This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-3028 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/31/2023 9:31 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/31/2023 9: 31 am ] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (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 CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REHABILITATION HOSPITAL OF INDIANA (15-3028) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

|   | SIGNATURE OF CHIEF FINA | NCIAL OFFICER OR ADMINISTRATOR    | CHECKBOX | ELECTRONI C   |   |
|---|-------------------------|-----------------------------------|----------|---|---|
|   | 1                       |                                   |          | SIGNATURE STATEMENT   |   |
| 1 | Mar                     | jorie Basey                       | ı        | 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 |

| V Part | A Part E                 |  |   |   |
|--------|--------------------------|--|---|---|
|        | A lait L                 | HIT  | Title XIX   |   |
| 2.00   | 3.00                     | 4. 00  | 5. 00   |   |
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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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems REHABILITATION HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-3028 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/31/2023 9:31 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 4141 SHORE DRIVE 1.00 PO Box: 1.00 State: IN 2.00 City: INDIANAPOLIS Zip Code: 46254 County: MARION 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)
V | XVIII | XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 REHABILITATION HOSPITAL 153028 26900 5 01/07/1992 3.00 OF INDIANA Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 Hospital -Based (CMHC) I 17.00 17.00 17. 10 Hospital -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 21.00 4 1. 00 3.00 2.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for N Ν 22 01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν 22.02 Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N Ν N 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 2 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

|                  | Financial Systems  | REHABI LI TAT  |  | L OF INDIAN   | ΙA  |  | In Lieu          | of For                                      | m CMS-                   | 2552-10          |
|------------------|--|--|--|---|---|--|------------------|---|--------------------------|------------------|
| HOSPI T          | TAL AND HOSPITAL HEALTH CARE COMPLEX IC  | DENTIFICATION DA   | ATA  | Provider CC   | N: 15-3028  | Period:<br>From 01/0°<br>To 12/3°  | 1/2022<br>1/2022 | Workshoper I<br>Part I<br>Date/T<br>5/31/20 |                          | pared:           |
|                  |  |  | In-State<br>Medicaid<br>paid days  | In-State<br>Medicaid<br>eligible<br>unpaid<br>days                                  | Out-of<br>State<br>Medicaid<br>paid days  | State<br>Medicaid<br>eligible<br>unpaid  | Medica<br>HMO da | ys Med                                      | ther<br>di cai d<br>days |                  |
| 24.00            | 16 this against a sa 1000 has site.  |  | 1.00   | 2.00  | 3.00  | 4. 00  | 5. 00            |   | 5. 00                    | 24.00            |
| 24. 00<br>25. 00 | If this provider is an IPPS hospital, in-state Medicaid paid days in column Medicaid eligible unpaid days in colum out-of-state Medicaid paid days in columout-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible but column 5, and other Medicaid days in column 5, and other Medicaid days in column 1, the in Medicaid paid days in column 1, the in Medicaid eligible unpaid days in column 1, the in out-of-state Medicaid days in column 1, the in Medicaid eligible unpaid days in column 1, the in Medicaid eligible unpaid days in column 1, the in Medicaid eligible unpaid days in column 1, the in Medicaid eligible unpaid days in column 1, the in Medicaid eligible unpaid days in column 1, the in Medicaid eligible unpaid days in column 2, the medicaid eligible but unpaid days | 1, in-state nn 2, umn 3, days in column unpaid days in column 6. in-state n-state nn 2, 3, out-of-state nn 4, Medicaid | 534  |   | 0   | 0  | 4,               | 331   | O                        | 24. 00<br>25. 00 |
|                  | primo para ana erigibre bat unpara days  | TH COLUMN 5.   |  |   |   | Urban/Ru   | ural S           | Date of                                     | Geogr                    |                  |
| 04 55            | le de la companya de   | Clarity Control  |  |   |   | 1. 0   |                  | 2.  |                          |                  |
| 26. 00           | Enter your standard geographic classificost reporting period. Enter "1" for u  |  |  | s at the be   | ginning of  | tne  | 1                |   |                          | 26. 00           |
|                  | Enter your standard geographic classif<br>reporting period. Enter in column 1, '<br>enter the effective date of the geogra   | fication (not w<br>'1" for urban o<br>aphic reclassif  | age) status<br>r "2" for i<br>ïcation in   | rural. If a<br>column 2.  | ppl i cabl e,   |  | 1                |   |                          | 27.00            |
| 35. 00           | If this is a sole community hospital (effect in the cost reporting period.   | (SCH), enter th  | e number of  | periods S   | CH status i   | n  | 0                |   |                          | 35.00            |
|                  | perfect in the cost reporting period.  |  |  |   |   | Begi nn  | i ng:            | Endi  | ng:                      |                  |
| 24 00            | Enter appliable beginning and anding   | datas of CCII o  | tatua Cubi   | onint lino  | 2/ for num  | 1.0  | 0                | 2.  | 00                       | 24 00            |
| 36.00            | Enter applicable beginning and ending of periods in excess of one and enter  |  |  | script iine   | 36 TOT NUM  | ber  |                  |   |                          | 36.00            |
| 37. 00           | If this is a Medicare dependent hospit   | tal (MDH), ente  |  | er of perio   | ds MDH stat   | us   | О                |   |                          | 37.00            |
| 37. 01           | is in effect in the cost reporting per<br>Is this hospital a former MDH that is<br>accordance with FY 2016 OPPS final rul  | eligible for t   |  |   |   |  |                  |   |                          | 37. 01           |
| 38. 00           | instructions) If line 37 is 1, enter the beginning a greater than 1, subscript this line for enter subsequent dates.   |  |  |   |   |  |                  |   |                          | 38.00            |
|                  |  |  |  |   |   | Y/N  |                  | Υ/  |                          |                  |
| 39. 00           | Does this facility qualify for the inp   | nationt bosnita  | L paymont o  | adi ustmont   | for Low vol   | 1.0<br>ume N   | 0                | 2.  |                          | 39.00            |
|                  | hospitals in accordance with 42 CFR §4<br>1 "Y" for yes or "N" for no. Does the<br>accordance with 42 CFR 412.101(b)(2)(i<br>or "N" for no. (see instructions)   | 412.101(b)(2)(i<br>facility meet<br>), (ii), or (i   | ), (ii), on<br>the mileage<br>ii)? Enter   | (iii)? En<br>e requireme<br>in column   | ter in colu<br>nts in<br>2 "Y" for y  | mn<br>es   |                  | ,   |                          | 40.00            |
| 40.00            | Is this hospital subject to the HAC pr<br>"N" for no in column 1, for discharges<br>no in column 2, for discharges on or a   | s prior to Octo  | ber 1. Ente  | er "Y" for  |   |  |                  |   |                          | 40.00            |
|                  |  |  |  |   |   |  | 1. 00            | 2. 00                                       | 3. 00                    | -                |
|                  | Prospective Payment System (PPS)-Capi  |  |  |   |   |  |                  |   |                          |                  |
| 45. 00           | Does this facility qualify and receive with 42 CFR Section §412.320? (see ins  |  | nt for disp  | proporti ona  | te share in   | accordance   | N                | N   | N                        | 45.00            |
| 46. 00           | Is this facility eligible for addition pursuant to 42 CFR §412.348(f)? If yes Pt. III.   | nal payment exc  |  |   |   |  | N                | N   | N                        | 46. 00           |
| 47. 00           | Is this a new hospital under 42 CFR §4   |  |  |   |   |  | N                | N   | N                        | 47.00            |
| 48. 00<br>56. 00 | Is the facility electing full federal<br>Teaching Hospitals<br>Is this a hospital involved in training   |  |  |   |   |  | N                | N   | N                        | 48. 00<br>56. 00 |
|                  | periods beginning prior to December 27 cost reporting periods beginning on of the instructions. For column 2, if the involved in training residents in appliand are you are impacted by CR 11642 ("Y" for yes; otherwise, enter "N" for  | 7, 2020, enter<br>rafter Decembe<br>e response to c<br>roved GME progr<br>(or applicable<br>no in column 2             | "Y" for yes<br>r 27, 2020,<br>olumn 1 is<br>ams in the<br>CRs) MA dir                            | s or "N" fo<br>under 42<br>"Y", or if<br>prior year<br>rect GME pa                  | r no in col<br>CFR 413.78(<br>this hospi<br>or penulti<br>yment reduc                           | umn 1. For<br>b)(2), see<br>tal was<br>mate year,<br>tion? Enter                   |                  | ı   |                          |                  |
| 57. 00           | For cost reporting periods beginning pist this the first cost reporting period at this facility? Enter "Y" for yes cresidents start training in the first "N" for no in column 2. If column 2 icomplete Wkst. D, Parts III & IV and I beginning on or after December 27, 202 which month(s) of the cost report the for yes, enter "Y" for yes in column of   | od during which or "N" for no i month of this s "Y", complet 0-2, Pt. II, if 20, under 42 CF residents were            | residents<br>n column 1.<br>cost report<br>e Worksheet<br>applicable<br>R 413.77(e<br>on duty, i | in approve If column ting period t E-4. If column e. For cost )(1)(iv) a f the resp | d GME progr<br>1 is "Y",<br>? Enter "Y<br>olumn 2 is<br>reporting<br>nd (v), reg<br>onse to lin | ams trained<br>did<br>" for yes on<br>"N",<br>periods<br>ardless of<br>e 56 is "Y" |                  |   |                          | 57.00            |

| 3, the IME FTE unweighted count. Enter in column 4,   | ŀ     |       |
|---|-------|-------|
| the direct GME FTE unweighted count.  |       |       |
|   |       |       |
|   | 1.00  |       |
| ACA Provisions Affecting the Health Resources and Services Administration (HRSA)                            |       |       |
| 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which  | 0. 00 | 62.00 |
| your hospital received HRSA PCRE funding (see instructions)   | i     |       |
| 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital | 0.00  | 62.01 |
| during in this cost reporting period of HRSA THC program. (see instructions)                                |       |       |
| Teaching Hospitals that Claim Residents in Nonprovider Settings   |       |       |
| 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter  | N     | 63.00 |
| "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)             | i     |       |

instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column

| Health Financial Systems<br>HOSPITAL AND HOSPITAL HEALTH CARE COMP   |  | ON HOSPITAL OF INDIATA Provider  | CCN: 15-3028 F                               | In Lie<br>Period:<br>From 01/01/2022<br>To 12/31/2022 | wof Form CMS-2<br>Worksheet S-2<br>Part I<br>Date/Time Pre<br>5/31/2023 9:3 | pared: |
|--|--|--|--|---|---|--------|
|  |  |  | Unwei ghted<br>FTEs<br>Nonprovi der<br>Si te | Unwei ghted<br>FTEs in<br>Hospi tal                   | Ratio (col.<br>1/ (col. 1 +<br>col. 2))                                     | 1 dili |
| Section 5504 of the ACA Base Yea   | ar FTF Residents in N  | onnrovider Settings  | 1.00   | 2.00  | 3.00  |        |
| period that begins on or after s  64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to re settings. Enter in column 2 the resident FTEs that trained in ye  | July 1, 2009 and before yes, or your faciling the of unweighted no patations occurring in a number of unweighted | re June 30, 2010.<br>ty trained residents<br>n-primary care<br>all nonprovider<br>d non-primary care | 5 0.00                                       |   |   | 64.00  |
| of (column 1 divided by (column  | 1 + column 2)). (see<br>Program Name   | instructions) Program Code   | Unwei ghted                                  | Unwei ghted   | Ratio (col.   |        |
|  | Program Name   | Program code   | FTEs<br>Nonprovi der<br>Si te                | FTEs in<br>Hospital                                   | 3/ (col. 3 + col. 4))   |        |
| 65.00 Enter in column 1, if line 63 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 3 + column 4)). (see instructions) | 1.00   | 2.00   | 3.00<br>0.00                                 | Unweighted<br>FTEs in                                 | Ratio (col.<br>1/ (col. 1 +   | 65. 00 |
|  |  |  | Nonprovi der<br>Si te                        | Hospi tal   | col. 2))  |        |
| Section 5504 of the ACA Current  |  | n Nonprovider Setti  |  |   |   |        |
| beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +   | unweighted non-prima<br>occurring in all nonp<br>unweighted non-prima<br>al. Enter in column                     | rovider settings.<br>ry care resident<br>3 the ratio of  | 0.00   | 2. 84   | 0. 000000   | 66.00  |
|  | Program Name   | Program Code   | Unwei ghted<br>FTEs<br>Nonprovi der<br>Si te | Unwei ghted<br>FTEs in<br>Hospi tal                   | Ratio (col.<br>3/ (col. 3 +<br>col. 4))                                     |        |
| (7.00 Enter in column 1. the column  | 1. 00  | 2.00   | 3.00   | 4. 00   | 5. 00   | (7.00  |
| 67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)   |  |  | 0.00   | 0.00  | 0.000000  | 67.00  |

| Health Financial Systems REHABILITATION HOSP   | TTAL OF INDIANA   | In                                     | Li eu | of Form   | CMS-2552-        |
|--|---|--|-------|---|------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  | Provi der CCN: 15-3028  | Peri od:<br>From 01/01/2<br>To 12/31/2 | 2022  | Worksheet<br>Part I<br>Date/Time                      |                  |
|  |   |  |       | 1. 00   |                  |
| Direct GME in Accordance with the FY 2023 IPPS Final Rule, 8 68.00 For a cost reporting period beginning prior to October 1, 20 MAC to apply the new DGME formula in accordance with the FY  | 022, did you obtain permi   | ssion from you                         |       | N   | 68.0             |
| (August 10, 2022)?   |   |  | 1. 00 | 2.00 3  | . 00             |
| Inpatient Psychiatric Facility PPS   |   |  |       | 2.00   3  |                  |
| 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or Enter "Y" for yes or "N" for no.  |   | ·                                      | N     |   | 70.0             |
| 71.00 If line 70 is yes: Column 1: Did the facility have an approve recent cost report filed on or before November 15, 2004? Er 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility the program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Er Column 3: If column 2 is Y, indicate which program year begates instructions)   | nter "Y" for yes or "N" f<br>rain residents in a new t<br>nter "Y" for yes or "N" f     | for no. (see<br>leaching<br>for no.    |       |   | 0 71.0           |
| Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF),   | or does it contain an I   | RF                                     | Υ     |   | 75. C            |
| subprovider? Enter "Y" for yes and "N" for no.  76.00 If line 75 is yes: Column 1: Did the facility have an approver recent cost reporting period ending on or before November 15 no. Column 2: Did this facility train residents in a new teator CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. indicate which program year began during this cost reporting  | 5, 2004? Enter "Y" for ye<br>aching program in accorda<br>Column 3: If column 2 i       | es or "N" for<br>ince with 42<br>s Y,  | Y     | N   | 0 76.0           |
|  |   |  |       | 1. 00   |                  |
| Long Term Care Hospital PPS  80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part c "Y" for yes and "N" for no.  |   | ing period? E                          | nter  | N<br>N  | 80. C<br>81. C   |
| TEFRA Providers  85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)  86.00 Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.   |   |  | no.   | N   | 85. C<br>86. C   |
| 87.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.  | nl classified under secti   | on                                     |       | N   | 87. C            |
|  |   | Approved Permaner Adjustme (Y/N) 1.00  | nt    | Number<br>Approve<br>Permane<br>Adjustme<br>2.00      | ed<br>nt         |
| 88.00 Column 1: Is this hospital approved for a permanent adjustme amount per discharge? Enter "Y" for yes or "N" for no. If ye 89. (see instructions) Column 2: Enter the number of approved permanent adjustments  | es, complete col. 2 and I   |  |       |   | 0 88.0           |
|  | Wkst. A Li<br>No.   | Date                                   | ve    | Approve<br>Permane<br>Adjustme<br>Amount F<br>Dischar | nt<br>ent<br>Per |
| 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A I on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA taper discharge.  Column 3: Enter the amount of the approved permanent adjustment approval was column 2: Enter the per discharge permanent adjustment adjustment approval was column 2: Enter the per discharge permanent adjustment approval was column 3: Enter the amount of the approval adjustment adjustm | s based.<br>g period<br>arget amount  | 2.00                                   |       | 3.00  | 0 89.0           |
| TEFRA target amount per discharge.   |   | 1. 00                                  |       | XI X<br>2. 00   |                  |
| TEFRA target amount per discharge.   |   |  |       |   |                  |
| Title V and XIX Services   | ıl services? Enter "Y" fo   |  |       | Υ   | 90.0             |
| Title V and XIX Services   |   | or N                                   |       | Y   | 90.0             |
| Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applicable of the column of the properties of the column of th | the cost report either in icable column.  | or N                                   |       | N   | 91.0             |
| Title V and XIX Services  90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.  91.00 Is this hospital reimbursed for title V and/or XIX through the service of the service  | the cost report either in<br>icable column.<br>ual certification)? (see<br>able column. | or N                                   |       |   |                  |

0.00

Ν

0.00

0.00

Ν

0.00

95.00

96.00

97.00

95.00 | If line 94 is "Y", enter the reduction percentage in the applicable column.
96.00 | Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.
97.00 | If line 96 is "Y", enter the reduction percentage in the applicable column.

| Health Financial Systems REHABILITATION HOSP   |   |   |   | u of Form CMS |                    |
|--|---|---|---|---------------|--------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  | Provider C                                      | CN: 15-3028                               | Period:<br>From 01/01/2022<br>To 12/31/2022 |               | repared:           |
|  | <u> </u>  |   | V   | XIX           |                    |
| 98.00 Does title V or XIX follow Medicare (title XVIII) for the in   | iterns and re                                   | sidents post                              | 1. 00<br>N                                  | 2. 00<br>Y    | 98.00              |
| stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f column 1 for title V, and in column 2 for title XIX.  | or yes or "N                                    | "for no in                                |   |               |                    |
| 98.01 Does title V or XIX follow Medicare (title XVIII) for the re<br>C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti<br>title XIX.   |   |   |   | Y             | 98. 0              |
| 98.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o   |   |   | N   | Y             | 98. 02             |
| for title V, and in column 2 for title XIX.  98.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for years.   |   |   |   | N             | 98. 03             |
| for title V, and in column 2 for title XIX.  98.04 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 1                                    | 01% 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 c  | ick the RCE d                                   | isallowance or                            | n N   | Y             | 98. 05             |
| column 2 for title XIX.  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  |   |   | N   | Y             | 98. 06             |
| column 2 for title XIX.  Rural Providers   |   |   |   | <u> </u>      |                    |
| 105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)  | inclusive me                                    | thod of paymer                            | nt N  |               | 105. 00<br>106. 00 |
| 107.00 Column 1: If line 105 is Y, is this facility eligible for contraining 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 approved medical education program in the CAH's excluded IF Enter "Y" for yes or "N" for no in column 2. (see instructions)  | ı 1. (see in<br>you train I&<br>PF and/or IRF   | structions)<br>Rs in an                   |   |               | 107.00             |
| 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.   |   | edul e? See 42                            | 2 N   |               | 108.00             |
| -  | Physi cal                                       | Occupati ona                              |   | Respiratory   |                    |
| 109.00  f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.  | 1. 00<br>N                                      | 2.00<br>N                                 | 3. 00<br>N                                  | 4.00<br>N     | 109.00             |
|  |   |   | ,   | 1.00          |                    |
| 110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.  | Y" for yes o                                    | r "N" for no.                             | If yes,                                     | 1.00<br>N     | 110.00             |
|  |   |   | 1. 00                                       | 2.00          | $\dashv$           |
| 111.00  f this facility qualifies as a CAH, did it participate in t<br>Health Integration Project (FCHIP) demonstration for this co<br>"Y" for yes or "N" for no in column 1. If the response to co<br>integration prong of the FCHIP demo in which this CAH is par<br>Enter all that apply: "A" for Ambulance services; "B" for ac<br>for tele-health services.   | ost reporting<br>Dlumn 1 is Y,<br>rticipating i | period? Enter<br>enter the<br>n column 2. | N N   |               | 111.00             |
|  |   | 1.00                                      | 2.00  | 3. 00         | 4                  |
| 112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If comparting the property of the data the hospital began participated to the comparticipate of the property of the prope | eporting<br>Dumn 1 is<br>Dating in the          | N   | 2.00  | 3.00          | 112.00             |
| demonstration. In column 3, enter the date the hospital cear<br>participation in the demonstration, if applicable.  113.00 Did this hospital participate in the Community Health Access<br>Transformation (CHART) model for any portion of the current   | and Rural                                       |   |   |               | 113.00             |
| reporting period? Enter "Y" for ves or "N" for no  |   |   |   |               |                    |
| reporting period? Enter "Y" for yes or "N" for no.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or  |   | l N                                       |   |               | 0115.00            |

in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208. 1.

116.00 Is this facility legally-required to carry mal practice insurance? Enter 116. 00 117.00 is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. Ν 117.00 118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence. 118.00

|   |  | 1. 00              | 2. 00           | 3. 00       |                    |  |
|---|--|--------------------|-----------------|-------------|--------------------|--|
| 118.01 List amounts of malpractice prem                                 | iums and paid losses:  | 67, 405            | 0               |             | 0118.01            |  |
|   |  |                    | 1 00            | 0.00        |                    |  |
| 119 02 Aro mal practice promitime and pai                               | d losses reported in a cost center other   | than tho           | 1. 00<br>N      | 2. 00       | 118. 02            |  |
|   | yes, submit supporting schedule listing c  |                    | IN IN           |             | 110.02             |  |
| and amounts contained therein.  | 7  |                    |                 |             |                    |  |
| 119.00 DO NOT USE THIS LINE   |  |                    |                 |             | 119. 00            |  |
|   | fies for the Outpatient Hold Harmless pro  |                    | N               | N           | 120. 00            |  |
|   | '(see instructions) Enter in column 1, "Y<br>ital with < 100 beds that qualifies for t       |                    |                 |             |                    |  |
|   | 3121 and applicable amendments? (see inst  |                    |                 |             |                    |  |
| Enter in column 2, "Y" for yes o  |  | ,                  |                 |             |                    |  |
|   | rt costs for high cost implantable device  | s charged to       | N               |             | 121. 00            |  |
| patients? Enter "Y" for yes or "  | N" for no.<br>Ithcare related taxes as defined in §1903                                      | (w)(2) of the      | N               |             | 122. 00            |  |
|   | no in column 1. If column 1 is "Y", ente   |                    | IN IN           |             | 122.00             |  |
| the Worksheet A line number when  |  | 2                  |                 |             |                    |  |
|   | roviders (if applicable) purchase profess  |                    |                 |             | 123. 00            |  |
|   | g, tax preparation, bookkeeping, payroll,  |                    |                 |             |                    |  |
| for yes or "N" for no.  | from an unrelated organization? In column  | i, enter "Y"       |                 |             |                    |  |
|   | ority of the expenses, i.e., greater than  | 50% of total       |                 |             |                    |  |
|   | for services purchased from unrelated org  |                    |                 |             |                    |  |
|   | main hospital CBSA? In column 2, enter "   | Y" for yes or      |                 |             |                    |  |
| "N" for no.   | anati an   |                    |                 |             |                    |  |
| Certified Transplant Center Info  | icare-certified transplant center? Enter   | "V" for yes        | N               |             | 125. 00            |  |
|   | rtification date(s) (mm/dd/yyyy) below.  | i ioi yes          | IN .            |             | 123.00             |  |
| j .   | kidney transplant program, enter the cert  | ification date     |                 |             | 126. 00            |  |
| in column 1 and termination date  |  |                    |                 |             |                    |  |
| 127.00  f this is a Medicare-certified in column 1 and termination date | heart transplant program, enter the certi  | fication date      |                 |             | 127. 00            |  |
|   | , it appireable, it column 2.<br>Liver transplant program, enter the certi                   | fication date      |                 |             | 128. 00            |  |
| in column 1 and termination date  |  | dati di. data      |                 |             | 1.20.00            |  |
|   | 129.00 If this is a Medicare-certified lung transplant program, enter the certification date |                    |                 |             |                    |  |
|   | in column 1 and termination date, if applicable, in column 2.                                |                    |                 |             |                    |  |
|   | pancreas transplant program, enter the ce<br>date, if applicable, in column 2.               | rtification        |                 |             | 130. 00            |  |
|   | intestinal transplant program, enter the   | certification      |                 |             | 131.00             |  |
|   | date, if applicable, in column 2.  |                    |                 |             |                    |  |
|   | islet transplant program, enter the certi  | fication date      |                 |             | 132. 00            |  |
| in column 1 and termination date  | , if applicable, in column 2.  |                    |                 |             | 122.00             |  |
| 133.00 Removed and reserved   | n procurement organization (OPO), enter t  | he OPO number      |                 |             | 133. 00<br>134. 00 |  |
| in column 1 and termination date  |  | ric of o ridiliber |                 |             | 134.00             |  |
| All Providers   | ,  |                    |                 |             |                    |  |
|   | on or home office costs as defined in CMS  |                    | Υ               | 15H059      | 140. 00            |  |
|   | "N" for no in column 1. If yes, and home   |                    |                 |             |                    |  |
| 1.00  | he home office chain number. (see instruc  | LT OIIS)           | 3. 00           |             |                    |  |
|   | ain organization, enter on lines 141 thro  | ough 143 the na    |                 | of the home | ;                  |  |
|   | contractor name and contractor number.   |                    |                 |             |                    |  |
| 141. 00 Name: IU HEALTH   | Contractor's Name: WPS   | Contractor         | 's Number: 0810 | )1          | 141.00             |  |
| 142.00 Street: 340 W 10TH STREET  | PO Box:<br>State: IN   | 7: p. Codo.        | 44.00           | 10          | 142.00             |  |
| 143. 00 Ci ty: INDI ANAPOLI S   | State: IN  | Zi p Code:         | 4620            | ) <u>Z</u>  | 143. 00            |  |
|   |  |                    |                 | 1. 00       |                    |  |
| 144.00 Are provider based physicians' c                                 | osts included in Worksheet A?  |                    |                 | N           | 144. 00            |  |
|   |  |                    |                 |             |                    |  |
| 145 0016  | alaimad as What A Lisa 74 assatha aast   | - 6                | 1. 00           | 2. 00       | 1.45 00            |  |
|   | claimed on Wkst. A, line 74, are the cost<br>Y" for yes or "N" for no in column 1. If        |                    |                 |             | 145. 00            |  |
|   | nclude Medicare utilization for this cost  |                    |                 |             |                    |  |
| period? Enter "Y" for yes or "N   | " for no in column 2.  |                    |                 |             |                    |  |
|   | ogy changed from the previously filed cos  |                    | N               |             | 146. 00            |  |
| 3   | in column 1. (See CMS Pub. 15-2, chapter   | 40, §4020) If      |                 |             |                    |  |
| yes, enter the approval date (mm  | /du/yyyy) in column 2.   |                    | I               | I           | I                  |  |
|   |  |                    |                 |             |                    |  |
|   |  |                    |                 |             |                    |  |

| Health Financial Systems  | REHABILITATION HOSP                                       | PITAL OF INDIA                  | NA           | In Lie                                      | eu of Form CMS | -2552-10           |
|---|---|---------------------------------|--------------|---|----------------|--------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLE  | EX IDENTIFICATION DATA                                    | Provi der CC                    | N: 15-3028   | Period:<br>From 01/01/2022<br>To 12/31/2022 |                | epared:            |
|   |   |                                 |              |   |                |                    |
| 147.00Was there a change in the statist   |   |                                 |              |   | 1. 00<br>N     | 147. 00            |
| 148.00 Was there a change in the order of 149.00 Was there a change to the simplif  |   |                                 |              | nr no                                       | N<br>N         | 148. 00<br>149. 00 |
| 147. 00 mas there a change to the simpiri   | rea cost irriarily metrica: Er                            | Part A                          | Part B       | Ti tle V                                    | Title XIX      | 147.00             |
|   |   | 1. 00                           | 2. 00        | 3. 00                                       | 4.00           |                    |
| Does this facility contain a prov<br>or charges? Enter "Y" for yes or   |   |                                 |              |   |                |                    |
| 155. 00 Hospi tal   |   | N                               | N            | N   | N              | 155. 00            |
| 156.00 Subprovi der - IPF   |   | N                               | N N          | N N   | N              | 156. 00            |
| 157.00 Subprovi der -   RF<br>158.00 SUBPROVI DER   |   | N                               | N            | N   | N              | 157. 00<br>158. 00 |
| 159. 00 SNF   |   | N                               | N N          | N<br>N                                      | N              | 159.00             |
| 160.00 HOME HEALTH AGENCY<br>161.00 CMHC  |   | N                               | l N<br>N     | N<br>N                                      | N<br>N         | 160. 00<br>161. 00 |
| 161. 10 CORF  |   |                                 | N N          | N N   | N              | 161. 10            |
| 101110 00111  | <u>'</u>  |                                 |              |   |                | 101110             |
|   |   |                                 |              |   | 1. 00          |                    |
| Multicampus  165.00 s this hospital part of a Multication Enter "Y" for yes or "N" for no.  | ampus hospital that has one                               | e or more camp                  | uses in dif  | ferent CBSAs?                               | N              | 165. 00            |
| Effect 1 101 yes of N 101 no.   | Name  | County                          | State Z      | ip Code   CBSA                              | FTE/Campus     |                    |
|   | 0   | 1. 00                           | 2. 00        | 3.00 4.00                                   | 5. 00          |                    |
| 166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) |   |                                 |              |   | 0. 0           | 00 166. 00         |
|   |   |                                 |              |   | 1.00           | _                  |
| Health Information Technology (HI   | T) incentive in the America                               | an Recovery an                  | nd Reinvestm | ent Act                                     | 1.00           |                    |
| 167.00 Is this provider a meaningful use<br>168.00 If this provider is a CAH (line 1)<br>reasonable cost incurred for the   | r under §1886(n)? Enter "\<br>O5 is "Y") and is a meaning | Y" for yes or<br>gful user (lin | "N" for no.  |   | N              | 167. 00<br>168. 00 |
| 168. 01 If this provider is a CAH and is exception under §413. 70(a)(6)(ii)   | not a meaningful user, does                               | s this provide                  |              |   |                | 168. 01            |
| 169.00 If this provider is a meaningful transition factor. (see instruction   |   | is not a CAH                    | (line 105 i  | s "N"), enter the                           | 0.0            | 00169.00           |
|   |   |                                 |              | Begi nni ng                                 | Endi ng        |                    |
| 170 00 Feeters in and 1 and 2 the FUD   |   |                                 |              | 1.00  | 2. 00          | 170.00             |
| 170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)  | beginning date and ending d                               | date for the r                  | eporting     |   |                | 170. 00            |
|   |   |                                 |              | 1.00  | 2. 00          |                    |
| 171.00  f   line 167 is "Y", does this pro-<br>section 1876 Medicare cost plans<br>"Y" for yes and "N" for no in col-<br>1876 Medicare days in column 2. (                                      | reported on Wkst. S-3, Pt. umn 1. If column 1 is yes,     | I, line 2, co                   | I. 6? Enter  | i on  |                | 0 171. 00          |

| HOSPI 7          | Financial Systems REHABILITATION HOS<br>TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE  | Provider C                 |               | Peri od:<br>From 01/01/2022 | worksheet S-2                  |                  |
|------------------|---|----------------------------|---------------|-----------------------------|--------------------------------|------------------|
|                  |   |                            |               | To 12/31/2022               | Date/Time Pro<br>5/31/2023 9:3 |                  |
|                  |   |                            |               | Y/N<br>1. 00                | Date<br>2.00                   |                  |
|                  | PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSI   |                            |               |                             |                                |                  |
|                  | General Instruction: Enter Y for all YES responses. Enter Imm/dd/yyyy format.  COMPLETED BY ALL HOSPITALS   | N for all NO re            | esponses. Ent | er all dates in             | the                            |                  |
| 1. 00            | Provider Organization and Operation Has the provider changed ownership immediately prior to the   | o boginning of             | the cost      | N                           |                                | 1, 00            |
| 1.00             | reporting period? If yes, enter the date of the change in   | column 2. (see             | instructions  |                             |                                | 1.00             |
|                  |   |                            | Y/N<br>1.00   | Date 2.00                   | V/I<br>3. 00                   |                  |
| 2. 00            | Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in colu  |                            | N N           | 2.00                        | 3.00                           | 2.00             |
| 3. 00            | voluntary or "I" for involuntary. Is the provider involved in business transactions, includicontracts, with individuals or entities (e.g., chain home)  |                            | Y             |                             |                                | 3. 00            |
|                  | or medical supply companies) that are related to the providence, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions) | der or its<br>of the board |               |                             |                                |                  |
|                  | relationships: (see instructions)   |                            | Y/N           | Туре                        | Date                           |                  |
|                  | Financial Data and Reports  |                            | 1.00          | 2. 00                       | 3. 00                          |                  |
| 4. 00            | Column 1: Were the financial statements prepared by a Cer<br>Accountant? Column 2: If yes, enter "A" for Audited, "C"<br>or "R" for Reviewed. Submit complete copy or enter date av                             | for Compiled,              | Y             | A                           |                                | 4.00             |
| 5. 00            | column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difficulties on the filed financial statements? If yes, submit re                                   |                            | N             |                             |                                | 5. 00            |
|                  | These on the fired financial statements. If yes, submit to  | concrete att on.           |               | Y/N<br>1.00                 | Legal Oper.<br>2.00            |                  |
| 6. 00            | Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column   | 2: If ves. i:              | s the provide |                             |                                | 6.00             |
| 7. 00            | the legal operator of the program?  Are costs claimed for Allied Health Programs? If "Y" see i  | •                          | o the provide | N                           |                                | 7.00             |
| 8. 00            | Were nursing programs and/or allied health programs approved cost reporting period? If yes, see instructions.   | ed and/or rene             | · ·           | e N                         |                                | 8. 00            |
| 9. 00<br>10. 00  | Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instructio Was an approved Intern and Resident GME program initiated                                 | ns.                        |               | Y                           |                                | 9.00             |
| 11. 00           | cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than   |                            |               | N                           |                                | 11.00            |
|                  | Teaching Program on Worksheet A? If yes, see instructions.  | •                          |               |                             | Y/N                            |                  |
|                  | Bad Debts   |                            |               |                             | 1. 00                          |                  |
| 12. 00<br>13. 00 | Is the provider seeking reimbursement for bad debts? If ye If line 12 is yes, did the provider's bad debt collection  |                            |               | ost reporting               | Y<br>N                         | 12. 00<br>13. 00 |
| 14. 00           | period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or coinsur- instructions.   | ance amounts wa            | aived? If yes | , see                       | N                              | 14. 00           |
| 15 00            | Bed Complement Did total beds available change from the prior cost report   | ing period2 lf             | vas saa ins   | tructions                   | N                              | 15. 00           |
| 13.00            | plu total beds available change from the pirol cost report  |                            | t A           |                             | t B                            | 13.00            |
|                  |   | Y/N<br>1.00                | 2. 00         | Y/N<br>3. 00                | Date<br>4.00                   |                  |
|                  | PS&R Data   |                            |               |                             |                                |                  |
| 16. 00           | Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see  | Y                          | 04/03/2023    | Y                           | 04/03/2023                     | 16. 00           |
| 17. 00           | instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date                              | N                          |               | N                           |                                | 17. 00           |
| 18. 00           | in columns 2 and 4. (see instructions) If line 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 cost report? If yes, see instructions.  |                            |               |                             |                                | 1                |

| Heal th | Financial Systems REHABILITATION HOS  | SPITAL OF INDIA    | ANA           | In Lie                                       | u of Form CM   | S-2552-10 |
|---------|---|--------------------|---------------|--|--|-----------|
| HOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE   |                    | CCN: 15-3028  | Peri od:<br>From 01/01/2022<br>To 12/31/2022 | Worksheet S<br>Part II<br>Date/Time F<br>5/31/2023 S | Prepared: |
|         |   |                    | iption        | Y/N  | Y/N  |           |
| 20.00   | If line 14 on 17 is yes were adjustments made to DCOD   |                    | 0             | 1. 00  | 3.00   | 20.00     |
| 20.00   | If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:                                     |                    |               | N  | N  | 20.00     |
|         | <u></u>   | Y/N                | Date          | Y/N  | Date   |           |
|         |   | 1.00               | 2.00          | 3. 00  | 4. 00  |           |
| 21. 00  | Was the cost report prepared only using the provider's records? If yes, see instructions.   | N                  |               | N  |  | 21.00     |
|         |   |                    |               |  | 1. 00  |           |
|         | COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC  | EPT CHILDRENS      | HOSPI TALS)   |  |  |           |
|         | Capital Related Cost  |                    |               |  |  |           |
| 22. 00  | Have assets been relifed for Medicare purposes? If yes, se  |                    |               |  | Y  | 22.00     |
| 23. 00  | Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.  | e due to apprai    | sais made du  | ring the cost                                | N  | 23. 00    |
| 24. 00  | Were new leases and/or amendments to existing leases enter<br>lf yes, see instructions  | ed into during     | this cost r   | eporting period?                             | N  | 24. 00    |
| 25. 00  | Have there been new capitalized leases entered into during linstructions.   | the cost repo      | orting period | ? If yes, see                                | N  | 25. 00    |
| 26. 00  | Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.   | he cost report     | ing period?   | f yes, see                                   | N  | 26. 00    |
| 27. 00  | Has the provider's capitalization policy changed during th copy.  | ne cost reporti    | ng period? I  | f yes, submit                                | N  | 27. 00    |
|         | Interest Expense  |                    |               |  |  |           |
| 28. 00  | Were new loans, mortgage agreements or letters of credit eperiod? If yes, see instructions.   | entered into du    | iring the cos | t reporting                                  | N  | 28. 00    |
| 29. 00  |   |                    |               |  |  | 29. 00    |
| 30. 00  |   |                    |               |  |  |           |
| 31. 00  |   |                    |               |  |  |           |
| 32. 00  | Purchased Services Have changes or new agreements occurred in patient care se   | arul coc. furni ch | and through o | antroctual                                   | N  | 32.00     |
| 33. 00  | arrangements with suppliers of services? If yes, see instr<br>If line 32 is yes, were the requirements of Sec. 2135.2 ap<br>no, see instructions. | ructi ons.         | J             |  | , IN   | 33.00     |
|         | Provi der-Based Physi ci ans  |                    |               |  |  |           |
| 34.00   | Were services furnished at the provider facility under an   | arrangement wi     | th provider-  | pased physicians?                            | N  | 34.00     |
| 35. 00  | If yes, see instructions.  If line 34 is yes, were there new agreements or amended explains during the sector reporting period? If yes            |                    | ents with the | provi der-based                              |  | 35. 00    |
|         | physicians during the cost reporting period? If yes, see i  | IISTI UCTI OIIS.   |               | Y/N  | Date   |           |
|         |   |                    |               | 1.00   | 2.00   |           |
|         | Home Office Costs   |                    |               |  |  |           |
| 36.00   | Were home office costs claimed on the cost report?  |                    |               | Y  |  | 36.00     |
| 37. 00  | If line 36 is yes, has a home office cost statement been p<br>If yes, see instructions.   | prepared by the    | nome office   | ? Y  |  | 37.00     |
| 38. 00  | If line 36 is yes, was the fiscal year end of the home of<br>the provider? If yes, enter in column 2 the fiscal year er                           |                    |               | F N  |  | 38. 00    |
| 39. 00  | If line 36 is yes, did the provider render services to oth  |                    |               | s, Y   |  | 39. 00    |
| 40. 00  | see instructions. If line 36 is yes, did the provider render services to the instructions.  | e home office?     | If yes, see   | N  |  | 40. 00    |
|         | THISTI UCTIONS.   |                    |               |  |  |           |
|         |   | 1.                 | . 00          | 2.   | 00   |           |
|         | Cost Report Preparer Contact Information  |                    |               |  |  |           |
| 41. 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  |  | 41.00     |
| 42. 00  | respectively. Enter the employer/company name of the cost report  | I NDI ANA UNI VEF  | RSITY HEALTH  |  |  | 42.00     |
| 43. 00  | preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.                              | 317. 962. 1093     |               | RUTTER@I UHEALT                              | H. ORG   | 43. 00    |
|         | 1. opo. t proper or the continues it and 2, respectivery.   | 1                  |               | ı  |  | П         |

| Health Financial Systems                       | REHABILITATION HOS | SPITAL OF INDIANA    |          | In Lie                   | u of Form CMS-           | 2552-10          |
|--|--------------------|----------------------|----------|--------------------------|--------------------------|------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMEN | IT QUESTI ONNAI RE | Provi der CCN: 15-   |          | eriod:<br>rom 01/01/2022 | Worksheet S-2<br>Part II | 2                |
|  |                    |                      |          | o 12/31/2022             |                          | epared:<br>31 am |
|  |                    |                      |          |                          |                          |                  |
|  |                    | 3.00                 |          |                          |                          |                  |
| Cost Report Preparer Contact Information       | n                  |                      |          |                          |                          |                  |
| 41.00 Enter the first name, last name and the  |                    | DI RECTOR-GOVERNMENT | PROGRAMS |                          |                          | 41.00            |
| held by the cost report preparer in col        | umns 1, 2, and 3,  |                      |          |                          |                          |                  |
| respectively.                                  |                    |                      |          |                          |                          |                  |
| 42.00 Enter the employer/company name of the   | cost report        |                      |          |                          |                          | 42.00            |
| preparer.                                      | •                  |                      |          |                          |                          |                  |
| 43.00 Enter the telephone number and email ad  | dress of the cost  |                      |          |                          |                          | 43.00            |
| report preparer in columns 1 and 2, res        | pecti vel y.       |                      |          |                          |                          |                  |

Health Financial Systems REHABILITATION HOSPITAL OF INDIANA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: In Lieu of Form CMS-2552-10 Peri od: Worksheet S-3
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared: 5/31/2023 9:31 am Provider CCN: 15-3028

|        |  |             |    |         |              |           | 5/31/2023 9: 3 | 1 am   |
|--------|--|-------------|----|---------|--------------|-----------|----------------|--------|
|        |  |             |    |         |              |           | I/P Days /     |        |
|        |  |             |    |         |              |           | 0/P Visits /   |        |
|        |  |             |    |         |              |           | Tri ps         |        |
|        | Component                                    | Worksheet A | No | of Beds | Bed Days     | CAH Hours | Title V        |        |
|        |  | Li ne No.   |    |         | Avai I abl e |           |                |        |
|        |  | 1. 00       |    | 2. 00   | 3. 00        | 4. 00     | 5. 00          |        |
|        | PART I - STATISTICAL DATA                    |             |    |         |              |           |                |        |
| 1.00   | Hospital Adults & Peds. (columns 5, 6, 7 and | 30.00       |    | 91      | 33, 215      | 0.00      | 0              | 1.00   |
|        | 8 exclude Swing Bed, Observation Bed and     |             |    |         |              |           |                |        |
|        | Hospice days)(see instructions for col. 2    |             |    |         |              |           |                |        |
|        | for the portion of LDP room available beds)  |             |    |         |              |           |                |        |
| 2.00   | HMO and other (see instructions)             |             |    |         |              |           |                | 2.00   |
| 3.00   | HMO IPF Subprovider                          |             |    |         |              |           |                | 3.00   |
| 4.00   | HMO IRF Subprovider                          |             |    |         |              |           |                | 4.00   |
| 5.00   | Hospital Adults & Peds. Swing Bed SNF        |             |    |         |              |           | 0              | 5.00   |
| 6.00   | Hospital Adults & Peds. Swing Bed NF         |             |    |         |              |           | 0              | 6.00   |
| 7.00   | Total Adults and Peds. (exclude observation  |             |    | 91      | 33, 215      | 0. 00     | 0              | 7.00   |
|        | beds) (see instructions)                     |             |    |         |              |           |                |        |
| 8.00   | INTENSIVE CARE UNIT                          |             |    |         |              |           |                | 8.00   |
| 9. 00  | CORONARY CARE UNIT                           |             |    |         |              |           |                | 9.00   |
| 10.00  | BURN INTENSIVE CARE UNIT                     |             | İ  |         |              |           |                | 10.00  |
| 11. 00 | SURGICAL INTENSIVE CARE UNIT                 |             | ĺ  |         |              |           |                | 11.00  |
| 12.00  | OTHER SPECIAL CARE (SPECIFY)                 |             | ĺ  |         |              |           |                | 12.00  |
| 13.00  | NURSERY                                      |             |    |         |              |           |                | 13.00  |
| 14.00  | Total (see instructions)                     |             |    | 91      | 33, 215      | 0. 00     | 0              | 14.00  |
| 15.00  | CAH visits                                   |             |    |         |              |           | 0              | 15.00  |
| 16.00  | SUBPROVIDER - IPF                            |             |    |         |              |           |                | 16.00  |
| 17. 00 | SUBPROVIDER - IRF                            |             |    |         |              |           |                | 17.00  |
| 18.00  | SUBPROVI DER                                 |             |    |         |              |           |                | 18.00  |
| 19.00  | SKILLED NURSING FACILITY                     |             |    |         |              |           |                | 19.00  |
| 20.00  | NURSING FACILITY                             |             |    |         |              |           |                | 20.00  |
| 21.00  | OTHER LONG TERM CARE                         |             |    |         |              |           |                | 21.00  |
| 22.00  | HOME HEALTH AGENCY                           |             |    |         |              |           |                | 22.00  |
| 23.00  | AMBULATORY SURGICAL CENTER (D. P.)           |             |    |         |              |           |                | 23.00  |
| 24.00  | HOSPI CE                                     |             |    |         |              |           |                | 24.00  |
| 24. 10 | HOSPICE (non-distinct part)                  | 30.00       |    |         |              |           |                | 24. 10 |
| 25.00  | CMHC - CMHC                                  | 99. 00      |    |         |              |           | 0              | 25.00  |
| 25. 10 | CMHC - CORF                                  | 99. 10      | ĺ  |         |              |           | 0              | 25. 10 |
| 26.00  | RURAL HEALTH CLINIC                          |             | ĺ  |         |              |           |                | 26.00  |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER            | 89. 00      | İ  |         |              |           | 0              | 26. 25 |
| 27. 00 | Total (sum of lines 14-26)                   |             |    | 91      |              |           |                | 27.00  |
| 28. 00 | Observation Bed Days                         |             |    |         |              |           | 0              | 28.00  |
| 29. 00 | Ambul ance Trips                             |             |    |         |              |           |                | 29.00  |
| 30.00  | Employee discount days (see instruction)     |             |    |         |              |           |                | 30.00  |
| 31.00  | Employee discount days - IRF                 |             | İ  |         |              |           |                | 31.00  |
| 32.00  | Labor & delivery days (see instructions)     |             |    | 0       | o            |           |                | 32.00  |
| 32. 01 | Total ancillary labor & delivery room        |             |    |         |              |           |                | 32. 01 |
|        | outpatient days (see instructions)           |             |    |         |              |           |                |        |
| 33.00  | LTCH non-covered days                        |             |    |         |              |           |                | 33.00  |
|        | LTCH site neutral days and discharges        |             |    |         |              |           |                | 33. 01 |
|        | Temporary Expansion COVID-19 PHE Acute Care  | 30.00       |    | 0       | О            |           | 0              | 34.00  |
|        |  |             |    |         |              | ·         |                |        |

 Heal th Fi nancial
 Systems
 REHABILITATI

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE
 COMPLEX
 STATISTICAL
 DATA

Provi der CCN: 15-3028

Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/31/2023 9:31 am

|        |  |                               |            |           | 1                            | 5/31/2023 9: 3          | 1 am             |
|--------|--|-------------------------------|------------|-----------|------------------------------|-------------------------|------------------|
|        |  | I/P Days / O/P Visits / Trips |            |           | Full Time                    |                         |                  |
|        |  |                               |            |           |                              |                         |                  |
|        | Component  | Title XVIII                   | T: +Lo VIV | Total All | Total Intorno                | Employees Op            |                  |
|        | Component  | II tie xviii                  | Title XIX  | Patients  | Total Interns<br>& Residents | Employees On<br>Payroll |                  |
|        |  | 6. 00                         | 7. 00      | 8.00      | 9. 00                        | 10.00                   |                  |
|        | PART I - STATISTICAL DATA                                      | 0.00                          | 7.00       | 0.00      | 7.00                         | 10.00                   |                  |
| 1. 00  | Hospital Adults & Peds. (columns 5, 6, 7 and                   | 5, 542                        | 534        | 18, 734   |                              |                         | 1.00             |
| 1.00   | 8 exclude Swing Bed, Observation Bed and                       | 3, 342                        | 334        | 10, 734   |                              |                         | 1.00             |
|        | Hospice days) (see instructions for col. 2                     |                               |            |           |                              |                         |                  |
|        | for the portion of LDP room available beds)                    |                               |            |           |                              |                         |                  |
| 2. 00  | HMO and other (see instructions)                               | 3, 704                        | 4, 402     |           |                              |                         | 2.00             |
| 3. 00  | HMO IPF Subprovider  | 0,751                         | 0          |           |                              |                         | 3.00             |
| 4. 00  | HMO IRF Subprovider  |                               | 0          |           |                              |                         | 4.00             |
| 5. 00  | Hospital Adults & Peds. Swing Bed SNF                          |                               | 0          |           |                              |                         | 5.00             |
| 6. 00  | Hospital Adults & Peds. Swing Bed NF                           | Ĭ                             | 0          |           |                              |                         | 6.00             |
| 7. 00  | Total Adults and Peds. (exclude observation                    | 5, 542                        | 534        | · -       |                              |                         | 7.00             |
| 7.00   | beds) (see instructions)                                       | 0,012                         | 00.        | 10,70.    |                              |                         | 7.00             |
| 8.00   | INTENSIVE CARE UNIT  |                               |            |           |                              |                         | 8.00             |
| 9.00   | CORONARY CARE UNIT   |                               |            |           |                              |                         | 9.00             |
| 10.00  | BURN INTENSIVE CARE UNIT                                       |                               |            |           |                              |                         | 10.00            |
| 11.00  | SURGICAL INTENSIVE CARE UNIT                                   |                               |            |           |                              |                         | 11.00            |
| 12.00  | OTHER SPECIAL CARE (SPECIFY)                                   |                               |            |           |                              |                         | 12.00            |
| 13.00  | NURSERY  |                               |            |           |                              |                         | 13.00            |
| 14.00  | Total (see instructions)                                       | 5, 542                        | 534        | 18, 734   | 2. 83                        | 319. 66                 | 14.00            |
| 15.00  | CAH visits   | o                             | 0          | 0         |                              |                         | 15.00            |
| 16.00  | SUBPROVI DER - I PF  |                               |            |           |                              |                         | 16.00            |
| 17.00  | SUBPROVIDER - IRF  |                               |            |           |                              |                         | 17.00            |
| 18.00  | SUBPROVI DER   |                               |            |           |                              |                         | 18.00            |
| 19.00  | SKILLED NURSING FACILITY                                       |                               |            |           |                              |                         | 19.00            |
| 20.00  | NURSING FACILITY   |                               |            |           |                              |                         | 20.00            |
| 21.00  | OTHER LONG TERM CARE   |                               |            |           |                              |                         | 21.00            |
| 22. 00 | HOME HEALTH AGENCY   |                               |            |           |                              |                         | 22.00            |
| 23.00  | AMBULATORY SURGICAL CENTER (D. P.)                             |                               |            |           |                              |                         | 23.00            |
| 24. 00 | HOSPI CE   |                               |            |           |                              |                         | 24.00            |
| 24. 10 | HOSPICE (non-distinct part)                                    |                               |            | 0         |                              |                         | 24. 10           |
| 25.00  | CMHC - CMHC  | 0                             | 0          | ·         |                              |                         | 1                |
| 25. 10 | CMHC - CORF  | 0                             | 0          | 0         | 0. 00                        | 0.00                    | 1                |
| 26. 00 | RURAL HEALTH CLINIC  |                               |            |           |                              |                         | 26. 00           |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER                              | 0                             | 0          | 0         |                              | 0.00                    | 1                |
| 27. 00 | Total (sum of lines 14-26)                                     |                               | _          | _         | 2. 83                        | 319. 66                 | 1                |
| 28. 00 | Observation Bed Days   | _                             | 0          | 0         |                              |                         | 28. 00           |
| 29. 00 | Ambul ance Tri ps  | 0                             |            | _         |                              |                         | 29.00            |
| 30.00  | Employee discount days (see instruction)                       |                               |            | 0         |                              |                         | 30.00            |
| 31.00  | Employee discount days - IRF                                   |                               | -          | 0         |                              |                         | 31.00            |
| 32.00  | Labor & delivery days (see instructions)                       | 0                             | 0          | ·         |                              |                         | 32.00            |
| 32. 01 | Total ancillary labor & delivery room                          |                               |            | 0         |                              |                         | 32. 01           |
| 22 00  | outpatient days (see instructions)                             |                               |            |           |                              |                         | 22 00            |
| 33.00  | LTCH non-covered days<br>LTCH site neutral days and discharges | 0                             |            |           |                              |                         | 33. 00<br>33. 01 |
|        | Temporary Expansion COVID-19 PHE Acute Care                    | 0                             | 0          | 0         |                              |                         | 34.00            |
| 34.00  | Transporary Expansion COVID-19 PRE Acute Care                  | ı Y                           | U          | ı         | 1                            | I                       | J 34. UU         |

 Heal th Fi nancial
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 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE
 COMPLEX
 STATISTICAL
 DATA

Provi der CCN: 15-3028

Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared: 5/31/2023 0:31 am Peri od:

|   | 5/31/2023 9: 31       | l am             |
|---|-----------------------|------------------|
| Full Time Discharges Equivalents                                |                       |                  |
| Component Nonpaid Title V Title XVIII Title XIX                 | Total All<br>Patients |                  |
| Workers         11.00         12.00         13.00         14.00 | 15. 00                |                  |
| PART I - STATISTICAL DATA                                       | 13.00                 |                  |
| 1. 00 Hospital Adults & Peds. (columns 5, 6, 7 and 0 426 34     | 1, 351                | 1.00             |
| 8 exclude Swing Bed, Observation Bed and                        | .,                    |                  |
| Hospice days) (see instructions for col. 2                      |                       |                  |
| for the portion of LDP room available beds)                     |                       |                  |
| 2.00 HMO and other (see instructions) 267 300                   |                       | 2.00             |
| 3.00 HMO IPF Subprovider 0                                      |                       | 3.00             |
| 4.00 HMO IRF Subprovider 0                                      |                       | 4.00             |
| 5.00 Hospital Adults & Peds. Swing Bed SNF                      |                       | 5.00             |
| 6.00 Hospital Adults & Peds. Swing Bed NF                       |                       | 6.00             |
| 7.00 Total Adults and Peds. (exclude observation                |                       | 7.00             |
| beds) (see instructions)  |                       |                  |
| 8.00 INTENSIVE CARE UNIT  |                       | 8. 00            |
| 9.00 CORONARY CARE UNIT   |                       | 9.00             |
| 10.00 BURN INTENSIVE CARE UNIT                                  |                       | 10.00            |
| 11.00 SURGICAL INTENSIVE CARE UNIT                              |                       | 11.00            |
| 12. 00 OTHER SPECIAL CARE (SPECIFY)                             |                       | 12.00            |
| 13. 00   NURSERY  |                       | 13.00            |
| 14. 00   Total (see instructions)                               | 1, 351                | 14.00            |
| 15. 00 CAH visits   |                       | 15.00            |
| 16. 00 SUBPROVI DER - I PF                                      |                       | 16.00            |
| 17. 00 SUBPROVI DER - I RF                                      |                       | 17.00            |
| 18.00   SUBPROVIDER<br>19.00   SKILLED NURSING FACILITY         |                       | 18. 00<br>19. 00 |
| 19.00   SKILLED NURSING FACILITY 20.00   NURSING FACILITY       |                       | 20.00            |
| 21. 00 OTHER LONG TERM CARE                                     |                       | 21.00            |
| 22. 00 HOME HEALTH AGENCY                                       |                       | 22.00            |
| 23. 00 AMBULATORY SURGI CAL CENTER (D. P. )                     |                       | 23. 00           |
| 24. 00 HOSPI CE   |                       | 24.00            |
| 24.10 HOSPICE (non-distinct part)                               |                       | 24. 10           |
| 25. 00 CMHC - CMHC 0. 00  |                       | 25. 00           |
| 25. 10 CMHC - CORF 0.00   |                       | 25. 10           |
| 26.00 RURAL HEALTH CLINIC                                       |                       | 26.00            |
| 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00                   |                       | 26. 25           |
| 27.00 Total (sum of lines 14-26) 0.00                           |                       | 27.00            |
| 28.00 Observation Bed Days                                      |                       | 28.00            |
| 29.00 Ambulance Trips   |                       | 29.00            |
| 30.00 Employee discount days (see instruction)                  |                       | 30.00            |
| 31.00 Employee discount days - IRF                              |                       | 31.00            |
| 32.00 Labor & delivery days (see instructions)                  |                       | 32.00            |
| 32.01 Total ancillary labor & delivery room                     |                       | 32.01            |
| outpatient days (see instructions)                              |                       |                  |
| 33.00 LTCH non-covered days 0                                   |                       | 33.00            |
| 33.01 LTCH site neutral days and discharges 0                   |                       | 33. 01           |
| 34.00   Temporary Expansion COVID-19 PHE Acute Care             |                       | 34.00            |

|  | BILITATION HOSP |              |               | In Lie                           | u of Form CMS-2 | 2552-10  |
|--|-----------------|--------------|---------------|----------------------------------|-----------------|----------|
| RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O                | F EXPENSES      | Provi der C  |               | Peri od:                         | Worksheet A     |          |
|  |                 |              |               | From 01/01/2022<br>Fo 12/31/2022 | Date/Time Pre   | narod.   |
|  |                 |              |               | 10 12/31/2022                    | 5/31/2023 9: 3  |          |
| Cost Center Description  | Sal ari es      | Other        | Total (col. 1 | Recl assi fi cat                 | Recl assi fi ed |          |
|  |                 |              | + col . 2)    | ions (See                        | Trial Balance   |          |
|  |                 |              |               | A-6)                             | (col. 3 +-      |          |
|  |                 |              |               |                                  | col. 4)         |          |
|  | 1. 00           | 2.00         | 3. 00         | 4. 00                            | 5. 00           |          |
| GENERAL SERVICE COST CENTERS                                       |                 |              |               |                                  |                 |          |
| 1. 00 O0100 CAP REL COSTS-BLDG & FLXT                              |                 | 1, 090, 391  | 1, 090, 39    | 1 0                              | 1, 090, 391     | 1.00     |
| 2. 00   00200 CAP REL COSTS-MVBLE EQUI P                           |                 | 640, 700     |               |                                  | 640, 700        | 2.00     |
| 3. 00 00300 OTHER CAP REL COSTS                                    |                 | 0.0,700      | 1             |                                  | 0.07,700        | 3.00     |
| 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT                           | 285, 245        | 6, 150, 474  | 6, 435, 719   | -10, 686                         | 6, 425, 033     | 4.00     |
| 5. 01   00591 ADMI NI STRATI VE AND GENERAL                        | 3, 005, 724     | 2, 509, 016  |               |                                  | 5, 328, 627     | 5. 01    |
| 5. 02 00590 OTHER A&G - NON FOUNDATION                             | 833, 725        | 282, 774     |               |                                  | 1, 115, 572     | 5.02     |
| 7. 00   00700   OPERATION OF PLANT                                 | 31, 091         | 1, 703, 563  |               |                                  | 1, 722, 219     | 7.00     |
| 8. 00   00800 LAUNDRY & LINEN SERVICE                              | 31, 071         | 100, 960     |               |                                  | 100, 960        | 8.00     |
| 9. 00   00900   HOUSEKEEPI NG                                      | 369, 803        | 175, 030     |               |                                  | 544, 399        |          |
| 10. 00   01000 DI ETARY  | 56, 622         | 1, 228, 060  |               |                                  | 750, 969        |          |
| 11. 00   01100   CAFETERI A  | 50, 022         | 1, 220, 000  | 1, 204, 002   |                                  | 533, 425        |          |
|  | 1 ( 4 4 771     | 202 027      |               |                                  |                 |          |
| 13. 00   01300   NURSI NG ADMI NI STRATI ON                        | 1, 644, 771     | 293, 937     |               |                                  | 2, 188, 218     |          |
| 14. 00   01400   CENTRAL SERVI CES & SUPPLY                        | 67, 189         | 288, 230     |               |                                  | 525, 463        |          |
| 15. 00   01500   PHARMACY  | 579, 731        | 175, 368     |               |                                  | 738, 555        |          |
| 16. 00   01600   MEDI CAL RECORDS & LI BRARY                       | 412, 620        | 101, 852     |               |                                  | 514, 472        |          |
| 17. 00   01700   SOCI AL   SERVI CE                                | 468, 503        | 171, 155     |               |                                  | 633, 062        |          |
| 22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV                 | 0               | 222, 453     | 222, 453      | 3  0                             | 222, 453        | 22.00    |
| INPATIENT ROUTINE SERVICE COST CENTERS                             |                 |              |               |                                  |                 |          |
| 30. 00 03000 ADULTS & PEDIATRICS                                   | 7, 412, 965     | 1, 765, 545  | 9, 178, 510   | -168, 390                        | 9, 010, 120     | 30.00    |
| ANCILLARY SERVICE COST CENTERS                                     |                 |              | 1             |                                  |                 |          |
| 50. 00   05000   OPERATI NG ROOM                                   | 0               | 0            | (             | -                                | 0               | 50.00    |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C                           | 139, 322        | 32, 476      |               |                                  | 168, 437        |          |
| 60. 00   06000   LABORATORY  | 0               | 422, 790     |               |                                  | 422, 790        |          |
| 65. 00 06500 RESPI RATORY THERAPY                                  | 488, 819        | 95, 304      |               |                                  | 533, 269        |          |
| 66. 00   06600   PHYSI CAL THERAPY                                 | 1, 556, 767     | 413, 390     |               |                                  | 2, 547, 298     |          |
| 66. 01 06601 PHYSI CAL THERAPY - CARMEL                            | 50, 249         | 31, 603      | 81, 852       | 4, 013                           | 85, 865         | 66. 01   |
| 67. 00 06700 OCCUPATI ONAL THERAPY                                 | 2, 136, 054     | 244, 838     | 2, 380, 892   | -155, 106                        | 2, 225, 786     | 67.00    |
| 68. 00 06800 SPEECH PATHOLOGY                                      | 902, 249        | 92, 511      | 994, 760      | 327, 699                         | 1, 322, 459     |          |
| 68. 01   06801   VI SI ON  | 0               | 0            | (             | 0                                | 0               | 68. 01   |
| 68. 02   06802   FAC RESOURCE                                      | 1, 152, 694     | 263, 737     | 1, 416, 431   | -156, 002                        | 1, 260, 429     | 68. 02   |
| 69. 00 06900 ELECTROCARDI OLOGY                                    | 0               | 0            | (             | 0                                | 0               | 69.00    |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                    | 0               | 0            | (             | 184, 263                         | 184, 263        | 71.00    |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS                         | 0               | 0            | (             | 0                                | 0               | 72.00    |
| 73.00 07300 DRUGS CHARGED TO PATIENTS                              | 0               | 1, 491, 251  | 1, 491, 251   | 0                                | 1, 491, 251     | 73.00    |
| 74.00 07400 RENAL DIALYSIS   | 0               | 0            | (             | 0                                | 0               | 74.00    |
| 77.00 07700 ALLOGENEIC HSCT ACQUISITION                            | O               | 0            | (             | ol ol                            | 0               | 77.00    |
| OUTPATIENT SERVICE COST CENTERS                                    |                 |              |               |                                  |                 | 1        |
| 90. 00 09000 CLINIC  | 211, 763        | 58, 401      | 270, 164      | -15, 815                         | 254, 349        | 90.00    |
| 90. 01   09001   SLEEP CENTER                                      | O               | 0            |               | ol ol                            | 0               | 90. 01   |
| 91. 00 09100 EMERGENCY   | o               | 0            |               | ol ol                            | 0               | 91.00    |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART                    |                 |              |               |                                  |                 | 92.00    |
| OTHER REIMBURSABLE COST CENTERS                                    |                 |              |               |                                  |                 |          |
| 99. 00 09900 CMHC  | 0               | 0            |               | 0                                | 0               | 99.00    |
| 99. 10   09910   CORF  | 682, 680        | 173, 893     |               |                                  | 0               |          |
| 102. 00 10200 OPI OI D TREATMENT PROGRAM                           | 0               | 0            | (             |                                  |                 | 102.00   |
| SPECIAL PURPOSE COST CENTERS                                       |                 | -            |               | -1                               |                 |          |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)                      | 22, 488, 586    | 20, 219, 702 | 42, 708, 288  | -127, 454                        | 42, 580, 834    | 118 00   |
| NONREI MBURSABLE COST CENTERS                                      | 227 1007 000    | 20/21///02   | 12//00/200    | , 12,7,10,1                      | 12/000/001      | 1        |
| 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN                    | 0               | 0            |               |                                  | 0               | 190. 00  |
| 192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES                       | 856, 635        | 553, 407     | 1, 410, 042   | 121, 770                         |                 |          |
| 194. 00 07950  FOUNDATION  | 341, 597        | 156, 997     |               |                                  | 504, 539        |          |
| 194. 01 07951 PUBLI C RELATIONS                                    | 166, 143        | 179, 148     |               |                                  | 345, 291        |          |
| 194. 01 07931 POBLIC RELATIONS<br>194. 02 07952 ST. VI NCENT - ARU | 100, 143        | 1/7, 140     | 340, 29       |                                  |                 | 194.01   |
| 194. 03 07953 MUNCI E - ARU  |                 | 0            | '             |                                  |                 | 194. 02  |
|  | o o             | 0            | ]             |                                  |                 |          |
| 194. 04 07954 RI LEY - ARU   | 220 250         | 1 010 500    | 1 220 25      | 0 0                              |                 | 194.04   |
| 194. 05 07955 RETAIL PHARMACY                                      | 228, 359        | 1, 010, 598  |               |                                  | 1, 238, 696     |          |
| 200.00   TOTAL (SUM OF LINES 118 through 199)                      | 24, 081, 320    | 22, 119, 852 | 46, 201, 172  | 2  0                             | 46, 201, 172    | J∠UU. UU |
|  |                 |              |               |                                  |                 |          |

Peri od: Worksheet A From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/21/2023 9:31 am

|         |   |             |              | 5/31/2023 9: 31 |          |
|---------|---|-------------|--------------|-----------------|----------|
|         | Cost Center Description                   | Adjustments | Net Expenses |                 |          |
|         | ·   | (See A-8)   | For          |                 |          |
|         |   | , ,         | Allocation   |                 |          |
|         |   | 6. 00       | 7. 00        |                 |          |
|         | GENERAL SERVICE COST CENTERS              |             |              |                 |          |
| 1.00    | 00100 CAP REL COSTS-BLDG & FLXT           | 180, 857    | 1, 271, 248  |                 | 1.00     |
| 2.00    | 00200 CAP REL COSTS-MVBLE EQUIP           | 175, 075    | 815, 775     |                 | 2.00     |
| 3.00    | 00300 OTHER CAP REL COSTS                 | 0           | 0            |                 | 3.00     |
| 4.00    | 00400 EMPLOYEE BENEFITS DEPARTMENT        | -1, 350     | 6, 423, 683  |                 | 4.00     |
| 5. 01   | 00591 ADMINISTRATIVE AND GENERAL          | 2, 178, 896 | 7, 507, 523  |                 | 5.01     |
| 5. 02   | 00590 OTHER A&G - NON FOUNDATION          | 0           | 1, 115, 572  |                 | 5.02     |
| 7. 00   | 00700 OPERATION OF PLANT                  | -34, 080    |              |                 | 7.00     |
| 8. 00   | 00800 LAUNDRY & LINEN SERVICE             | 0           | 100, 960     |                 | 8.00     |
| 9. 00   | 00900 HOUSEKEEPI NG                       | 0           | 544, 399     |                 | 9.00     |
| 10.00   | 01000 DI ETARY                            | 0           | 750, 969     |                 | 10.00    |
| 11.00   | 01100 CAFETERI A                          | -177, 801   | 355, 624     |                 | 11.00    |
| 1       | 01300 NURSING ADMINISTRATION              | -400        | 1            | 1               | 13.00    |
|         | 01400 CENTRAL SERVICES & SUPPLY           | -268        | 1            | 1               | 14.00    |
| 1       | 01500 PHARMACY                            | -40, 621    | 697, 934     |                 | 15.00    |
|         | 01600 MEDICAL RECORDS & LIBRARY           | -106        | 1            | l l             | 16.00    |
|         | 01700 SOCIAL SERVICE                      | 0           | l '          | 1               | 17. 00   |
| 4       | 02200 I&R SERVICES-OTHER PRGM COSTS APPRV | 0           | 1            | 1               | 22. 00   |
|         | INPATIENT ROUTINE SERVICE COST CENTERS    |             | 2227 100     |                 | 22.00    |
|         | 03000 ADULTS & PEDIATRICS                 | 0           | 9, 010, 120  |                 | 30.00    |
|         | ANCILLARY SERVICE COST CENTERS            |             | .,           |                 |          |
|         | 05000 OPERATING ROOM                      | 0           | 0            |                 | 50.00    |
|         | 05400 RADI OLOGY-DI AGNOSTI C             | 0           | ł            |                 | 54.00    |
| 4       | 06000 LABORATORY                          | -37, 505    |              |                 | 60.00    |
| 4       | 06500 RESPI RATORY THERAPY                | -482        | l .          | 1               | 65.00    |
| 4       | 06600 PHYSI CAL THERAPY                   | 0           | · ·          |                 | 66.00    |
|         | 06601 PHYSI CAL THERAPY - CARMEL          | -391        | 85, 474      |                 | 66. 01   |
|         | 06700 OCCUPATI ONAL THERAPY               | 0           | 2, 225, 786  |                 | 67.00    |
| 4       | 06800 SPEECH PATHOLOGY                    | 0           | 1, 322, 459  |                 | 68.00    |
|         | 06801 VI SI 0N                            | 0           | 0            | 1               | 68. 01   |
|         | 06802 FAC RESOURCE                        | -22         | 1, 260, 407  |                 | 68. 02   |
|         | 06900 ELECTROCARDI OLOGY                  | 0           | 1            |                 | 69.00    |
|         | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0           | 1            |                 | 71.00    |
|         | 07200 IMPL. DEV. CHARGED TO PATIENTS      | 0           | 0            |                 | 72.00    |
|         | 07300 DRUGS CHARGED TO PATIENTS           | 0           | 1, 491, 251  |                 | 73.00    |
|         | 07400 RENAL DIALYSIS                      | 0           | 0            |                 | 74.00    |
|         | 07700 ALLOGENEIC HSCT ACQUISITION         | 0           | 0            |                 | 77. 00   |
| -       | OUTPATIENT SERVICE COST CENTERS           |             |              |                 |          |
|         | 09000 CLI NI C                            | 0           | 254, 349     |                 | 90.00    |
| 1       | 09001 SLEEP CENTER                        | 0           |              | 1               | 90. 01   |
|         | 09100 EMERGENCY                           | 0           | l .          |                 | 91.00    |
|         | 09200 OBSERVATION BEDS (NON-DISTINCT PART | ŭ           | Ĭ            |                 | 92.00    |
|         | OTHER REIMBURSABLE COST CENTERS           |             |              |                 | ,2,00    |
|         | 09900 CMHC                                | 0           | 0            |                 | 99.00    |
|         | 09910 CORF                                | 0           |              | 1               | 99. 10   |
|         | 10200 OPI OI D TREATMENT PROGRAM          | 0           | l e          |                 | 102.00   |
|         | SPECIAL PURPOSE COST CENTERS              |             |              |                 | .02.00   |
| 118. 00 | SUBTOTALS (SUM OF LINES 1 through 117)    | 2, 241, 802 | 44, 822, 636 |                 | 118. 00  |
|         | NONREI MBURSABLE COST CENTERS             | 2/211/002   | 11/022/000   |                 |          |
|         | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN   | 0           | 0            |                 | 190. 00  |
|         | 19200 PHYSI CI ANS PRI VATE OFFI CES      | 0           | 1            |                 | 192.00   |
|         | 07950 FOUNDATION                          | 559, 862    | 1, 064, 401  | 1               | 194.00   |
|         | 07951 PUBLIC RELATIONS                    | 007,002     | 345, 291     |                 | 194. 01  |
|         | 07952 ST. VINCENT - ARU                   | n           | 0 343, 271   |                 | 194. 01  |
|         | 07953 MUNCIE - ARU                        | n           | 0            |                 | 194. 02  |
|         | 07954 RILEY - ARU                         | 0           | l 0          |                 | 194. 03  |
|         | 07955 RETAIL PHARMACY                     | 0           | 1, 238, 696  | 1               | 194. 05  |
| 200.00  | •   | 2, 801, 664 | ,            |                 | 200.00   |
| 200.00  | 1.3.7.12 (35 3. 2.1420 110 th ough 177)   | 2,001,004   | , 002, 000   | 1 If            | _ 50. 00 |

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: | Provider CCN: 15-3028

|       |                             |                 |             |                          | /31/2023 9:31 am |
|-------|-----------------------------|-----------------|-------------|--------------------------|------------------|
|       |                             | Increases       |             |                          |                  |
|       | Cost Center                 | Li ne #         | Sal ary     | 0ther                    |                  |
|       | 2. 00                       | 3. 00           | 4. 00       | 5. 00                    |                  |
|       | A - CAFETERIA               |                 |             |                          |                  |
| . 00  | CAFETERI A                  | 11. 00          | 23, 516     | 509, 909                 | 1.               |
|       |                             |                 | 23, 516     | 509, 909                 |                  |
|       | B - NURSING ADMINISTRATION  |                 | <u> </u>    |                          |                  |
| . 00  | NURSI NG ADMI NI STRATI ON  | 13. 00          | 204, 901    | 0                        | 1.               |
|       | 0                           | +               | 204, 901    | 0                        |                  |
|       | C - NCR (CORF)              |                 |             |                          |                  |
| 00    | PHYSI CAL THERAPY           | 66.00           | 289, 998    | 73, 078                  | 1.               |
| 00    | OCCUPATI ONAL THERAPY       | 67. 00          | 224, 273    | 56, 515                  | 2.               |
| 00    | SPEECH PATHOLOGY            | 68. 00          | 168, 409    | 42, 438                  | 3.               |
| 00    | n Tribeout                  |                 | 682, 680    | 172, 031                 | J.               |
|       | D - MEDICAL SUPPLIES        |                 | 002, 000    | 172,031                  |                  |
| 00    | CENTRAL SERVICES & SUPPLY   | 14. 00          | ol          | 233, 881                 | 1                |
| . 00  | 1                           |                 | -1          |                          | 1.               |
| . 00  | MEDICAL SUPPLIES CHARGED TO | 71. 00          | 0           | 184, 263                 | 2.               |
| 00    | PATI ENT                    | 0.00            |             |                          |                  |
| . 00  |                             | 0.00            | 0           | 0                        | 3.               |
| . 00  |                             | 0.00            | 0           | 0                        | 4.               |
| . 00  |                             | 0. 00           | 0           | 0                        | 5.               |
| 00    |                             | 0. 00           | 0           | 0                        | 6.               |
| 00    |                             | 0. 00           | 0           | 0                        | 7.               |
| 00    |                             | 0. 00           | 0           | 0                        | 8.               |
| 00    |                             | 0.00            | 0           | О                        | 9.               |
| 0. 00 |                             | 0.00            | 0           | О                        | 10.              |
| 1.00  |                             | 0.00            | 0           | О                        | 11.              |
| 2. 00 |                             | 0.00            | 0           | 0                        | 12.              |
| 3. 00 |                             | 0.00            | o           | 0                        | 13.              |
| 4. 00 |                             | 0.00            | o           | Ö                        | 14.              |
| 5. 00 |                             | 0.00            | o           | Ö                        | 15.              |
| 5. 00 |                             | 0.00            | Ö           | Ö                        | 16.              |
| 7. 00 |                             | 0.00            | Ö           | Ö                        | 17.              |
| 3. 00 |                             | 0.00            | 0           | Ö                        | 18.              |
| 9. 00 |                             | 0.00            | 0           | Ö                        | 19.              |
|       |                             |                 | O O         | 0                        | 20.              |
| 0.00  |                             | 0.00            | -1          | 0                        |                  |
| 1.00  |                             | 0.00            | 0           |                          | 21.              |
| 2. 00 |                             | 0.00            | 0           | 0                        | 22.              |
| 3. 00 |                             | 0.00            |             | 0                        | 23.              |
|       | 0                           |                 | 0           | 418, 144                 |                  |
|       | E - THERAPY ADMIN           |                 |             |                          |                  |
| 00    | ADMINISTRATIVE AND GENERAL  | 5. 01           | 16, 903     | 2, 529                   | 1.               |
| 00    | NURSING ADMINISTRATION      | 13. 00          | 48, 623     | 7, 274                   | 2.               |
| 00    | PHYSI CAL THERAPY           | 66. 00          | 192, 022    | 28, 724                  | 3.               |
| 00    | PHYSICAL THERAPY - CARMEL   | 66. 01          | 3, 806      | 569                      | 4.               |
| 00    | SPEECH PATHOLOGY            | 68. 00          | 102, 276    | 15, 300                  | 5.               |
| 00    | FOUNDATI ON                 | 194. 00         | 10, 656     | 1, 594                   | 6.               |
|       |                             |                 | 374, 286    | 55, 990                  |                  |
|       | F - RTOC ADMIN              |                 | ,           |                          |                  |
| 00    | PHYSICIANS PRIVATE OFFICES  | 192. 00         | 135, 695    | 16, 141                  | 1.               |
| - 0   | 0                           | — · <u>··</u> - | 135, 695    | $-\frac{16,111}{16,141}$ | ''               |
|       | Grand Total: Increases      |                 | 1, 421, 078 | 1, 172, 215              | 500.             |

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: | Provider CCN: 15-3028

|        |                              |                    |                  |                   | '              | /2023 9:31 am |
|--------|------------------------------|--------------------|------------------|-------------------|----------------|---------------|
|        |                              | Decreases          |                  |                   |                |               |
|        | Cost Center                  | Li ne #            | Sal ary          | Other             | Wkst. A-7 Ref. |               |
|        | 6. 00                        | 7. 00              | 8. 00            | 9. 00             | 10.00          |               |
|        | A - CAFETERIA                |                    |                  |                   |                |               |
| 1.00   | DI ETARY                     | <u>10.</u> 00      | 2 <u>3, 5</u> 16 | 50 <u>9, 9</u> 09 | 90             | 1.00          |
|        | 0                            |                    | 23, 516          | 509, 909          |                |               |
|        | B - NURSING ADMINISTRATION   |                    |                  |                   |                |               |
| 1.00   | ADMINISTRATIVE AND GENERAL   | 5. 01              | 204, 901         |                   | 00             | 1.00          |
|        | 0                            |                    | 204, 901         |                   |                |               |
|        | C - NCR (CORF)               |                    |                  |                   |                |               |
| 1.00   | CORF                         | 99. 10             | 682, 680         | 172, 031          |                | 1.00          |
| 2.00   |                              | 0. 00              | 0                | C                 | 0              | 2.00          |
| 3.00   |                              | 000                | 0                | 0                 |                | 3.00          |
|        | 0                            |                    | 682, 680         | 172, 031          |                |               |
|        | D - MEDICAL SUPPLIES         |                    |                  |                   |                |               |
| 1.00   | EMPLOYEE BENEFITS DEPARTMENT | 4. 00              | 0                | 10, 686           | 0              | 1.00          |
| 2.00   | ADMINISTRATIVE AND GENERAL   | 5. 01              | 0                | 644               |                | 2. 00         |
| 3.00   | OTHER A&G - NON FOUNDATION   | 5. 02              | 0                | 927               | 0              | 3.00          |
| 4.00   | OPERATION OF PLANT           | 7. 00              | o                | 12, 435           | 0              | 4.00          |
| 5.00   | HOUSEKEEPI NG                | 9. 00              | O                | 434               | 1 0            | 5.00          |
| 6.00   | DI ETARY                     | 10.00              | О                | 288               | 0              | 6.00          |
| 7.00   | NURSING ADMINISTRATION       | 13. 00             | 0                | 11, 288           | 0              | 7.00          |
| 8.00   | CENTRAL SERVICES & SUPPLY    | 14.00              | o                | 63, 837           | 0              | 8.00          |
| 9.00   | PHARMACY                     | 15. 00             | 0                | 16, 544           |                | 9. 00         |
| 10.00  | SOCI AL SERVI CE             | 17. 00             | 0                | 6, 596            |                | 10.00         |
| 11. 00 | ADULTS & PEDIATRICS          | 30.00              | 0                | 168, 390          | -              | 11. 00        |
| 12. 00 | RADI OLOGY-DI AGNOSTI C      | 54.00              | 0                | 3, 361            |                | 12.00         |
| 13. 00 | RESPIRATORY THERAPY          | 65. 00             | 0                | 50, 854           |                | 13.00         |
| 14. 00 | PHYSI CAL THERAPY            | 66. 00             | Ö                | 6, 681            |                | 14. 00        |
| 15. 00 | PHYSI CAL THERAPY - CARMEL   | 66. 01             | o o              | 362               |                | 15. 00        |
| 16. 00 | OCCUPATIONAL THERAPY         | 67. 00             | 0                | 5, 618            | -              | 16.00         |
| 17. 00 | SPEECH PATHOLOGY             | 68. 00             | 0                | 724               |                | 17.00         |
| 18.00  | FAC RESOURCE                 | 68. 02             | 0                | 4, 166            |                | 18.00         |
| 19. 00 | CLINIC                       | 90.00              | 0                | 15, 815           |                | 19.00         |
| 20.00  | CORF                         | 99. 10             | 0                | 1, 862            |                | 20.00         |
| 21.00  | PHYSICIANS PRIVATE OFFICES   |                    | 0                |                   |                | 21.00         |
| 21.00  | FOUNDATION                   | 192. 00<br>194. 00 | 9                | 30, 066<br>6, 305 |                | 22.00         |
| 23. 00 | RETAIL PHARMACY              | 194.00             | 0                | 261               |                | 23.00         |
| 23.00  | O PHARMACT                   | 194.05             |                  |                   | +              | 23.00         |
|        | E - THERAPY ADMIN            |                    | U                | 410, 144          | ł              |               |
| 1. 00  | OCCUPATIONAL THERAPY         | 67. 00             | 374, 286         | 55, 990           | 0              | 1.00          |
|        | OCCUPATIONAL THERAPT         | 0.00               | 374, 200         |                   |                | 1             |
| 2.00   |                              |                    | 0                | C                 |                | 2.00          |
| 3.00   |                              | 0.00               | 0                | C                 | 1              | 3.00          |
| 4.00   |                              | 0.00               | U                | C                 | -              | 4.00          |
| 5.00   |                              | 0.00               | 0                | C                 | ,              | 5.00          |
| 6. 00  |                              |                    |                  |                   |                | 6. 00         |
|        | U DTOC ADMIN                 |                    | 374, 286         | 55, 990           | <u>/ </u>      |               |
| 1 00   | F - RTOC ADMIN               | 40.00              | 125 (05          | 17 141            |                | 1 00          |
| 1. 00  | FAC RESOURCE                 |                    | 135, 695         | 16, 141           |                | 1.00          |
| E00 00 | Chand Tatal Design           |                    | 135, 695         | 16, 141           |                | F00 00        |
| 500.00 | Grand Total: Decreases       |                    | 1, 421, 078      | 1, 172, 215       | P              | 500.00        |

In Lieu of Form CMS-2552-10

| Period: | Worksheet A-7 |
| From 01/01/2022 | Part |
| To 12/31/2022 | Date/Time Prepared: |
| 5/31/2023 9: 31 am | Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS REHABILITATION HOSPITAL OF INDIANA Provider CCN: 15-3028

|       |  |              |              |              |              | 5/31/2023 9: 3  | 1 am  |
|-------|--|--------------|--------------|--------------|--------------|-----------------|-------|
|       |  |              |              | Acquisitions |              |                 |       |
|       |  | Begi nni ng  | Purchases    | Donati on    | Total        | Di sposal s and |       |
|       |  | Bal ances    |              |              |              | Retirements     |       |
|       |  | 1. 00        | 2.00         | 3.00         | 4. 00        | 5. 00           |       |
|       | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE | T BALANCES   |              |              |              |                 |       |
| 1.00  | Land   | 2, 506, 638  | 0            | 0            | 0            | 0               | 1.00  |
| 2.00  | Land Improvements                            | 370, 910     | 386, 132     | 0            | 386, 132     | 0               | 2.00  |
| 3.00  | Buildings and Fixtures                       | 20, 813, 508 | 12, 684, 596 | 0            | 12, 684, 596 | 0               | 3.00  |
| 4.00  | Building Improvements                        | 205, 018     | 0            | 0            | 0            | 0               | 4.00  |
| 5.00  | Fixed Equipment                              | 2, 265, 857  | 257, 174     | 0            | 257, 174     | 0               | 5.00  |
| 6.00  | Movable Equipment                            | 15, 297, 150 | 718, 123     | 0            | 718, 123     | 19, 740         | 6.00  |
| 7.00  | HIT designated Assets                        | 0            | 0            | 0            | 0            | 0               | 7. 00 |
| 8.00  | Subtotal (sum of lines 1-7)                  | 41, 459, 081 | 14, 046, 025 | 0            | 14, 046, 025 | 19, 740         | 8. 00 |
| 9.00  | Reconciling Items                            | 0            | 0            | 0            | 0            | 0               | 9. 00 |
| 10.00 | Total (line 8 minus line 9)                  | 41, 459, 081 | 14, 046, 025 | 0            | 14, 046, 025 | 19, 740         | 10.00 |
|       |  | Endi ng      | Ful I y      |              |              |                 |       |
|       |  | Bal ance     | 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                            | 757, 042     | 250, 663     |              |              |                 | 2.00  |
| 3.00  | Buildings and Fixtures                       | 33, 498, 104 | 13, 878, 995 |              |              |                 | 3.00  |
| 4.00  | Building Improvements                        | 205, 018     | 187, 578     |              |              |                 | 4. 00 |
| 5.00  | Fixed Equipment                              | 2, 523, 031  | 1, 789, 083  |              |              |                 | 5.00  |
| 6.00  | Movable Equipment                            | 15, 995, 533 | 12, 002, 716 |              |              |                 | 6.00  |
| 7.00  | HIT designated Assets                        | 0            | 0            |              |              |                 | 7. 00 |
| 8.00  | Subtotal (sum of lines 1-7)                  | 55, 485, 366 | 28, 109, 035 |              |              |                 | 8. 00 |
| 9.00  | Reconciling Items                            | 0            | 0            |              |              |                 | 9. 00 |
| 10.00 | Total (line 8 minus line 9)                  | 55, 485, 366 | 28, 109, 035 |              |              |                 | 10.00 |

| Health Financial Systems                | REHABILITATION HOSPITAL OF INDIANA | In Lie                      | u of Form CMS-2552-10    |
|---|------------------------------------|-----------------------------|--------------------------|
| RECONCILIATION OF CAPITAL COSTS CENTERS | Provi der CCN: 15-3028             | Peri od:<br>From 01/01/2022 | Worksheet A-7<br>Part II |

|       |  |                  |                 |                 | o 12/31/2022                       | Date/Time Prep<br>5/31/2023 9:3 |       |
|-------|--|------------------|-----------------|-----------------|------------------------------------|---------------------------------|-------|
|       |  |                  | SL              | JMMARY OF CAPIT | AL                                 |                                 |       |
|       | Cost Center Description                      | Depreciation     | Lease           | Interest        | Insurance<br>(see<br>instructions) | Taxes (see instructions)        |       |
|       |  | 9. 00            | 10. 00          | 11.00           | 12. 00                             | 13.00                           |       |
|       | PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLU   | MN 2, LINES 1 a | and 2           |                                    |                                 |       |
| 1.00  | CAP REL COSTS-BLDG & FIXT                    | 788, 520         | 0               | 239, 187        | 62, 684                            | 0                               | 1.00  |
| 2.00  | CAP REL COSTS-MVBLE EQUIP                    | 626, 025         | 0               | 0               | 4, 079                             | 0                               | 2.00  |
| 3.00  | Total (sum of lines 1-2)                     | 1, 414, 545      | 0               | 239, 187        | 66, 763                            | 0                               | 3.00  |
|       |  | SUMMARY 0        | F CAPITAL       |                 |                                    |                                 |       |
|       | Cost Center Description                      | Other            | Total (1)       |                 |                                    |                                 |       |
|       |  | Capi tal -Rel at |                 |                 |                                    |                                 |       |
|       |  | ed Costs (see    | 9 through 14)   |                 |                                    |                                 |       |
|       |  | instructions)    |                 |                 |                                    |                                 |       |
|       |  | 14. 00           | 15. 00          |                 |                                    |                                 |       |
|       | PART II - RECONCILIATION OF AMOUNTS FROM WOR | KSHEET A, COLU   |                 |                 |                                    |                                 |       |
| 1. 00 | CAP REL COSTS-BLDG & FIXT                    | 0                | 1, 090, 391     | 1               |                                    |                                 | 1.00  |
| 2.00  | CAP REL COSTS-MVBLE EQUIP                    | 10, 596          |                 |                 |                                    |                                 | 2.00  |
| 3. 00 | Total (sum of lines 1-2)                     | 10, 596          | 1, 731, 091     |                 |                                    | l                               | 3. 00 |

| Heal | th Financial Systems REHA   | ABILITATION HOS     | EPITAL OF LNDLA     | NΔ             | In lie          | u of Form CMS-2                 | 2552_10 |
|------|---|---------------------|---------------------|----------------|-----------------|---------------------------------|---------|
|      | ONCILIATION OF CAPITAL COSTS CENTERS  | IDI ELI TATTON 1103 | Provi der Co        |                | Peri od:        | Worksheet A-7                   |         |
|      | THE COURT OF SHIP THE COURT OF |                     |                     |                | From 01/01/2022 | Part III                        |         |
|      |   |                     |                     | -              | Γο 12/31/2022   | Date/Time Pre                   |         |
|      |   | COM                 | <br>PUTATION OF RAT | FLOC           | ALLOCATION OF   | 5/31/2023 9: 3<br>OTHER CAPITAL | ı am    |
|      |   | COM                 | PUTATION OF RAT     | 1105           | ALLUCATION OF   | OTHER CAPITAL                   |         |
|      | Cost Center Description   | Gross Assets        | Capi tal i zed      | 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 C  |                     |                     |                |                 |                                 |         |
| 1.00 |   | 39, 489, 834        |                     | 39, 489, 83    |                 |                                 | 1.00    |
| 2.00 |   | 15, 995, 533        | 0                   | 15, 995, 53    |                 | 0                               | 2.00    |
| 3.00 | Total (sum of lines 1-2)  | 55, 485, 367        | 0                   | 55, 485, 36    |                 |                                 | 3.00    |
|      |   | ALLOCA <sup>-</sup> | TION OF OTHER (     | CAPI TAL       | SUMMARY C       | F CAPITAL                       |         |
|      | Cost Center Description   | Taxes               | Other               | Total (sum of  | Depreciation    | Lease                           |         |
|      |   |                     | Capi tal -Rel at    | cols. 5        |                 |                                 |         |
|      |   |                     | ed Costs            | through 7)     |                 |                                 |         |
|      |   | 6. 00               | 7. 00               | 8. 00          | 9. 00           | 10.00                           |         |
|      | PART III - RECONCILIATION OF CAPITAL COSTS C  | ENTERS              |                     |                |                 |                                 |         |
| 1.00 | CAP REL COSTS-BLDG & FLXT   | 0                   | 0                   |                | 982, 050        | 0                               | 1.00    |
| 2.00 |   | 0                   | 0                   |                | 801, 100        | 0                               | 2.00    |
| 3.00 | Total (sum of lines 1-2)  | 0                   | 0                   | (              | 1, 783, 150     | 0                               | 3.00    |
|      |   |                     | SL                  | JMMARY OF CAPI | TAL             |                                 |         |
|      | Cost Center Description   | Interest            | Insurance           | Taxes (see     | Other           | Total (2)                       |         |
|      |   |                     | (see                | instructions)  |                 |                                 |         |
|      |   |                     | instructions)       | ,              | ed Costs (see   |                                 |         |
|      |   |                     |                     |                | instructions)   | 3 ,                             |         |
|      |   | 11 00               | 12.00               | 12 00          | 14.00           | 15 00                           |         |

11. 00

213, 217

213, 217

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT
CAP REL COSTS-MVBLE EQUIP

12.00

62, 684 4, 079 66, 763 13.00

0 0 0 15.00

1, 271, 248 1. 00 815, 775 2. 00 2, 087, 023 3. 00

14.00

13, 297 10, 596 23, 893

1.00

2.00

3.00 Total (sum of lines 1-2)

Health Financial Systems
ADJUSTMENTS TO EXPENSES REHABILITATION HOSPITAL OF INDIANA

Provider CCN: 15-3028 In Lieu of Form CMS-2552-10 

|                  |  |              |             |   | 12/31/2022      | 5/31/2023 9: 3 |                 |
|------------------|--|--------------|-------------|---|-----------------|----------------|-----------------|
|                  |  |              |             | Expense Classification on To/From Which the Amount is t |                 |                |                 |
|                  |  |              |             | TOTT OIL WITCH THE AMOUNT IS                            | to be Aujusteu  |                |                 |
|                  |  |              |             |   |                 |                |                 |
|                  |  |              |             |   |                 |                |                 |
|                  |  |              |             |   |                 |                |                 |
|                  | Cost Center Description  | Basi s/Code  | Amount      | Cost Center   | Li ne #         | Wkst. A-7      |                 |
|                  |  | (2)<br>1. 00 | 2. 00       | 3.00  | 4. 00           | Ref.<br>5.00   |                 |
| 1. 00            | Investment income - CAP REL  | В            |             | CAP REL COSTS-BLDG & FIXT                               | 1. 00           | 11             | 1. 00           |
| 2. 00            | COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL                      |              | 0           | CAP REL COSTS-MVBLE EQUIP                               | 2. 00           | 0              | 2. 00           |
|                  | COSTS-MVBLE EQUIP (chapter 2)  |              | _           |   |                 |                |                 |
| 3. 00            | Investment income - other (chapter 2)  |              | 0           |   | 0. 00           | 0              | 3. 00           |
| 4. 00            | Trade, quantity, and time discounts (chapter 8)                                |              | 0           |   | 0. 00           | o              | 4. 00           |
| 5. 00            | Refunds and rebates of   |              | 0           |   | 0. 00           | 0              | 5. 00           |
| 6. 00            | expenses (chapter 8) Rental of provider space by                               |              | 0           |   | 0. 00           | 0              | 6. 00           |
|                  | suppliers (chapter 8)  | _            |             |   |                 |                |                 |
| 7. 00            | Tel ephone services (pay stations excluded) (chapter 21)                       | A            | -20, 988    | OPERATION OF PLANT                                      | 7. 00           | 0              | 7. 00           |
| 8. 00            | Tel evi si on and radi o servi ce (chapter 21)                                 | А            | -13, 092    | OPERATION OF PLANT                                      | 7. 00           | 0              | 8. 00           |
| 9. 00<br>10. 00  | Parking Lot (chapter 21) Provider-based physician                              | A-8-2        | 0           |   | 0. 00           | 0              | 9. 00<br>10. 00 |
|                  | adj ustment  | N 0 2        |             |   |                 |                |                 |
| 11. 00           | Sale of scrap, waste, etc. (chapter 23)  |              | 0           |   | 0. 00           | 0              | 11. 00          |
| 12. 00           | Related organization<br>transactions (chapter 10)                              | A-8-1        | 2, 590, 834 |   |                 | 0              | 12. 00          |
| 13. 00<br>14. 00 | Laundry and linen service<br>Cafeteria-employees and guests                    | В            | _177_801    | CAFETERI A  | 0. 00<br>11. 00 | 0              |                 |
| 15. 00           | Rental of quarters to employee   |              | 0           | SAI ETERTA  | 0. 00           | Ö              |                 |
| 16. 00           | and others Sale of medical and surgical supplies to other than                 | В            | 0           | CENTRAL SERVICES & SUPPLY                               | 14. 00          | 0              | 16. 00          |
| 17. 00           | patients<br>Sale of drugs to other than  | В            | -40, 621    | PHARMACY  | 15. 00          | 0              | 17. 00          |
| 18. 00           | patients Sale of medical records and   | В            | -89         | MEDICAL RECORDS & LIBRARY                               | 16. 00          | 0              | 18. 00          |
|                  | abstracts  |              | 0           |   |                 |                |                 |
| 19.00            | Nursing and allied health education (tuition, fees, books, etc.)               |              | 0           |   | 0. 00           | 0              | 19. 00          |
| 20.00            | Vending machines   |              | 0           |   | 0.00            | 0              |                 |
| 21. 00           | Income from imposition of interest, finance or penalty                         |              | 0           |   | 0.00            | 0              | 21. 00          |
| 22. 00           | charges (chapter 21)   |              | 0           |   | 0. 00           | 0              | 22. 00          |
| 22.00            | overpayments and borrowings to   |              |             |   | 0.00            | o l            | 22.00           |
| 23. 00           | repay Medicare overpayments Adjustment for respiratory                         | A-8-3        | 0           | RESPIRATORY THERAPY                                     | 65. 00          |                | 23. 00          |
|                  | therapy costs in excess of   |              | _           |   |                 |                |                 |
| 24. 00           | limitation (chapter 14) 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 -   |              | 0           | *** Cost Center Deleted ***                             | 114. 00         |                | 25. 00          |
|                  | physicians' compensation (chapter 21)  |              |             |   |                 |                |                 |
| 26. 00           | Depreciation - CAP REL<br>COSTS-BLDG & FIXT                                    |              | 0           | CAP REL COSTS-BLDG & FIXT                               | 1. 00           | 0              | 26. 00          |
| 27. 00           | Depreciation - CAP REL   |              | 0           | CAP REL COSTS-MVBLE EQUIP                               | 2. 00           | 0              | 27. 00          |
| 28. 00           | COSTS-MVBLE EQUIP Non-physician Anesthetist                                    |              | 0           | *** Cost Center Deleted ***                             | 19. 00          |                | 28. 00          |
| 29. 00           | Physicians' assistant  | 4.6.3        | 0           |   | 0. 00           | 0              | 29. 00          |
| 30. 00           | Adjustment for occupational therapy costs in excess of limitation (chapter 14) | A-8-3        | 0           | OCCUPATI ONAL THERAPY                                   | 67. 00          |                | 30. 00          |
| 30. 99           | Hospice (non-distinct) (see instructions)                                      |              | 0           | ADULTS & PEDIATRICS                                     | 30. 00          |                | 30. 99          |
|                  | instructions)  | I            | I           | ı   | l               | I              | ı               |

ADJUSTMENTS TO EXPENSES Provi der CCN: 15-3028 Peri od: Worksheet A-8 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/31/2023 9:31 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5.00 68.00 31.00 Adjustment for speech A-8-3 O SPEECH PATHOLOGY 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 32.00 0 0.00 Depreciation and Interest MI SCELLANEOUS REVENUE -1, 126 EMPLOYEE BENEFITS DEPARTMENT В 4.00 33.00 33. 01 MI SCELLANEOUS REVENUE -80, 273 ADMINISTRATIVE AND GENERAL 5.01 33.01 В ol MI SCELLANEOUS REVENUE 33.02 33.02 В -268 CENTRAL SERVICES & SUPPLY 14.00 33.03 MI SCELLANEOUS REVENUE В -482 RESPIRATORY THERAPY 65.00 33.03 33.07 RHI FOUNDATION 559, 862 FOUNDATION 194.00 33.07 Α -10FAC RESOURCE 33 08 ADVERTI SI NG 68 02 33.08 Α ADVERTI SI NG O ADMINISTRATIVE AND GENERAL 33.09 Α 5.01 33.09 33. 10 ADVERTI SI NG Α -400 NURSING ADMINISTRATION 13.00 33.10 -120 ADMINISTRATIVE AND GENERAL 33. 11 **TAXES** 5.01 33.11 Α BOND ISSUANCE COST 14, 182 CAP REL COSTS-BLDG & FIXT 1.00 14 33. 13 33.13 Α AMORTIZATION CARR 33.14 LATE FEES Α -885 CAP REL COSTS-BLDG & FIXT 1.00 14 33.14 LATE FEES -17 MEDICAL RECORDS & LIBRARY 33.15 33. 15 Α 16.00 33. 16 LATE FEES -391 PHYSI CAL THERAPY - CARMEL 0 33. 16 Α 66.01 o LATE FEES -12 FAC RESOURCE 33.17 Α 68. 02 33.17

2, 801, 664

-445 ADMINISTRATIVE AND GENERAL

-224 EMPLOYEE BENEFITS DEPARTMENT

5.01

4.00

33.18

33.19

50.00

Α

Α

TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,

DONATI ONS/CONTRI BUTI ONS

DONATI ONS/CONTRI BUTI ONS

column 6, line 200.)

33. 18

33. 19

50.00

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

<sup>(2)</sup> Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provi der CCN: 15-3028 | Peri od: | From 01/01/2022

Worksheet A-8-1

| 2. 00     2. 00 CAP REL COSTS-MVBLE EQUI P     ALLOCATION FROM HO REPORT     175, 075     0     2. 00       3. 00     5. 01 ADMINISTRATIVE AND GENERAL     ALLOCATION FROM HO REPORT     2, 259, 734     0     3. 00       4. 00     5. 01 ADMINISTRATIVE AND GENERAL     RELATED PARTY FEES     828     828     4. 00       4. 01     54. 00 RADI OLOGY-DI AGNOSTI C     ALLOCATION FROM RELATED PARTY     501     501     501     4. 01       4. 02     60. 00 LABORATORY     ALLOCATION FROM RELATED PARTY     385, 345     422, 850     4. 02       4. 03     5. 01 ADMINISTRATIVE AND GENERAL     RELATED PARTY FEES     361, 842     361, 842     4. 03       4. 04     54. 00 RADI OLOGY-DI AGNOSTI C     RELATED PARTY FEES     2, 727     2, 727     2, 727     4. 04  |      |                              |                               |                              | To 12/31/2022     | Date/Time Pre |        |
|---|------|------------------------------|-------------------------------|------------------------------|-------------------|---------------|--------|
| Allowable Cost   Included in   Wks. A, column   5   |      | Line No                      | Cost Contor                   | Evnonso I toms               | Amount of         |               | ı allı |
| 1.00  |      | Little No.                   | cost center                   | Expense i tellis             |                   | * * * *       |        |
| 1.00  |      |                              |                               |                              |                   |               |        |
| 1.00   2.00   3.00   4.00   5.00  |      |                              |                               |                              |                   | · ·           |        |
| 1.00  |      | 1.00                         | 2. 00                         | 3.00                         | 4. 00             |               |        |
| 1. 00     1. 00 CAP REL COSTS-BLDG & FIXT     ALLOCATION FROM HO REPORT     193,530     0     1. 00       2. 00     2. 00 CAP REL COSTS-MVBLE EQUIP     ALLOCATION FROM HO REPORT     175,075     0     2. 00       3. 00     5. 01 ADMINISTRATIVE AND GENERAL     ALLOCATION FROM HO REPORT     2, 259,734     0     3. 00       4. 00     5. 01 ADMINISTRATIVE AND GENERAL     RELATED PARTY FEES     828     828     4. 00       4. 01     54. 00 RADIOLOGY-DIAGNOSTIC     ALLOCATION FROM RELATED PART     501     501     501     4. 01       4. 02     60. 00 LABORATORY     ALLOCATION FROM RELATED PART     385, 345     422, 850     4. 02       4. 03     5. 01 ADMINISTRATIVE AND GENERAL     RELATED PARTY FEES     361, 842     361, 842     4. 03       4. 04     54. 00 RADIOLOGY-DIAGNOSTIC     RELATED PARTY FEES     2, 727     2, 727     4. 04  |      | A. COSTS INCURRED AND ADJUST | MENTS REQUIRED AS A RESULT OF | TRANSACTIONS WITH RELATED O  | RGANI ZATI ONS OF | CLAIMED HOME  |        |
| 2. 00       2. 00 CAP REL COSTS-MVBLE EQUI P       ALLOCATION FROM HO REPORT       175, 075       0       2. 00         3. 00       5. 01 ADMINISTRATIVE AND GENERAL       ALLOCATION FROM HO REPORT       2, 259, 734       0       3. 00         4. 00       5. 01 ADMINISTRATIVE AND GENERAL       RELATED PARTY FEES       828       828       4. 00         4. 01       54. 00 RADI OLOGY-DI AGNOSTI C       ALLOCATION FROM RELATED PART       501       501       501       4. 01         4. 02       60. 00 LABORATORY       ALLOCATION FROM RELATED PART       385, 345       422, 850       4. 02         4. 03       5. 01 ADMINISTRATIVE AND GENERAL       RELATED PARTY FEES       361, 842       361, 842       4. 03         4. 04       54. 00 RADI OLOGY-DI AGNOSTI C       RELATED PARTY FEES       2, 727       2, 727       2, 727       4. 04  |      | OFFICE COSTS:                |                               |                              |                   |               |        |
| 3. 00   5. 01   ADMINISTRATIVE AND GENERAL   ALLOCATION FROM HO REPORT   2, 259, 734   0   3. 00   4. 00   4. 01   54. 00   RADIOLOGY-DIAGNOSTIC   ALLOCATION FROM RELATED PART   501   501   4. 01   4. 02   60. 00   LABORATORY   ALLOCATION FROM RELATED PART   385, 345   422, 850   4. 02   4. 03   5. 01   ADMINISTRATIVE AND GENERAL   RELATED PARTY FEES   361, 842   361, 842   4. 03   4. 04   54. 00   RADIOLOGY-DIAGNOSTIC   RELATED PARTY FEES   2, 727   2, 727   4. 04   | 1.00 | 1.00                         | CAP REL COSTS-BLDG & FIXT     | ALLOCATION FROM HO REPORT    | 193, 530          | 0             | 1.00   |
| 4. 00     5. 01 ADMINISTRATIVE AND GENERAL     RELATED PARTY FEES     828     828     4. 00       4. 01     54. 00 RADI OLOGY-DI AGNOSTI C     ALLOCATION FROM RELATED PART     501     501     4. 01       4. 02     60. 00 LABORATORY     ALLOCATION FROM RELATED PART     385, 345     422, 850     4. 02       4. 03     5. 01 ADMINISTRATIVE AND GENERAL     RELATED PARTY FEES     361, 842     361, 842     4. 03       4. 04     54. 00 RADI OLOGY-DI AGNOSTI C     RELATED PARTY FEES     2, 727     2, 727     4. 04  | 2.00 | 2. 00                        | CAP REL COSTS-MVBLE EQUIP     | ALLOCATION FROM HO REPORT    | 175, 075          | 0             | 2.00   |
| 4. 01     54. 00 RADI OLOGY-DI AGNOSTI C     ALLOCATI ON FROM RELATED PART ALLOCATION FROM RELATED PART ALLOCATION FROM RELATED PART STATE PART ALLOCATION FROM RELATED PART STATE PART S | 3.00 | 5. 01                        | ADMINISTRATIVE AND GENERAL    | ALLOCATION FROM HO REPORT    | 2, 259, 734       | 0             | 3.00   |
| 4. 02       60. 00 LABORATORY       ALLOCATION FROM RELATED PART RELATED PART PART S42, 850 4. 02       4. 02         4. 03       5. 01 ADMINISTRATIVE AND GENERAL A. 04       RELATED PARTY FEES S41, 842 361, 842 4. 03       361, 842 361, 842 4. 03         4. 04       54. 00 RADI OLOGY-DI AGNOSTI C       RELATED PARTY FEES 2, 727 2, 727 4. 04   | 4.00 | 5. 01                        | ADMINISTRATIVE AND GENERAL    | RELATED PARTY FEES           | 828               | 828           | 4.00   |
| 4.03       5.01 ADMINISTRATIVE AND GENERAL RELATED PARTY FEES       361,842       361,842       4.03         4.04       54.00 RADIOLOGY-DIAGNOSTIC       RELATED PARTY FEES       2,727       2,727       4.04  | 4.01 | 54.00                        | RADI OLOGY-DI AGNOSTI C       | ALLOCATION FROM RELATED PART | 501               | 501           | 4.01   |
| 4. 04 54. 00 RADI OLOGY-DI AGNOSTI C RELATED PARTY FEES 2, 727 2, 727 4. 04   | 4.02 | 60.00                        | LABORATORY                    | ALLOCATION FROM RELATED PART | 385, 345          | 422, 850      | 4.02   |
|   | 4.03 | 5. 01                        | ADMINISTRATIVE AND GENERAL    | RELATED PARTY FEES           | 361, 842          | 361, 842      | 4.03   |
| 4 OF CONTINUE ON THE PARTY FEEC (7/ 4 OF  | 4.04 | 54.00                        | RADI OLOGY-DI AGNOSTI C       | RELATED PARTY FEES           | 2, 727            | 2, 727        | 4.04   |
| 4. US   OO. UUJPHYSICAL THERAPY   KELATED PARTY FEES   O70  O70  4. US  | 4.05 | 66.00                        | PHYSI CAL THERAPY             | RELATED PARTY FEES           | 676               | 676           | 4.05   |
| 4. 06   15. 00 PHARMACY   RELATED PARTY FEES   12, 201   12, 201   4. 06  | 4.06 | 15. 00                       | PHARMACY                      | RELATED PARTY FEES           | 12, 201           | 12, 201       | 4.06   |
| 4.07   192.00 PHYSICIANS PRIVATE OFFICES   RELATED PARTY FEES   382,569 382,569 4.07  | 4.07 | 192. 00                      | PHYSICIANS PRIVATE OFFICES    | RELATED PARTY FEES           | 382, 569          | 382, 569      | 4.07   |
| 4. 08 7. 00 0PERATI ON 0F PLANT   RELATED PARTY FEES   230, 253   230, 253   4. 08  | 4.08 | 7. 00                        | OPERATION OF PLANT            | RELATED PARTY FEES           | 230, 253          | 230, 253      | 4.08   |
| 4.09 4.00 EMPLOYEE BENEFITS DEPARTMENT RELATED PARTY FEES 16,978 16,978 4.09  | 4.09 | 4. 00                        | EMPLOYEE BENEFITS DEPARTMENT  | RELATED PARTY FEES           | 16, 978           | 16, 978       | 4.09   |
| 5.00 TOTALS (sum of lines 1-4). 4,022,259 1,431,425 5.00  | 5.00 | TOTALS (sum of lines 1-4).   |                               |                              | 4, 022, 259       | 1, 431, 425   | 5.00   |
| Transfer column 6, line 5 to  |      | Transfer column 6, line 5 to |                               |                              |                   |               |        |
| Worksheet A-8, column 2,  |      | Worksheet A-8, column 2,     |                               |                              |                   |               |        |
| line 12.  |      | 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 | i |
|-------------------------------|-------------------------------|---------------|------------------------------|----------------|---|
|                               |                               |               | •                            |                | i |
|                               |                               |               |                              |                | 1 |
|                               |                               |               |                              |                | i |
|                               |                               |               |                              |                | i |
| Symbol (1)                    | Name                          | Percentage of | Name                         | Percentage of  |   |
| •                             |                               | Ownershi p    |                              | Ownershi p     |   |
| 1. 00                         | 2. 00                         | 3. 00         | 4. 00                        | 5. 00          |   |
| B. INTERRELATIONSHIP TO RELAT | TED ORGANIZATION(S) AND/OR HO | ME OFFICE:    |                              |                |   |

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

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

| 6.00   | В                       | 51. 00 I U HEALTH 51. 00 | 6. 00  |
|--------|-------------------------|--------------------------|--------|
| 7.00   | В                       | 49.00 ST. VINCENT 49.00  | 7. 00  |
| 8.00   |                         | 0.00                     | 8. 00  |
| 9.00   |                         | 0.00                     | 9. 00  |
| 10.00  |                         | 0.00                     | 10.00  |
| 100.00 | G. Other (financial or  |                          | 100.00 |
|        | non-financial) specify: |                          |        |

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- 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.

|       |                |                 |                |                |               |              | 12,01,2022         | 5/31/2023 9:3 | 31 am |
|-------|----------------|-----------------|----------------|----------------|---------------|--------------|--------------------|---------------|-------|
|       | Net            | Wkst. A-7 Ref.  |                |                |               |              |                    |               |       |
|       | Adjustments    |                 |                |                |               |              |                    |               |       |
|       | (col. 4 minus  |                 |                |                |               |              |                    |               |       |
|       | col. 5)*       |                 |                |                |               |              |                    |               |       |
|       | 6. 00          | 7. 00           |                |                |               |              |                    |               |       |
|       | A. COSTS INCUR | RED AND ADJUSTI | MENTS REQUIRED | AS A RESULT OF | TRANSACTI ONS | WITH RELATED | ORGANI ZATI ONS OR | CLAIMED HOME  |       |
|       | OFFICE COSTS:  |                 |                |                |               |              |                    |               |       |
| 1.00  | 193, 530       |                 |                |                |               |              |                    |               | 1.00  |
| 2.00  | 175, 075       |                 |                |                |               |              |                    |               | 2.00  |
| 3.00  | 2, 259, 734    | 0               |                |                |               |              |                    |               | 3.00  |
| 4.00  | 0              | 0               |                |                |               |              |                    |               | 4.00  |
| 4.01  | 0              | 0               |                |                |               |              |                    |               | 4. 01 |
| 4.02  | -37, 505       | 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 | 2, 590, 834    |                 |                |                |               |              |                    |               | 5.00  |

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

|   | Related Organization(s)      |   |  |
|---|------------------------------|---|--|
|   | and/or Home Office           |   |  |
|   |                              |   |  |
|   |                              |   |  |
|   | Type of Business             |   |  |
|   |                              |   |  |
|   | 6. 00                        |   |  |
| - | B. INTERRELATIONSHIP TO RELA | TED ORGANIZATION(S) AND/OR HOME OFFICE: |  |
|   |                              |   |  |

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

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

| 6. 00             | HOME OFFICE  | 6.00         |
|-------------------|--------------|--------------|
|                   | MGMT COMPANY | 7.00         |
| 8. 00<br>9. 00    |              | 8.00<br>9.00 |
| 9.00              |              | 9.00         |
| 10. 00<br>100. 00 |              | 10.00        |
| 100.00            |              | 100.00       |

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

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Peri od: Worksheet B From 01/01/2022 Part I Provider CCN: 15-3028

|                        |  |                            |                    | Fr<br>To    | om 01/01/2022<br>12/31/2022 | Part I<br>Date/Time Pre    |                    |
|------------------------|--|----------------------------|--------------------|-------------|-----------------------------|----------------------------|--------------------|
|                        |  |                            | CAPI TAL REI       | LATED COSTS |                             | 5/31/2023 9: 3             | i am               |
|                        | Cost Center Description  | Net Expenses               | BLDG & FIXT        | MVBLE EQUIP | EMPLOYEE                    | Subtotal                   |                    |
|                        | oust denter beschiptron  | for Cost                   | DEDG & TTXT        | MVDEE EQUIT | BENEFI TS                   | Subtotal                   |                    |
|                        |  | Allocation<br>(from Wkst A |                    |             | DEPARTMENT                  |                            |                    |
|                        |  | col. 7)                    |                    |             |                             |                            |                    |
| CE                     | NERAL SERVICE COST CENTERS   | 0                          | 1.00               | 2.00        | 4. 00                       | 4A                         |                    |
|                        | 1100 CAP REL COSTS-BLDG & FLXT   | 1, 271, 248                | 1, 271, 248        |             |                             |                            | 1.00               |
| 2.00 00                | 200 CAP REL COSTS-MVBLE EQUIP  | 815, 775                   |                    | 815, 775    |                             |                            | 2.00               |
|                        | 1400 EMPLOYEE BENEFITS DEPARTMENT                                      | 6, 423, 683                | 13, 727            |             | 6, 446, 219                 | 0 000 070                  | 4.00               |
|                        | 1591 ADMINISTRATIVE AND GENERAL<br>1590 OTHER A&G - NON FOUNDATION     | 7, 507, 523<br>1, 115, 572 | 32, 010<br>5, 458  |             | 763, 305<br>225, 851        | 8, 323, 379<br>1, 350, 384 | 5. 01<br>5. 02     |
|                        | 0700 OPERATION OF PLANT  | 1, 688, 139                |                    |             | 8, 422                      | 2, 164, 835                | 7.00               |
|                        | 800 LAUNDRY & LINEN SERVICE  | 100, 960                   |                    |             | 0                           | 100, 960                   | 8.00               |
|                        | 1900 HOUSEKEEPI NG   | 544, 399                   |                    |             | 100, 177                    | 663, 676                   | 9.00               |
|                        | 000 DI ETARY<br>100 CAFETERI A   | 750, 969<br>355, 624       | 29, 003<br>20, 596 |             | 8, 968<br>6, 370            | 807, 552<br>395, 807       | 10.00<br>11.00     |
|                        | 300 NURSING ADMINISTRATION   | 2, 187, 818                |                    |             | 514, 237                    | 2, 711, 377                | 13.00              |
|                        | 400 CENTRAL SERVICES & SUPPLY  | 525, 195                   | 0                  | _           | 18, 201                     | 543, 396                   | 1                  |
|                        | 500 PHARMACY   | 697, 934                   | 19, 544            |             | 157, 046                    | 887, 065                   | 1                  |
|                        | 600 MEDICAL RECORDS & LIBRARY<br>700 SOCIAL SERVICE                    | 514, 366<br>633, 062       |                    |             | 111, 776<br>126, 915        | 637, 723<br>766, 109       | 16. 00<br>17. 00   |
|                        | 1200 I&R SERVICES-OTHER PRGM COSTS APPRV                               | 222, 453                   | 5, 343             |             | 120, 719                    | 231, 224                   | 22.00              |
| IN                     | PATIENT ROUTINE SERVICE COST CENTERS                                   |                            | ·                  |             |                             | •                          |                    |
|                        | 000 ADULTS & PEDIATRICS  | 9, 010, 120                | 523, 288           | 335, 799    | 2, 008, 135                 | 11, 877, 342               | 30.00              |
|                        | CILLARY SERVICE COST CENTERS   | ol                         | 0                  | ol          | ol                          | 0                          | 50.00              |
|                        | 4400 RADI OLOGY-DI AGNOSTI C   | 168, 437                   | 4, 117             |             | 37, 741                     | 212, 937                   | 54.00              |
|                        | 000 LABORATORY   | 385, 285                   | 20, 608            |             | 0                           | 419, 117                   | 60.00              |
|                        | 500  RESPI RATORY THERAPY<br>600  PHYSI CAL THERAPY                    | 532, 787                   | 3, 886             |             | 132, 418                    | 671, 584                   | 65.00              |
|                        | 601 PHYSICAL THERAPY - CARMEL  | 2, 547, 298<br>85, 474     | 82, 870<br>0       |             | 552, 295<br>14, 643         | 3, 235, 642<br>100, 117    | 1                  |
|                        | 700 OCCUPATI ONAL THERAPY  | 2, 225, 786                | Ĭ                  | 1           | 538, 007                    | 2, 896, 007                | 1                  |
|                        | 800 SPEECH PATHOLOGY   | 1, 322, 459                | 43, 031            |             | 317, 741                    | 1, 710, 845                | 1                  |
|                        | 801 VISION<br>802 FAC RESOURCE   | 0<br>1, 260, 407           | 0                  |             | 0 <br>275, 499              | 0<br>1, 535, 906           | 68. 01<br>68. 02   |
|                        | 1900 ELECTROCARDI OLOGY  | 1, 260, 407                | 0                  |             | 275, 499                    | 1, 555, 900                | 69.00              |
|                        | 100 MEDICAL SUPPLIES CHARGED TO PATIENT                                | 184, 263                   | 0                  | Ō           | ō                           | 184, 263                   | 71.00              |
|                        | 200 IMPL. DEV. CHARGED TO PATIENTS                                     | 0                          | 0                  | 0           | 0                           | 0                          | 72.00              |
|                        | 300 DRUGS CHARGED TO PATIENTS<br>400 RENAL DIALYSIS                    | 1, 491, 251<br>0           | 0                  | 0           | 0                           | 1, 491, 251<br>0           | 73.00<br>74.00     |
|                        | 7700 ALLOGENEIC HSCT ACQUISITION                                       | 0                          |                    |             | ol<br>ol                    | 0                          | 77.00              |
| OU                     | TPATIENT SERVICE COST CENTERS  |                            |                    |             | - 1                         |                            |                    |
|                        | 2000 CLINIC  | 254, 349                   | 41, 574            |             | 57, 365                     | 379, 966                   | 90.00              |
|                        | 2001   SLEEP CENTER<br>2100   EMERGENCY                                | 0                          | 0                  | 0           | 0                           | 0                          | 90. 01<br>91. 00   |
|                        | 200 OBSERVATION BEDS (NON-DISTINCT PART                                |                            |                    |             | Ĭ                           | 0                          | 92.00              |
|                        | HER REIMBURSABLE COST CENTERS  |                            |                    |             |                             |                            |                    |
| 99. 00 09<br>99. 10 09 |  | 0                          | 0                  |             | 0                           | 0                          | 1                  |
| 102.0010               | 200 OPIOID TREATMENT PROGRAM   | 0                          |                    |             | ol                          |                            | 102.00             |
| SP                     | ECIAL PURPOSE COST CENTERS   |                            |                    |             | -                           |                            |                    |
| 118. 00                | SUBTOTALS (SUM OF LINES 1 through 117)<br>  NREIMBURSABLE COST CENTERS | 44, 822, 636               | 1, 238, 925        | 795, 033    | 5, 975, 112                 | 44, 298, 464               | 118.00             |
|                        | 1000 GIFT FLOWER COFFEE SHOP & CANTEEN                                 | O                          | 0                  | O           | ol                          | 0                          | 190.00             |
|                        | 200 PHYSICIANS PRIVATE OFFICES   | 1, 531, 812                |                    |             | 268, 816                    | 1, 809, 096                |                    |
|                        | 950 FOUNDATION   | 1, 064, 401                | 19, 255            |             | 95, 423                     | 1, 191, 435                | 1                  |
|                        | '951 PUBLIC RELATIONS<br>'952 ST. VINCENT - ARU                        | 345, 291                   | 7, 910             |             | 45, 007                     | 403, 284                   | 194. 01<br>194. 02 |
|                        | 952 ST. VINCENT - ARU<br>953 MUNCIE - ARU                              |                            | 0                  | - 1         | 0<br>0                      |                            | 194. 02            |
| 194. 04 07             | 954 RILEY - ARU  | o                          | 0                  | 1           | Ö                           | 0                          | 194. 04            |
|                        | 955 RETAIL PHARMACY  | 1, 238, 696                | 0                  | 0           | 61, 861                     | 1, 300, 557                |                    |
| 200. 00<br>201. 00     | Cross Foot Adjustments Negative Cost Centers                           |                            | _                  |             |                             |                            | 200. 00<br>201. 00 |
| 201.00                 | TOTAL (sum lines 118 through 201)                                      | 49, 002, 836               | 1, 271, 248        | 815, 775    | 6, 446, 219                 | 49, 002, 836               |                    |
|                        |  | · '                        | -                  | . "         | '                           |                            | -                  |

Provider CCN: 15-3028

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared: 5/31/2023 9:31 am

|             |   |                  |              | '           | 0 12/31/2022                          | 5/31/2023 9: 3 |         |
|-------------|---|------------------|--------------|-------------|---------------------------------------|----------------|---------|
|             | Cost Center Description                 | ADMI NI STRATI V | Subtotal     | OTHER A&G - | OPERATION OF                          | LAUNDRY &      |         |
|             |   | E AND GENERAL    |              | NON         | PLANT                                 | LINEN SERVICE  |         |
|             |   |                  |              | FOUNDATI ON |                                       |                |         |
|             |   | 5. 01            | 5A. 01       | 5. 02       | 7. 00                                 | 8. 00          |         |
|             | NERAL SERVICE COST CENTERS              |                  |              |             |                                       |                |         |
|             | 100 CAP REL COSTS-BLDG & FLXT           |                  |              |             |                                       |                | 1. 00   |
|             | 200 CAP REL COSTS-MVBLE EQUIP           |                  |              |             |                                       |                | 2.00    |
|             | 400 EMPLOYEE BENEFITS DEPARTMENT        |                  |              |             |                                       |                | 4. 00   |
|             | 591 ADMINISTRATIVE AND GENERAL          | 8, 323, 379      |              |             |                                       |                | 5. 01   |
|             | 590 OTHER A&G - NON FOUNDATION          | 276, 301         | 1, 626, 685  |             |                                       |                | 5. 02   |
| 7. 00 00    | 700 OPERATION OF PLANT                  | 442, 945         | 2, 607, 780  | 89, 541     | 2, 697, 321                           |                | 7.00    |
| 8.00 00     | 800 LAUNDRY & LINEN SERVICE             | 20, 657          | 121, 617     | 4, 176      | 0                                     | 125, 793       | 8.00    |
| 9.00 00     | 900 HOUSEKEEPI NG                       | 135, 794         | 799, 470     | 27, 451     | 33, 568                               | 0              | 9. 00   |
| 10. 00   01 | 000 DI ETARY                            | 165, 232         | 972, 784     | 33, 402     | 83, 686                               | 0              | 10.00   |
| 11. 00   01 | 100 CAFETERI A                          | 80, 986          | 476, 793     | 16, 371     | 59, 428                               | 0              | 11.00   |
| 13. 00   01 | 300 NURSING ADMINISTRATION              | 554, 772         | 3, 266, 149  | 112, 146    | 16, 384                               | 0              | 13.00   |
| 14. 00   01 | 400 CENTRAL SERVICES & SUPPLY           | 111, 184         | 654, 580     | 22, 476     | 0                                     | 0              | 14.00   |
| 15. 00   01 | 500 PHARMACY                            | 181, 501         | 1, 068, 566  | 36, 690     | 56, 392                               | 0              | 15.00   |
| 16. 00 01   | 600 MEDICAL RECORDS & LIBRARY           | 130, 484         | 768, 207     | 26, 377     | 20, 354                               | 0              | 16.00   |
| 17. 00   01 | 700 SOCIAL SERVICE                      | 156, 753         | 922, 862     | 31, 687     | 10, 778                               | 0              | 17.00   |
| 22. 00 02   | 200 I&R SERVICES-OTHER PRGM COSTS APPRV | 47, 311          | 278, 535     | 9, 564      | 15, 416                               | 0              | 22.00   |
|             | PATIENT ROUTINE SERVICE COST CENTERS    | <u> </u>         |              |             | · · · · · · · · · · · · · · · · · · · |                |         |
| 30.00 03    | 000 ADULTS & PEDIATRICS                 | 2, 430, 208      | 14, 307, 550 | 491, 243    | 1, 509, 894                           | 123, 217       | 30.00   |
|             | CILLARY SERVICE COST CENTERS            |                  |              |             |                                       |                |         |
| 50.00 05    | 000 OPERATING ROOM                      | 0                | 0            | 0           | 0                                     | 0              | 50.00   |
| 54.00 05    | 400 RADI OLOGY-DI AGNOSTI C             | 43, 569          | 256, 506     | 8, 807      | 11, 879                               | 0              | 54.00   |
| 60.00 06    | 000 LABORATORY                          | 85, 755          | 504, 872     | 17, 335     | 59, 461                               | 0              | 60.00   |
| 65. 00 06   | 500 RESPI RATORY THERAPY                | 137, 412         | 808, 996     | 27, 778     | 11, 212                               | 0              | 65.00   |
| 66.00 06    | 600 PHYSI CAL THERAPY                   | 662, 041         | 3, 897, 683  | 133, 831    | 239, 114                              | 179            | 66.00   |
| 66. 01 06   | 601 PHYSICAL THERAPY - CARMEL           | 20, 485          | 120, 602     | 4, 141      | 0                                     | 2, 155         | 66. 01  |
| 67. 00 06   | 700 OCCUPATI ONAL THERAPY               | 592, 549         | 3, 488, 556  | 119, 783    | 232, 373                              | 138            | 67.00   |
| 68. 00 06   | 800 SPEECH PATHOLOGY                    | 350, 054         | 2, 060, 899  | 70, 763     | 124, 162                              | 104            | 68.00   |
|             | 801 VI SI ON                            | o                | 0            | 0           | 0                                     | 0              | 68. 01  |
|             | 802 FAC RESOURCE                        | 314, 260         | 1, 850, 166  | 63, 527     | o                                     | 0              | 68. 02  |
|             | 900 ELECTROCARDI OLOGY                  | o                | 0            | 0           | o                                     | 0              | 69.00   |
| 71. 00   07 | 100 MEDICAL SUPPLIES CHARGED TO PATIENT | 37, 702          | 221, 965     | 7, 621      | o                                     | 0              | 71.00   |
|             | 200 IMPL. DEV. CHARGED TO PATIENTS      | o                | 0            | 0           | o                                     | 0              | 72.00   |
|             | 300 DRUGS CHARGED TO PATIENTS           | 305, 123         | 1, 796, 374  | 61, 680     | o                                     | 0              | 73.00   |
|             | 400 RENAL DIALYSIS                      | 0                | 0            | 0           | 0                                     | 0              | 74.00   |
|             | 700 ALLOGENEIC HSCT ACQUISITION         | o                | o            | 0           | 0                                     | 0              | 77. 00  |
|             | TPATIENT SERVICE COST CENTERS           |                  |              |             | '                                     |                |         |
| 90.00 09    | 000 CLI NI C                            | 77, 744          | 457, 710     | 15, 716     | 119, 957                              | 0              | 90.00   |
| 90. 01 09   | 001 SLEEP CENTER                        | 0                | 0            | 0           | 0                                     | 0              | 90. 01  |
| 91.00 09    | 100 EMERGENCY                           | o                | 0            | 0           | 0                                     | 0              | 91.00   |
|             | 200 OBSERVATION BEDS (NON-DISTINCT PART |                  | 0            |             |                                       |                | 92.00   |
|             | HER REIMBURSABLE COST CENTERS           |                  |              |             |                                       |                |         |
| 99.00 09    | 900 CMHC                                | 0                | 0            | 0           | 0                                     | 0              | 99. 00  |
| 99. 10 09   |   | o                | 0            | 0           | 0                                     | 0              | 99. 10  |
| 102. 00 10  | 200 OPIOID TREATMENT PROGRAM            | 0                | 0            | 0           | 0                                     | 0              | 102.00  |
| SPI         | ECIAL PURPOSE COST CENTERS              |                  |              |             |                                       |                |         |
| 118. 00     | SUBTOTALS (SUM OF LINES 1 through 117)  | 7, 360, 822      | 43, 335, 907 | 1, 432, 106 | 2, 604, 058                           | 125, 793       | 118.00  |
| NO          | NREIMBURSABLE COST CENTERS              |                  |              |             |                                       |                |         |
| 190. 00 19  | 000 GIFT FLOWER COFFEE SHOP & CANTEEN   | 0                | 0            | 0           | 0                                     |                | 190.00  |
|             | 200 PHYSICIANS PRIVATE OFFICES          | 370, 157         | 2, 179, 253  | 74, 827     | 14, 882                               | 0              | 192.00  |
| 194. 00 07  | 950 FOUNDATI ON                         | 243, 778         | 1, 435, 213  | 49, 279     | 55, 557                               | 0              | 194.00  |
|             | 951 PUBLIC RELATIONS                    | 82, 516          | 485, 800     | 16, 680     | 22, 824                               |                | 194. 01 |
| 194. 02 07  | 952 ST. VINCENT - ARU                   |                  | 0            | 0           | o                                     | 0              | 194. 02 |
| 194. 03 07  | 953 MUNCIE - ARU                        |                  | o            | 0           | o                                     |                | 194. 03 |
| 194. 04 07  | 954 RILEY - ARU                         | 0                | o            | 0           | o                                     |                | 194. 04 |
| 194. 05 07  | 955 RETAIL PHARMACY                     | 266, 106         | 1, 566, 663  | 53, 793     | o                                     | 0              | 194. 05 |
| 200.00      | Cross Foot Adjustments                  |                  | О            |             |                                       |                | 200. 00 |
| 201.00      | Negative Cost Centers                   | o                | o            | 0           | o                                     |                | 201. 00 |
| 202. 00     | TOTAL (sum lines 118 through 201)       | 8, 323, 379      | 49, 002, 836 | 1, 626, 685 | 2, 697, 321                           | 125, 793       | 202. 00 |
|             |   | ·                |              |             |                                       | · ·            |         |

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-3028

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

5/31/2023 9:31 am Cost Center Description HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL ADMI NI STRATI O SERVICES & Ν **SUPPLY** 9. 00 10.00 11 00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.01 00591 ADMINISTRATIVE AND GENERAL 5.01 00590 OTHER A&G - NON FOUNDATION 5.02 5.02 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 860, 489 9.00 10.00 01000 DI ETARY 27,034 1, 116, 906 10.00 01100 CAFETERI A 19, 197 571, 789 11.00 11.00 01300 NURSING ADMINISTRATION 5, 292 13.00 r 62.888 3, 462, 859 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY C 4, 484 681, 540 14.00 15.00 01500 PHARMACY 18, 217 0 20, 548 281, 365 28, 371 15.00 01600 MEDICAL RECORDS & LIBRARY 15, 227 16.00 16.00 6,575 208, 508 C 0 17.00 01700 SOCIAL SERVICE 3, 482 11, 615 11, 311 17.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 4, 980 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 487, 751 1, 116, 906 198, 464 136, 257 30.00 2, 717, 540 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 50.00 05400 RADI OLOGY-DI AGNOSTI C 5, 748 54.00 3,837 0 4.546 62, 252 54.00 60.00 06000 LABORATORY 19, 208 0 8, 031 Λ 60.00 65.00 06500 RESPIRATORY THERAPY 3,622 0 14, 109 193, 194 80,862 65.00 66.00 06600 PHYSI CAL THERAPY 77, 242 0 59, 298 12, 783 66.00 06601 PHYSICAL THERAPY - CARMEL 66.01 0 0 1.175 0 621 66.01 67.00 06700 OCCUPATI ONAL THERAPY 75,065 0 52,072 0 10, 526 67.00 06800 SPEECH PATHOLOGY 0 68.00 40, 109 31, 584 2,008 68.00 o 06801 VI SI ON 0 68.01 0 0 0 68.01 0 06802 FAC RESOURCE 0 68.02 C 35, 928 1, 128 68.02 69.00 06900 ELECTROCARDI OLOGY 0 0 0 O 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 o 71.00 0 0 315, 993 71.00 0 0 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 O 72 00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 7,096 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 0 74.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 0 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 38, 751 09000 CLI NI C 0 8, 362 0 0 90.00 09001 SLEEP CENTER 0 90.01 90.01 0 0 91 00 09100 EMERGENCY 0 0 0 ol Ω 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 0 0 0 99.00 99. 10 09910 CORF 0 0 0 99 10 Ω 0 102.00 10200 OPI OID TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 830, 362 1, 116, 906 528, 331 3, 462, 859 612, 704 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT FLOWER COFFEE SHOP & CANTEEN 0 190, 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 4.807 57, 576 192. 00 27, 175 0 194. 00 07950 FOUNDATI ON 17, 947 0 10, 812 194.00 0 10.741 194. 01 07951 PUBLIC RELATIONS 7.373 Ω 5.542 0 0 194 01 194. 02 07952 ST. VINCENT - ARU 0 0 194. 02 0 194. 03 07953 MUNCIE - ARU 0 0 0 0 0 194. 03 194. 04 07954 RILEY - ARU o 0 194.04 0 0 0 448 194. 05 194. 05 07955 RETAIL PHARMACY 0 O 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 681, 540 202. 00 202.00 TOTAL (sum lines 118 through 201) 860.489 1, 116, 906 571, 789 3, 462, 859

Provider CCN: 15-3028

Peri od:

From 01/01/2022

Health Financial Systems

COST ALLOCATION - GENERAL SERVICE COSTS

In Lieu of Form CMS-2552-10 Worksheet B

Part I

Date/Time Prepared: 12/31/2022 5/31/2023 9:31 am INTERNS & **RESI DENTS** Cost Center Description **PHARMACY** MEDI CAL SOCI AL SERVI CES-OTHE Subtotal R PRGM COSTS RECORDS & SERVI CE LI BRARY **APPRV** 15. 00 16. 00 17.00 22.00 24.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00591 ADMINISTRATIVE AND GENERAL 5.01 5.01 00590 OTHER A&G - NON FOUNDATION 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 1, 510, 149 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1,045,248 16.00 01700 SOCIAL SERVICE 17.00 0 991, 735 17.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 308, 495 22.00 0 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 30.00 1, 045, 248 991, 735 308, 495 23, 434, 300 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 0 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 353, 575 54.00 06000 LABORATORY 0 0 60.00 0 0 608, 907 60.00 0 65 00 06500 RESPIRATORY THERAPY 0 0 0 0 1, 139, 773 65 00 06600 PHYSI CAL THERAPY 0 0 66.00 0 4, 420, 130 66.00 06601 PHYSI CAL THERAPY - CARMEL 0 0 0 128, 694 66.01 66.01 06700 OCCUPATI ONAL THERAPY 67.00 0 0 0 0 0 0 3, 978, 513 67.00 06800 SPEECH PATHOLOGY 68 00 Ω 0 2, 329, 629 68 00 0 68.01 06801 VLSLON 0 68.01 06802 FAC RESOURCE 0 0 1, 950, 749 68.02 68.02 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 0 o 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 71 00 Ω 545, 579 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 1, 510, 149 0 73.00 0 3, 375, 299 73.00 74.00 07400 RENAL DIALYSIS 0 0 ol 74.00 0 0 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 0 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 0 0 0 640, 496 90 00 09001 SLEEP CENTER 90.01 0 0 90.01 0 0 0 09100 EMERGENCY O 91.00 0 r 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 99 00 109900 CMHC 0 Ω 0 0 0 99 00 99. 10 09910 CORF 0 C 0 0 0 99.10 102.00 10200 OPI OID TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 1, 510, 149 1, 045, 248 991, 735 308, 495 42, 905, 644 118. 00 118 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 0 190. 00 192. 00 19200 PHYSICIANS PRIVATE OFFICES 0 0 0 2, 358, 520 192. 00 C 0 194. 00 07950 FOUNDATI ON 0 0 0 1, 579, 549 194. 00 0 538, 219 194. 01 194. 01 07951 PUBLIC RELATIONS 0 0 0 194. 02 07952 ST. VINCENT - ARU 0 0 0 0 194.02 194. 03 07953 MUNCIE - ARU 0 0 194.03 0 0 0 194. 04 07954 RILEY - ARU 0 C 0 0 0 194, 04 194. 05 07955 RETAIL PHARMACY 0 0 1, 620, 904 194. 05 0 ol 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers  $\cap$ 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 1, 510, 149 1, 045, 248 991, 735 308, 495 49, 002, 836 202. 00

| Period: | Worksheet B | From 01/01/2022 | Part | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS REHABILITATION HOSPITAL OF INDIANA Provi der CCN: 15-3028

|                    |  |             |                  | To 12/31/2022 Date/Time Prep |                    |
|--------------------|--|-------------|------------------|------------------------------|--------------------|
|                    | Cost Center Description                    | Intern &    | Total            | 5/31/2023 9: 31              | 1 am               |
|                    | cost center bescription                    | Residents   | iotai            |                              |                    |
|                    |  | Cost & Post |                  |                              |                    |
|                    |  | Stepdown    |                  |                              |                    |
|                    |  | Adjustments |                  |                              |                    |
|                    |  | 25. 00      | 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              |
|                    | 01300 NURSING ADMINISTRATION               |             |                  |                              | 13.00              |
|                    | 01400 CENTRAL SERVICES & SUPPLY            |             |                  |                              | 14.00              |
|                    | 01500 PHARMACY                             |             |                  |                              | 15. 00             |
|                    | 01600 MEDICAL RECORDS & LIBRARY            |             |                  |                              | 16. 00             |
| 17. 00             | 01700 SOCI AL SERVI CE                     |             |                  |                              | 17. 00             |
| 22. 00             | 02200 I &R SERVICES-OTHER PRGM COSTS APPRV |             |                  |                              | 22.00              |
|                    | INPATIENT ROUTINE SERVICE COST CENTERS     |             |                  |                              |                    |
| 30.00              | 03000 ADULTS & PEDI ATRI CS                | -308, 495   | 23, 125, 805     |                              | 30. 00             |
|                    | ANCILLARY SERVICE COST CENTERS             |             | -1               |                              |                    |
| 50.00              |  | 0           | 0                |                              | 50.00              |
| 54.00              | 05400 RADI OLOGY-DI AGNOSTI C              | 0           | 353, 575         |                              | 54.00              |
| 60.00              | 06000 LABORATORY                           | 0           | 608, 907         |                              | 60.00              |
| 65.00              | 06500 RESPI RATORY THERAPY                 | 0           | 1, 139, 773      |                              | 65.00              |
| 66. 00             | 06600 PHYSI CAL THERAPY                    | 0           | 4, 420, 130      |                              | 66.00              |
| 66. 01             | 06601 PHYSI CAL THERAPY - CARMEL           |             | 128, 694         |                              | 66. 01             |
| 67.00              | 06700 OCCUPATI ONAL THERAPY                | 0           | 3, 978, 513      |                              | 67. 00<br>68. 00   |
| 68. 01             | 06800 SPEECH PATHOLOGY<br>06801 VI SI ON   |             | 2, 329, 629      |                              | 68. 01             |
|                    | 06802 FAC RESOURCE                         |             | 1, 950, 749      |                              | 68. 02             |
|                    | 06900 ELECTROCARDI OLOGY                   |             | 1, 930, 749      |                              | 69.00              |
|                    | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  |             | 545, 579         |                              | 71.00              |
|                    | 07200 I MPL. DEV. CHARGED TO PATIENTS      |             | 0                |                              | 72.00              |
|                    | 07300 DRUGS CHARGED TO PATIENTS            |             | 3, 375, 299      |                              | 73.00              |
|                    | 07400 RENAL DI ALYSI S                     |             | 0, 0, 0, 2, 7    |                              | 74.00              |
|                    | 07700 ALLOGENEIC HSCT ACQUISITION          | l ol        | 0                |                              | 77. 00             |
|                    | OUTPATIENT SERVICE COST CENTERS            | -1          | -1               |                              |                    |
| 90.00              | 09000 CLI NI C                             | 0           | 640, 496         |                              | 90.00              |
| 90. 01             | 09001 SLEEP CENTER                         | o           | 0                |                              | 90. 01             |
| 91.00              | 09100 EMERGENCY                            | o           | 0                |                              | 91.00              |
| 92.00              | 09200 OBSERVATION BEDS (NON-DISTINCT PART  | o           |                  |                              | 92.00              |
|                    | OTHER REIMBURSABLE COST CENTERS            |             |                  |                              |                    |
| 99.00              | 09900 CMHC                                 | 0           | 0                |                              | 99.00              |
| 99. 10             | 09910 CORF                                 | 0           | 0                |                              | 99. 10             |
| 102.00             | 10200 OPIOID TREATMENT PROGRAM             | 0           | 0                | •                            | 102.00             |
|                    | SPECIAL PURPOSE COST CENTERS               |             |                  |                              |                    |
| 118.00             |  | -308, 495   | 42, 597, 149     |                              | 118. 00            |
|                    | NONREI MBURSABLE COST CENTERS              |             |                  |                              |                    |
|                    | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN    | 0           | 0                |                              | 190. 00            |
|                    | 19200 PHYSICIANS PRIVATE OFFICES           | 0           | 2, 358, 520      |                              | 192. 00            |
|                    | 07950 FOUNDATI ON                          | 0           | 1, 579, 549      |                              | 194. 00            |
|                    | 07951 PUBLIC RELATIONS                     | 0           | 538, 219         |                              | 194. 01            |
|                    | 207952 ST. VINCENT - ARU                   | 0           | 0                |                              | 194. 02            |
|                    | 3 07953  MUNCI E - ARU                     | 0           | 0                |                              | 194. 03            |
|                    | 07954 RILEY - ARU                          | 0           | 1 (20 004        |                              | 194.04             |
|                    | 07955 RETAIL PHARMACY                      | 0           | 1, 620, 904<br>0 |                              | 194. 05<br>200. 00 |
| 200. 00<br>201. 00 |  | 0           | 0                |                              | 200. 00<br>201. 00 |
| 201.00             |  | -308, 495   | 48, 694, 341     |                              | 201.00<br>202.00   |
| 202.00             | p   TOTAL (Sum TITIES TTO LITEOUGH 201)    | -300, 493   | 40, 074, 341     | ŀ                            | ZUZ. UU            |

| Period: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3028

|         |  |                          |                   | To           | 12/31/2022        | Date/Time Pre        | pared:             |
|---------|--|--------------------------|-------------------|--------------|-------------------|----------------------|--------------------|
|         |  |                          | CAPI TAL REI      | LATED COSTS  |                   | 5/31/2023 9: 3       | ı allı             |
|         |  |                          |                   |              |                   |                      |                    |
|         | Cost Center Description  | Directly<br>Assigned New | BLDG & FIXT       | MVBLE EQUIP  | Subtotal          | EMPLOYEE<br>BENEFITS |                    |
|         |  | Capi tal                 |                   |              |                   | DEPARTMENT           |                    |
|         |  | Related Costs            |                   |              |                   | <i>52.7.</i>         |                    |
|         |  | 0                        | 1. 00             | 2. 00        | 2A                | 4. 00                |                    |
|         | GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FLXT            |                          |                   |              |                   |                      | 1. 00              |
|         | 00200 CAP REL COSTS-BLDG & FIXT  |                          |                   |              |                   |                      | 2. 00              |
|         | 00400 EMPLOYEE BENEFITS DEPARTMENT                                       | 0                        | 13, 727           | 8, 809       | 22, 536           | 22, 536              | 4. 00              |
|         | 00591 ADMINISTRATIVE AND GENERAL   | 0                        | 32, 010           | 20, 541      | 52, 551           | 2, 668               | 5. 01              |
|         | 00590 OTHER A&G - NON FOUNDATION   | 0                        | 5, 458            |              | 8, 961            | 790                  | 5. 02              |
|         | 00700 OPERATION OF PLANT<br>00800 LAUNDRY & LINEN SERVICE                | 0                        | 285, 235<br>0     |              | 468, 274<br>0     | 29<br>0              | 7. 00<br>8. 00     |
|         | 00900 HOUSEKEEPI NG  | 0                        | 11, 634           | _            | 19, 100           | 350                  | 9. 00              |
|         | 01000 DI ETARY   | 0                        | 29, 003           | 18, 612      | 47, 615           | 31                   | 10.00              |
|         | 01100 CAFETERI A   | 0                        | 20, 596           |              | 33, 813           | 22                   | 11.00              |
|         | 01300 NURSI NG ADMI NI STRATI ON<br>01400 CENTRAL SERVI CES & SUPPLY     | 0                        | 5, 678<br>0       |              | 9, 322<br>0       | 1, 798<br>64         | 13. 00<br>14. 00   |
|         | 01500 PHARMACY   | 0                        | 19, 544           |              | 32, 085           | 549                  | 15. 00             |
|         | 01600 MEDICAL RECORDS & LIBRARY  | 0                        | 7, 054            |              | 11, 581           | 391                  | 16. 00             |
|         | 01700 SOCIAL SERVICE   | 0                        | 3, 735            |              | 6, 132            | 444                  | 17. 00             |
| 22. 00  | 02200 & SERVICES-OTHER PRGM COSTS APPRV                                  | 0                        | 5, 343            | 3, 428       | 8, 771            | 0                    | 22. 00             |
| 30. 00  | O3000 ADULTS & PEDIATRICS  | 0                        | 523, 288          | 335, 799     | 859, 087          | 7, 020               | 30. 00             |
|         | ANCILLARY SERVICE COST CENTERS   |                          | 020, 200          | 000,777      | 007,007           | 7,020                | 00.00              |
|         | 05000 OPERATING ROOM   | 0                        |                   |              | 0                 | 0                    | 50.00              |
|         | 05400 RADI OLOGY-DI AGNOSTI C  | 0                        | 4, 117            |              | 6, 759            | 132                  | 54.00              |
|         | 06000 LABORATORY<br>06500 RESPI RATORY THERAPY                           | 0                        | 20, 608<br>3, 886 |              | 33, 832<br>6, 379 | 0<br>463             | 60. 00<br>65. 00   |
|         | 06600 PHYSI CAL THERAPY  | 0                        | 82, 870           |              | 136, 049          | 1, 931               | 66. 00             |
|         | 06601 PHYSI CAL THERAPY - CARMEL   | 0                        | 0                 | _            | 0                 | 51                   | 66. 01             |
|         | 06700 OCCUPATI ONAL THERAPY  | 0                        | 80, 534           |              | 132, 214          | 1, 881               | 67.00              |
|         | 06800 SPEECH PATHOLOGY<br>06801 VI SI ON                                 | 0                        | 43, 031<br>0      | 27, 614<br>0 | 70, 645<br>0      | 1, 111<br>0          | 68. 00<br>68. 01   |
|         | 06802 FAC RESOURCE   | 0                        | 0                 | 0            | ő                 | 963                  | 68. 02             |
| 69. 00  | 06900 ELECTROCARDI OLOGY   | 0                        | 0                 | 0            | О                 | 0                    | 69. 00             |
|         | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                                | 0                        | 0                 | 0            | 0                 | 0                    | 71.00              |
|         | 07200 IMPL. DEV. CHARGED TO PATIENTS<br>07300 DRUGS CHARGED TO PATIENTS  | 0                        | 0                 | 0            | 0                 | 0                    | 72. 00<br>73. 00   |
|         | 07400 RENAL DIALYSIS   | 0                        | 0                 | 0            | 0                 | 0                    | 74.00              |
|         | 07700 ALLOGENEIC HSCT ACQUISITION  | 0                        | 0                 |              | Ō                 | 0                    | 77. 00             |
|         | OUTPATIENT SERVICE COST CENTERS  |                          |                   |              |                   |                      |                    |
|         | 09000 CLINIC<br>09001 SLEEP CENTER                                       | 0                        | 41, 574           |              | 68, 252           | 201                  | 90.00              |
|         | 09100 EMERGENCY  | 0                        | 0                 | 0            | 0                 | 0                    | 90. 01<br>91. 00   |
|         | 09200 OBSERVATION BEDS (NON-DISTINCT PART                                |                          |                   |              | Ö                 | · ·                  | 92.00              |
|         | OTHER REIMBURSABLE COST CENTERS  | I                        |                   |              |                   |                      |                    |
|         | 09900 CMHC   | 0                        |                   |              | 0                 | 0                    | 99.00              |
|         | 09910 CORF<br>10200 OPIOID TREATMENT PROGRAM                             | 0                        |                   |              | 0<br>0            |                      | 99. 10<br>102. 00  |
| 102.00  | SPECIAL PURPOSE COST CENTERS   |                          | 0                 | <u> </u>     | <u> </u>          | 0                    | 102.00             |
| 118. 00 | SUBTOTALS (SUM OF LINES 1 through 117)                                   | 0                        | 1, 238, 925       | 795, 033     | 2, 033, 958       | 20, 889              | 118. 00            |
|         | NONREI MBURSABLE COST CENTERS  |                          | _                 |              | ما                |                      | 100.00             |
|         | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSICIANS PRIVATE OFFICES | 0                        | 0<br>5, 158       |              | 8, 468            |                      | 190. 00<br>192. 00 |
|         | 07950 FOUNDATION   | 0                        | 19, 255           |              | 31, 611           |                      | 194. 00            |
| 194. 01 | 07951 PUBLIC RELATIONS   | 0                        | 7, 910            |              | 12, 986           | 157                  | 194. 01            |
|         | 07952 ST. VINCENT - ARU  | 0                        | 0                 | _            | 0                 |                      | 194. 02            |
|         | 07953 MUNCI E - ARU<br>07954 RI LEY - ARU                                | 0                        | 0                 | _            | 0                 |                      | 194. 03<br>194. 04 |
|         | 07954 RILEY - ARU<br>07955 RETAIL PHARMACY                               | 0                        | 0                 | 0            | 0                 |                      | 194. 04<br>194. 05 |
| 200. 00 | l e e e e e e e e e e e e e e e e e e e                                  |                          |                   |              | o                 |                      | 200. 00            |
| 201.00  | Negative Cost Centers  |                          | 0                 | 0            | О                 | 0                    | 201. 00            |
| 202. 00 | TOTAL (sum lines 118 through 201)  | 0                        | 1, 271, 248       | 815, 775     | 2, 087, 023       | 22, 536              | 202. 00            |
|         |  |                          |                   |              |                   |                      |                    |

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3028 | Period: From 01/01/2022 | Part II Date/Time Prepared: 5/31/2023 9: 31 am

|                  |   |                  |             | T            | o 12/31/2022  | Date/Time Pre 5/31/2023 9:3 |         |
|------------------|---|------------------|-------------|--------------|---------------|-----------------------------|---------|
|                  | Cost Center Description   | ADMI NI STRATI V | OTHER A&G - | OPERATION OF | LAUNDRY &     | HOUSEKEEPI NG               | I alli  |
|                  | oust defiter bescription  | E AND GENERAL    | NON         | PLANT        | LINEN SERVICE | HOUSEREELLING               |         |
|                  |   | 2 7110 021121012 | FOUNDATI ON |              | ETTEN GENTIGE |                             |         |
|                  |   | 5. 01            | 5. 02       | 7. 00        | 8. 00         | 9. 00                       |         |
|                  | GENERAL SERVICE COST CENTERS  |                  |             | •            |               |                             |         |
| 1.00             | 00100 CAP REL COSTS-BLDG & FLXT   |                  |             |              |               |                             | 1.00    |
| 2.00             | 00200 CAP REL COSTS-MVBLE EQUIP   |                  |             |              |               |                             | 2.00    |
| 4.00             | 00400 EMPLOYEE BENEFITS DEPARTMENT  |                  |             |              |               |                             | 4.00    |
| 5. 01            | 00591 ADMINISTRATIVE AND GENERAL  | 55, 219          |             |              |               |                             | 5. 01   |
| 5.02             | 00590 OTHER A&G - NON FOUNDATION  | 1, 832           | 11, 583     |              |               |                             | 5. 02   |
| 7.00             | 00700 OPERATION OF PLANT  | 2, 938           | 636         | 471, 877     |               |                             | 7.00    |
| 8.00             | 00800 LAUNDRY & LINEN SERVICE   | 137              | 30          | 0            | 167           |                             | 8.00    |
| 9.00             | 00900 HOUSEKEEPI NG   | 901              | 195         | 5, 872       | 0             | 26, 418                     | 9. 00   |
| 10.00            | 01000 DI ETARY  | 1, 096           | 237         | 14, 640      | 0             | 830                         | 10.00   |
| 11. 00           | 01100 CAFETERI A  | 537              | 116         |              | 0             | 589                         | 11. 00  |
| 13. 00           | 01300 NURSING ADMINISTRATION  | 3, 679           | 797         | 2, 866       | 0             | 162                         | 13.00   |
| 14. 00           | 01400 CENTRAL SERVICES & SUPPLY   | 737              | 160         |              | 0             | 0                           | 14.00   |
| 15. 00           | 01500 PHARMACY  | 1, 204           | 261         | 9, 865       | 0             | 559                         | 15.00   |
| 16. 00           | 01600 MEDI CAL RECORDS & LI BRARY   | 865              | 187         | 3, 561       | 0             | 202                         | 16.00   |
|                  | 01700 SOCIAL SERVICE  | 1, 040           | 225         |              | 0             | 107                         | 17.00   |
| 22. 00           | 02200 I &R SERVICES-OTHER PRGM COSTS APPRV                                  | 314              | 68          | 2, 697       | 0             | 153                         | 22. 00  |
| 20.00            | I NPATI ENT ROUTI NE SERVI CE COST CENTERS                                  | 1/ 122           | 2 51/       | 2/4 147      | 1/4           | 14.075                      | 1 20 00 |
| 30. 00           | 03000 ADULTS & PEDIATRICS   | 16, 133          | 3, 516      | 264, 147     | 164           | 14, 975                     | 30.00   |
| EO 00            | ANCILLARY SERVICE COST CENTERS    05000   OPERATING ROOM                    | l                | 0           | 0            | 0             | 0                           | 50.00   |
| 50. 00<br>54. 00 | 05400 RADI OLOGY-DI AGNOSTI C   | 289              |             |              | 0             | 118                         | 1       |
| 60.00            | 06000 LABORATORY  | 569              | 63<br>123   |              | 0             | 590                         | 60.00   |
| 65.00            | 06500 RESPIRATORY THERAPY   | 911              | 123         | 1, 961       | 0             | 111                         | 65.00   |
| 66. 00           | 06600 PHYSI CAL THERAPY   | 4, 391           | 951         | 41, 831      | 0             | 2, 371                      | 66.00   |
| 66. 01           | 06601 PHYSI CAL THERAPY - CARMEL  | 136              | 29          |              | 3             | 2,3/1                       | 66. 01  |
| 67. 00           | 06700 OCCUPATI ONAL THERAPY   | 3, 930           | 851         | 40, 652      | 0             | 2, 305                      | 67.00   |
| 68. 00           | 06800 SPEECH PATHOLOGY  | 2, 322           | 503         |              | 0             | 1, 231                      | 68.00   |
| 68. 01           | 06801 VI SI ON  | 0                | 0           | 0            | 0             | 0                           | 68. 01  |
| 68. 02           | 06802 FAC RESOURCE  | 2, 084           | 451         | 0            | 0             | 0                           | 68. 02  |
| 69. 00           | 06900 ELECTROCARDI OLOGY  | 0                | 0           | 0            | 0             | 0                           | 69.00   |
| 71. 00           | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                                   | 250              | 54          | 0            | 0             | 0                           | 71.00   |
| 72.00            | 07200 IMPL. DEV. CHARGED TO PATIENTS  | o                | 0           | 0            | 0             | 0                           | 72.00   |
| 73.00            | 07300 DRUGS CHARGED TO PATIENTS   | 2, 024           | 438         | 0            | 0             | 0                           | 73.00   |
| 74.00            | 07400 RENAL DIALYSIS  | o                | 0           | 0            | 0             | 0                           | 74.00   |
| 77. 00           | 07700 ALLOGENEIC HSCT ACQUISITION   | 0                | 0           | 0            | 0             | 0                           | 77. 00  |
|                  | OUTPATIENT SERVICE COST CENTERS   |                  |             |              |               |                             |         |
| 90.00            | 09000  CLI NI C   | 516              | 112         | 20, 986      | 0             | 1, 190                      | 90.00   |
| 90. 01           | 09001 SLEEP CENTER  | 0                | 0           |              | 0             | 0                           | 90. 01  |
| 91. 00           | 09100 EMERGENCY   | 0                | 0           | 0            | 0             | 0                           | 91.00   |
| 92. 00           | 09200 OBSERVATION BEDS (NON-DISTINCT PART                                   |                  |             |              |               |                             | 92.00   |
| 00.00            | OTHER REIMBURSABLE COST CENTERS   |                  |             |              | 0             |                             | 00.00   |
|                  | 09900 CMHC  | 0                | 0           |              | 0             | 0                           |         |
|                  | 09910 CORF  | 0                | 0           |              | 0             | 0                           | 99. 10  |
| 102.00           | 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS                 | 0                | 0           | 0            | 0             | 0                           | 102.00  |
| 110 00           |   | 48, 835          | 10, 200     | 455, 561     | 167           | 25, 493                     | 110 00  |
| 110.00           | SUBTOTALS (SUM OF LINES 1 through 117)                                      | 40, 033          | 10, 200     | 455, 561     | 107           | 20, 493                     | 1116.00 |
| 100 00           | NONREIMBURSABLE COST CENTERS<br>  19000   GIFT FLOWER COFFEE SHOP & CANTEEN | O                | 0           | 0            | 0             | 0                           | 190. 00 |
|                  | 19200 PHYSI CLANS PRI VATE OFFI CES   | 2, 455           | 532         |              | 0             |                             | 192.00  |
|                  | 07950 FOUNDATION  | 1, 617           | 350         |              | _             |                             | 194. 00 |
|                  | 07951 PUBLIC RELATIONS  | 547              | 119         |              | 0             |                             | 194. 01 |
|                  | 07952 ST. VINCENT - ARU   | 0                | 0           |              | 0             |                             | 194. 02 |
|                  | 07953 MUNCI E - ARU   |                  | 0           | · ·          | Ö             |                             | 194. 03 |
|                  | 07954 RI LEY - ARU  |                  | 0           |              | Ö             |                             | 194. 04 |
|                  | 07955 RETAIL PHARMACY   | 1, 765           | 382         |              | 0             |                             | 194. 05 |
| 200.00           |   | , 11             |             | 1            |               |                             | 200.00  |
| 201.00           |   | 0                | 0           | 0            | 0             | 0                           | 201.00  |
| 202.00           | TOTAL (sum lines 118 through 201)   | 55, 219          | 11, 583     | 471, 877     | 167           | 26, 418                     | 202.00  |
|                  |   | ·                |             |              | '             |                             |         |

From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/31/2023 9:31 am Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL PHARMACY ADMI NI STRATI O SERVICES & **SUPPLY** Ν 10. 00 11.00 15.00 13 00 14 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.01 00591 ADMINISTRATIVE AND GENERAL 5.01 00590 OTHER A&G - NON FOUNDATION 5.02 5.02 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 64, 449 10.00 01100 CAFETERI A 45, 474 11.00 11.00 0 01300 NURSING ADMINISTRATION 13.00 0 5,001 23, 625 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 357 1, 318 14.00 15.00 01500 PHARMACY 0 1, 634 1, 920 55 48, 132 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 16.00 1.211 1, 423 0 0 17.00 01700 SOCIAL SERVICE 0 924 0 22 0 17.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 64, 449 15, 784 30.00 18, 539 263 0 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 362 425 11 0 54.00 60.00 06000 LABORATORY 0 639 0 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 0 1, 122 1, 318 156 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 4, 716 25 0 66.00 0 06601 PHYSICAL THERAPY - CARMEL 66.01 93 0 0 66.01 0 67.00 06700 OCCUPATI ONAL THERAPY 4, 141 0 20 0 67.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 2, 512 0 0 68.00 06801 VI SI ON 0 ol 0 68.01 68.01 06802 FAC RESOURCE 0 2 68.02 2,857 0 68.02 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 0 0 612 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS Ω 0 0 0 72 00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 14 48, 132 73.00 74.00 07400 RENAL DIALYSIS 0 C 0 0 0 74.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 665 0 0 0 90.00 09001 SLEEP CENTER 0 0 0 0 90.01 90.01 91 00 09100 EMERGENCY 0 0 0 ol Ω 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 0 0 0 99.00 99. 10 09910 CORF 0 0 99 10 0 0 0 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 64, 449 42, 018 23, 625 1, 185 48, 132 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT FLOWER COFFEE SHOP & CANTEEN 0 0 190.00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 0 192.00 2, 161 111 0 194. 00 07950 FOUNDATI ON 0 0 194.00 854 21 194. 01 07951 PUBLIC RELATIONS 441 0 0 0 194 01 194. 02 07952 ST. VINCENT - ARU 0 0 0 0 194. 02 194. 03 07953 MUNCIE - ARU 0 0 0 0 0 194. 03 194. 04 07954 RILEY - ARU 0 0 194.04 C 0 0 0 194.05 194. 05 07955 RETAIL PHARMACY 0 r 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 64, 449 45.474 23.625 1, 318 48, 132 202. 00

| Period: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3028

|   |   |   |   | T  | 0 12/31/2022  | Date/Time Pre<br>5/31/2023 9:3  |  |
|---|---|---|---|--|---|---|--|
| Cost Cente  | er Description  | MEDI CAL<br>RECORDS &<br>LI BRARY                   | SOCI AL<br>SERVI CE   | INTERNS & RESI DENTS SERVI CES-OTHE R PRGM COSTS APPRV | Subtotal  | Intern & Residents Cost & Post Stepdown Adjustments   | I dili   |
|   |   | 16. 00  | 17. 00  | 22. 00   | 24. 00  | 25. 00  |  |
| GENERAL SERVICE   |   |   |   |  |   |   |  |
| 2. 00 00200 CAP REL CO 4. 00 00400 EMPLOYEE E 5. 01 00591 ADMI NI STRA 5. 02 00590 OTHER A&G 7. 00 00700 PERATI ON 8. 00 00800 LAUNDRY & 9. 00 00900 HOUSEKEEPI 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG AD 14. 00 01400 CENTRAL SE 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RE 17. 00 01700 SOCI AL SER 22. 00 02200 I &R SERVICO  | LINEN SERVICE NG OMINISTRATION ERVICES & SUPPLY ECORDS & LIBRARY  | 19, 421<br>0<br>0                                   | 10, 779<br>0  |  |   |   | 1. 00<br>2. 00<br>4. 00<br>5. 01<br>5. 02<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>22. 00 |
| 30. 00 03000 ADULTS & F   |   | 19, 421   | 10, 779   |  | 1, 294, 277   | 0   | 30.00  |
| ANCILLARY SERVI   | CE COST CENTERS   | ,   | ,   |  | ., =, = [   |   |  |
| 50. 00   05000   0PERATI NG   54. 00   05400   RADI OLOGY. 60. 00   06600   LABORATORY. 66. 00   06600   PHYSI CAL   167. 00   06601   PHYSI CAL   167. 00   06601   PHYSI CAL   168. 01   06801   VI SI ON   68. 02   06802   FAC RESOUF   69. 00   06900   ELECTROCAF   71. 00   07100   MEDI CAL   SI CAL   72. 00   07200   IMPL. DEV. 73. 00   07300   DRUGS CHAF   74. 00   07400   RENAL DI AL   77. 00   07000   LOGENEI COUTPATI ENT SERV. 90. 00   09000   CLI NI C   90. 01   09001   SLEEP CENT | ROOM -DIAGNOSTIC // CY THERAPY -HERAPY -HERAPY - CARMEL JAL THERAPY -HOLOGY -ROE RDIOLOGY JPPLIES CHARGED TO PATIENT CHARGED TO PATIENTS GED TO PATIENTS LYSIS -HSCT ACQUISITION LCE COST CENTERS | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 |  | 0<br>10, 237<br>46, 155<br>12, 618<br>192, 265<br>313<br>185, 994<br>100, 09<br>6, 357<br>0<br>916<br>0<br>50, 608<br>0 | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 50. 00<br>54. 00<br>60. 00<br>65. 00<br>66. 01<br>67. 00<br>68. 01<br>68. 02<br>69. 00<br>71. 00<br>72. 00<br>74. 00<br>77. 00<br>90. 00<br>90. 01   |
| 91. 00   09100   EMERGENCY  | LK  | 0   | 0   |  | 0   | 0   | 91.00  |
|   | ON BEDS (NON-DISTINCT PART  |   |   |  |   | 0   | 92.00  |
| 99. 00<br>99. 10<br>102. 00<br>10200 OPI 0I D TRE<br>SPECI AL PURPOSE   | COST CENTERS  | 0 0   | 0 0 0   |  | 0 0 0   | 0   | 102.00   |
| 118. 00 SUBTOTALS NONREI MBURSABLE  | (SUM OF LINES 1 through 117)  | 19, 421   | 10, 779   | 0  | 1, 991, 711   | 0   | 118. 00  |
| 190. 00 19000 GI FT FLOW 192. 00 19200 PHYSI CI ANS 194. 00 07950 FOUNDATI ON 194. 01 07951 PUBLI C REL 194. 03 07952 ST. VI NCEM 194. 04 07954 RI LEY - AF 194. 05 07955 RETAI L PHZ 200. 00 Negati ve O   | VER COFFEE SHOP & CANTEEN S PRIVATE OFFICES I LATIONS IT - ARU RU   | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0           | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0   | 12, 003<br>0   | 0   | 0<br>0<br>0<br>0<br>0<br>0<br>0   | 190. 00<br>192. 00<br>194. 00<br>194. 01<br>194. 02<br>194. 03<br>194. 04<br>194. 05<br>200. 00<br>201. 00<br>202. 00                                |

202.00

Part II

Date/Time Prepared: 12/31/2022 5/31/2023 9:31 am Cost Center Description Total 26. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FIXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00591 ADMINISTRATIVE AND GENERAL 5.01 5.01 5.02 00590 OTHER A&G - NON FOUNDATION 5.02 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 13 00 01300 NURSING ADMINISTRATION 13 00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15. 00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17 00 17 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 294, 277 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 05400 RADI OLOGY-DI AGNOSTI C 10, 237 54.00 54.00 06000 LABORATORY 60 00 46, 155 60 00 06500 RESPIRATORY THERAPY 65.00 12, 618 65.00 06600 PHYSI CAL THERAPY 192, 265 66.00 66.00 66. 01 06601 PHYSI CAL THERAPY - CARMEL 313 66.01 06700 OCCUPATI ONAL THERAPY 67.00 67 00 185.994 68.00 06800 SPEECH PATHOLOGY 100, 049 68.00 06801 VI SI ON 68.01 68.01 06802 FAC RESOURCE 68.02 68.02 6, 357 69 00 06900 ELECTROCARDI OLOGY 0 69 00 916 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 50,608 73.00 07400 RENAL DIALYSIS 74.00 74.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 90.00 91.922 90.01 09001 SLEEP CENTER 90.01 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 99.00 99. 10 09910 CORF 99. 10 0 102.00 10200 OPI OID TREATMENT PROGRAM 102.00 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 1, 991, 711 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 190.00 192.00 19200 PHYSICIANS PRIVATE OFFICES 17, 419 192.00 194. 00 07950 FOUNDATI ON 45, 057 194.00 194. 01 07951 PUBLIC RELATIONS 194.01 18 469 194. 02 07952 ST. VINCENT - ARU 194. 02 0 194. 03 07953 MUNCIE - ARU 0 194.03 194. 04 07954 RILEY - ARU 0 194.04 194. 05 07955 RETAIL PHARMACY 194. 05 2 364 200.00 Cross Foot Adjustments 12,003 200.00 201.00 Negative Cost Centers 201.00

2, 087, 023

Provider CCN: 15-3028

Peri od:

From 01/01/2022

202.00

TOTAL (sum lines 118 through 201)

Health Financial Systems REHABILITATION HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3028 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/31/2023 9:31 am CAPITAL RELATED COSTS Reconciliatio ADMINISTRATIV Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** (SQUARE FEET) (SQUARE FEET) BENEFITS E AND GENERAL n DEPARTMENT (ACCUM. COST) (GROSS SALARI ES) 1. 00 2.00 4.00 5A. 01 5. 01 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 109, 928 1 00 00200 CAP REL COSTS-MVBLE EQUIP 109, 928 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 187 1, 187 23, 796, 075 4.00 00591 ADMINISTRATIVE AND GENERAL 2, 817, 726 5.01 2, 768 40, 679, 457 -8, 323, 379 5.01 2, 768 5.02 00590 OTHER A&G - NON FOUNDATION 472 472 833, 725 1, 350, 384 5.02 7.00 00700 OPERATION OF PLANT 24, 665 24,665 31, 091 0 2, 164, 835 7.00 00800 LAUNDRY & LINEN SERVICE 0 100, 960 8.00 8 00 0 C 0 1,006 369, 803 00900 HOUSEKEEPI NG 0 9.00 1,006 663, 676 9.00 10.00 01000 DI ETARY 2,508 2,508 33, 106 807, 552 10.00 11.00 01100 CAFETERI A 1, 781 1, 781 23, 516 0 0 395, 807 11.00 01300 NURSING ADMINISTRATION 1 898 295 2, 711, 377 13 00 13 00 491 491 14.00 01400 CENTRAL SERVICES & SUPPLY 0 C 67, 189 543, 396 14.00 15.00 01500 PHARMACY 1, 690 1, 690 579, 731 0 887, 065 15.00 ol 16.00 01600 MEDICAL RECORDS & LIBRARY 412,620 637, 723 16.00 610 610 01700 SOCIAL SERVICE 17.00 0 766, 109 323 323 468, 503 17.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 462 462 0 231, 224 22.00 C INPATIENT ROUTINE SERVICE COST CENTERS 45, 250 45, 250 30 00 03000 ADULTS & PEDIATRICS 7, 412, 965 0 11, 877, 342 30 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 356 356 139, 322 0 212, 937 54.00 60 00 06000 LABORATORY 1, 782 1, 782 0 419, 117 60 00 0 06500 RESPIRATORY THERAPY 0 65.00 336 336 488.819 671, 584 65.00 06600 PHYSI CAL THERAPY 2, 038, 787 0 3, 235, 642 66.00 7, 166 7, 166 66.00 06601 PHYSI CAL THERAPY - CARMEL 0 0 0 100, 117 66.01 54.055 66.01 06700 OCCUPATIONAL THERAPY 1, 986, 041 6.964 6.964 2, 896, 007 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 3, 721 3, 721 1, 172, 934 1, 710, 845 68.00 06801 VI SI ON 68 01 0 68.01 0 1, 016, 999 68.02 06802 FAC RESOURCE 0 0 1, 535, 906 68.02 06900 ELECTROCARDI OLOGY 69 00 0 C 0 Λ 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 184, 263 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 1, 491, 251 73.00 0 0 73.00 07400 RENAL DIALYSIS 0 0 74.00 0 C 0 74.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 379, 966 90 00 3,595 3, 595 211, 763 0 90.01 09001 SLEEP CENTER 0 0 0 90.01 91.00 09100 EMERGENCY 0 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 99.00 0 0 99. 10 09910 CORF 0 99.10

| 102. 00 1020 | O OPIOID TREATMENT PROGRAM             | 0           | 0         | 0            | 0            | 0 102.00             |
|--------------|--|-------------|-----------|--------------|--------------|----------------------|
| SPEC         | I AL PURPOSE COST CENTERS              |             |           |              |              |                      |
| 118. 00      | SUBTOTALS (SUM OF LINES 1 through 117) | 107, 133    | 107, 133  | 22, 056, 990 | -8, 323, 379 | 35, 975, 085 118. 00 |
| NONR         | EIMBURSABLE COST CENTERS               |             |           |              |              |                      |
| 190. 00 1900 | O GIFT FLOWER COFFEE SHOP & CANTEEN    | 0           | 0         | 0            | 0            | 0 190. 00            |
| 192. 00 1920 | O PHYSICIANS PRIVATE OFFICES           | 446         | 446       | 992, 330     | 0            | 1, 809, 096 192. 00  |
| 194. 00 0795 | O FOUNDATI ON                          | 1, 665      | 1, 665    | 352, 253     | 0            | 1, 191, 435 194. 00  |
| 194. 01 0795 | 1 PUBLIC RELATIONS                     | 684         | 684       | 166, 143     | 0            | 403, 284 194. 01     |
| 194. 02 0795 | 2 ST. VINCENT - ARU                    | 0           | 0         | 0            | 0            | 0 194. 02            |
| 194. 03 0795 | 3 MUNCIE - ARU                         | 0           | 0         | 0            | 0            | 0 194. 03            |
| 194. 04 0795 | 4 RILEY - ARU                          | 0           | 0         | 0            | 0            | 0 194. 04            |
| 194. 05 0795 | 5 RETAIL PHARMACY                      | 0           | 0         | 228, 359     | 0            | 1, 300, 557 194. 05  |
| 200. 00      | Cross Foot Adjustments                 |             |           |              |              | 200.00               |
| 201. 00      | Negative Cost Centers                  |             |           |              |              | 201.00               |
| 202. 00      | Cost to be allocated (per Wkst. B,     | 1, 271, 248 | 815, 775  | 6, 446, 219  |              | 8, 323, 379 202. 00  |
|              | Part I)                                |             |           |              |              |                      |
| 203. 00      | Unit cost multiplier (Wkst. B, Part I) | 11. 564369  | 7. 420994 | 0. 270894    |              | 0. 204609 203. 00    |
| 204.00       | Cost to be allocated (per Wkst. B,     |             |           | 22, 536      |              | 55, 219 204. 00      |
|              | Part II)                               |             |           |              |              |                      |
| 205. 00      | Unit cost multiplier (Wkst. B, Part    |             |           | 0. 000947    |              | 0. 001357 205. 00    |
|              | 11)                                    |             |           |              |              |                      |
| 206. 00      | NAHE adjustment amount to be allocated |             |           |              |              | 206. 00              |
|              | (per Wkst. B-2)                        |             |           |              |              |                      |
| 207. 00      | NAHE unit cost multiplier (Wkst. D,    |             |           |              |              | 207. 00              |
|              | Parts III and IV)                      |             | I         |              |              |                      |
|              |  |             |           |              |              |                      |
|              |  |             |           |              |              |                      |
|              |  |             |           |              |              |                      |

Provider CCN: 15-3028

|                    |  |               |                            |                        | 12/31/2022 | Date/lime Pre<br>5/31/2023 9:3 |                    |
|--------------------|--|---------------|----------------------------|------------------------|------------|--------------------------------|--------------------|
|                    | Cost Center Description  | Reconciliatio | OTHER A&G -                | OPERATION OF           | LAUNDRY &  | HOUSEKEEPI NG                  |                    |
|                    |  | n             | NON<br>FOUNDATI ON         | PLANT<br>(SQUARE FEET) | (POUNDS OF | (SQUARE FEET)                  |                    |
|                    |  |               | (ACCUM. COST)              | ` ′                    | LAUNDRY)   |                                |                    |
|                    | CENEDAL CEDITION OF COST OFNITEDS  | 5A. 02        | 5. 02                      | 7. 00                  | 8. 00      | 9. 00                          |                    |
|                    | GENERAL SERVICE COST CENTERS DO100 CAP REL COSTS-BLDG & FIXT             |               |                            | 1                      |            |                                | 1.00               |
|                    | 00200 CAP REL COSTS-BLDG & FIXT  |               |                            |                        |            |                                | 2.00               |
|                    | 00400 EMPLOYEE BENEFITS DEPARTMENT                                       |               |                            |                        |            |                                | 4.00               |
|                    | 00591 ADMINISTRATIVE AND GENERAL   |               |                            |                        |            |                                | 5. 01              |
|                    | OO590 OTHER A&G - NON FOUNDATION   | -1, 626, 685  | 47, 376, 151               |                        |            |                                | 5. 02              |
|                    | 00700 OPERATION OF PLANT   | 0             | 2, 607, 780                |                        |            |                                | 7. 00              |
|                    | 00800 LAUNDRY & LINEN SERVICE  | 0             | 121, 617                   |                        | 158, 580   | 70.000                         | 8.00               |
|                    | 00900 HOUSEKEEPI NG<br>01000 DI ETARY                                    | 0             | 799, 470<br>972, 784       |                        | 0          | 79, 830<br>2, 508              | 9. 00<br>10. 00    |
|                    | 01100 CAFETERI A   | 0             | 476, 793                   |                        | 0          | 1, 781                         | 1                  |
|                    | 01300 NURSING ADMINISTRATION   | 0             | 3, 266, 149                |                        | 0          | 491                            | 1                  |
| 14.00              | 01400 CENTRAL SERVICES & SUPPLY  | 0             | 654, 580                   | 0                      | 0          | 0                              | 14.00              |
|                    | D1500 PHARMACY   | 0             | 1, 068, 566                |                        | 0          | 1, 690                         | 1                  |
|                    | 01600 MEDICAL RECORDS & LIBRARY  | 0             | 768, 207                   |                        | 0          | 610                            | 1                  |
|                    | 01700 SOCIAL SERVICE<br>02200 I&R SERVICES-OTHER PRGM COSTS APPRV        | 0             | 922, 862<br>278, 535       |                        | 0          | 323<br>462                     | 1                  |
| <u> </u>           | NPATIENT ROUTINE SERVICE COST CENTERS                                    | ı o           | 270, 555                   | 402                    | U          | 402                            | 22.00              |
|                    | 03000 ADULTS & PEDIATRICS  | 0             | 14, 307, 550               | 45, 250                | 155, 332   | 45, 250                        | 30.00              |
|                    | ANCILLARY SERVICE COST CENTERS   |               |                            |                        |            |                                |                    |
|                    | O5000 OPERATING ROOM   | 0             | 0                          | 0                      | 0          | 0                              | 50.00              |
|                    | 05400 RADI OLOGY-DI AGNOSTI C  | 0             | 256, 506                   |                        | 0          | 356                            | 1                  |
|                    | 06000 LABORATORY<br>06500 RESPI RATORY THERAPY                           | 0             | 504, 872<br>808, 996       |                        | 0          | 1, 782<br>336                  | 60.00<br>65.00     |
|                    | 06600 PHYSI CAL THERAPY  | 0             | 3, 897, 683                |                        | 226        | 7, 166                         | 66.00              |
|                    | 06601 PHYSI CAL THERAPY - CARMEL   | 0             | 120, 602                   |                        | 2, 717     | 0                              | 66. 01             |
|                    | 06700 OCCUPATI ONAL THERAPY  | 0             | 3, 488, 556                | 6, 964                 | 174        | 6, 964                         | 67.00              |
|                    | O6800 SPEECH PATHOLOGY   | 0             | 2, 060, 899                |                        | 131        | 3, 721                         | 1                  |
|                    | 06801 VI SI ON   | 0             | 0 0 0 0 0                  | 0                      | 0          | 0                              | 68. 01             |
|                    | 06802 FAC RESOURCE<br>06900 ELECTROCARDI OLOGY                           | 0             | 1, 850, 166                | 0                      | 0          | 0                              | 68. 02<br>69. 00   |
|                    | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                                | 0             | 221, 965                   |                        | 0          | 0                              | 71.00              |
|                    | 07200 IMPL. DEV. CHARGED TO PATIENTS                                     | 0             | 0                          | o o                    | 0          | ő                              | 72.00              |
|                    | 07300 DRUGS CHARGED TO PATIENTS  | 0             | 1, 796, 374                | 0                      | 0          | 0                              | 73.00              |
| 1                  | 07400 RENAL DIALYSIS   | 0             | 0                          | 0                      | 0          | 0                              | 74.00              |
|                    | 07700 ALLOGENEIC HSCT ACQUISITION  | 0             | 0                          | 0                      | 0          | 0                              | 77. 00             |
|                    | DUTPATIENT SERVICE COST CENTERS 09000 CLINIC                             | 0             | 457, 710                   | 3, 595                 | 0          | 3, 595                         | 90.00              |
|                    | 09001 SLEEP CENTER   | 0             | 437,710                    | 1                      | 0          | 0, 373                         | 90.00              |
|                    | 09100 EMERGENCY  | 0             | 0                          | 1                      | 0          | Ö                              | 91.00              |
|                    | 09200 OBSERVATION BEDS (NON-DISTINCT PART                                |               |                            |                        |            |                                | 92.00              |
|                    | OTHER REIMBURSABLE COST CENTERS  | 1 -           |                            |                        | _          |                                |                    |
|                    | 09900 CMHC<br>09910 CORF   | 0             | 0                          | 1                      | 0          | 0                              | 1                  |
| 1                  | 10200 OPI OI D TREATMENT PROGRAM   | 0             | 0                          |                        | 0          |                                | 102.00             |
|                    | SPECIAL PURPOSE COST CENTERS   | J             |                            | ,                      | <u> </u>   |                                | 102.00             |
| 118. 00            | SUBTOTALS (SUM OF LINES 1 through 117)                                   | -1, 626, 685  | 41, 709, 222               | 78, 041                | 158, 580   | 77, 035                        | 118. 00            |
|                    | NONREI MBURSABLE COST CENTERS  |               |                            |                        | _          |                                |                    |
|                    | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSICIANS PRIVATE OFFICES | 0             | 0 170 252                  | 0                      | 0          |                                | 190.00             |
|                    | 07950 FOUNDATION   | 0             | 2, 179, 253<br>1, 435, 213 |                        | 0          |                                | 192. 00<br>194. 00 |
|                    | 07951 PUBLIC RELATIONS   | 0             | 485, 800                   |                        | 0          |                                | 194.00             |
|                    | 07952 ST. VINCENT - ARU  | 0             | 0                          | 0                      | 0          |                                | 194. 02            |
|                    | D7953 MUNCIE - ARU   | 0             | 0                          | 0                      | 0          | 0                              | 194. 03            |
|                    | 07954 RILEY - ARU  | 0             | 0                          | 0                      | 0          |                                | 194. 04            |
|                    | 07955 RETAIL PHARMACY  | 0             | 1, 566, 663                | 0                      | 0          | 0                              | 194. 05            |
| 200. 00<br>201. 00 | Cross Foot Adjustments Negative Cost Centers                             |               |                            |                        |            |                                | 200. 00<br>201. 00 |
| 202.00             | Cost to be allocated (per Wkst. B,                                       |               | 1, 626, 685                | 2, 697, 321            | 125, 793   | 860, 489                       |                    |
|                    | Part I)  |               | .,,                        |                        | ,          |                                |                    |
| 203. 00            | Unit cost multiplier (Wkst. B, Part I)                                   |               | 0. 034336                  | 33. 367819             | 0. 793246  |                                |                    |
| 204. 00            | Cost to be allocated (per Wkst. B,                                       |               | 11, 583                    | 471, 877               | 167        | 26, 418                        | 204. 00            |
| 30E 00             | Part II)   |               | 0.000044                   | E 0274/4               | 0.001053   | 0 220020                       | 205 00             |
| 205. 00            | Unit cost multiplier (Wkst. B, Part                                      |               | 0. 000244                  | 5. 837461              | 0. 001053  | 0. 330928                      | 203.00             |
| 206. 00            | NAHE adjustment amount to be allocated                                   | 1             |                            |                        |            |                                | 206. 00            |
|                    | (per Wkst. B-2)  |               |                            |                        |            |                                |                    |
| 207. 00            | NAHE unit cost multiplier (Wkst. D,                                      |               |                            |                        |            |                                | 207. 00            |
|                    | Parts III and IV)  |               |                            | 1                      |            | I                              | I                  |

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3028 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/31/2023 9:31 am Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI O SERVICES & (MEALS (HOURS PAID) (COSTED SERVED) **SUPPLY** REQUIS.) Ν (DLRECT (COSTED NRSING HRS) REQUIS.) 10.00 11.00 13.00 14.00 15.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00591 ADMINISTRATIVE AND GENERAL 5.01 5.01 00590 OTHER A&G - NON FOUNDATION 5.02 5.02 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 56, 202 10.00 10.00 11.00 01100 CAFETERI A 533, 774 11.00 13.00 01300 NURSING ADMINISTRATION 0 58, 707 236, 080 13.00 01400 CENTRAL SERVICES & SUPPLY 0 4, 186 397, 424 14.00 14.00 19, 182 01500 PHARMACY 0 100 15.00 19, 182 16, 544 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 14, 215 14, 215 0 16.00 01700 SOCIAL SERVICE 17.00 0 10, 843 0 0 17.00 6.596 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 22.00  $\cap$ 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 56, 202 185, 268 185, 268 79, 455 0 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 4, 244 4, 244 3, 352 0 54.00 0 60.00 06000 LABORATORY 7, 497 0 60.00 65 00 06500 RESPIRATORY THERAPY 0 0 13, 171 65 00 13, 171 47 153 0 66.00 06600 PHYSI CAL THERAPY 55, 356 0 7, 454 0 66.00 06601 PHYSI CAL THERAPY - CARMEL 1, 097 0 362 0 66.01 66.01 06700 OCCUPATI ONAL THERAPY 67.00 00000000 48, 610 0 6, 138 0 67.00 68 00 06800 SPEECH PATHOLOGY 0 68 00 29, 484 1, 171 0 0 68.01 06801 VI SI ON 0 68.01 06802 FAC RESOURCE 33, 539 0 68.02 68.02 658 0 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 0 184, 263 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 4, 138 100 73.00 74.00 07400 RENAL DIALYSIS 0 C 0 0 74.00 0 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 0 C 0 0 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 7, 806 0 0 0 90 00 09001 SLEEP CENTER 90.01 0 0 90.01 0 0 09100 EMERGENCY O 91.00 0 r 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 99 00 99 00 09900 CMHC 0 Ω 0 0 Ω 99. 10 09910 CORF 0 0 0 0 99.10 102.00 10200 OPI OID TREATMENT PROGRAM 0 O 0 102.00 SPECIAL PURPOSE COST CENTERS 56, 202 493, 205 236, 080 100 118. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 357, 284 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN n 0 190. 00 192. 00 19200 PHYSICIANS PRIVATE OFFICES 0 0 0 192, 00 0 25, 368 33.574 194. 00 07950 FOUNDATI ON 0 10,027 6, 305 0 194.00 0 194. 01 07951 PUBLIC RELATIONS 5, 174 0 0 0 194. 01 194. 02 07952 ST. VINCENT - ARU 0 0 194.02 0 C 194. 03 07953 MUNCIE - ARU 0 0 0 194.03 C 0 194. 04 07954 RILEY - ARU 0 C 0 0 0 194.04 194. 05 07955 RETAIL PHARMACY 0 194.05 261 200.00 200. 00 Cross Foot Adjustments 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1, 116, 906 571, 789 3, 462, 859 681, 540 1, 510, 149 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 19.873065 1.071219 14.668159 1. 714894 15, 101. 490000 203. 00 Cost to be allocated (per Wkst. B, 204.00 64, 449 45, 474 23, 625 1, 318 48, 132 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.085193 0.100072 481. 320000 205. 00 1.146739 0.003316 11) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3028

Peri od:
From 01/01/2022
To 12/31/2022 Date/Ti me Prepared:

5/31/2023 9:31 am INTERNS & **RESI DENTS** MEDI CAL SOCI AL SERVI CES-OTHE Cost Center Description R PRGM COSTS RECORDS & **SERVICE** (TOTAL PATI **APPRV** LI BRARY (TOTAL PATI ENT DAYS) (ASSI GNED ENT DAYS) TIME) 16. 00 17. 00 22.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00591 ADMINISTRATIVE AND GENERAL 5.01 5.01 5.02 00590 OTHER A&G - NON FOUNDATION 5.02 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 18, 734 16,00 16,00 01700 SOCIAL SERVICE 17.00 18, 734 17.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 100 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 100 30 00 03000 ADULTS & PEDIATRICS 18, 734 18, 734 30 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 0 06000 LABORATORY 0 60 00 60 00 0 0 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 000000000000 0 66.00 66.00 06601 PHYSI CAL THERAPY - CARMEL 0 66.01 0 66.01 0 06700 OCCUPATI ONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 06801 VI SI ON 0 68.01 68.01 06802 FAC RESOURCE 0 0 68.02 68.02 06900 ELECTROCARDI OLOGY 0 69 00 C 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 73.00 07400 RENAL DIALYSIS 74.00 C 74.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLI NI C 0 0 0 90.01 09001 SLEEP CENTER 0 C 90.01 91.00 09100 EMERGENCY 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 99.00 99. 10 09910 CORF 0 0 99.10 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 0 0 SPECIAL PURPOSE COST CENTERS 18, 734 100 SUBTOTALS (SUM OF LINES 1 through 117) 18, 734 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 C 0 192.00 194. 00 07950 FOUNDATI ON 0 0 0 194.00 0 194. 01 07951 PUBLIC RELATIONS 0 0 194. 01 194. 02 07952 ST. VINCENT - ARU 0 C 194.02 194. 03 07953 MUNCIE - ARU 0 0 194.03 194. 04 07954 RILEY - ARU 0 0 194.04 C 194. 05 07955 RETAIL PHARMACY 0 0 194 05 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1.045.248 991, 735 308.495 202.00 Part I) 203.00 55. 794171 52. 937707 3, 084. 950000 203 00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, 19, 421 10,779 12,003 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 120.030000 205.00 1.036671 0.575371 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207 00 Parts III and IV)

|        |   | ABILITATION HOS                                     | PITAL OF INDIA        | NA           | In Lie                                      | u of Form CMS-2 | 2552-10 |
|--------|---|---|-----------------------|--------------|---|-----------------|---------|
| COMPU  | TATION OF RATIO OF COSTS TO CHARGES       |   | Provider Co           | F            | Period:<br>From 01/01/2022<br>To 12/31/2022 |                 | pared:  |
|        |   |   | Title                 | XVIII        | Hospi tal                                   | PPS             |         |
|        |   |   |                       |              | Costs                                       |                 |         |
|        | Cost Center Description                   | Total Cost<br>(from Wkst.<br>B, Part I,<br>col. 26) | Therapy Limit<br>Adj. | Total Costs  | RCE<br>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, 125, 805  |                       | 23, 125, 805 | 0   | 23, 125, 805    | 30.00   |
|        | ANCILLARY SERVICE COST CENTERS            |   |                       |              |   |                 |         |
| 50.00  | 05000 OPERATING ROOM                      | 0   |                       | (            | 0   | 0               | 50.00   |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C             | 353, 575  |                       | 353, 575     | 0   | 353, 575        | 54.00   |
| 60.00  | 06000 LABORATORY                          | 608, 907  |                       | 608, 907     | 0   | 608, 907        | 60.00   |
| 65.00  | 06500 RESPI RATORY THERAPY                | 1, 139, 773   | 0                     | 1, 139, 773  | 0   | 1, 139, 773     | 65.00   |
| 66.00  | 06600 PHYSI CAL THERAPY                   | 4, 420, 130   | 0                     | 4, 420, 130  | 0   | 4, 420, 130     | 66.00   |
| 66. 01 | 06601 PHYSI CAL THERAPY - CARMEL          | 128, 694  | 0                     | 128, 694     | 0   | 128, 694        | 66. 01  |
| 67.00  | 06700 OCCUPATI ONAL THERAPY               | 3, 978, 513   | 0                     | 3, 978, 513  | 0   | 3, 978, 513     | 67.00   |
| 68.00  | 06800 SPEECH PATHOLOGY                    | 2, 329, 629   | 0                     | 2, 329, 629  | 0   | 2, 329, 629     | 68.00   |
| 68. 01 | 06801 VI SI ON                            | 0   | 0                     | (            |   | 0               | 68. 01  |
| 68. 02 | 06802 FAC RESOURCE                        | 1, 950, 749   | 0                     | 1, 950, 749  | 0   | 1, 950, 749     | 68. 02  |
| 69.00  | 06900 ELECTROCARDI OLOGY                  | 0   |                       |              | 0   | 0               | 69.00   |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 545, 579  |                       | 545, 579     | 0   | 545, 579        | 71.00   |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENTS     | 0   |                       |              | 0   | 0               | 72.00   |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS           | 3, 375, 299   |                       | 3, 375, 299  | 0   | 3, 375, 299     | 73.00   |
| 74.00  | 07400 RENAL DIALYSIS                      | 0   |                       | (            |   | 0               | 74.00   |
| 77. 00 | 07700 ALLOGENEIC HSCT ACQUISITION         | 0   |                       | (            | 0   | 0               | 77. 00  |
|        | OUTPATIENT SERVICE COST CENTERS           |   |                       |              | -   |                 | 1       |
| 90.00  | 09000 CLI NI C                            | 640, 496  |                       | 640, 496     | 0   | 640, 496        | 90.00   |
| 90. 01 | 09001 SLEEP CENTER                        | 0   |                       | (            |   | 0               | 1       |
| 91. 00 | 09100 EMERGENCY                           | 0   |                       |              |   | 0               | 91.00   |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART | l 0   |                       |              |   | 0               | 92.00   |
| 00     | OTHER REIMBURSABLE COST CENTERS           |   |                       |              |   |                 | 1       |
| 99 00  | 09900 CWHC                                | 0   |                       | (            |   | 0               | 99 00   |

0

42, 597, 149

42, 597, 149

0

0

42, 597, 149

42, 597, 149

0

0

42, 597, 149 200. 00 0 201. 00 42, 597, 149 202. 00

99. 00 99. 10

0 102.00

99. 00 09900 CMHC

99. 10 09910 CORF

200.00

201.00

202.00

102.00 10200 OPIOID TREATMENT PROGRAM

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

| Health Financial Systems REHA   | ABILITATION HOSE | PITAL OF INDIA | NA                         | In Lie                                      | u of Form CMS-2                | 2552-10          |
|---|------------------|----------------|----------------------------|---|--------------------------------|------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES                                |                  | Provi der Co   |                            | Period:<br>From 01/01/2022<br>To 12/31/2022 | Date/Time Pre 5/31/2023 9:3    | pared:<br>1 am   |
|   | _                |                | XVIII                      | Hospi tal                                   | PPS                            |                  |
|   |                  | Charges        |                            |   |                                |                  |
| Cost Center Description   | Inpati ent       | Outpati ent    | Total (col. 6<br>+ col. 7) | Cost or Other<br>Ratio                      | TEFRA<br>I npati ent<br>Rati o |                  |
|   | 6. 00            | 7.00           | 8.00                       | 9. 00                                       | 10.00                          |                  |
| INPATIENT ROUTINE SERVICE COST CENTERS                                  |                  |                |                            |   |                                |                  |
| 30. 00 03000 ADULTS & PEDIATRICS  | 43, 250, 643     |                | 43, 250, 64                | 3   |                                | 30.00            |
| ANCILLARY SERVICE COST CENTERS  |                  |                |                            |   |                                |                  |
| 50.00   05000   OPERATING ROOM  | 0                | 0              |                            | 0. 000000                                   | 0. 000000                      |                  |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                                    | 1, 950, 091      | 27, 456        |                            |   | 0. 000000                      |                  |
| 60. 00   06000   LABORATORY   | 1, 929, 324      | 665            |                            |   | 0. 000000                      |                  |
| 65. 00 06500 RESPI RATORY THERAPY                                       | 2, 982, 838      | 0              | 2, 982, 83                 |   | 0. 000000                      |                  |
| 66. 00   06600   PHYSI CAL THERAPY                                      | 12, 628, 708     | 6, 740, 263    |                            |   | 0. 000000                      |                  |
| 66. 01 06601 PHYSI CAL THERAPY - CARMEL                                 | 0                | 270, 230       |                            |   | 0. 000000                      |                  |
| 67. 00 06700 OCCUPATI ONAL THERAPY                                      | 14, 950, 432     | 3, 872, 161    |                            |   | 0. 000000                      |                  |
| 68. 00 06800 SPEECH PATHOLOGY   | 7, 238, 339      | 2, 819, 703    |                            |   | 0. 000000                      |                  |
| 68. 01   06801   VI SI 0N   | 0                | 0              |                            | 0. 000000                                   | 0. 000000                      |                  |
| 68. 02   06802   FAC   RESOURCE   | 0                | 678, 580       | 678, 58                    |   | 0. 000000                      |                  |
| 69. 00 06900 ELECTROCARDI OLOGY   | 0                | 0              |                            | 0. 000000                                   | 0. 000000                      |                  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                         | 2, 207, 500      | 71, 476        |                            |   | 0. 000000                      |                  |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS                              | 0                | 0              | 1                          | 0. 000000                                   | 0. 000000                      |                  |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS                                  | 8, 293, 788      | 4, 501, 461    | 12, 795, 24                |   | 0. 000000                      |                  |
| 74. 00   07400   RENAL DI ALYSI S                                       | 0                | 0              |                            | 0. 000000                                   | 0. 000000                      |                  |
| 77. 00 07700 ALLOGENEI C HSCT ACQUISITION                               | 0                | 0              |                            | 0. 000000                                   | 0. 000000                      | 77. 00           |
| OUTPATIENT SERVICE COST CENTERS   |                  | 1 001 000      | 1 224 22                   | 0 000100                                    |                                |                  |
| 90. 00   09000   CLI NI C   | 0                | 1, 984, 909    | 1, 984, 90                 |   | 0. 000000                      |                  |
| 90. 01   09001   SLEEP CENTER   | 0                | 0              |                            | 0. 000000                                   | 0. 000000                      |                  |
| 91. 00   09100   EMERGENCY  | 0                | 0              |                            | 0. 000000                                   | 0. 000000                      |                  |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART                        | 0                | 0              |                            | 0. 000000                                   | 0. 000000                      | 92.00            |
| OTHER REIMBURSABLE COST CENTERS   |                  |                | I                          |   |                                | 00 00            |
| 99. 00   09900   CMHC<br>99. 10   09910   CORF                          | 0                | 0              |                            | 0   |                                | 99. 00<br>99. 10 |
| 99. 10   09910   CORF<br>102. 00   10200   OPLOLD   TREATMENT   PROGRAM |                  | 0              |                            | 0   |                                | 102.00           |
|   | OF 421 ((2)      | 20.044.004     | 11/ 200 5/                 | 0   |                                | 200.00           |
| 200.00 Subtotal (see instructions) 201.00 Less Observation Beds         | 95, 431, 663     | 20, 966, 904   | 116, 398, 56               | <u>'</u>                                    |                                | 200.00           |
| 201.00 Less Observation Beds<br>202.00 Total (see instructions)         | 95, 431, 663     | 20, 966, 904   | 116, 398, 56               | 7   |                                | 201.00           |
| 202.00 [Total (See Histinctions)  | 75, 451, 003     | 20, 700, 904   | 1 110, 370, 30             | <b>'</b>                                    |                                | 1202.00          |

|   |               |             | 10 12/31/2022 | Date/lime Prepared:<br>  5/31/2023 9:31 am |
|---|---------------|-------------|---------------|--|
|   |               | 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                                      |
| ANCILLARY SERVICE COST CENTERS                  |               |             |               |  |
| 50.00 05000 OPERATING ROOM                      | 0. 000000     |             |               | 50.00                                      |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C        | 0. 178795     |             |               | 54.00                                      |
| 60. 00  06000   LABORATORY                      | 0. 315498     |             |               | 60.00                                      |
| 65. 00   06500   RESPI RATORY THERAPY           | 0. 382110     |             |               | 65. 00                                     |
| 66. 00   06600 PHYSI CAL THERAPY                | 0. 228207     |             |               | 66.00                                      |
| 66.01 06601 PHYSI CAL THERAPY - CARMEL          | 0. 476239     |             |               | 66. 01                                     |
| 67. 00 06700 OCCUPATI ONAL THERAPY              | 0. 211369     |             |               | 67.00                                      |
| 68.00   06800   SPEECH PATHOLOGY                | 0. 231619     |             |               | 68. 00                                     |
| 68. 01  06801  VI SI ON                         | 0. 000000     |             |               | 68. 01                                     |
| 68. 02   06802   FAC   RESOURCE                 | 2. 874752     |             |               | 68. 02                                     |
| 69. 00   06900   ELECTROCARDI OLOGY             | 0. 000000     |             |               | 69.00                                      |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 239397     |             |               | 71.00                                      |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS      | 0. 000000     |             |               | 72.00                                      |
| 73.00 07300 DRUGS CHARGED TO PATIENTS           | 0. 263793     |             |               | 73.00                                      |
| 74. 00   07400   RENAL DI ALYSI S               | 0. 000000     |             |               | 74.00                                      |
| 77.00 07700 ALLOGENEIC HSCT ACQUISITION         | 0. 000000     |             |               | 77. 00                                     |
| OUTPATIENT SERVICE COST CENTERS                 |               |             |               |  |
| 90. 00  09000   CLI NI C                        | 0. 322683     |             |               | 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                                     |
| 102.00 10200 OPIOID TREATMENT PROGRAM           |               |             |               | 102.00                                     |
| 200.00 Subtotal (see instructions)              |               |             |               | 200. 00                                    |
| 201.00 Less Observation Beds                    |               |             |               | 201.00                                     |
| 202.00 Total (see instructions)                 |               |             |               | 202.00                                     |
|   |               |             |               |  |

| Health Financial Systems REH                    | HABILITATION HOS | PITAL OF INDIA | NA            | In Lie                                      | u of Form CMS-2             | 2552-10        |
|---|------------------|----------------|---------------|---|-----------------------------|----------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES        |                  | Provi der C    | CN: 15-3028 F | Period:<br>From 01/01/2022<br>To 12/31/2022 | Date/Time Pre 5/31/2023 9:3 | pared:<br>1 am |
|   |                  | Ti tl          | e XIX         | Hospi tal                                   | PPS                         |                |
|   |                  |                |               | Costs                                       |                             |                |
| Cost Center Description                         | Total Cost       | Therapy Limit  | Total Costs   | RCE   | Total Costs                 |                |
|   | (from Wkst.      | Adj .          |               | Di sal I owance                             |                             |                |
|   | B, Part I,       |                |               |   |                             |                |
|   | col. 26)         |                |               |   |                             |                |
|   | 1. 00            | 2. 00          | 3.00          | 4.00  | 5. 00                       |                |
| INPATIENT ROUTINE SERVICE COST CENTERS          |                  |                |               |   |                             |                |
| 30. 00 03000 ADULTS & PEDIATRICS                | 23, 125, 805     |                | 23, 125, 805  | 0   | 23, 125, 805                | 30.00          |
| ANCILLARY SERVICE COST CENTERS                  |                  |                |               |   |                             |                |
| 50.00   05000   OPERATING ROOM                  | 0                |                | (             | 0   | 0                           | 50.00          |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C        | 353, 575         |                | 353, 575      | 0   | 353, 575                    | 54.00          |
| 60. 00   06000   LABORATORY                     | 608, 907         |                | 608, 907      | 0   | 608, 907                    | 60.00          |
| 65. 00 06500 RESPIRATORY THERAPY                | 1, 139, 773      | 0              | 1, 139, 773   | 0   | 1, 139, 773                 | 65.00          |
| 66. 00   06600 PHYSI CAL THERAPY                | 4, 420, 130      | 0              | 4, 420, 130   | 0   | 4, 420, 130                 | 66.00          |
| 66. 01   06601 PHYSI CAL THERAPY - CARMEL       | 128, 694         | 0              | 128, 694      | 0   | 128, 694                    | 66. 01         |
| 67. 00 06700 OCCUPATI ONAL THERAPY              | 3, 978, 513      | 0              | 3, 978, 513   | 0   | 3, 978, 513                 | 67.00          |
| 68. 00 06800 SPEECH PATHOLOGY                   | 2, 329, 629      | 0              | 2, 329, 629   | 0   | 2, 329, 629                 | 68.00          |
| 68. 01   06801   VI SI ON                       | 0                | 0              | (             | 0   | 0                           | 68. 01         |
| 68. 02   06802   FAC   RESOURCE                 | 1, 950, 749      | 0              | 1, 950, 749   | 0   | 1, 950, 749                 | 68. 02         |
| 69. 00 06900 ELECTROCARDI OLOGY                 | 0                |                |               | 0   | 0                           | 69.00          |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 545, 579         |                | 545, 579      | 0   | 545, 579                    | 71.00          |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS      | 0                |                | 1             | 0   | 0                           | 72.00          |
| 73.00 07300 DRUGS CHARGED TO PATIENTS           | 3, 375, 299      |                | 3, 375, 299   | 0   | 3, 375, 299                 | 73.00          |
| 74. 00 07400 RENAL DI ALYSI S                   | 0                |                | (             | 0   | 0                           | 74.00          |
| 77.00 07700 ALLOGENEIC HSCT ACQUISITION         | 0                |                |               | 0   | 0                           | 77. 00         |
| OUTPATIENT SERVICE COST CENTERS                 |                  |                |               |   | -                           | 1              |
| 90. 00 09000 CLINIC                             | 640, 496         |                | 640, 496      | 0   | 640, 496                    | 90.00          |
| 90. 01   09001   SLEEP CENTER                   | 0.107.170        |                | 1             | o o   | 0 0                         | 1              |
| 01 00 00100 EMEDIENCY                           | 1                |                | 1             |   | ٥                           |                |

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0 201.00

91. 00 09100 EMERGENCY

102.00 10200 OPIOID TREATMENT PROGRAM

99. 00 09900 CMHC

99. 10 | 09910 | CORF

92.00

200.00

201.00

202.00

09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

| Health Financial Systems                    | REHABILITATION HOS |              |                            |   | u of Form CMS-2                | 2552-10 |
|---|--------------------|--------------|----------------------------|---|--------------------------------|---------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES    |                    | Provi der C  |                            | Period:<br>From 01/01/2022<br>To 12/31/2022 | Date/Time Pre 5/31/2023 9:3    |         |
|   |                    |              | e XIX                      | Hospi tal                                   | PPS                            |         |
|   |                    | Charges      |                            |   |                                |         |
| Cost Center Description                     | I npati ent        | Outpati ent  | Total (col. (<br>+ col. 7) | Cost or Other<br>Ratio                      | TEFRA<br>I npati ent<br>Rati o |         |
|   | 6. 00              | 7. 00        | 8. 00                      | 9. 00                                       | 10.00                          |         |
| INPATIENT ROUTINE SERVICE COST CENTI        |                    |              |                            |   |                                |         |
| 30. 00 03000 ADULTS & PEDIATRICS            | 43, 250, 643       |              | 43, 250, 64                | 3   |                                | 30.00   |
| ANCILLARY SERVICE COST CENTERS              |                    |              |                            |   |                                |         |
| 50. 00 05000 OPERATI NG ROOM                | 0                  | 0            |                            | 0. 000000                                   | 0.000000                       | 50.00   |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C        | 1, 950, 091        | 27, 456      | 1, 977, 54                 | 7 0. 178795                                 | 0.000000                       | 54.00   |
| 60. 00 06000 LABORATORY                     | 1, 929, 324        | 665          |                            |   | 0.000000                       | 60.00   |
| 65. 00 06500 RESPIRATORY THERAPY            | 2, 982, 838        | 0            | 2, 982, 83                 | 8 0. 382110                                 | 0.000000                       | 65.00   |
| 66. 00 06600 PHYSI CAL THERAPY              | 12, 628, 708       | 6, 740, 263  | 19, 368, 97                | 1 0. 228207                                 | 0.000000                       | 66.00   |
| 66. 01 06601 PHYSI CAL THERAPY - CARMEL     | 0                  | 270, 230     | 270, 23                    | 0. 476239                                   | 0.000000                       | 66. 01  |
| 67. 00 06700 OCCUPATI ONAL THERAPY          | 14, 950, 432       | 3, 872, 161  | 18, 822, 59                | 3 0. 211369                                 | 0.000000                       | 67.00   |
| 68. 00 06800 SPEECH PATHOLOGY               | 7, 238, 339        | 2, 819, 703  | 10, 058, 04                | 2 0. 231619                                 | 0.000000                       | 68.00   |
| 68. 01   06801   VI SI ON                   | 0                  | 0            |                            | 0. 000000                                   | 0.000000                       | 68. 01  |
| 68. 02 06802 FAC RESOURCE                   | 0                  | 678, 580     | 678, 58                    | 0 2.874752                                  | 0.000000                       | 68. 02  |
| 69. 00 06900 ELECTROCARDI OLOGY             | 0                  | 0            |                            | 0. 000000                                   | 0.000000                       | 69.00   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PA  | TI ENT 2, 207, 500 | 71, 476      | 2, 278, 97                 | 6 0. 239397                                 | 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, 293, 788        | 4, 501, 461  | 12, 795, 24                | 9 0. 263793                                 | 0.000000                       | 73.00   |
| 74.00 07400 RENAL DIALYSIS                  | 0                  | 0            |                            | 0. 000000                                   | 0.000000                       | 74.00   |
| 77.00 07700 ALLOGENEIC HSCT ACQUISITION     | 0                  | 0            |                            | 0. 000000                                   | 0.000000                       | 77. 00  |
| OUTPATIENT SERVICE COST CENTERS             |                    |              |                            |   |                                |         |
| 90. 00  09000   CLI NI C                    | 0                  | 1, 984, 909  | 1, 984, 90                 | 9 0. 322683                                 | 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                      |         |
| 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            |                            | 0   |                                | 99. 00  |
| 99. 10   09910   CORF                       | 0                  | 0            |                            | 0   |                                | 99. 10  |
| 102.00 10200 OPIOLD TREATMENT PROGRAM       | 0                  | 0            |                            | 0   |                                | 102.00  |
| 200.00 Subtotal (see instructions)          | 95, 431, 663       | 20, 966, 904 | 116, 398, 56               | 7   |                                | 200.00  |
| 201.00 Less Observation Beds                |                    |              |                            |   |                                | 201.00  |
| 202.00 Total (see instructions)             | 95, 431, 663       | 20, 966, 904 | 116, 398, 56               | 7   |                                | 202.00  |

|   |               |           | To 12/31/2022 | Date/Time Prepared:<br>  5/31/2023 9:31 am |
|---|---------------|-----------|---------------|--|
|   |               | Title XIX | Hospi tal     | PPS  |
| Cost Center Description                         | PPS Inpatient |           | <u> </u>      |  |
|   | Ratio         |           |               |  |
|   | 11. 00        |           |               |  |
| INPATIENT ROUTINE SERVICE COST CENTERS          |               |           |               |  |
| 30. 00 03000 ADULTS & PEDIATRICS                |               |           |               | 30.00                                      |
| ANCILLARY SERVICE COST CENTERS                  |               |           |               |  |
| 50.00   05000   OPERATING ROOM                  | 0. 000000     |           |               | 50.00                                      |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C        | 0. 178795     |           |               | 54.00                                      |
| 60. 00   06000   LABORATORY                     | 0. 315498     |           |               | 60.00                                      |
| 65. 00 06500 RESPIRATORY THERAPY                | 0. 382110     |           |               | 65.00                                      |
| 66. 00 06600 PHYSI CAL THERAPY                  | 0. 228207     |           |               | 66.00                                      |
| 66. 01   06601 PHYSI CAL THERAPY - CARMEL       | 0. 476239     |           |               | 66. 01                                     |
| 67. 00 06700 OCCUPATI ONAL THERAPY              | 0. 211369     |           |               | 67.00                                      |
| 68.00 06800 SPEECH PATHOLOGY                    | 0. 231619     |           |               | 68.00                                      |
| 68. 01   06801   VI SI ON                       | 0. 000000     |           |               | 68. 01                                     |
| 68. 02   06802   FAC   RESOURCE                 | 2. 874752     |           |               | 68. 02                                     |
| 69. 00 06900 ELECTROCARDI OLOGY                 | 0. 000000     |           |               | 69.00                                      |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 239397     |           |               | 71.00                                      |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS      | 0. 000000     |           |               | 72.00                                      |
| 73.00 07300 DRUGS CHARGED TO PATIENTS           | 0. 263793     |           |               | 73.00                                      |
| 74.00 07400 RENAL DIALYSIS                      | 0. 000000     |           |               | 74.00                                      |
| 77.00 07700 ALLOGENEIC HSCT ACQUISITION         | 0. 000000     |           |               | 77. 00                                     |
| OUTPATIENT SERVICE COST CENTERS                 |               |           |               |  |
| 90. 00  09000  CLI NI C                         | 0. 322683     |           |               | 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                                     |
| 102.00 10200 OPIOID TREATMENT PROGRAM           |               |           |               | 102.00                                     |
| 200.00 Subtotal (see instructions)              |               |           |               | 200. 00                                    |
| 201.00 Less Observation Beds                    |               |           |               | 201.00                                     |
| 202.00   Total (see instructions)               |               |           |               | 202.00                                     |

Health Financial Systems REHABILITATION H
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICALD ONLY Period: Worksheet C From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared: Provi der CCN: 15-3028

|  |              |              |                         | 10 12/31/2022 | 5/31/2023 9: 3 | epared:<br>1 am |
|--|--------------|--------------|-------------------------|---------------|----------------|-----------------|
|  |              | Ti tl        | e XIX                   | Hospi tal     | PPS            |                 |
| Cost Center Description                          | Total Cost   | Capital Cost | Operating               | Capi tal      | Operati ng     |                 |
|  | (Wkst. B,    | (Wkst. B,    | Cost Net of             | Reducti on    | Cost           |                 |
|  | Part I, col. | Part II col. | Capital Cost            |               | Reducti on     |                 |
|  | 26)          | 26)          | (col. 1 -               |               | Amount         |                 |
|  |              |              | col. 2)                 |               |                |                 |
|  | 1. 00        | 2. 00        | 3. 00                   | 4. 00         | 5. 00          |                 |
| ANCILLARY SERVICE COST CENTERS                   |              |              |                         | _1            |                |                 |
| 50. 00   05000   OPERATING ROOM                  | 0            | 0            | (                       | 0             | 0              |                 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C             | 353, 575     | 10, 237      |                         |               | 0              | 54.00           |
| 60. 00   06000   LABORATORY                      | 608, 907     | 46, 155      |                         |               | 0              | 60.00           |
| 65. 00   06500   RESPI RATORY THERAPY            | 1, 139, 773  | 12, 618      |                         |               | 0              | 65.00           |
| 66. 00   06600   PHYSI CAL THERAPY               | 4, 420, 130  | 192, 265     |                         |               | 0              | 66.00           |
| 66. 01 06601 PHYSI CAL THERAPY - CARMEL          | 128, 694     | 313          |                         |               | 0              | 66. 01          |
| 67. 00 06700 OCCUPATI ONAL THERAPY               | 3, 978, 513  | 185, 994     |                         |               | 0              | 67.00           |
| 68. 00 06800 SPEECH PATHOLOGY                    | 2, 329, 629  | 100, 049     | 2, 229, 580             | 0             | 0              | 68.00           |
| 68. 01   06801   VI SI ON                        | 0            | 0            |                         | 0             | 0              | 68. 01          |
| 68. 02   06802   FAC   RESOURCE                  | 1, 950, 749  | 6, 357       | 1, 944, 39              | 2 0           | 0              | 68. 02          |
| 69. 00 06900 ELECTROCARDI OLOGY                  | 0            | 0            |                         | 0             | 0              |                 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 545, 579     | 916          | 544, 66                 | 3 0           | 0              |                 |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS     | 0            | 0            | (                       | 0             | 0              |                 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS            | 3, 375, 299  | 50, 608      | 3, 324, 69 <sup>-</sup> | 1 0           | 0              | ,               |
| 74. 00   07400   RENAL DI ALYSI S                | 0            | 0            | (                       | 0             | 0              |                 |
| 77. 00 07700 ALLOGENEIC HSCT ACQUISITION         | 0            | 0            |                         | 0             | 0              | 77. 00          |
| OUTPATIENT SERVICE COST CENTERS                  |              |              |                         | .1            | _              |                 |
| 90. 00   09000   CLI NI C                        | 640, 496     | 91, 922      | 548, 57                 | 0             | _              |                 |
| 90. 01   09001   SLEEP CENTER                    | 0            | 0            | (                       | 0             | 0              |                 |
| 91. 00   09100   EMERGENCY                       | 0            | 0            | (                       | 0             | 0              |                 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0            | 0            |                         | ) 0           | 0              | 92.00           |
| OTHER REIMBURSABLE COST CENTERS                  |              |              |                         |               |                | 00.00           |
| 99. 00 09900 CMHC                                | 0            | 0            | (                       | 0             | _              |                 |
| 99. 10   09910   CORF                            | 0            | 0            | 9                       | 0             | 0              | 1 , , , , , ,   |
| 102. 00 10200 OPI OI D TREATMENT PROGRAM         | 10 474 044   | (07.404      | 40 770 044              | 0             |                | 102.00          |
| 200.00 Subtotal (sum of lines 50 thru 199)       | 19, 471, 344 | 697, 434     | 18, 773, 910            |               |                | 200.00          |
| 201.00 Less Observation Beds                     | 10 471 044   | 407.404      | 10 772 04               |               |                | 201.00          |
| 202.00   Total (line 200 minus line 201)         | 19, 471, 344 | 697, 434     | 18, 773, 910            | טן ט          | 0              | 202. 00         |

Peri od: Worksheet C From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared: 5/31/2023 9:31 am

|              |                                     |              |               |                       |  | 5/31/2023 9:31 am |    |
|--------------|-------------------------------------|--------------|---------------|-----------------------|--|-------------------|----|
|              |                                     |              |               | e XIX                 | Hospi tal  | PPS               | _  |
|              | Cost Center Description             | Cost Net of  | Total Charges | Outpati ent           |  |                   |    |
|              |                                     | Capital and  | (Worksheet C, | Cost to               |  |                   |    |
|              |                                     | Operati ng   | Part I,       | Charge Ratio          |  |                   |    |
|              |                                     | Cost         | column 8)     | (col. 6 /             |  |                   |    |
|              |                                     | Reducti on   |               | col. 7)               |  |                   |    |
|              |                                     | 6. 00        | 7. 00         | 8. 00                 |  |                   |    |
| ANCI L       | LARY SERVICE COST CENTERS           |              |               |                       |  |                   |    |
| 50.00 05000  | OPERATING ROOM                      | 0            | 0             | 0. 000000             | O  | 50.00             |    |
| 54.00 05400  | RADI OLOGY-DI AGNOSTI C             | 353, 575     | 1, 977, 547   | 0. 17879!             | 5  | 54.00             | Ю  |
| 60.00 06000  | LABORATORY                          | 608, 907     | 1, 929, 989   | 0. 31549              | 3  | 60.00             | Ю  |
| 65. 00 06500 | RESPIRATORY THERAPY                 | 1, 139, 773  | 2, 982, 838   | 0. 382110             | 0  | 65. 00            | Ю  |
| 66.00 06600  | PHYSI CAL THERAPY                   | 4, 420, 130  | 19, 368, 971  | 0. 22820              | 7  | 66. 00            | Ю  |
| 66. 01 0660° | I PHYSICAL THERAPY - CARMEL         | 128, 694     | 270, 230      | 0. 47623              | 9  | 66. 0             | )1 |
| 67. 00 06700 | OCCUPATIONAL THERAPY                | 3, 978, 513  | 18, 822, 593  | 0. 21136              | 9  | 67. 00            | 00 |
| 68.00 06800  | SPEECH PATHOLOGY                    | 2, 329, 629  | 10, 058, 042  | 0. 231619             | 9  | 68.00             | 00 |
| 68. 01 0680° | I VI SI ON                          | 0            | 0             | 0. 000000             | 0  | 68. 0             | )1 |
| 68. 02 06802 | FAC RESOURCE                        | 1, 950, 749  | 678, 580      | 2. 87475              | 2  | 68. 02            | )2 |
| 69.00 06900  | ELECTROCARDI OLOGY                  | 0            | 0             | 0. 000000             | 0  | 69.00             | 00 |
| 71.00 07100  | MEDICAL SUPPLIES CHARGED TO PATIENT | 545, 579     | 2, 278, 976   | 0. 23939 <sup>-</sup> | 7  | 71.00             | 00 |
| 72. 00 07200 | IMPL. DEV. CHARGED TO PATIENTS      | 0            | 0             | 0. 000000             | 0  | 72.00             | 00 |
|              | DRUGS CHARGED TO PATIENTS           | 3, 375, 299  | 12, 795, 249  | 0. 26379:             | 3  | 73.00             | 00 |
| 74. 00 07400 | RENAL DIALYSIS                      | 0            | 0             | 0. 000000             |  | 74.00             | 00 |
|              | ALLOGENEIC HSCT ACQUISITION         | 0            | 0             | 0. 000000             |  | 77. 00            | 00 |
|              | ATIENT SERVICE COST CENTERS         |              |               |                       |  |                   |    |
|              | CLINIC                              | 640, 496     | 1, 984, 909   | 0. 322683             | 3  | 90.00             | 00 |
| 90. 01 0900  | SLEEP CENTER                        | 0            | 0             | 0. 000000             |  | 90.0              | )1 |
| 91.00 09100  | EMERGENCY                           | 0            | 0             | 0. 000000             |  | 91.00             | 00 |
| 92.00 09200  | OBSERVATION BEDS (NON-DISTINCT PART | 0            | 0             | 0. 000000             |  | 92.00             | 00 |
|              | R REIMBURSABLE COST CENTERS         |              |               |                       | -  |                   |    |
|              | CMHC                                | 0            | 0             | 0. 000000             |  | 99.00             | 00 |
| 99. 10 09910 |                                     | 1 0          | l o           | 0. 000000             |  | 99. 10            |    |
|              | OPIOID TREATMENT PROGRAM            | 0            | 0             | 0. 000000             |  | 102.00            |    |
| 200. 00      | Subtotal (sum of lines 50 thru 199) | 19, 471, 344 | 73, 147, 924  |                       | -  | 200. 00           |    |
| 201.00       | Less Observation Beds               | 0            | 0             |                       |  | 201. 00           |    |
| 202. 00      | Total (line 200 minus line 201)     | 19, 471, 344 | 73, 147, 924  |                       |  | 202.00            |    |
|              | 11.1.1. (1.1.1.6.2.0.1.1.1.6.2.0.1) | 1 , , 0      | 1 .0, , , 2 ! | ı                     | T. Control of the Con | 1202.00           | _  |

| Health Financial Systems REHA                                    | ABILITATION HOS                              | PITAL OF INDIA                                   | NA  | In Lie                                      | In Lieu of Form CMS-2552-10      |                   |  |
|--|--|--|---|---|----------------------------------|-------------------|--|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL               | COSTS  | Provider Co                                      |   | Period:<br>From 01/01/2022<br>To 12/31/2022 |                                  |                   |  |
|  |  | Title  | XVIII   | Hospi tal                                   | PPS                              |                   |  |
| Cost Center Description  | Capital Related Cost (from Wkst. B, Part II, | Swing Bed<br>Adjustment                          | Reduced<br>Capital<br>Related Cost<br>(col. 1 - | Total Patient<br>Days                       | Per Diem<br>(col. 3 /<br>col. 4) |                   |  |
|  | col . 26)<br>1.00                            | 2.00   | col. 2)<br>3.00                                 | 4. 00                                       | 5. 00                            |                   |  |
| INPATIENT ROUTINE SERVICE COST CENTERS                           | 11.00  | 2.00   | 0.00  | 1.00  | 0.00                             |                   |  |
| 30.00 ADULTS & PEDIATRICS  | 1, 294, 277                                  | 0  | 1, 294, 27                                      | 7 18, 734                                   | 69. 09                           | 30.00             |  |
| 200.00 Total (lines 30 through 199)                              | 1, 294, 277                                  |  | 1, 294, 27                                      | 7 18, 734                                   |                                  | 200.00            |  |
| Cost Center Description  | Inpatient<br>Program days                    | Inpatient Program Capital Cost (col. 5 x col. 6) |   |   |                                  |                   |  |
|  | 6. 00  | 7. 00  |   |   |                                  |                   |  |
| INPATIENT ROUTINE SERVICE COST CENTERS                           |  |  |   |   |                                  |                   |  |
| 30.00 ADULTS & PEDIATRICS<br>200.00 Total (lines 30 through 199) | 5, 542<br>5, 542                             |  |   |   |                                  | 30. 00<br>200. 00 |  |

| Health Financial Systems REHA   | ABILITATION HOS    | PITAL OF INDIA | NA                    | In Lie                     | u of Form CMS-2        | 2552-10          |
|---|--------------------|----------------|-----------------------|----------------------------|------------------------|------------------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA                           | AL COSTS           | Provi der C    |                       | Period:<br>From 01/01/2022 | Worksheet D<br>Part II |                  |
|   |                    |                |                       | To 12/31/2022              |                        | nared·           |
|   |                    |                |                       | 10 12/01/2022              | 5/31/2023 9: 3         |                  |
|   |                    |                | XVIII                 | Hospi tal                  | PPS                    |                  |
| Cost Center Description   | Capi tal           | Total Charges  |                       |                            | Capital Costs          |                  |
|   | Related Cost       | (from Wkst.    | to Charges            | Program                    | (column 3 x            |                  |
|   | (from Wkst.        | C, Part I,     | (col . 1 ÷            | Charges                    | column 4)              |                  |
|   | B, Part II,        | col. 8)        | col. 2)               |                            |                        |                  |
|   | col. 26)           |                |                       |                            |                        |                  |
| ANOLILIARY OFFICE OFFICE  | 1. 00              | 2. 00          | 3. 00                 | 4. 00                      | 5. 00                  |                  |
| ANCILLARY SERVICE COST CENTERS  |                    |                | 0.00000               |                            | 0                      |                  |
| 50.00   05000   OPERATI NG ROOM<br>54.00   05400   RADI OLOGY-DI AGNOSTI C    | 10, 237            | U<br>1 077 F47 | 0. 000000<br>0. 00517 |                            | 0                      | 50.00<br>54.00   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C<br>60. 00   06000   LABORATORY       |                    |                | •                     |                            | •                      |                  |
| 65. 00   06500  RESPIRATORY THERAPY   | 46, 155<br>12, 618 |                | •                     |                            |                        | 60. 00<br>65. 00 |
| 66. 00   06600   PHYSI CAL THERAPY  | 192, 265           |                |                       |                            | •                      |                  |
| 66. 00   06600  PHYSICAL THERAPY<br>66. 01   06601  PHYSICAL THERAPY - CARMEL | 313                |                |                       |                            |                        | 66.00            |
| 67. 00 06700 OCCUPATI ONAL THERAPY  | 185, 994           |                |                       |                            | Ĭ                      | 67.00            |
| 68. 00 06800 SPEECH PATHOLOGY   | 100, 049           |                |                       |                            |                        | 68.00            |
| 68. 01   06801 VI SI ON   | 100,049            | 10,038,042     | 0.00000               | 1 '                        | 20, 477                | 68. 01           |
| 68. 02   06802   FAC   RESOURCE   | 6, 357             | 678, 580       |                       |                            | 0                      | 68. 02           |
| 69. 00   06900   ELECTROCARDI OLOGY   | 0, 337             | 070, 300       | 0.00000               |                            | 0                      | 69.00            |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                              | 916                | 2, 278, 976    |                       |                            |                        | 71.00            |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS                                  | 0                  | 2,270,770      | 0. 000000             |                            | 0                      | 72.00            |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS  | 50, 608            | 12, 795, 249   |                       |                            | 9, 884                 |                  |
| 74. 00 07400 RENAL DI ALYSI S   | 00,000             | 12,770,217     | 0. 000000             |                            | 0                      | 74.00            |
| 77. 00 07700 ALLOGENEIC HSCT ACQUISITION                                      | 0                  | 0              | 0. 000000             |                            | 0                      | 77. 00           |
| OUTPATIENT SERVICE COST CENTERS   |                    |                | 0.00000               | <u> </u>                   |                        | ,,,,             |
| 90. 00 09000 CLI NI C   | 91, 922            | 1, 984, 909    | 0. 046310             | 0                          | 0                      | 90.00            |
| 90. 01   09001   SLEEP CENTER   | . 0                | 0              | 0. 00000              |                            | 0                      | 90. 01           |
| 91. 00 09100 EMERGENCY  | 0                  | 0              | 0. 00000              | 0                          | 0                      | 91.00            |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART                               | 0                  | 0              | 0. 000000             |                            | 0                      | 92.00            |
| 200.00 Total (lines 50 through 199)   | 697, 434           | 73, 147, 924   |                       | 15, 468, 140               | 133, 043               | 200.00           |
|   |                    |                |                       |                            |                        |                  |

| Health Financial Systems REHA  | ABILITATION HOS  | PITAL OF INDIA                                       | NA  | In Lie                                      | u of Form CMS-                    | 2552-10           |
|--|--|--|---|---|-----------------------------------|-------------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA                          | ASS THROUGH COS  | TS Provider Co                                       |   | Period:<br>From 01/01/2022<br>To 12/31/2022 |                                   | epared:<br>31 am  |
|  |  |  | XVIII   | Hospi tal                                   | PPS                               |                   |
| Cost Center Description  | Nursi ng<br>Program<br>Post-Stepdown                       | Nursi ng<br>Program                                  | Allied Health<br>Post-Stepdowr<br>Adjustments | Allied Health<br>Cost                       | All Other<br>Medical<br>Education |                   |
|  | Adjustments  |  |   |   | Cost                              |                   |
|  | 1A   | 1. 00  | 2A  | 2. 00                                       | 3. 00                             |                   |
| INPATIENT ROUTINE SERVICE COST CENTERS                                       |  |  |   |   |                                   |                   |
| 30. 00 03000 ADULTS & PEDIATRICS   | 0  | 0  | (   | 0   | 0                                 | 1 00.00           |
| 200.00   Total (lines 30 through 199)  | 0  | 0  | (   | 0   |                                   | 200.00            |
| Cost Center Description  | Swing-Bed Adjustment Amount (see instructions)             | Total Costs (sum of cols. 1 through 3, minus col. 4) | Total Patient<br>Days                         | Per Diem<br>(col. 5 ÷<br>col. 6)            | Inpatient<br>Program Days         |                   |
|  | 4. 00  | 5. 00  | 6. 00   | 7. 00                                       | 8. 00                             |                   |
| INPATIENT ROUTINE SERVICE COST CENTERS                                       |  |  |   |   |                                   |                   |
| 30.00 03000 ADULTS & PEDIATRICS<br>200.00 Total (lines 30 through 199)       | 0  | 0  | 18, 73<br>18, 73                              |   | 5, 542<br>5, 542                  | 30. 00<br>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 & PEDIATRICS<br>200.00   Total (lines 30 through 199) | 0  |  |   |   |                                   | 30. 00<br>200. 00 |

In Lieu of Form CMS-2552-10

| Period: | Worksheet D |
| From 01/01/2022 | Part IV |
| To 12/31/2022 | Date/Time Prepared: |
| 5/31/2023 9:31 am | THROUGH COSTS

|   |               |               |          |               | 5/31/2023 9: 3 | 1 am    |
|---|---------------|---------------|----------|---------------|----------------|---------|
|   |               | Title         | XVIII    | Hospi tal     | PPS            |         |
| Cost Center Description                         | Non Physician | Nursi ng      | Nursi ng | Allied Health | Allied Health  |         |
|   | Anesthetist   | Program       | Program  | Post-Stepdown |                |         |
|   | Cost          | Post-Stepdown |          | Adjustments   |                |         |
|   |               | Adjustments   |          |               |                |         |
|   | 1. 00         | 2A            | 2.00     | 3A            | 3. 00          |         |
| ANCILLARY SERVICE COST CENTERS                  |               |               |          |               |                |         |
| 50. 00   05000   OPERATING ROOM                 | 0             | 0             |          | 0 0           | 0              | 50.00   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C        | 0             | 0             |          | 0 0           | 0              | 54.00   |
| 60. 00   06000   LABORATORY                     | 0             | 0             |          | 0 0           | 0              | 60.00   |
| 65. 00 06500 RESPIRATORY THERAPY                | 0             | 0             |          | 0 0           | 0              | 65.00   |
| 66. 00 06600 PHYSI CAL THERAPY                  | 0             | 0             |          | 0 0           | 0              | 66.00   |
| 66. 01   06601 PHYSI CAL THERAPY - CARMEL       | 0             | 0             |          | 0             | 0              | 66. 01  |
| 67. 00 06700 OCCUPATI ONAL THERAPY              | 0             | 0             |          | 0             | 0              | 67.00   |
| 68. 00 06800 SPEECH PATHOLOGY                   | 0             | 0             |          | 0             | 0              | 68. 00  |
| 68. 01   06801   VI SI ON                       | 0             | 0             |          | 0             | 0              | 68. 01  |
| 68. 02   06802   FAC   RESOURCE                 | 0             | 0             |          | 0             | 0              | 68. 02  |
| 69. 00 06900 ELECTROCARDI OLOGY                 | 0             | 0             |          | 0             | 0              | 69.00   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0             | 0             |          | 0             | 0              | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS      | 0             | 0             |          | 0             | 0              | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS           | 0             | 0             |          | 0             | 0              | 73.00   |
| 74. 00   07400   RENAL DI ALYSI S               | 0             | 0             |          | 0             | 0              | 74.00   |
| 77.00 07700 ALLOGENEIC HSCT ACQUISITION         | 0             | 0             |          | 0             | 0              | 77. 00  |
| OUTPATIENT SERVICE COST CENTERS                 |               |               |          |               |                |         |
| 90. 00 09000 CLI NI C                           | 0             | 0             |          | 0 0           | 0              | 90.00   |
| 90. 01   09001   SLEEP CENTER                   | 0             | 0             |          | 0             | 0              | 90. 01  |
| 91. 00 09100 EMERGENCY                          | 0             | 0             |          | 0 0           | 0              | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0             |               |          | 0             | 0              | 92.00   |
| 200.00 Total (lines 50 through 199)             | 0             | 0             |          | 0 0           | 0              | 200. 00 |
|   |               |               |          |               |                |         |

| Health Financial Systems               | REHABILITATION HOSPITAL OF INDIANA                   |          | In Lieu of Form CMS-2552-10 |
|--|--|----------|-----------------------------|
| ADDODTI ONMENT OF INDATIENT/OUTDATIENT | ANCILLADY SERVICE OTHER DASS   Provider CCN: 15 2029 | Pori od: | Workshoot D                 |

Period: From 01/01/2022 To 12/31/2022 Part IV THROUGH COSTS Date/Time Prepared: 5/31/2023 9:31 am Title XVIII Hospi tal Cost Center Description All Other Total Charges Ratio of Cost Total Cost Total to Charges Medi cal (sum of cols. Outpati ent (from Wkst. Educati on 1, 2, 3, and Cost (sum of C, Part I, (col. 5 ÷ 4) Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 4. 00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0.000000 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 1, 977, 547 0.000000 54.00 54.00 0 0 0 0 0 0 0 0 0 0 0 0 06000 LABORATORY 1, 929, 989 0 0.000000 60.00 60.00 0 06500 RESPIRATORY THERAPY 0 0 65.00 2, 982, 838 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 19, 368, 971 0.000000 66.00 06601 PHYSI CAL THERAPY - CARMEL 0 270, 230 0.000000 66.01 66.01 Ol 06700 OCCUPATI ONAL THERAPY 18, 822, 593 67.00 0 0.000000 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 10, 058, 042 0.000000 68.00 68.01 06801 VI SI ON 0.000000 68.01 06802 FAC RESOURCE 0 678, 580 0.000000 68.02 68.02 06900 ELECTROCARDI OLOGY 0 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 278, 976 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0.000000 72.00 0 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 12, 795, 249 0.000000 73 00 0 74.00 07400 RENAL DIALYSIS 0 0.000000 74.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0.000000 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 0 n 1, 984, 909 0.000000 90 00 09000 CLI NI C 0 0 0 0 09001 SLEEP CENTER 0 90.01 0 0.000000 90.01 91. 00 09100 EMERGENCY 0 0.000000 91.00

0

ol

73, 147, 924

0.000000

92.00

200.00

0

0

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

200.00

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

From 01/01/2022 Part IV To 12/31/2022 Part IV Date/Time Prepared: 5/31/2023 9:31 am THROUGH COSTS Title XVIII Hospi tal PPS Cost Center Description Outpati ent I npati ent I npati ent Outpati ent Outpati ent Program Ratio of Cost Program Program Program to Charges Pass-Through Pass-Through Charges Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col . 12) x col. 10) 11.00 9. 00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0.000000 50.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 506, 791 17, 196 0 54.00 06000 LABORATORY 0.000000 630, 934 0 0 60.00 60.00 0 06500 RESPIRATORY THERAPY 0.000000 990, 509 0 65.00 65.00 0 0 06600 PHYSI CAL THERAPY 0.000000 3, 675, 674 66.00 0 0 66.00 66.01 06601 PHYSI CAL THERAPY - CARMEL 0.000000 0 66.01 67.00 06700 OCCUPATI ONAL THERAPY 0. 000000 4, 405, 612 67.00 1.465 06800 SPEECH PATHOLOGY 2, 108, 923 0.000000 0 68.00 0 0 68.00 06801 VI SI ON 68.01 0.000000 0 0 68.01 68.02 06802 FAC RESOURCE 0.000000 68.02 06900 ELECTROCARDI OLOGY 0 69.00 0.000000 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0.000000 17, 084 0 71.00 71.00 650, 693 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 0.000000 2, 499, 004 1, 949, 349 0 07400 RENAL DIALYSIS 74.00 0.000000 0 74.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 507, 789 0 90.00 0 09001 SLEEP CENTER 0.000000 90. 01 90.01 C 0 91.00 91.00 09100 EMERGENCY 0.000000 0 0 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.000000 0 0 200.00 Total (lines 50 through 199) 15, 468, 140 2, 492, 883 0 200.00

| Health Financial Systems REHA                       | ABILITATION HOS | SPITAL OF INDIA | NA            | In Lie                                      | u of Form CMS-2             | 2552-10 |
|---|-----------------|-----------------|---------------|---|-----------------------------|---------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST    | Provi der Co    | <u> </u>      | Period:<br>From 01/01/2022<br>To 12/31/2022 | Date/Time Pre 5/31/2023 9:3 | pared:  |
|   |                 | Title           | XVIII         | Hospi tal                                   | PPS                         |         |
|   |                 |                 | Charges       |   | Costs                       |         |
| Cost Center Description                             | Cost to         | PPS             | Cost          | Cost  | PPS Services                |         |
|   | Charge Ratio    | Rei mbursed     | Reimbursed    | Rei mbursed                                 | (see inst.)                 |         |
|   | From            | Services (see   | Servi ces     | Services Not                                |                             |         |
|   | Worksheet C,    | inst.)          | Subject To    | Subject To                                  |                             |         |
|   | Part I, col.    |                 | Ded. & Coins. | Ded. & Coins.                               |                             |         |
|   | 9               |                 | (see inst.)   | (see inst.)                                 |                             |         |
|   | 1. 00           | 2.00            | 3. 00         | 4. 00                                       | 5. 00                       |         |
| ANCILLARY SERVICE COST CENTERS                      |                 |                 |               |   |                             |         |
| 50.00 05000 OPERATING ROOM                          | 0. 000000       | l .             |               | 0   | 0                           | 50.00   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C            | 0. 178795       |                 |               | 0   | 3, 075                      |         |
| 60. 00  06000  LABORATORY                           | 0. 315498       |                 |               | 0   | 0                           | 60.00   |
| 65. 00 06500 RESPIRATORY THERAPY                    | 0. 382110       |                 |               | 0   | 0                           | 65.00   |
| 66. 00  06600 PHYSI CAL THERAPY                     | 0. 228207       |                 |               | 0   | 0                           | 66.00   |
| 66.01 06601 PHYSICAL THERAPY - CARMEL               | 0. 476239       |                 |               | 0   | 0                           | 66. 01  |
| 67. 00  06700 OCCUPATI ONAL THERAPY                 | 0. 211369       | 1, 465          |               | 0   | 310                         | 67.00   |
| 68. 00   06800   SPEECH PATHOLOGY                   | 0. 231619       | 0               |               | 0   | 0                           | 68. 00  |
| 68. 01  06801  VI SI ON                             | 0. 000000       | 0               |               | 0   | 0                           | 68. 01  |
| 68. 02   06802   FAC RESOURCE                       | 2. 874752       | 0               |               | 0   | 0                           | 68. 02  |
| 69. 00 06900 ELECTROCARDI OLOGY                     | 0. 000000       | 0               |               | 0   | 0                           | 69.00   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 0. 239397       | 17, 084         |               | 0   | 4, 090                      | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 0. 000000       | 0               |               | 0   | 0                           | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 0. 263793       | 1, 949, 349     |               | 0   | 514, 225                    | 73.00   |
| 74.00 07400 RENAL DIALYSIS                          | 0. 000000       | 0               |               | 0   | 0                           | 74.00   |
| 77.00 07700 ALLOGENEIC HSCT ACQUISITION             | 0. 000000       | 0               |               | o o   | 0                           | 77.00   |
| OUTPATIENT SERVICE COST CENTERS                     |                 |                 |               |   |                             |         |
| 90. 00 09000 CLI NI C                               | 0. 322683       | 507, 789        | (             | 0   | 163, 855                    | 90.00   |
| 90. 01   09001   SLEEP CENTER                       | 0. 000000       | 0               |               | ol o  | 0                           | 90. 01  |
| 91. 00 09100 EMERGENCY                              | 0. 000000       | 0               |               | ol o  | 0                           | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART     | 0. 000000       | 0               |               | ol ol                                       | 0                           | 92.00   |
| 200.00 Subtotal (see instructions)                  |                 | 2, 492, 883     |               | ol ol                                       | 685, 555                    | 200.00  |
| 201.00 Less PBP Clinic Lab. Services-Program        |                 |                 |               | ol ol                                       |                             | 201.00  |
| Only Charges  |                 |                 |               |   | ı                           |         |
| 202.00 Net Charges (line 200 - line 201)            |                 | 2, 492, 883     |               | ol ol                                       | 685, 555                    | 202.00  |

| Peri od: | Worksheet D | From 01/01/2022 | Part V | To | 12/31/2022 | Date/Time Prepared:

|   |               |               |         | 10 12/31/2022 | Date/IIme Pre<br>  5/31/2023 9:3 |         |
|---|---------------|---------------|---------|---------------|----------------------------------|---------|
|   |               | Ti tl e       | e XVIII | Hospi tal     | PPS                              |         |
| <u> </u>  | Cos           | sts           |         |               |                                  |         |
| Cost Center Description                         | Cost          | Cost          |         |               |                                  |         |
|   | Rei mbursed   | Rei mbursed   |         |               |                                  |         |
|   | Servi ces     | Services Not  |         |               |                                  |         |
|   | Subject To    | Subject To    |         |               |                                  |         |
|   | Ded. & Coins. | Ded. & Coins. |         |               |                                  |         |
|   | (see inst.)   | (see inst.)   |         |               |                                  |         |
|   | 6. 00         | 7.00          |         |               |                                  |         |
| ANCILLARY SERVICE COST CENTERS                  |               |               |         |               |                                  |         |
| 50.00   05000   OPERATING ROOM                  | 0             | C             | 1       |               |                                  | 50.00   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C        | 0             | C             |         |               |                                  | 54.00   |
| 60. 00   06000   LABORATORY                     | 0             | C             |         |               |                                  | 60.00   |
| 65. 00 06500 RESPI RATORY THERAPY               | 0             | C             |         |               |                                  | 65. 00  |
| 66. 00 06600 PHYSI CAL THERAPY                  | 0             | C             |         |               |                                  | 66. 00  |
| 66. 01 06601 PHYSI CAL THERAPY - CARMEL         | 0             | C             |         |               |                                  | 66. 01  |
| 67. 00 06700 OCCUPATI ONAL THERAPY              | 0             | C             |         |               |                                  | 67.00   |
| 68. 00 06800 SPEECH PATHOLOGY                   | 0             | C             |         |               |                                  | 68.00   |
| 68. 01   06801   VI SI ON                       | 0             | C             |         |               |                                  | 68. 01  |
| 68. 02   06802   FAC   RESOURCE                 | 0             | C             |         |               |                                  | 68. 02  |
| 69. 00 06900 ELECTROCARDI OLOGY                 | 0             | C             |         |               |                                  | 69.00   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0             | C             |         |               |                                  | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS      | 0             | C             |         |               |                                  | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS           | 0             | C             |         |               |                                  | 73.00   |
| 74. 00   07400   RENAL DI ALYSI S               | 0             | C             | 1       |               |                                  | 74.00   |
| 77. 00 07700 ALLOGENEIC HSCT ACQUISITION        | 0             | C             | )       |               |                                  | 77. 00  |
| OUTPATIENT SERVICE COST CENTERS                 | _             | 1 -           | .1      |               |                                  |         |
| 90. 00 09000 CLI NI C                           | 0             |               | 1       |               |                                  | 90.00   |
| 90. 01   09001   SLEEP CENTER                   | 0             | C             | )       |               |                                  | 90. 01  |
| 91. 00   09100   EMERGENCY                      | 0             | C             | )       |               |                                  | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0             |               | )       |               |                                  | 92.00   |
| 200.00 Subtotal (see instructions)              | 0             | C             |         |               |                                  | 200. 00 |
| 201.00 Less PBP Clinic Lab. Services-Program    | 0             |               |         |               |                                  | 201. 00 |
| Only Charges                                    | _             | _             |         |               |                                  |         |
| 202.00   Net Charges (line 200 - line 201)      | 0             | ( C           | )       |               |                                  | 202. 00 |

| Health Financial Systems REHA                      | ABILITATION HOS                              | PITAL OF INDIA                                   | NA  | In Lie                                      | u of Form CMS-                   | 2552-10 |
|--|--|--|---|---|----------------------------------|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL | COSTS  | Provider C                                       |   | Period:<br>From 01/01/2022<br>To 12/31/2022 |                                  |         |
|  |  | Ti tl  | e XIX   | Hospi tal                                   | PPS                              |         |
| Cost Center Description                            | Capital Related Cost (from Wkst. B, Part II, | Swing Bed<br>Adjustment                          | Reduced<br>Capital<br>Related Cost<br>(col. 1 - | Total Patient<br>Days                       | Per Diem<br>(col. 3 /<br>col. 4) |         |
|  | col . 26)<br>1.00                            | 2. 00  | col. 2)<br>3.00                                 | 4. 00                                       | 5. 00                            |         |
| INPATIENT ROUTINE SERVICE COST CENTERS             | 1.00   | 2.00   | 3.00  | 4.00  | 3.00                             |         |
| 30. 00 ADULTS & PEDIATRICS                         | 1, 294, 277                                  | 0  | 1, 294, 27                                      | 7 18, 734                                   | 69. 09                           | 30.00   |
| 200.00 Total (lines 30 through 199)                | 1, 294, 277                                  |  | 1, 294, 27                                      | 7 18, 734                                   |                                  | 200.00  |
| Cost Center Description                            | Inpatient<br>Program days                    | Inpatient Program Capital Cost (col. 5 x col. 6) |   |   |                                  |         |
|  | 6. 00  | 7. 00  |   |   |                                  |         |
| INPATIENT ROUTINE SERVICE COST CENTERS             |  |  |   |   |                                  |         |
| 30.00 ADULTS & PEDIATRICS                          | 534  |  |   |   |                                  | 30.00   |
| 200.00 Total (lines 30 through 199)                | 534  | 36, 894  |   |   |                                  | 200.00  |

| Health Financial Systems REHA                       | BILITATION 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:<br>From 01/01/2022<br>To 12/31/2022 |                 |         |
|   |                |                | e XIX      | Hospi tal                                   | PPS             |         |
| Cost Center Description                             | Capi tal       | Total Charges  |            |   | Capital Costs   |         |
|   | Related Cost   | (from Wkst.    | to Charges | Program                                     | (column 3 x     |         |
|   | (from Wkst.    | C, Part I,     | (col . 1 ÷ | Charges                                     | column 4)       |         |
|   | B, Part II,    | col. 8)        | col. 2)    |   |                 |         |
|   | col. 26)       |                |            |   |                 |         |
|   | 1. 00          | 2. 00          | 3. 00      | 4. 00                                       | 5. 00           |         |
| ANCILLARY SERVICE COST CENTERS                      |                |                |            |   |                 |         |
| 50.00 05000 OPERATING ROOM                          | 0              | 0              | 0. 00000   |   | 0               | 50.00   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C            | 10, 237        | 1, 977, 547    |            |   | 279             | 54.00   |
| 60. 00   06000   LABORATORY                         | 46, 155        |                |            |   | 1, 297          | 60.00   |
| 65. 00 06500 RESPIRATORY THERAPY                    | 12, 618        |                |            |   | 450             | 65.00   |
| 66. 00 06600 PHYSI CAL THERAPY                      | 192, 265       |                |            |   | 3, 655          |         |
| 66. 01 06601 PHYSI CAL THERAPY - CARMEL             | 313            | 270, 230       |            |   | 0               | 66. 01  |
| 67. 00  06700 OCCUPATI ONAL THERAPY                 | 185, 994       |                |            |   | 4, 130          | 67.00   |
| 68.00 06800 SPEECH PATHOLOGY                        | 100, 049       | 10, 058, 042   |            |   | 2, 377          | 68. 00  |
| 68. 01   06801   VI SI ON                           | 0              | 0              | 0. 00000   |   | 0               | 68. 01  |
| 68. 02   06802   FAC   RESOURCE                     | 6, 357         | 678, 580       |            |   | 0               | 68. 02  |
| 69. 00 06900 ELECTROCARDI OLOGY                     | 0              | 0              | 0. 00000   |   | 0               | 69. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 916            | 2, 278, 976    |            |   | 22              | 71.00   |
| 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS          | 0              | 0              | 0. 00000   | 0   | 0               | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 50, 608        | 12, 795, 249   | 0. 00395   | 5 217, 759                                  | 861             | 73.00   |
| 74. 00   07400   RENAL DI ALYSI S                   | 0              | 0              | 0.00000    |   | 0               | 74.00   |
| 77.00 07700 ALLOGENEIC HSCT ACQUISITION             | 0              | 0              | 0.00000    | 0 0   | 0               | 77. 00  |
| OUTPATIENT SERVICE COST CENTERS                     |                |                |            |   |                 |         |
| 90. 00  09000   CLI NI C                            | 91, 922        | 1, 984, 909    | 0. 04631   | 0   | 0               | 90.00   |
| 90. 01   09001   SLEEP CENTER                       | 0              | 0              | 0.00000    | 0   | 0               | 90. 01  |
| 91. 00   09100   EMERGENCY                          | 0              | 0              | 0.00000    | 0   | 0               | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART     | 0              | 0              | 0.00000    | 0   | 0               | 92.00   |
| 200.00 Total (lines 50 through 199)                 | 697, 434       | 73, 147, 924   |            | 1, 511, 379                                 | 13, 071         | 200. 00 |

| Heal th Finar           | ncial Systems REF                                   | HABILITATION HOS                                      | PITAL OF INDIA      | ANA   | In Lie                                      | u of Form CMS-                    | 2552-10           |
|-------------------------|---|---|---------------------|---|---|-----------------------------------|-------------------|
| APPORTI ONME            | NT OF INPATIENT ROUTINE SERVICE OTHER I             | PASS THROUGH COS                                      | TS Provider C       |   | Period:<br>From 01/01/2022<br>To 12/31/2022 |                                   | epared:<br>31 am  |
|                         |   |   |                     | e XIX   | Hospi tal                                   | PPS                               |                   |
|                         | Cost Center Description                             | Nursing<br>Program<br>Post-Stepdown                   | Nursi ng<br>Program | Allied Health<br>Post-Stepdown<br>Adjustments | Allied Health<br>Cost                       | All Other<br>Medical<br>Education |                   |
|                         |   | Adj ustments  | 1.00                |   |   | Cost                              |                   |
| LAIDAT                  | LENT DOUTLINE CERVI OF COCT CENTERS                 | 1A  | 1.00                | 2A  | 2. 00                                       | 3. 00                             |                   |
|                         | IENT ROUTINE SERVICE COST CENTERS                   | 1   |                     |   |   |                                   |                   |
| 30. 00 03000<br>200. 00 | ADULTS & PEDIATRICS<br>Total (lines 30 through 199) | 0   |                     |   | 0   | 0                                 | 30. 00<br>200. 00 |
| 200.00                  | Cost Center Description                             | Swi ng-Bed  | Total Costs         | Total Patien                                  | Per Diem                                    | Inpatient                         | 200.00            |
|                         | Cost Center Description                             | Adjustment  | (sum of cols.       | Days  | (col. 5 ÷                                   | Program Days                      |                   |
|                         |   | Amount (see   | 1 through 3,        |   | col. 6)                                     | l og. a bajo                      |                   |
|                         |   |   | minus col. 4)       |   |   |                                   |                   |
|                         |   | 4. 00   | 5. 00               | 6.00  | 7. 00                                       | 8. 00                             |                   |
| I NPAT                  | IENT ROUTINE SERVICE COST CENTERS                   |   |                     |   |   |                                   |                   |
| 30.00 03000             | ADULTS & PEDIATRICS                                 | 0   | C                   | 18, 73  | 4 0.00                                      | 534                               | 30.00             |
| 200. 00                 | Total (lines 30 through 199)                        |   | C                   | 18, 73  | 4   | 534                               | 200.00            |
|                         | Cost Center Description                             | Inpatient Program Pass-Through Cost (col. 7 x col. 8) |                     |   |   |                                   |                   |
| LAIDAT                  | LENT POUTLINE CERVILOE COCT CENTERS                 | 9. 00   |                     |   |   |                                   |                   |
|                         | I ENT ROUTI NE SERVI CE COST CENTERS                |   | I                   |   |   |                                   | 20.00             |
| 30. 00 03000<br>200. 00 | ADULTS & PEDLATRICS<br>Total (lines 30 through 199) | 0   | ŀ                   |   |   |                                   | 30. 00<br>200. 00 |
| 200.00                  | Tiotal (Titles 30 through 199)                      | 1   | I                   |   |   |                                   | 1200.00           |

| Peri od: | Worksheet D | From 01/01/2022 | Part IV | To | 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | Date/Time Pre THROUGH COSTS

|                                      |                 |            |             |          |               | 5/31/2023 9: 3 <sup>2</sup> | 1 am   |
|--------------------------------------|-----------------|------------|-------------|----------|---------------|-----------------------------|--------|
|                                      |                 |            |             | e XIX    | Hospi tal     | PPS                         |        |
| Cost Center Descripti                | on Non Pl       | hysi ci an | Nursi ng    | Nursi ng | Allied Health | Allied Health               |        |
|                                      | Anes            | thetist    | Program     | Program  | Post-Stepdown |                             |        |
|                                      | C               | cost Pos   | st-Stepdown |          | Adjustments   |                             |        |
|                                      |                 | Ac         | djustments  |          |               |                             |        |
|                                      |                 | . 00       | 2A          | 2. 00    | 3A            | 3. 00                       |        |
| ANCILLARY SERVICE COST CEN           | TERS            |            |             |          |               |                             |        |
| 50.00 05000 OPERATING ROOM           |                 | 0          | 0           | 0        | 0             | 0                           | 50.00  |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C |                 | 0          | 0           | 0        | 0             | 0                           | 54.00  |
| 60. 00   06000   LABORATORY          |                 | 0          | 0           | 0        | 0             | 0                           | 60.00  |
| 65. 00 06500 RESPIRATORY THERAPY     |                 | 0          | 0           | 0        | 0             | 0                           | 65.00  |
| 66.00 06600 PHYSI CAL THERAPY        |                 | o          | o           | 0        | 0             | 0                           | 66.00  |
| 66. 01 06601 PHYSI CAL THERAPY - CA  | ARMEL           | o          | o           | 0        | 0             | 0                           | 66.01  |
| 67. 00 06700 OCCUPATIONAL THERAPY    |                 | o          | o           | 0        | 0             | 0                           | 67.00  |
| 68.00 06800 SPEECH PATHOLOGY         |                 | o          | o           | 0        | 0             | 0                           | 68.00  |
| 68. 01   06801   VI SI ON            |                 | o          | o           | 0        | o             | 0                           | 68. 01 |
| 68. 02   06802   FAC   RESOURCE      |                 | o          | o           | 0        | o             | 0                           | 68. 02 |
| 69. 00 06900 ELECTROCARDI OLOGY      |                 | o          | o           | 0        | o             | 0                           | 69.00  |
| 71.00 07100 MEDICAL SUPPLIES CHAF    | RGED TO PATIENT | o          | o           | 0        | o             | 0                           | 71.00  |
| 72.00 07200 I MPL. DEV. CHARGED TO   | ) PATIENTS      | o          | o           | 0        | o             | 0                           | 72.00  |
| 73.00 07300 DRUGS CHARGED TO PATI    | ENTS            | o          | o           | 0        | o             | 0                           | 73.00  |
| 74.00 07400 RENAL DIALYSIS           |                 | o          | o           | 0        | o             | 0                           | 74.00  |
| 77.00 07700 ALLOGENEIC HSCT ACQUI    | SITION          | o          | o           | 0        | o             | 0                           | 77.00  |
| OUTPATIENT SERVICE COST CE           | NTERS           |            | •           |          |               |                             |        |
| 90. 00 09000 CLI NI C                |                 | 0          | 0           | 0        | 0             | 0                           | 90.00  |
| 90. 01 09001 SLEEP CENTER            |                 | o          | ol          | 0        | o             | 0                           | 90.01  |
| 91. 00 09100 EMERGENCY               |                 | o          | ol          | 0        | o             | 0                           | 91.00  |
| 92.00 09200 OBSERVATION BEDS (NO     | N-DISTINCT PART | o          |             | 0        |               | 0                           | 92.00  |
| 200.00 Total (lines 50 throu         |                 | o          | o           | 0        | o             | 0                           | 200.00 |
| ,                                    |                 |            | '           | ,        | '             |                             |        |

| Health Financial Systems              | REHABILITATION HOSPITAL OF INDIANA |                       | ITAL OF INDIANA In Lieu of Form ( |             |
|---------------------------------------|------------------------------------|-----------------------|-----------------------------------|-------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT | ANCILLARY SERVICE OTHER PASS       | Provider CCN: 15-3028 | Peri od:                          | Worksheet D |

From 01/01/2022 Part IV To 12/31/2022 Date/Tim THROUGH COSTS Date/Time Prepared: 5/31/2023 9:31 am Title XIX Hospi tal Cost Center Description All Other Total Charges Ratio of Cost Total Cost Total to Charges Medi cal (sum of cols. Outpati ent (from Wkst. Educati on 1, 2, 3, and Cost (sum of C, Part I, (col. 5 ÷ 4) Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 4. 00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0.000000 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 1, 977, 547 0.000000 54.00 54.00 0 0 0 0 0 0 0 0 0 0 0 0 06000 LABORATORY 1, 929, 989 0 0.000000 60.00 60.00 0 06500 RESPIRATORY THERAPY 0 0 65.00 2, 982, 838 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 19, 368, 971 0.000000 66.00 06601 PHYSI CAL THERAPY - CARMEL 0 270, 230 0.000000 66.01 66.01 Ol 06700 OCCUPATI ONAL THERAPY 18, 822, 593 67.00 0 0.000000 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 10, 058, 042 0.000000 68.00 68.01 06801 VI SI ON 0.000000 68.01 06802 FAC RESOURCE 0 678, 580 0.000000 68.02 68.02 06900 ELECTROCARDI OLOGY 0 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 278, 976 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0.000000 72.00 0 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 12, 795, 249 0.000000 73 00 0 74.00 07400 RENAL DIALYSIS 0 0.000000 74.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0.000000 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 0 0 0 0 0 n 1, 984, 909 0.000000 90 00 09000 CLI NI C 0 09001 SLEEP CENTER 90.01 0 0.000000 90.01 91. 00 09100 EMERGENCY 0 0.000000 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 ol 0.000000 92.00

0

73, 147, 924

200.00

200.00

Total (lines 50 through 199)

| Health Financial Systems              | REHABILITATION HOSPITAL OF INDIANA |                       | ITAL OF INDIANA In Lieu of Form ( |             |
|---------------------------------------|------------------------------------|-----------------------|-----------------------------------|-------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT | ANCILLARY SERVICE OTHER PASS       | Provider CCN: 15-3028 | Peri od:                          | Worksheet D |

From 01/01/2022 To 12/31/2022 Part IV THROUGH COSTS Date/Time Prepared: 5/31/2023 9:31 am Title XIX Hospi tal PPS Cost Center Description Outpati ent I npati ent Outpati ent I npati ent Outpati ent Ratio of Cost Program Program Program Program to Charges Pass-Through Pass-Through Charges Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col . 12) x col. 10) 9. 00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0.000000 50.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 53, 802 4, 992 0 54.00 06000 LABORATORY 0.000000 54, 250 0 60.00 60.00 0 0 06500 RESPIRATORY THERAPY 0.000000 0 65.00 106, 387 65.00 0 0 0 06600 PHYSI CAL THERAPY 0.000000 66.00 368, 187 393, 058 0 66.00 66.01 06601 PHYSI CAL THERAPY - CARMEL 0.000000 0 0 66.01 67.00 06700 OCCUPATI ONAL THERAPY 0. 000000 417, 944 0 260, 404 67.00 06800 SPEECH PATHOLOGY 0 0.000000 223, 841 68.00 238, 963 0 68.00 68.01 06801 VI SI ON 0.000000 C 0 0 68.01 68.02 06802 FAC RESOURCE 0.000000 68.02 06900 ELECTROCARDI OLOGY 0 69.00 0.000000 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0.000000 71.00 71.00 54, 087 5, 790 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 73.00 73.00 217, 759 107, 966 07400 RENAL DIALYSIS 0 74.00 0.000000 0 74.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 167, 743 0 90.00 0 90. 01 09001 SLEEP CENTER 0.000000 90.01 C 0 91.00 09100 EMERGENCY 0.000000 0 0 0 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.000000 0

1, 511, 379

1, 163, 794

0 200.00

200.00

Total (lines 50 through 199)

| Health Financial Systems REHA                       | ABILITATION HOS | SPITAL OF INDIA | NA            | In Lie                                      | u of Form CMS-2             | 2552-10 |
|---|-----------------|-----------------|---------------|---|-----------------------------|---------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST    | Provi der C     |               | Period:<br>From 01/01/2022<br>To 12/31/2022 | Date/Time Pre 5/31/2023 9:3 |         |
|   |                 | Titl            | e XIX         | Hospi tal                                   | PPS                         |         |
|   |                 |                 | Charges       |   | Costs                       |         |
| Cost Center Description                             | Cost to         | PPS             | Cost          | Cost  | PPS Services                |         |
|   | Charge Ratio    | Rei mbursed     | Rei mbursed   | Rei mbursed                                 | (see inst.)                 |         |
|   | From            | Services (see   | Servi ces     | Servi ces Not                               |                             |         |
|   | Worksheet C,    | inst.)          | Subject To    | Subj ect To                                 |                             |         |
|   | Part I, col.    |                 | Ded. & Coins. |   |                             |         |
|   | 9               |                 | (see inst.)   | (see inst.)                                 |                             |         |
|   | 1. 00           | 2. 00           | 3. 00         | 4. 00                                       | 5. 00                       |         |
| ANCILLARY SERVICE COST CENTERS                      |                 |                 |               |   |                             | 1       |
| 50.00 05000 OPERATING ROOM                          | 0. 000000       |                 | 1             | 0   | 0                           |         |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C            | 0. 178795       |                 |               | 0   | 893                         |         |
| 60. 00   06000   LABORATORY                         | 0. 315498       |                 | 1             | 0   | 0                           |         |
| 65. 00 06500 RESPI RATORY THERAPY                   | 0. 382110       |                 | 1             | 0   | 0                           |         |
| 66. 00 06600 PHYSI CAL THERAPY                      | 0. 228207       |                 |               | 0   | 89, 699                     |         |
| 66. 01   06601 PHYSI CAL THERAPY - CARMEL           | 0. 476239       |                 | 1             | 0   | 0                           |         |
| 67. 00   06700 OCCUPATI ONAL THERAPY                | 0. 211369       |                 |               | 0   | 55, 041                     |         |
| 68. 00   06800   SPEECH PATHOLOGY                   | 0. 231619       |                 |               | 0   | 51, 846                     |         |
| 68. 01   06801   VI SI ON                           | 0. 000000       |                 | 1             | 0   | 0                           | 00.0.   |
| 68. 02   06802   FAC   RESOURCE                     | 2. 874752       |                 | 1             | 0   | 0                           | 00.02   |
| 69. 00   06900   ELECTROCARDI OLOGY                 | 0. 000000       |                 | 1             | 0   | 0                           |         |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 0. 239397       | 5, 790          |               | 0   | 1, 386                      | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 0. 000000       | 0               |               | 0   | 0                           | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 0. 263793       | 107, 966        |               | 0   | 28, 481                     | 73.00   |
| 74.00 07400 RENAL DIALYSIS                          | 0. 000000       | 0               |               | 0   | 0                           | 74.00   |
| 77.00 07700 ALLOGENEIC HSCT ACQUISITION             | 0. 000000       | 0               |               | 0 0   | 0                           | 77. 00  |
| OUTPATIENT SERVICE COST CENTERS                     |                 |                 |               |   |                             |         |
| 90. 00 09000 CLI NI C                               | 0. 322683       | 167, 743        |               | 0 0   | 54, 128                     | 90.00   |
| 90. 01   09001   SLEEP CENTER                       | 0. 000000       | 0               |               | 0   | 0                           | 90. 01  |
| 91. 00   09100   EMERGENCY                          | 0. 000000       | 0               |               | 0   | 0                           | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART     | 0. 000000       | 0               |               | 0   | 0                           | 92.00   |
| 200.00 Subtotal (see instructions)                  |                 | 1, 163, 794     |               | 0   | 281, 474                    | 200.00  |
| 201.00 Less PBP Clinic Lab. Services-Program        |                 |                 |               | 0 0   |                             | 201.00  |
| Only Charges  |                 |                 |               |   |                             |         |
| 202.00 Net Charges (line 200 - line 201)            |                 | 1, 163, 794     | .[            | 0 0   | 281, 474                    | 202.00  |

| Period: | Worksheet D | From 01/01/2022 | Part V | To | 12/31/2022 | Date/Time | Prepared:

|   |               |               | Т     | o 12/31/2022 | Date/Time Prepared: 5/31/2023 9:31 am |   |
|---|---------------|---------------|-------|--------------|---------------------------------------|---|
|   |               | Ti tl         | e XIX | Hospi tal    | PPS                                   | _ |
|   | Cos           | sts           |       |              |                                       |   |
| Cost Center Description   | Cost          | Cost          | 1     |              |                                       |   |
|   | Rei mbursed   | Rei mbursed   |       |              |                                       |   |
|   | Servi ces     | Servi ces Not |       |              |                                       |   |
|   | Subject To    | Subject To    |       |              |                                       |   |
|   | Ded. & Coins. | Ded. & Coins. |       |              |                                       |   |
|   | (see inst.)   | (see inst.)   |       |              |                                       |   |
|   | 6. 00         | 7. 00         |       |              |                                       |   |
| ANCILLARY SERVICE COST CENTERS  |               |               |       |              |                                       |   |
| 50. 00   05000   OPERATI NG 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             |       |              | 66.00                                 |   |
| 66. 01 06601 PHYSI CAL THERAPY - CARMEL                                   | 0             | 0             | )     |              | 66. 01                                |   |
| 67. 00 06700 OCCUPATI ONAL THERAPY  | 0             | 0             | )     |              | 67.00                                 |   |
| 68.00 06800 SPEECH PATHOLOGY  | 0             | 0             | )     |              | 68.00                                 |   |
| 68. 01   06801   VI SI ON   | 0             | 0             | )     |              | 68. 01                                |   |
| 68. 02   06802   FAC RESOURCE   | 0             | 0             | )     |              | 68. 02                                |   |
| 69. 00 06900 ELECTROCARDI OLOGY   | 0             | 0             | )     |              | 69.00                                 |   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                           | 0             | 0             | )     |              | 71.00                                 |   |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS                              | 0             | 0             | )     |              | 72.00                                 |   |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS                                    | 0             | 0             | )     |              | 73.00                                 |   |
| 74. 00   07400   RENAL DI ALYSI S   | 0             | 0             | 1     |              | 74.00                                 |   |
| 77. 00 07700 ALLOGENEI C HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS | ] 0           | 0             | )     |              | 77.00                                 | J |
| 90. 00   09000   CLINIC   | 1 0           | 0             | \     |              | 90.00                                 | ^ |
| 90. 01   09000  CLINIC<br>90. 01   09001  SLEEP CENTER                    | 0             |               | 1     |              | 90.00                                 |   |
| 91. 00   09100   EMERGENCY  |               |               |       |              | 91.00                                 |   |
| 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART                      |               |               |       |              | 92.00                                 |   |
| 200.00 Subtotal (see instructions)  |               |               | 1     |              | 200.00                                |   |
| 201. 00 Less PBP Clinic Lab. Services-Program                             |               |               | Ί     |              | 201.00                                |   |
| Only Charges  |               |               |       |              | 201.00                                | J |
| 202.00 Net Charges (line 200 - line 201)                                  | 0             | 0             |       |              | 202.00                                | Ω |
| 202.00  | 1             | 1             | Ί     |              | 1202.00                               | _ |

| Health Financial Systems                | REHABILITATION HOSPITAL OF INDIANA | In Lie                                       | u of Form CMS-2       | 2552-10 |
|---|------------------------------------|--|-----------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 15-3028             | Peri od:<br>From 01/01/2022<br>To 12/31/2022 | Date/Time Pre         |         |
|   | Title XVIII                        | Hospi tal                                    | 5/31/2023 9: 3<br>PPS | 1 am    |
| Cost Center Description                 |                                    |  |                       |         |
|   |                                    |  | 1. 00                 |         |
| PART I - ALL PROVIDER COMPONENTS        |                                    |  |                       |         |

| -                |  | Title XVIII                    | Hospi tal                               | 5/31/2023 9: 3<br>PPS | ı allı           |
|------------------|--|--------------------------------|---|-----------------------|------------------|
|                  | Cost Center Description  |                                |   |                       |                  |
|                  | DART I ALL DROUBER COMPONENTS  |                                |   | 1. 00                 |                  |
|                  | PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS  |                                |   |                       |                  |
| 1.00             | Inpatient days (including private room days and swing-bed day  | s, excluding newborn)          |   | 18, 734               | 1.00             |
| 2.00             | Inpatient days (including private room days, excluding swing-  |                                |   | 18, 734               | 2.00             |
| 3.00             | Private room days (excluding swing-bed and observation bed da  | ys). If you have only pr       | ivate room days,                        | 0                     | 3. 00            |
| 4. 00            | do not complete this line.  Semi-private room days (excluding swing-bed and observation b  | ed days)                       |   | 18, 734               | 4. 00            |
| 5. 00            | Total swing-bed SNF type inpatient days (including private ro  |                                | r 31 of the cost                        | •                     | 5. 00            |
|                  | reporting period   | 3 / 3                          |   |                       |                  |
| 6.00             | Total swing-bed SNF type inpatient days (including private ro  | om days) after December        | 31 of the cost                          | 0                     | 6. 00            |
| 7. 00            | reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo          | m days) through Docombor       | 21 of the cost                          | 0                     | 7. 00            |
| 7.00             | reporting period   | iii days) tiii dugii beceiibei | 31 Of the Cost                          | 0                     | 7.00             |
| 8.00             | Total swing-bed NF type inpatient days (including private roo  | m days) after December 3       | 1 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 newborn days) (see instructions)                                   | o the Program (excluding       | swing-bed and                           | 5, 542                | 9. 00            |
| 10.00            | Swing-bed SNF type inpatient days applicable to title XVIII o  | nly (including private r       | oom days)                               | 0                     | 10. 00           |
|                  | through December 31 of the cost reporting period (see instruc  | tions)                         | ,                                       |                       |                  |
| 11. 00           | Swing-bed SNF type inpatient days applicable to title XVIII o  |                                | oom days) after                         | 0                     | 11. 00           |
| 12. 00           | December 31 of the cost reporting period (if calendar year, e<br>Swing-bed NF type inpatient days applicable to titles V or XI   |                                | e room days)                            | 0                     | 12. 00           |
| 12.00            | through December 31 of the cost reporting period   | X only (Therearing private     | c room days)                            |                       | 12.00            |
| 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  |                                |   | 0                     | 14.00            |
| 14. 00<br>15. 00 | Medically necessary private room days applicable to the Progr<br>Total nursery days (title V or XIX only)                        | am (excluding swing-bed        | days)                                   | 0                     | 14. 00<br>15. 00 |
| 16. 00           | Nursery days (title V or XIX only)   |                                |   | 0                     | 16. 00           |
|                  | SWING BED ADJUSTMENT   |                                |   |                       |                  |
| 17. 00           | Medicare rate for swing-bed SNF services applicable to service   | es through December 31 c       | f the cost                              | 0. 00                 | 17. 00           |
| 18. 00           | reporting period Medicare rate for swing-bed SNF services applicable to service  | es after December 31 of        | the cost                                | 0.00                  | 18. 00           |
|                  | reporting period   |                                |   |                       |                  |
| 19. 00           | Medicaid rate for swing-bed NF services applicable to service  | s through December 31 of       | the cost                                | 0. 00                 | 19. 00           |
| 20. 00           | reporting period Medicaid rate for swing-bed NF services applicable to service   | s after December 31 of t       | he cost                                 | 0. 00                 | 20. 00           |
|                  | reporting period   |                                |   |                       |                  |
| 21.00            | Total general inpatient routine service cost (see instruction  |                                |   | 23, 125, 805          |                  |
| 22. 00           | Swing-bed cost applicable to SNF type services through Decemb $5 \times 1$ ine 17)   | er 31 of the cost report       | ing period (line                        | 0                     | 22. 00           |
| 23. 00           | Swing-bed cost applicable to SNF type services after December  | 31 of the cost reportin        | g period (line d                        | 0                     | 23. 00           |
|                  | x line 18)   | ·                              |   |                       |                  |
| 24. 00           | Swing-bed cost applicable to NF type services through Decembe $ 7 \times  $ Line 19)   | r 31 of the cost reporti       | ng period (line                         | 0                     | 24. 00           |
| 25. 00           | Swing-bed cost applicable to NF type services after December   | 31 of the cost reporting       | period (line 8                          | 0                     | 25. 00           |
|                  | x line 20)   | ar ar arra again apar ar ng    | ( |                       |                  |
| 26.00            | Total swing-bed cost (see instructions)  | (1)                            |   | 0                     | 26.00            |
| 27. 00           | General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT                                | (line 21 minus line 26)        |   | 23, 125, 805          | 27.00            |
| 28. 00           | General inpatient routine service charges (excluding swing-be  | d and observation bed ch       | arges)                                  | 0                     | 28. 00           |
| 29. 00           | Private room charges (excluding swing-bed charges)   |                                |   | 0                     | 29. 00           |
| 30.00            | Semi-private room charges (excluding swing-bed charges)  |                                |   | 0                     | 30.00            |
| 31. 00           | General inpatient routine service cost/charge ratio (line 27   | ÷ line 28)                     |   | 0. 000000             |                  |
| 32.00            | Average private room per diem charge (line 29 ÷ line 3)  |                                |   | 0.00                  |                  |
| 33.00            | Average semi-private room per diem charge (line 30 ÷ line 4)   | 20) (                          |   | 0.00                  |                  |
| 34.00            | Average per diem private room charge differential (line 32 mi  |                                | u ons)                                  | 0.00                  |                  |
| 35.00            | Average per diem private room cost differential (line 34 x li  | 116 31)                        |   | 0.00                  |                  |
| 36. 00<br>37. 00 | Private room cost differential adjustment (line 3 x line 35)<br>General inpatient routine service cost net of swing-bed cost     | and private room cost di       | fferential (line                        | 0<br>23, 125, 805     | 36. 00<br>37. 00 |
| 37.00            | 27 minus line 36)  | and private room cost di       | Trefelitial (Tille                      | 23, 123, 603          | 37.00            |
|                  | PART II - HOSPITAL AND SUBPROVIDERS ONLY   |                                |   |                       |                  |
|                  | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ  |                                |   |                       |                  |
| 38. 00           | Adjusted general inpatient routine service cost per diem (see  | •                              |   | 1, 234. 43            |                  |
| 39.00            | Program general inpatient routine service cost (line 9 x line  | •                              |   | 6, 841, 211           |                  |
| 40. 00<br>41. 00 | Medically necessary private room cost applicable to the Programal Total Program general inpatient routine service cost (line 39) | ,                              |   | 0<br>6, 841, 211      | 40. 00<br>41. 00 |
| 00               | 1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.   |                                | ı                                       | 3,511,211             | 00               |

| MPUT           | ATION OF INPATIENT OPERATING COST   |   | Provi der (                | CCN: 15-3028                           | Peri od:<br>From 01/01/2022<br>To 12/31/2022 |                                      | epared     |
|----------------|---|---|----------------------------|--|--|--------------------------------------|------------|
|                |   |   | Titl                       | e XVIII                                | Hospi tal                                    | 5/31/2023 9: 3<br>PPS                | 81 am      |
|                | Cost Center Description   | Total<br>Inpatient<br>Cost                                      | Total<br>Inpatient<br>Days | Average Per<br>Diem (col.<br>÷ col. 2) |  | Program Cost<br>(col. 3 x<br>col. 4) |            |
| 00             | NURSERY (title V & XIX only)  | 1. 00   | 2.00                       | 3. 00                                  | 4. 00  | 5. 00                                | 42.0       |
| . 00           | Intensive Care Type Inpatient Hospital Units  |   |                            |  |  |                                      | 42.0       |
| 3. 00          | INTENSIVE CARE UNIT   |   |                            |  |  |                                      | 43.0       |
| i. 00          | CORONARY CARE UNIT BURN INTENSIVE CARE UNIT   |   |                            |  |  |                                      | 44.0       |
| . 00           | SURGICAL INTENSIVE CARE UNIT  |   |                            |  |  |                                      | 46.0       |
| . 00           | OTHER SPECIAL CARE (SPECIFY)  |   |                            |  |  |                                      | 47.0       |
|                | Cost Center Description   |   |                            |  |  | 1. 00                                |            |
| 3. 00          | Program inpatient ancillary service cost (Wks   | st. D-3, col.   | 3, line 200)               |  |  | 3, 741, 639                          | 48.0       |
| 3. 01          | Program inpatient cellular therapy acquisition  | on cost (Works  | heet D-6, Par              |  | , column 1)                                  | 0                                    |            |
| 0. 00          | Total Program inpatient costs (sum of lines A<br>PASS THROUGH COST ADJUSTMENTS  | 41 through 48.  | 01)(see instru             | uctions)                               |  | 10, 582, 850                         | 49. (      |
| 0. 00          | Pass through costs applicable to Program inpa   | atient routine  | services (fro              | om Wkst. D, su                         | m of Parts I and                             | 382, 897                             | 50.0       |
|                |   |   |                            |  | 6.5  |                                      | ,          |
| . 00           | Pass through costs applicable to Program inpa<br>and IV)  | allent ancilla  | ry services (1             | rom WKSt. D,                           | sum or Parts II                              | 133, 043                             | 51.0       |
| 2. 00          | Total Program excludable cost (sum of lines!  | 50 and 51)  |                            |  |  | 515, 940                             | 52.0       |
| 8. 00          | Total Program inpatient operating cost exclu  |   | el ated, non-pl            | nysician anest                         | hetist, and                                  | 10, 066, 910                         | 53.0       |
|                | medical education costs (line 49 minus line !<br>TARGET AMOUNT AND LIMIT COMPUTATION  | 52)   |                            |  |  |                                      | -          |
| . 00           | Program di scharges   |   |                            |  |  | 0                                    | 54.        |
| . 00           | Target amount per discharge   |   |                            |  |  | 0.00                                 |            |
| . 01<br>. 02   | Permanent adjustment amount per discharge<br>Adjustment amount per discharge (contractor)   | (v lno azı  |                            |  |  | 0. 00<br>0. 00                       |            |
| . 00           | Target amount (line 54 x sum of lines 55, 55.   |   | )                          |  |  | 0.00                                 | 1          |
| . 00           | Difference between adjusted inpatient operati   | ng cost and t   | arget amount               | (line 56 minus                         | line 53)                                     | 0                                    |            |
| 3. 00<br>9. 00 | Bonus payment (see instructions)<br>Trended costs (lesser of line 53 ÷ line 54, o   | or lino 55 fro  | m the cost re              | porting poriod                         | anding 1006                                  | 0<br>0. 00                           |            |
| . 00           | updated and compounded by the market basket)  | or title 33 tro   | iii the cost rep           | or tring period                        | enaring 1770,                                | 0.00                                 | 37.        |
| 0. 00          |   | line 54, or line 55 from prior year cost report, updated by the |                            |  |  |                                      |            |
| . 00           | market basket)  Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) |   |                            |  |  | 0                                    | 61.        |
| 2. 00          | Relief payment (see instructions)   |   |                            |  |  | 0                                    | 62.        |
| . 00           | Allowable Inpatient cost plus incentive payme   | ent (see instr  | ucti ons)                  |  |  | 0                                    | 63.        |
| 00             | PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos   | ts through Dec  | ember 31 of th             | ne cost renort                         | ing period (See                              | 0                                    | 64.        |
| . 00           | instructions)(title XVIII only)   | ts through bee  | ciliber 31 01 ti           | ic cost report                         | riig perrou (see                             |                                      | 04.        |
| . 00           | Medicare swing-bed SNF inpatient routine cos  | ts after Decem  | ber 31 of the              | cost reportin                          | g period (See                                | 0                                    | 65.        |
| . 00           | instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi  | ne costs (line  | 64 plus line               | 65)(title XVI                          | II only): for                                | 0                                    | 66.        |
|                | CAH, see instructions   |   |                            |  |  |                                      |            |
| . 00           | Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)   | e costs throug  | h December 31              | of the cost r                          | eporting period                              | 0                                    | 67.        |
| . 00           | Title V or XIX swing-bed NF inpatient routing   | e costs after   | December 31 of             | f the cost rep                         | orting period                                | 0                                    | 68.        |
|                | (line 13 x line 20)<br>Total title V or XIX swing-bed NF inpatient (  | couting costs   | (lipo 47 : lir             | 20 49)                                 |  | 0                                    | 69.        |
| . 00           | PART III - SKILLED NURSING FACILITY, OTHER NU   | JRSING FACILIT  | Y, AND ICF/II              | ONLY                                   |  | J                                    | 07.        |
| . 00           | Skilled nursing facility/other nursing facili   |   |                            |  | )  |                                      | 70.        |
| . 00           | Adjusted general inpatient routine service co<br>Program routine service cost (line 9 x line  | ,   | line /U ÷ line             | e 2)                                   |  |                                      | 71.        |
| . 00           | Medically necessary private room cost applica   |   | m (line 14 x l             | ine 35)                                |  |                                      | 73.        |
| . 00           | Total Program general inpatient routine servi   |   |                            | *                                      | B  |                                      | 74.        |
| . 00           | Capital-related cost allocated to inpatient (26, line 45)   | routine servic  | e costs (from              | worksneet B,                           | Part II, column                              |                                      | 75.        |
| . 00           | Per diem capital-related costs (line 75 ÷ li  | ne 2)   |                            |  |  |                                      | 76.        |
| . 00           | Program capital -related costs (line 9 x line   |   |                            |  |  |                                      | 77.        |
| . 00           | Inpatient routine service cost (line 74 minus<br>Aggregate charges to beneficiaries for excess  |   | provi der recoi            | rds)                                   |  |                                      | 78.<br>79. |
| . 00           | Total Program routine service costs for compa   |   |                            |  | nus line 79)                                 |                                      | 80.        |
| . 00           | Inpatient routine service cost per diem limi  |   | 1)                         |  |  |                                      | 81.        |
| 2. 00          | Inpatient routine service cost limitation (li<br>Reasonable inpatient routine service costs (:  |   | *                          |  |  |                                      | 82.<br>83. |
| . 00           | Program inpatient ancillary services (see in  |   | ~/                         |  |  |                                      | 84.        |
| 00             | , , , , , ,   |   |                            |  |  |                                      | 85.        |
|                | Total Program inpatient operating costs (sum  |   | ııı ouyn 85)               |  |  |                                      | 86.        |
| s. 00          | PART IV - COMPUTATION OF OBSERVATION BED PASS   | S THROUGH COST  |                            |  |  |                                      |            |

| Health Financial Systems REHA                      | nancial Systems REHABILITATION HOSPITAL OF INDIANA In Lieu |              |            |                                  |               | 2552-10 |
|--|--|--------------|------------|----------------------------------|---------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST            |  | Provi der CC |            | Peri od:                         | Worksheet D-1 |         |
|  |  |              |            | From 01/01/2022<br>To 12/31/2022 |               |         |
|  |  | Title        | XVIII      | Hospi tal                        | PPS           |         |
| Cost Center Description                            |  |              |            |                                  |               |         |
|  |  |              |            |                                  | 1. 00         |         |
| 89.00 Observation bed cost (line 87 x line 88) (se | e instructions   | )            |            |                                  | 0             | 89. 00  |
| Cost Center Description                            | Cost   | Routine Cost | column 1 ÷ | Total                            | Observati on  |         |
|  |  | (from line   | column 2   | Observati on                     | Bed Pass      |         |
|  |  | 21)          |            | Bed Cost                         | Through Cost  |         |
|  |  | ·            |            | (from line                       | (col. 3 x     |         |
|  |  |              |            | 89)                              | col. 4) (see  |         |
|  |  |              |            |                                  | instructions) |         |
|  | 1. 00  | 2.00         | 3. 00      | 4. 00                            | 5. 00         |         |
| COMPUTATION OF OBSERVATION BED PASS THROUGH        | COST   |              |            |                                  |               |         |
| 90.00 Capital -related cost                        | 1, 294, 277  | 23, 125, 805 | 0. 05596   | 7 0                              | 0             | 90.00   |
| 91.00 Nursing Program cost                         | 0  | 23, 125, 805 | 0.00000    | 0                                | 0             | 91.00   |
| 92.00 Allied health cost                           | 0  | 23, 125, 805 | 0.00000    | 0                                | 0             | 92.00   |
| 93.00 All other Medical Education                  | 0  | 23, 125, 805 | 0.00000    | 0                                | 0             | 93.00   |
|  |  |              |            |                                  |               |         |

| Health Financial Systems                   | REHABILITATION HOSPITAL OF INDIANA            | In Lie                                       | u of Form CMS-2                           | 2552-10 |
|--|---|--|---|---------|
| COMPUTATION OF INPATIENT OPERATING COST    | Provi der CCN: 15-3028                        | Peri od:<br>From 01/01/2022<br>To 12/31/2022 | Worksheet D-1 Date/Time Pre 5/31/2023 9:3 |         |
|  | Title XIX                                     | Hospi tal                                    | PPS                                       |         |
| Cost Center Description                    |   |  |   |         |
| ·  |   |  | 1. 00                                     |         |
| PART I - ALL PROVIDER COMPONENTS           |   |  |   |         |
| I NPATI ENT DAYS                           |   |  |   |         |
| 1 00 Inpatient days (including private roo | om days and swing-bed days excluding newborn) |  | 18 734                                    | 1 00    |

|                  |   | Title XIX Hospital                           | PPS           |                  |
|------------------|---|--|---------------|------------------|
|                  | Cost Center Description   |  | 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)                       | 18, 734       | 1.00             |
| 2.00             | Inpatient days (including private room days, excluding swing-   |  | 18, 734       | 2.00             |
| 3.00             | Private room days (excluding swing-bed and observation bed days   | ays). If you have only private room days     | , 0           | 3.00             |
|                  | do not complete this line.  |  | 10 701        |                  |
| 4.00             | Semi-private room days (excluding swing-bed and observation to  |  | 18, 734       | 4.00             |
| 5. 00            | Total swing-bed SNF type inpatient days (including private reporting period   | boili days) through beceiliber 31 of the cos | 1             | 5. 00            |
| 6. 00            | Total swing-bed SNF type inpatient days (including private ro   | oom days) after December 31 of the cost      | 0             | 6.00             |
|                  | reporting period (if calendar year, enter 0 on this line)   |  |               |                  |
| 7.00             | Total swing-bed NF type inpatient days (including private roo   | om days) through December 31 of the cost     | 0             | 7. 00            |
|                  | reporting period  |  |               |                  |
| 8. 00            | Total swing-bed NF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)      | om days) after December 31 of the cost       | 0             | 8. 00            |
| 9. 00            | Total inpatient days including private room days applicable t   | to the Program (excluding swing-hed and      | 534           | 9. 00            |
| 7. 00            | newborn days) (see instructions)  | to the riogram (exertaining swring bed and   | 334           | 7.00             |
| 10.00            | Swing-bed SNF type inpatient days applicable to title XVIII of  | only (including private room days)           | 0             | 10.00            |
|                  | through December 31 of the cost reporting period (see instruc   |  |               |                  |
| 11. 00           | Swing-bed SNF type inpatient days applicable to title XVIII o   |  | 0             | 11. 00           |
| 12. 00           | December 31 of the cost reporting period (if calendar year, & Swing-bed NF type inpatient days applicable to titles V or XI   |  | 0             | 12. 00           |
| 12.00            | through December 31 of the cost reporting period  | ix only (flictually private room days)       |               | 12.00            |
| 13. 00           | Swing-bed NF type inpatient days applicable to titles V or XI   | IX only (including private room days)        | 0             | 13. 00           |
|                  | after December 31 of the cost reporting period (if calendar y   |  |               |                  |
| 14.00            | Medically necessary private room days applicable to the Progr   | ram (excluding swing-bed days)               | 0             |                  |
| 15. 00           | Total nursery days (title V or XIX only)  |  | 0             |                  |
| 16. 00           | Nursery days (title V or XIX only) SWING BED ADJUSTMENT   |  | 0             | 16. 00           |
| 17. 00           | Medicare rate for swing-bed SNF services applicable to service  | ces through December 31 of the cost          | 0.00          | 17. 00           |
| 17.00            | reporting period  | ces through becember 51 of the cost          | 0.00          | 17.00            |
| 18.00            | Medicare rate for swing-bed SNF services applicable to service  | ces after December 31 of the cost            | 0.00          | 18. 00           |
|                  | reporting period  |  |               |                  |
| 19. 00           | Medicaid rate for swing-bed NF services applicable to service   | es through December 31 of the cost           | 0.00          | 19. 00           |
| 20.00            | reporting period  | os after December 21 of the cost             | 0.00          | 20. 00           |
| 20. 00           | Medicaid rate for swing-bed NF services applicable to service reporting period  | es after beceiiber 31 of the cost            | 0.00          | 20.00            |
| 21. 00           | Total general inpatient routine service cost (see instruction   | ns)  | 23, 125, 805  | 21.00            |
| 22. 00           | Swing-bed cost applicable to SNF type services through Decemb   |  |               |                  |
|                  | 5 x line 17)  |  |               |                  |
| 23. 00           | Swing-bed cost applicable to SNF type services after December   | r 31 of the cost reporting period (line      | 6 0           | 23. 00           |
| 24. 00           | x line 18)<br> Swing-bed cost applicable to NF type services through Decembe  | or 21 of the cost reporting period (line     | 0             | 24. 00           |
| 24.00            | 7 x line 19)  | er 31 of the cost reporting period (fine     |               | 24.00            |
| 25. 00           | Swing-bed cost applicable to NF type services after December  | 31 of the cost reporting period (line 8      | 0             | 25. 00           |
|                  | 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, 125, 805  | 27. 00           |
| 28. 00           | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-be                           | and observation had charges)                 | 1             | 28. 00           |
| 29. 00           | Private room charges (excluding swing-bed charges)  | ed and observation bed charges)              | 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)                                   | 0.000000      |                  |
| 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          | •                |
| 34.00            | Average per diem private room charge differential (line 32 mi   | inus line 33)(see instructions)              | 0.00          | •                |
| 35.00            | Average per diem private room cost differential (line 34 x li   |  | 0.00          | •                |
| 36. 00           | Private room cost differential adjustment (line 3 x line 35)  | ,  | 0             | 36.00            |
| 37. 00           | General inpatient routine service cost net of swing-bed cost  | and private room cost differential (lin      | 23, 125, 805  | •                |
|                  | 27 minus line 36)   | <u> </u>                                     | <u> </u>      |                  |
|                  | PART II - HOSPITAL AND SUBPROVIDERS ONLY  | HICTMENTS                                    |               |                  |
| 20.00            | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ   |  | 1 004 10      | 20.00            |
| 38.00            | Adjusted general inpatient routine service cost per diem (see   |  | 1, 234. 43    | •                |
| 39. 00<br>40. 00 | Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program | •  | 659, 186<br>0 | 39. 00<br>40. 00 |
| 41.00            | Total Program general inpatient routine service cost (line 39   | ,  | 659, 186      |                  |
|                  | 1   | <del>/</del>                                 | , 337, .00    |                  |

| <b>MPUT</b> | Financial Systems REH ATION OF INPATIENT OPERATING COST  |                            | PITAL OF INDIA<br>Provider ( | CCN: 15-3028                           | Peri od:                         | u of Form CMS-<br>Worksheet D-1    |            |
|-------------|--|----------------------------|------------------------------|--|----------------------------------|------------------------------------|------------|
| , O 1       |  |                            |                              | 30.11. 10 0020                         | From 01/01/2022<br>To 12/31/2022 |                                    | epare      |
|             | Cost Center Description  | Total<br>Inpatient<br>Cost | Tit Total Inpatient Days     | Average Per<br>Diem (col.<br>÷ col. 2) |                                  | PPS Program Cost (col. 3 x col. 4) |            |
| 2. 00       | NURSERY (title V & XIX only)   | 1. 00                      | 2.00                         | 3.00                                   | 4. 00                            | 5. 00                              | 42.        |
| 2. 00       | Intensive Care Type Inpatient Hospital Units   |                            |                              |  |                                  |                                    | 42.        |
| . 00        | INTENSIVE CARE UNIT  |                            |                              |  |                                  |                                    | 43.        |
| . 00        | CORONARY CARE UNIT<br>BURN INTENSIVE CARE UNIT   |                            |                              |  |                                  |                                    | 44.<br>45. |
|             | SURGI CAL I NTENSI VE CARE UNI T   |                            |                              |  |                                  |                                    | 46.        |
| . 00        | OTHER SPECIAL CARE (SPECIFY)   |                            |                              |  |                                  |                                    | 47         |
|             | Cost Center Description  |                            |                              |  |                                  | 1. 00                              |            |
|             | Program inpatient ancillary service cost (W  |                            |                              |  |                                  | 365, 490                           |            |
|             | Program inpatient cellular therapy acquisiti<br>Total Program inpatient costs (sum of lines  |                            |                              |  | , column 1)                      | 1 024 474                          |            |
| 00          | PASS THROUGH COST ADJUSTMENTS  | 41 through 48.             | n) (see mstrt                | actions)                               |                                  | 1, 024, 676                        | 49         |
| 00          | Pass through costs applicable to Program in  | patient routine            | services (fro                | om Wkst. D, su                         | m of Parts I and                 | 36, 894                            | 50         |
| 00          | <pre>III) Pass through costs applicable to Program in</pre>  | nationt ancilla            | ry sarvicas (f               | from Wkst D                            | sum of Darts II                  | 13. 071                            | 51         |
| 00          | and IV)  | patrent andiria            | y services (i                | TOII WKSt. D,                          | Sum of rarts if                  | 13, 07 1                           |            |
| 00          | Total Program excludable cost (sum of lines  |                            |                              |  |                                  | 49, 965                            |            |
| 00          | Total Program inpatient operating cost exclumedical education costs (line 49 minus line  |                            | erated, non-ph               | nysician anest                         | netist, and                      | 974, 711                           | 53         |
|             | TARGET AMOUNT AND LIMIT COMPUTATION  | 02)                        |                              |  |                                  |                                    |            |
| 00          | Program discharges Target amount per discharge   |                            |                              |  |                                  | 0. 00                              |            |
| 01          | Permanent adjustment amount per discharge  |                            |                              |  |                                  | 0.00                               |            |
| 02          | Adjustment amount per discharge (contractor  |                            |                              |  |                                  | 0. 00                              |            |
| 00          | Target amount (line 54 x sum of lines 55, 55.01, and 55.02)  |                            |                              |  |                                  |                                    |            |
| 00          | Bonus payment (see instructions)   | ting cost and ta           | arget amount (               | (TITIE 36 IIITIUS                      | 111le 55)                        | C                                  |            |
| 00          | Trended costs (lesser of line 53 ÷ line 54,  |                            | n the cost rep               | oorting period                         | endi ng 1996,                    | 0.00                               | 59         |
| .00         | updated and compounded by the market basket)  Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the  |                            |                              |  |                                  |                                    | 60         |
|             | market basket)   |                            |                              |  |                                  |                                    |            |
| . 00        | Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise |                            |                              |  |                                  |                                    | 61         |
| . 00        | enter zero. (see instructions)<br>Relief payment (see instructions)  |                            |                              |  |                                  | C                                  | 62         |
|             | Allowable Inpatient cost plus incentive pays PROGRAM INPATIENT ROUTINE SWING BED COST  | ment (see instru           | uctions)                     |  |                                  | C                                  |            |
| 00          | Medicare swing-bed SNF inpatient routine cos   | sts through Dece           | ember 31 of th               | ne cost report                         | ing period (See                  | C                                  | 64         |
|             | instructions)(title XVIII only)  | Ü                          |                              | ·                                      |                                  |                                    |            |
| 00          | Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)  | sts after Decemb           | per 31 of the                | cost reportin                          | g period (See                    | C                                  | 65         |
| 00          | Total Medicare swing-bed SNF inpatient routi   | ine costs (line            | 64 plus line                 | 65)(title XVI                          | ll only); for                    | C                                  | 66         |
| 00          | CAH, see instructions Title V or XIX swing-bed NF inpatient routing  | ne coete through           | December 31                  | of the cost n                          | enorting period                  | C                                  | 67         |
| 00          | (line 12 x line 19)  | ne costs through           | i becember 31                | or the cost r                          | cportring period                 | C                                  | 10,        |
| 00          | Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)  | ne costs after [           | December 31 of               | f the cost rep                         | orting period                    | C                                  | 68         |
| 00          | Total title V or XIX swing-bed NF inpatient  |                            |                              |  |                                  | C                                  | 69         |
| 00          | PART III - SKILLED NURSING FACILITY, OTHER N<br>Skilled nursing facility/other nursing facil   |                            |                              |  | ,                                |                                    | 70         |
| .00         | Adjusted general inpatient routine service of  | •                          |                              |  | ,                                |                                    | 70         |
| . 00        | Program routine service cost (line 9 x line  | 71)                        |                              | ŕ                                      |                                  |                                    | 72         |
| . 00        | Medically necessary private room cost applic<br>Total Program general inpatient routine serv   |                            |                              |  |                                  |                                    | 73         |
| 00          | Capital -related cost allocated to inpatient 26, line 45)  | •                          |                              | •                                      | Part II, column                  |                                    | 75         |
| 00          | Per diem capital-related costs (line 75 ÷ li   | ine 2)                     |                              |  |                                  |                                    | 76         |
| 00          | Program capital -related costs (line 9 x line  |                            |                              |  |                                  |                                    | 77         |
| 00          | Inpatient routine service cost (line 74 min<br>Aggregate charges to beneficiaries for exce   |                            | provi den inecor             | rds)                                   |                                  |                                    | 78<br>  79 |
| 00          | Total Program routine service costs for comp   | parison to the o           |                              |  | nus line 79)                     |                                    | 80         |
| . 00        | Inpatient routine service cost per diem limitation (   |                            | 1)                           |  |                                  |                                    | 81         |
| . 00        | Inpatient routine service cost limitation (<br>Reasonable inpatient routine service costs  |                            | *                            |  |                                  |                                    | 82         |
| . 00        | Program inpatient ancillary services (see i  | nstructions)               |                              |  |                                  |                                    | 84         |
| . 00        | Utilization review - physician compensation<br>Total Program inpatient operating costs (sur  |                            |                              |  |                                  |                                    | 85<br>86   |
| . 00        |  |                            | ii ougii oo <i>)</i>         |  |                                  |                                    | ┦ °°       |
|             | PART IV - COMPUTATION OF OBSERVATION BED PAS   | SS THRUUGH CUST            |                              |  |                                  |                                    |            |

| Heal th | ealth Financial Systems REHABILITATION HOSPITAL OF INDIANA In Lieu |                 |              |            |                                  | u of Form CMS-2 | 2552-10 |
|---------|--|-----------------|--------------|------------|----------------------------------|-----------------|---------|
| COMPUT  | ATION OF INPATIENT OPERATING COST                                  |                 | Provi der CC |            | Peri od:                         | Worksheet D-1   |         |
|         |  |                 |              |            | From 01/01/2022<br>To 12/31/2022 |                 |         |
|         |  |                 | Ti tl        | e XIX      | Hospi tal                        | PPS             |         |
|         | Cost Center Description  |                 |              |            |                                  |                 |         |
|         |  |                 |              |            |                                  | 1. 00           |         |
| 89. 00  | Observation bed cost (line 87 x line 88) (se                       | ee instructions | )            |            |                                  | 0               | 89. 00  |
|         | Cost Center Description  | Cost            | Routine Cost | column 1 ÷ | Total                            | Observation     |         |
|         |  |                 | (from line   | column 2   | Observati on                     | Bed Pass        |         |
|         |  |                 | 21)          |            | Bed Cost                         | Through Cost    |         |
|         |  |                 |              |            | (from line                       | (col. 3 x       |         |
|         |  |                 |              |            | 89)                              | col. 4) (see    |         |
|         |  |                 |              |            |                                  | instructions)   |         |
|         |  | 1. 00           | 2.00         | 3.00       | 4. 00                            | 5. 00           |         |
|         | COMPUTATION OF OBSERVATION BED PASS THROUGH                        | COST            |              |            |                                  |                 |         |
| 90.00   | Capi tal -rel ated cost  | 1, 294, 277     | 23, 125, 805 | 0. 05596   | 7 0                              | 0               | 90.00   |
| 91.00   | Nursing Program cost   | 0               | 23, 125, 805 | 0.00000    | 0                                | 0               | 91.00   |
| 92.00   | Allied health cost   | 0               | 23, 125, 805 | 0.00000    | 0                                | 0               | 92.00   |
| 93.00   | All other Medical Education  | 0               | 23, 125, 805 | 0.00000    | 0                                | 0               | 93. 00  |
|         |  |                 |              |            |                                  |                 |         |

| Health Financial Systems REHABILITATION HOST INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provi der C   |                      | Peri od:        | Worksheet D-3               | 1                |
|---|---------------|----------------------|-----------------|-----------------------------|------------------|
|   |               |                      | From 01/01/2022 |                             |                  |
|   |               |                      | To 12/31/2022   | Date/Time Pre 5/31/2023 9:3 | pared:<br>1 am   |
|   | Title         | : XVIII              | Hospi tal       | PPS                         |                  |
| Cost Center Description   |               | Ratio of Cos         |                 | I npati ent                 |                  |
|   |               | To Charges           | Program         | Program Costs               |                  |
|   |               |                      | Charges         | (col. 1 x                   |                  |
|   |               | 1.00                 | 2.00            | col . 2)<br>3.00            |                  |
| INPATIENT ROUTINE SERVICE COST CENTERS  |               | 1.00                 | 2.00            | 3.00                        |                  |
| 30. 00 03000 ADULTS & PEDIATRICS  |               |                      | 12, 712, 551    |                             | 30.00            |
| ANCI LLARY SERVICE COST CENTERS   |               |                      | 12,712,331      |                             | 30.00            |
| 50. 00 05000 OPERATING ROOM   |               | 0.00000              | 00 0            | 0                           | 50.00            |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C  |               | 0. 17879             |                 | 90, 612                     | 54.00            |
| 60. 00   06000   LABORATORY   |               | 0. 31549             | 630, 934        | 199, 058                    | 60.00            |
| 65. 00 06500 RESPIRATORY THERAPY  |               | 0. 38211             | 990, 509        | 378, 483                    | 65.00            |
| 66. 00   06600   PHYSI CAL THERAPY  |               | 0. 22820             |                 | 838, 815                    |                  |
| 66. 01 06601 PHYSI CAL THERAPY - CARMEL   |               | 0. 47623             |                 | 0                           |                  |
| 67. 00 06700 OCCUPATI ONAL THERAPY  |               | 0. 21136             |                 | 931, 210                    |                  |
| 68. 00 06800 SPEECH PATHOLOGY   |               | 0. 23161             | ,               | 488, 467                    | 68.00            |
| 68. 01   06801   VI SI ON   |               | 0.00000              |                 | 0                           |                  |
| 68. 02   06802   FAC RESOURCE<br>69. 00   06900   ELECTROCARDI OLOGY                        |               | 2. 87475             |                 | 0                           | 68. 02<br>69. 00 |
| 71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT                                       |               | 0. 00000<br>0. 23939 |                 | 1                           |                  |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS   |               | 0. 23737             | · ·             | 155, 774                    |                  |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS  |               | 0. 26379             |                 | 659, 220                    |                  |
| 74. 00   07400   RENAL DI ALYSI S   |               | 0. 00000             |                 | 0                           |                  |
| 77. 00 07700 ALLOGENEIC HSCT ACQUISITION  |               | 0.00000              |                 | Ō                           |                  |
| OUTPATIENT SERVICE COST CENTERS   |               |                      | -               | •                           | 1                |
| 90. 00 09000 CLI NI C   |               | 0. 32268             | 33 0            | 0                           | 90.00            |
| 90. 01   09001   SLEEP CENTER   |               | 0. 00000             |                 | 0                           | 90. 01           |
| 91. 00   09100   EMERGENCY  |               | 0. 00000             |                 | 0                           |                  |
| 92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART   |               | 0. 00000             |                 | 0                           |                  |
| 200.00 Total (sum of lines 50 through 94 and 96 through 98)                                 |               |                      | 15, 468, 140    |                             |                  |
| 201.00 Less PBP Clinic Laboratory Services-Program only char                                | ges (line 61) |                      | 0               | l                           | 201.00           |
| 202.00 Net charges (line 200 minus line 201)  |               |                      | 15, 468, 140    |                             | 202. 00          |

| Health Financial Systems REHABILITATION HOSE                | DITAL OF LADIA | .NA          | Inlie                       | u of Form CMS-2             | 2552_10 |
|---|----------------|--------------|-----------------------------|-----------------------------|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT              | Provider C     | CN: 15-3028  | Peri od:<br>From 01/01/2022 | Worksheet D-3               |         |
|   |                |              | To 12/31/2022               | Date/Time Pre 5/31/2023 9:3 |         |
|   | Ti tl          | e XIX        | Hospi tal                   | PPS                         |         |
| Cost Center Description                                     |                | Ratio of Cos | t Inpatient                 | I npati ent                 |         |
|   |                | To Charges   | Program                     | Program Costs               |         |
|   |                |              | Charges                     | (col. 1 x                   |         |
|   |                |              |                             | col . 2)                    |         |
|   |                | 1. 00        | 2. 00                       | 3. 00                       |         |
| INPATIENT ROUTINE SERVICE COST CENTERS                      |                |              |                             |                             |         |
| 30. 00 03000 ADULTS & PEDI ATRI CS                          |                |              | 1, 287, 781                 |                             | 30.00   |
| ANCILLARY SERVICE COST CENTERS                              |                |              |                             |                             |         |
| 50. 00   05000   OPERATING ROOM                             |                | 0.00000      | 0 0                         | 0                           | 50.00   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C                    |                | 0. 17879     | 53, 802                     | 9, 620                      | 54.00   |
| 60. 00   06000   LABORATORY                                 |                | 0. 31549     | 98 54, 250                  | 17, 116                     | 60.00   |
| 65. 00 06500 RESPIRATORY THERAPY                            |                | 0. 38211     | 0 106, 387                  | 40, 652                     | 65.00   |
| 66. 00   06600 PHYSI CAL THERAPY                            |                | 0. 22820     | 368, 187                    | 84, 023                     | 66.00   |
| 66. 01 06601 PHYSI CAL THERAPY - CARMEL                     |                | 0. 47623     | 9 0                         | 0                           | 66. 01  |
| 67. 00 06700 OCCUPATI ONAL THERAPY                          |                | 0. 21136     | 9 417, 944                  | 88, 340                     | 67.00   |
| 68. 00 06800 SPEECH PATHOLOGY                               |                | 0. 23161     | 9 238, 963                  | 55, 348                     | 68.00   |
| 68. 01  06801  VI SI ON                                     |                | 0.00000      | 0 0                         | 0                           | 68. 01  |
| 68. 02   06802   FAC RESOURCE                               |                | 2. 87475     | 52 0                        | 0                           | 68. 02  |
| 69. 00 06900 ELECTROCARDI OLOGY                             |                | 0.00000      | 0 0                         | 0                           | 69.00   |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT            |                | 0. 23939     | 54, 087                     | 12, 948                     | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS                  |                | 0.00000      | 0                           | 0                           | 72.00   |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS                      |                | 0. 26379     | 217, 759                    | 57, 443                     | 73.00   |
| 74. 00 07400 RENAL DI ALYSI S                               |                | 0. 00000     | 0                           | 0                           | 74.00   |
| 77. 00 07700 ALLOGENEIC HSCT ACQUISITION                    |                | 0. 00000     | 0                           | 0                           | 77.00   |
| OUTPATIENT SERVICE COST CENTERS                             |                |              | -                           |                             |         |
| 90. 00 09000 CLI NI C                                       |                | 0. 32268     | 3 0                         | 0                           | 90.00   |
| 90. 01 09001 SLEEP CENTER                                   |                | 0. 00000     | 0                           | 0                           | 90. 01  |
| 91. 00   09100   EMERGENCY                                  |                | 0.00000      |                             | 0                           | 91.00   |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART            |                | 0.00000      |                             | Ō                           | 92.00   |
| 200 00 Total (sum of Lines 50 through 04 and 06 through 09) |                |              | 1 511 270                   | 265 400                     |         |

91.00 OPTION EMERGENCY
92.00 OP200 OBSERVATION BEDS (NON-DISTINCT PART
200.00 Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

Net charges (line 200 minus line 201)

0 91.00 0 92.00 365, 490 200.00 201.00

202.00

1, 511, 379

202.00

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2022 Part A Exhi bi t 4 To 12/31/2022 Date/Time Prepared: 5/31/2023 9:31 am Provider CCN: 15-3028

|                  |  |                          |                  | T1.11.           | V0.41.1               |                      | 5/31/2023 9: 3      | <u> 1 am</u> |
|------------------|--|--------------------------|------------------|------------------|-----------------------|----------------------|---------------------|--------------|
|                  |  | W/S E, Part A            | Amounts (from    | Pre/Post         | XVIII<br>Period Prior | Hospi tal<br>Peri od | PPS<br>Total (Col 2 |              |
|                  |  | line                     | E, Part A)       | Entitlement      | to 10/01              | On/After             | through 4)          |              |
|                  |  |                          | , i              |                  |                       | 10/01                |                     |              |
| 1.00             |  | 0                        | 1. 00            | 2. 00            | 3. 00                 | 4. 00                | 5. 00               | 1 00         |
| 1. 00            | DRG amounts other than outlier payments  | 1. 00                    | 0                | 0                | 0                     | 0                    | 0                   | 1.00         |
| 1. 01            | DRG amounts other than outlier payments for discharges   | 1. 01                    | 0                | 0                | 0                     |                      | 0                   | 1. 01        |
| 1. 02            | occurring prior to October 1<br>DRG amounts other than outlier<br>payments for discharges<br>occurring on or after October | 1. 02                    | 0                | 0                |                       | 0                    | 0                   | 1. 02        |
| 1. 03            | 1<br>DRG for Federal specific<br>operating payment for Model 4<br>BPCI occurring prior to                                  | 1. 03                    | O                | 0                | 0                     |                      | 0                   | 1.03         |
| 1. 04            | October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after                                | 1. 04                    | 0                | 0                |                       | 0                    | 0                   | 1. 04        |
| 2. 00            | October 1 Outlier payments for discharges (see instructions)   | 2. 00                    |                  |                  |                       |                      |                     | 2. 00        |
| 2. 01            | Outlier payments for discharges for Model 4 BPCI   | 2. 02                    | 0                | 0                | 0                     | 0                    | 0                   | 2. 01        |
| 2. 02            | Outlier payments for discharges occurring prior to   | 2. 03                    | 0                | 0                | 0                     |                      | 0                   | 2. 02        |
| 2. 03            | October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see                          | 2.04                     | 0                | 0                |                       | 0                    | 0                   | 2.03         |
| 3. 00            | instructions)<br>Operating outlier   | 2. 01                    | 0                | 0                | 0                     | 0                    | 0                   | 3. 00        |
| 4. 00            | reconciliation Managed care simulated  | 3. 00                    | 0                | 0                | -1, 493, 129          | 1, 493, 129          | 0                   | 4. 00        |
|                  | payments Indirect Medical Education Adju   | ıstment                  |                  |                  |                       |                      |                     |              |
| 5. 00            | Amount from Worksheet E, Part A, line 21 (see instructions)  | 21. 00                   | 0. 000000        | 0. 000000        | 0. 000000             | 0. 000000            |                     | 5.00         |
| 6. 00            | IME payment adjustment (see instructions)  | 22. 00                   | 0                | 0                | 0                     | 0                    | 0                   | 6. 00        |
| 6. 01            | IME payment adjustment for managed care (see instructions)   | 22. 01                   | O                | 0                | 0                     | 0                    | 0                   | 6. 01        |
|                  | Indirect Medical Education Adju  | ustment for the          | e Add-on for Se  | ection 422 of 1  | the MMA               |                      |                     |              |
| 7. 00            | IME payment adjustment factor (see instructions)   | 27. 00                   | 0. 000000        | 0. 000000        | 0. 000000             | 0. 000000            |                     | 7. 00        |
| 8. 00            | IME adjustment (see instructions)  | 28. 00                   | 0                | 0                | 0                     | 0                    | 0                   | 8. 00        |
| 8. 01            | IME payment adjustment add on for managed care (see  | 28. 01                   | O                | 0                | 0                     | 0                    | 0                   | 8. 01        |
| 9. 00            | Total IME payment (sum of lines 6 and 8)   | 29. 00                   | 0                | 0                | 0                     | 0                    | 0                   | 9. 00        |
| 9. 01            | Total IME payment for managed care (sum of lines 6.01 and  | 29. 01                   | О                | 0                | 0                     | 0                    | 0                   | 9. 01        |
|                  | 8.01) Disproportionate Share Adjustmo  | ent                      |                  |                  |                       |                      |                     |              |
| 10. 00           | Allowable disproportionate share percentage (see instructions)   | 33. 00                   | 0. 0000          | 0. 0000          | 0. 0000               | 0. 0000              |                     | 10.00        |
| 11. 00           | Disproportionate share adjustment (see instructions)   | 34. 00                   | 0                | 0                | 0                     | 0                    | 0                   | 11. 00       |
| 11. 01           | Uncompensated care payments  | 36.00                    | 0                | 0                | 0                     | 0                    | 0                   | 11. 01       |
| 12. 00           | Additional payment for high per<br>Total ESRD additional payment   | rcentage of ESI<br>46.00 | beneficiary<br>0 | di scharges<br>0 | 0                     | 0                    | 0                   | 12.00        |
| 13. 00<br>14. 00 | (see instructions) Subtotal (see instructions) Hospital specific payments  | 47. 00<br>48. 00         | 0                | 0                | 0                     | 0                    | 0                   |              |
| 15. 00           | (completed by SCH and MDH,<br>small rural hospitals only.)<br>(see instructions)<br>Total payment for inpatient            | 49. 00                   | O                | 0                | 0                     | 0                    | 0                   | 15. 00       |
|                  | operating costs (see instructions)   |                          |                  |                  |                       |                      |                     |              |

In Lieu of Form CMS-2552-10 LOW VOLUME CALCULATION EXHIBIT 4 Provi der CCN: 15-3028 Peri od: Worksheet E From 01/01/2022 Part A Exhibit 4 Date/Time Prepared: 5/31/2023 9:31 am 12/31/2022 Title XVIII Hospi tal W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od E, Part A) Entitlement to 10/01 On/After through 4) I i ne 10/01 5.00 0 1.00 2.00 3.00 4.00 16.00 Payment for inpatient program 50.00 0 16.00 capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for 54.00 0 17.00 0 new technologies 17.01 Net organ aquisition cost 17.01 17.02 Credits received from 68.00 0 0 0 17.02 manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 18.00 adjustment amount (see instructions) 19. 00 SUBTOTAL 19.00 O 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 О 0 0 О 20.00 Model 4 BPCI Capital DRG other 0 20.01 1.01 0 0 20.01 than outlier 21.00 Capital DRG outlier payments 2.00 0 21.00 Model 4 BPCI Capital DRG 21.01 2. 01 0 0 21.01 outlier payments 22.00 Indirect medical education 5.00 0.0000 0.0000 22.00 0.0000 0.0000 percentage (see instructions) 23.00 Indirect medical education 6.00 0 23.00 0 adjustment (see instructions) Allowable disproportionate 0.0000 0.0000 0.0000 0.0000 24.00 10.00 24.00 share percentage (see instructions) 25.00 Disproportionate share 11.00 0 C 0 0 25.00 adjustment (see instructions) Total prospective capital 12.00 0 26,00 payments (see instructions) W/S E, Part A (Amounts to line Part A) 2.00 4. 00 3. 00 5.00 0.000000 27.00 Low volume adjustment factor 0.000000 27.00 Low volume adjustment 70.96 28.00 28.00 (transfer amount to Wkst. E, Pt. A, line) 29.00 Low volume adjustment 70.97 0 29.00 (transfer amount to Wkst. E, Pt. A, line)

100.00

100.00 Transfer low volume

adjustments to Wkst. E, Pt. A.

 
 Heal th Financial
 Systems
 REHABILITATION HOSPITAL OF INDIANA

 HOSPITAL
 ACQUIRED
 CONDITION (HAC)
 REDUCTION CALCULATION EXHIBIT 5
 Provider CCN:
 Peri od: Worksheet E From 01/01/2022 Part A Exhi bi t 5 To 12/31/2022 Date/Ti me Prepared: 5/31/2023 9:31 am Provi der CCN: 15-3028

|                  |   |                         |                                 |                    | 0 12/31/2022             | 5/31/2023 9: 3           |                  |
|------------------|---|-------------------------|---------------------------------|--------------------|--------------------------|--------------------------|------------------|
|                  |   |                         |                                 | XVIII              | Hospi tal                | PPS                      |                  |
|                  |   | Wkst. E, Pt.<br>A, line | Amt. from<br>Wkst. E, Pt.<br>A) | Period to<br>10/01 | Period on<br>after 10/01 | Total (cols.<br>2 and 3) |                  |
|                  |   | 0                       | 1. 00                           | 2. 00              | 3. 00                    | 4. 00                    |                  |
| 1. 00<br>1. 01   | DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1 | 1. 00<br>1. 01          | O                               | 0                  |                          | 0                        | 1. 00<br>1. 01   |
| 1. 02            | DRG amounts other than outlier payments for discharges occurring on or after October 1                                      | 1. 02                   | 0                               |                    | 0                        | 0                        | 1. 02            |
| 1.03             | DRG for Federal specific operating payment<br>for Model 4 BPCI occurring prior to October                                   | 1. 03                   | O                               | 0                  |                          | 0                        | 1.03             |
| 1. 04            | DRG for Federal specific operating payment<br>for Model 4 BPCI occurring on or after<br>October 1                           | 1. 04                   | O                               |                    | 0                        | 0                        | 1. 04            |
| 2. 00            | Outlier payments for discharges (see instructions)  | 2. 00                   |                                 |                    |                          |                          | 2. 00            |
| 2. 01            | Outlier payments for discharges for Model 4 BPCI  | 2. 02                   | 0                               | 0                  | 0                        | 0                        | 2. 01            |
| 2. 02            | Outlier payments for discharges occurring prior to October 1 (see instructions)   | 2. 03                   | 0                               | 0                  |                          | 0                        | 2. 02            |
| 2. 03            | Outlier payments for discharges occurring on or after October 1 (see instructions)  | 2. 04                   | 0                               |                    | 0                        | 0                        | 2. 03            |
| 3. 00<br>4. 00   | Operating outlier reconciliation Managed care simulated payments  | 2. 01<br>3. 00          | 0                               | 0<br>4, 515, 796   | 0<br>1, 493, 129         | 0<br>6, 008, 925         | 3. 00<br>4. 00   |
|                  | Indirect Medical Education Adjustment   |                         |                                 |                    |                          |                          |                  |
| 5. 00            | Amount from Worksheet E, Part A, line 21 (see instructions)   | 21. 00                  | 0. 000000                       | 0. 000000          | 0. 000000                |                          | 5. 00            |
| 6. 00            | IME payment adjustment (see instructions)   | 22. 00                  | 0                               | 0                  | 0                        | 0                        | 6.00             |
| 6. 01            | IME payment adjustment for managed care (see instructions)  |                         | 0<br>notion 422 of t            | U ho MMA           | U                        | 0                        | 6. 01            |
| 7. 00            | Indirect Medical Education Adjustment for the IME payment adjustment factor (see  | 27. 00                  | 0. 000000                       | 0. 000000          | 0. 000000                |                          | 7.00             |
| 7.00             | instructions)   | 27.00                   | 0.00000                         | 0.00000            | 0.000000                 |                          | 7.00             |
| 8.00             | IME adjustment (see instructions)   | 28. 00                  | 0                               | 0                  | 0                        | 0                        | 8. 00            |
| 8. 01            | IME payment adjustment add on for managed care (see instructions)   | 28. 01                  | 0                               | 0                  | 0                        | 0                        | 8. 01            |
| 9. 00<br>9. 01   | Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)                    | 29. 00<br>29. 01        | 0                               | 0                  | 0                        | 0                        | 9. 00<br>9. 01   |
|                  | Disproportionate Share Adjustment   |                         |                                 |                    |                          |                          |                  |
| 10. 00           | Allowable disproportionate share percentage (see instructions)  | 33. 00                  | 0. 0000                         | 0. 0000            | 0. 0000                  |                          | 10.00            |
| 11. 00           | Disproportionate share adjustment (see instructions)  | 34. 00                  | 0                               | 0                  | 0                        | 0                        | 11. 00           |
| 11. 01           | Uncompensated care payments   | 36. 00                  | 0                               | 0                  | 0                        | 0                        | 11. 01           |
| 40.00            | Additional payment for high percentage of ES  |                         | di scharges                     | _                  | ما                       |                          | 1 40 00          |
| 12. 00           | Total ESRD additional payment (see instructions)  | 46. 00                  | 0                               | 0                  | 0                        | 0                        | 12.00            |
| 13.00            | Subtotal (see instructions)   | 47. 00                  | 0                               | 0                  | 0                        | 0                        | 13.00            |
| 14.00            | Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)                       | 48. 00                  | U                               | 0                  | U                        | 0                        | 14.00            |
| 15. 00           | Total payment for inpatient operating costs (see instructions)  | 49. 00                  | 0                               | 0                  | 0                        | 0                        | 15.00            |
| 16. 00           | Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)  | 50. 00                  | 0                               | 0                  | 0                        | 0                        | 16. 00           |
| 17. 00<br>17. 01 | Special add-on payments for new technologies<br>Net organ acquisition cost  | 54. 00                  | 0                               | 0                  | 0                        | 0                        | 17. 00<br>17. 01 |
| 17. 02           | Credits received from manufacturers for replaced devices for applicable MS-DRGs   | 68. 00                  | 0                               | 0                  | 0                        | 0                        | 1                |
| 18. 00           | Capital outlier reconciliation adjustment amount (see instructions)   | 93. 00                  | 0                               | 0                  | 0                        | 0                        |                  |
| 19. 00           | SUBTOTAL  |                         |                                 | 0                  | o                        | 0                        | 19. 00           |

| Heal th  | Financial Systems REHA                        | ABILITATION HOS | PITAL OF INDIA | NA          |    | In Lie    | u of Form CMS-2                | 2552-10 |
|----------|---|-----------------|----------------|-------------|----|-----------|--------------------------------|---------|
| HOSPI TA | AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA | ATION EXHIBIT 5 | Provi der C    | CN: 15-3028 |    | i od:     | Worksheet E<br>Part A Exhibi   | + 5     |
|          |   |                 |                |             | To |           | Date/Time Pre<br>5/31/2023 9:3 | 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  | o         | 0                              | 20. 01  |
| 21 00    | Carital DDC autilian assuments                | 2 00            | _              | i           | 0  | ام        | 0                              | 21 00   |

| 20.00  | Todal tal bito other than outlier            | 1.00         |                    |         | U       | 1            | 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            | 21. 01 |
| 22.00  | Indirect medical education percentage (see   | 5. 00        | 0.0000             | 0.0000  | 0.0000  |              | 22. 00 |
|        | instructions)                                |              |                    |         |         |              |        |
| 23.00  | Indirect medical education adjustment (see   | 6. 00        | 0                  | 0       | 0       | 0            | 23. 00 |
|        | instructions)                                |              |                    |         |         |              |        |
| 24. 00 | Allowable disproportionate share percentage  | 10. 00       | 0. 0000            | 0. 0000 | 0. 0000 |              | 24. 00 |
|        | (see instructions)                           |              |                    |         |         |              |        |
| 25. 00 | Disproportionate share adjustment (see       | 11. 00       | 0                  | 0       | 0       | 0            | 25. 00 |
|        | instructions)                                | 10.00        |                    |         |         |              |        |
| 26. 00 |  | 12. 00       | 0                  | 0       | 0       | 0            | 26. 00 |
|        | i nstructi ons)                              | WI+ E D+     | (A+ £              |         |         |              |        |
|        |  | Wkst. E, Pt. | (Amt. from         |         |         |              |        |
|        |  | A, line      | Wkst. E, Pt.<br>A) |         |         |              |        |
|        |  | 0            | 1. 00              | 2.00    | 3. 00   | 4. 00        |        |
| 27. 00 |  | U            | 1.00               | 2.00    | 3.00    | 4.00         | 27. 00 |
| 28. 00 | Low volume adjustment prior to October 1     | 70. 96       | _                  |         |         | 0            |        |
| 29. 00 |  | 70. 90       | 0                  | U       | 0       | 0            | 29.00  |
|        | HVBP payment adjustment (see instructions)   | 70. 93       | 0                  | 0       | 0       | 0            | 1      |
| 30. 00 | ,      | 70. 90       | 0                  | 0       | 0       | 0            |        |
| 30.01  | payment (see instructions)                   | 70.70        |                    | J       | O       | Ĭ            | 30.01  |
| 31 00  | HRR adjustment (see instructions)            | 70. 94       | 0                  | 0       | 0       | 0            | 31.00  |
| 31. 01 | HRR adjustment for HSP bonus payment (see    | 70. 91       | o o                | 0       | 0       | 0            |        |
|        | instructions)                                |              | _                  |         | -       |              |        |
|        | ,,,  |              |                    |         |         | (Amt. to     |        |
|        |  |              |                    |         |         | Wkst. E, Pt. |        |
|        |  |              |                    |         |         | A)           |        |
|        |  | 0            | 1. 00              | 2.00    | 3. 00   | 4. 00        |        |
| 32.00  | HAC Reduction Program adjustment (see        | 70. 99       |                    | 0       | 0       | 0            | 32. 00 |
|        | instructions)                                |              |                    |         |         |              |        |
| 100.00 | Transfer HAC Reduction Program adjustment to |              | N                  |         |         |              | 100.00 |
|        | Wkst. E, Pt. A.                              |              |                    |         |         | ĺ            |        |
|        |  |              |                    |         |         |              |        |

| Health Financial Systems                | REHABILITATION HOSPIT | AL OF INDIANA          | In Lieu                                      | u of Form CMS-2552-10                                    |
|---|-----------------------|------------------------|--|--|
| CALCULATION OF REIMBURSEMENT SETTLEMENT |                       | Provi der CCN: 15-3028 | Peri od:<br>From 01/01/2022<br>To 12/31/2022 | Worksheet E Part B Date/Time Prepared: 5/31/2023 9:31 am |

|        |  |            | 10 12/31/2022   | 5/31/2023 9: 3 |        |
|--------|--|------------|-----------------|----------------|--------|
|        | Title XVI  | 11         | Hospi tal       | PPS            |        |
|        |  | <u> </u>   |                 |                |        |
|        |  |            |                 | 1.00           |        |
|        | PART B - MEDICAL AND OTHER HEALTH SERVICES   |            |                 |                |        |
| 1.00   | Medical and other services (see instructions)                                      |            |                 | 0              | 1.00   |
| 2.00   | Medical and other services reimbursed under OPPS (see instructions)                |            |                 | 685, 555       | 2.00   |
| 3.00   | OPPS payments  |            |                 | 616, 392       | 3.00   |
| 4.00   | Outlier payment (see instructions)   |            |                 | 0              | 4.00   |
| 4.01   | Outlier reconciliation amount (see instructions)                                   |            |                 | 0              | 4. 01  |
| 5.00   | Enter the hospital specific payment to cost ratio (see instructions)               |            |                 | 0.000          | 5.00   |
| 6.00   | Line 2 times line 5  |            |                 | 0              | 6.00   |
| 7.00   | Sum of lines 3, 4, and 4.01, divided by line 6                                     |            |                 | 0.00           | 7.00   |
| 8.00   | Transitional corridor payment (see instructions)                                   |            |                 | 0              | 8.00   |
| 9.00   | Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, li       | ne 200     |                 | 0              | 9.00   |
| 10.00  | Organ acqui si ti ons  |            |                 | 0              | 10.00  |
| 11.00  | Total cost (sum of lines 1 and 10) (see instructions)                              |            |                 | 0              | 11.00  |
|        | COMPUTATION OF LESSER OF COST OR CHARGES   |            |                 |                |        |
|        | Reasonable charges   |            |                 |                |        |
| 12.00  | Ancillary service charges  |            |                 | 0              | 12.00  |
| 13.00  | Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)               |            |                 | 0              | 13.00  |
| 14.00  | Total reasonable charges (sum of lines 12 and 13)                                  |            |                 | 0              | 14.00  |
|        | Customary charges  |            |                 |                |        |
| 15. 00 | Aggregate amount actually collected from patients liable for payment for services. | vices on a | charge basis    | 0              | 15.00  |
| 16.00  | Amounts that would have been realized from patients liable for payment for so      | ervices or | n a chargebasis | 0              | 16.00  |
|        | had such payment been made in accordance with 42 CFR §413.13(e)                    |            |                 |                |        |
| 17.00  | Ratio of line 15 to line 16 (not to exceed 1.000000)                               |            |                 | 0.000000       | 17.00  |
| 18. 00 | Total customary charges (see instructions)   |            |                 | 0              | 18.00  |
| 19. 00 | Excess of customary charges over reasonable cost (complete only if line 18 ex      | xceeds lir | ne 11) (see     | 0              | 19.00  |
|        | instructions)  |            |                 |                |        |
| 20.00  | Excess of reasonable cost over customary charges (complete only if line 11 ex      | xceeds lir | ne 18) (see     | 0              | 20.00  |
|        | instructions)  |            |                 |                |        |
| 21. 00 | Lesser of cost or charges (see instructions)                                       |            |                 | 0              | 21.00  |
| 22. 00 | Interns and residents (see instructions)   |            |                 | 0              | 22. 00 |
| 23.00  | Cost of physicians' services in a teaching hospital (see instructions)             |            |                 | 0              | 23.00  |
| 24.00  | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)                       |            |                 | 616, 392       | 24.00  |
|        | COMPUTATION OF REIMBURSEMENT SETTLEMENT  |            |                 |                |        |
| 25.00  | Deductibles and coinsurance amounts (for CAH, see instructions)                    |            |                 | 0              | 25.00  |
| 26.00  | Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH,        | see instru | ıcti ons)       | 130, 448       | 26.00  |
| 27.00  | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of       | lines 22   | and 23] (see    | 485, 944       | 27. 00 |
|        | instructions)  |            |                 |                |        |
| 28. 00 | Direct graduate medical education payments (from Wkst. E-4, line 50)               |            |                 | 0              | 28. 00 |
| 29. 00 | ESRD direct medical education costs (from Wkst. E-4, line 36)                      |            |                 | 0              | 29. 00 |
| 30.00  | Subtotal (sum of lines 27 through 29)  |            |                 | 485, 944       | 30.00  |
| 31.00  | Primary payer payments   |            |                 | 566            |        |
| 32.00  | Subtotal (line 30 minus line 31)   |            |                 | 485, 378       | 32.00  |
|        | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)                  |            |                 |                |        |
| 33.00  | Composite rate ESRD (from Wkst. I-5, line 11)                                      |            |                 | 0              | 1      |
| 34.00  | Allowable bad debts (see instructions)   |            |                 | 84, 176        | 1      |
| 35. 00 | Adjusted reimbursable bad debts (see instructions)                                 |            |                 | 54, 714        | 35.00  |
| 36.00  | Allowable bad debts for dual eligible beneficiaries (see instructions)             |            |                 | 84, 176        | 36.00  |
| 37.00  | Subtotal (see instructions)  |            |                 | 540, 092       | 37.00  |
| 38. 00 | MSP-LCC reconciliation amount from PS&R  |            |                 | -37            | 38. 00 |
| 39. 00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)                                     |            |                 | 0              | 39.00  |
| 39. 50 | Pioneer ACO demonstration payment adjustment (see instructions)                    |            |                 |                | 39. 50 |
| 39. 75 | N95 respirator payment adjustment amount (see instructions)                        |            |                 | 0              | 1      |
| 39. 97 | Demonstration payment adjustment amount before sequestration                       |            |                 | 0              |        |
| 39. 98 | Partial or full credits received from manufacturers for replaced devices (see      | e instruct | i ons)          | 0              | 39. 98 |
| 39. 99 | RECOVERY OF ACCELERATED DEPRECIATION   |            |                 | 0              | 39. 99 |
| 40.00  | Subtotal (see instructions)  |            |                 | 540, 129       | 40.00  |
| 40. 01 | Sequestration adjustment (see instructions)  |            |                 | 6, 805         | •      |
| 40.02  | Demonstration payment adjustment amount after sequestration                        |            |                 | 0              | 40. 02 |
| 40.03  | Sequestration adjustment-PARHM or CHART pass-throughs                              |            |                 |                | 40.03  |
| 41.00  | Interim payments   |            |                 | 479, 617       | 41.00  |
| 41. 01 | Interim payments-PARHM or CHART  |            |                 |                | 41.01  |
| 42.00  | Tentative settlement (for contractors use only)                                    |            |                 | 0              | 42.00  |
| 42. 01 | Tentative settlement-PARHM or CHART (for contractor use only)                      |            |                 |                | 42. 01 |
| 43.00  | Balance due provider/program (see instructions)                                    |            |                 | 53, 707        | 43.00  |
| 43. 01 | Balance due provider/program-PARHM (see instructions)                              |            |                 |                | 43. 01 |
| 44.00  | Protested amounts (nonallowable cost report items) in accordance with CMS Pul      | b. 15-2, c | chapter 1,      | 7, 880         | 1      |
|        | §115. 2  |            | ·               |                | ]      |
|        | TO BE COMPLETED BY CONTRACTOR  |            |                 |                |        |
| 90.00  | Original outlier amount (see instructions)   |            |                 | 0              | 90.00  |
| 91.00  | Outlier reconciliation adjustment amount (see instructions)                        |            |                 | 0              | 91.00  |
| 92.00  | The rate used to calculate the Time Value of Money                                 |            |                 | 0. 00          | 92.00  |
| 93.00  | Time Value of Money (see instructions)   |            |                 | 0              | 93.00  |
| 94.00  | Total (sum of lines 91 and 93)   |            |                 | 0              | 94.00  |
|        |  |            | ·               |                |        |

| Health Financial Systems                | REHABILITATION HOSPITAL OF INDIANA | In Lie          | u of Form CMS-              | 2552-10          |
|---|------------------------------------|-----------------|-----------------------------|------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-3028             | From 01/01/2022 |                             |                  |
|   |                                    | To 12/31/2022   | Date/Time Pre 5/31/2023 9:3 | epared:<br>31 am |
|   | Title XVIII                        | Hospi tal       | PPS                         |                  |
|   |                                    |                 |                             |                  |
|   |                                    |                 | 1. 00                       |                  |
| MEDICARE PART B ANCILLARY COSTS         |                                    |                 |                             |                  |
| 200.00 Part B Combined Billed Days      |                                    |                 | 0                           | 200.00           |

In Lieu of Form CMS-2552-10

| Period: | Worksheet E-1 |
| From 01/01/2022 | Part |
| To 12/31/2022 | Date/Time Prepared: |
| 5/31/2023 9: 31 am | 
 Heal th
 Financial
 Systems
 REHABILIT

 ANALYSIS
 OF
 PAYMENTS
 TO
 PROVIDERS
 FOR
 SERVICES
 RENDERED
 Provi der CCN: 15-3028

|       |  |            | '           |                | 5/31/2023 9: 3      | 1 am  |
|-------|--|------------|-------------|----------------|---------------------|-------|
|       |  | Title      | XVIII       | Hospi tal      | PPS                 |       |
|       |  | Inpatien   | t Part A    | Par            | t B                 |       |
|       |  | mm/dd/yyyy | Amount      | mm/dd/yyyy     | Amount              |       |
|       |  | 1. 00      | 2. 00       | 3.00           | 4. 00               |       |
| 1. 00 | Total interim payments paid to provider                            | 1.00       | 9, 722, 240 |                | 479, 617            | 1.00  |
| 2. 00 | Interim payments payable on individual bills, either               |            | 7, 722, 240 |                | 477,017             | 2. 00 |
| 2.00  | submitted or to be submitted to the contractor for                 |            |             |                | Ĭ                   | 2.00  |
|       | services rendered in the cost reporting period. If none,           |            |             |                |                     |       |
|       | write "NONE" or enter a zero                                       |            |             |                |                     |       |
| 3.00  | List separately each retroactive lump sum adjustment               |            |             |                |                     | 3.00  |
|       | amount based on subsequent revision of the interim rate            |            |             |                |                     |       |
|       | for the cost reporting period. Also show date of each              |            |             |                |                     |       |
|       | payment. If none, write "NONE" or enter a zero. (1)                |            |             |                |                     |       |
|       | Program to Provider  |            |             |                |                     |       |
| 3. 01 | ADJUSTMENTS TO PROVIDER  |            | 0           |                | 0                   | 3.01  |
| 3.02  |  |            | 0           |                | 0                   | 3.02  |
| 3.03  |  |            | 0           |                | 0                   | 3.03  |
| 3.04  |  |            | 0           |                | 0                   | 3.04  |
| 3.05  |  |            | 0           |                | 0                   | 3.05  |
|       | Provider to Program  |            |             |                |                     |       |
| 3. 50 | ADJUSTMENTS TO PROGRAM   |            | 0           |                | 0                   | 3.50  |
| 3. 51 |  |            | 0           |                | 0                   | 3. 51 |
| 3. 52 |  |            | 0           |                | 0                   | 3. 52 |
| 3. 53 |  |            | 0           |                | 0                   | 3. 53 |
| 3. 54 |  |            | 0           |                | 0                   | 3. 54 |
| 3. 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines                |            | 0           |                | 0                   | 3. 99 |
| 4 00  | 3. 50-3. 98)   |            | 0 700 040   |                | 470 (17             | 4 00  |
| 4. 00 | Total interim payments (sum of lines 1, 2, and 3.99)               |            | 9, 722, 240 |                | 479, 617            | 4. 00 |
|       | (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) |            |             |                |                     |       |
|       | TO BE COMPLETED BY CONTRACTOR                                      |            |             |                |                     |       |
| 5. 00 | List separately each tentative settlement payment after            |            |             |                |                     | 5. 00 |
| 5. 00 | desk review. Also show date of each payment. If none,              |            |             |                |                     | 5.00  |
|       | write "NONE" or enter a zero. (1)                                  |            |             |                |                     |       |
|       | Program to Provider  |            |             |                |                     |       |
| 5. 01 | TENTATI VE TO PROVI DER  |            | 0           |                | 0                   | 5. 01 |
| 5.02  |  |            | 0           |                | 0                   | 5.02  |
| 5.03  |  |            | 0           |                | 0                   | 5.03  |
|       | Provider to Program  |            |             |                |                     |       |
| 5. 50 | TENTATI VE TO PROGRAM  |            | 0           |                | 0                   | 5.50  |
| 5. 51 |  |            | 0           |                | 0                   | 5. 51 |
| 5. 52 |  |            | 0           |                | 0                   | 5. 52 |
| 5. 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines                |            | 0           |                | 0                   | 5. 99 |
|       | 5. 50-5. 98)   |            |             |                |                     |       |
| 6. 00 | Determined net settlement amount (balance due) based on            |            |             |                |                     | 6.00  |
|       | the cost report. (1)   |            |             |                |                     |       |
| 6. 01 | SETTLEMENT TO PROVIDER   |            | 89, 670     |                | 53, 707             | 6. 01 |
| 6. 02 | SETTLEMENT TO PROGRAM  |            | 0 044 040   |                | 0                   | 6. 02 |
| 7. 00 | Total Medicare program liability (see instructions)                |            | 9, 811, 910 |                | 533, 324            | 7. 00 |
|       |  |            |             | Contractor     | NPR Date            |       |
|       |  |            | )           | Number<br>1.00 | (Mo/Day/Yr)<br>2.00 |       |
| 8. 00 | Name of Contractor   |            | J           | 1.00           | 2.00                | 8. 00 |
| 5. 00 | maine of contractor  |            |             | I              | ı l                 | 0.00  |

| Health Financial Systems                | REHABILITATION HOSPITA | AL OF INDIANA         | In Lieu                                      | u of Form CMS-2552-10   |
|---|------------------------|-----------------------|--|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT |                        | Provider CCN: 15-3028 | Peri od:<br>From 01/01/2022<br>To 12/31/2022 | Worksheet E-3<br>Part III<br>Date/Time Prepared:<br>5/31/2023 9:31 am |
|   |                        | T                     |  | 200   |

| PART III - MEDICARE PART A SERVICES - IRF PPS  | -      |   | Title XVIII                | Hospi tal         | PPS          | ı aiii |
|--|--------|---|----------------------------|-------------------|--------------|--------|
| PART_III - MEDICANE_PART A SERVICES - INF PPS  |        |   |                            |                   |              |        |
| 1.00   Net Federal PSP Psyment (see Instructions)   9,005,914   1.00   |        | DADT III MEDICADE DADT A CEDVICEC LDE DOC   |                            |                   | 1. 00        |        |
| Medicare SSI ratio (IRF PS only) (see instructions)  | 1 00   |   |                            |                   | 0 005 014    | 1 00   |
| Inpati ent Rehabilitation LIP Payments (see instructions)   362, 322 4.00  |        | , ,   |                            |                   |              |        |
| 0.00      |        | ,   |                            |                   |              |        |
| bowesher 15, 2004 (see instructions) cap increases for the unweighted intern and resident FTE count for residents that were displaced by cap increases for the unweighted intern and resident FTE count for residents that were displaced by cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 (FR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) 6.00 New Teaching program displaced in (see instructions) 7.00 Current year's unweighted FTE count of IAR excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 7.00 Current year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 7.00 Current year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 7.00 Current year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 7.00 Current year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 7.00 Count for a program of the form of the program growth period of a "new teaching program" (see instructions) 7.00 Count for a program of the program growth period of a "new teaching program" (see instructions) 7.00 Count for a program of the program growth period of a "new teaching program" (see instructions) 7.00 Count for a program of the program growth period of a "new teaching program" (see instructions) 7.00 Count for a program of the program growth period of a "new teaching program of the program growth period of a "new teaching program of the program growth period of a "new teaching program of the program growth period of a "new teaching program of the program growth period of a "new teaching program of the program growth period of a "new teaching program grow |        |   |                            |                   |              |        |
| Cap Increases for the unwelghted Intern and resident FTE count for residents that were displaced by program or hospit fall closure, that would not be counted without a temporary cap adjustment under 42 CFR \$412.424(0)(1)(III)(F)(1) or (2) (see Instructions)   |        | Unweighted intern and resident FTE count in the most recent c   | ost reporting period en    | nding on or prior |              |        |
| New Teaching program adjustment. (see instructions)   0.00   6.00  | 5. 01  | Cap increases for the unweighted intern and resident FTE coun program or hospital closure, that would not be counted withou |                            |                   | 0. 00        | 5. 01  |
| teaching program" (see instructions)  1.00 | 6. 00  |   |                            |                   | 0.00         | 6. 00  |
| Second   Current year's unweighted IAR FIE count for residents within the new program growth period of a "new to be eaching program" (see instructions)   0.34 9.00  | 7. 00  |   | the new program growth p   | period of a "new  | 2. 83        | 7. 00  |
| 9.00   Intern and resident count for IRF PPS medical education adjustment (see instructions)   0.34   9.00   | 8. 00  | Current year's unweighted I&R FTE count for residents within  | the new program growth p   | period of a "new  | 0. 00        | 8. 00  |
| 10. 0  | 9. 00  |   | tment (see instructions    | )                 | 0. 34        | 9.00   |
| 11.00   Teaching Adjustment Factor (see instructions)   0.006732   11.00   12.00   Total PPS Payment (see instructions)   10.211, 478   13.00   10.014   PPS Payment (see instructions)   10.211, 478   13.00   10.0   |        | 1   |                            |                   |              |        |
| Total PPS Payment (see instructions)   10, 211, 478   13, 00   | 11.00  |   |                            |                   | 0.006732     | 11. 00 |
| 14. 00   Nursing and Állied Health Managed Care payments (see instruction)   1,4 0.0   1,5 0.0   | 12.00  | Teaching Adjustment (see instructions)  |                            |                   | 60, 628      | 12.00  |
| 15.00   Organ acquisition (DO NOT USE THIS LINE)   15.00   16.00   10.00   1   | 13.00  | ,   |                            |                   | 10, 211, 478 | 13.00  |
| 16.00   Cost of physicians' services in a teaching hospital (see instructions)   0   16.00   10.211, 478   17.00   18.00   Primary payer payments   10.211, 478   17.00   4.659   18.00   19.00   Subtotal (line 17 less line 18).   10.206, 819   19.00   20.00   Deductibles   59.056   20.00   21.00   Subtotal (line 19 minus line 20)   10,147,763   21.00   23.00   Subtotal (line 21 minus line 22)   9,901,054   23.00   246,709   22.00   246,709   22.00   246,709   22.00   246,709   22.00   246,709   22.00   23.00   240,00   Aljusted reimbursable bad debts (see instructions)   55,483   24.00   25.00   24.00   Aljusted reimbursable bad debts (see instructions)   36,064   25.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.0   |        |   | i on)                      |                   | 0            |        |
| 17.00   Subtotal (isee instructions)   10,211,478   17,00   19,00   10,00   10,00   10,00   10,00   10,00   10,00   10,00   10,00   10,00   10,00   10,00   10,00   10,00   10,147,763   10,00   10,147,763   10,00   10,147,763   10,00   10,147,763   10,000   10,147,763   10,147,763   10,000   10,147,763   1   |        | , ,   |                            |                   | _            |        |
| 18. 00   Primary payer payments  |        |   | ructi ons)                 |                   | -            |        |
| 19. 00   Subtotai (line 17 less line 18).   10, 206, 819   19. 00   20. 0   |        | , ,   |                            |                   |              |        |
| 20. 00   Deductibles   Sp. 056   20. 00   21. 00   Subtotal (line 19 minus line 20)   10, 147, 763   21. 00   22. 00   23. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   25. 00     |        | 1 3 1 3 1 3   |                            |                   |              |        |
| 21. 00   Subtotal (line 19 minus line 20)   10, 147, 763   21. 00   22. 00   246, 709   22. 00   246, 709   22. 00   246, 709   22. 00   240, 709   23. 00   240, 709   240, 7   |        | ,   |                            |                   |              |        |
| 22. 00   Coinsurance   246, 709   22. 00   23. 00   Subtotal (line 21 minus line 22)   23. 00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   55, 483   24. 00   25. 00   Adjusted reimbursable bad debts (see instructions)   36, 064   25. 00   26. 00   Allowable bad debts for dual eligible beneficiaries (see instructions)   36, 064   25. 00   27. 00   Subtotal (sum of lines 23 and 25)   9, 937, 118   27. 00   28. 00   Direct graduate medical education payments (from Wkst. E-4, line 49)   9, 28. 00   00   Other pass through costs (see instructions)   0   28. 00   00   Other pass through costs (see instructions)   0   29. 00   00   Other pass through costs (see instructions)   0   30. 00   00   00   Other pass through costs (see instructions)   0   31. 50   00   00   00   00   00   00   00  |        |   |                            |                   |              |        |
| 23.00   Subtotal (line 21 minus line 22)   9,901,054   23.00   24.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   55,483   24.00   25.00   Adjusted reimbursable bad debts (see instructions)   36,064   25.00   26.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   55,483   26.00   27.00   Subtotal (sum of lines 23 and 25)   9,937,118   27.00   28.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0   28.00   29.00   Other pass through costs (see instructions)   0   29.00   0   0   0   0   0   0   0   0   0  |        |   |                            |                   |              |        |
| 24. 00   All owable bad debts (exclude bad debts for professional services) (see instructions)   55, 483   24. 00   25. 00   27. 00   28. 00   All owable bad debts for dual eligible beneficiaries (see instructions)   55, 483   26. 00   27. 00   Subtotal (sum of lines 23 and 25)   9, 937, 118   27. 00   28. 00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0   28. 00   29. 00   Other pass through costs (see instructions)   0   29. 00   29. 00   00   00   00   00   00   00   00   |        |   |                            |                   |              |        |
| 25.00  |        | · · · · · · · · · · · · · · · · · · ·   | ces) (see instructions)    |                   |              |        |
| 26.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       55, 483       26.00         27.00       Subtotal (sum of lines 23 and 25)       9, 937, 118       27.00         28.00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0 28.00         29.00       Other pass through costs (see instructions)       0 29.00         30.00       Outlier payments reconcillation       0 30.00         31.50       Pioneer ACO demonstration payment adjustment (see instructions)       0 31.00         31.98       Recovery of accelerated depreciation.       0 31.98         31.99       Demonstration payment adjustment amount before sequestration       0 31.99         32.01       Sequestration adjustment (see instructions)       9, 937, 118       32.00         32.02       Demonstration payment adjustment amount after sequestration       125, 208       32.01         32.02       Demonstration payment adjustment amount after sequestration       9, 937, 118       32.00         33.00       Interim payments       9, 722, 240       33.00         34.00       Tentative settlement (for contractor use only)       9, 722, 240       33.00         35.00       Bal ance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)       89,670       35.00         50.00  |        | ,   | (333 11131 431 3113)       |                   |              |        |
| 27. 00       Subtotal (sum of lines 23 and 25)       9, 937, 118       27. 00         28. 00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       28. 00         29. 00       Other pass through costs (see instructions)       0       29. 00         30. 00       Outlier payments reconciliation       0       30. 00         31. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       31. 50         31. 98       Recovery of accelerated depreciation.       0       31. 98         31. 99       Demonstration payment adjustment amount before sequestration       0       31. 99         32. 00       Sequestration adjustment (see instructions)       9, 937, 118       32. 00         32. 01       Interim payment adjustment amount after sequestration       9, 937, 118       32. 00         32. 02       Demonstration payment adjustment amount after sequestration       0       31. 99         33. 00       Interim payments       9, 722, 240       33. 00         34. 00       Fortative settlement (for contractor use only)       0       34. 00         35. 00       Balance due provider/program (line 32 minus lines 32. 01, 32. 02, 33, and 34)       89, 670       35. 00         50. 00       Di BE COMPLETED BY CONTRACTOR       0       0   |        | ,   | ructions)                  |                   |              |        |
| 28.00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       28.00         29.00       Other pass through costs (see instructions)       0       29.00         30.00       Outlier payments reconciliation       0       30.00         31.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       31.00         31.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       31.50         31.98       Recovery of accelerated depreciation.       0       31.98         31.99       Demonstration payment adjustment amount before sequestration       0       31.98         32.01       Sequestration adjustment (see instructions)       9,937,118       32.00         32.02       Demonstration payment adjustment amount after sequestration       125,208       32.01         32.02       Demonstration payment adjustment amount after sequestration       9,722,240       33.00         31.00       Interim payments       9,722,240       33.00         32.02       Demonstration payment adjustment amount after sequestration       0       32.02         33.00       Interim payments       9,722,240       33.00         34.00       Tentative settlement (for contractor use only)       0       34.00         35.00  |        | ,   | ,                          |                   |              |        |
| 30.00 Outlier payments reconciliation 0 0 31.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 31.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 31.00 31.98 Recovery of accelerated depreciation. 0 31.98 Recovery of accelerated depreciation. 0 31.99 Demonstration payment adjustment amount before sequestration 0 31.99 Outlier amount payable to the provider (see instructions) 9,937,118 32.00 Sequestration adjustment (see instructions) 9,937,118 32.01 Demonstration payment adjustment amount after sequestration 0 32.02 Sequestration adjustment amount after sequestration 0 32.02 Sequestration 0 9,722,240 33.00 Interim payments 9,722,240 33.00 Interim payments 9,722,240 33.00 Protested amounts (for contractor use only) 9,722,240 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 139,710 \$15.0 Demonstration adjustment amount (see instructions) 0 Original outlier amount from Wkst. E-3, Pt. III, line 4 362,322 50.00 Outlier reconciliation adjustment amount (see instructions) 0 Original outlier amount from Wkst. E-3, Pt. III, line 4 362,322 50.00 The rate used to calculate the Time Value of Money 52.00 The rate used to calculate the Time Value of Money 52.00 The Value of Money (see instructions) 0 Time Value of Money (see instructions) 0 Original outlier amount for the cost reporting period immediately preceding February 29, 2020. 0.005988 99.00   |        | ,   | ine 49)                    |                   |              |        |
| 31.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 31.50 Pi oneer ACO demonstration payment adjustment (see instructions) 31.98 Recovery of accelerated depreciation. 31.99 Demonstration payment adjustment amount before sequestration 31.99 Total amount payable to the provider (see instructions) 32.00 Sequestration adjustment (see instructions) 32.01 Sequestration adjustment (see instructions) 32.02 Demonstration payment adjustment amount after sequestration 32.02 Interim payments 33.00 Interim payments 44.00 Tentative settlement (for contractor use only) 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 139,710 Sequestration adjustment amount (see instructions) 36.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 362,322 TO BE COMPLETED BY CONTRACTOR 36.00 Outlier reconciliation adjustment amount (see instructions) 37.00 Outlier reconciliation adjustment amount (see instructions) 38.00 Outlier reconciliation adjustment amount (see instructions) 39.00 Outlier reconciliation adjustment amount (see instructions) 40.00 Second Money (see instructions) 40. | 29.00  | Other pass through costs (see instructions)   | ŕ                          |                   | 0            | 29. 00 |
| 31.50 Pi oneer ACO demonstration payment adjustment (see instructions) 31.98 Recovery of accelerated depreciation. 31.98 Demonstration payment adjustment amount before sequestration 32.00 Total amount payable to the provider (see instructions) 32.01 Sequestration adjustment (see instructions) 32.02 Demonstration payment adjustment amount after sequestration 32.02 Demonstration payment adjustment amount after sequestration 32.02 Demonstration payment adjustment amount after sequestration 32.02 Demonstration payment adjustment amount after sequestration 32.02 Demonstration payment adjustment amount after sequestration 32.02 Demonstration payment adjustment amount after sequestration 32.02 Demonstration payment adjustment amount after sequestration 32.02 Demonstration payment adjustment amount after sequestration 32.02 Demonstration payment adjustment amount after sequestration 32.02 Demonstration payment adjustment amount after sequestration 32.02 Demonstration payment adjustment amount after sequestration 32.02 Demonstration payment adjustment amount after sequestration 32.02 Demonstration payment adjustment amount after sequestration 32.02 Demonstration payment adjustment amount after sequestration 32.02 Demonstration payment adjustment amount after sequestration 32.02 Demonstration payment adjustment amount after sequestration 32.02 Demonstration payment adjustment amount after sequestration 32.02 Demonstration payment adjustment amount after sequestration 32.02 Demonstration payment adjustment amount after sequestrations 32.02 Demonstration adjustment amount after sequestrations 32.02 Demonstration adjustment amount after sequestrations 32.02 Demonstration adjustment amount after sequestrations 32.02 Demonstration adjustment amount after sequestrations 32.02 Demonstration adjustment amount after sequestrations 32.02 Demonstration adjustment amount after sequestrations 32.02 Demonstration adjustment amount after sequestration 32.02 Demonstration adjustment amount after sequestration 32.02 Demonstration adjustm | 30.00  | Outlier payments reconciliation   |                            |                   | 0            | 30.00  |
| 31. 98 Recovery of accelerated depreciation.  31. 99 Demonstration payment adjustment amount before sequestration  31. 99 Total amount payable to the provider (see instructions)  32. 00 Sequestration adjustment (see instructions)  32. 01 Demonstration payment adjustment amount after sequestration  32. 02 Demonstration payment adjustment amount after sequestration  32. 02 Demonstration payment adjustment amount after sequestration  32. 02 Interim payments  33. 00 Interim payments  40. 00 Tentative settlement (for contractor use only)  35. 00 Balance due provider/program (line 32 minus lines 32. 01, 32. 02, 33, and 34)  70 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 139, 710 Since 15. 2  70 BE COMPLETED BY CONTRACTOR  70 Original outlier amount from Wkst. E-3, Pt. III, line 4  90 Outlier reconciliation adjustment amount (see instructions)  10 Outlier reconciliation adjustment amount (see instructions)  11 Time Value of Money (see instructions)  12 Outlier reconciliation adjustment amount (see instructions)  13 Outlier reconciliation adjustment amount (see instructions)  14 Outlier reconciliation adjustment amount (see instructions)  15 Outlier reconciliation adjustment amount (see instructions)  15 Outlier reconciliation adjustment amount (see instructions)  15 Outlier reconciliation adjustment amount (see instructions)  15 Outlier reconciliation adjustment amount (see instructions)  16 Outlier reconciliation adjustment amount (see instructions)  17 Outlier reconciliation adjustment amount (see instructions)  18 Outlier reconciliation adjustment amount (see instructions)  19 Outlier reconciliation adjustment amount (see instructions)  10 Outlier reconciliation adjustment amount (see instructions)  10 Outlier reconciliation adjustment amount (see instructions)  19 Outlier reconciliation adjustment amount (see instructions)  10 Outlier reconciliation adjustment amount (see instructions)  10 Outlier reconciliation adjustment amount (see instructions)  10 Outlier re | 31.00  | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  |                            |                   | 0            | 31.00  |
| 31. 99 32.00 32.01 32.02 32.02 32.02 32.02 33.00 32.01 32.02 33.00 32.01 32.02 33.00 33.00 34.00 35.00 36.00 37.00 38.00 38.00 38.00 38.00 38.00 38.00 39.00 | 31. 50 | Pioneer ACO demonstration payment adjustment (see instruction   | s)                         |                   | 0            | 31. 50 |
| Total amount payable to the provider (see instructions)  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Jemonstration payment adjustment amount amount after  |        | '   |                            |                   | -            |        |
| 32.01 Sequestration adjustment (see instructions) 32.02 Demonstration payment adjustment amount after sequestration 32.03 Demonstration payment adjustment amount after sequestration 32.02 Interim payments 33.00 Interim payments 34.00 Tentative settlement (for contractor use only) 35.00 Bal ance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 139,710 36.00 Since the settlement of the settleme |        |   |                            |                   | -            |        |
| 32.02 33.00 Interim payments Interim payments 32.01 33.00 Interim payments Interim payments 32.02 33.00 Interim payments Interim payments 32.02 33.00 Interim payments Interim p |        |   |                            |                   |              |        |
| 33.00 Interim payments 33.00 Tentative settlement (for contractor use only) 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 139, 710 Since the settlement of the set |        | , ,   |                            |                   |              |        |
| 34.00 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 89,670 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 139,710 Since the settlement (for contractor use only) 89,670 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 139,710 Since the settlement (for contractor use only) 89,670 35.00 Since the settlement (for contractor use only) 89,670 35.00 Since the settlement (for contractor use only) 89,670 80,00 Since the settlement (for contractor use only) 89,670 80,00 Since the settlement (for contractor use only) 89,670 80,00 Since the settlement (for contractor use only) 89,670 80,00 Since the settlement (for contractor use only) 89,670 80,00 Since the settlement (for contractor use only) 89,670 80,00 Since the settlement (for contractor use only) 89,670 80,00 Since the settlement (for contractor use only) 89,670 80,00 Since the settlement (for contractor use only) 89,670 80,00 Since the settlement (for contractor use only) 89,670 80,00 Since the settlement (for contractor use only) 89,670 80,00 Since the settlement (for contractor use only) 89,670 80,00 Since the settlement (for contractor use only) 89,670 80,00 Since the settlement (for contractor use only) 89,670 80,00 Since the settlement (for contractor use only) 89,670 80,00 80, |        |   |                            |                   | - 1          |        |
| 35. 00 Balance due provider/program (line 32 minus lines 32. 01, 32. 02, 33, and 34)  89, 670 35. 00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 139, 710 36. 00  S115. 2  TO BE COMPLETED BY CONTRACTOR  Original outlier amount from Wkst. E-3, Pt. III, line 4  Outlier reconciliation adjustment amount (see instructions)  12.00 The rate used to calculate the Time Value of Money  136. 00  Time Value of Money (see instructions)  137. 00  To BE COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE  99. 00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  138. 00  139, 710  139, 710  36. 00   |        |   |                            |                   |              |        |
| 36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 139,710 36.00 \$\frac{\text{\$\frac{\text{\$\grace}{115.2}}}{\text{\$\grace}{1000000000000000000000000000000000000  |        | ,   | 2 22 and 24)               |                   | -            |        |
| \$115. 2 TO BE COMPLETED BY CONTRACTOR  50. 00 Original outlier amount from Wkst. E-3, Pt. III, line 4 Outlier reconciliation adjustment amount (see instructions)  51. 00 The rate used to calculate the Time Value of Money  52. 00 Time Value of Money (see instructions)  FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE  99. 00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0. 005988 0. 00  |        |   | •                          | chanter 1         |              |        |
| TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 Outlier reconciliation adjustment amount (see instructions)  51.00 The rate used to calculate the Time Value of Money  52.00 Time Value of Money (see instructions)  FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0.005988 0.00 0.005988  | 30.00  |   | rice with construct. 15 2, | chapter 1,        | 137, 710     | 30.00  |
| 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4  51.00 Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  Time Value of Money (see instructions)  FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0.005988  99.00   |        |   |                            |                   |              |        |
| 51.00 Outlier reconciliation adjustment amount (see instructions)  52.00 The rate used to calculate the Time Value of Money  Time Value of Money (see instructions)  FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0.005988  99.00  | 50.00  |   |                            |                   | 362, 322     | 50.00  |
| 52.00 The rate used to calculate the Time Value of Money  Time Value of Money (see instructions)  FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0.00 52.00 53 |        |   |                            |                   |              |        |
| 53.00 Time Value of Money (see instructions) 0 53.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.005988 99.00   |        | ,   |                            |                   | 0.00         |        |
| 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.005988 99.00   | 53.00  |   |                            |                   |              |        |
|  |        | FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND   | BEGINNING BEFORE THE EN    | ND OF THE COVID-1 | 9 PHE        |        |
| 99.01   Calculated Teaching Adjustment Factor for the current year. (see instructions) 0.006732   99.01  |        |   |                            | ary 29, 2020.     |              |        |
|  | 99. 01 | Calculated Teaching Adjustment Factor for the current year. (   | see instructions)          |                   | 0. 006732    | 99. 01 |

|   | Financial Systems REHABILITATION HOSPITAL  GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT PROPERTY.   | rovider CCN: 15-   |   | ri od:  | u of Form CMS-2<br>Worksheet E-4          |  |
|---|--|--|---|---|---|--|
| EDI CA  | AL EDUCATION COSTS   |  | Fr<br>To  | om 01/01/2022<br>12/31/2022   | Date/Time Prep<br>5/31/2023 9:3           |  |
|   |  | Title XVIII  |   | Hospi tal   | PPS                                       | ı diii   |
|   |  |  |   |   | 1.00                                      |  |
|   | COMPUTATION OF TOTAL DIRECT GME AMOUNT   |  |   |   |   |  |
| . 00  | Unweighted resident FTE count for allopathic and osteopathic prolending on or before December 31, 1996.  | ograms for cost  | reporti n   | g periods   | 0. 00                                     | 1.00   |
| . 01  | FTE cap adjustment under §131 of the CAA 2021 (see instructions)   | )  |   |   | 0.00                                      | 1.01   |
| . 00  | Unweighted FTE resident cap add-on for new programs per 42 CFR   |  |   |   | 0. 00                                     | 2.00   |
| . 26  | Rural track program FTE cap limitation adjustment after the cap-<br>the CAA 2021 (see instructions)  | -building windo  | w closed i  | under §127 of   |   | 2. 2   |
| 00  | Amount of reduction to Direct GME cap under section 422 of MMA   |  |   |   | 0.00                                      | 3.00   |
| 01  | Direct GME cap reduction amount under ACA §5503 in accordance wi   | ith 42 CFR §413  | .79 (m).  | (see  | 0. 00                                     | 3.0  |
| 02  | instructions for cost reporting periods straddling 7/1/2011) Adjustment (increase or decrease) to the hospital's rural track   | FTE limitation   | (s) for r   | ıral track  |   | 3. 0.  |
|   | programs with a rural track Medicare GME affiliation agreement   |  |   |   |   |  |
| . 00  | 49075 (August 10, 2022) (see instructions)<br>  Adjustment (plus or minus) to the FTE cap for allopathic and os  | toonathic progr  | ame dua t   | a Modicara  | 0. 00                                     | 4.00   |
| . 00  | GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))   | reopatilic progr   | allis due ti  | o a wedicare  | 0.00                                      | 4.0  |
| 01  | ACA Section 5503 increase to the Direct GME FTE Cap (see instruc   | ctions for cost  | reporti n   | g periods   | 0. 00                                     | 4.0  |
| 02  | straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slots  | (see instructi   | ons for c   | nst renorting   | 0. 00                                     | 4.0  |
| 02  | periods straddling 7/1/2011)   | (300 111311 4011   | 0113 101 0  | Jac Topol triig   | 0.00                                      | 1.0  |
| 21  | The amount of increase if the hospital was awarded FTE cap slots   | s under §126 of  | the CAA   | 2021 (see   |   | 4. 2   |
| 00  | <pre>instructions) FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines</pre>   | s lines 3 and  | 0. 00   | 5.0   |   |  |
|   | 3.01, plus or minus line 3.02, plus or minus line 4, plus lines  | 4.01 through 4   | . 27  |   |   |  |
| . 00  | Unweighted resident FTE count for allopathic and osteopathic processors (see instructions)   | ograms for the   | current y   | ear from your   | 2. 83                                     | 6.0  |
| . 00  | Enter the lesser of line 5 or line 6   |  |   |   | 0.00                                      | 7.0  |
|   |  |  | ary Care  | Other   | Total                                     |  |
| . 00  | Weighted FTE count for physicians in an allopathic and osteopatl   |  | 0.00  | 2. 00   | 3. 00                                     | 8.00   |
|   | program for the current year.  |  |   |   |   |  |
| . 00  | If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount  |  | 0. 00   | 0. 00   | 0. 00                                     | 9.00   |
|   | 6. For cost reporting periods beginning on or after October 1, 2   |  |   |   |   |  |
|   | if Worksheet S-2, Part I, line 68, is "Y", see instructions.   |  |   | 0.00  |   |  |
| 00 .0   | Weighted dental and podiatric resident FTE count for the curren<br>Unweighted dental and podiatric resident FTE count for the curren   |  |   | 0.00  |   | 10. 0<br>10. 0   |
|   | Johnson gritted derital and podratific resident file count for the curre   |  |   |   |   |  |
| 0. 01   | Total weighted FTE count   | ent year   | 0. 00   | 0. 00<br>0. 00  |   |  |
| 0. 01<br>1. 00  | Total weighted FTE count Total weighted resident FTE count for the prior cost reporting y  |  | 0. 00<br>0. 00  |   |   | 11.0   |
| 0. 01<br>1. 00<br>2. 00   | Total weighted resident FTE count for the prior cost reporting $\underline{\underline{y}}$ instructions)   | year (see  | 0. 00   | 0. 00<br>0. 00  |   | 11. 0<br>12. 0   |
| 0. 01<br>1. 00<br>2. 00   | Total weighted resident FTE count for the prior cost reporting   | year (see  |   | 0. 00   |   | 11. 0<br>12. 0   |
| 0. 01<br>1. 00<br>2. 00<br>3. 00  | Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by   | year (see<br>rting   | 0. 00<br>0. 00<br>0. 00   | 0. 00<br>0. 00<br>0. 00<br>0. 00  |   | 11. 00<br>12. 00<br>13. 00<br>14. 00   |
| 0. 01<br>1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00  | Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs   | year (see<br>rting<br>y 3).                                      | 0. 00<br>0. 00<br>0. 00<br>0. 00  | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00                                     |   | 11. 0<br>12. 0<br>13. 0<br>14. 0<br>15. 0  |
| 0. 01<br>1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00<br>5. 01   | Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs  | year (see<br>rting<br>y 3).                                      | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00                                     | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00                            |   | 11. 0<br>12. 0<br>13. 0<br>14. 0<br>15. 0<br>15. 0   |
| 0. 01<br>1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 01<br>5. 00   | Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs Adjustment for residents displaced by program or hospital closure.   | year (see<br>rting<br>y 3).<br>grams                             | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00                            | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00                   |   | 11. 0<br>12. 0<br>13. 0<br>14. 0<br>15. 0<br>15. 0   |
| 0. 01<br>1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00<br>5. 01<br>6. 00  | Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs  | year (see<br>rting<br>y 3).<br>grams                             | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00                                     | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00                            |   | 11. 0<br>12. 0<br>13. 0<br>14. 0<br>15. 0<br>15. 0   |
| 0. 01<br>1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00<br>5. 01<br>6. 01<br>7. 00   | Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs of Adjustment for residents displaced by program or hospital closur Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count  | year (see<br>rting<br>y 3).<br>grams                             | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00                   | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00          |   | 11. 0<br>12. 0<br>13. 0<br>14. 0<br>15. 0<br>15. 0<br>16. 0<br>16. 0   |
| 0. 01<br>1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00<br>5. 01<br>6. 00<br>6. 01<br>7. 00<br>3. 00   | Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program or hospital closus Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount  | year (see<br>rting<br>y 3).<br>grams                             | 0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00                          | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00          |   | 11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>16. 0<br>17. 00<br>18. 00                                      |
| 0. 01<br>1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00<br>5. 01<br>6. 00<br>6. 01<br>7. 00<br>8. 00   | Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program or hospital closus Unweighted adjustment for residents displaced by program or hospital closus Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021   | year (see<br>rting<br>y 3).<br>grams                             | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00          | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00 | 0   | 11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>16. 00<br>17. 00<br>18. 00<br>18. 00                           |
| 0. 01<br>1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 00<br>5. 01<br>6. 00<br>6. 01<br>7. 00<br>8. 00<br>8. 01  | Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program or hospital closus Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount  | year (see<br>rting<br>y 3).<br>grams                             | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00                   | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00          | 0   | 11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>16. 00<br>17. 00<br>18. 00<br>18. 00                           |
| 0. 01<br>1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 01<br>6. 00<br>6. 01<br>7. 00<br>8. 00<br>8. 01<br>9. 00  | Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program or hospital closur Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs  | year (see<br>rting<br>y 3).<br>grams<br>re<br>pital              | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00 | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00          | 1.00                                      | 11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00                           |
| 0. 01<br>1. 00<br>2. 00<br>3. 00<br>4. 00<br>5. 01<br>6. 00<br>6. 01<br>7. 00<br>8. 00<br>8. 01<br>9. 00  | Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program or hospital closus Unweighted adjustment for residents displaced by program or hospital closus Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021   | year (see<br>rting<br>y 3).<br>grams<br>re<br>pital              | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00 | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00          | 1.00                                      | 11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>16. 00<br>17. 00<br>18. 00<br>18. 00                           |
| 0. 01<br>11. 00<br>22. 00<br>33. 00<br>44. 00<br>55. 00<br>55. 01<br>66. 00<br>77. 00<br>88. 00<br>88. 01<br>99. 00                               | Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost reporting year (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs  Unweighted adjustment for residents in initial years of new program or hospital closus unweighted adjustment for residents displaced by program or hospital closus Unweighted adjustment for residents displaced by program or hospital closure  Adjusted rolling average FTE count  Per resident amount  Per resident amount  Per resident amount under §131 of the CAA 2021  Approved amount for resident costs  Additional unweighted allopathic and osteopathic direct GME FTE Sec. 413.79(c)(4)  Direct GME FTE unweighted resident count over cap (see instructions)   | year (see rting y 3). grams re pital resident cap s ions)        | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00 | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00          | 1. 00<br>0. 00<br>2. 83                   | 11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00                           |
| 0. 01<br>11. 00<br>22. 00<br>33. 00<br>44. 00<br>55. 00<br>55. 01<br>66. 00<br>66. 01<br>77. 00<br>88. 00<br>88. 01<br>99. 00                     | Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost reporting year (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs  Unweighted adjustment for residents in initial years of new program or hospital closure  Adjustment for residents displaced by program or hospital closure  Adjusted rolling average FTE count  Per resident amount  Per resident amount  Per resident amount under §131 of the CAA 2021  Approved amount for resident costs  Additional unweighted allopathic and osteopathic direct GME FTE Sec. 413.79(c)(4)  Direct GME FTE unweighted resident count over cap (see instructional count over cap (see instructional count count (see instructional count count over cap (see instructional count count count (see instructional count count count count (see instructional count cou | year (see rting y 3). grams re pital resident cap s ions) tions) | 0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00          | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00          | 1. 00<br>0. 00<br>2. 83<br>0. 00          | 11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>20. 00<br>21. 00<br>22. 00       |
| 0. 01<br>11. 00<br>22. 00<br>33. 00<br>44. 00<br>55. 00<br>55. 01<br>66. 00<br>66. 01<br>77. 00<br>88. 00<br>99. 00<br>11. 00<br>22. 00<br>33. 00 | Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost reporting year (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs  Unweighted adjustment for residents in initial years of new program or hospital closus unweighted adjustment for residents displaced by program or hospital closus Unweighted adjustment for residents displaced by program or hospital closure  Adjusted rolling average FTE count  Per resident amount  Per resident amount  Per resident amount under §131 of the CAA 2021  Approved amount for resident costs  Additional unweighted allopathic and osteopathic direct GME FTE Sec. 413.79(c)(4)  Direct GME FTE unweighted resident count over cap (see instructions)   | year (see rting y 3). grams re pital resident cap s ions) tions) | 0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00          | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00<br>0. 00          | 1. 00<br>0. 00<br>2. 83<br>0. 00<br>0. 00 | 11. 0<br>12. 0<br>13. 0<br>14. 0<br>15. 0<br>16. 0<br>16. 0<br>17. 0<br>18. 0<br>19. 0<br>20. 0<br>21. 0<br>22. 0<br>23. 0 |

|         | GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT   | Provi der C  | CN: 15-3028   | Peri od:                         | Worksheet E-4                  |        |
|---------|---|--------------|---------------|----------------------------------|--------------------------------|--------|
| MEDI CA | LL EDUCATION COSTS  |              |               | From 01/01/2022<br>To 12/31/2022 | Date/Time Pre<br>5/31/2023 9:3 |        |
|         |   | Title        | : XVIII       | Hospi tal                        | PPS                            |        |
|         |   |              | I npati ent   | Managed Care                     | Total                          |        |
|         |   |              | Part A        |                                  |                                |        |
|         | [   |              | 1. 00         | 2. 00                            | 3. 00                          |        |
| 04 00   | COMPUTATION OF PROGRAM PATIENT LOAD   | V 11         |               | 0.704                            |                                | 0, 00  |
| 26.00   | Inpatient Days (see instructions) (Title XIX - see S-2 Part I 3.02, column 2)                               | x, line      | 5, 54         | 12 3, 704                        |                                | 26. 00 |
| 27. 00  | · · · · · · · · · · · · · · · · · · ·   |              | 18, 73        | 18, 734                          |                                | 27. 00 |
| 28. 00  | Ratio of inpatient days to total inpatient days   |              | 0. 29582      | · ·                              |                                | 28.00  |
| 29. 00  | ' '   |              | 0. 27302      | 0. 177713                        | 0                              |        |
|         | Percent reduction for MA DGME   |              |               | 3. 26                            | O                              | 29. 01 |
|         | Reduction for direct GME payments for Medicare Advantage  |              |               | 0.20                             | 0                              |        |
|         | Net Program direct GME amount   |              |               |                                  | 0                              |        |
|         |   |              | l.            |                                  |                                |        |
|         |   |              |               |                                  | 1. 00                          |        |
|         | DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)                              | E XVIII ONL' | Y (NURSING PR | OGRAM AND PARAME                 | DI CAL                         |        |
| 32. 00  | Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) |              |               |                                  |                                | 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. 000000                      | 34.00  |
| 35.00   | Medicare outpatient ESRD charges (see instructions)   |              | ,             |                                  | 0                              | 35.00  |
| 36.00   | Medicare outpatient ESRD direct medical education costs (line   | 34 x line    | 35)           |                                  | 0                              | 36.00  |
|         | APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII   | ONLY         |               |                                  |                                |        |
|         | Part A Reasonable Cost  |              |               |                                  |                                |        |
| 37. 00  | Reasonable cost (see instructions)  |              |               |                                  | 10, 582, 850                   |        |
| 38. 00  |   |              |               |                                  | 0                              |        |
| 39. 00  | Cost of physicians' services in a teaching hospital (see inst   | ructi ons)   |               |                                  | 0                              | 39.00  |
|         | Primary payer payments (see instructions)   |              |               |                                  | 4, 659                         | 1      |
| 41. 00  |   | s line 40)   |               |                                  | 10, 578, 191                   | 41.00  |
| 12 00   | Part B Reasonable Cost Reasonable cost (see instructions)   |              |               |                                  | 685, 555                       | 42.00  |
| 42.00   | Primary payer payments (see instructions)   |              |               |                                  | 566                            | 1      |
|         | Total Part B reasonable cost (line 42 minus line 43)  |              |               |                                  | 684, 989                       |        |
| 45.00   | Total reasonable cost (sum of lines 41 and 44)  |              |               |                                  | 11, 263, 180                   |        |
|         | Ratio of Part A reasonable cost to total reasonable cost (lin   | e 41 ± line  | 45)           |                                  | 0. 939183                      |        |
|         | Ratio of Part B reasonable cost to total reasonable cost (IIII  |              |               |                                  | 0. 060817                      | 1      |
| .,. 00  | ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA   |              | ,             |                                  | 3. 333017                      | 1 50   |
| 48. 00  | Total program GME payment (line 31)   |              |               |                                  | 0                              | 48. 00 |
| 49.00   | Part A Medicare GME payment (line 46 x 48) (title XVIII only)   | (see instr   | uctions)      |                                  | 0                              | 49.00  |
|         |   |              |               |                                  |                                |        |

| Heal th  | Financial Systems   | REHABILITATION HOSPIT | TAL OF INDIANA         | In Lieu of Form CMS-25           |                                 | 552-10         |
|--|---|-----------------------|------------------------|----------------------------------|---------------------------------|----------------|
| OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT                           |   |                       | Provi der CCN: 15-3028 | Peri od:                         | Worksheet E-5                   |                |
|  |   |                       |                        | From 01/01/2022<br>To 12/31/2022 | Date/Time Prep<br>5/31/2023 9:3 | oared:<br>1 am |
|  |   |                       | Title XVIII            |                                  | PPS                             |                |
|  | ·   |                       |                        |                                  |                                 |                |
|  |   |                       |                        |                                  | 1. 00                           |                |
| TO BE COMPLETED BY CONTRACTOR  |   |                       |                        |                                  |                                 |                |
| 1.00   | Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions) |                       |                        |                                  |                                 | 1.00           |
| 2.00   |   |                       |                        |                                  | 0                               | 2.00           |
| 3.00   | 3.00 Operating outlier reconciliation adjustment amount (see instructions)                        |                       |                        |                                  | 0                               | 3.00           |
| 4.00 Capital outlier reconciliation adjustment amount (see instructions) |   |                       | 0                      | 4.00                             |                                 |                |
| 5.00   | OD The rate used to calculate the time value of money (see instructions)                          |                       |                        | 0.00                             | 5.00                            |                |
| 6.00 Time value of money for operating expenses (see instructions)       |   |                       |                        |                                  | 0                               | 6.00           |
| 7.00 Time value of money for capital related expenses (see instructions) |   |                       |                        | ol                               | 7.00                            |                |

Health Financial Systems REHABILITATION F
BALANCE SHEET (If you are nonproprietary and do not maintain
fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 15-3028

Period: Worksheet G From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/31/2023 9:31 am

| oni y)           |  |                             |                      | 12/01/2022    | 5/31/2023 9: 3 | 1 am             |
|------------------|--|-----------------------------|----------------------|---------------|----------------|------------------|
|                  |  | General Fund                | Speci fi c           | Endowment     | Plant Fund     |                  |
|                  |  | 1.00                        | Purpose Fund<br>2.00 | Fund<br>3. 00 | 4. 00          |                  |
|                  | CURRENT ASSETS   | 1.00                        | 2.00                 | 3.00          | 4.00           |                  |
| 1.00             | Cash on hand in banks  | 239, 872                    | 0                    | 0             | 0              | 1.00             |
| 2.00             | Temporary investments  | 0                           | 0                    | 0             | 0              | 2.00             |
| 3. 00            | Notes receivable   | 0                           | 0                    | 0             | 0              | 3.00             |
| 4.00             | Accounts recei vable   | 16, 849, 977                | 0                    | 0             | 0              | 4.00             |
| 5. 00<br>6. 00   | Other receivable Allowances for uncollectible notes and accounts receivable                      | 581, 221<br>-11, 972, 261   | 0                    | 0             | 0              | 5. 00<br>6. 00   |
| 7. 00            | Inventory  | 314, 436                    | -                    | 0             | 0              | 7.00             |
| 8. 00            | Prepai d expenses  | 926, 879                    | 1                    | 0             | 0              | 8.00             |
| 9. 00            | Other current assets   | 0                           | 0                    | 0             | 0              | 9. 00            |
| 10.00            | Due from other funds   | 0                           | 0                    | 0             | 0              | 10.00            |
| 11. 00           | Total current assets (sum of lines 1-10) FIXED ASSETS  | 6, 940, 124                 | 0                    | 0             | 0              | 11.00            |
| 12. 00           | Land   | 2, 506, 638                 | 0                    | 0             | 0              | 12.00            |
| 13. 00           | Land improvements  | 757, 042                    |                      | 0             | Ö              | 13.00            |
| 14.00            | Accumul ated depreciation  | -365, 933                   | 1                    | 0             | 0              | 14.00            |
| 15. 00           | Bui I di ngs   | 33, 668, 301                | 0                    | 0             | 0              | 15.00            |
| 16.00            | Accumulated depreciation   | -15, 832, 762               |                      | 0             | 0              | 16.00            |
| 17.00            | Leasehold improvements   | 205, 018                    | 0                    | 0             | 0              | 17.00            |
| 18. 00<br>19. 00 | Accumulated depreciation Fixed equipment   | -193, 101<br>3, 318, 528    |                      | 0             | 0              | 18. 00<br>19. 00 |
| 20. 00           | Accumulated depreciation   | -2, 112, 055                |                      | 0             | 0              | 20.00            |
| 21. 00           | Automobiles and trucks   | 0                           | 0                    | 0             | 0              | 21.00            |
| 22. 00           | Accumulated depreciation   | 0                           | 0                    | 0             | 0              | 22. 00           |
| 23. 00           | Major movable equipment  | 15, 889, 700                | 1                    | 0             | 0              | 23.00            |
| 24. 00           | Accumulated depreciation   | -14, 072, 678               |                      | 0             | 0              | 24.00            |
| 25. 00<br>26. 00 | Minor equipment depreciable Accumulated depreciation   | 105, 832<br>-105, 832       | I                    | 0             | 0              | 25. 00<br>26. 00 |
| 27. 00           | HIT designated Assets  | -105, 632                   | 0                    | 0             | 0              | 27.00            |
| 28. 00           | Accumulated depreciation   | Ö                           | Ö                    | 0             | ő              | 28.00            |
| 29. 00           | Mi nor equi pment-nondepreci abl e   | 0                           | 0                    | 0             | 0              | 29. 00           |
| 30.00            | Total fixed assets (sum of lines 12-29)  | 23, 768, 698                | 0                    | 0             | 0              | 30.00            |
| 21 00            | OTHER ASSETS   |                             |                      | 0             |                | 21 00            |
| 31. 00<br>32. 00 | Investments Deposits on Leases   | 0                           | 0                    | 0             | 0              | 31. 00<br>32. 00 |
| 33. 00           | Due from owners/officers   | 966, 241                    | 0                    | 0             | 0              | 33.00            |
| 34. 00           | Other assets   | 633, 703                    | 0                    | 0             | 0              | 34.00            |
| 35.00            | Total other assets (sum of lines 31-34)  | 1, 599, 944                 | 0                    | 0             | 0              | 35.00            |
| 36. 00           | Total assets (sum of lines 11, 30, and 35)   | 32, 308, 766                | 0                    | 0             | 0              | 36.00            |
| 27 00            | CURRENT LIABILITIES Accounts payable   | 2 720 742                   |                      | 0             | 0              | 27.00            |
| 37. 00<br>38. 00 | Salaries, wages, and fees payable  | 2, 738, 743<br>2, 479, 362  | I                    | 0             | 0              | 37. 00<br>38. 00 |
| 39. 00           | Payrol I taxes payable   | 0                           | Ö                    | 0             | 0              | 39.00            |
| 40.00            | Notes and Loans payable (short term)   | 1, 295, 852                 | 0                    | 0             | 0              | 40.00            |
| 41. 00           | Deferred income  | 0                           | 0                    | 0             | 0              | 41.00            |
| 42.00            | Accel erated payments  | 0                           |                      |               |                | 42.00            |
| 43.00            | Due to other funds   | 014 112                     | 0                    | 0             | 0              | 43. 00<br>44. 00 |
| 44. 00<br>45. 00 | Other current liabilities Total current liabilities (sum of lines 37 thru 44)                    | 914, 112<br>7, 428, 069     |                      | 0             |                |                  |
| 43.00            | LONG TERM LIABILITIES  | 7, 420, 007                 | o o                  | <u> </u>      |                | 1 43.00          |
| 46.00            | Mortgage payable   | 0                           | 0                    | 0             | 0              | 46.00            |
| 47.00            | Notes payable  | 8, 177, 851                 | 0                    | 0             | 0              | 47.00            |
| 48. 00           | Unsecured Loans  | 0                           | 0                    | 0             | 0              | 48. 00           |
| 49. 00           | Other long term liabilities  | 0 177 051                   | 0                    | 0             | 0              | 49.00            |
| 50. 00<br>51. 00 | Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50) | 8, 177, 851<br>15, 605, 920 |                      | 0             |                | 50. 00<br>51. 00 |
| 31.00            | CAPITAL ACCOUNTS   | 13,003,720                  | 0                    |               | <u> </u>       | 31.00            |
| 52.00            | General fund balance   | 16, 702, 846                |                      |               |                | 52.00            |
| 53.00            | Specific purpose fund  |                             | 0                    |               |                | 53.00            |
| 54.00            | Donor created - endowment fund balance - restricted  |                             |                      | 0             |                | 54.00            |
| 55. 00           | Donor created - endowment fund balance - unrestricted  |                             |                      | 0             |                | 55.00            |
| 56. 00<br>57. 00 | Governing body created - endowment fund balance Plant fund balance - invested in plant           |                             |                      | U             | 0              | 56. 00<br>57. 00 |
| 58. 00           | Plant fund balance - reserve for plant improvement,  |                             |                      |               | 0              | 58.00            |
|                  | replacement, and expansion   |                             |                      |               |                |                  |
| 59. 00           | Total fund balances (sum of lines 52 thru 58)  | 16, 702, 846                | 1                    | 0             | 0              | 59.00            |
| 60. 00           | Total liabilities and fund balances (sum of lines 51 and   | 32, 308, 766                | 0                    | 0             | 0              | 60.00            |
|                  | [59]   | I                           | I I                  | ļ             | I              | I                |

19.00

STATEMENT OF CHANGES IN FUND BALANCES

Fund balance at end of period per balance

sheet (line 11 minus line 18)

Provider CCN: 15-3028

Peri od: Worksheet G-1 From 01/01/2022

Date/Time Prepared: 5/31/2023 9:31 am 12/31/2022 General Fund Special Purpose Fund Endowment Fund 5.00 1. 00 2.00 3. 00 4.00 1.00 Fund balances at beginning of period 17, 467, 746 0 1.00 Net income (loss) (from Wkst. G-3, line 29) -764, 900 2.00 2.00 3 00 Total (sum of line 1 and line 2) 16, 702, 846 ol 3.00 4.00 Additions (credit adjustments) (specify) 4.00 0 5.00 0000 0 5.00 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 16, 702, 846 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 00000 13.00 13.00 14.00 0 0 14.00 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 16, 702, 846 19.00 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 2.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 0 3.00 3.00 Total (sum of line 1 and line 2) 0 4.00 Additions (credit adjustments) (specify) 4.00 5.00 5.00 6.00 0 6.00 0 7.00 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 0 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 Deductions (debit adjustments) (specify) 12.00 12.00 13.00 0 13.00 14.00 0 14.00 15.00 15.00 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 0 18.00

0

0

 
 Heal th Financial
 Systems
 REHABI

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 Provi der CCN: 15-3028

|                  |  |             | 10           | 5 12/31/2022 | Date/IIme Prep<br>5/31/2023 9:3 |                  |  |
|------------------|--|-------------|--------------|--------------|---------------------------------|------------------|--|
|                  | Cost Center Description  |             | I npati ent  | Outpati ent  | Total                           | ı dili           |  |
|                  | 5551 5511t61 25551 Ft 1511                                     |             | 1.00         | 2. 00        | 3. 00                           |                  |  |
|                  | PART I - PATIENT REVENUES                                      |             |              |              |                                 |                  |  |
|                  | General Inpatient Routine Services                             |             |              |              |                                 |                  |  |
| 1.00             | Hospi tal  |             | 43, 250, 643 |              | 43, 250, 643                    | 1.00             |  |
| 2.00             | SUBPROVI DER - I PF  |             |              |              |                                 | 2.00             |  |
| 3.00             | SUBPROVI DER - I RF  |             |              |              |                                 | 3.00             |  |
| 4.00             | SUBPROVI DER   |             |              |              |                                 | 4.00             |  |
| 5.00             | Swing bed - SNF  |             | 0            |              | o                               | 5.00             |  |
| 6.00             | Swing bed - NF   |             | 0            |              | 0                               | 6.00             |  |
| 7.00             | SKILLED NURSING FACILITY                                       |             |              |              |                                 | 7.00             |  |
| 8.00             | NURSING FACILITY   |             |              |              |                                 | 8.00             |  |
| 9.00             | OTHER LONG TERM CARE   |             |              |              |                                 | 9.00             |  |
| 10.00            | Total general inpatient care services (sum of lines 1-9)       |             | 43, 250, 643 |              | 43, 250, 643                    | 10.00            |  |
|                  | Intensive Care Type Inpatient Hospital Services                |             |              |              |                                 |                  |  |
| 11. 00           | INTENSIVE CARE UNIT  |             |              |              |                                 | 11.00            |  |
| 12.00            | CORONARY CARE UNIT   |             |              |              |                                 | 12.00            |  |
| 13. 00           | BURN INTENSIVE CARE UNIT                                       |             |              |              |                                 | 13.00            |  |
| 14. 00           | SURGI CAL INTENSIVE CARE UNIT                                  |             |              |              |                                 | 14.00            |  |
| 15. 00           | OTHER SPECIAL CARE (SPECIFY)                                   |             |              |              |                                 | 15.00            |  |
| 16. 00           | Total intensive care type inpatient hospital services (sum of  | lines       | 0            |              | 0                               | 16.00            |  |
| 47.00            | 11-15)   |             | 40.050.440   |              | 40.050.440                      | 47.00            |  |
| 17.00            | Total inpatient routine care services (sum of lines 10 and 16) | )           | 43, 250, 643 | 40 004 005   | 43, 250, 643                    | 17.00            |  |
| 18.00            | Ancillary services   |             | 52, 181, 020 | 18, 981, 995 | 71, 163, 015                    | 18.00            |  |
| 19.00            | Outpati ent servi ces  |             | 199, 738     | 3, 077, 649  | 3, 277, 387                     | 19.00            |  |
| 20.00            | RURAL HEALTH CLINIC  |             | 0            | 0            | 0                               | 20.00            |  |
| 21.00            | FEDERALLY QUALIFIED HEALTH CENTER                              |             | 0            | 0            | 0                               | 21.00            |  |
| 22. 00           | HOME HEALTH AGENCY   |             |              |              |                                 | 22.00            |  |
| 23. 00           | AMBULANCE SERVICES   |             |              |              |                                 | 23. 00           |  |
| 24. 00           | CMHC<br>CORF   |             | 0            | O O          | 0                               | 24. 00<br>24. 10 |  |
| 24. 10<br>25. 00 |  |             | 0            | ۷            | ۷                               | 25. 00           |  |
| 26. 00           | AMBULATORY SURGI CAL CENTER (D. P. ) HOSPI CE                  |             |              |              |                                 | 26.00            |  |
| 27. 00           | OTHER (SPECIFY)  |             | 0            |              | 0                               | 27. 00           |  |
| 28. 00           | Total patient revenues (sum of lines 17-27)(transfer column 3  | to Wkst     | 95, 631, 401 | 22, 059, 644 | 117, 691, 045                   |                  |  |
| 20.00            | G-3, line 1)   | to wast.    | 73, 031, 401 | 22, 039, 044 | 117, 091, 045                   | 20.00            |  |
|                  | PART II - OPERATING EXPENSES                                   |             |              |              |                                 |                  |  |
| 29. 00           | Operating expenses (per Wkst. A, column 3, line 200)           |             |              | 46, 201, 172 |                                 | 29. 00           |  |
| 30.00            | ADD (SPECIFY)  |             | 0            | , ,          |                                 | 30.00            |  |
| 31.00            |  |             | 0            |              |                                 | 31.00            |  |
| 32.00            |  |             | 0            |              |                                 | 32.00            |  |
| 33.00            |  |             | 0            |              |                                 | 33.00            |  |
| 34.00            |  |             | 0            |              |                                 | 34.00            |  |
| 35.00            |  |             | 0            |              |                                 | 35.00            |  |
| 36.00            | Total additions (sum of lines 30-35)                           |             |              | o            |                                 | 36.00            |  |
| 37.00            | ROUNDI NG  |             | 4            |              |                                 | 37.00            |  |
| 38.00            |  |             | 0            |              |                                 | 38.00            |  |
| 39.00            |  | 1           | 0            |              |                                 | 39.00            |  |
| 40.00            |  | 1           | 0            |              |                                 | 40.00            |  |
| 41.00            | o  |             |              | 41.00        |                                 |                  |  |
| 42.00            | Total deductions (sum of lines 37-41)                          |             |              | 4            |                                 | 42.00            |  |
| 43.00            | Total operating expenses (sum of lines 29 and 36 minus line 42 | 2)(transfer |              | 46, 201, 168 |                                 | 43.00            |  |
|                  | to Wkst. G-3, line 4)  | I           |              |              | l                               |                  |  |
|                  |  |             |              |              |                                 |                  |  |

| Health Financial Systems REHABILITATION HOSPITAL OF INDIANA In Lieu of Form C |   |        |                                  |                             |        |  |
|---|---|--------|----------------------------------|-----------------------------|--------|--|
| STATEM  | STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-3028 Period:          |        | Worksheet G-3                    |                             |        |  |
|   |   |        | From 01/01/2022<br>To 12/31/2022 | Date/Time Pre 5/31/2023 9:3 |        |  |
|   |   |        |                                  | 070172020 7.0               |        |  |
|   |   |        |                                  | 1. 00                       |        |  |
| 1. 00   | Total patient revenues (from Wkst. G-2, Part I, column 3, li              | ne 28) |                                  | 117, 691, 045               | 1.00   |  |
| 2.00  | Less contractual allowances and discounts on patients' accounts           |        |                                  |                             | 2.00   |  |
| 3.00  | Net patient revenues (line 1 minus line 2)                                |        |                                  | 43, 156, 601                | 3.00   |  |
| 4.00  | Less total operating expenses (from Wkst. G-2, Part II, line              | 43)    |                                  | 46, 201, 168                | 4.00   |  |
| 5.00  | Net income from service to patients (line 3 minus line 4)                 |        |                                  | -3, 044, 567                | 5.00   |  |
|   | OTHER INCOME  |        |                                  |                             |        |  |
| 6.00  | Contributions, donations, bequests, etc                                   |        |                                  |                             | 6.00   |  |
| 7.00  | Income from investments   |        |                                  |                             | 7.00   |  |
| 8.00  | Revenues from telephone and other miscellaneous communication services    |        |                                  |                             | 8.00   |  |
| 9.00  |   |        |                                  |                             | 9.00   |  |
| 10.00   | Purchase di scounts   |        |                                  | 0                           | 10.00  |  |
| 11. 00  | Rebates and refunds of expenses   |        |                                  | 0                           | 11.00  |  |
| 12.00   | Parking lot receipts  |        |                                  | 0                           | 12.00  |  |
| 13.00   | Revenue from Laundry and Linen service                                    |        |                                  | 0                           | 13.00  |  |
| 14.00   | Revenue from meals sold to employees and guests                           |        |                                  | 0                           | 14.00  |  |
| 15.00   | Revenue from rental of living quarters                                    |        |                                  | 0                           | 15.00  |  |
| 16.00   | Revenue from sale of medical and surgical supplies to other than patients |        |                                  |                             | 16.00  |  |
| 17.00   | O Revenue from sale of drugs to other than patients                       |        |                                  |                             | 17.00  |  |
| 18. 00  | .00 Revenue from sale of medical records and abstracts                    |        |                                  |                             | 18.00  |  |
| 19. 00  | Tuition (fees, sale of textbooks, uniforms, etc.)                         |        |                                  | 0                           | 19.00  |  |
| 20.00   | 0.00 Revenue from gifts, flowers, coffee shops, and canteen               |        |                                  |                             |        |  |
| 21. 00  | Rental of vending machines  |        |                                  | 0                           | 21.00  |  |
|   | Rental of hospital space  |        |                                  | 0                           | 22. 00 |  |
|   | Governmental appropriations   |        |                                  | 0                           | 23. 00 |  |
| 24.00   | OO MISCELLANEOUS INCOME   |        |                                  |                             | 24 00  |  |

0 24.50

2, 279, 667 25. 00

-764, 900 26. 00

0

0 28.00 -764,900 29.00

27.00

2, 246, 197

24. 00 MI SCELLANEOUS I NCOME

27. 00 OTHER INCOME

26.00 Total (line 5 plus line 25)

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

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