIRATORY THERAPY 0 0 45.769 66.00 66.01 06601 PHYSICAL THERAPY 0 0 446.485 66.00 66.01 0601 PHYSICAL THERAPY 0 0 343.911 67.00 66.00 06000 SPEECH PATHOLOGY 0 0 75.041 68.00 68.01 06301 VISION 0 0 0 75.041 68.02 68.02 06900 ELECTROCARDIOLOGY 0 0 0 0 68.02 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 72.00 72.00 72.00 72.00 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 90.01 90.01 90.01 90.0	E0 00					0		50.00
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OTHER REI MBURSABLE COST CENTERS OP900 CMAC O	91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		0	-	
99.10 09910 CORF 0 0 0 0 99.10 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 35,666 12,401 0 2,488,577 0 118.00 NONRET MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192.00 194.00 07950 FOUNDATI ON 0 0 0 192.00 194.01 07951 PUBLI C RELATI ONS 0 0 0 194.00 194.02 07952 ST. VI NCENT - ARU 0 0 0 194.02 194.03 07953 MUNCI E - ARU 0 0 0 194.03 194.04 07954 RI LEY - ARU 0 0 0 194.04 194.05 07955 RETAI L PHARMACY 0 0 194.05 0	72.00				1		0	72.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 35,666 12,401 0 2,488,577 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.00 194.00 07950 FOUNDATI ON 0 0 0 0 192.00 194.01 07951 PUBLI C RELATI ONS 0 0 0 0 194.01 194.02 07952 ST. VI NCENT - ARU 0 0 0 0 194.01 194.02 07953 MUNCI E - ARU 0 0 0 0 194.02 194.03 07953 MUNCI E - ARU 0 0 0 0 194.02 194.04 07954 RI L PHARMACY 0 0 0 0 194.03 0 194.04<			C	0 0		0	0	99.00
I18.00 SUBTOTALS (SUM OF LINES 1 through 117) 35,666 12,401 0 2,488,577 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 197.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 57,90 0 192.00 194.00 07950 FOUNDATI ON 0 0 9,116 0 194.00 194.01 07951 PUBLIC RELATI ONS 0 0 9,116 0 194.00 194.02 07952 ST. VINCENT - ARU 0 0 0 194.01 194.03 07953 MUNCI E - ARU 0 0 0 194.02 194.04 07954 RI LEY - ARU 0 0 0 194.02 194.04 07954 RI LEY - ARU 0 0 0 194.03 194.05 07955 RETAI L PHARMACY 0 0 4,957 194.05 <tr< td=""><td>99.10</td><td></td><td>C</td><td>00</td><td></td><td>0</td><td>0</td><td>99.10</td></tr<>	99.10		C	00		0	0	99.10
NONREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 194.00 07950 FOUNDATI ON 0 0 0 192.00 194.01 07951 PUBLI C RELATI ONS 0 0 9, 116 0 194.01 194.02 07952 ST. VI NCENT - ARU 0 0 0 194.01 194.02 07952 ST. VI NCENT - ARU 0 0 0 194.02 194.03 07953 MUNCI E - ARU 0 0 0 194.02 194.04 07954 RI LEY - ARU 0 0 3 0 194.04 194.05 07955 RETAI L PHARMACY 0 0 4, 957 0 194.05 200.00 Negati ve Cost Centers	110 00		25.444	12 401	1	0 2 400 577	0	110 00
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 57,900 0 192.00 194.00 07950 FOUNDATION 0 0 9,116 0 194.00 194.01 07951 PUBLIC RELATIONS 0 0 9,116 0 194.01 194.02 07952 ST. VINCENT - ARU 0 0 0 194.02 194.03 07953 MUNCIE - ARU 0 0 0 194.02 194.03 07953 RILEY - ARU 0 0 0 194.03 194.04 07954 RILEY - ARU 0 0 0 194.03 194.04 07954 RILEY - ARU 0 0 194.04 194.04 194.05 07957 RETAIL PHARMACY 0 0 4,957 0 194.04 200.00 Cross Foot Adjustments 643 643 0 200.00 0 0 0 0 0 0 0 0 <t< td=""><td>118.00</td><td></td><td>30,000</td><td>12,401</td><td></td><td>0 2,488,577</td><td>0</td><td>1118.00</td></t<>	118.00		30,000	12,401		0 2,488,577	0	1118.00
192.00 PHYSI CI ANS' PRI VATE OFFICES 0 0 57,900 0 192.00 194.00 07950 FOUNDATI ON 0 0 9,116 0 194.00 194.01 07951 PUBLI C RELATI ONS 0 0 5,505 0 194.01 194.02 07952 ST. VI NCENT - ARU 0 0 0 194.02 194.03 07953 MUNCI E - ARU 0 0 0 194.02 194.04 07954 RI LEY - ARU 0 0 194.03 194.03 194.05 07955 RETAI L PHARMACY 0 0 4,957 0 194.04 194.05 07955 RETAI L PHARMACY 0 0 4,957 0 194.04 200.00 Cross Foot Adjustments 643 643 0 200.00 201.00 0 0 0 0 201.00	190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0 0		0	0	190.00
194.01 07951 PUBLIC RELATIONS 0 0 5,505 0 194.01 194.02 07952 ST. VINCENT - ARU 0 0 0 0 194.02 194.03 07953 MUNCI E - ARU 0 0 0 0 194.03 194.04 07954 RI LEY - ARU 0 0 3 0 194.04 194.05 07955 RETAI L PHARMACY 0 0 4,957 0 194.05 200.00 Cross Foot Adjustments 643 643 0 200.00 0 <td>192.00</td> <td>19200 PHYSICIANS' PRIVATE OFFICES</td> <td>C</td> <td>0</td> <td></td> <td>57, 900</td> <td></td> <td></td>	192.00	19200 PHYSICIANS' PRIVATE OFFICES	C	0		57, 900		
194.02 07952 ST. VINCENT - ARU 0 0 0 194.02 194.03 07953 MUNCIE - ARU 0 0 0 194.03 194.04 07954 RI LEY - ARU 0 0 3 0 194.04 194.05 07955 RETAIL PHARMACY 0 0 4,957 0 194.05 200.00 Cross Foot Adjustments 643 643 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00			C	0				
194.03 07953 MUNCIE - ARU 0 0 194.03 194.04 07954 RI LEY - ARU 0 0 3 0 194.04 194.05 07955 RETAI L PHARMACY 0 0 4,957 0 194.05 200.00 Cross Foot Adjustments 643 643 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			C	0		5, 505		1
194.04 07954 RI LEY - ARU 0 0 3 0 194.04 194.05 07955 RETAI L PHARMACY 0 0 4,957 0 194.05 200.00 Cross Foot Adjustments 643 643 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00						0		1
194.05 07955 RETAIL PHARMACY 0 0 4,957 0 194.05 200.00 Cross Foot Adjustments 643 643 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00						2		
200.00 Cross Foot Adjustments 643 643 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00						4, 957		
201.00 Negative Cost Centers 0 </td <td></td> <td></td> <td></td> <td></td> <td>6</td> <td></td> <td>0</td> <td>200.00</td>					6		0	200.00
202.00 T0TAL (sum lines 118 through 201) 35,666 12,401 643 2,566,701 0 202.00		Negative Cost Centers	C	0		0		
	202.00	IOTAL (sum lines 118 through 201)	35, 666	12, 401	64	43 2, 566, 701	0	202.00

ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider CCN: 15-3028	Peri od: From 01/01/2021 To 12/31/2021	Date/Time Pre	epared:
	Cost Center Description	Total			5/27/2022 7:3	34 am
	Cost center bescription	<u>Total</u> 26.00				
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00591 ADMINISTRATIVE AND GENERAL					5.01
5.02	00590 OTHER A&G - NON FOUNDATION					5.02
7.00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15.00	01500 PHARMACY					15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY					16.00
17.00	01700 SOCI AL SERVI CE					17.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD					22.00
	INPATIENT ROUTINE SERVICE COST CENTERS					4
30.00	03000 ADULTS & PEDIATRICS	1, 398, 123				30.00
	ANCI LLARY SERVICE COST CENTERS	-				
50.00	05000 OPERATING ROOM	0				50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	17,047				54.00
60.00	06000 LABORATORY	10, 791				60.00
65.00	06500 RESPI RATORY THERAPY	45, 769				65.00
66.00	06600 PHYSI CAL THERAPY	446, 485				66.00
66.01	06601 PHYSI CAL THERAPY - CARMEL	2, 631				66.01
67.00	06700 OCCUPATI ONAL THERAPY	343, 911				67.00
68.00	06800 SPEECH PATHOLOGY	75, 041				68.00
68.01		0				68.01
	06802 FAC RESOURCE	21, 982				68.02
69.00	06900 ELECTROCARDI OLOGY	10 520				69.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	10, 529				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	25 090				72.00
73.00	07300 DRUGS CHARGED TO PATTENTS	25, 989 0				74.00
74.00	OUTPATIENT SERVICE COST CENTERS	0				- 74.00
00 00	09000 CLINIC	90, 279				90.00
90.00 90.01	09001 SLEEP CENTER	90, 279 0				90.00
91.00	09100 EMERGENCY	0				91.00
92.00		0				92.00
72.00	OTHER REIMBURSABLE COST CENTERS					- 72.00
99 00	09900 CMHC	0				99.00
99, 10		Ö				99.10
	SPECIAL PURPOSE COST CENTERS	-1				-
118.00		2, 488, 577				118.00
	NONREI MBURSABLE COST CENTERS	_//				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	57,900				192.00
	07950 FOUNDATI ON	9, 116				194.00
194.01	07951 PUBLIC RELATIONS	5, 505				194.01
	07952 ST. VINCENT - ARU	0				194.02
	3 07953 MUNCI E - ARU	Ö				194.03
	07954 RI LEY - ARU	3				194.04
	07955 RETAIL PHARMACY	4, 957				194.05
200.00		643				200.00
201.00		0				201.00
202.00		2, 566, 701				202.00
		1				

REHABILITATION HOSPITAL OF INDIANA Provider CCN: 15-3028

 In Lieu of Form CMS-2552-10

 28
 Period: From 01/01/2021 To 12/31/2021
 Worksheet B-1

 Date/Time Prepared: 5/27/2022 7:34 am

					To 12/31/2021	Date/Time Pre	
		CAPI TAL REI	LATED COSTS			5/27/2022 7:3	
	Cast Conton Description				Decenciliation		
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFI TS	Reconciliation	ADMI NI STRATI VE AND GENERAL	
			,	DEPARTMENT		(ACCUM. COST)	
				(GROSS			
		1.00	2.00	SALARI ES) 4. 00	5A. 01	5. 01	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	92,060	92, 060				1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 558			3		4.00
5.01	00591 ADMINISTRATIVE AND GENERAL	2, 814				41, 802, 560	
	00590 OTHER A&G - NON FOUNDATION	1,933				1, 368, 079	
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 193	1, 193 0			1, 838, 038 116, 051	
9.00	00900 HOUSEKEEPI NG	778				603, 184	1
	01000 DI ETARY	3, 226				842, 447	
	01100 CAFETERIA 01300 NURSI NG ADMINI STRATI ON	1, 532 634	1, 532 634			239, 799 2, 531, 944	
	01400 CENTRAL SERVICES & SUPPLY	793	793			608, 303	
		392	392			869, 441	
	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	1, 046 278				642, 217 803, 069	
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0					1
-	INPATIENT ROUTINE SERVICE COST CENTERS	10.0(0		7 004 00		40,400,000	
	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	40, 069	40, 069	7, 881, 824	4 0	12, 428, 028	30.00
	05000 OPERATI NG ROOM	0	0	(0 0	0	50.00
	05400 RADI OLOGY-DI AGNOSTI C	525				216, 333	
	06000 LABORATORY 06500 RESPI RATORY THERAPY	301 1, 194	301 1, 194	(514, 098	-	462, 673 749, 752	
	06600 PHYSI CAL THERAPY	14, 915					
	06601 PHYSI CAL THERAPY - CARMEL	0	0			479, 804	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	11, 329 2, 276				3, 118, 453 1, 630, 050	
	06801 VI SI ON	0	0			0	
	06802 FAC RESOURCE	348	348	1, 213, 559	9 0	1, 827, 094	
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0			0 172, 839	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	1
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0		
	07400 RENAL DIALYSIS DUTPATIENT SERVICE COST CENTERS	0	0	(0 0	0	74.00
	09000 CLINIC	3, 048	3, 048	205, 563	3 0	385, 273	90.00
	09001 SLEEP CENTER	0	0		0 0		
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(0 0	0	91.00 92.00
-	OTHER REIMBURSABLE COST CENTERS						92.00
	09900 CMHC	0	0	(0 0	0	99.00
	09910 CORF SPECIAL PURPOSE COST CENTERS	0	0	(0 0	0	99.10
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	90, 182	90, 182	23, 129, 508	-9, 613, 619	37, 183, 386	118.00
	VONREI MBURSABLE COST CENTERS	-	-	-	-	-	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 1,609	0 1, 609) 967, 134			190.00
	07950 FOUNDATION	1,007					
	07951 PUBLIC RELATIONS	109				495, 475	
	07952 ST. VINCENT – ARU 07953 MUNCIE – ARU	0	0				194.02 194.03
	07954 RILEY - ARU	0	0				194.03
194.05	07955 RETAIL PHARMACY	0	0	232, 570	o o	1, 318, 633	
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200.00 201.00
201.00	Cost to be allocated (per Wkst. B,	1, 339, 641	1, 227, 060	6, 592, 368	3	9, 613, 619	
	Part I)						
203.00 204.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	14. 551825	13. 328916			0. 229977	
204.00	Part II)			43, 438		04, 152	204.00
205.00	Unit cost multiplier (Wkst. B, Part			0. 00175	7	0. 002013	205.00
206.00	II) NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Heal th	Fi nanci al	Systems	
COCT AL			

			ABILITATION HOS				u of Form CMS-	
COST A	LLOCA	TION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2021	Worksheet B-1	
					T	b 12/31/2021	Date/Time Pre 5/27/2022 7:3	
		Cost Center Description	Reconciliation	NON FOUNDATION	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	
			5A. 02	(ACCUM. COST) 5.02	7.00	LAUNDRY) 8.00	9.00	
	GENER	AL SERVICE COST CENTERS	5A. 02	5.02	7.00	0.00	7.00	
1.00		CAP REL COSTS-BLDG & FIXT						1.0
2.00		CAP REL COSTS-MVBLE EQUIP						2.0
4.00		EMPLOYEE BENEFITS DEPARTMENT						4.0
5.01		ADMINISTRATIVE AND GENERAL						5. C
5.02		OTHER A&G - NON FOUNDATION	-1, 682, 706					5.0
7.00	-	OPERATION OF PLANT	0	2, 260, 744		100 007		7.0
3.00 9.00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	142, 740 741, 902	0 778	188, 237	83, 784	8. 0 9. 0
10.00		DI ETARY	0	1, 036, 190		0	3, 226	
11.00		CAFETERIA	0	294, 947		0	1, 532	
13.00	1	NURSING ADMINISTRATION	0	3, 114, 233		0	634	1
14.00	01400	CENTRAL SERVICES & SUPPLY	0	748, 199	793	0	793	14.0
		PHARMACY	0	1, 069, 392	392	0	392	15. C
		MEDICAL RECORDS & LIBRARY	0	789, 912	1, 046	0	1, 046	
		SOCIAL SERVICE	0	987, 756		0	278	
22.00		I &R SERVICES-OTHER PRGM COSTS APPRVD	0	229, 252	0	0	0	22.0
30. 00		I ENT ROUTI NE SERVI CE COST CENTERS ADULTS & PEDI ATRI CS	0	15, 286, 182	40, 069	184, 989	40, 069	30. 0
50.00		LARY SERVICE COST CENTERS	0	13, 200, 102	40,007	104, 707	40,007	30.0
50.00		OPERATING ROOM	0	0	0	0	0	50.0
54.00	05400	RADI OLOGY-DI AGNOSTI C	0	266, 085	525	0	525	54. C
60.00	06000	LABORATORY	0	569, 077	301	0	301	
55.00		RESPI RATORY THERAPY	0	922, 178		0	1, 194	
6. 00		PHYSI CAL THERAPY	0	4, 083, 246		180	14, 915	
56.01		PHYSICAL THERAPY - CARMEL	0	590, 148		2, 717	0	
67.00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	3, 835, 625		214 137	11, 329	
68.00 68.01		VISION	0	2,004,924	2, 276	137	2, 276	1
68.02		FAC RESOURCE	0	2, 247, 284		0	348	
		ELECTROCARDI OLOGY	0	0	0.0	0	0.0	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	212, 588	0	0	0	71.0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.0
73.00		DRUGS CHARGED TO PATIENTS	0	2, 145, 515		0	0	
74.00		RENAL DIALYSIS	0	0	0	0	0	74.0
90.00		TIENT SERVICE COST CENTERS	0	473, 877	3, 048	0	3, 048	
		SLEEP CENTER	0	473,877	3,048	0	3, 048	1
		EMERGENCY	0	-	0	0	0	1
92.00		OBSERVATION BEDS (NON-DISTINCT PART)				-	-	92.0
	OTHER	REIMBURSABLE COST CENTERS						
	09900		0	0		0		99. C
99. 10			0	0	0	0	0	99.1
110 00		AL PURPOSE COST CENTERS	1 (02 70(44.051.004	02 (04	100 007	01 00/	1110 0
118.00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	-1, 682, 706	44, 051, 996	82, 684	188, 237	81, 906	1118.0
190 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 0
		PHYSICIANS' PRIVATE OFFICES	0	-	-	0		192.0
194.00	07950	FOUNDATION	0	1, 240, 060		0		194. C
194.01	07951	PUBLIC RELATIONS	0	609, 423		0	109	194. C
		ST. VINCENT - ARU	0	0	0	0		194.0
		MUNCIE - ARU	0	0	0	0		194.0
		RILEY - ARU	0	0	0	0		194.0
		RETAIL PHARMACY	0	1, 621, 888	0	0	0	194.0
200.00 201.00		Cross Foot Adjustments Negative Cost Centers						200. C
202.00	1	Cost to be allocated (per Wkst. B, Part I)		1, 682, 706	2, 337, 234	147, 569	788, 507	
203.00 204.00		Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,		0. 033834 58, 073		0. 783953 401	9. 411188 24, 716	
205.00	l	Part II) Unit cost multiplier (Wkst. B, Part		0. 001168	0. 469052	0. 002130	0. 294997	205. (
206. 00	l	II) NAHE adjustment amount to be allocated						206. (
207.00		(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.0
		Parts III and IV)						

	LOCATION - STATISTICAL BASIS		Provider C		eriod:	Worksheet B-1	
				F T	rom 01/01/2021 o 12/31/2021	Date/Time Pre	
	Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS PAI D)	NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	5/27/2022 7: 3 PHARMACY (COSTED REQUI S.)	4 am
		10.00	11.00	13.00	14.00	15.00	
	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT			1	I		1 1.
00 00 00 01 01 01 02 01 02 01 00 01 00 01 00 01 00 01 00 01 00 01 00 01 00 01 00 01 00 01 00 01 00 01 00 02 00 03 00 03	0200 CAP REL COSTS-MVBLE EQUI P 0400 EMPLOYEE BENEFITS DEPARTMENT 0591 ADMI NI STRATI VE AND GENERAL 0590 OTHER A&G - NON FOUNDATI ON 0700 OPERATI ON OF PLANT 0800 LAUNDRY & LI NEN SERVI CE 0900 HOUSEKEEPI NG 1000 DI ETARY 1100 CAFETERI A 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 2200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	59, 391 0 0 0 0 0 0 0 0	585, 565 62, 192 4, 534 20, 009 13, 360 10, 163 0	259, 785 0 20, 009 13, 360 0	439, 966 8, 430 0 2, 201 0	100 0 0 0	2. 4. 5. 7. 8. 9. 10. 11. 13. 14.
	NPATI ENT ROUTI NE SERVI CE COST CENTERS 3000 ADULTS & PEDI ATRI CS	59, 391	208, 048	208, 048	104, 726	0	30.
	NCI LLARY SERVICE COST CENTERS	37, 371	200, 040	200, 040	104,720	0	30.
	5000 OPERATING ROOM	0	0		0	0	50.
	5400 RADI OLOGY-DI AGNOSTI C 6000 LABORATORY	0	4, 321 7, 497		2, 096	0	54. 60.
	6500 RESPI RATORY THERAPY	0	14, 047		89, 123	0	65
	6600 PHYSI CAL THERAPY	0	53, 903		3, 076	0	66
	6601 PHYSI CAL THERAPY - CARMEL	0	5, 949		392	0	66
	6700 OCCUPATI ONAL THERAPY 6800 SPEECH PATHOLOGY	0	63, 504		4, 294	0	67
	6800 SPEECH PATHOLOGY 6801 VI SI ON	0	28, 329		1, 169 0	0	68
	6802 FAC RESOURCE	0	43, 947	, °	3, 841	0	68
	6900 ELECTROCARDI OLOGY	0	C	0	0	0	69
	7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	172, 839	0	71
	7200 IMPL. DEV. CHARGED TO PATIENTS 7300 DRUGS CHARGED TO PATIENTS	0		0	0	0 100	72
	7400 RENAL DIALYSIS	0	0		0	0	
	UTPATIENT SERVICE COST CENTERS			<u> </u>			
	9000 CLI NI C	0	7, 893	0	11, 756	0	90
	9001 SLEEP CENTER	0	0	-	0	0	90
		0	C	0	0	0	91
	9200 OBSERVATION BEDS (NON-DISTINCT PART) THER REIMBURSABLE COST CENTERS						92
	9900 CMHC	0	C	0	0	0	99
	9910 CORF	0	0		0	0	
SI	PECIAL PURPOSE COST CENTERS						
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	59, 391	547, 696	259, 785	403, 943	100	118
	ONREIMBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0	0	0	190
	9200 PHYSICIANS' PRIVATE OFFICES	0	26, 561		32, 776		192
	7950 FOUNDATION	0	6, 022		3, 104		194
	7951 PUBLIC RELATIONS	0	5, 286	0	90		194
	7952 ST. VINCENT - ARU	0	0	0	0		194
	7953 MUNCIE – ARU 7954 RILEY – ARU	0	0	0	0 53		194 194
	7955 RETAIL PHARMACY		0	0	0		194
. 00	Cross Foot Adjustments				Ű	Ū	200
. 00	Negative Cost Centers						201
. 00	Cost to be allocated (per Wkst. B, Part I)	1, 190, 772				1, 400, 641	
. 00 . 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	20. 049705 95, 380	0. 617672 44, 742		1. 831269 25, 285	14, 006. 410000 19, 972	
5. 00	Unit cost multiplier (Wkst. B, Part II)	1. 605967	0. 076408	0. 134022	0. 057470	199. 720000	205
		1					206
b. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						

T ALLOCAT	cial Systems REH TION - STATISTICAL BASIS		Provider CC	N: 15-3028	Period: From 01/01/2021	u of Form CMS-255 Worksheet B-1
					To 12/31/2021	Date/Time Prepar
				INTERNS &		5/27/2022 7:34 a
	Cost Center Description	MEDI CAL	SOCI AL SERVI CE	RESIDENTS	D	
	cost center bescription	RECORDS &	SUCIAL SERVICE	PRGM COSTS	R .	
		LI BRARY	(TOTAL PATIENT	(ASSI GNED		
		(TOTAL PATIENT	DAYS)	TIME)		
		DAYS) 16.00	17.00	22.00	-	
GENERA	AL SERVICE COST CENTERS	10.00	17:00	22.00		
	CAP REL COSTS-BLDG & FIXT					1
1 1	CAP REL COSTS-MVBLE EQUIP					2
	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE AND GENERAL					2
	OTHER A&G - NON FOUNDATION					Ę
	OPERATION OF PLANT					
00800	LAUNDRY & LINEN SERVICE					8
	HOUSEKEEPING					ç
	DIETARY					10
	CAFETERIA NURSING ADMINISTRATION					11
	CENTRAL SERVICES & SUPPLY					14
	PHARMACY					15
	MEDICAL RECORDS & LIBRARY	19, 797	1			16
	SOCIAL SERVICE	C				17
	I &R SERVICES-OTHER PRGM COSTS APPRVD ENT ROUTINE SERVICE COST CENTERS	C	0	10	0	22
	ADULTS & PEDIATRICS	19, 797	19, 797	10	0	30
	LARY SERVICE COST CENTERS			10	<u> </u>	
	OPERATING ROOM	C	0	(0	50
	RADI OLOGY-DI AGNOSTI C	C	0		0	54
		C	0		0	60
	RESPI RATORY THERAPY PHYSI CAL THERAPY					65
	PHYSICAL THERAPY - CARMEL		0		0	66
	OCCUPATIONAL THERAPY	C	0	(0	67
00 06800	SPEECH PATHOLOGY	C	0	(0	68
	VISION	C	0	(0	68
	FAC RESOURCE ELECTROCARDI OLOGY		0	(0	68
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0	71
	IMPL. DEV. CHARGED TO PATIENTS		0	(0	72
1 1	DRUGS CHARGED TO PATIENTS	C	0	(0	73
	RENAL DIALYSIS	C	0	(0	74
	TI ENT SERVICE COST CENTERS CLINIC	C	0		0	90
	SLEEP CENTER				0	90
	EMERGENCY				0	91
	OBSERVATION BEDS (NON-DISTINCT PART)					92
	REIMBURSABLE COST CENTERS	T	1 1		I	
00 09900 10 09910					0	99
	AL PURPOSE COST CENTERS		<u>ı</u> 0		0	99
	SUBTOTALS (SUM OF LINES 1 through 117)	19, 797	19, 797	10	0	118
	MBURSABLE COST CENTERS			-		
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0		0	190
	PHYSICIANS' PRIVATE OFFICES	C	0		0	192
	FOUNDATION PUBLIC RELATIONS		0		0	194 194
	ST. VINCENT - ARU				0	192
	MUNCIE - ARU		0	(0	194
. 04 07954	RILEY - ARU	C	0	(0	194
1 1	RETAIL PHARMACY	C	0	(0	194
1 1	Cross Foot Adjustments					200
1 1	Negative Cost Centers Cost to be allocated (per Wkst. B,	1,032,403	1, 041, 784	237, 00	0	201 202
	Part I)	1, 032, 403	1, 041, 784	237,00	7	202
	Unit cost multiplier (Wkst. B, Part I)	52. 149467	52. 623327	2, 370. 09000	0	203
	Cost to be allocated (per Wkst. B,	35, 666		64		204
1 1	Part II)					
	Unit cost multiplier (Wkst. B, Part	1. 801586	0. 626408	6. 43000	D	205
	II) NAHE adjustment amount to be allocated					206
	(per Wkst. B-2)					200
. 00	NAHE unit cost multiplier (Wkst. D,					207
	Parts III and IV)					

				From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/27/2022 7:3	
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	23, 646, 223		23, 646, 22	3 0	23, 646, 223	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	355, 628		355, 62		355, 628	
60. 00 06000 LABORATORY	604, 114		604, 11		604, 114	
65. 00 06500 RESPI RATORY THERAPY	1, 346, 937	0	1, 346, 93		1, 346, 937	
66. 00 06600 PHYSI CAL THERAPY	4, 813, 075	0	4, 813, 07		4, 813, 075	•
66. 01 06601 PHYSI CAL THERAPY - CARMEL	616, 638	0	616, 63		616, 638	•
67.00 06700 OCCUPATI ONAL THERAPY	4, 432, 401	0	4, 432, 40		4, 432, 401	•
68.00 06800 SPEECH PATHOLOGY	2, 176, 832	0	2, 176, 83	2 0	2, 176, 832	•
68. 01 06801 VI SI ON	0	0		0 0	0	
68. 02 06802 FAC RESOURCE	2, 370, 391	0	2, 370, 39	1 0	2, 370, 391	
69.00 06900 ELECTROCARDI OLOGY	0			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	536, 296		536, 29	6 0	536, 296	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0			0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 618, 747		3, 618, 74	7 0	3, 618, 747	
74.00 07400 RENAL DI ALYSI S	0			0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	629, 243		629, 24	3 0	629, 243	
90. 01 09001 SLEEP CENTER	0			0 0	0	
91.00 09100 EMERGENCY	0			0 0	0	1 / 11 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REI MBURSABLE COST CENTERS						
99. 00 09900 CMHC	0			0	0	1 // 00
99. 10 09910 CORF		0	45 144 50		0	
200.00 Subtotal (see instructions)	45, 146, 525	0	45, 146, 52	5 0	45, 146, 525	
201.00 Less Observation Beds		~	AE 144 50			201.00
202.00 Total (see instructions)	45, 146, 525	0	45, 146, 52	5 U	45, 146, 525	1202.00

COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/27/2022 7:3	
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpatient	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Rati o	
		6.00	7.00	8.00	9.00	10.00	
	ENT ROUTINE SERVICE COST CENTERS				-		
	ADULTS & PEDIATRICS	43, 245, 543		43, 245, 54	3		30.00
	ARY SERVICE COST CENTERS				-		
	OPERATING ROOM	0	0		0 0. 000000	0.00000	
	RADI OLOGY-DI AGNOSTI C	2, 319, 540	0	2, 319, 54		0.00000	
	LABORATORY	1, 782, 927	0	1, 782, 92		0. 000000	
	RESPI RATORY THERAPY	2, 979, 209	0	2, 979, 20		0.00000	
66.00 06600	PHYSI CAL THERAPY	12, 414, 161	5, 984, 795	18, 398, 95	6 0. 261595	0.000000	66.00
66.01 06601	PHYSICAL THERAPY - CARMEL	0	1, 671, 255	1, 671, 25	5 0. 368967	0.000000	66. 01
67.00 06700	OCCUPATI ONAL THERAPY	14, 115, 263	3, 648, 438	17, 763, 70	1 0. 249520	0.00000	67.00
68.00 06800	SPEECH PATHOLOGY	8, 952, 490	2, 122, 080	11, 074, 57	0 0. 196561	0.000000	68.00
68.01 06801	VISION	0	0		0.000000	0.00000	68.01
68.02 06802	FAC RESOURCE	0	746, 275	746, 27	5 3. 176297	0.00000	68.02
69.00 06900	ELECTROCARDI OLOGY	0	0		0.000000	0.000000	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 216, 424	69, 927	2, 286, 35	0. 234564	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	8, 399, 614	4, 786, 981	13, 186, 59	5 0. 274426	0. 000000	73.00
74.00 07400	RENAL DIALYSIS	0	0		0.000000	0. 000000	74.00
OUTPAT	TIENT SERVICE COST CENTERS						1
90.00 09000	CLINIC	73	2, 059, 359	2, 059, 43	2 0. 305542	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 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0.000000	0. 000000	92.00
OTHER	REIMBURSABLE COST CENTERS						1
99.00 09900		0	0		0		99.00
99.10 09910		0	0		0		99.10
200.00	Subtotal (see instructions)	96, 425, 244	21, 089, 110	117, 514, 35	4		200.00
	Less Observation Beds						201.00
	Total (see instructions)	96, 425, 244	21, 089, 110	117, 514, 35	4		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3028	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/27/2022 7:3	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
ANCI LLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 153318				54.00
60. 00 06000 LABORATORY	0. 338833				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 452112				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 261595				66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0. 368967				66.01
67.00 06700 OCCUPATI ONAL THERAPY	0. 249520				67.00
68.00 06800 SPEECH PATHOLOGY	0. 196561				68.00
68. 01 06801 VI SI ON	0. 000000				68.01
68. 02 06802 FAC RESOURCE	3. 176297				68.02
69.00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 234564				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 274426				73.00
74.00 07400 RENAL DIALYSIS	0. 000000				74.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 305542				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
	1				

				From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/27/2022 7:3	epared: 4 am
		Titl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost 1 (from Wkst. B, Part I, col. 26)	Гherapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	23, 646, 223		23, 646, 22	3 0	23, 646, 223	30.00
ANCI LLARY SERVI CE COST CENTERS			1	1		
50.00 05000 OPERATING ROOM	0			0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	355, 628		355, 62		355, 628	
60. 00 06000 LABORATORY	604, 114		604, 11		604, 114	
65. 00 06500 RESPI RATORY THERAPY	1, 346, 937	0	1, 346, 93		1, 346, 937	
66. 00 06600 PHYSI CAL THERAPY	4, 813, 075	0	4, 813, 07	5 0	4, 813, 075	•
66. 01 06601 PHYSI CAL THERAPY - CARMEL	616, 638	0	616, 63		616, 638	•
67.00 06700 OCCUPATI ONAL THERAPY	4, 432, 401	0	4, 432, 40	1 0	4, 432, 401	
68.00 06800 SPEECH PATHOLOGY	2, 176, 832	0	2, 176, 83	2 0	2, 176, 832	
68. 01 06801 VI SI ON	0	0		0 0	0	
68. 02 06802 FAC RESOURCE	2, 370, 391	0	2, 370, 39	1 0	2, 370, 391	
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	536, 296		536, 29	6 0	536, 296	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 618, 747		3, 618, 74	7 0	3, 618, 747	
74. 00 07400 RENAL DIALYSIS	0			0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS				-		
90. 00 09000 CLINIC	629, 243		629, 24	3 0	629, 243	
90. 01 09001 SLEEP CENTER	0			0 0	0	
91.00 09100 EMERGENCY	0			0 0	0	1 / 11 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS			1	-1	-	
99. 00 09900 CMHC	0			0	0	1 // 00
99. 10 09910 CORF	0	_		0	0	1 / / / / 0
200.00 Subtotal (see instructions)	45, 146, 525	0	45, 146, 52	5 0	45, 146, 525	
201.00 Less Observation Beds	0	_		0		201.00
202.00 Total (see instructions)	45, 146, 525	0	45, 146, 52	5 0	45, 146, 525	202.00

Health Financial Systems REF	HABILITATION HOS	PITAL OF INDIA	NA	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period:	Worksheet C	
				rom 01/01/2021	Part I	
				To 12/31/2021	Date/Time Pre 5/27/2022 7:3	
		Ti +1	e XIX	Hospi tal	PPS	4 dill
		Charges			PP3	
Cost Center Description	I npati ent	Outpatient	Total (col 6	Cost or Other	TEFRA	
Cost center bescription	inpatrent	outpatrent	+ col. 7)	Ratio	Inpatient	
			+ COL. 7)	Ratio	Ratio	
	6,00	7.00	8.00	9,00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
30. 00 03000 ADULTS & PEDI ATRI CS	43, 245, 543		43, 245, 543	3		30.00
ANCI LLARY SERVICE COST CENTERS				-		1
50. 00 05000 OPERATING ROOM	0	0	(0, 000000	0,00000	1 50. oc
54. 00 05400 RADI OLOGY - DI AGNOSTI C	2, 319, 540	0	2, 319, 540		0. 000000	
60. 00 06000 LABORATORY	1, 782, 927	0	1, 782, 927		0. 000000	
65. 00 06500 RESPIRATORY THERAPY	2, 979, 209	0	2, 979, 209		0, 000000	
66. 00 06600 PHYSI CAL THERAPY	12, 414, 161	5, 984, 795			0. 000000	
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	1, 671, 255			0. 000000	
67.00 06700 OCCUPATIONAL THERAPY	14, 115, 263	3, 648, 438			0,000000	
68.00 06800 SPEECH PATHOLOGY	8, 952, 490	2, 122, 080			0.000000	68.00
68. 01 06801 VI SI ON	0	0	(0. 000000	0.000000	68.01
68. 02 06802 FAC RESOURCE	0	746, 275	746, 275	3. 176297	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, 216, 424	69, 927	2, 286, 351	0. 234564	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	8, 399, 614	4, 786, 981	13, 186, 595	0. 274426	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	(0. 000000	0. 000000	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	73	2, 059, 359	2, 059, 432	0. 305542	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 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(0. 000000	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
99. 00 09900 CMHC	0	0	()		99.00
99. 10 09910 CORF	0	0	()		99.10
200.00 Subtotal (see instructions)	96, 425, 244	21, 089, 110	117, 514, 354	1		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	96, 425, 244	21, 089, 110	117, 514, 354	1		202.00

In Lieu of Form CMS-2552-10 Worksheet C

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN. 15-3026	From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/27/2022 7:3	
		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
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATI NG ROOM	0. 000000				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 153318				54.00
60. 00 06000 LABORATORY	0. 338833				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 452112				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 261595				66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0. 368967				66. 01
67.00 06700 OCCUPATI ONAL THERAPY	0. 249520				67.00
68.00 06800 SPEECH PATHOLOGY	0. 196561				68.00
68. 01 06801 VI SI ON	0. 000000				68.01
68. 02 06802 FAC RESOURCE	3. 176297				68.02
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 234564				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 274426				73.00
74.00 07400 RENAL DIALYSIS	0. 000000				74.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 305542				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 REF	HABILITATION HOS	PITAL OF INDIA	NA	In Lie	eu of Form CMS-2	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R	ATIOS NET OF	Provider C		Peri od:	Worksheet C	
REDUCTIONS FOR MEDICAID ONLY				From 01/01/2021		norod.
				To 12/31/2021	5/27/2022 7:3	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating Cos		Operating Cost	
	(Wkst. B, Part	(Wkst. B, Part	Net of Capita	I Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		1	1			
50.00 05000 OPERATI NG ROOM	0	C	D	0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	355, 628				0	54.00
60. 00 06000 LABORATORY	604, 114				0	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 346, 937				0	65.00
66. 00 06600 PHYSI CAL THERAPY	4, 813, 075				0	66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	616, 638				0	66. 01
67.00 06700 OCCUPATI ONAL THERAPY	4, 432, 401				0	67.00
68.00 06800 SPEECH PATHOLOGY	2, 176, 832	75, 041	2, 101, 79	1 0	0	68.00
68. 01 06801 VI SI ON	0	(C		0 0	0	68. 01
68. 02 06802 FAC RESOURCE	2, 370, 391	21, 982	2, 348, 40	9 0	0	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	536, 296	10, 529	525, 76	7 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 618, 747	25, 989	3, 592, 75	8 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	(0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	629, 243	90, 279	538, 96	4 0	0	90.00
90. 01 09001 SLEEP CENTER	0	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0)	0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS			1			
99.00 09900 CMHC	0	C		0 0	0	99.00
99. 10 09910 CORF	0	(C		0 0	0	
200.00 Subtotal (sum of lines 50 thru 199)	21, 500, 302	1, 090, 454	20, 409, 84	8 0		200. 00
201.00 Less Observation Beds	0	(C		0 0		201.00
202.00 Total (line 200 minus line 201)	21, 500, 302	1, 090, 454	20, 409, 84	8 0	0	202.00

Health Financial Systems REH.	ABILITATION HOSP	ITAL OF INDIA	NA	In Lie	u of Form CMS	-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY	TIOS NET OF	Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part II Date/Time Pr 5/27/2022 7:	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description		otal Charges				
		Worksheet C,				
	Operating Cost Pa			6		
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCI LLARY SERVI CE COST CENTERS			1			_
50. 00 05000 OPERATI NG ROOM	0	0	010000			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	355, 628	2, 319, 540				54.00
60. 00 06000 LABORATORY	604, 114	1, 782, 927				60.00
65. 00 06500 RESPI RATORY THERAPY	1, 346, 937	2, 979, 209				65.00
66. 00 06600 PHYSI CAL THERAPY	4, 813, 075	18, 398, 956				66.00
66.01 06601 PHYSI CAL THERAPY - CARMEL	616, 638	1, 671, 255				66. 01
67.00 06700 OCCUPATI ONAL THERAPY	4, 432, 401	17, 763, 701				67.00
68.00 06800 SPEECH PATHOLOGY	2, 176, 832	11, 074, 570	0. 19650	51		68.00
68. 01 06801 VI SI ON	0	0	0.0000	00		68.01
68. 02 06802 FAC RESOURCE	2, 370, 391	746, 275	3. 17629	97		68.02
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.0000	00		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	536, 296	2, 286, 351	0. 23456	54		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.0000	00		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 618, 747	13, 186, 595	0. 27442	26		73.00
74.00 07400 RENAL DIALYSIS	0	0	0.0000	00		74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	629, 243	2,059,432	0. 30554	12		90.00
90.01 09001 SLEEP CENTER	0	0	0.0000	00		90.01
91.00 09100 EMERGENCY	0	0	0.0000	00		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.0000	00		92.00
OTHER REIMBURSABLE COST CENTERS						
99.00 09900 CMHC	0	0	0.0000	00		99.00
99. 10 09910 CORF	0	0	0.0000	00		99.10
200.00 Subtotal (sum of lines 50 thru 199)	21, 500, 302	74, 268, 811				200.00
201.00 Less Observation Beds	0	0				201.00
202.00 Total (line 200 minus line 201)	21, 500, 302	74, 268, 811				202.00

Health Financial Systems R	EHABILITATION HOS	SPITAL OF INDIA	NA	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	IL COSTS	Provider C		Period: From 01/01/2021 To 12/31/2021		pared: 4 am
		Titl∈	e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 398, 123	C	1, 398, 12	3 19, 797	70.62	30.00
200.00 Total (lines 30 through 199)	1, 398, 123		1, 398, 12	3 19, 797		200.00
Cost Center Description	Inpatient Program days	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)	5, 600 5, 600					30. 00 200. 00

Health Financial Systems REH.	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/27/2022 7:3	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	r	1	-	-	
50.00 05000 OPERATI NG ROOM	0	0	0.00000		0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	17,047					
60. 00 06000 LABORATORY	10, 791					
65. 00 06500 RESPI RATORY THERAPY	45, 769					
66. 00 06600 PHYSI CAL THERAPY	446, 485				85, 957	66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	2, 631				0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	343, 911	17, 763, 701	0. 01936	0 3, 959, 172	76, 650	67.00
68.00 06800 SPEECH PATHOLOGY	75, 041	11, 074, 570			17, 529	68.00
68. 01 06801 VI SI ON	0	0	0.00000	0 0	0	68. 01
68. 02 06802 FAC RESOURCE	21, 982	746, 275	0. 02945	6 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	10, 529	2, 286, 351	0. 00460	5 670, 888	3, 089	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	25, 989	13, 186, 595	0. 00197	1 2, 391, 181	4, 713	73.00
74.00 07400 RENAL DIALYSIS	0	0	0.00000	0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	90, 279	2, 059, 432	0. 04383	7 0	0	90.00
90. 01 09001 SLEEP CENTER	0	0	0. 00000	0 0	0	90.01
91.00 09100 EMERGENCY	0	0	0. 00000	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0. 00000	0 0	0	92.00
200.00 Total (lines 50 through 199)	1, 090, 454	74, 268, 811		15, 335, 156	210, 632	200. 00

Health Financial Systems REHA	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS			Period: From 01/01/2021 To 12/31/2021	5/27/2022 7:3	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown	Nursi ng Program	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	(0 0	0	30.00 200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Dation	t Per Diem (col.	Inpati ent	200.00
Cost Center Description	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	Duys	0 001.0)		
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•	-	ł	
30. 00 03000 ADULTS & PEDIATRICS	0	() 19, 79	7 0.00	5, 600	30.00
200.00 Total (lines 30 through 199)		(19, 79	7	5, 600	200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1					
30.00 03000 ADULTS & PEDLATRICS 200.00 Total (Lines 30 through 199)	0					30. 00 200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-3028 Period: From 01/01/2021 To 12/31/2021 Worksheet D Part IV Date/Time Prepared: 5/27/2022 7: 34 am	Health Financial Systems REF	IABILITATION HOS	PITAL OF INDIA	NA	In Lie	eu of Form CMS-	2552-10
Cost Center Description Non Physician Anesthetist Cost Nursing Program Adjustments Nursing Program Adjustments Allied Health Post-Stepdown Adjustments 50.00 05000 0PERATING ROM 05000 0		RVICE OTHER PAS	S Provider C	CN: 15-3028	From 01/01/2021	Part IV Date/Time Pre	pared: 4 am
Anesthetist Cost Program Post-Stepdown Adjustments Program Adjustments Program Post-Stepdown Adjustments Program Adjustments ANCI LLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 50.00 05000 0PERATI NG ROOM 0 0 0 0 0 50.00 05000 0PERATI NG ROOM 0 0 0 0 0 0 60.00 05000 LABORATORY 0			Title	XVIII	Hospi tal	PPS	
ACILLARY SERVICE COST CENTERS Acjustments Adjustments ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 50.00 05400 DPERATING ROM 0	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
Adj ustments Adj ustments Adj ustments 1.00 2A 2.00 3A 3.00 50.00 05000 OPERATI NG ROM 0 0 0 0 50.00 54.00 05400 RADI LLARY SERVI CE COST CENTERS 0 0 0 0 50.00 54.00 05400 RADRARTORY 0 0 0 0 64.00 60.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 66.01 66.01 06700 0CUPATI ONAL THERAPY 0 0 0 66.01 66.01 06700 0CUPATI ONAL THERAPY 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.01 68.01 06801 VI SI ON 0 0 0 0 68.01 69.00 064000 0 0							
I.00 2A 2.00 3A 3.00 ANCI LLARY SERVICE COST CENTERS		Cost			Adjustments		
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 0 0 0 0 50.00 54.00 OS400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 54.00 60.00 O6600 LABORATORY 0 <							
50.00 05000 OPERATING ROOM 0 0 0 0 50.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 0 54.00 60.00 LABORATORY 0 <td></td> <td>1.00</td> <td>2A</td> <td>2.00</td> <td>3A</td> <td>3.00</td> <td></td>		1.00	2A	2.00	3A	3.00	
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 66.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 66.01 06600 PHYSI CAL THERAPY CARMEL 0 0 0 0 66.00 66.01 06600 SPECH PATHOLOGY 0 0 0 0 66.01 67.00 06700 OCUPATI ONAL THERAPY CARMEL 0 0 0 67.00 68.01 06801 VISI ON 0 0 0 0 68.01 68.01 68.02 6802 FAC RESOURCE 0 0 0 0 68.01 68.01 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 71.00 71.00 07100 MEDICAL SUPPLI ES CHARGED TO PATI ENTS 0 <t< td=""><td></td><td></td><td></td><td>1</td><td></td><td>1</td><td></td></t<>				1		1	
60.00 06000 LABORATORY 0		0	0		0 0	0	
65.00 06500 RESPIRATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 66.00 66.01 06600 PHYSI CAL THERAPY - CARMEL 0 0 0 0 66.01 67.00 06700 0CCUPATI ONAL THERAPY - CARMEL 0 0 0 0 66.01 68.01 06800 SPEECH PATHOLOGY 0 0 0 0 68.01 68.01 06801 VISION 0 0 0 0 0 68.01 68.02 06802 FAC RESOURCE 0 0 0 0 68.01 68.02 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07400 RENAL DI ALYSI S 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0		0	0		0 0	0	
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 0CCUPATI ONAL THERAPY 0 0 0 0 66.01 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 68.01 06801 VISI ON 0 0 0 0 68.00 68.02 66802 FAC RESOURCE 0 0 0 0 68.01 68.02 66802 FAC RESOURCE 0 0 0 0 68.02 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 73.00 73.00 73.00 73.00 73.00 74.00 74.00 74.00 90.00 90.00 90.0		0	0		0 0	0	
66.01 06601 PHYSI CAL THERAPY - CARMEL 0 0 0 0 0 0 66.01 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68.00 68.01 06801 VI SI ON 0 0 0 0 0 68.01 68.02 06802 FAC RESOURCE 0 0 0 0 68.01 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.00 OT400 RENAL DI ALYSIS 0 0 0 0 0 90.00 90.01 090000		0	0		0 0	0	
67.00 06700 0CCUPATIONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68.00 68.01 06801 VI SI ON 0 0 0 0 0 68.01 68.02 06802 FAC RESOURCE 0 0 0 0 68.01 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.00 OT400 RENAL DI ALYSIS 0 0 0 0 74.00 01.01 OL 0 0 0 0 0 0 0 90.00 02.01 NI C 0 0 0 0 0		0	0		0 0	0	
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 68.01 06801 VI SI ON 0 0 0 0 0 0 68.01 68.02 06802 FAC RESOURCE 0 0 0 0 0 68.01 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.00 OT400 RENAL DI ALYSIS 0 0 0 0 74.00 00100 OP000 CLI NI C 0 0 0 0 90.01 90.01 09001 SLEEP CENTER 0 0 0 0 90.01 90.01 09100 EMERGENCY 0 0 0 0<	66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	0		0 0	0	66. 01
68.01 06801 VI SI ON 0 0 0 0 0 0 68.01 68.02 06802 FAC RESOURCE 0 0 0 0 0 0 68.02 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 73.00 74.00 09000 CLI NI C 0 0 0 0 90.00 90.01 09000 CLI NI C 0 0 0 0 90.01 91.00 9100 EMERGENCY 0 0 0 0 90.01 92.00 09200 DSERVATI ON BEDS (NON	67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.02 06802 FAC RESOURCE 0 0 0 0 0 68.02 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 73.00 74.00 09000 CLI NI C 0 0 0 0 90.00 90.01 09000 CLI NI C 0 0 0 90.00 90.01 90.01 09000 CLI NI C 0 0 0 0 90.00 91.00 09100 EMERGENCY 0 0 0 0 90.01 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0	68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 71.00 71.00 71.00 0 0 0 0 0 0 0 0 0 0 71.00 72.00 0 0 0 0 0 0 0 0 72.00 0 0 0 0 0 0 0 72.00 73.00 0 0 0 0 0 0 0 0 73.00 73.00 0 0 0 0 0 0 0 0 73.00 73.00 0 0 0 0 0 0 0 0 73.00 73.00 <	68. 01 06801 VI SI ON	0	0		0 0	0	68.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 72.00 73.00 72.00 73.00 73.00 74	68. 02 06802 FAC RESOURCE	0	0		0 0	0	68. 02
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 74.00 OT400 RENAL DI ALYSIS 0 0 0 0 0 74.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 90.00 90000 CLINIC 90.00 90.00 90.00 90.00 90.00 90.01 90001 SLEEP CENTER 0 0 0 90.01	69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 0 0 0 0 0 0 74.00 74.00 00 0 0 74.00 00 0 0 0 74.00 00 0 0 0 74.00 00 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 74. 00 OUTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 90. 00 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 91. 00 91. 00 92. 00 085ERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92. 00 92.00 09200 005ERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
OUTPATI ENT_SERVICE_COST_CENTERS 90. 00 09000 CLINIC 0<	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
90. 00 09000 CLINIC 0 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 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 92. 00	74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00
90.01 09001 SLEEP CENTER 0 0 0 0 90.01 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 92.00	OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY 0 0 0 91.00 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92.00 0 92.00 0 0 92.00 0 0 92.00 0 0 0 92.00 0 0 0 0 92.00 0 0 0 0 0 0 92.00 0 <td>90. 00 09000 CLINIC</td> <td>0</td> <td>0</td> <td>1</td> <td>0 0</td> <td>0</td> <td>90.00</td>	90. 00 09000 CLINIC	0	0	1	0 0	0	90.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92. 00	90. 01 09001 SLEEP CENTER	0	0		0 0	0	90.01
	91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
200,00 Total (Lines 50 through 199) 0 0 0 0 0 0 0 0 0	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	200.00 Total (lines 50 through 199)	0	0		o c	0	200.00

Health Financial Systems REF	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	S Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/27/2022 7:3	
		Title	× XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	-1					
50.00 05000 OPERATING ROOM	0	0		0 0	0. 000000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 2, 319, 540		
60. 00 06000 LABORATORY	0	0		0 1, 782, 927		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 2, 979, 209		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 18, 398, 956		66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	0		0 1, 671, 255		66. 01
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 17, 763, 701	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 11, 074, 570		68.00
68. 01 06801 VI SI ON	0	0		0 0	0. 000000	68. 01
68. 02 06802 FAC RESOURCE	0	0		0 746, 275		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 2, 286, 351	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 13, 186, 595		
74.00 07400 RENAL DI ALYSI S	0	0		0 0	0.00000	74.00
OUTPATIENT SERVICE COST CENTERS	-		í	- i		
90. 00 09000 CLINIC	0	0		0 2, 059, 432		•
90. 01 09001 SLEEP CENTER	0	0		0 0	0. 000000	90.01
91. 00 09100 EMERGENCY	0	0		0 0	0. 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0. 000000	•
200.00 Total (lines 50 through 199)	0	0		0 74, 268, 811		200. 00

Health Financial Systems REH/	ABILITATION HOSP	ITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS	Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/27/2022 7:3	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	TT					
50.00 05000 OPERATI NG ROOM	0. 000000	0		0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	714, 016		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	553, 157	(0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	917, 707	(0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	3, 542, 127	(0 558	0	66.00
66.01 06601 PHYSI CAL THERAPY - CARMEL	0. 000000	0	(0 0	0	66. 01
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	3, 959, 172	(0 837	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	2, 586, 908	(0 0	0	68.00
68. 01 06801 VI SI ON	0. 000000	0	(0 0	0	68.01
68. 02 06802 FAC RESOURCE	0. 000000	0	(0 0	0	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0	(0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	670, 888	(22, 034	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	(0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 391, 181	(1, 933, 929	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0	(0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0	(0 565, 625	0	90.00
90. 01 09001 SLEEP CENTER	0. 000000	0	(0 0	0	90.01
91.00 09100 EMERGENCY	0. 000000	0	(0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	(0 0	0	92.00
200.00 Total (lines 50 through 199)		15, 335, 156	(2, 522, 983	0	200. 00

Health Financial Systems REH	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/27/2022 7:3	
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 000000			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 153318	0		0 0	0	54.00
60. 00 06000 LABORATORY	0. 338833	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 452112	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 261595	558		0 0	146	66.00
66.01 06601 PHYSICAL THERAPY - CARMEL	0. 368967	0		0 0	0	66. 01
67.00 06700 OCCUPATI ONAL THERAPY	0. 249520	837		0 0	209	67.00
68.00 06800 SPEECH PATHOLOGY	0. 196561	0		o o	0	68.00
68. 01 06801 VI SI ON	0. 000000	0		o o	0	68.01
68. 02 06802 FAC RESOURCE	3. 176297	0		o o	0	68.02
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		o o	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 234564	22, 034		o o	5, 168	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			o o	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 274426	1, 933, 929		o o	530, 720	73.00
74.00 07400 RENAL DIALYSIS	0.00000			0 0	0	
OUTPATIENT SERVICE COST CENTERS			I	- I		
90. 00 09000 CLI NI C	0. 305542	565, 625		0 0	172, 822	90.00
90. 01 09001 SLEEP CENTER	0. 000000			o o	0	
91. 00 09100 EMERGENCY	0. 000000			0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			0 0	0	
200.00 Subtotal (see instructions)		2, 522, 983		0 0	709, 065	
201.00 Less PBP Clinic Lab. Services-Program		_, , ,		0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		2, 522, 983		0 0	709, 065	202.00

Health Financial Systems REI	HABILITATION HOS	SPITAL OF INDIA	NA	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	Provider C		Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/27/2022 7:3	
		Title	XVIII	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.					
	(see inst.)	(see inst.)	-			
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS			1			1 - 0 - 00
50. 00 O5000 OPERATING ROOM	0	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66.00 06600 PHYSI CAL THERAPY	0	0 0				66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	0				66. 01
67.00 06700 OCCUPATI ONAL THERAPY	0	0 0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0 0				68.00
68. 01 06801 VI SI ON	0	0 0				68. 01
68. 02 06802 FAC RESOURCE	0	0				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				73.00
74.00 07400 RENAL DIALYSIS	0	0 0				74.00
OUTPATIENT SERVICE COST CENTERS	1	1				
90. 00 09000 CLINIC	0	0				90.00
90. 01 09001 SLEEP CENTER	0	0				90.01
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	0	1			202.00

Health Financial Systems RE	HABILITATION HOS	SPITAL OF INDIA	NA	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	_ COSTS	Provider C		Period: From 01/01/2021 To 12/31/2021		pared: 4 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capital Related Cost	Days	Per Diem (col. 3 / col. 4)	
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 398, 123	0	1, 398, 12	19, 797	70.62	30.00
200.00 Total (lines 30 through 199)	1, 398, 123		1, 398, 12	19, 797		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	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDI ATRI CS	653	46, 115	;			30.00
200.00 Total (lines 30 through 199)	653					200.00

Health Financial Systems REH	ABILITATION HOS	SPITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/27/2022 7:3	
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		1	1			
50.00 O5000 OPERATI NG ROOM	0		0100000		0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	17,047					54.00
60. 00 06000 LABORATORY	10, 791					60.00
65. 00 06500 RESPI RATORY THERAPY	45, 769					65.00
66. 00 06600 PHYSI CAL THERAPY	446, 485	18, 398, 956			5, 671	66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	2, 631				0	66. 01
67.00 06700 OCCUPATI ONAL THERAPY	343, 911	17, 763, 701	0. 01936	0 261, 326	5, 059	67.00
68.00 06800 SPEECH PATHOLOGY	75, 041	11, 074, 570	0. 00677	6 125, 784	852	68.00
68. 01 06801 VI SI ON	0	0	0.00000	0 0	0	68. 01
68. 02 06802 FAC RESOURCE	21, 982	746, 275	0. 02945	6 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	10, 529	2, 286, 351	0.00460	5 36, 246	167	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	25, 989	13, 186, 595	0. 00197	1 206, 720	407	73.00
74.00 07400 RENAL DIALYSIS	0	0	0.00000	0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS	_					
90. 00 09000 CLINIC	90, 279	2, 059, 432	0. 04383	7 0	0	90.00
90. 01 09001 SLEEP CENTER	0	0	0.00000	0 0	0	90.01
91.00 09100 EMERGENCY	0	0	0.00000	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.00000	0 0	0	92.00
200.00 Total (lines 50 through 199)	1, 090, 454	74, 268, 811		1, 000, 639	13, 643	200.00
						•

Health Financial Systems REH/	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	rs Provider C		Period: From 01/01/2021 Fo 12/31/2021		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			2.1	2100	0.00	
30.00 O3000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0	0		0 0	0	30.00 200.00
Cost Center Description	Swing-Bed Adjustment 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	1		1	T		
30.00 03000 ADULTS & PEDLATRICS 200.00 Total (lines 30 through 199)	0	0	19, 79 [°] 19, 79 [°]			30.00 200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDLATRICS 200. 00 Total (Lines 30 through 199)	0					30. 00 200. 00

	ABILITATION HOS		NA	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PASS	S Provider C	CN: 15-3028	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2021 To 12/31/2021		nared
				10 12/31/2021	5/27/2022 7:3	4 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						50.00
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0			0 0	0	60.00
	0			0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY 66. 01 06601 PHYSI CAL THERAPY - CARMEL	0			0 0	0	66.00
	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 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0				0	72.00 73.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S	0				0	73.00
OUTPATIENT SERVICE COST CENTERS	0	0	1	0 0	0	74.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 SLEEP CENTER	0				0	90.00
91. 00 09100 EMERGENCY	0				0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
200.00 Total (lines 50 through 199)		C		0 0	-	200.00
	1 0		1	ч 0	0	200.00

Health Financial Systems REI	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	6 Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/27/2022 7:3	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATI NG ROOM	0	0		0 0	0. 000000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 2, 319, 540		
60. 00 06000 LABORATORY	0	0		0 1, 782, 927		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 2, 979, 209		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 18, 398, 956		66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	0		0 1, 671, 255	0. 000000	66. 01
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 17, 763, 701	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 11, 074, 570	0.000000	68.00
68. 01 06801 VI SI ON	0	0		0 0	0.000000	68. 01
68. 02 06802 FAC RESOURCE	0	0		0 746, 275		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 2, 286, 351	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 13, 186, 595	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 0	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 2, 059, 432	0.000000	90.00
90. 01 09001 SLEEP CENTER	0	0		0 0	0. 000000	90. 01
91. 00 09100 EMERGENCY	0	0		0 0	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0.000000	•
200.00 Total (lines 50 through 199)	0	0		0 74, 268, 811		200. 00

Health Financial Systems REH	ABILITATION HOSP	ITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS	Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/27/2022 7:3	
			e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	1 1			1	-	
50.00 05000 OPERATI NG ROOM	0. 000000	0		0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	34, 137		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	36, 732		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	65, 998		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	233, 696		0 0	0	66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0.000000	0		0 0	0	66. 01
67.00 06700 OCCUPATI ONAL THERAPY	0.000000	261, 326		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	125, 784		0 0	0	68.00
68. 01 06801 VI SI ON	0.000000	0		0 0	0	68. 01
68. 02 06802 FAC RESOURCE	0.00000	0		0 0	0	68.02
69. 00 06900 ELECTROCARDI OLOGY	0.000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	36, 246		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	206, 720		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	0		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
90. 01 09001 SLEEP CENTER	0.000000	0		0 0	0	90.01
91.00 09100 EMERGENCY	0.000000	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		1, 000, 639		0 0	0	200. 00

Health Financial Systems REH	ABILITATION HOS	SPITAL OF INDIA	NA	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Period: From 01/01/2021 To 12/31/2021		
		Titl	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000			0 0	0	00.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 153318	C C		0 0	0	54.00
60. 00 06000 LABORATORY	0. 338833	C		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 452112	c		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 261595	C C	406, 94	2 0	0	66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0. 368967	0	2, 61	8 0	0	66.01
67.00 06700 OCCUPATIONAL THERAPY	0. 249520	c c	253, 86	9 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 196561	0	93, 66	2 0	0	68.00
68. 01 06801 VI SI ON	0. 000000	o c		o o	0	68.01
68. 02 06802 FAC RESOURCE	3. 176297	d c	1, 25	o o	0	68.02
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	o c		o o	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 234564		4, 54	6 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	o c		o o	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 274426	c c	431, 02	3 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000			o o	0	74.00
OUTPATIENT SERVICE COST CENTERS			1	·		
90. 00 09000 CLINIC	0. 305542	0	159, 46	2 0	0	90.00
90. 01 09001 SLEEP CENTER	0.000000			0 0	0	
91. 00 09100 EMERGENCY	0. 000000			0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0, 000000			0 0	0	
200.00 Subtotal (see instructions)		0	1, 353, 37	2 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	1, 353, 37	2 0	0	202.00

Health Financial Systems RE	HABILITATION HOS	SPITAL OF INDIA	NA	In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ND VACCINE COST	Provider C		Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/27/2022 7:3	
			e XIX	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	-			
	6.00	7.00				-
ANCI LLARY SERVI CE COST CENTERS						50.00
50. 00 05000 OPERATI NG ROOM		0	•			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	0	0				60.00
65. 00 06500 RESPIRATORY THERAPY	10/ 15/	0				65.00
66.00 06600 PHYSI CAL THERAPY	106, 454					66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	966					66.01
67. 00 06700 OCCUPATI ONAL THERAPY	63, 345					67.00
68. 00 06800 SPEECH PATHOLOGY	18, 410					68.00
68. 01 06801 VI SI ON	C	-				68.01
68. 02 06802 FAC RESOURCE	3, 970					68.02
69. 00 06900 ELECTROCARDI OLOGY	C	-				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,066					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	-				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	118, 284					73.00
74.00 07400 RENAL DI ALYSI S	C	0				74.00
OUTPATIENT SERVICE COST CENTERS		-	1			
90. 00 09000 CLINIC	48, 722					90.00
90. 01 09001 SLEEP CENTER	C	0				90.01
91.00 09100 EMERGENCY	C	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	0				92.00
200.00 Subtotal (see instructions)	361, 217					200.00
201.00 Less PBP Clinic Lab. Services-Program	C	1				201.00
Only Charges		-				
202.00 Net Charges (line 200 - line 201)	361, 217	0	1			202.00

cartin	Financial Systems REHABILITATION HOSPI	TAL OF INDIANA	In Lie	u of Form CMS-2	2552-
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-3028	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Pre	pared
			11	5/27/2022 7: 34	4 am
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	cost center bescription			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				1
. 00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		19, 797	1.0
. 00	Inpatient days (including private room days, excluding swing-			19, 797	2.0
. 00	Private room days (excluding swing-bed and observation bed da	ays). If you have only pr	rivate room days,	0	3.0
	do not complete this line.				
. 00	Semi-private room days (excluding swing-bed and observation k			19, 797	4. (
. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decembe	er 31 of the cost	0	5.0
. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	and dave) after Decomber	21 of the cost	0	6.0
. 00	reporting period (if calendar year, enter 0 on this line)	Join days) arter becember	ST OF THE COST	0	0.0
. 00	Total swing-bed NF type inpatient days (including private roo	om days) through December	r 31 of the cost	0	7.0
. 00	reporting period	all days) through become	of of the cost	Ű	/. (
. 00	Total swing-bed NF type inpatient days (including private roo	om davs) after December (31 of the cost	0	8.0
	reporting period (if calendar year, enter 0 on this line)				
. 00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	5, 600	9.0
	newborn days) (see instructions)				
0.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10. 0
	through December 31 of the cost reporting period (see instruc				
1.00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		room days) after	0	11. (
2.00	Swing-bed NF type inpatient days applicable to titles V or XI		to room dave)	0	12. (
2.00	through December 31 of the cost reporting period	ix only (menduring priva	te room days)	0	12.0
3.00	Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including privat	te room davs)	0	13. (
0.00	after December 31 of the cost reporting period (if calendar y				
4.00	Medically necessary private room days applicable to the Progr			0	14.0
5.00	Total nursery days (title V or XIX only)			0	15.
6.00	Nursery days (title V or XIX only)			0	16.0
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 d	of the cost	0.00	17. (
8.00	reporting period Medicare rate for swing-bed SNF services applicable to servic	and after December 21 of	the cost	0.00	10 (
8.00	reporting period	ces al tel December 31 01	the cost	0.00	10.0
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19.0
	reporting period				
0.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	the cost	0.00	20. 0
	reporting period				
1.00	Total general inpatient routine service cost (see instruction		himm mented (lime	23, 646, 223	
2.00	Swing-bed cost applicable to SNF type services through Decemb 5×10^{-1} x line 17)	ber 31 of the cost report	ting period (line	0	22.0
3. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportio	na period (line 6	0	23.0
0.00	x line 18)			Ű	20.0
4.00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	24.0
	7 x line 19)		0 1 1		
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25. (
	x line 20)				
6.00	Total swing-bed cost (see instructions)			0	
7.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 26)		23, 646, 223	27.0
8. 00	General inpatient routine service charges (excluding swing-be	ad and observation bed ch	parges)	0	28.
9.00	Private room charges (excluding swing-bed charges)	ed and observation bed ci	lai ges)	0	
0.00	Semi-private room charges (excluding swing-bed charges)			0	30.
1.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
2.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	32.
3.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.
4.00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
5.00	Average per diem private room cost differential (line 34 x li	ine 31)		0.00	
6.00	Private room cost differential adjustment (line 3 x line 35)			0	36.
	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	23, 646, 223	37.
7.00	27 minus line 36)				
7.00					
7.00	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ILISTMENTS			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			1 10/ /2	30
8. 00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 194. 43 6, 688, 808	
7.00 8.00 9.00 0.00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	e instructions) e 38)		1, 194. 43 6, 688, 808 0	39.

Heal th	Fi nanci al	Systems	

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	Financial Systems REH, ATION OF INPATIENT OPERATING COST	ABILITATION HOS	Provider C	CN: 15-3028 F	Period:	u of Form CMS- Worksheet D-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 7:3	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days		Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	
2.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	3.00	42.0
	Intensive Care Type Inpatient Hospital Units						
3.00	INTENSIVE CARE UNIT						43.0
4.00	CORONARY CARE UNIT						44.0
5.00 5.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.0
	OTHER SPECIAL CARE (SPECIFY)						40.
	Cost Center Description		I	I	1		
						1.00	
3.00 9.00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ns)		3, 948, 355 10, 637, 163	
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	of Parts I and	395, 472	50.
1.00	Pass through costs applicable to Program inp and IV)	atient ancillar	ry services (fr	om Wkst. D, su	m of Parts II	210, 632	51.
2. 00	Total Program excludable cost (sum of lines	50 and 51)				606, 104	52.
3. 00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		elated, non-phy	sician anesthe	etist, and	10, 031, 059	53.
	TARGET AMOUNT AND LIMIT COMPUTATION					-	
1.00 5.00	Program discharges Target amount per discharge					0.00	
5.00 5.00	Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (I	ine 56 minus l	ine 53)	0	
. 00	Bonus payment (see instructions)	-	-			0	
. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi ng 1996, ι	pdated and con	pounded by the	0.00	59.
. 00 . 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				he amount by	0.00 0	
	which operating costs (line 53) are less tha		ts (lines 54 x	60), or 1% of	the target		
2.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	Instructions)				0	62.
	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reportir	ng period (See	0	64.
5. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	ts after Decemb	per 31 of the c	ost reporting	period (See	0	65.
. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66.
7.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 31 c	f the cost rep	oorting period	0	67.
3. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [December 31 of	the cost repor	ting period	0	68.
	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY		0	1
). 00 . 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70.
. 00	Program routine service cost (line 9 x line			<i>∠</i>)			72.
. 00	Medically necessary private room cost applic		n (line 14 x li	ne 35)			73.
. 00 . 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	ice costs (line	e 72 + line 73)		art II, column		74. 75.
. 00	26, line 45) Per diem capital-related costs (line 75 + li						76.
. 00	Program capital -related costs (line 9 x line						77.
. 00 . 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi der record	s)			78.
. 00	Total Program routine service costs for comp				ıs line 79)		80.
. 00	Inpatient routine service cost per diem limi				- 1		81.
. 00	Inpatient routine service cost limitation (I						82.
8.00	Reasonable inpatient routine service costs (ns)				83.
. 00	Program inpatient ancillary services (see in		ns)				84. 85.
5.00 5.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85.
	PART IV - COMPUTATION OF OBSERVATION BED PAS						1 50.
7.00	Total observation bed days (see instructions)				0	
	Adjusted general inpatient routine cost per	diem (line 27 ÷	ling 2)			0.00	88
	Observation bed cost (line 87 x line 88) (se	•					89

Health Financial Systems REH	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 398, 123	23, 646, 223	0. 05912	7 0	0	90.00
91.00 Nursing Program cost	0	23, 646, 223	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	23, 646, 223	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	23, 646, 223	0. 00000	0 0	0	93.00

Heal th	Financial Systems REHABILITATION HOSPI	TAL OF INDIANA	In Lie	u of Form CMS-2	2552-1
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-3028	Peri od:	Worksheet D-1	
			From 01/01/2021	Data /Tima Drow	narad
			To 12/31/2021	Date/Time Pre 5/27/2022 7:34	4 am
		Title XIX	Hospi tal	PPS	1 Gill
	Cost Center Description	in the wirk	noopritui		
	•			1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			19, 797	1.00
2.00	Inpatient days (including private room days, excluding swing-			19, 797	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3.00
4 00	do not complete this line.			10 707	1 4 00
4.00 5.00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		an 21 of the east	19, 797 0	4.00 5.00
5.00	reporting period	Join days) thi ough becenbe	el si ul the cust	0	5.0
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.00
5.00	reporting period (if calendar year, enter 0 on this line)	days) arter becomber		0	0.0
7.00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	~ 31 of the cost	0	7.00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private roo	om days) after December :	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	653	9.00
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private)	coom davic)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		Uulii uays)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room davs) 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 priva	te room days)	0	12.00
	through December 31 of the cost reporting period			_	
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			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			0	14.0
15.00	Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	0	14.0
16.00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 (of the cost	0.00	17.00
	reporting period	-			
18.00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18.00
10 00	reporting period	a through December 21 a	E the east	0.00	10.00
19.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through becember 31 of	the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.00
	reporting period				
21.00	Total general inpatient routine service cost (see instruction	าร)		23, 646, 223	21.00
22.00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost repor	ting period (line	0	22.00
~~ ~~	5 x line 17)				
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24.00
21.00	7 x line 19)		ng period (inne	0	21.0
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25.0
	x line 20)				
26.00	Total swing-bed cost (see instructions)			0	
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		23, 646, 223	27.0
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and observation had a		0	28.00
29.00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	and observation bed ci	lai yes)	0	
30.00	Semi-private room charges (excluding swing bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.0
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	
36.00	Private room cost differential adjustment (line 3 x line 35)	and make a set	66	0	36.0
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	Trerential (line	23, 646, 223	37.0
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				ł
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	IUSTMENTS			1
				1 104 42	38.00
38.00	Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 194. 43	1 30.00
		•		779, 963	
38.00 39.00 40.00 41.00	Adjusted general inpatient routine service cost per diem (see	e 38) ram (line 14 x line 35)			39.00 40.00

Heal th	Fi nanci al	Systems	

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OMPLIT	· · · · · · · · · · · · · · · · · · ·		PITAL OF INDIA			u of Form CMS-	
	ATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2021	Worksheet D-1	
					To 12/31/2021	Date/Time Pre 5/27/2022 7:3	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
			inpatrent bays	col. 2)	-	4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit	te					42
. 00	INTENSIVE CARE UNIT						43
. 00	CORONARY CARE UNI T						44
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGICAL INTENSIVE CARE UNIT						46
00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
	·					1.00	
00	Program inpatient ancillary service cost ()	Wkst. D-3, col. 3	, line 200)			263, 813	
. 00	Total Program inpatient costs (sum of line: PASS THROUGH COST ADJUSTMENTS	s 41 through 48)(:	see instructic	ns)		1, 043, 776	49
. 00	Pass through costs applicable to Program in	npatient routine :	services (from	Wkst. D. sum	of Parts I and	46, 115	50
	111)	•					
. 00	Pass through costs applicable to Program in	npatient ancillar	y services (fr	om Wkst. D, s	um of Parts II	13, 643	51
. 00	and IV) Total Program excludable cost (sum of line:	s 50 and 51)				59, 758	52
. 00	Total Program inpatient operating cost exc		lated, non-phy	sician anesth	etist, and	984, 018	
	medical education costs (line 49 minus line	e 52)					
00	TARGET AMOUNT AND LIMIT COMPUTATION					0	
. 00 . 00	Program discharges Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operation	ating cost and ta	rget amount (I	ine 56 minus	line 53)	0	57
00	Bonus payment (see instructions)					0	
00	Lesser of lines 53/54 or 55 from the cost market basket	reporting period (ending 1996, u	pdated and co	mpounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year	r cost report, up	dated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of lin				the amount by	0	61
	which operating costs (line 53) are less the		s (lines 54 x	60), or 1% of	the target		
. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	e instructions)				о	62
. 00	Allowable Inpatient cost plus incentive pay	yment (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine co	osts through Dece	mber 31 of the	cost reporti	ng period (See	0	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	osts after Decemb	er 31 of the c	ost reporting	period (See	0	65
	instructions) (title XVIII only)					-	
. 00	Total Medicare swing-bed SNF inpatient rou	tine costs (line (64 plus line 6	5)(title XVII	l only). For	0	66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient rout	ine costs through	December 31 c	f the cost re	norting period	о	67
. 00	(line 12 x line 19)	The costs through	December 51 c	T the cost re	por tring period	0	
. 00	Title V or XIX swing-bed NF inpatient rout	ine costs after D	ecember 31 of	the cost repo	rting period	0	68
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatien	t routino costs (lino 67 - lino	60)		0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER					0	09
. 00	Skilled nursing facility/other nursing fac						70
. 00	Adjusted general inpatient routine service		ine 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x line		(line 14 v li	no 25)			72
. 00 . 00	Medically necessary private room cost appli Total Program general inpatient routine se	Ű	•				73
. 00	Capital -related cost allocated to inpatient				art II, column		75
_	26, line 45)						
. 00	Per diem capital -related costs (line 75 ÷)						76
00	Program capital-related costs (line 9 x lin Inpatient routine service cost (line 74 min						77
00	Aggregate charges to beneficiaries for exc	,	rovider record	s)			79
00	Total Program routine service costs for co	• •		· · · ·	us line 79)		80
00	Inpatient routine service cost per diem lin						81
00	Inpatient routine service cost limitation	•					82
00	Reasonable inpatient routine service costs Program inpatient ancillary services (see i	•	5)				83
. 00	Utilization review - physician compensation		ns)				85
. 00	Total Program inpatient operating costs (s						86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PART	ASS THROUGH COST					
		``					
. 00	Total observation bed days (see instruction Adjusted general inpatient routine cost pe		line 2)			0 0.00	

Health Financial Systems REH	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 398, 123	23, 646, 223	0. 05912	7 0	0	90.00
91.00 Nursing Program cost	0	23, 646, 223	0.00000	0 0	0	91.00
92.00 Allied health cost	0	23, 646, 223	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	23, 646, 223	0.00000	0 0	0	93.00

Heal th Financial Systems REHABILITATION HOSPITAL				u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	rovider CC		Period: From 01/01/2021	Worksheet D-3	
			To 12/31/2021	Date/Time Pre	pared:
				5/27/2022 7:3	
	Title		Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
	-	1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS	I		12, 223, 904		30.00
ANCI LLARY SERVICE COST CENTERS	I			I	1
50. 00 05000 OPERATI NG ROOM	I	0.00000	0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 15331	8 714,016	109, 472	54.00
60. 00 06000 LABORATORY		0. 33883	553, 157	187, 428	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 45211	2 917, 707	414, 906	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 26159	3, 542, 127	926, 603	66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL		0. 36896	07 0	0	66. 0 ⁻
67. 00 06700 OCCUPATI ONAL THERAPY		0. 24952	3, 959, 172		
68. 00 06800 SPEECH PATHOLOGY		0. 19656	1	508, 485	
68. 01 06801 VI SI ON		0.00000		0	68.0
68. 02 06802 FAC RESOURCE		3. 17629		0	68.0
69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 23456			
72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS		0.00000		0	1 / 2 / 0 /
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 27442		656, 202	
74. 00 O7400 RENAL DI ALYSI S		0.00000	00 0	0	74.00
0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C		0 20554	2 0	0	
		0.30554		0	
90. 01 09001 SLEEP CENTER 91. 00 09100 EMERGENCY		0. 00000 0. 00000		0	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 00000		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.00000	15, 335, 156	-	
201.00 Less PBP Clinic Laboratory Services-Program only charges (Line 61)		15, 355, 150		200.00
202.00 Net charges (line 200 minus line 201)			15, 335, 156		201.00
202.00 Inet charges (The 200 millios The 201)	I		10, 000, 100	I	1202.0

	ION HOSPITAL OF INDIA			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period: From 01/01/2021	Worksheet D-3	
			To 12/31/2021	Date/Time Pre	pared.
			10 12/01/2021	5/27/2022 7:3	
	Titl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cost		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	700.444		
30. 00 03000 ADULTS & PEDI ATRI CS			798, 466		30.00
ANCI LLARY SERVI CE COST CENTERS		0.00000		0	50.00
50. 00 05000 OPERATING ROOM		0.00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 15331			
60. 00 06000 LABORATORY		0. 33883			
65. 00 06500 RESPI RATORY THERAPY		0. 45211			
66. 00 06600 PHYSI CAL THERAPY		0. 26159			
66. 01 06601 PHYSI CAL THERAPY - CARMEL 67. 00 06700 OCCUPATI ONAL THERAPY		0. 36896		0	
68. 00 106700 DECEMPATIONAL THERAPY 68. 00 106800 SPEECH PATHOLOGY		0. 24952		65, 206 24, 724	
68. 01 06801 VISION		0. 19656		24,724	
68. 02 06802 FAC RESOURCE		3. 17629		0	68.02
69. 00 06900 ELECTROCARDI OLOGY		0. 00000			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 23456			
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 23430		0, 302	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 27442		-	
74. 00 07400 RENAL DI ALYSI S		0.00000		00,727	
OUTPATIENT SERVICE COST CENTERS		0100000	<u> </u>		1 / 00
90. 00 09000 CLINIC		0. 30554	2 0	0	90.00
90. 01 09001 SLEEP CENTER		0.00000		0	
91. 00 09100 EMERGENCY		0.00000		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.00000		0	
200.00 Total (sum of lines 50 through 94 and 96 through	gh 98)		1,000,639	263, 813	
201.00 Less PBP Clinic Laboratory Services-Program on			0		201.00
202.00 Net charges (line 200 minus line 201)		1	1,000,639		202.00

I VO	LUME CALCULATION EXHIBIT 4			Provider C	F	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibi Date/Time Pre 5/27/2022 7:34	pare
		W/S E, Part A	Amounts (from	Title Pre/Post	XVIII Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
0	DRG amounts other than outlier	0	1.00	2.00	3.00	4.00	5.00 0	1.
.0	payments	1.00	0	0		, ,	0	
)1	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	C		0	1.
)2	DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	O	0		0	0	1.
)3	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	Ο	0	C		0	1.
)4	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	Ο	0		0	0	1.
00	Outlier payments for	2.00						2
	discharges (see instructions)	0.00	_	_	_		_	
11	Outlier payments for discharges for Model 4 BPCI	2.02	0	0		0	0	2
2	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	C		0	2
3	Outlier payments for discharges occurring on or after October 1 (see	2.04	0	0		0	0	2
	instructions)							
0	Operating outlier	2. 01	0	0	C	0 0	0	3
0	reconciliation Managed care simulated payments	3.00	0	0	-1, 343, 911	1, 343, 911	0	4
0	Indirect Medical Education Adju	1 <u>stment</u> 21.00	0. 000000	0. 000000	0.000000	0. 000000		
0	Amount from Worksheet E, Part A, line 21 (see instructions) IME payment adjustment (see	21.00	0.000000	0.000000		0.000000	0	5
1	instructions) IME payment adjustment for managed care (see instructions)	22.01	0	0	C	0	0	6
	Indirect Medical Education Adju	stment for the	e Add-on for Se					
0	IME payment adjustment factor (see instructions) IME adjustment (see	27.00 28.00	0. 000000	0. 000000			0	7 8
1	instructions) IME payment adjustment add on	28.01	0	0	C	0 0	0	
0	for managed care (see instructions) Total IME payment (sum of	29.00	0	0	C	0 0	0	9
)1	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and	29.01	0	0	C	0 0	0	9
	8.01) Disproporti opoto Sharo Adiustro	nt						
00	Disproportionate Share Adjustme Allowable disproportionate share percentage (see	33.00	0. 0000	0.0000	0. 0000	0.0000		10
00	instructions) Disproportionate share adjustment (see instructions)	34.00	0	0	c	0 0	0	11
01	Uncompensated care payments	36.00	0	0	0	0 0	0	11
00	Additional payment for high per Total ESRD additional payment (see instructions)	<u>centage of ESF</u> 46.00	D beneficiary 0	di scharges 0	C	0	0	12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	0 0	0 0			0 0	
00	(see instructions) Total payment for inpatient operating costs (see	49.00	О	0	c	0 0	0	15
00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	0	0	C	0	0	16

	Financial Systems	REHA	BILITATION HOS				u of Form CMS-2	2552-1
LOW VO	LUME CALCULATION EXHIBIT 4			Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibi Date/Time Pre 5/27/2022 7:3	pared:
				Title	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	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	0	0		0 0	0	
17.01	Net organ aquisition cost							17.0
17.02	Credits received from	68.00	0	0		0 0	0	17.0
	manufacturers for replaced devices for applicable MS-DRGs							
18.00	Capital outlier reconciliation	93.00	0	0		0 0	0	18.00
	adjustment amount (see							
	instructions)							
19.00	SUBTOTAL			0		0 0	0	19.0
		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 than outlier	1. 01	0	0		0 0	0	20. 0
21.00	Capital DRG outlier payments	2.00	0	0		0 0	0	21.0
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21. 0
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0 0.0000		22. 0
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23. 0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.000	0 0.0000		24.0
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25. 0
26.00	Total prospective capital payments (see instructions)	12.00	0	0		0 0	0	26. 0
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.00000	0 0.00000		27.0
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96				0	0	28. 0
29. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29. 0
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 0

Heal th	Financial Systems REHA	ABILITATION HOS	PITAL OF INDIAN	AI	In Lie	eu of Form CMS-2	2552-10
HOSPI	FAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC	1	Period: From 01/01/2021 Fo 12/31/2021		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt.	Amt. from	Period to	Period on	Total (cols. 2	
		A, line	Wkst. E, Pt.	10/01	after 10/01	and 3)	
			A)				
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for	1.01	0	(C	0	1.01
	discharges occurring prior to October 1						
1.02	DRG amounts other than outlier payments for	1.02	0		0	0	1.02
	discharges occurring on or after October 1						
1.03	DRG for Federal specific operating payment	1.03	0	(C	0	1.03
	for Model 4 BPCI occurring prior to October						
	1						
1.04	DRG for Federal specific operating payment	1.04	0		0	0	1.04
	for Model 4 BPCI occurring on or after						
	October 1						
2.00	Outlier payments for discharges (see	2.00					2.00
	instructions)						
2.01	Outlier payments for discharges for Model 4	2.02	0	(0 0	0	2.01
	BPCI						
2.02	Outlier payments for discharges occurring	2.03	0	(C	0	2.02
	prior to October 1 (see instructions)						
2.03	Outlier payments for discharges occurring on	2.04	0		0	0	2.03
	or after October 1 (see instructions)		_		_		
3.00	Operating outlier reconciliation	2.01	0	(0 0	0	3.00
1 00	Managad aara aimulated normante	2 00		1 410 25	1 1 2/2 011	E 007 242	1 00

3.00		2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	4, 643, 351	1, 343, 911	5, 987, 262	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0.000000	0.00000		5.00
	(see instructions)						
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see	22.01	0	0	0	0	6. 01
	instructions)						
	Indirect Medical Education Adjustment for the	Add-on for Se	ction 422 of th	he MMA			
7.00	IME payment adjustment factor (see	27.00	0. 000000	0.000000	0.00000		7.00
	instructions)						
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed	28.01	0	0	0	0	8.01
	care (see instructions)						
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of	29.01	0	0	0	0	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
	(see instructions)						
11.00	Disproportionate share adjustment (see	34.00	0	0	0	0	11.00
	instructions)						
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
	Additional payment for high percentage of ESR	D beneficiary	di scharges				
12.00	Total ESRD additional payment (see	46.00	0	0	0	0	12.00
	instructions)						
13.00		47.00	0	0	0		13.00
14.00		48.00	0	0	0	0	14.00
	and MDH, small rural hospitals only.) (see						
	instructions)						
15.00	Total payment for inpatient operating costs	49.00	0	0	0	0	15.00
	(see instructions)						
16.00	Payment for inpatient program capital (from	50.00	0	0	0	0	16.00
	Wkst. L, Pt. I, if applicable)						
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for	68.00	0	0	0	0	17.02
	replaced devices for applicable MS-DRGs						
18.00	Capital outlier reconciliation adjustment	93.00	0	0	0	0	18.00
	amount (see instructions)						
19.00	SUBTOTAL			0	0	0	19.00

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC	N: 15-3028	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibi Date/Time Pre 5/27/2022 7:3	pared:
			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	0	20.01
21.00	Capital DRG outlier payments	2.00	0		0 0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage	10.00	0. 0000	0.000	0.0000		24.00
5. 00	(see instructions) Disproportionate share adjustment (see	11.00	0		0 0	0	25.0
26. 00	instructions) Total prospective capital payments (see instructions)	12.00	о		0 0	0	26. 0
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.0
28.00	Low volume adjustment prior to October 1	70.96	0		0	0	28.0
9.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.0
30.00	HVBP payment adjustment (see instructions)	70, 93	o		0 0	0	30.0
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 0
31.00	HRR adjustment (see instructions)	70, 94	0		0	0	31.0
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99			0 0	0	32.0
100.00	Transfer HAC Reduction Program adjustment to Wkst. E. Pt. A.		Ν				100. 0

CULA	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3028	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Pre 5/27/2022 7:3	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	tions)		0 709, 065	
	OPPS payments			635, 131	
	Outlier payment (see instructions)			0	4
	Outlier reconciliation amount (see instructions)			0	4
	Enter the hospital specific payment to cost ratio (see instru	ctions)		0.000	
	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
	Transitional corridor payment (see instructions)			0	
	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
	Organ acquisitions			0	10
	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			0	11
- H	Reasonable charges				1
	Ancillary service charges			0	12
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
	Total reasonable charges (sum of lines 12 and 13)			0	14
	Customary charges Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15
	Amounts that would have been realized from patients liable fo			0	16
	had such payment been made in accordance with 42 CFR §413.13(e)	Ū		
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds l	ing 11) (see	0	18
	instructions)	Ty IT ITTLE TO EXCEEdS I	(366	0	17
	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds l	ine 18) (see	0	20
	instructions)				
	Lesser of cost or charges (see instructions)			0	21
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	ructions)		0	22
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			635, 131	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance amounts (for CAH, see instruction	-		0	
	Deductibles and Coinsurance amounts relating to amount on lin Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			133, 976 501, 155	
	instructions)	prus the sum of triffes 2		501, 155	2'
	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29) Primary payer payments			501, 155 0	30
	Subtotal (line 30 minus line 31)			501, 155	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIO	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			71, 378	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		46, 396 71, 378	
	Subtotal (see instructions)	,		547, 551	
	MSP-LCC reconciliation amount from PS&R			0	38
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	c)		0	
	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	5)		0	39
	Partial or full credits received from manufacturers for repla	ced devices (see instru	ctions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION		/	0	39
	Subtotal (see instructions)			547, 551	
	Sequestration adjustment (see instructions)			0	40
	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40
	Interim payments			548, 140	
	Interim payments-PARHM				41
	Tentative settlement (for contractors use only)			0	
	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			-589	42
	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-589	43
00	Protested amounts (nonallowable cost report items) in accorda §115.2	nce with CMS Pub. 15-2,	chapter 1,	6, 424	
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0.00	
00	Total (sum of lines 91 and 93)			0	94

VALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part I Date/Time Prep 5/27/2022 7:34	pare
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		9, 825, 08	8 0	548, 140 0	1. 2. 3.
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01	ADJUSTMENTS TO PROVIDER			0	0	3
)2)3				0	0	3
03 04				0	0	3
05				0	0	3
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3
51 52				0	0	3
52 53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		9, 825, 08	8	548, 140	4
00	TO BE COMPLETED BY CONTRACTOR					5
50	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
N1	Program to Provider TENTATIVE TO PROVIDER			0	0	5
01 02	ILMATIVE TO FROVIDER			0	0) 3 5
03				0	0	5
	Provider to Program					
50	TENTATIVE TO PROGRAM			0	0	5
51 52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
D1	SETTLEMENT TO PROVIDER		179, 62		0	6
02 00	SETTLEMENT TO PROGRAM		10, 004, 71	0	589 547, 551	6
50	Total Medicare program liability (see instructions)		10, 004, 71	Contractor Number	NPR Date (Mo/Day/Yr)	
		C		1.00	2.00	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-3028	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part III Date/Time Pre 5/27/2022 7:3	pared
		Title XVIII	Hospi tal	PPS	4 0111
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
. 00	Net Federal PPS Payment (see instructions)			9, 094, 372	1.0
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0332	
. 00	Inpatient Rehabilitation LIP Payments (see instructions)			803, 942	
. 00	Outlier Payments			355, 480	
. 00	Unweighted intern and resident FTE count in the most recento November 15, 2004 (see instructions)	t cost reporting period e	nding on or prior	0.34	5. (
. 01	Cap increases for the unweighted intern and resident FTE c program or hospital closure, that would not be counted wit CFR $\frac{12}{2}$ (22) (see instructions)			0.00	5.0
. 00	New Teaching program adjustment. (see instructions)			0.00	6.0
. 00	Current year's unweighted FTE count of I&R excluding FTEs	in the new program growth p	period of a "new	2.84	7.0
. 00	teaching program" (see instructions) Current year's unweighted I&R FTE count for residents with teaching program" (see instructions)	in the new program growth p	period of a "new	0.00	8. 0
. 00	Intern and resident count for IRF PPS medical education ad	liustment (see instructions)		0.34	9. (
0.00			,	54. 238356	
1.00				0.006372	
2.00	Teaching Adjustment (see instructions)			57, 949	
3.00	Total PPS Payment (see instructions)			10, 311, 743	
4.00	Nursing and Allied Health Managed Care payments (see instr	ruction)		0	14.
5.00	Organ acquisition (DO NOT USE THIS LINE)				15.
6.00	Cost of physicians' services in a teaching hospital (see i	nstructions)		0	16.
7.00	Subtotal (see instructions)			10, 311, 743	17.
8.00				50, 223	
9.00				10, 261, 520	
	Deducti bl es			54, 528	
	Subtotal (line 19 minus line 20)			10, 206, 992	
	Coinsurance			227, 683	
	Subtotal (line 21 minus line 22)			9, 979, 309	
	Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)		39,079	
5.00 6.00		netructione)		25, 401 39, 079	
	Subtotal (sum of lines 23 and 25)	listi ucti olis)		10, 004, 710	
	Direct graduate medical education payments (from Wkst. E-4	line 49)		10,004,710	27.
	Other pass through costs (see instructions)			0	29.
	Outlier payments reconciliation			0	
1.00	1 3			0	
1.50	Pioneer ACO demonstration payment adjustment (see instruct	ions)		0	31.
1. 98	Recovery of accel erated depreciation.			0	31.
1. 99	Demonstration payment adjustment amount before sequestrati	on		0	31.
2.00	Total amount payable to the provider (see instructions)			10, 004, 710	32.
2. 01				0	
2. 02	Demonstration payment adjustment amount after sequestratio	'n		0	
3.00	Interim payments			9, 825, 088	
4.00	Tentative settlement (for contractor use only)			0	34.
5.00	Balance due provider/program (line 32 minus lines 32.01, 3			179, 622	
6.00	Protested amounts (nonallowable cost report items) in acco §115.2 TO BE COMPLETED BY CONTRACTOR	rdance with CMS Pub. 15-2,	chapter 1,	307, 910	36.
0. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			355, 480	50.
1.00	Outlier reconciliation adjustment amount (see instructions)		0	51.
2.00	The rate used to calculate the Time Value of Money	/		0.00	
3.00				0.00	
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020	AND BEGINNING BEFORE THE EN	ND OF THE COVID-19		1
9.00	Teaching Adjustment Factor for the cost reporting period i			0.00000	99.

I REU I	Financial Systems REHABILITATION HOSPIT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CC		Peri od:	u of Form CMS-2 Worksheet E-4	
EDI CA	L EDUCATION COSTS			From 01/01/2021 To 12/31/2021	Date/Time Pre	pared
		Title		Hospi tal	5/27/2022 7: 3 PPS	
		<u> </u>	AVIII	nospi tai		
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
. 00	Unweighted resident FTE count for allopathic and osteopathic p	programs for	cost reporti	ng periods	0.00	1. (
. 00	ending on or before December 31, 1996. Unweighted FTE resident cap add-on for new programs per 42 CFF		1) (see instr	uctions)	0.00	2.0
. 00 . 01	Amount of reduction to Direct GME cap under section 422 of MMA Direct GME cap reduction amount under ACA §5503 in accordance		8412 70 (m)	(500	0.00 0.00	3. (3. (
	instructions for cost reporting periods straddling 7/1/2011)					
00	Adjustment (plus or minus) to the FTE cap for allopathic and c GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))		orograms due	to a Medicare	0.00	4.
01	ACA Section 5503 increase to the Direct GME FTE Cap (see instr straddling 7/1/2011)	ructions for	cost reporti	ng periods	0.00	4.
02	ACA Section 5506 number of additional direct GME FTE cap slots periods straddling 7/1/2011)	s (see instr	ructions for	cost reporting	0.00	4.
00					0.00	5.
. 00					2.84	6.
. 00	Enter the lesser of line 5 or line 6				0.00	7.
		-	Primary Care		Total	
00	Weighted FTE count for physicians in an allopathic and osteopa	athi c	1.00	2.00 0 2.84	3.00	8.
00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherwi		0.0	0 0.00	0.00	9.
00	multiply line 8 times the result of line 5 divided by the amou 6.		0.0	0.00	0.00	7.
. 00	o. Weighted dental and podiatric resident FTE count for the curre	ent year		0.00		10.
. 01	Unweighted dental and podiatric resident FTE count for the cur	rrent year	0.0	0.00		10.
. 00 . 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting	g year (see	0.0 0.0			11. 12.
. 00	instructions) Total weighted resident FTE count for the penultimate cost rep	porting	0.0	0 0.00		13.
I. 00	year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	0.0	0.00		14.
. 00	Adjustment for residents in initial years of new programs		0.0			15.
. 01	Unweighted adjustment for residents in initial years of new pr		0.0			15.
. 00	Adjustment for residents displaced by program or hospital clos		0.0			16.
. 01	Unweighted adjustment for residents displaced by program or ho closure	ospi tal	0.0	0 0.00		16.
. 00	Adjusted rolling average FTE count		0.0			17.
. 00	Per resident amount		0.0		0	18
. 00	Approved amount for resident costs			0 0	0	19.
. 00	Additional unweighted allopathic and osteopathic direct GME F1	TE rocidont	an clote roo	alved under 42	1.00	20.
. 00	Sec. 413.79(c)(4)		cap stors rec		0.00	20.
. 00	Direct GME FTE unweighted resident count over cap (see instruc				2.84	
. 00	Allowable additional direct GME FTE Resident Count (see instru		+		0.00	
. 00 . 00	Enter the locality adjustment national average per resident an Multiply line 22 time line 23	nount (see Fr	nstructions)		0. 00 0	
00	Total direct GME amount (sum of lines 19 and 24)				0	
				t Managed Care	Total	
		-	A 1.00	2.00	3.00	
. 00	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) (Title XIX - see S-2 Part I)	K, line	5, 60	0 3, 793		26.
. 00	3.02, column 2) Total Inpatient Days (see instructions)		19, 79	7 19, 797		27.
. 00 3. 00	Ratio of inpatient days to total inpatient days		0. 28287			28.
	Program direct GME amount			0 0	0	
9.00 9.01 0.00	Percent reduction for MA DGME Reduction for direct GME payments for Medicare Advantage			0	0	29. 30.

Heal th	Financial Systems REHABILITATION HOSPI	TAL OF INDIANA	In Lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-3028	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 01/01/2021 To 12/31/2021	Date/Time Pre	narad
			10 12/31/2021	5/27/2022 7:3	
		Title XVIII	Hospi tal	PPS	
		· ·			
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL	E XVIII ONLY (NURSING PF	ROGRAM AND PARAMED	OI CAL	
32.00	EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B,	Dt I sum of col 20 or	ad 22 Lines 74	0	32.00
32.00	and 94)	Pt. 1, Sull of Col. 20 al	iu 23, TTHES 74	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	0	33.00
34.00	Ratio of direct medical education costs to total charges (lin		,	0.00000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line			0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)			10, 637, 163	
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)			50, 223	•
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minu	is line 40)		10, 586, 940	41.00
	Part B Reasonable Cost			700.0/5	
	Reasonable cost (see instructions)			709, 065	
43.00	Primary payer payments (see instructions)			0 709, 065	
44.00	Total Part B reasonable cost (line 42 minus line 43)				
45.00 46.00	Total reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (lin	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)		11, 296, 005 0. 937229	
46.00	Ratio of Part & reasonable cost to total reasonable cost (III) Ratio of Part B reasonable cost to total reasonable cost (III)			0. 937229	
47.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA			0.002771	47.00
48.00	Total program GME payment (line 31)			0	48.00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		0	
50.00				0	
00.00				0	00.00

	SHEET (If you are nonproprietary and do not maintain	Provider C	CN: 15-3028	Period: From 01/01/2021	Worksheet G	
una-ty nl y)	ype accounting records, complete the General Fund column			To 12/31/2021	Date/Time Pre 5/27/2022 7:3	
		General Fund	Specific Purpose Func		Plant Fund	
1		1.00	2.00	3.00	4.00	
	CURRENT ASSETS Cash on hand in banks	5, 380, 566		0 0	0	1 1
	Temporary investments	281		0 0	0	
	Notes receivable	C		0 0	0	
	Accounts receivable	16, 176, 276		0 0	0	4
00	Other receivable	940, 151		0 0	0	5
00	Allowances for uncollectible notes and accounts receivable	-11, 238, 686		0 0	0	6
	Inventory	385, 443		0 0	0	
	Prepaid expenses	593, 056		0 0	0	8
	Other current assets	0		0 0	0	9
	Due from other funds	0		0 0	0	10
	Total current assets (sum of lines 1-10)	12, 237, 087		0 0	0	11
	FI XED ASSETS	1 004 144	1	0 0	0	1 1 1
	Land Land improvements	1, 904, 164 370, 910		0 0	0	
	Accumulated depreciation	-334, 152		0 0	0	14
	Buildings	30, 839, 253		0 0	0	15
	Accumulated depreciation	-15, 077, 186		0 0	0	16
	Leasehold improvements	205, 018		0 0	0	17
	Accumul ated depreciation	-191, 938		0 0	0	18
	Fixed equipment	2, 429, 179		0 0	0	19
	Accumul ated depreciation	-2, 066, 364		0 0	0	20
	Automobiles and trucks	C		0 0	0	21
2.00	Accumulated depreciation	C		0 0	0	22
3.00	Major movable equipment	15, 191, 318		0 0	0	23
4.00	Accumulated depreciation	-13, 512, 083		0 0	0	24
5.00	Minor equipment depreciable	105, 832		0 0	0	25
	Accumulated depreciation	-105, 832		0 0	0	26
	HIT designated Assets	C		0 0	0	
	Accumulated depreciation	0		0 0	0	28
	Minor equipment-nondepreciable	0		0 0	0	29
	Total fixed assets (sum of lines 12-29)	19, 758, 119		0 0	0	30
	OTHER ASSETS Investments	0		0 0	0	31
	Deposits on Leases			0 0	0	32
	Due from owners/officers	1, 306, 123		0 0	0	
	Other assets	602, 474		0 0	0	
	Total other assets (sum of lines 31-34)	1, 908, 597		0 0	0	
	Total assets (sum of lines 11, 30, and 35)	33, 903, 803		0 0	0	
	CURRENT LI ABI LI TI ES		1	-1 -		1
7.00	Accounts payable	2, 675, 059		0 0	0	37
	Salaries, wages, and fees payable	2, 981, 109		0 0	0	38
9.00	Payroll taxes payable	C		0 0	0	39
0. 00	Notes and Loans payable (short term)	905, 000		0 0	0	40
	Deferred income	0		0 0	0	
	Accelerated payments	C				42
	Due to other funds	C		0 0	0	
	Other current liabilities	1,034,889		0 0	0	
H	Total current liabilities (sum of lines 37 thru 44)	7, 596, 057		0 0	0	45
	LONG TERM LI ABI LI TI ES	0	1	0 0	0	1
	Mortgage payable Notes payable	8, 840, 000		0 0	0	
	Unsecured Loans	8, 840, 000		0 0	0	
	Other long term liabilities			0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	8, 840, 000		0 0	0	
	Total liabilities (sum of lines 45 and 50)	16, 436, 057		0 0		
+	CAPITAL ACCOUNTS					1
	General fund balance	17, 467, 746				52
	Specific purpose fund			0		53
	Donor created - endowment fund balance - restricted			0		54
5.00	Donor created - endowment fund balance - unrestricted			0		55
5.00	Governing body created - endowment fund balance			0		56
7.00	Plant fund balance - invested in plant				0	57
8.00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					.
	Total fund balances (sum of lines 52 thru 58)	17, 467, 746		0 0	0	
	Total liabilities and fund balances (sum of lines 51 and	33, 903, 803	1	0 0	0	60

STATE	IENT OF CHANGES IN FUND BALANCES		Provider CC	N: 15-3028	Period: From 01/01/2021 To 12/31/2021		Worksheet G- Date/Time Pr 5/27/2022 7:	epa	ared: am
		General	Fund	Speci al	Pur	rpose Fund	Endowment Fun		
		1.00	2.00	3.00		4.00	5.00	-	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		16, 739, 405 728, 341 17, 467, 746 0 17, 467, 746 17, 467, 746			0 0 0 0 0 0 0			$\begin{array}{c} 1. \ 000\\ 2. \ 000\\ 3. \ 000\\ 4. \ 000\\ 5. \ 000\\ 6. \ 000\\ 7. \ 000\\ 8. \ 000\\ 10. \ 000\\ 11. \ 000\\ 11. \ 000\\ 12. \ 000\\ 13. \ 000\\ 14. \ 000\\ 15. \ 000\\ 15. \ 000\\ 16. \ 000\\ 17. \ 000\\ 18. \ 000\\ 19. \ 000\\ 19. \ 000\\ 19. \ 000\\ 19. \ 000\\ 19. \ 000\\ 19. \ 000\\ 19. \ 000\\ 19. \ 000\\ 19. \ 000\\ 19. \ 000\\ 19. \ 000\\ 19. \ 000\\ 19. \ 000\\ 19. \ 000\\ 10. \ 000\ 000\\ 10. \ 000\ 000\ 000\ 000\ 000\ 000\ 000$
		Endowment Fund	PI ant	Fund					
1 00		6.00	7.00	8.00					1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0 0	0 0 0 0 0		0 0				10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00

ATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-3028		riod: om 01/01/2021 12/31/2021	Worksheet G-2 Parts I & II Date/Time Pre 5/27/2022 7:3	pared
	Cost Center Description		Inpatient		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						-
~~	General Inpatient Routine Services		42 245 5	4.2		42 245 542	1 1 0
00	Hospi tal		43, 245, 5	43		43, 245, 543	
00	SUBPROVIDER - IPF						2.0
00	SUBPROVIDER - IRF						3.0
00	SUBPROVIDER			~		0	4.0
00	Swing bed - SNF			0		0	
00	Swing bed - NF			0		0	
00	SKILLED NURSING FACILITY						7.0
00	NURSI NG FACI LI TY						8. C
00	OTHER LONG TERM CARE						9.0
. 00	Total general inpatient care services (sum of lines 1-9)		43, 245, 5	43		43, 245, 543	10. C
	Intensive Care Type Inpatient Hospital Services				1		
. 00	INTENSIVE CARE UNIT						11.0
. 00	CORONARY CARE UNI T						12.0
	BURN INTENSIVE CARE UNIT						13.0
. 00	SURGI CAL I NTENSI VE CARE UNI T						14.0
. 00	OTHER SPECIAL CARE (SPECIFY)						15.0
. 00	Total intensive care type inpatient hospital services (sum of I	lines		0		0	16.0
	11-15)						
. 00	Total inpatient routine care services (sum of lines 10 and 16)		43, 245, 5	43		43, 245, 543	17.0
. 00	Ancillary services		53, 179, 6	28	19, 029, 751	72, 209, 379	18.0
. 00	Outpatient services	1	240, 7	84	3, 289, 962	3, 530, 746	19.0
. 00	RURAL HEALTH CLINIC			0	0	0	20.0
. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.0
. 00	HOME HEALTH AGENCY						22.0
. 00	AMBULANCE SERVI CES						23.0
. 00	СМНС				o	0	24.0
. 10	CORF			0	0	0	
. 00	AMBULATORY SURGICAL CENTER (D. P.)			-	-		25.0
. 00	HOSPICE						26.0
. 00	OTHER (SPECIFY)			0	0	0	27.0
. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	96, 665, 9	55	22, 319, 713	118, 985, 668	
	G-3, line 1)		, 0, 000, ,	00	22,017,710	110, 700, 000	20.0
	PART II - OPERATING EXPENSES	L			I		1
. 00	Operating expenses (per Wkst. A, column 3, line 200)				47,007,529		29.0
. 00	ADD (SPECIFY)			0			30. (
. 00				0			31. (
. 00				0			32. (
. 00				0			33. (
. 00				0			34. (
. 00				0			35.0
. 00	Total additions (sum of lines 30-35)			Ŭ	o		36.0
. 00	DEDUCT (SPECIFY)			0	0		37.0
. 00				0			38.0
. 00				0			39.0
. 00				0			
							40.0
. 00	Tatal daduations (sum of lines 27 41)			0	~		41.0
. 00	Total deductions (sum of lines 37-41)				0		42.0
. 00	Total operating expenses (sum of lines 29 and 36 minus line 42) to Wkst. G-3, line 4)	(transfer			47, 007, 529		43.0

Health Financial Systems REHABILITATION HO STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-3028	Peri od:	u of Form CMS-2552- Worksheet G-3	
STATEMENT OF REVENUES AND EXPENSES Provider O		PLOVIDEL CON. 13-3028	From 01/01/2021	WULKSHEEL G-3	
	To 12/31/2021			Date/Time Prepare	
				5/27/2022 7:34	4 am
				1.00	
				1.00	1.0
. 00	otal patient revenues (from Wkst. G-2, Part I, column 3, line 28)			118, 985, 668	1.0
2.00				73, 534, 284	
. 00	Net patient revenues (line 1 minus line 2)			45, 451, 384	
. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			47,007,529	
. 00	Net income from service to patients (line 3 minus line 4	.)		-1, 556, 145	5.0
00	OTHER I NCOME				
. 00	Contributions, donations, bequests, etc			0	6.
. 00	Income from investments			0	7.
. 00	Revenues from telephone and other miscellaneous communic	ation services		0	8.
. 00	Revenue from television and radio service			0	
0. 00	Purchase di scounts			0	10.
1. 00	Rebates and refunds of expenses			0	11.
2.00	Parking lot receipts			0	12.
3.00	Revenue from laundry and linen service			0	13.
	Revenue from meals sold to employees and guests			0	14.
	Revenue from rental of living quarters			0	15.
5.00	Revenue from sale of medical and surgical supplies to ot	her than patients		0	16.
7.00	Revenue from sale of drugs to other than patients			0	17.
8.00	Revenue from sale of medical records and abstracts			0	18.
9.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.
0. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.
1.00	Rental of vending machines			0	21.
2.00	Rental of hospital space			0	22.
3.00	Governmental appropriations			0	23.
	MI SCELLANEOUS I NCOME			2, 186, 149	24.
	COVID-19 PHE Funding			98, 337	
5.00	Total other income (sum of lines 6-24)			2, 284, 486	
6.00	Total (line 5 plus line 25)			728, 341	26.
	OTHER EXPENSES (SPECIFY)			, 20, 011	27.
8.00	Total other expenses (sum of line 27 and subscripts)			0	28.
9.00	Net income (or loss) for the period (line 26 minus line	00)		728, 341	