

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2012

Open to Public Inspection

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990. ▶ See separate instructions.

Department of the Treasury
Internal Revenue Service

Name of the organization REHABILITATION HOSPITAL OF INDIANA, INC.	Employer identification number 35 1786005
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Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a ✓	
b If "Yes," was it a written policy?	1b ✓	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____%	3a ✓	
b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____%	3b ✓	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4 ✓	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a ✓	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b ✓	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c	✓
6a Did the organization prepare a community benefit report during the tax year?	6a ✓	
b If "Yes," did the organization make it available to the public?	6b ✓	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			702,982	0	702,982	1.93
b Medicaid (from Worksheet 3, column a)			3,639,366	1,800,897	1,838,469	5.04
c Costs of other means-tested government programs (from Worksheet 3, column b)			0	0	0	0.00
d Total Financial Assistance and Means-Tested Government Programs	0	0	4,342,348	1,800,897	2,541,451	6.97
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			33,996	9,305	24,691	0.07
f Health professions education (from Worksheet 5)			221,246	107,605	113,641	0.31
g Subsidized health services (from Worksheet 6)			0	0	0	0.00
h Research (from Worksheet 7)			93,524	0	93,524	0.26
i Cash and in-kind contributions for community benefit (from Worksheet 8)			5,700	0	5,700	0.02
j Total Other Benefits	0	0	354,466	116,910	237,556	0.66
k Total. Add lines 7d and 7j	0	0	4,696,814	1,917,807	2,779,007	7.63

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing				0	0.00
2	Economic development				0	0.00
3	Community support				0	0.00
4	Environmental improvements				0	0.00
5	Leadership development and training for community members				0	0.00
6	Coalition building				0	0.00
7	Community health improvement advocacy				0	0.00
8	Workforce development				0	0.00
9	Other				0	0.00
10	Total	0	0	0	0	0.00

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

	Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	✓
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2	0
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3	0
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5	14,924,991
6 Enter Medicare allowable costs of care relating to payments on line 5	6	15,360,169
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-435,178
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

Section C. Collection Practices

9a Did the organization have a written debt collection policy during the tax year?	9a	✓
b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	9b	✓

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1				
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12				
13				

Part V Facility Information (continued)

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or facility reporting group REHABILITATION HOSPITAL OF INDIANA

For single facility filers only: line number of hospital facility (from Schedule H, Part V, Section A) 1

Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)

1 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9.

If "Yes," indicate what the CHNA report describes (check all that apply):

- a A definition of the community served by the hospital facility
- b Demographics of the community
- c Existing health care facilities and resources within the community that are available to respond to the health needs of the community
- d How data was obtained
- e The health needs of the community
- f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
- g The process for identifying and prioritizing community health needs and services to meet the community health needs
- h The process for consulting with persons representing the community's interests
- i Information gaps that limit the hospital facility's ability to assess the community's health needs
- j Other (describe in Part VI)

2 Indicate the tax year the hospital facility last conducted a CHNA: 20__

3 In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted

4 Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI

5 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):

- a Hospital facility's website
- b Available upon request from the hospital facility
- c Other (describe in Part VI)

6 If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply to date):

- a Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA
- b Execution of the implementation strategy
- c Participation in the development of a community-wide plan
- d Participation in the execution of a community-wide plan
- e Inclusion of a community benefit section in operational plans
- f Adoption of a budget for provision of services that address the needs identified in the CHNA
- g Prioritization of health needs in its community
- h Prioritization of services that the hospital facility will undertake to meet health needs in its community
- i Other (describe in Part VI)

7 Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs.

8a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?

b If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?

c If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$

	Yes	No
1		
3		
4		
5		
7		
8a		
8b		

Part V Facility Information (continued)

Financial Assistance Policy		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	9	✓
10	Used federal poverty guidelines (FPG) to determine eligibility for providing <i>free</i> care? If "Yes," indicate the FPG family income limit for eligibility for free care: <u>2</u> <u>0</u> <u>0</u> % If "No," explain in Part VI the criteria the hospital facility used.	10	✓
11	Used FPG to determine eligibility for providing <i>discounted</i> care? If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>4</u> <u>0</u> <u>0</u> % If "No," explain in Part VI the criteria the hospital facility used.	11	✓
12	Explained the basis for calculating amounts charged to patients? If "Yes," indicate the factors used in determining such amounts (check all that apply):	12	✓
a	<input checked="" type="checkbox"/> Income level		
b	<input checked="" type="checkbox"/> Asset level		
c	<input checked="" type="checkbox"/> Medical indigency		
d	<input checked="" type="checkbox"/> Insurance status		
e	<input checked="" type="checkbox"/> Uninsured discount		
f	<input checked="" type="checkbox"/> Medicaid/Medicare		
g	<input checked="" type="checkbox"/> State regulation		
h	<input type="checkbox"/> Other (describe in Part VI)		
13	Explained the method for applying for financial assistance?	13	✓
14	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	14	✓
a	<input checked="" type="checkbox"/> The policy was posted on the hospital facility's website		
b	<input type="checkbox"/> The policy was attached to billing invoices		
c	<input type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d	<input type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e	<input checked="" type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f	<input checked="" type="checkbox"/> The policy was available on request		
g	<input checked="" type="checkbox"/> Other (describe in Part VI)		
Billing and Collections			
15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	15	✓
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Part VI)		
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged:	17	✓
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Part VI)		

Part V Facility Information *(continued)*

- 18** Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):
- a** Notified individuals of the financial assistance policy on admission
 - b** Notified individuals of the financial assistance policy prior to discharge
 - c** Notified individuals of the financial assistance policy in communications with the patients regarding the patients' bills
 - d** Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy
 - e** Other (describe in Part VI)

Policy Relating to Emergency Medical Care

		Yes	No
19	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?		✓
If "No," indicate why:			
a	<input checked="" type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility's policy was not in writing		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)		
d	<input checked="" type="checkbox"/> Other (describe in Part VI)		

Charges to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)

20	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	<input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged		
b	<input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged		
c	<input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged		
d	<input checked="" type="checkbox"/> Other (describe in Part VI)		
21	During the tax year, did the hospital facility charge any of its FAP-eligible individuals, to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care?		✓
If "Yes," explain in Part VI.			
22	During the tax year, did the hospital facility charge any FAP-eligible individuals an amount equal to the gross charge for any service provided to that individual?		✓
If "Yes," explain in Part VI.			

Part V Facility Information *(continued)*

Section C. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? 2

Name and address	Type of Facility (describe)
1 NEURO REHAB CENTER 9531 VALPARAISO COURT INDIANAPOLIS, IN 45268	OUTPATIENT NEURO REHAB THERAPY
2 REHABILITATION HOSPITAL OF INDIANA - CARMEL 12425 OLD MERIDIAN STREET, SUITE B2 CARMEL, IN 46032	OUTPATIENT REHABILITATION THERAPY
3	
4	
5	
6	
7	
8	
9	
10	

Part VI

Supplemental Information

Complete this part to provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B
- 3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves
- 5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.)
- 6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served
- 7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

Return Reference	Identifier	Explanation
SCHEDULE H, PART I, LINE 7	COSTING METHODOLOGY USED TO CALCULATE FINANCIAL ASSISTANCE	THE COST TO CHARGE RATIO BASED ON WORKSHEET 2 WAS USED TO CALCULATE THE AMOUNTS REPORTED ON LINES A-D. LINES E-J ARE REPORTED BASED ON ACTUAL COSTS INCURRED.
SCHEDULE H, PART I, LINE 7, COLUMN(F)	BAD DEBT EXPENSE EXCLUDED FROM FINANCIAL ASSISTANCE CALCULATION	0
SCHEDULE H, PART III, LINE 2	BAD DEBT EXPENSE - METHODOLOGY USED TO ESTIMATE AMOUNT	ALLOWANCES FOR DOUBTFUL ACCOUNTS: THE PROVISION FOR BAD DEBTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED COLLECTIONS OF ACCOUNTS RECEIVABLE CONSIDERING BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTHCARE COVERAGE, AND OTHER COLLECTION INDICATORS. ACCOUNTS RECEIVABLE ARE WRITTEN OFF AND CHARGED TO THE PROVISION FOR BAD DEBTS AFTER COLLECTION EFFORTS HAVE BEEN MADE IN ACCORDANCE WITH THE HOSPITAL'S POLICIES. RECOVERIES ARE TREATED AS A REDUCTION TO THE PROVISION FOR BAD DEBTS. ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS. PERIODICALLY, MANAGEMENT ASSESSES THE ADEQUACY OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS BASED UPON HISTORICAL WRITE-OFF EXPERIENCE BY MAJOR PAYER CATEGORY. DATA ABOUT THE MAJOR PAYER SOURCES OF REVENUE IS ANALYZED TO ESTABLISH AN APPROPRIATE ALLOWANCE FOR UNCOLLECTIBLE RECEIVABLES AND PROVISION FOR BAD DEBTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, CONTRACTUALLY DUE AMOUNTS ARE ANALYZED AND COMPARED TO ACTUAL CASH COLLECTED OVER TIME TO ENHANCE THE QUALITY OF THE ESTIMATE OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS PROVISION FOR BAD DEBTS. FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), A SIGNIFICANT ALLOWANCE FOR DOUBTFUL ACCOUNTS IS RECORDED ON THE BASIS OF HISTORICAL EXPERIENCE, WHICH INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. AN ESTIMATE OF THE DIFFERENCE BETWEEN CONTRACTED RATES AND AMOUNTS ACTUALLY COLLECTED, AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED, IS CHARGED TO THE PROVISION FOR BAD DEBTS AND CREDITED TO THE ALLOWANCE FOR DOUBTFUL ACCOUNTS.
SCHEDULE H, PART III, LINE 3	BAD DEBT EXPENSE - METHODOLOGY USED TO ESTIMATE AMOUNT AS COMMUNITY BENEFIT	N/A
SCHEDULE H, PART III, LINE 4	BAD DEBT EXPENSE - FINANCIAL STATEMENT FOOTNOTE	FOOTNOTE TO THE AUDITED FINANCIAL STATEMENT. ALLOWANCES FOR DOUBTFUL ACCOUNTS: THE PROVISION FOR BAD DEBTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED COLLECTIONS OF ACCOUNTS RECEIVABLE CONSIDERING BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTHCARE COVERAGE, AND OTHER COLLECTION INDICATORS. ACCOUNTS RECEIVABLE ARE WRITTEN OFF AND CHARGED TO THE PROVISION FOR BAD DEBTS AFTER COLLECTION EFFORTS HAVE BEEN MADE IN ACCORDANCE WITH THE HOSPITAL'S POLICIES. RECOVERIES ARE TREATED AS A REDUCTION TO THE PROVISION FOR BAD DEBTS. ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS. PERIODICALLY, MANAGEMENT ASSESSES THE ADEQUACY OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS BASED UPON HISTORICAL WRITE-OFF EXPERIENCE BY MAJOR PAYER CATEGORY. DATA ABOUT THE MAJOR PAYER SOURCES OF REVENUE IS ANALYZED TO ESTABLISH AN APPROPRIATE ALLOWANCE FOR UNCOLLECTIBLE RECEIVABLES AND PROVISION FOR BAD DEBTS. FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD-PARTY COVERAGE, CONTRACTUALLY DUE AMOUNTS ARE ANALYZED AND COMPARED TO ACTUAL CASH COLLECTED OVER TIME TO ENHANCE THE QUALITY OF THE ESTIMATE OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS PROVISION FOR BAD DEBTS. FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS (WHICH INCLUDES BOTH PATIENTS WITHOUT INSURANCE AND PATIENTS WITH DEDUCTIBLE AND COPAYMENT BALANCES DUE FOR WHICH THIRD-PARTY COVERAGE EXISTS FOR PART OF THE BILL), A SIGNIFICANT ALLOWANCE FOR DOUBTFUL ACCOUNTS IS RECORDED ON THE BASIS OF HISTORICAL EXPERIENCE, WHICH

Return Reference	Identifier	Explanation	
		INDICATES THAT MANY PATIENTS ARE UNABLE OR UNWILLING TO PAY THE PORTION OF THEIR BILL FOR WHICH THEY ARE FINANCIALLY RESPONSIBLE. AN ESTIMATE OF THE DIFFERENCE BETWEEN CONTRACTED RATES AND AMOUNTS ACTUALLY COLLECTED, AFTER ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED, IS CHARGED TO THE PROVISION FOR BAD DEBTS AND CREDITED TO THE ALLOWANCE FOR DOUBTFUL ACCOUNTS.	
SCHEDULE H, PART III, LINE 8	COMMUNITY BENEFIT & METHODOLOGY FOR DETERMINING MEDICARE COSTS	ANY COST INCURRED FOR TREATMENT OF A PATIENT IN WHICH THE TOTAL AMOUNT OF REVENUE WAS NOT COLLECTED, IS REPORTED AS A SHORTFALL. THE SHORTFALL IS DUE TO CONTINUED CUTS IN MEDICARE REIMBURSEMENT WHILE RHI CONTINUES TO INVEST IN STATE-OF-THE-ART EQUIPMENT AND FACILITIES TO MEET THE CHALLENGING HEALTHCARE NEEDS OF THE COMMUNITY. MEDICARE ALLOWABLE COSTS WERE DETERMINED BASED ON THE COST TO CHARGE RATIO FROM THE FY 2012 MEDICARE COST REPORT.	
SCHEDULE H, PART III, LINE 9B	COLLECTION PRACTICES FOR PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE	THE HOSPITAL'S COLLECTION POLICY CONTAINS PROVISIONS ON PRACTICES TO BE FOLLOWED FOR PATIENTS WHO ARE KNOWN TO QUALIFY FOR FINANCIAL ASSISTANCE. THE COLLECTION POLICY STATES THAT RHI WILL NOT ENGAGE IN EXTRAORDINARY COLLECTION ACTIONS BEFORE MAKING REASONABLE EFFORTS TO DETERMINE WHETHER A PATIENT IS ELIGIBLE FOR ASSISTANCE UNDER RHI'S FINANCIAL ASSISTANCE POLICY.	
SCHEDULE H, PART V SECTION B, LINE 14G	OTHER WAYS HOSPITAL PUBLICIZED FINANCIAL ASSISTANCE POLICY	(a) Facility	(b) Explanation
		(1) REHABILITATION HOSPITAL OF INDIANA	INSTEAD OF THE DETAILED POLICY, THE HOSPITAL FACILITY PROVIDED A SUMMARY OF THE POLICY WITH EACH PATIENT'S STATEMENT IN A MANNER LISTED IN LINES 14 A-F.
SCHEDULE H, PART V SECTION B, LINE 19D	NONDISCRIMINATORY POLICY	(a) Facility	(b) Explanation
		(1) REHABILITATION HOSPITAL OF INDIANA	RHI IS NOT A GENERAL ACUTE CARE HOSPITAL/FACILITY NOR IS RHI EQUIPPED TO PROVIDE CARE TO PATIENTS WITH URGENT CARE NEEDS. RHI IS A SPECIALTY PROVIDER OF REHABILITATION SERVICES SUCH AS PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY.
SCHEDULE H, PART V SECTION B, LINE 20D	MEANS USED TO DETERMINE AMOUNTS BILLED	(a) Facility	(b) Explanation
		(1) REHABILITATION HOSPITAL OF INDIANA	THE HOSPITAL LIMITS THE AMOUNT CHARGED TO FAP ELIGIBLE INDIVIDUALS. FAP ELIGIBLE INDIVIDUALS WILL NOT BE CHARGED MORE THAN THE AMOUNTS GENERALLY BILLED (AGB) TO THOSE INDIVIDUALS WHO DO HAVE INSURANCE. THE AGB IS CALCULATED BASED ON THE LOOK-BACK METHOD FOR PAYERS INCLUDING MEDICARE FEE FOR SERVICES ALONG WITH ALL PRIVATE HEALTH INSURERS.
SCHEDULE H, PART VI, LINE 2	NEEDS ASSESSMENT.	RHI COMPLETED THE COMMUNITY HEALTH NEEDS ASSESSMENT IN CONJUNCTION WITH OUR MAJORITY OWNER/MEMBER HOSPITAL (INDIANA UNIVERSITY HEALTH). RHI'S PRIMARY SERVICE AREA (PSA) IS MARION COUNTY. THE AREAS OF NEED THAT WERE IDENTIFIED FROM THIS PSA BY THE NEEDS ASSESSMENT WERE : OBESITY, ACCESS TO CARE, MENTAL HEALTH, PRENATAL CARE AND TOBACCO USE. RHI DETERMINED THAT WE COULD IMPACT 3 OF THESE AREAS OF NEED. THE THREE AREAS CHOSEN BY RHI WERE: OBESITY, ACCESS TO CARE AND MENTAL HEALTH NEEDS. AN IMPLEMENTATION STRATEGY IS BEING DEVELOPED WHICH ADDRESSES HOW RHI WILL CONTRIBUTE TO EACH OF THESE THREE COMMUNITY HEALTH NEEDS. RHI ALSO EVALUATES THE HOSPITAL'S ACCESSIBILITY ON AN ANNUAL BASIS VIA AN ANNUAL ACCESSIBILITY STUDY. THIS PLAN INCLUDES ACTIONS TO FURTHER THE INTENT OF CREATING ACCESSIBLE FACILITIES, PROGRAMS AND COMMUNITIES FOR PERSONS WITH DISABILITIES. IN ADDITION, RHI ATTEMPTS TO ADDRESS THE NEEDS OF PEOPLE WITH DISABILITIES THROUGH TREATMENT PROGRAMS AND SERVICES, COMMUNITY PROGRAMMING AND COMMUNITY AWARENESS. THE PLAN WAS DEVELOPED WITH INPUT FROM PERSONS SERVED, SUPPORT GROUP INPUT, CLINICAL OUTCOMES DATA, SATISFACTION SURVEYS, RHI PERSONNEL USING SUGGESTIONS AND INPUT FROM COMMUNITY INVOLVEMENT AND OTHER STAKEHOLDERS.	
SCHEDULE H, PART VI, LINE 3	PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE.	PATIENTS ARE INFORMED ABOUT FINANCIAL ASSISTANCE BEFORE ADMISSIONS BY THE CLINICAL LIAISON. THIS OCCURS WITH THE PATIENT IS AT THE GENERAL ACUTE CARE HOSPITAL BEFORE TRANSFERRING TO RHI. PATIENTS ARE ALSO INFORMED OF FINANCIAL ASSISTANCE DURING REGISTRATION BY THE ADMISSIONS REPRESENTATIVE AND A SUMMARY OF THE FINANCIAL ASSISTANCE POLICY IS INCLUDED IN EACH ADMISSION PACKET. DURING THE PATIENT'S STAY, THE DISCHARGE PLANNER WILL WORK WITH THE PATIENT IN COMPLETING THE FINANCIAL ASSISTANCE APPLICATION. PATIENTS ARE INFORMED AGAIN OF FINANCIAL ASSISTANCE DURING THE DISCHARGE PROCESS BY THE DISCHARGE PLANNERS. THE DISCHARGE PLANNERS WILL CONTINUE TO WORK WITH THE PATIENTS AFTER DISCHARGE, IF THE SITUATION REQUIRES. PATIENTS RECEIVE A SUMMARY OF THE FAP WITH ALL STATEMENTS. RHI WILL ALSO MAIL A SUMMARY OF THE POLICY ALONG WITH A FINANCIAL ASSISTANCE APPLICATION TO ANY UNINSURED PATIENT THAT HAS A BALANCE ON HIS/HER ACCOUNT. RHI ALSO PUBLICIZES ITS FAP ON THE HOSPITAL WEBSITE. RHI WILL PROVIDE REPRESENTATIVES TO ASSIST PATIENTS WITH THE FINANCIAL ASSISTANCE PROCESS MONDAY THROUGH FRIDAY FROM 8AM TO 5PM.	
SCHEDULE H, PART VI, LINE 4	COMMUNITY INFORMATION.	RHI SERVES ADOLESCENTS THROUGH ADULTS WITH PHYSICAL AND COGNITIVE DISABILITIES PRIMARILY FROM 100-MILE RADIUS OF RHI BUT CATCHMENT AREA NORMALLY INCLUDES ALL 92 INDIANA COUNTIES AND SURROUNDING STATES. RHI OFFERS SERVICES FOR INPATIENT FOR 91 BEDS AND 3 OUTPATIENT LOCATIONS. ONE LOCATION IS LOCATED WITHIN THE HOSPITAL AND TWO OFFICES CONVENIENTLY LOCATED AT SEPARATE LOCATIONS. RHI'S CORE SERVICES ARE STRUCTURED THROUGH SPECIALIZED UNITS. BY DOING SO, A REHABILITATIVE ENVIRONMENT IS CREATED THAT FOSTERS PROGRESSIVE LEADERSHIP, INNOVATION AND QUALITY THAT WILL LEAD TO PREEMINENT PATIENT CARE AND OUTCOMES. RHI'S MAIN SERVICES INCLUDE BUT NOT LIMITED TO STROKE REHABILITATION, BRAIN AND SPINAL CORD INJURY, MULTIPLE TRAUMA REHABILITATION AND ORTHOPEDIC REHABILITATION. RHI IS THE LARGEST FREESTANDING ACUTE REHABILITATION HOSPITAL IN INDIANA COUPLED WITH BEING THE ONLY REHAB HOSPITAL WITH CARF CERTIFICATION IN SPINAL CORD INJURY, GENERAL COMPREHENSIVE REHAB, BRAIN INJURY AND STROKE REHABILITATION.	

Return Reference	Identifier	Explanation
		<p>FOR 2012, NINETY FIVE PERCENT OF PATIENTS TREATED WERE NATIVES OF INDIANA. SIXTY PERCENT OF THE PATIENTS WERE FROM MARION COUNTY (INDIANAPOLIS), WHEREAS TWENTY-FIVE PERCENT WERE RESIDENTS OF COUNTIES SURROUNDING MARION COUNTY. RHI'S PRIMARY SERVICE AREA (PSA) IS IDENTIFIED AS MARION COUNTY. BASED ON THE MOST RECENT CENSUS BUREAU STATISTICS (2010), MARION COUNTY HAS A POPULATION OF 903,393 PERSONS WITH APPROXIMATELY 52% BEING FEMALE AND 48% BEING MALE. THE COUNTY'S POPULATION ESTIMATES BY RACE ARE 59.6% WHITE, 27.0% BLACK, 9.6% HISPANIC OR LATINO, 2.1% ASIAN, 0.5% AMERICAN INDIAN OR ALASKA NATIVE, AND 2.5% PERSON REPORTING TWO OR MORE RACES. A POVERTY RATE OF 19.7% WAS REPORTED IN 2009 FOR MARION COUNTY, RISING FROM 16.5% IN 2008. BASED ON US CENSUS BUREAU DATA (2009), MARION COUNTY'S PER CAPITAL PERSONAL INCOME WAS ESTIMATED TO BE \$36,409, WHICH IS ABOVE THE STATE'S AVERAGE OF \$33,323; AND A MEDIAN HOUSEHOLD INCOME OF \$41,201, WHICH IS BELOW THE STATE'S AVERAGE OF \$45,427.</p> <p>BASED ON INPATIENT DISCHARGE DATA FROM INDIANA HOSPITAL ASSOCIATION (IHA), 31% OF MARION COUNTY RESIDENTS HAVE COMMERCIAL INSURANCE, 22% ARE INSURED THROUGH MEDICAID, 30% ARE INSURED THROUGH MEDICARE, 11% ARE UNINSURED AND 6% HAVE OTHER GOVERNMENT INSURANCE OR ARE UNKNOWN. AT RHI, IT IS ESTIMATED THAT 54% OF PATIENTS HAVE MEDICARE, 11% HAVE MEDICAID, 2% ARE UNINSURED, AND 33% HAVE COMMERCIAL OR UNKNOWN INSURANCE.</p>
<p>SCHEDULE H, PART VI, LINE 5</p>	<p>PROMOTION OF COMMUNITY HEALTH</p>	<p>RHI CONTINUES TO FORGE POSITIVE RELATIONSHIPS WITH ALL REFERRAL SOURCES TO IDENTIFY ACCESS CHALLENGES AND IMPROVEMENT. THIS IS PRIMARILY FOCUSED ON PARENT HEALTH SYSTEMS, REFERRAL SOURCES AND DISCHARGE SOURCES. RHI ALSO PROVIDES SUPPORT GROUPS FOR PATIENTS AND FAMILIES INCLUDING:</p> <ul style="list-style-type: none"> • STROKE SUPPORT GROUP - MONTHLY ON MAIN CAMPUS • BRAIN INJURY SUPPORT GROUP - MONTHLY ON MAIN CAMPUS AND AT NRC • STROKE CARE GIVERS SUPPORT GROUP - MONTHLY ON MAIN CAMPUS <p>RHI PROVIDES THE SUPPORT GROUPS WITH A MEETING ROOM, ONE STAFF MEMBER'S TIME AND REFRESHMENTS AT NO COST TO THE PATIENTS AND FAMILIES ATTENDING.</p> <p>SUMMARY OF GROUPS AND THEIR PURPOSES:</p> <p>STROKE SUPPORT GROUP</p>
		<p>THERE ARE TWO STROKE SUPPORT GROUPS OFFERED AT RHI. ONE GROUP IS TO TEACH INDIVIDUALS RECOVERING FROM A STROKE COPING SKILLS. THE SECOND STROKE SUPPORT GROUP IS TO PROVIDE TRAINING TO FAMILIES AND LOVED ONES OF THE RECOVERING STROKE PATIENT. THE GROUPS MEET MONTHLY ON THE MAIN HOSPITAL CAMPUS.</p> <p>BRAIN INJURY SUPPORT GROUP</p> <p>THE BRAIN INJURY SUPPORT GROUP TEACHES SURVIVORS OF BRAIN INJURY AND THEIR FAMILY AND CAREGIVERS THROUGH PERTINENT SITUATIONS, GOAL SETTING AND PROVIDING INFORMATION ABOUT RETURN TO WORK. APART FROM THE MONTHLY MEETINGS, SOCIAL GATHERINGS MEET TO DECREASE SOCIAL LONELINESS AND INCREASE SUPPORT IN THE COMMUNITY.</p> <p>RHI BELIEVES SUPPORT GROUPS PROVIDE ITS ATTENDEES WITH COPING SKILLS WHILE PROMOTING THE HEALTH OF THE COMMUNITY IT SERVES. THE SUPPORT GROUPS ENCOURAGE THE COMMUNICATION AMONG VICTIMS AND/OR FAMILY MEMBERS WITH THOSE WHO HAVE SUSTAINED A SIMILAR INJURY AND HAVE RETURNED TO THE COMMUNITY.</p> <p>RHI ALSO PROVIDED AN AQUATICS WELLNESS PROGRAM FOR INDIVIDUALS WITHIN THE COMMUNITY. THIS PROGRAM BENEFITS MEMBERS OF THE COMMUNITY SUCH AS INDIVIDUALS WITH ARTHRITIS AND WOMEN DURING PREGNANCY. THE WATER ALLOWS THEM TO EXERCISE UNDER CONDITIONS THAT THEY NORMALLY WOULD NOT BE ABLE TO EXERCISE. THIS PROGRAM COLLECTS A SMALL FEE TO OFFSET A SMALL PORTION OF THE COST OF THE PROGRAM.</p> <p>EVERY TUESDAY AND THURSDAY EVENINGS, RHI OFFERS A COMMUNITY FITNESS PROGRAM BY MAKING THE THERAPY GYM AVAILABLE TO ALL MEMBERS OF THE COMMUNITY THAT HAVE A PHYSICAL DISABILITY. RHI RECOGNIZES THAT AN INDIVIDUAL WITH PHYSICAL DISABILITY NEEDS TO CONTINUE A HEALTHY LIFE STYLE BY EXERCISING WHICH MAY REQUIRE THE NEED OF SPECIALIZED EQUIPMENT. ONE OR TWO RHI VOLUNTEERS WHO ARE LICENSED THERAPISTS SUPERVISE THE COMMUNITY FITNESS PROGRAM. RHI STAFF VOLUNTEERS THEIR TIME TO PROVIDE SUPERVISION FOR THE PROGRAM, WHICH IS AT NO COST TO THE ATTENDEES.</p> <p>RHI RECOGNIZES THAT MEDICAL REHABILITATION IS A COMPLEX, INTERDISCIPLINARY SYSTEM OF INPATIENT AND OUTPATIENT THERAPIES THAT IS PART OF MORE COMPLEX SYSTEM THAT INCLUDES EMERGENT AND ACUTE CARE FOLLOWING CATASTROPHIC ILLNESS OR INJURY AS WELL AS NETWORKS THAT PROVIDE LONG-TERM SERVICES AND SUPPORT. THIS SYSTEM AND ITS COMPONENTS PROVIDE OPPORTUNITIES FOR A BROAD DIVERSITY OF APPLIED RESEARCH STUDIES. THE TARGETS OF CURRENT RESEARCH AT RHI RANGE FROM INTERVENTIONS TO REDUCE DISABILITY TO A WAY TO BETTER MEASURE REHABILITATION EFFECTIVENESS TO LEADING EDGE METHODS TO EVALUATE PATIENTS AND MAXIMIZE THEIR OUTCOMES.</p> <p>OVERVIEW OF THE RESEARCH RHI CONDUCTS:</p> <ul style="list-style-type: none"> • IDENTIFYING MEDICATIONS THAT ENHANCE RECOVERY FOLLOWING BRAIN INJURY, • IDENTIFYING COMMONLY PRESCRIBED MEDICATIONS FOLLOWING BRAIN INJURY THAT MAY HAVE ADVERSE EFFECTS ON RECOVERY • EVALUATING THE EFFECTIVENESS OF GROUP THERAPY FOR PATIENTS AND FAMILIES TO IMPROVE COPING SKILLS • IMPROVE RETURN TO WORK RATES BY DEVELOPING NETWORKS OF COMMUNITY SERVICES • STUDYING OUTCOMES (COMMUNITY REINTEGRATION, WELL-BEING, AND LIFE SATISFACTION) AFTER BRAIN AND SPINAL INJURIES. • COLLABORATING WITH THE MAYO CLINIC TRAUMATIC BRAIN INJURY SYSTEM, INDIANA UNIVERSITY SCHOOL OF MEDICINE, INDIANA UNIVERSITY HEALTH, ST. VINCENT AND PURDUE UNIVERSITY.
		<ul style="list-style-type: none"> • IMPROVE RETURN TO WORK RATES BY DEVELOPING NETWORKS OF COMMUNITY SERVICES • STUDYING OUTCOMES (COMMUNITY REINTEGRATION, WELL-BEING, AND LIFE SATISFACTION) AFTER BRAIN AND SPINAL INJURIES. • COLLABORATING WITH THE MAYO CLINIC TRAUMATIC BRAIN INJURY SYSTEM, INDIANA UNIVERSITY SCHOOL OF MEDICINE, INDIANA UNIVERSITY HEALTH, ST. VINCENT AND PURDUE UNIVERSITY.

Return Reference	Identifier	Explanation
		AS WE CONTINUE TO GROW AS A REHABILITATION HOSPITAL AND LEADER IN MEDICINE AND RESEARCH DEVELOPMENT, RHI INVITES PHYSICIANS TO CONTACT US ABOUT PATIENTS THAT COULD BE ELIGIBLE FOR REHABILITATION AND PARTICIPATION IN OUR STUDIES AND MEDICAL ADVANCEMENT. THE PARTNERSHIP BETWEEN RHI AND PHYSICIANS IS IMPORTANT IN THE CONTINUAL EFFORT TO SUPPORT AND PROVIDE THE BEST CARE FOR THE PATIENT.
SCHEDULE H, PART VI, LINE 6	AFFILIATED HEALTH CARE SYSTEM	RHI IS OWNED BY TWO MAJOR HEALTH SYSTEMS, INDIANA UNIVERSITY HEALTH (IUH) AND ST. VINCENT HEALTH. IUH IS THE MAJORITY OWNER OF RHI. RHI WORKS PRIMARILY WITH THE IUH SYSTEM ON VARIOUS ACTIVITIES TO ADDRESS THE COMMUNITY NEEDS.
SCHEDULE H, PART VI, LINE 7	STATE FILING OF COMMUNITY BENEFIT REPORT	IN