number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(3) Settled with Audit

(4) Reopened (5) Amended

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 01/01/2023 and ending 12/31/2023 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 |   |   |
|---|-------------------------|-----------------------------------|----------|---|---|
|   |                         | 1                                 | 2        | SI GNATURE STATEMENT  |   |
| 1 | Mar                     | jorie Basey                       | T        | 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  | Marj ori e Basey                  |          |   | 2 |
| 3 | Signatory Title         | CHIEF FINANCIAL OFFICER           |          |   | 3 |
| 4 | Date                    | (Dated when report is electronica |          |   | 4 |

|        |                               |         | Title   | XVIII   |       |           |        |
|--------|-------------------------------|---------|---------|---------|-------|-----------|--------|
|        |                               | Title V | Part A  | Part B  | HI T  | Title XIX |        |
|        |                               | 1. 00   | 2. 00   | 3. 00   | 4. 00 | 5. 00     |        |
|        | PART III - SETTLEMENT SUMMARY |         |         |         |       |           |        |
| 1.00   | HOSPI TAL                     | 0       | 22, 984 | -9, 939 | 0     | 0         | 1. 00  |
| 2.00   | SUBPROVI DER - I PF           | 0       | 0       | 0       |       | 0         | 2. 00  |
| 3.00   | SUBPROVI DER - I RF           | 0       | 0       | 0       |       | 0         | 3. 00  |
| 5.00   | SWING BED - SNF               | 0       | 0       | 0       |       | 0         | 5. 00  |
| 6.00   | SWING BED - NF                | 0       |         |         |       | 0         | 6. 00  |
| 12.00  | CMHC I                        | 0       |         | 0       |       | 0         | 12. 00 |
| 200.00 | TOTAL                         | 0       | 22, 984 | -9, 939 | 0     | 0         | 200.00 |

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The 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.

| Heal th          | Financial Systems  | REHABILITATION HOSP         | ITAL OF I | NDI ANA   |           | 11                     | n Lieu         | of For                       | m CMS-           | 2552-10          |
|------------------|--|-----------------------------|-----------|-----------|-----------|------------------------|----------------|------------------------------|------------------|------------------|
|                  | AL AND HOSPITAL HEALTH CARE COMPLEX I  |                             | _         | er CCN: 1 |           | Period:<br>From 01/01/ | ′2023<br>′2023 | Workshe<br>Part I<br>Date/Ti | et S-2<br>me Pre | pared:           |
|                  | 1.00   | 2.00                        |           | 3. 00     |           |                        | 4. 00          | 5/30/20                      | 24 8: 3          | 5 am             |
|                  | Hospital and Hospital Health Care Co   |                             |           | 3. 00     |           |                        | 4. 00          |                              |                  |                  |
| 1.00             | Street: 4141 SHORE DRIVE   | PO Box:                     |           |           |           |                        |                |                              |                  | 1.00             |
| 2.00             | City: INDIANAPOLIS   | State: IN                   | Zip Code  |           |           | y: MARION              |                |                              |                  | 2. 00            |
|                  |  | Component Name              | CCN       | CBSA      | Provi der |                        |                | nt Syste                     |                  |                  |
|                  |  |                             | Number    | Number    | Туре      | Certi fi ed            | V ,            | 0, or                        | XIX              |                  |
|                  |  | 1.00                        | 2.00      | 3. 00     | 4.00      | 5. 00                  | 6. 00          | 7. 00                        | 8.00             |                  |
|                  | Hospital and Hospital-Based Componen   |                             |           |           |           |                        |                |                              |                  |                  |
| 3.00             | Hospi tal  | REHABILITATION HOSPITAL     | 153028    | 26900     | 5         | 01/07/1992             | N              | P                            | Р                | 3. 00            |
| 4. 00            | Subprovi der – IPF   | OF INDIANA                  |           |           |           |                        |                |                              |                  | 4. 00            |
| 5. 00            | Subprovider - IRF  |                             |           |           |           |                        |                |                              |                  | 5.00             |
| 6. 00            | Subprovider - (Other)  |                             |           |           |           |                        |                |                              |                  | 6.00             |
| 7.00             | Swing Beds - SNF   |                             |           |           |           |                        |                |                              |                  | 7. 00            |
| 8.00             | Swing Beds - NF  |                             |           |           |           |                        |                |                              |                  | 8. 00            |
| 9.00             | Hospi tal Based SNF  |                             |           |           |           |                        |                |                              |                  | 9. 00<br>10. 00  |
| 10. 00<br>11. 00 | Hospi tal -Based NF<br>Hospi tal -Based OLTC                                 |                             |           |           |           |                        |                |                              |                  | 11.00            |
|                  | Hospi tal -Based HHA   |                             |           |           |           |                        |                |                              |                  | 12.00            |
| 13.00            | Separately Certified ASC   |                             |           |           |           |                        |                |                              |                  | 13. 00           |
|                  | Hospi tal -Based Hospi ce  |                             |           |           |           |                        |                |                              |                  | 14. 00           |
|                  | Hospital Based Health Clinic - RHC   |                             |           |           |           |                        |                |                              |                  | 15.00            |
|                  | Hospital-Based Health Clinic - FQHC<br>Hospital-Based (CMHC) I               |                             |           |           |           |                        |                |                              |                  | 16. 00<br>17. 00 |
|                  | Hospital-Based (CORF) I  |                             |           |           |           |                        |                |                              |                  | 17. 10           |
|                  | Renal Dialysis   |                             |           |           |           |                        |                |                              |                  | 18.00            |
| 19. 00           | 0ther  |                             |           |           |           |                        |                |                              |                  | 19. 00           |
|                  |  |                             |           |           |           | From:                  |                | To:                          |                  |                  |
| 20.00            | Cost Reporting Period (mm/dd/yyyy)   |                             |           |           |           | 1.00                   | 023            | 2.0                          |                  | 20. 00           |
|                  | Type of Control (see instructions)   |                             |           |           |           | 4                      | 023            | 12/31/                       | 2023             | 21.00            |
|                  | ,                                      |                             |           |           |           |                        |                |                              |                  |                  |
|                  | T  |                             |           |           | 1. 00     | 2. 00                  |                | 3. 0                         | 0                |                  |
| 22.00            | Inpatient PPS Information  Does this facility qualify and is it              | currently receiving pay     | monts for | .         | N         | N                      |                |                              |                  | 22. 00           |
| 22. 00           | disproportionate share hospital adju   | 3 0.3                       |           |           | IN        | IN IN                  |                |                              |                  | 22.00            |
|                  | §412.106? In column 1, enter "Y" fo  |                             |           |           |           |                        |                |                              |                  |                  |
|                  | facility subject to 42 CFR Section §   | 412.106(c)(2)(Pickle ame    | ndment    |           |           |                        |                |                              |                  |                  |
| 22 01            | hospital?) In column 2, enter "Y" fo   |                             | -I UCD-   | £         | N         | N.                     |                |                              |                  | 22 01            |
| 22. 01           | Did this hospital receive interim UC this cost reporting period? Enter in    |                             |           |           | N         | N                      |                |                              |                  | 22. 01           |
|                  | for the portion of the cost reportin   |                             |           |           |           |                        |                |                              |                  |                  |
|                  | 1. Enter in column 2, "Y" for yes or   |                             | ion of th | ie        |           |                        |                |                              |                  |                  |
|                  | cost reporting period occurring on o   | r after October 1. (see     |           |           |           |                        |                |                              |                  |                  |
| 22 02            | instructions)<br>Is this a newly merged hospital that                        | requires a final HCP to     | he        |           | N         | N                      |                |                              |                  | 22. 02           |
| 22.02            | determined at cost report settlement   | ? (see instructions) Ent    | er in col | umn       | 14        | "                      |                |                              |                  | 22.02            |
|                  | 1, "Y" for yes or "N" for no, for th   | e portion of the cost re    | porting   |           |           |                        |                |                              |                  |                  |
|                  | period prior to October 1. Enter in  |                             |           | no,       |           |                        |                |                              |                  |                  |
| 22 02            | for the portion of the cost reportin<br>Did this hospital receive a geograph |                             |           |           | N         | N                      |                | N                            |                  | 22. 03           |
| 22. 03           | rural as a result of the OMB standar   |                             |           |           | IV        | 14                     |                | IN                           |                  | 22.03            |
|                  | adopted by CMS in FY2015? Enter in c   |                             |           |           |           |                        |                |                              |                  |                  |
|                  | for the portion of the cost reportin   |                             |           | er        |           |                        |                |                              |                  |                  |
|                  | in column 2, "Y" for yes or "N" for reporting period occurring on or aft     |                             |           |           |           |                        |                |                              |                  |                  |
|                  | Does this hospital contain at least  |                             |           | ıs        |           |                        |                |                              |                  |                  |
|                  | counted in accordance with 42 CFR 41   |                             |           |           |           |                        |                |                              |                  |                  |
|                  | yes or "N" for no.   |                             |           |           |           |                        |                |                              |                  |                  |
| 22. 04           | Did this hospital receive a geograph<br>rural as a result of the revised OMB |                             |           |           |           |                        |                |                              |                  | 22. 04           |
|                  | adopted by CMS in FY 2021? Enter in  |                             |           |           |           |                        |                |                              |                  |                  |
|                  | for the portion of the cost reportin   |                             |           |           |           |                        |                |                              |                  |                  |
|                  | in column 2, "Y" for yes or "N" for  |                             |           |           |           |                        |                |                              |                  |                  |
|                  | reporting period occurring on or aft   |                             |           |           |           |                        |                |                              |                  |                  |
|                  | Does this hospital contain at least counted in accordance with 42 CFR 41     |                             |           |           |           |                        |                |                              |                  |                  |
|                  | yes or "N" for no.   | zoo, . Litter i'il corullin | S, 1 1    | J.        |           |                        |                |                              |                  |                  |
| 23. 00           | Which method is used to determine Me   |                             |           |           |           | 2 N                    |                |                              |                  | 23. 00           |
|                  | below? In column 1, enter 1 if date  |                             |           |           |           |                        |                |                              |                  |                  |
|                  | if date of discharge. Is the method reporting period different from the      |                             |           | .051      |           |                        |                |                              |                  |                  |
|                  | reporting period? In column 2, ente  |                             |           |           |           |                        |                |                              |                  |                  |
|                  |  | -                           |           | •         |           |                        |                |                              |                  |                  |

| 7251 I | Financial Systems REHABILITAT AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA   |   | Provider CC   |  | Peri od:   |                  | Worksh          | rm CMS-<br>neet S-2        |     |
|--------|---|---|---|--|--|------------------|-----------------|----------------------------|-----|
|        |   |   |   |  | From 01/0<br>To 12/3                                     |                  |                 | ime Pre<br>2024 8:3        |     |
|        |   | 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                 | Out-of<br>State<br>Medi cai d<br>el i gi bl e<br>unpai d | Medica<br>HMO da | aid (<br>ays Me | Other<br>edi cai d<br>days |     |
|        |   | 1. 00   | 2. 00   | 3. 00  | 4. 00  | 5. 00            |                 | 6. 00                      |     |
|        | If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. | 751   |   |  | 15   | 4                | , 049           | C                          | 25. |
|        |   |   |   |  |  |                  |                 | f Geogr                    |     |
| 5. 00  | Enter your standard geographic classification (not wa   | age) status   | at the ben  | innina of t  |  | 00 1             |                 | 00                         | 26. |
|        | cost reporting period. Enter "1" for urban or "2" for<br>Enter your standard geographic classification (not we<br>reporting period. Enter in column 1, "1" for urban or   | rural.<br>age) status   | at the end  | of the cos   |  | 1                |                 |                            | 27. |
| 5. 00  | enter the effective date of the geographic reclassifing this is a sole community hospital (SCH), enter the effect in the cost reporting period.   | cation in   | column 2.   |  | ı  | C                | )               |                            | 35. |
|        |   |   |   |  | Begi n   |                  |                 | i ng:                      |     |
| 5. 00  | Enter applicable beginning and ending dates of SCH st   | tatus. Subs   | cript line  | 36 for numb  | ner 1.   | 00               | 2.              | 00                         | 36  |
| 7 00   | of periods in excess of one and enter subsequent date<br>If this is a Medicare dependent hospital (MDH), enter  |   | r of period   | ls MDH stati   | ıs   | C                |                 |                            | 37  |
|        | is in effect in the cost reporting period.<br>Is this hospital a former MDH that is eligible for th   | ne MDH tran   | sitional pa   | nyment in  |  |                  |                 |                            | 37  |
| 3. 00  | accordance with FY 2016 OPPS final rule? Enter "Y" foinstructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of  | of MDH st   | atus. If li   | ne 37 is   |  |                  |                 |                            | 38  |
|        | enter subsequent dates.   |   |   |  | Y,   | /N               | Y               | /N                         |     |
|        |   |   |   |  | 1.   | 00               | 2.              | 00                         |     |
|        | Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)   | ), (ii), or<br>the mileage<br>i)? Enter                             | (iii)? Ent<br>requiremen<br>in column 2                 | er in colum<br>nts in<br>?"Y" for ye                     | nn<br>es   | N.               |                 | N                          | 39  |
| 0. 00  | Is this hospital subject to the HAC program reduction<br>"N" for no in column 1, for discharges prior to Octob<br>no in column 2, for discharges on or after October 1.   | oer 1. Ente   | r "Y" for y   |  |  | N .              |                 | N                          | 40  |
|        |   |   |   |  |  | 1. 00            | XVIII<br>2. 00  |                            |     |
| 5. 00  | Prospective Payment System (PPS)-Capital  Does this facility qualify and receive Capital paymen   | nt for disp   | roporti onat  | e share in   | accordance   | N                | N               | N                          | 45  |
|        | with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst   | eption for  | extraordi na  | nry circumst   | ances  | N                | N               | N                          | 46  |
|        | Pt. III.<br>Is this a new hospital under 42 CFR §412.300(b) PPS of<br>Is the facility electing full federal capital payment   |   |   |  |  | N<br>N           | N<br>N          | N<br>N                     | 47  |
| 00     | Teaching Hospitals  |   | МГ ю:   | -2 Fa:- :  | none+'   |                  |                 |                            |     |
| 5. 00  | Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter 'cost reporting periods beginning on or after December the instructions. For column 2, if the response to coinvolved in training residents in approved GME program are you are impacted by CR 11642 (or applicable ("Y" for yes; otherwise, enter "N" for no in column 2.  | 'Y" for yes<br>27, 2020,<br>olumn 1 is<br>ams in the<br>CRs) MA dir | or "N" for<br>under 42 C<br>"Y", or if<br>prior year    | no in colu<br>CFR 413.78(b<br>this hospit<br>or penultin | umn 1. For<br>b)(2), see<br>cal was<br>nate year,        | Y                | Y               |                            | 56  |
| . 00   | For cost reporting periods beginning prior to Decembe is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no ir residents start training in the first month of this of  | er 27, 2020<br>residents<br>n column 1.<br>cost report              | in approved<br>If column<br>ing period?                 | I GME progra<br>1 is "Y", o<br>P Enter "Y'               | nms trained<br>lid<br>for yes o                          |                  |                 |                            | 57  |
|        | "N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFF which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not complete If line 56 is yes, did this facility elect cost reimb  | applicable<br>R 413.77(e<br>on duty, i<br>ete column                | . For cost<br>)(1)(iv) an<br>f the respo<br>2, and comp | nd (v), rega<br>onse to line<br>olete Worksh             | erdless of<br>e 56 is "Y"<br>neet E-4.                   | N                |                 |                            | 58  |

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3028 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 8: 35 am 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. Y/N IMF Direct GME IME Direct GME 2. 00 3. 00 4.00 5.00 1 00 61.00 Did your hospital receive FTE slots under ACA Ν 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61 03 Enter the base line FTE count for primary care 61 03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 2.00 1.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00

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)

|       |  |             | Adjustment<br>(Y/N) | Permanent<br>Adjustments                           |        |
|-------|--|-------------|---------------------|--|--------|
|       |  |             | 1.00                | 2. 00  | 4      |
|       | Column 1: Is this hospital approved for a permanent adjustment to the TEFR, amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.   |             | N N                 | 2.00   | 88.00  |
|       | por unit 2. Litter the number of approved permanent adjustments.   | No.         | Effective Date      | Permanent<br>Adjustment<br>Amount Per<br>Discharge |        |
|       |  | 1. 00       | 2. 00               | 3. 00  |        |
|       | Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based.  Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.  Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.  | 0. 00       |                     | 0  | 89.00  |
|       | , and the second |             | V                   | XI X   |        |
|       |  |             | 1. 00               | 2.00   |        |
|       | Title V and XIX Services   |             |                     |  |        |
|       | Does this facility have title V and/or XIX inpatient hospital services? Engyes or "N" for no in the applicable column.   | ter "Y" for | N                   | Υ  | 90.00  |
|       | Is this hospital reimbursed for title V and/or XIX through the cost report full or in part? Enter "Y" for yes or "N" for no in the applicable column.  | either in   | N                   | N  | 91.00  |
| 92.00 | Are title XIX NF patients occupying title XVIII SNF beds (dual certification) in the applicable column.  | on)? (see   |                     | N  | 92. 00 |
|       | Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column.   | XIX? Enter  | N                   | N  | 93. 00 |
|       | Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no applicable column.  | in the      | N                   | N  | 94. 00 |
|       | If line 94 is "Y", enter the reduction percentage in the applicable column.  |             | 0. 00               | 0.00   | 95.00  |
|       | Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no applicable column.  | in the      | N                   | N  | 96. 00 |
|       | If line 96 is "Y", enter the reduction percentage in the applicable column.  |             | 0.00                | 0.00   | 97.00  |

| HUSPI I                              | AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  | Provi der Co   |  |                                   |                              |  |
|--------------------------------------|--|--|--|-----------------------------------|------------------------------|--|
|                                      | THE THE HEALTH SAILE SOME EEX TRENTT ON BATTA  |  | F  | eriod:<br>rom 01/01/2023          | Worksheet S-<br>Part I       |  |
|                                      |  |  | T  | o 12/31/2023                      | Date/Time Pr<br>5/30/2024 8: | repared                                |
|                                      |  |  |  | V                                 | XI X                         | JJ alli                                |
|                                      |  |  |  | 1. 00                             | 2.00                         |  |
| 98. 00                               | Does title V or XIX follow Medicare (title XVIII) for the int<br>stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" fo<br>column 1 for title V, and in column 2 for title XIX.   |  |  | N                                 | Y                            | 98. 0                                  |
| 98. 01                               | Does title V or XIX follow Medicare (title XVIII) for the rep<br>C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit   |  |  | N                                 | Y                            | 98. 0                                  |
| 8. 02                                | title XIX.<br>Does title V or XIX follow Medicare (title XVIII) for the cal<br>bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or   |  |  | N                                 | Y                            | 98. 0                                  |
| 98. 03                               | for title V, and in column 2 for title XIX.<br>Does title V or XIX follow Medicare (title XVIII) for a criti<br>reimbursed 101% of inpatient services cost? Enter "Y" for yes  | ical access h  | ospital (CAH)  | N                                 | N                            | 98. 0                                  |
| 98. 04                               | for title V, and in column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) for a CAH r outpatient services cost? Enter "Y" for yes or "N" for no in  | reimbursed 10  | 1% of  | N                                 | N                            | 98. 0                                  |
| 8. 05                                | in column 2 for title XIX.<br>Does title V or XIX follow Medicare (title XVIII) and add bad  | ck the RCE di  | sallowance on  | N                                 | Y                            | 98. (                                  |
| 98. 06                               | Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co<br>column 2 for title XIX.<br>Does title V or XIX follow Medicare (title XVIII) when cost r  |  |  | N                                 | Y                            | 98. (                                  |
| . 00                                 | Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.   |  |  | , v                               |                              | 70.0                                   |
| 105 00                               | Rural Providers  Does this hospital qualify as a CAH?  |  |  | N                                 | I                            | 105. (                                 |
|                                      | If this facility qualifies as a CAH, has it elected the all-i<br>for outpatient services? (see instructions)   | inclusive met  | hod of payment   |                                   |                              | 106. 0                                 |
| 07. 00                               | Column 1: If line 105 is Y, is this facility eligible for costraining 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 Y   | 1. (see ins  | tructions)   |                                   |                              | 107. (                                 |
| 07.01                                | approved medical education program in the CAH's excluded IPF<br>Enter "Y" for yes or "N" for no in column 2. (see instruction  | F and/or IRF ons)  | uni t(s)?  |                                   |                              | 107                                    |
| 07. 01                               | If this facility is a REH (line 3, column 4, is "12"), is it reimbursement for I&R training programs? Enter "Y" for yes or instructions)   |  |  |                                   |                              | 107.                                   |
| 08. 00                               | Is this a rural hospital qualifying for an exception to the (<br>CFR Section §412.113(c). Enter "Y" for yes or "N" for no.   |  |  | N                                 |                              | 108.                                   |
|                                      |  | Physi cal<br>1.00  | Occupational<br>2.00   | Speech<br>3.00                    | Respiratory<br>4.00          | <u>/</u>                               |
| 09. 00                               | If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"   | N N  | N N  | N N                               | N N                          | 109.                                   |
|                                      | for yes or "N" for no for each therapy.  |  |  |                                   |                              |  |
|                                      |  |  |  |                                   |                              |  |
| 40 00                                |  |  |  |                                   | 1.00                         | 110                                    |
| 10. OC                               | Did this hospital participate in the Rural Community Hospital<br>Demonstration)for the current cost reporting period? Enter "\<br>complete Worksheet E, Part A, lines 200 through 218, and Work<br>applicable.   | Y" for yes or  | "N" for no. If   | yes,                              | 1.00<br>N                    | 110.                                   |
| 10. OC                               | Demonstration)for the current cost reporting period? Enter "\complete Worksheet E, Part A, lines 200 through 218, and Work   | Y" for yes or  | "N" for no. If   | yes,<br>yh 215, as                | N                            | 110.                                   |
|                                      | Demonstration) for the current cost reporting period? Enter "\ complete Worksheet E, Part A, lines 200 through 218, and Work applicable.  If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part   | Y" for yes or ksheet E-2, I he Frontier Cost reporting lumn 1 is Y, ticipating in  | "N" for no. If ines 200 througommunity period? Enter the column 2. | yes,                              |                              |  |
|                                      | Demonstration) for the current cost reporting period? Enter "\ complete Worksheet E, Part A, lines 200 through 218, and Work applicable.  If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col   | Y" for yes or ksheet E-2, I he Frontier Cost reporting lumn 1 is Y, ticipating in  | "N" for no. If ines 200 througommunity period? Enter the column 2. | yes,<br>yh 215, as                | N                            |  |
|                                      | Demonstration) for the current cost reporting period? Enter "\ complete Worksheet E, Part A, lines 200 through 218, and Work applicable.  If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add   | Y" for yes or ksheet E-2, I he Frontier Cost reporting lumn 1 is Y, ticipating in  | "N" for no. If ines 200 througommunity period? Enter the column 2. | yes,<br>yh 215, as                | N                            |  |
| 11. 00                               | Demonstration) for the current cost reporting period? Enter "\ complete Worksheet E, Part A, lines 200 through 218, and Work applicable.  If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.  Did this hospital participate in the Pennsylvania Rural Healt (PARHM) demonstration for any portion of the current cost rep  | Y" for yes or ksheet E-2, I he Frontier C st reporting I umn 1 is Y, ticipating in ditional beds th Model porting  | ommunity period? Enter enter the column 2. ; and/or "C"            | 7 yes,<br>gh 215, as<br>1.00<br>N | N 2. 00                      | 111.                                   |
| 11. 00                               | Demonstration) for the current cost reporting period? Enter "Yomplete Worksheet E, Part A, Lines 200 through 218, and Work applicable.  If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to colintegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for addition tele-health services.  Did this hospital participate in the Pennsylvania Rural Healt (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If col "Y", enter in column 2, the date the hospital began participal demonstration. In column 3, enter the date the hospital cease.  | Y" for yes or ksheet E-2, I he Frontier C st reporting lumn 1 is Y, ticipating in ditional beds th Model porting lumn 1 is ating in the  | ommunity period? Enter enter the column 2. ; and/or "C"            | 7 yes,<br>gh 215, as<br>1.00<br>N | N 2. 00                      | 111.                                   |
| 11.00                                | Demonstration) for the current cost reporting period? Enter "Y complete Worksheet E, Part A, lines 200 through 218, and Work applicable.  If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to colintegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.  Did this hospital participate in the Pennsylvania Rural Healt (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If col "Y", enter in column 2, the date the hospital began participate demonstration. In column 3, enter the date the hospital ceas participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information   | Y" for yes or ksheet E-2, I he Frontier C st reporting I umn 1 is Y, ticipating in ditional beds th Model porting I umn 1 is ating in the sed  | ommunity period? Enter enter the column 2. ; and/or "C"            | 7 yes,<br>gh 215, as<br>1.00<br>N | N 2. 00                      | 111.                                   |
| 11. 00                               | Demonstration) for the current cost reporting period? Enter "Y complete Worksheet E, Part A, Lines 200 through 218, and Work applicable.  If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to colintegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.  Did this hospital participate in the Pennsylvania Rural Healt (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If col "Y", enter in column 2, the date the hospital began participatementarion. In column 3, enter the date the hospital cease participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93"  | Y" for yes or ksheet E-2, I he Frontier C st reporting lumn 1 is Y, ticipating in ditional beds th Model porting lumn 1 is ating in the sed  "N" for no , or E only) 3" percent  | ommunity period? Enter enter the column 2. ; and/or "C"            | 7 yes,<br>gh 215, as<br>1.00<br>N | N 2. 00                      | 111.                                   |
| 11.00                                | Demonstration) for the current cost reporting period? Enter "\complete Worksheet E, Part A, lines 200 through 218, and Work applicable.  If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to colintegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for additional to tele-health services.  Did this hospital participate in the Pennsylvania Rural Healt (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If col "Y", enter in column 2, the date the hospital began participatements and the demonstration of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If col "Y", enter in column 3, enter the date the hospital cease participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B,  | Y" for yes or ksheet E-2, I he Frontier C st reporting I umn 1 is Y, ticipating in ditional beds th Model porting I umn 1 is ating in the sed "N" for no or E only) 3" percent includes                                    | ommunity period? Enter enter the column 2. and/or "C"              | 7 yes,<br>gh 215, as<br>1.00<br>N | N 2. 00                      | 111.                                   |
| 11. 00                               | Demonstration) for the current cost reporting period? Enter "Yomplete Worksheet E, Part A, Lines 200 through 218, and Workapplicable.  If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to colintegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.  Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If col "Y", enter in column 2, the date the hospital began participate demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93 for short term hospital or "98" percent for long term care (i psychiatric, rehabilitation and long term hospitals providers  | Y" for yes or ksheet E-2, I he Frontier C st reporting lumn 1 is Y, ticipating in ditional beds th Model porting lumn 1 is ating in the sed  "N" for no, or E only) 3" percent includes s) based on                        | ommunity period? Enter enter the column 2. and/or "C"              | 7 yes,<br>gh 215, as<br>1.00<br>N | N 2. 00                      | 111.                                   |
| 11. 00<br>12. 00<br>15. 00<br>16. 00 | Demonstration) for the current cost reporting period? Enter "Y complete Worksheet E, Part A, lines 200 through 218, and Work applicable.  If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.  Did this hospital participate in the Pennsylvania Rural Healt (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If col "Y", enter in column 2, the date the hospital began participated demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93 for short term hospital or "98" percent for long term care (ip psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub. 15-1, chapter 22, \$2208.1.  Is this facility classified as a referral center? Enter "Y" for | Y" for yes or ksheet E-2, I he Frontier C st reporting I umn 1 is Y, ticipating in ditional beds th Model porting I umn 1 is ating in the sed "N" for no or E only) 3" percent includes s) based on for yes or ance? Enter | ommunity period? Enter enter the column 2. and/or "C"              | 7 yes,<br>gh 215, as<br>1.00<br>N | N 2. 00                      | 110.<br>111.<br>111.<br>112.<br>0 115. |

| 142.00 Street: 340 W TOTH STREET         | PO BOX:             |                  |                    |       |      | [142.00 |
|--|---------------------|------------------|--------------------|-------|------|---------|
| 143.00 City: INDIANAPOLIS                | State:              | I N              | Zi p Code:         | 4620  | 2    | 143.00  |
|  | •                   |                  |                    |       |      |         |
|  |                     |                  |                    |       | 1.00 |         |
| 144.00 Are provider based physicians' co | sts included in Wor | ksheet A?        |                    |       | N    | 144. 00 |
|  |                     |                  |                    |       |      |         |
|  |                     |                  |                    | 1. 00 | 2.00 |         |
| 145.00 If costs for renal services are c | laimed on Wkst. A,  | line 74, are the | costs for          |       |      | 145. 00 |
| inpatient services only? Enter "Y        |                     |                  |                    |       |      |         |
| no, does the dialysis facility in        |                     |                  | cost reporting     |       |      |         |
| period? Enter "Y" for yes or "N"         |                     |                  |                    |       |      |         |
| 146.00 Has the cost allocation methodolo |                     |                  |                    | N     |      | 146. 00 |
| Enter "Y" for yes or "N" for no i        | •                   |                  | pter 40, §4020) If |       |      |         |
| yes, enter the approval date (mm/        | dd/yyyy) in column  | 2.               |                    |       |      |         |

| HOSPITAL AND HOSPITAL HEALTH CARE COMPLE  | X IDENTIFICATION DATA                                    | Provider CC          | N: 15-3028  |           | 1/01/2023<br>2/31/2023 | Worksheet S-<br>Part I<br>Date/Time Pr<br>5/30/2024 8: | epared:            |
|---|--|----------------------|-------------|-----------|------------------------|--|--------------------|
|   |  |                      |             |           |                        | 1.00   | _                  |
| 147.00 Was there a change in the statisti   | cal basis? Enter "Y" for                                 | ves or "N" for       | no.         |           |                        | N N  | 147. 00            |
| 148.00 Was there a change in the order of   |  |                      |             |           |                        | N  | 148. 00            |
| 149.00 Was there a change to the simplifi   | ed cost finding method? E                                | nter "Y" for ye      | s or "N" f  | or no.    |                        | N  | 149. 00            |
|   |  | Part A               | Part B      |           | itle V                 | Title XIX  |                    |
|   |  | 1.00                 | 2.00        |           | 3. 00                  | 4.00   |                    |
| Does this facility contain a provi<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  | 156. 0             |
| 157.00 Subprovi der - IRF   |  | N                    | N           |           | N                      | N  | 157. 0             |
| 158. 00 SUBPROVI DER  |  |                      |             |           |                        |  | 158. 0             |
| 159. 00 SNF   |  | N                    | N           |           | N                      | N  | 159. 00            |
| 160.00 HOME HEALTH AGENCY   |  | N                    | N           |           | N                      | N  | 160. 00            |
| 161. 00 CMHC  |  |                      | N           |           | N                      | N  | 161. 0             |
| 161. 10 CORF  |  |                      | N           |           | N                      | N  | 161. 10            |
|   |  |                      |             |           |                        | 1.00   | _                  |
| Mul ti campus   |  |                      |             |           |                        |  |                    |
| 165.00 Is this hospital part of a Multica<br>Enter "Y" for yes or "N" for no.   | mpus hospital that has on                                | ne or more campu     | ıses in dif | ferent CB | SAs?                   | N  | 165. 00            |
| Enter 1 for yes of N for no.  | Name   | County               | State       | Zip Code  | CBSA                   | FTE/Campus   |                    |
|   | 0  | 1. 00                | 2.00        | 3. 00     | 4. 00                  | 5. 00  |                    |
| 166.00 If line 165 is yes, for each   |  |                      |             |           |                        | 0. (   | 00 166. 00         |
| 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)   |  |                      |             |           |                        |  |                    |
|   |  |                      |             |           |                        | 1. 00  |                    |
| Heal th Information Technology (HI  |  |                      |             | nent Act  |                        | T  | ٠,,,               |
| 167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10   |  |                      |             | ''' \ +   | 41                     | N  | 167. 00<br>168. 00 |
| reasonable cost incurred for the  |  |                      | 9 107 IS Y  | ), enter  | tne                    |  | 108.0              |
| 168.01 If this provider is a CAH and is r   |  |                      | nualify f   | or a hard | shi n                  |  | 168. 0             |
| exception under §413.70(a)(6)(ii)   |  |                      |             |           | эш р                   |  | 100.0              |
| 169.00 If this provider is a meaningful u   |  |                      |             |           | nter the               | 0. (   | 00169.00           |
| transition factor. (see instruction   | ons)   |                      | •           |           |                        |  |                    |
|   |  |                      |             |           | gi nni ng              | Endi ng  |                    |
| 470 00 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  |  |                      |             |           | 1. 00                  | 2. 00  | 170 01             |
| 170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)  | beginning date and ending                                | date for the re      | eporting    |           |                        |  | 170. 00            |
|   |  |                      |             |           | 1 00                   | 2.00   |                    |
| 171 00 If line 167 is "V" does this pro-  | dor have any days for in                                 | udi vi dual c. opest | Lodin       |           | 1. 00<br>N             | 2.00   | 0171 0             |
| 171.00 If line 167 is "Y", does this proving section 1876 Medicare cost plans in "Y" for yes and "N" for no in column 2. (s | reported on Wkst. S-3, Pt.<br>umn 1. If column 1 is yes, | I, line 2, col       | . 6? Enter  |           | IN                     |  | 0 171. 00          |

|    | TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE   | Provi der C       | CN: 15-3028    | Period:<br>From 01/01/2023<br>To 12/31/2023 | Date/Time Pr<br>5/30/2024 8: | epare |
|----|--|-------------------|----------------|---|------------------------------|-------|
|    |  |                   |                | Y/N   | Date                         |       |
|    | PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE  | MENT OUESTION     | MAIRE          | 1. 00                                       | 2.00                         |       |
|    | General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS   |                   |                | er all dates in                             | the                          |       |
| ~~ | Provider Organization and Operation  Has the provider changed ownership immediately prior to the   |                   |                |   | T                            | ۱.    |
| 00 | reporting period? If yes, enter the date of the change in c  |                   |                | N   |                              | 1.    |
|    | Treporting period: 11 yes, enter the date of the change in t   | 201 uiii1 2. (3ee | Y/N            | Date  | V/I                          |       |
|    |  |                   | 1.00           | 2.00  | 3.00                         |       |
| 00 | Has the provider terminated participation in the Medicare F  | Program? If       | N              |   |                              | 2     |
|    | yes, enter in column 2 the date of termination and in colum  |                   |                |   |                              |       |
|    | voluntary or "I" for involuntary.  |                   |                |   |                              |       |
| 00 | Is the provider involved in business transactions, includir  | ng management     | Y              |   |                              | 3     |
|    | contracts, with individuals or entities (e.g., chain home of   | offices, drug     |                |   |                              |       |
|    | or medical supply companies) that are related to the provid  |                   |                |   |                              |       |
|    | officers, medical staff, management personnel, or members of   |                   |                |   |                              |       |
|    | of directors through ownership, control, or family and other   | er similar        |                |   |                              |       |
|    | relationships? (see instructions)  |                   | Y/N            | Type  | Date                         |       |
|    |  |                   | 1.00           | 2. 00                                       | 3. 00                        |       |
|    | Financial Data and Reports   |                   |                | 2. 30                                       | 5. 55                        |       |
| 0  | Column 1: Were the financial statements prepared by a Cert   | tified Public     | Y              | А   |                              | 7 4   |
|    | Accountant? Column 2: If yes, enter "A" for Audited, "C" f   | for Compiled,     |                |   |                              |       |
|    | or "R" for Reviewed. Submit complete copy or enter date ava  | ailable in        |                |   |                              |       |
|    | column 3. (see instructions) If no, see instructions.  |                   |                |   |                              |       |
| 0  | Are the cost report total expenses and total revenues diffe  |                   | N              |   |                              | 5     |
|    | those on the filed financial statements? If yes, submit rec  | conciliation.     |                | \/ /N                                       | 1 1 0                        |       |
|    |  |                   |                | Y/N<br>1. 00                                | Legal Oper.<br>2.00          | +-    |
|    | Approved Educational Activities  |                   |                | 1.00  | 2.00                         | _     |
| 0  | Column 1: Are costs claimed for a nursing program? Column  | 2. If yes is      | s the provide  | r N   |                              | ٦ 6   |
| •  | the legal operator of the program?   | 2 joo,            | s the provide  |   |                              |       |
| 0  | Are costs claimed for Allied Health Programs? If "Y" see in  | nstructions.      |                | N   |                              | 7     |
| 0  | Were nursing programs and/or allied health programs approve  | ed and/or renew   | wed during the | e N   |                              | 8     |
|    | cost reporting period? If yes, see instructions.   |                   | •              |   |                              |       |
| 0  | Are costs claimed for Interns and Residents in an approved   |                   | cal education  | Υ   |                              | 9     |
|    | program in the current cost report? If yes, see instruction  |                   |                |   |                              | ١     |
| 00 | Was an approved Intern and Resident GME program initiated of   | or renewed in t   | the current    | N   |                              | 10    |
| 00 | cost reporting period? If yes, see instructions.   | l O Din on And    | a may and      | N   |                              | 111   |
| 00 | Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.   | ı «Kınan App      | orovea         | IN  |                              | 11    |
|    | reaching Frogram on worksheet A: 11 yes, see instructions.   |                   |                |   | Y/N                          |       |
|    |  |                   |                |   | 1.00                         |       |
|    | Bad Debts  |                   |                |   |                              |       |
|    | Is the provider seeking reimbursement for bad debts? If yes  | s, see instruct   | tions.         |   | Y                            | 12    |
| 00 | If line 12 is yes, did the provider's bad debt collection p  | oolicy change o   | during this c  | ost reporting                               | N                            | 13    |
| 00 | period? If yes, submit copy.   |                   |                |   |                              | ١.,   |
|    | If line 12 is yes, were patient deductibles and/or coinsura  | ance amounts wa   | aived? it yes  | , see                                       | N                            | 14    |
|    | instructions. Bed Complement   |                   |                |   |                              |       |
|    |  | ina period? If    | ves. see ins   | tructions.                                  | N                            | 15    |
| 00 |  |                   |                | Par   | t B                          |       |
| 00 | Did total beds available change from the prior cost reporti  | Par               | rt A           | 27.721                                      | Date                         |       |
| 00 |  | Par<br>Y/N        | nt A<br>Date   | Y/N   |                              |       |
| 00 | Did total beds available change from the prior cost reporti  |                   | 1              | 3. 00                                       | 4. 00                        |       |
| 00 | Did total beds available change from the prior cost reporti  | Y/N<br>1.00       | Date 2.00      | 3. 00                                       |                              |       |
| 00 | PS&R Data 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/N               | Date           | 3. 00                                       | 4.00                         | 16    |
| 00 | PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)  | Y/N<br>1.00       | Date 2.00      | 3. 00<br>Y                                  |                              |       |
| 00 | PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for   | Y/N<br>1.00       | Date 2.00      | 3. 00                                       |                              |       |
| 00 | PS&R Data  Was the cost report prepared using the PS&R Report only?  If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)  Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If  | Y/N<br>1.00       | Date 2.00      | 3. 00<br>Y                                  |                              |       |
| 00 | PS&R Data  Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 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  | Y/N<br>1.00       | Date 2.00      | 3. 00<br>Y                                  |                              |       |
| 00 | PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)  | Y/N<br>1.00       | Date 2.00      | 3. 00<br>Y                                  |                              | 17    |
| 00 | PS&R Data  Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 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  | Y/N<br>1.00<br>Y  | Date 2.00      | 3. 00<br>Y                                  |                              | 17    |
| 00 | PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R   | Y/N<br>1.00<br>Y  | Date 2.00      | 3. 00<br>Y                                  |                              | 17    |
| 00 | PS&R Data  Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed  | Y/N<br>1.00<br>Y  | Date 2.00      | 3. 00<br>Y                                  |                              | 16    |
| 00 | PS&R Data  Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.  If line 16 or 17 is yes, were adjustments made to PS&R | Y/N<br>1.00<br>Y  | Date 2.00      | 3. 00<br>Y                                  |                              | 17    |
| 00 | PS&R Data  Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.   | Y/N<br>1.00       | Date 2.00      | 3. 00<br>Y<br>N                             |                              | 1     |

| Heal th          | Financial Systems REHABILITATION HOS   | SPITAL OF INDIA | INA            | In Lie                                       | u of Form CM:  | S-2552-10 |
|------------------|--|-----------------|----------------|--|--|-----------|
| HOSPI T          | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE  | Provi der C     | CN: 15-3028    | Peri od:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet S<br>Part II<br>Date/Time P<br>5/30/2024 8 | repared:  |
|                  |  |                 | i pti on       | Y/N  | Y/N  |           |
| 20. 00           | If line 16 or 17 is yes, were adjustments made to PS&R   |                 | 0              | 1. 00<br>N                                   | 3. 00<br>N   | 20.00     |
|                  | Report data for Other? Describe the other adjustments:   |                 |                |  |  | 20.00     |
|                  |  | Y/N             | Date           | Y/N  | Date   |           |
| 21. 00           | Was the cost report prepared only using the provider's   | 1. 00<br>N      | 2. 00          | 3. 00<br>N                                   | 4. 00  | 21. 00    |
|                  | records? If yes, see instructions.   |                 |                |  |  | 21100     |
|                  |  |                 |                |  | 1. 00  |           |
|                  | COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE  | PT CHILDRENS H  | OSPI TALS)     |  |  |           |
|                  | Capital Related Cost   |                 |                |  |  |           |
| 22. 00<br>23. 00 | Have assets been relifed for Medicare purposes? If yes, see<br>Have changes occurred in the Medicare depreciation expense  |                 | sals made dur  | ing the cost                                 | Y<br>N   | 22. 00    |
| 23.00            | reporting period? If yes, see instructions.  | due to apprais  | sais made dui  | ing the cost                                 | IV   | 23.00     |
| 24. 00           | Were new leases and/or amendments to existing leases entered if yes, see instructions                                      | ed into during  | this cost re   | porting period?                              | N  | 24. 00    |
| 25. 00           | Have there been new capitalized leases entered into during   | the cost repor  | ting period?   | If yes, see                                  | N  | 25. 00    |
| 24 00            | instructions.  |                 | na nonioda I   | £ 1/00 000                                   | N  | 24 00     |
| 26. 00           | Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.  | ie cost reporti | ng period? i   | r yes, see                                   | N  | 26. 00    |
| 27. 00           | Has the provider's capitalization policy changed during the copy.  | e cost reportir | ng period? If  | yes, submit                                  | N  | 27. 00    |
|                  | Interest Expense   |                 |                |  |  |           |
| 28. 00           | Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.                              | ntered into dur | ing the cost   | reporting                                    | N  | 28. 00    |
| 29. 00           | Did the provider have a funded depreciation account and/or   | bond funds (De  | ebt Service R  | eserve Fund)                                 | N  | 29. 00    |
| 30. 00           | treated as a funded depreciation account? If yes, see instr<br>Has existing debt been replaced prior to its scheduled matu |                 | deht? If ves   | 500  | N  | 30.00     |
|                  | instructions.  | ,               | ,              |  | 14   |           |
| 31. 00           | Has debt been recalled before scheduled maturity without is instructions.  | ssuance of new  | debt? If yes   | , see  | N  | 31.00     |
|                  | Purchased Services   |                 |                |  |  |           |
| 32. 00           | Have changes or new agreements occurred in patient care ser<br>arrangements with suppliers of services? If yes, see instru |                 | ed through co  | ntractual                                    | N  | 32. 00    |
| 33. 00           | If line 32 is yes, were the requirements of Sec. 2135.2 app  | olied pertainir | ng to competi  | tive bidding? If                             |  | 33. 00    |
|                  | no, see instructions.  | '               |                |  |  |           |
| 24.00            | Provider-Based Physicians Were services furnished at the provider facility under an a                                      | nnongoment wit  | th provider b  | and physicians?                              | N  | 24 00     |
| 34. 00           | If yes, see instructions.  | arrangement wr  | iii provider-b | aseu physicians?                             | IN   | 34.00     |
| 35. 00           | If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in     |                 | nts with the   | provi der-based                              |  | 35. 00    |
|                  | priysterans durring the cost reporting perrod: 11 yes, see 11  | istructions.    |                | Y/N  | Date   |           |
|                  |  |                 |                | 1. 00  | 2. 00  |           |
| 36. 00           | Home Office Costs 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 pr  | repared by the  | home office?   |  |  | 37.00     |
|                  | If yes, see instructions.  |                 |                |  |  |           |
| 38. 00           | If line 36 is yes, was the fiscal year end of the home off<br>the provider? If yes, enter in column 2 the fiscal year end  |                 |                | N  |  | 38. 00    |
| 39. 00           | If line 36 is yes, did the provider render services to other   | er chain compor | nents? If yes  | , Y  |  | 39. 00    |
| 40. 00           | see instructions.<br>If line 36 is yes, did the provider render services to the  | home office?    | If yes, see    | N  |  | 40. 00    |
|                  | i nstructi ons.  |                 |                |  |  |           |
|                  |  | 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   | INDIANA UNIVER  | SITY HEALTH    |  |  | 42. 00    |
|                  | preparer.  |                 |                | DUTTEDALINEALT                               | 1 ODC  |           |
| 43. 00           | Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.                 | 317. 556. 3910  |                | RUTTER@I UHEALTI                             | ד. טאט   | 43. 00    |

| Heal th | Financial Systems RI                         | EHABILITATION HOS | PITAL OF INDIANA     |                 | In Lie                     | u of Form CMS-2                | 2552-10        |
|---------|--|-------------------|----------------------|-----------------|----------------------------|--------------------------------|----------------|
| HOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT Q  | QUESTI ONNAI RE   | Provi der CCN: 15-   |                 | Period:<br>From 01/01/2023 | Worksheet S-2<br>Part II       |                |
|         |  |                   |                      |                 | o 12/31/2023               | Date/Time Pre<br>5/30/2024 8:3 | pared:<br>5 am |
|         |  |                   |                      |                 |                            |                                |                |
|         |  |                   | 3. 00                |                 |                            |                                |                |
|         | Cost Report Preparer Contact Information     |                   |                      |                 |                            |                                |                |
| 41.00   | Enter the first name, last name and the ti   | tle/position      | DI RECTOR-GOVERNMENT | <b>PROGRAMS</b> |                            |                                | 41.00          |
|         | held by the cost report preparer in column:  | is 1, 2, and 3,   |                      |                 |                            |                                |                |
|         | respecti vel y.                              |                   |                      |                 |                            |                                |                |
| 42.00   | Enter the employer/company name of the cos   | st report         |                      |                 |                            |                                | 42.00          |
|         | preparer.                                    |                   |                      |                 |                            |                                |                |
| 43.00   | Enter the telephone number and email address | ess of the cost   |                      |                 |                            |                                | 43.00          |
|         | report preparer in columns 1 and 2, respec   | ti vel y.         |                      |                 |                            |                                |                |

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

|        |  |             |             | '            | 0 12/31/2023  | 5/30/2024 8: 35 |        |
|--------|--|-------------|-------------|--------------|---------------|-----------------|--------|
|        |  |             |             |              |               | I/P Days / 0/P  | , can  |
|        |  |             |             |              |               | Visits / Trips  |        |
|        | Component                                    | Worksheet A | No. of Beds | Bed Days     | CAH/REH Hours | Title V         |        |
|        | <b>'</b>                                     | 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                     |             |             |              |               |                 | 10. 00 |
| 11. 00 | SURGICAL INTENSIVE CARE UNIT                 |             |             |              |               |                 | 11. 00 |
| 12. 00 | OTHER SPECIAL CARE (SPECIFY)                 |             |             |              |               |                 | 12. 00 |
| 13.00  | NURSERY                                      |             |             |              |               |                 | 13.00  |
| 14. 00 | Total (see instructions)                     |             | 91          | 33, 215      | 0.00          | 0               | 14. 00 |
| 15. 00 | CAH visits                                   |             |             |              |               | 0               | 15. 00 |
| 15. 10 | REH hours and visits                         |             |             |              | 0. 00         | 0               | 15. 10 |
| 16. 00 | SUBPROVI DER - I PF                          |             |             |              |               |                 | 16. 00 |
| 17. 00 | SUBPROVI DER - I RF                          |             |             |              |               |                 | 17. 00 |
| 18. 00 | SUBPROVI DER                                 |             |             |              |               |                 | 18. 00 |
| 19. 00 | SKILLED NURSING FACILITY                     |             |             |              |               |                 | 19. 00 |
| 20. 00 | NURSING FACILITY                             |             |             |              |               |                 | 20.00  |
| 21. 00 | OTHER LONG TERM CARE                         |             |             |              |               |                 | 21. 00 |
| 22. 00 | HOME HEALTH AGENCY                           |             |             |              |               |                 | 22. 00 |
| 23. 00 | AMBULATORY SURGICAL CENTER (D. P. )          |             |             |              |               |                 | 23. 00 |
| 24. 00 | HOSPI CE                                     |             |             |              |               |                 | 24. 00 |
| 24. 10 | HOSPICE (non-distinct part)                  | 30. 00      |             |              |               | _               | 24. 10 |
| 25. 00 | CMHC - CMHC                                  | 99. 00      |             |              |               | 0               | 25. 00 |
| 25. 10 | CMHC - CORF                                  | 99. 10      |             |              |               | 0               | 25. 10 |
| 26. 00 | RURAL HEALTH CLINIC                          |             |             |              |               |                 | 26. 00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER            | 89. 00      |             |              |               | 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 Tri ps                            |             |             |              |               |                 | 29. 00 |
| 30. 00 | Employee discount days (see instruction)     |             |             |              |               |                 | 30. 00 |
| 31. 00 | Employee discount days - IRF                 |             | _           | _            |               |                 | 31. 00 |
| 32. 00 | Labor & delivery days (see instructions)     |             | 0           | C            |               |                 | 32. 00 |
| 32. 01 | Total ancillary labor & delivery room        |             |             |              |               |                 | 32. 01 |
| 22.00  | outpatient days (see instructions)           |             |             |              |               |                 | 22.00  |
| 33. 00 | LTCH non-covered days                        |             |             |              |               |                 | 33. 00 |
| 33. 01 | LTCH site neutral days and discharges        | 20.00       |             | _            |               |                 | 33. 01 |
| 34. 00 | Temporary Expansion COVID-19 PHE Acute Care  | 30. 00      | 0           | C            |               | 0               | 34. 00 |
|        |  |             |             |              |               |                 |        |

Heal th Financial Systems REHABILITATION HOSPITAL OF INDIANA
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-3028

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared:
5/30/2024 8:35 am

|        |  |             |              |                       |                              | 5/30/2024 8: 3          | 5 am   |
|--------|--|-------------|--------------|-----------------------|------------------------------|-------------------------|--------|
|        |  | I/P Days    | / O/P Visits | / Trips               | Full Time E                  | Equi val ents           |        |
|        | Component  | Title XVIII | Title XIX    | Total All<br>Patients | Total Interns<br>& Residents | Employees On<br>Payroll |        |
|        |  | 6. 00       | 7. 00        | 8. 00                 | 9. 00                        | 10.00                   |        |
|        | PART I - STATISTICAL DATA  | 9. 52       |              | 2. 22                 | 1.00                         |                         |        |
| 1.00   | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and  | 5, 231      | 751          | 18, 813               |                              |                         | 1.00   |
|        | Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) |             |              |                       |                              |                         |        |
| 2. 00  | HMO and other (see instructions)   | 4, 299      | 4, 210       |                       |                              |                         | 2. 00  |
| 3. 00  | HMO I PF Subprovi der  | 0           | 0            |                       |                              |                         | 3. 00  |
| 4.00   | HMO IRF Subprovider  | 0           | 0            |                       |                              |                         | 4. 00  |
| 5. 00  | Hospital Adults & Peds. Swing Bed SNF  | 0           | 0            | C                     |                              |                         | 5. 00  |
| 6. 00  | Hospital Adults & Peds. Swing Bed NF   |             | 0            | C                     | 1                            |                         | 6. 00  |
| 7. 00  | Total Adults and Peds. (exclude observation beds) (see instructions)                   | 5, 231      | 751          | 18, 813               |                              |                         | 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, 231      | 751          | 18, 813               | 2. 99                        | 275. 21                 |        |
| 15.00  | CAH visits   | o           | o            |                       | )                            |                         | 15. 00 |
| 15. 10 | REH hours and visits   | o           | o            | C                     | )                            |                         | 15. 10 |
| 16.00  | SUBPROVI DER - I PF  |             |              |                       |                              |                         | 16. 00 |
| 17.00  | SUBPROVI DER - I RF  |             |              |                       |                              |                         | 17. 00 |
| 18.00  | SUBPROVI DER   |             |              |                       |                              |                         | 18. 00 |
| 19.00  | SKILLED NURSING FACILITY   |             |              |                       |                              |                         | 19. 00 |
| 20.00  | NURSING FACILITY   |             |              |                       |                              |                         | 20.00  |
| 21. 00 | OTHER LONG TERM CARE   |             |              |                       |                              |                         | 21. 00 |
| 22. 00 | HOME HEALTH AGENCY   |             |              |                       |                              |                         | 22. 00 |
| 23. 00 | AMBULATORY SURGICAL CENTER (D. P.)   |             |              |                       |                              |                         | 23. 00 |
| 24.00  | HOSPI CE   |             |              |                       |                              |                         | 24. 00 |
| 24. 10 | HOSPICE (non-distinct part)  |             |              | C                     |                              |                         | 24. 10 |
| 25. 00 | CMHC - CMHC  | 0           | 0            | C                     |                              | 0.00                    |        |
| 25. 10 | CMHC - CORF  | 0           | 0            | C                     | 0.00                         | 0.00                    |        |
| 26. 00 | RURAL HEALTH CLINIC  |             |              |                       |                              |                         | 26. 00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER  | 0           | 0            | C                     |                              | 0.00                    |        |
| 27. 00 | Total (sum of lines 14-26)   |             |              |                       | 2. 99                        | 275. 21                 |        |
| 28. 00 | Observation Bed Days   |             | 0            | C                     |                              |                         | 28. 00 |
| 29. 00 | Ambul ance Tri ps  | 0           |              |                       |                              |                         | 29. 00 |
| 30. 00 | Employee discount days (see instruction)   |             |              | C                     | 1                            |                         | 30.00  |
| 31. 00 | Employee discount days - IRF   | _           | _            | C                     |                              |                         | 31.00  |
| 32. 00 | Labor & delivery days (see instructions)   | 0           | 0            | C                     | )                            |                         | 32. 00 |
| 32. 01 | Total ancillary labor & delivery room outpatient days (see instructions)               |             |              | C                     |                              |                         | 32. 01 |
| 33. 00 | LTCH non-covered days  | ol          |              |                       |                              |                         | 33.00  |
| 33. 01 | LTCH site neutral days and discharges  | ا           |              |                       |                              |                         | 33. 01 |
|        | Temporary Expansi on COVID-19 PHE Acute Care   | o o         | 0            | С                     | )                            |                         | 34. 00 |
|        |  |             |              |                       |                              |                         |        |

 Heal th Financial
 Systems
 REHABILITATION

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA

Provi der CCN: 15-3028

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared: 5/30/2024 8:35 am

|                  |   |                          |         |             |           | 5/30/2024 8: 3        | 5 am             |
|------------------|---|--------------------------|---------|-------------|-----------|-----------------------|------------------|
|                  |   | Full Time<br>Equivalents |         | Di sch      | arges     |                       |                  |
|                  | Component   | Nonpai d<br>Workers      | Title V | Title XVIII | Title XIX | Total All<br>Patients |                  |
|                  |   | 11.00                    | 12. 00  | 13. 00      | 14.00     | 15. 00                |                  |
|                  | PART I - STATISTICAL DATA   | <u> </u>                 |         |             |           |                       |                  |
| 1. 00            | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and |                          | 0       | 403         | 61        | 1, 387                | 1. 00            |
|                  | Hospice days) (see instructions for col. 2  |                          |         |             |           |                       |                  |
| 2.00             | for the portion of LDP room available beds)   |                          |         | 21/         | 292       |                       | 2 00             |
| 2. 00<br>3. 00   | HMO and other (see instructions)  |                          |         | 316         | 292       |                       | 2. 00<br>3. 00   |
| 4. 00            | HMO IPF Subprovider<br>HMO IRF Subprovider  |                          |         |             | 0         |                       | 4. 00            |
| 5.00             | Hospital Adults & Peds. Swing Bed SNF   |                          |         |             | U         |                       | 5. 00            |
| 6.00             | Hospital Adults & Peds. Swing Bed SNI   |                          |         |             |           |                       | 6. 00            |
| 7. 00            | Total Adults and Peds. (exclude observation   |                          |         |             |           |                       | 7. 00            |
| 7.00             | beds) (see instructions)  |                          |         |             |           |                       | 7.00             |
| 8. 00            | INTENSIVE CARE UNIT   |                          |         |             |           |                       | 8. 00            |
| 9. 00            | CORONARY CARE UNIT  |                          |         |             |           |                       | 9. 00            |
| 10.00            | BURN INTENSIVE CARE UNIT  |                          |         |             |           |                       | 10.00            |
| 11. 00           | SURGICAL INTENSIVE CARE UNIT  |                          |         |             |           |                       | 11. 00           |
| 12.00            | OTHER SPECIAL CARE (SPECIFY)  |                          |         |             |           |                       | 12.00            |
| 13.00            | NURSERY   |                          |         |             |           |                       | 13.00            |
| 14.00            | Total (see instructions)  | 0.00                     | 0       | 403         | 61        | 1, 387                | 14.00            |
| 15.00            | CAH visits  |                          |         |             |           |                       | 15. 00           |
| 15. 10           | REH hours and visits  |                          |         |             |           |                       | 15. 10           |
| 16.00            | SUBPROVI DER - I PF   |                          |         |             |           |                       | 16.00            |
| 17. 00           | SUBPROVI DER - I RF   |                          |         |             |           |                       | 17. 00           |
| 18. 00           | SUBPROVI DER  |                          |         |             |           |                       | 18. 00           |
| 19. 00           | SKILLED NURSING FACILITY  |                          |         |             |           |                       | 19. 00           |
| 20. 00           | NURSING FACILITY  |                          |         |             |           |                       | 20. 00           |
| 21. 00           | OTHER LONG TERM CARE  |                          |         |             |           |                       | 21. 00           |
| 22. 00           | HOME HEALTH AGENCY  |                          |         |             |           |                       | 22. 00           |
| 23. 00           | AMBULATORY SURGICAL CENTER (D. P. )   |                          |         |             |           |                       | 23. 00           |
| 24. 00           | HOSPI CE  |                          |         |             |           |                       | 24. 00           |
| 24. 10           | HOSPICE (non-distinct part)   | 0.00                     |         |             |           |                       | 24. 10           |
| 25. 00           | CMHC - CMHC   | 0.00                     |         |             |           |                       | 25. 00           |
| 25. 10<br>26. 00 | CMHC - CORF<br>  RURAL HEALTH CLINIC  | 0. 00                    |         |             |           |                       | 25. 10<br>26. 00 |
| 26. 25           | FEDERALLY QUALIFIED HEALTH CENTER   | 0.00                     |         |             |           |                       | 26. 25           |
| 27. 00           | Total (sum of lines 14-26)  | 0.00                     |         |             |           |                       | 20. 23           |
| 28. 00           | Observation Bed Days  | 0.00                     |         |             |           |                       | 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   |                          |         | О           |           |                       | 33. 00           |
| 33. 01           | LTCH site neutral days and discharges   |                          |         | 0           |           |                       | 33. 01           |
| 34.00            | Temporary Expansion COVID-19 PHE Acute Care   |                          |         |             |           |                       | 34. 00           |
|                  |   |                          |         |             |           |                       |                  |

| <u>Heal</u> th | Financial Systems REHA                          | BILITATION HOSPI |              |               | In Lie           | u of Form CMS-2 | 2552-10 |
|----------------|---|------------------|--------------|---------------|------------------|-----------------|---------|
| RECLAS         | SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF | EXPENSES         | Provi der Co |               | Peri od:         | Worksheet A     |         |
|                |   |                  |              |               | From 01/01/2023  | 5 . (=1 5       |         |
|                |   |                  |              |               | To 12/31/2023    | Date/Time Pre   |         |
|                |   |                  |              | I = 1 1 1 1 1 | 5                | 5/30/2024 8: 3  | 5 am    |
|                | Cost Center Description                         | Sal ari es       | Other        |               | Reclassi fi cati | Reclassi fied   |         |
|                |   |                  |              | + col . 2)    | ons (See A-6)    | Trial Balance   |         |
|                |   |                  |              |               |                  | (col. 3 +-      |         |
|                |   |                  |              |               |                  | col . 4)        |         |
|                |   | 1.00             | 2. 00        | 3.00          | 4. 00            | 5. 00           |         |
|                | GENERAL SERVICE COST CENTERS                    |                  |              |               |                  |                 |         |
| 1.00           | 00100 CAP REL COSTS-BLDG & FIXT                 |                  | 1, 478, 307  | 1, 478, 30    | 7 0              | 1, 478, 307     | 1.00    |
| 2.00           | 00200 CAP REL COSTS-MVBLE EQUIP                 |                  | 625, 600     |               |                  | 625, 600        | 2.00    |
| 3.00           | 00300 OTHER CAP REL COSTS                       |                  | 0            | 1             |                  | 0               | 3. 00   |
| 4. 00          | 00400 EMPLOYEE BENEFITS DEPARTMENT              | 413, 034         | 5, 854, 853  | 6, 267, 88    | 7 -283           | 6, 267, 604     | 4. 00   |
| 5. 01          | 00591 ADMINISTRATIVE AND GENERAL                | 3, 314, 330      | 2, 427, 940  |               |                  |                 | 5. 01   |
|                |   |                  |              |               |                  |                 |         |
| 5. 02          | 00590 OTHER A&G - NON FOUNDATION                | 786, 101         | 274, 708     |               | ·                | 1, 059, 399     | 5. 02   |
| 7.00           | 00700 OPERATION OF PLANT                        | 49, 443          | 1, 777, 645  |               |                  |                 | 7. 00   |
| 8. 00          | 00800 LAUNDRY & LINEN SERVICE                   | 0                | 103, 084     |               |                  | 103, 084        | 8. 00   |
| 9.00           | 00900 HOUSEKEEPI NG                             | 390, 678         | 168, 536     | 559, 21       | 4 -171           | 559, 043        | 9. 00   |
| 10.00          | 01000 DI ETARY                                  | 62, 466          | 1, 393, 869  | 1, 456, 33    | 5 -579, 994      | 876, 341        | 10.00   |
| 11.00          | 01100 CAFETERI A                                | o                | 0            |               | 0 579, 917       | 579, 917        | 11.00   |
| 13.00          | 01300 NURSI NG ADMI NI STRATI ON                | 1, 633, 943      | 313, 864     | 1, 947, 80    | 7 258, 793       | 2, 206, 600     | 13.00   |
| 14. 00         | 01400 CENTRAL SERVICES & SUPPLY                 | 56, 895          | 261, 721     | 318, 61       |                  | 491, 537        |         |
| 15. 00         | 01500 PHARMACY                                  | 591, 069         | 159, 745     |               |                  |                 | 1       |
|                |   |                  |              |               |                  |                 |         |
| 16.00          | 01600 MEDICAL RECORDS & LIBRARY                 | 412, 233         | 108, 594     |               |                  | 520, 827        | 16.00   |
| 17. 00         | 01700 SOCI AL SERVI CE                          | 517, 562         | 179, 348     |               |                  |                 | 1       |
| 22. 00         | 02200 I &R SERVICES-OTHER PRGM COSTS APPRV      | 0                | 243, 374     | 243, 37       | 4 0              | 243, 374        | 22. 00  |
|                | INPATIENT ROUTINE SERVICE COST CENTERS          |                  |              |               |                  |                 |         |
| 30.00          | 03000 ADULTS & PEDIATRICS                       | 7, 102, 500      | 2, 671, 169  | 9, 773, 66    | 9 -238, 969      | 9, 534, 700     | 30. 00  |
|                | ANCILLARY SERVICE COST CENTERS                  |                  |              |               |                  |                 | 1       |
| 50.00          | 05000 OPERATI NG ROOM                           | 0                | 0            |               | 0                | 0               | 50.00   |
| 54. 00         | 05400 RADI OLOGY-DI AGNOSTI C                   | 135, 308         | 36, 799      | 172, 10       | 7 -2, 586        |                 | 1       |
| 60.00          | 06000 LABORATORY                                | 133, 300         | 432, 316     |               |                  |                 |         |
|                | 1   | ٧                |              |               |                  |                 |         |
| 65. 00         | 06500 RESPI RATORY THERAPY                      | 512, 068         | 128, 190     |               |                  | · ·             |         |
| 66. 00         | 06600 PHYSI CAL THERAPY                         | 1, 694, 172      | 458, 035     |               |                  |                 | 1       |
| 66. 01         | 06601 PHYSI CAL THERAPY - CARMEL                | 0                | -8, 893      |               |                  | 0               | 66. 01  |
| 67. 00         | 06700 OCCUPATI ONAL THERAPY                     | 2, 111, 844      | 311, 039     | 2, 422, 88    | 3 -238, 107      | 2, 184, 776     | 67. 00  |
| 68.00          | 06800 SPEECH PATHOLOGY                          | 914, 490         | 112, 448     | 1, 026, 93    | 8 309, 878       | 1, 336, 816     | 68. 00  |
| 68. 01         | 06801 VI SI ON                                  | 0                | 0            |               | 0 0              | 0               | 68. 01  |
| 68. 02         | 06802 FAC RESOURCE                              | 35, 329          | 15, 345      | 50, 67        | 4 -50, 674       | 0               | 68. 02  |
| 69. 00         | 06900 ELECTROCARDI OLOGY                        | 0                | . 0          |               | o o              | 0               | 69. 00  |
| 71. 00         | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT       | ا                | 0            |               | 0 214, 703       | 214, 703        |         |
| 72. 00         | 07200 IMPL. DEV. CHARGED TO PATIENTS            | ol o             | 0            |               | 211,700          | 0               | 72.00   |
| 73. 00         | 07300 DRUGS CHARGED TO PATIENTS                 | 0                | 1 200 040    | 1 200 04      |                  |                 | 1       |
|                |   | -1               | 1, 308, 849  | 1, 308, 84    | 9                | 1, 308, 849     |         |
| 74. 00         | 07400 RENAL DI ALYSI S                          | 0                | 0            | 1             | 0                | 0               | 74. 00  |
| 77. 00         | 07700 ALLOGENEIC HSCT ACQUISITION               | 0                | 0            | 1             | 이                | 0               | 77. 00  |
| 78. 00         | 07800 CAR T-CELL IMMUNOTHERAPY                  | 0                | 0            |               | 0 0              | 0               | 78. 00  |
|                | OUTPATIENT SERVICE COST CENTERS                 |                  |              |               |                  |                 |         |
| 90.00          | 09000 CLI NI C                                  | 206, 725         | 65, 602      | 272, 32       | 7 -22, 242       | 250, 085        | 90.00   |
| 90. 01         | 09001 SLEEP CENTER                              | 0                | 0            |               | 0                | 0               | 90. 01  |
| 91.00          | 09100 EMERGENCY                                 | o                | 0            | )             | ol ol            | 0               | 91.00   |
| 92. 00         |   |                  |              |               |                  | Ī               | 92.00   |
| 72.00          | OTHER REIMBURSABLE COST CENTERS                 |                  |              |               |                  |                 | 72.00   |
| 99. 00         |   | ٥                | 0            | d             |                  | 0               | 99. 00  |
|                |   | (44 025          | 1/2 054      | 000 77        | 000 770          |                 |         |
|                | 09910 CORF                                      | 644, 925         | 163, 854     | 808, 77       | 9 -808, 779      |                 |         |
| 102.00         | 10200 OPI OI D TREATMENT PROGRAM                | 0                | 0            |               | 0  0             | 0               | 102. 00 |
|                | SPECIAL PURPOSE COST CENTERS                    |                  |              |               |                  |                 | 1       |
| 118.00         | SUBTOTALS (SUM OF LINES 1 through 117)          | 21, 585, 115     | 21, 065, 941 | 42, 651, 05   | 6 -36, 639       | 42, 614, 417    | 118. 00 |
|                | NONREI MBURSABLE COST CENTERS                   |                  |              |               |                  |                 | 1       |
| 190.00         | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN         | 0                | 0            |               | 0 0              | 0               | 190. 00 |
|                | 19200 PHYSICIANS PRIVATE OFFICES                | 480, 440         | 439, 150     | 919, 59       | 0 27, 072        |                 |         |
|                | 07950 FOUNDATION                                | 203, 613         | 81, 513      |               |                  |                 |         |
|                |   |                  |              |               |                  | 192, 621        |         |
|                | 107951 PUBLIC RELATIONS                         | 127, 182         | 66, 222      | 1             |                  |                 |         |
|                | 2 07952 ST. VINCENT - ARU                       | 0                | 0            | '             | 0                |                 | 194. 02 |
|                | 07953 MUNCI E - ARU                             | 0                | 0            | 1             | 이                |                 | 194. 03 |
|                | 1 07954 RI LEY - ARU                            | 0                | 0            | 1             | 이                |                 | 194. 04 |
|                | 07955 RETAIL PHARMACY                           | 221, 663         | 1, 265, 132  |               |                  | 1, 486, 795     |         |
| 200.00         | TOTAL (SUM OF LINES 118 through 199)            | 22, 618, 013     | 22, 917, 958 | 45, 535, 97   | 1 0              | 45, 535, 971    | 200. 00 |
|                |   | ,                |              | -             |                  |                 | -       |

| Health Financial Systems REHA   | ABILITATION HOS | PITAL OF INDIANA | In Lieu of Form CM                    | IS-2552-10       |
|---|-----------------|------------------|---------------------------------------|------------------|
| RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O                                   |                 | Provider CCN:    | 15-3028 Period: Worksheet A           |                  |
|   |                 |                  | From 01/01/2023                       | Dronorod.        |
|   |                 |                  | To 12/31/2023 Date/Time F 5/30/2024 8 |                  |
| Cost Center Description   | Adjustments     | Net Expenses     | 070072021                             | 5. 00 diii       |
|   |                 | For Allocation   |                                       |                  |
|   | 6.00            | 7. 00            |                                       |                  |
| GENERAL SERVICE COST CENTERS  |                 |                  |                                       |                  |
| 1.00 O0100 CAP REL COSTS-BLDG & FLXT  | 113, 607        | 1, 591, 914      |                                       | 1. 00            |
| 2.00 O0200 CAP REL COSTS-MVBLE EQUIP  | 134, 373        | 759, 973         |                                       | 2. 00            |
| 3.00  00300 0THER CAP REL COSTS   | 0               | 0                |                                       | 3. 00            |
| 4.00   00400   EMPLOYEE BENEFITS DEPARTMENT   | -839            | 6, 266, 765      |                                       | 4. 00            |
| 5.01   00591   ADMINISTRATIVE AND GENERAL   | 1, 979, 350     | 7, 558, 222      |                                       | 5. 01            |
| 5.02 00590 OTHER A&G - NON FOUNDATION   | 0               | 1, 059, 399      |                                       | 5. 02            |
| 7.00 O0700 OPERATION OF PLANT   | -32, 469        | 1, 792, 803      |                                       | 7. 00            |
| 8.00   00800   LAUNDRY & LINEN SERVICE  | 0               | 103, 084         |                                       | 8. 00            |
| 9. 00   00900   HOUSEKEEPI NG   | 0               | 559, 043         |                                       | 9. 00            |
| 10. 00  01000   DI ETARY  | 0               | 876, 341         |                                       | 10. 00           |
| 11. 00  01100   CAFETERI A  | -193, 137       | 386, 780         |                                       | 11. 00           |
| 13.00 O1300 NURSING ADMINISTRATION  | -68             | 2, 206, 532      |                                       | 13. 00           |
| 14. 00 01400 CENTRAL SERVICES & SUPPLY  | 0               | 491, 537         |                                       | 14. 00           |
| 15. 00   01500   PHARMACY   | -29, 303        | 715, 771         |                                       | 15. 00           |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY  | -60             | 520, 767         |                                       | 16. 00           |
| 17. 00   01700   SOCIAL SERVICE   | 0               | 696, 022         |                                       | 17. 00           |
| 22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV                                    | 0               | 243, 374         |                                       | 22. 00           |
| INPATIENT ROUTINE SERVICE COST CENTERS  |                 | 0.504.700        |                                       |                  |
| 30. 00 03000 ADULTS & PEDIATRICS  | 0               | 9, 534, 700      |                                       | 30.00            |
| ANCILLARY SERVICE COST CENTERS  |                 |                  |                                       | - FO 00          |
| 50. 00 05000 OPERATING ROOM   | 0               | 0                |                                       | 50.00            |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C  | 0               | 169, 521         |                                       | 54. 00           |
| 60. 00   06000   LABORATORY   | -66, 858        | 365, 694         |                                       | 60.00            |
| 65. 00 06500 RESPIRATORY THERAPY  | 40.701          | 563, 849         |                                       | 65. 00           |
| 66. 00 06600 PHYSI CAL THERAPY  | -40, 781        | 2, 720, 912      |                                       | 66. 00           |
| 66. 01   06601   PHYSI CAL THERAPY - CARMEL<br>67. 00   06700   OCCUPATI ONAL THERAPY | -379            | 2 104 207        |                                       | 66. 01<br>67. 00 |
| 68. 00   06800   SPEECH PATHOLOGY   | -3/9            | 2, 184, 397      |                                       | 68. 00           |
| 68. 01   06801   VI SI ON   | 0               | 1, 336, 816      |                                       | 68. 01           |
| 68. 02   06802   FAC RESOURCE   | 0               | 0                |                                       | 68. 02           |
| 69. 00 06900 ELECTROCARDI OLOGY   |                 | 0                |                                       | 69. 00           |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                                      |                 | 214, 703         |                                       | 71. 00           |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS   | l ő             | 214, 705         |                                       | 72.00            |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS  |                 | 1, 308, 849      |                                       | 73. 00           |
| 74. 00 07400 RENAL DI ALYSI S   | l o             | 0                |                                       | 74. 00           |
| 77. 00 07700 ALLOGENEIC HSCT ACQUISITION  | o               | o                |                                       | 77. 00           |
| 78. 00 07800 CAR T-CELL IMMUNOTHERAPY   | l o             | 0                |                                       | 78. 00           |
| OUTPATIENT SERVICE COST CENTERS   | <u> </u>        |                  |                                       | 70.00            |
| 90. 00 09000 CLINIC   | O               | 250, 085         |                                       | 90.00            |
| 90. 01   09001   SLEEP CENTER   | l ol            | 0                |                                       | 90. 01           |
| 91. 00 09100 EMERGENCY  | l ol            | o                |                                       | 91.00            |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART                                       |                 |                  |                                       | 92. 00           |
| OTHER REIMBURSABLE COST CENTERS   |                 | '                |                                       |                  |
| 99. 00 09900 CMHC   | 0               | 0                |                                       | 99. 00           |
| 99. 10 09910 CORF   | o               | O                |                                       | 99. 10           |
| 102.00 10200 OPIOLD TREATMENT PROGRAM   | o               | O                |                                       | 102.00           |
| SPECIAL PURPOSE COST CENTERS  | ·               | '                |                                       |                  |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)   | 1, 863, 436     | 44, 477, 853     |                                       | 118. 00          |
| NONREI MBURSABLE COST CENTERS   |                 | <u>'</u>         |                                       |                  |
| 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN  | 0               | 0                |                                       | 190. 00          |
| 192.00 19200 PHYSICIANS PRIVATE OFFICES   | O               | 946, 662         |                                       | 192. 00          |
| 194. 00 07950 FOUNDATI ON   | 710, 393        | 1, 005, 869      |                                       | 194. 00          |
| 194. 01 07951 PUBLI C RELATI ONS  | 0               | 192, 621         |                                       | 194. 01          |
| 194. 02 07952 ST. VINCENT - ARU   | o               | 0                |                                       | 194. 02          |
| 194. 03 07953 MUNCI E - ARU   | 0               | 0                |                                       | 194. 03          |
| 194. 04 07954 RI LEY - ARU  | 0               | 0                |                                       | 194. 04          |
| 194. 05 07955 RETAIL PHARMACY   | 0               | 1, 486, 795      |                                       | 194. 05          |
| 200.00 TOTAL (SUM OF LINES 118 through 199)   | 2, 573, 829     | 48, 109, 800     |                                       | 200. 00          |
|   |                 |                  |                                       |                  |

Health Financial Systems RECLASSIFICATIONS | Period: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/30/2024 8: 35 am Provider CCN: 15-3028

|        |                               |               |                   |                   | 5/30/2024 8:35 am |
|--------|-------------------------------|---------------|-------------------|-------------------|-------------------|
|        |                               | Increases     |                   |                   |                   |
|        | Cost Center                   | Li ne #       | Sal ary           | 0ther             |                   |
|        | 2. 00                         | 3. 00         | 4. 00             | 5. 00             |                   |
|        | A - CAFETERIA                 |               |                   |                   |                   |
| 1.00   | CAFETERI A                    | 11. 00        | 24, 875           | 55 <u>5, 0</u> 42 | 1.00              |
|        | 0                             |               | 24, 875           | 555, 042          |                   |
|        | B - NURSING ADMINISTRATION    |               |                   |                   |                   |
| 1.00   | NURSING ADMINISTRATION        | 1300          | 19 <u>6, 7</u> 10 | 0                 | 1.00              |
|        | 0                             |               | 196, 710          | 0                 |                   |
|        | C - NCR (CORF)                |               |                   |                   |                   |
| 1.00   | PHYSI CAL THERAPY             | 66.00         | 302, 656          | 76, 199           | 1.00              |
| 2.00   | OCCUPATI ONAL THERAPY         | 67.00         | 188, 625          | 47, 490           | 2. 00             |
| 3.00   | SPEECH PATHOLOGY              | 68. 00        | 153, 644          | 38, 683           | 3.00              |
|        |                               |               | 644, 925          | 162, 372          |                   |
|        | D - MEDICAL SUPPLIES          |               | <u>.</u>          |                   |                   |
| 1.00   | CENTRAL SERVICES & SUPPLY     | 14.00         | 0                 | 241, 039          | 1.00              |
| 2.00   | MEDICAL SUPPLIES CHARGED TO   | 71.00         | o                 | 214, 703          | 2.00              |
|        | PATI ENT                      |               |                   |                   |                   |
| 3.00   | LABORATORY                    | 60.00         | o                 | 236               | 3.00              |
| 4.00   |                               | 0.00          | o                 | 0                 | 4. 00             |
| 5.00   |                               | 0.00          | o                 | 0                 | 5. 00             |
| 6.00   |                               | 0.00          | o                 | 0                 | 6. 00             |
| 7.00   |                               | 0.00          | o                 | 0                 | 7.00              |
| 8. 00  |                               | 0.00          | o                 | 0                 | 8.00              |
| 9. 00  |                               | 0.00          | ol                | 0                 | 9.00              |
| 10.00  |                               | 0.00          | ol                | 0                 | 10.00             |
| 11. 00 |                               | 0.00          | 0                 | 0                 | 11.00             |
| 12. 00 |                               | 0.00          | o                 | Ö                 | 12. 00            |
| 13. 00 |                               | 0.00          | o                 | 0                 | 13. 00            |
| 14. 00 |                               | 0.00          | 0                 | 0                 | 14. 00            |
| 15. 00 |                               | 0.00          | 0                 | Ö                 | 15. 00            |
| 16. 00 |                               | 0.00          | Ö                 | Ö                 | 16. 00            |
| 17. 00 |                               | 0.00          | o o               | Ö                 | 17. 00            |
| 18. 00 |                               | 0.00          | Ö                 | Ö                 | 18. 00            |
| 19. 00 |                               | 0.00          | Ö                 | Ö                 | 19. 00            |
| 20. 00 |                               | 0.00          | 0                 | Ö                 | 20.00             |
| 21. 00 |                               | 0.00          | 0                 | Ö                 | 21.00             |
| 22. 00 |                               | 0.00          | 0                 | Ö                 | 22.00             |
| 22.00  |                               |               |                   |                   | 22.00             |
|        | E - THERAPY ADMIN             |               | <u> </u>          | 433, 770          |                   |
| 1. 00  | ADMINISTRATIVE AND GENERAL    | 5. 01         | 17, 745           | 2, 526            | 1.00              |
| 2.00   | NURSING ADMINISTRATION        | 13. 00        | 59, 056           | 8, 408            | 2.00              |
| 3.00   | PHYSICAL THERAPY              | 66.00         | 213, 856          | 30, 446           | 3.00              |
| 4.00   | SPEECH PATHOLOGY              | 68.00         | 108, 347          | 15, 425           | 4.00              |
| 5.00   | FOUNDATI ON                   | 194. 00       | 10, 569           | 1, 505            | 5.00              |
| 5.00   | POUNDATION                    |               |                   |                   | 5.00              |
|        | F - RTOC ADMIN                |               | 409, 573          | 58, 310           |                   |
| 1 00   |                               | 192.00        | 35, 329           | 1 7/1             | 1.00              |
| 1. 00  | PHYSICIANS PRIVATE OFFICES    | 192.00        |                   |                   | 1.00              |
|        | C OUTDT CARME                 |               | 35, 329           | 1, 761            |                   |
| 1 00   | G - OUTPT- CARMEL             | (( 04         | ام                | 0.000             | 1.00              |
| 1.00   | PHYSICAL THERAPY - CARMEL     | <u>66.</u> 01 | 0                 | <u>8, 893</u>     | 1.00              |
|        | TOTALS                        |               | U                 | 8, 893            |                   |
|        | H - CLINICAL RES FACILITATION |               |                   | 40.040            |                   |
| 1.00   | ADMINISTRATIVE AND GENERAL    |               | 0                 | 13,068            | 1.00              |
| F00 60 | TOTALS                        |               | 0                 | 13, 068           |                   |
| 500.00 | Grand Total: Increases        |               | 1, 311, 412       | 1, 255, 424       | 500.00            |

REHABILITATION HOSPITAL OF INDIANA
Provider CCN: 15-3028 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 8:35 am

|        |                               | Decreases | ·              |                        |                | 373072024 0.33 8 |       |
|--------|-------------------------------|-----------|----------------|------------------------|----------------|------------------|-------|
|        | 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                      | 10.00     | 24, 875        | 555, 042               | . 0            |                  | 1. 00 |
|        |                               |           | 24, 875        | 555, 042               |                |                  |       |
|        | B - NURSING ADMINISTRATION    | <u> </u>  |                |                        |                |                  |       |
| 1.00   | ADMINISTRATIVE AND GENERAL    | 5. 01     | 196, 710       | 0                      | 0              |                  | 1. 00 |
|        |                               |           | 196, 710       |                        |                |                  |       |
|        | C - NCR (CORF)                |           |                |                        |                |                  |       |
| 1.00   | CORF                          | 99. 10    | 644, 925       | 162, 372               | . 0            |                  | 1. 00 |
| 2.00   |                               | 0.00      | 0              | 0                      | 0              |                  | 2. 00 |
| 3.00   |                               | 0.00      | O              | 0                      | 0              |                  | 3. 00 |
|        |                               |           | 644, 925       | 162, 372               |                |                  |       |
|        | D - MEDICAL SUPPLIES          |           |                | •                      |                |                  |       |
| 1.00   | EMPLOYEE BENEFITS DEPARTMENT  | 4.00      | 0              | 283                    | 0              |                  | 1. 00 |
| 2.00   | ADMINISTRATIVE AND GENERAL    | 5. 01     | o              | 27                     | 0              |                  | 2. 00 |
| 3.00   | OTHER A&G - NON FOUNDATION    | 5. 02     | o              | 1, 410                 | 0              |                  | 3. 00 |
| 4.00   | OPERATION OF PLANT            | 7.00      | o              | 1, 816                 |                |                  | 4. 00 |
| 5.00   | HOUSEKEEPI NG                 | 9. 00     | o              | 171                    |                | 1                | 5. 00 |
| 6.00   | DI ETARY                      | 10, 00    | o              | 77                     |                | 1                | 6. 00 |
| 7. 00  | NURSING ADMINISTRATION        | 13. 00    | 0              | 5, 381                 | 0              |                  | 7. 00 |
| 8. 00  | CENTRAL SERVICES & SUPPLY     | 14. 00    | 0              | 68, 118                |                |                  | 8. 00 |
| 9. 00  | PHARMACY                      | 15. 00    | 0              | 5, 740                 |                |                  | 9. 00 |
| 10.00  | SOCI AL SERVI CE              | 17. 00    | 0              | 888                    |                | 1                | 0.00  |
| 11. 00 | ADULTS & PEDIATRICS           | 30.00     | 0              | 238, 969               |                | l l              | 1. 00 |
| 12. 00 | RADI OLOGY-DI AGNOSTI C       | 54.00     | Ö              | 2, 586                 | _              | l -              | 2. 00 |
| 13. 00 | RESPIRATORY THERAPY           | 65. 00    | 0              | 76, 409                |                |                  | 3. 00 |
| 14. 00 | PHYSI CAL THERAPY             | 66.00     | 0              | 4, 778                 |                | l l              | 4. 00 |
| 15. 00 | OCCUPATI ONAL THERAPY         | 67.00     | 0              | 6, 339                 |                |                  | 5. 00 |
| 16. 00 | SPEECH PATHOLOGY              | 68.00     | 0              | 6, 221                 | 0              |                  | 6. 00 |
| 17. 00 | FAC RESOURCE                  | 68. 02    | 0              | 516                    |                | l l              | 7. 00 |
| 18. 00 | CLI NI C                      | 90.00     | 0              | 22, 242                | _              | 1 -              | 8. 00 |
| 19. 00 | CORF                          | 99. 10    | 0              | 1, 482                 |                | l l              | 9. 00 |
| 20. 00 | PHYSICIANS PRIVATE OFFICES    | 192. 00   | 0              | 10, 018                |                |                  | 0.00  |
| 21. 00 | FOUNDATION                    | 194. 00   | 0              | 1, 724                 |                | l l              | 1. 00 |
| 22. 00 | PUBLIC RELATIONS              | 194. 01   | 0              | 783                    |                | l l              | 2. 00 |
| 22.00  | O COLLECTIONS                 |           |                |                        |                |                  | 2.00  |
|        | E - THERAPY ADMIN             |           | U <sub>I</sub> | 433, 770               |                |                  |       |
| 1. 00  | OCCUPATIONAL THERAPY          | 67. 00    | 409, 573       | 58, 310                | 0              |                  | 1. 00 |
| 2. 00  | DOCOLATIONAL HILRAFT          | 0.00      | 407, 5/3       | 36, 310                |                |                  | 2. 00 |
| 3. 00  |                               | 0.00      | 0              | 0                      |                |                  | 3. 00 |
| 4. 00  |                               | 0.00      | 0              | 0                      |                | 1                | 4. 00 |
| 5. 00  |                               | 0.00      | 0              | 0                      | 0              | 1                | 5. 00 |
| 5.00   |                               |           | 409, 573       | 0                      | <del> </del>   |                  | 5.00  |
|        | F - RTOC ADMIN                | L         | 409, 573       | 58, 310                | 1              |                  |       |
| 1 00   |                               | (0.00     | 25 220         | 1 7/1                  |                |                  | 1 00  |
| 1. 00  | FAC RESOURCE                  |           | 35, 329        | $ \frac{1,761}{1,761}$ |                |                  | 1. 00 |
|        | U OUTDE CARME                 |           | 35, 329        | 1, 761                 |                |                  |       |
|        | G - OUTPT- CARMEL             |           | ما             | 0.000                  |                |                  |       |
| 1. 00  | PHYSI CAL THERAPY             |           |                |                        |                |                  | 1. 00 |
|        | TOTALS                        |           | 0              | 8, 893                 |                |                  |       |
|        | H - CLINICAL RES FACILITATION |           | _1             | 40                     |                |                  |       |
| 1. 00  | FAC RESOURCE                  |           |                | 13, 068                |                |                  | 1. 00 |
|        | TOTALS                        |           | 0              | 13, 068                |                |                  |       |
| 500.00 | Grand Total: Decreases        |           | 1, 311, 412    | 1, 255, 424            | •              | 500              | 0. 00 |

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-3028 Peri od: Worksheet A-7 From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/30/2024 8:35 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2, 506, 638 0 1.00 757, 042 0 2.00 Land Improvements 0 2.00 0 3.00 33, 498, 105 3.00 Buildings and Fixtures 123, 659 123, 659 0 0 4.00 Building Improvements 205, 018 0 4.00 5.00 Fixed Equipment 2, 523, 031 12, 396 0 12, 396 5.00 0 6.00 Movable Equipment 15, 995, 533 344, 028 344, 028 26, 784 6.00 0 7.00 HIT designated Assets Ω 7.00 0 8.00 Subtotal (sum of lines 1-7) 55, 485, 367 480, 083 480, 083 26, 784 8.00 9.00 Reconciling Items 0 0 9.00 480, 083 480, 083 Total (line 8 minus line 9) 55, 485, 367 26, 784 10.00 0 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2, 506, 638 1.00 2.00 Land Improvements 757, 042 250, 663 2.00 33, 621, 764 3.00 Buildings and Fixtures 13, 878, 995 3.00 4.00 Building Improvements 205, 018 187, 578 4.00 5.00 Fi xed Equipment 2, 535, 427 1, 789, 083 5.00 Movable Equipment 6.00 16, 312, 777 12, 002, 716 6.00 7. 00 7.00 HIT designated Assets

55, 938, 666

55, 938, 666

28, 109, 035

28, 109, 035

| 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 01/01/2023 | Worksheet A-7<br>Part II |
|   |                                    | To 12/31/2023               | Date/Time Prepared:      |

|   |                  |                | Т               | o 12/31/2023           | Date/Time Pre 5/30/2024 8:3 |       |
|---|------------------|----------------|-----------------|------------------------|-----------------------------|-------|
|   |                  | SU             | IMMARY OF CAPIT | AL                     |                             |       |
| Cost Center Description                       | Depreciation     | Lease          | Interest        | Insurance (see         | •                           |       |
|   | 9. 00            | 10.00          | 11. 00          | instructions)<br>12.00 | instructions)<br>13.00      |       |
| PART II - RECONCILIATION OF AMOUNTS FROM WORK |                  |                | nd 2            | 12.00                  | 13.00                       |       |
| 1. 00 CAP REL COSTS-BLDG & FLXT               | 1, 260, 024      |                | 156, 481        | 61, 802                | 0                           | 1.00  |
| 2. 00 CAP REL COSTS-MVBLE EQUIP               | 612, 109         |                | 100, 101        | 3, 880                 | 0                           | 2. 00 |
| 3.00 Total (sum of lines 1-2)                 | 1, 872, 133      |                | 156, 481        |                        | 0                           | 3. 00 |
|   | SUMMARY 0        | F CAPITAL      |                 |                        |                             |       |
|   |                  |                |                 |                        |                             |       |
| Cost Center Description                       |                  | Total (1) (sum |                 |                        |                             |       |
|   | Capi tal -Relate | of cols. 9     |                 |                        |                             |       |
|   | d Costs (see     | through 14)    |                 |                        |                             |       |
|   | instructions)    |                |                 |                        |                             |       |
|   | 14. 00           | 15. 00         |                 |                        |                             |       |
| PART II - RECONCILIATION OF AMOUNTS FROM WORK | SHEET A, COLUM   | N 2, LINES 1 a | nd 2            |                        |                             |       |
| 1.00 CAP REL COSTS-BLDG & FLXT                | 0                | 1, 478, 307    |                 |                        |                             | 1.00  |
| 2.00 CAP REL COSTS-MVBLE EQUIP                | 9, 611           | 625, 600       |                 |                        |                             | 2.00  |
| 3.00 Total (sum of lines 1-2)                 | 9, 611           | 2, 103, 907    |                 |                        |                             | 3. 00 |

| Heal th                     | n Financial Systems REHA                      | ABILITATION HOS | PITAL OF INDIA   | NA             | In Lie                                      | u of Form CMS-2                | 2552-10 |
|-----------------------------|---|-----------------|------------------|----------------|---|--------------------------------|---------|
| RECON                       | CILIATION OF CAPITAL COSTS CENTERS            |                 | Provider Co      |                | Period:<br>From 01/01/2023<br>To 12/31/2023 | Date/Time Pre<br>5/30/2024 8:3 | pared:  |
|                             |   | COM             | PUTATION OF RAT  | ΓΙOS           | ALLOCATION OF                               | OTHER CAPITAL                  |         |
|                             | Cost Center Description                       | Gross Assets    | Capi tal i zed   | Gross Assets   |   | Insurance                      |         |
|                             |   |                 | Leases           | for Ratio      | instructions)                               |                                |         |
|                             |   |                 |                  | 2)             | ,   |                                |         |
|                             |   | 1. 00           | 2.00             | 3.00           | 4. 00                                       | 5. 00                          |         |
|                             | PART III - RECONCILIATION OF CAPITAL COSTS CE | NTERS           |                  |                |   |                                |         |
| 1.00                        | CAP REL COSTS-BLDG & FIXT                     | 39, 625, 889    | 0                | 39, 625, 88    | 9 0. 708381                                 | 0                              | 1. 00   |
| 2.00                        | CAP REL COSTS-MVBLE EQUIP                     | 16, 312, 777    | l .              | 16, 312, 77    |   | -                              | 2. 00   |
| 3.00                        | Total (sum of lines 1-2)                      | 55, 938, 666    |                  | 55, 938, 66    |   |                                | 3. 00   |
| ALLOCATION OF OTHER CAPITAL |   |                 | SUMMARY O        | F CAPITAL      |   |                                |         |
|                             | Cost Center Description                       | Taxes           | Other            | Total (sum of  | Depreciation                                | Lease                          |         |
|                             |   |                 | Capi tal -Relate |                |   |                                |         |
|                             |   |                 | d Costs          | through 7)     |   |                                |         |
|                             |   | 6. 00           | 7. 00            | 8. 00          | 9. 00                                       | 10. 00                         |         |
|                             | PART III - RECONCILIATION OF CAPITAL COSTS CE | NTERS           |                  |                |   |                                |         |
| 1.00                        | CAP REL COSTS-BLDG & FIXT                     | 0               | 0                |                | 1, 380, 961                                 | 0                              |         |
| 2.00                        | CAP REL COSTS-MVBLE EQUIP                     | 0               | 0                |                | 746, 482                                    |                                | 2. 00   |
| 3.00                        | Total (sum of lines 1-2)                      | 0               | 0                |                | 2, 127, 443                                 | 0                              | 3. 00   |
|                             |   |                 | Sl               | JMMARY OF CAPI | TAL   |                                |         |
|                             | Cost Center Description                       | Interest        | Insurance (see   | Taxes (see     | Other                                       | Total (2) (sum                 |         |
|                             |   |                 | instructions)    | instructions)  | Capi tal -Rel ate                           | of cols. 9                     |         |
|                             |   |                 |                  |                | d Costs (see                                | through 14)                    |         |
|                             |   |                 |                  |                | instructions)                               |                                |         |
|                             | DART III DECONCLITATION OF CARLTAL COCTO OF   | 11. 00          | 12. 00           | 13. 00         | 14. 00                                      | 15. 00                         |         |

153, 345

0

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

61, 802 3, 880 65, 682

0 0 0

1, 591, 914 1. 00 759, 973 2. 00 2, 351, 887 3. 00

-4, 194 9, 611 5, 417

1.00

2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

REHABILITATION HOSPITAL OF INDIANA
Provider CCN: 15-3028 Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Peri od: Worksheet A-From 01/01/2023 | Date/Time Pt

|                  |   |                         |                |                             | Fo 12/31/2023   |                        |                  |
|------------------|---|-------------------------|----------------|-----------------------------|-----------------|------------------------|------------------|
|                  |   |                         |                | Expense Classification or   | Worksheet A     | 5/30/2024 8: 3         | 5 am             |
|                  |   |                         |                | To/From Which the Amount is | to be Adjusted  |                        |                  |
|                  |   |                         |                |                             |                 |                        |                  |
|                  |   |                         |                |                             |                 |                        |                  |
|                  | Cost Center Description                                     | Basi s/Code (2)<br>1.00 | Amount<br>2.00 | Cost Center<br>3.00         | Li ne #<br>4.00 | Wkst. A-7 Ref.<br>5.00 |                  |
| 1. 00            | Investment income - CAP REL                                 | В                       |                | CAP REL COSTS-BLDG & FIXT   | 1.00            |                        | 1. 00            |
| 2. 00            | COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL   |                         | 0              | CAP REL COSTS-MVBLE EQUIP   | 2. 00           | 0                      | 2. 00            |
| 3. 00            | COSTS-MVBLE EQUIP (chapter 2) Investment income - other     |                         | 0              |                             | 0.00            | 0                      | 3. 00            |
|                  | (chapter 2)   |                         | 0              |                             |                 |                        |                  |
| 4. 00            | Trade, quantity, and time discounts (chapter 8)             |                         | 0              |                             | 0.00            | 0                      | 4. 00            |
| 5.00             | Refunds and rebates of expenses (chapter 8)                 |                         | 0              |                             | 0.00            | О                      | 5. 00            |
| 6. 00            | Rental of provider space by                                 |                         | 0              |                             | 0.00            | 0                      | 6. 00            |
| 7. 00            | suppliers (chapter 8) Telephone services (pay               | А                       | -18, 118       | OPERATION OF PLANT          | 7. 00           | 0                      | 7. 00            |
|                  | stations excluded) (chapter 21)                             |                         |                |                             |                 |                        |                  |
| 8. 00            | Television and radio service                                | А                       | -14, 351       | OPERATION OF PLANT          | 7. 00           | 0                      | 8. 00            |
| 9. 00            | (chapter 21) Parking Lot (chapter 21)                       |                         | 0              |                             | 0.00            | 0                      | 9. 00            |
| 10. 00           | Provi der-based physici an                                  | A-8-2                   | 0              |                             |                 | 0                      | 10. 00           |
| 11. 00           | adjustment<br>Sale of scrap, waste, etc.                    |                         | 0              |                             | 0.00            | 0                      | 11. 00           |
| 12. 00           | (chapter 23)<br>Related organization                        | A-8-1                   | 2, 239, 917    |                             |                 | 0                      | 12. 00           |
|                  | transactions (chapter 10)                                   | ,, , ,                  |                |                             | 0.00            |                        |                  |
| 13. 00<br>14. 00 | Laundry and linen service<br>Cafeteria-employees and guests | В                       | 0<br>-193, 137 | CAFETERI A                  | 0. 00<br>11. 00 |                        |                  |
| 15. 00           | Rental of quarters to employee and others                   |                         | 0              |                             | 0.00            | 0                      | 15. 00           |
| 16. 00           | Sale of medical and surgical                                | В                       | 0              | CENTRAL SERVICES & SUPPLY   | 14. 00          | 0                      | 16. 00           |
|                  | supplies to other than patients                             |                         |                |                             |                 |                        |                  |
| 17. 00           | Sale of drugs to other than patients                        | В                       | -29, 303       | PHARMACY                    | 15. 00          | 0                      | 17. 00           |
| 18. 00           | Sale of medical records and                                 | В                       | -60            | MEDICAL RECORDS & LIBRARY   | 16. 00          | 0                      | 18. 00           |
| 19. 00           | abstracts Nursing and allied health                         |                         | 0              |                             | 0.00            | 0                      | 19. 00           |
|                  | education (tuition, fees, books, etc.)                      |                         |                |                             |                 |                        |                  |
| 20. 00           | Vending machines  |                         | 0              |                             | 0.00            |                        |                  |
| 21. 00           | Income from imposition of interest, finance or penalty      |                         | 0              |                             | 0.00            | 0                      | 21. 00           |
| 22 00            | charges (chapter 21) Interest expense on Medicare           |                         | 0              |                             | 0.00            | 0                      | 22. 00           |
| 22.00            | overpayments and borrowings to                              |                         | 0              |                             | 0.00            | J                      | 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 limitation (chapter 14)          |                         |                |                             |                 |                        |                  |
| 24. 00           | Adjustment for physical                                     | A-8-3                   | 0              | PHYSICAL THERAPY            | 66.00           |                        | 24. 00           |
|                  | therapy costs in excess of limitation (chapter 14)          |                         |                |                             |                 |                        |                  |
| 25. 00           | Utilization review - physicians' compensation               |                         | 0              | *** Cost Center Deleted *** | 114. 00         |                        | 25. 00           |
|                  | (chapter 21)  |                         |                |                             |                 |                        |                  |
| 26. 00           | Depreciation - CAP REL<br>COSTS-BLDG & FLXT                 |                         | 0              | CAP REL COSTS-BLDG & FIXT   | 1.00            | 0                      | 26. 00           |
| 27. 00           | Depreciation - CAP REL<br>COSTS-MVBLE EQUIP                 |                         | 0              | CAP REL COSTS-MVBLE EQUIP   | 2. 00           | О                      | 27. 00           |
| 28. 00           | Non-physician Anesthetist                                   |                         | 0              | *** Cost Center Deleted *** | 19. 00          |                        | 28. 00           |
| 29. 00<br>30. 00 | Physicians' assistant Adjustment for occupational           | A-8-3                   | 0              | OCCUPATI ONAL THERAPY       | 0. 00<br>67. 00 |                        | 29. 00<br>30. 00 |
|                  | therapy costs in excess of                                  |                         | J              |                             |                 |                        |                  |
| 30. 99           | limitation (chapter 14)<br>Hospice (non-distinct) (see      |                         | 0              | ADULTS & PEDIATRICS         | 30.00           |                        | 30. 99           |
| 31. 00           | instructions) Adjustment for speech                         | A-8-3                   | Λ              | SPEECH PATHOLOGY            | 68.00           |                        | 31. 00           |
| 50               | pathology costs in excess of                                |                         | 0              |                             | 33.30           |                        | 55               |
| 32. 00           |   |                         | 0              |                             | 0.00            | 0                      | 32. 00           |
| 33 00            | Depreciation and Interest MISCELLANEOUS REVENUE             | В                       | -834           | EMPLOYEE BENEFITS DEPARTMEN | 4.00            | 0                      | 33. 00           |
|                  | I GOZZEZ WZGOGO NEVENOL                                     | 1 2 1                   | 034            | I COTEC DENETTIO DELAKTMEN  | 4.00            | ١                      | 00.00            |

From 01/01/2023

|        |                                |                 |             | T                            | 0 12/31/2023   | Date/Time Prep<br>5/30/2024 8:3 |        |
|--------|--------------------------------|-----------------|-------------|------------------------------|----------------|---------------------------------|--------|
|        |                                |                 |             | Expense Classification on    | Worksheet A    |                                 |        |
|        |                                |                 |             | To/From Which the Amount is  | to be Adjusted |                                 |        |
|        |                                |                 |             |                              |                |                                 |        |
|        |                                |                 |             |                              |                |                                 |        |
|        |                                |                 |             |                              |                |                                 |        |
|        | Cost Center Description        | Basi s/Code (2) | Amount      | Cost Center                  | Li ne #        | Wkst. A-7 Ref.                  |        |
|        | · ·                            | 1.00            | 2. 00       | 3. 00                        | 4. 00          | 5. 00                           |        |
| 33. 01 | MI SCELLANEOUS REVENUE         | В               | -63, 508    | ADMINISTRATIVE AND GENERAL   | 5. 01          | 0                               | 33. 01 |
| 33. 02 | MI SCELLANEOUS REVENUE         | В               | -40, 781    | PHYSICAL THERAPY             | 66.00          | 0                               | 33. 02 |
| 33. 03 | RHI FOUNDATION                 | A               | 710, 393    | FOUNDATI ON                  | 194. 00        | 0                               | 33. 03 |
| 33. 07 | DONATI ONS/CONTRI BUTI ONS     | A               | -76         | EMPLOYEE BENEFITS DEPARTMENT | 4. 00          | 0                               | 33. 07 |
| 33. 08 | DONATI ONS/CONTRI BUTI ONS     | A               | -8, 469     | ADMINISTRATIVE AND GENERAL   | 5. 01          | 0                               | 33. 08 |
| 33. 09 | ADVERTI SI NG                  | A               | -68         | NURSING ADMINISTRATION       | 13. 00         | 0                               | 33. 09 |
| 33. 10 | ADVERTI SI NG                  | A               | -379        | OCCUPATI ONAL THERAPY        | 67. 00         | 0                               | 33. 10 |
| 33. 11 | TAXES                          | A               | -138        | ADMINISTRATIVE AND GENERAL   | 5. 01          | 0                               | 33. 11 |
| 33. 13 | TAXES                          | A               | 71          | EMPLOYEE BENEFITS DEPARTMENT | 4. 00          | 0                               | 33. 13 |
| 33. 14 | BOND ISSUANCE COST             | A               | 14, 182     | CAP REL COSTS-BLDG & FIXT    | 1. 00          | 14                              | 33. 14 |
|        | AMORTIZATION CARR              |                 |             |                              |                |                                 |        |
| 33. 15 | LATE FEES                      | A               | ·           | CAP REL COSTS-BLDG & FIXT    | 1. 00          | 14                              | 33. 15 |
| 50.00  | TOTAL (sum of lines 1 thru 49) |                 | 2, 573, 829 |                              |                |                                 | 50. 00 |
|        | (Transfer to Worksheet A,      |                 |             |                              |                |                                 |        |
|        | column 6, line 200.)           |                 |             |                              |                |                                 |        |

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

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 15-3028 Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared:

|      |   |                              |                              | 10 12/31/2023  | 5/30/2024 8: 3 |       |  |  |  |  |
|------|---|------------------------------|------------------------------|----------------|----------------|-------|--|--|--|--|
|      | Li ne No.   | Cost Center                  | Expense Items                | Amount of      | Amount         |       |  |  |  |  |
|      |   |                              |                              | Allowable Cost | Included in    |       |  |  |  |  |
|      |   |                              |                              |                | Wks. A, column |       |  |  |  |  |
|      |   |                              |                              |                | 5              |       |  |  |  |  |
|      | 1. 00   | 2.00                         | 3. 00                        | 4. 00          | 5. 00          |       |  |  |  |  |
|      | A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: |                              |                              |                |                |       |  |  |  |  |
| 1.00 |   | CAP REL COSTS-BLDG & FIXT    | ALLOCATION FROM HO REPORT    | 120, 937       | 0              | 1.00  |  |  |  |  |
| 2.00 | 2.00  | CAP REL COSTS-MVBLE EQUIP    | ALLOCATION FROM HO REPORT    | 134, 373       | 0              | 2. 00 |  |  |  |  |
| 3.00 | 5. 01   | ADMINISTRATIVE AND GENERAL   | ALLOCATION FROM HO REPORT    | 2, 051, 465    | 0              | 3.00  |  |  |  |  |
| 4.00 | 54.00   | RADI OLOGY-DI AGNOSTI C      | ALLOCATION FROM RELATED PART | 3, 285         | 3, 285         | 4.00  |  |  |  |  |
| 4.01 | 60.00   | LABORATORY                   | ALLOCATION FROM RELATED PART | 367, 925       | 434, 783       | 4. 01 |  |  |  |  |
| 4.02 | 5. 01   | ADMINISTRATIVE AND GENERAL   | RELATED PARTY FEES           | 653, 117       | 653, 117       | 4. 02 |  |  |  |  |
| 4.03 | 54.00   | RADI OLOGY-DI AGNOSTI C      | RELATED PARTY FEES           | 4, 079         | 4, 079         | 4. 03 |  |  |  |  |
| 4.04 | 66.00   | PHYSI CAL THERAPY            | RELATED PARTY FEES           | 420            | 420            | 4. 04 |  |  |  |  |
| 4.05 | 15. 00  | PHARMACY                     | RELATED PARTY FEES           | 400            | 400            | 4. 05 |  |  |  |  |
| 4.06 | 192. 00   | PHYSICIANS PRIVATE OFFICES   | RELATED PARTY FEES           | 259, 453       | 259, 453       | 4. 06 |  |  |  |  |
| 4.07 | 7. 00   | OPERATION OF PLANT           | RELATED PARTY FEES           | 437, 153       | 437, 153       | 4. 07 |  |  |  |  |
| 4.08 | 4.00  | EMPLOYEE BENEFITS DEPARTMENT | RELATED PARTY FEES           | 22, 341        | 22, 341        | 4. 08 |  |  |  |  |
| 4.09 | 0.00  |                              |                              | o              | 0              | 4.09  |  |  |  |  |
| 5.00 | TOTALS (sum of lines 1-4).  |                              |                              | 4, 054, 948    | 1, 815, 031    | 5.00  |  |  |  |  |
|      | Transfer column 6, line 5 to  |                              |                              |                |                |       |  |  |  |  |
|      | Worksheet A-8, column 2,  |                              |                              |                |                |       |  |  |  |  |
|      | line 12.  |                              |                              |                |                |       |  |  |  |  |

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

|          |                               |                               |               | cara be riiai carea rii ceraiiir i |                |  |
|----------|-------------------------------|-------------------------------|---------------|------------------------------------|----------------|--|
|          |                               |                               |               | Related Organization(s) and/       | or Home Office |  |
|          |                               |                               |               |                                    |                |  |
|          |                               |                               |               |                                    |                |  |
|          |                               |                               |               |                                    |                |  |
|          | Symbol (1)                    | Name                          | Percentage of | Name                               | Percentage of  |  |
|          |                               |                               | Ownershi p    |                                    | Ownershi p     |  |
| ·        | 1. 00                         | 2.00                          | 3. 00         | 4. 00                              | 5. 00          |  |
| <u> </u> | 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. VI NCENT 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.

|       |                |                 |                                    |                           | 5/30/2024 8: 3          | 35 am |
|-------|----------------|-----------------|------------------------------------|---------------------------|-------------------------|-------|
|       | Net            | Wkst. A-7 Ref.  |                                    |                           |                         |       |
|       | Adjustments    |                 |                                    |                           |                         |       |
|       | (col. 4 minus  |                 |                                    |                           |                         |       |
|       | col. 5)*       |                 |                                    |                           |                         |       |
|       | 6. 00          | 7. 00           |                                    |                           |                         |       |
|       | A. COSTS INCUR | RED AND ADJUSTN | MENTS REQUIRED AS A RESULT OF TRAN | NSACTIONS WITH RELATED OF | RGANIZATIONS OR CLAIMED |       |
|       | HOME OFFICE CO | STS:            |                                    |                           |                         |       |
| 1.00  | 120, 937       | 9               |                                    |                           |                         | 1.00  |
| 2.00  | 134, 373       | 9               |                                    |                           |                         | 2.00  |
| 3.00  | 2, 051, 465    | 0               |                                    |                           |                         | 3.00  |
| 4.00  | 0              | 0               |                                    |                           |                         | 4.00  |
| 4.01  | -66, 858       | 0               |                                    |                           |                         | 4. 01 |
| 4.02  | 0              | 0               |                                    |                           |                         | 4. 02 |
| 4.03  | 0              | 0               |                                    |                           |                         | 4. 03 |
| 4.04  | 0              | 0               |                                    |                           |                         | 4. 04 |
| 4.05  | 0              | 0               |                                    |                           |                         | 4. 05 |
| 4.06  | 0              | 0               |                                    |                           |                         | 4.06  |
| 4.07  | 0              | 0               |                                    |                           |                         | 4. 07 |
| 4.08  | 0              | 0               |                                    |                           |                         | 4. 08 |
| 4.09  | 0              | 0               |                                    |                           |                         | 4. 09 |
| 5. 00 | 2, 239, 917    |                 |                                    |                           |                         | 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 RELAT | FED 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.

| i Ci ilibui     | Schieff dider title Aviii. |        |
|-----------------|----------------------------|--------|
| 6.00            | HOME OFFICE                | 6.00   |
|                 | MGMT COMPANY               | 7.00   |
| 8.00            |                            | 8.00   |
| 9.00            |                            | 9.00   |
| 9. 00<br>10. 00 |                            | 10.00  |
| 100.00          |                            | 100.00 |

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

|                    |   |                            |                    | F             | rom 01/01/2023<br>b 12/31/2023 | Part I<br>Date/Time Pre<br>5/30/2024 8:3 | pared:              |
|--------------------|---|----------------------------|--------------------|---------------|--------------------------------|--|---------------------|
|                    |   |                            | CAPI TAL REI       | ATED COSTS    |                                | 1070072021 0.0                           | O dill              |
|                    | Cost Center Description   | Net Expenses               | BLDG & FIXT        | MVBLE EQUIP   | EMPLOYEE                       | Subtotal                                 |                     |
|                    | ·   | for Cost                   |                    |               | BENEFITS                       |  |                     |
|                    |   | Allocation<br>(from Wkst A |                    |               | DEPARTMENT                     |  |                     |
|                    |   | col . 7)                   | 1.00               | 2.00          | 4.00                           | 4.0                                      |                     |
|                    | GENERAL SERVICE COST CENTERS  | 0                          | 1. 00              | 2.00          | 4. 00                          | 4A                                       |                     |
|                    | 00100 CAP REL COSTS-BLDG & FIXT   | 1, 591, 914                | 1, 591, 914        |               |                                |  | 1. 00               |
|                    | 00200 CAP REL COSTS-MVBLE EQUIP   | 759, 973                   | 47.454             | 759, 973      | , 000 100                      |  | 2.00                |
|                    | 00400 EMPLOYEE BENEFITS DEPARTMENT<br>00591 ADMINISTRATIVE AND GENERAL                | 6, 266, 765<br>7, 558, 222 | 17, 154<br>35, 883 |               | 6, 292, 108<br>888, 453        | 8, 499, 688                              | 4. 00<br>5. 01      |
|                    | 00590 OTHER A&G - NON FOUNDATION  | 1, 059, 399                | 24, 047            |               | 222, 754                       | 1, 317, 680                              |                     |
|                    | 00700 OPERATION OF PLANT  | 1, 792, 803                | 356, 442           | 1             | 14, 010                        | 2, 333, 419                              | 7. 00               |
|                    | 00800 LAUNDRY & LINEN SERVICE<br>00900 HOUSEKEEPING                                   | 103, 084<br>559, 043       | 0<br>14, 538       |               | 0<br>110, 704                  | 103, 084<br>691, 225                     | 8. 00<br>9. 00      |
|                    | 01000 DI ETARY  | 876, 341                   | 37, 299            |               | 10, 704                        | 942, 098                                 | 10.00               |
|                    | 01100 CAFETERI A  | 386, 780                   |                    |               | 7, 049                         | 430, 295                                 | 11. 00              |
|                    | 01300 NURSI NG ADMI NI STRATI ON  | 2, 206, 532                | 7, 096             |               | 535, 477                       | 2, 752, 492                              | 13.00               |
|                    | 01400 CENTRAL SERVICES & SUPPLY<br>01500 PHARMACY                                     | 491, 537<br>715, 771       | 16, 749<br>24, 423 |               | 16, 122<br>167, 488            | 532, 404<br>919, 341                     | 14. 00<br>15. 00    |
|                    | 01600 MEDICAL RECORDS & LIBRARY   | 520, 767                   | 1, 373             |               | 116, 812                       | 639, 607                                 | 16. 00              |
| 17. 00             | 01700 SOCIAL SERVICE  | 696, 022                   | 4, 668             |               | 146, 659                       | 849, 577                                 | 17. 00              |
|                    | 02200   L&R SERVICES-OTHER PRGM COSTS APPRV<br>INPATIENT ROUTINE SERVICE COST CENTERS | 243, 374                   | 6, 677             | 3, 187        | 0                              | 253, 238                                 | 22. 00              |
|                    | 03000 ADULTS & PEDIATRICS   | 9, 534, 700                | 650, 755           | 310, 671      | 2, 012, 593                    | 12, 508, 719                             | 30. 00              |
|                    | ANCILLARY SERVICE COST CENTERS  |                            |                    |               |                                |  |                     |
|                    | 05000 OPERATING ROOM<br>05400 RADIOLOGY-DIAGNOSTIC                                    | 0<br>169, 521              | 0<br>5. 145        |               | 0<br>38, 342                   | 0<br>215, 464                            | 50. 00<br>54. 00    |
|                    | 06000 LABORATORY  | 365, 694                   | 7, 847             |               | 30, 342                        | 377, 287                                 | 60.00               |
|                    | 06500 RESPI RATORY THERAPY  | 563, 849                   | 4, 856             |               | 145, 102                       | 716, 125                                 | 65. 00              |
|                    | 06600 PHYSI CAL THERAPY   | 2, 720, 912                | 110, 712           |               | 626, 430                       | 3, 510, 907                              | 66. 00              |
|                    | 06601 PHYSI CAL THERAPY - CARMEL<br>06700 OCCUPATI ONAL THERAPY                       | 2, 184, 397                | 0<br>94, 699       | 1             | 0<br>535, 814                  | 0<br>2, 860, 119                         | 66. 01<br>67. 00    |
|                    | 06800 SPEECH PATHOLOGY  | 1, 336, 816                | 54, 149            |               | 333, 374                       | 1, 750, 190                              | 68. 00              |
|                    | 06801 VI SI 0N  | 0                          | 0                  |               | 0                              | 0  | 68. 01              |
|                    | 06802 FAC RESOURCE<br>06900 ELECTROCARDI OLOGY  | 0                          | 0                  | 0             | 0                              | 0  | 68. 02<br>69. 00    |
|                    | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT   | 214, 703                   | 0                  | 0             | 0                              | 214, 703                                 |                     |
|                    | 07200 IMPL. DEV. CHARGED TO PATIENTS  | 0                          | 0                  | 0             | O                              | 0  | 72. 00              |
|                    | 07300 DRUGS CHARGED TO PATIENTS<br>07400 RENAL DIALYSIS                               | 1, 308, 849                | 0                  | 0             | 0                              | 1, 308, 849                              | 73.00               |
|                    | 07700 ALLOGENEIC HSCT ACQUISITION   | 0                          | 0                  |               | 0                              | 0  | 74. 00<br>77. 00    |
| 78. 00             | 07800 CAR T-CELL IMMUNOTHERAPY  | 0                          | 0                  |               | 0                              | 0  | 78. 00              |
|                    | OUTPATIENT SERVICE COST CENTERS 09000 CLINIC  | 250, 085                   | 51, 952            | 24, 802       | E0 E70                         | 385, 418                                 | 90. 00              |
|                    | 09001 SLEEP CENTER  | 250, 065                   | 0 31, 932          |               | 58, 579<br>0                   | 365, 416                                 | 90.00               |
| 91. 00             | 09100 EMERGENCY   | 0                          | 0                  |               | O                              | 0  | 91. 00              |
|                    | 09200 OBSERVATION BEDS (NON-DISTINCT PART   |                            |                    |               |                                | 0  | 92. 00              |
|                    | OTHER REIMBURSABLE COST CENTERS 09900 CMHC  | 0                          | 0                  | 0             | o                              | 0  | 99. 00              |
| 99. 10             | 09910 CORF  | 0                          | 0                  |               | О                              | 0  | 99. 10              |
|                    | 10200 OPI OI D TREATMENT PROGRAM  | 0                          | 0                  | 0             | 0                              | 0  | 102. 00             |
| 118. 00            | SPECIAL PURPOSE COST CENTERS  SUBTOTALS (SUM OF LINES 1 through 117)                  | 44, 477, 853               | 1, 551, 147        | 740, 510      | 5, 986, 414                    | 44, 111, 929                             | 118. 00             |
|                    | NONREI MBURSABLE COST CENTERS   |                            |                    |               |                                |  |                     |
|                    | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSICIANS PRIVATE OFFICES              | 946, 662                   | 0<br>10, 636       |               | 0<br>146, 151                  | 0<br>1, 108, 527                         | 190.00              |
|                    | 07950 FOUNDATION  | 1, 005, 869                | 21, 619            |               | 60, 692                        | 1, 108, 527                              |                     |
|                    | 07951 PUBLIC RELATIONS  | 192, 621                   | 8, 512             |               | 36, 039                        | 241, 236                                 | 1                   |
|                    | 07952 ST. VINCENT - ARU   | 0                          | 0                  |               | 0                              |  | 194. 02             |
|                    | 07953 MUNCIE - ARU<br>07954 RILEY - ARU   | 0                          | 0                  | 0             | 0                              |  | 194. 03<br>194. 04  |
|                    | 07955 RETAIL PHARMACY   | 1, 486, 795                | ő                  | ő             | 62, 812                        | 1, 549, 607                              | 194. 05             |
| 200.00             | Cross Foot Adjustments  |                            |                    |               |                                | 0  | 200. 00             |
| 201. 00<br>202. 00 |   | 48, 109, 800               | 0<br>1, 591, 914   | 0<br>759, 973 | 0<br>6, 292, 108               |  | 201. 00             |
| 202.00             | TIVIAL (Sum TITIES TTO THEOUGH 201)   | 1 40, 107, 000             | 1, 371, 714        | 107, 7/3      | 0, 272, 100                    | 40, 107, 000                             | <sub>1</sub> 202.00 |

| Period: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS REHABILITATION HOSPITAL OF INDIANA

Provider CCN: 15-3028

|                  |   |   |                         | Ť              | o 12/31/2023 |                             |                  |
|------------------|---|---|-------------------------|----------------|--------------|-----------------------------|------------------|
|                  | Cost Center Description                                 | ADMI NI STRATI VE                       | Subtotal                | OTHER A&G -    | OPERATION OF | 5/30/2024 8: 3<br>LAUNDRY & | 5 am             |
|                  | cost center bescriptron                                 | AND GENERAL                             | Subtotal                | NON FOUNDATION |              | LINEN SERVICE               |                  |
|                  |   | 5. 01                                   | 5A. 01                  | 5. 02          | 7. 00        | 8. 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                        | 8, 499, 688                             |                         |                |              |                             | 5. 01            |
| 5. 02            | 00590 OTHER A&G - NON FOUNDATION                        | 282, 753                                | 1, 600, 433             |                |              |                             | 5. 02            |
| 7. 00            | 00700 OPERATION OF PLANT                                | 500, 714                                | 2, 834, 133             |                |              |                             | 7. 00            |
| 8.00             | 00800 LAUNDRY & LINEN SERVICE                           | 22, 120                                 | 125, 204                | 1              |              | 129, 512                    | 8. 00            |
| 9.00             | 00900 HOUSEKEEPI NG                                     | 148, 326                                | 839, 551                |                |              | 0                           |                  |
| 10.00            | 01000 DI ETARY  | 202, 159                                | 1, 144, 257             |                |              | 0                           | 10.00            |
| 11.00            | 01100 CAFETERI A  | 92, 334                                 | 522, 629                |                |              | 0                           | 11.00            |
| 13.00            | 01300 NURSI NG ADMI NI STRATI ON                        | 590, 641                                | 3, 343, 133             | 1              | 17, 958      | 0                           | 13.00            |
| 14.00            | 01400 CENTRAL SERVICES & SUPPLY                         | 114, 245                                | 646, 649                | 1              |              | 0                           | 14.00            |
| 15. 00<br>16. 00 | 01500   PHARMACY<br>  01600   MEDICAL RECORDS & LIBRARY | 197, 276                                | 1, 116, 617<br>776, 856 |                |              |                             | 15. 00<br>16. 00 |
| 17. 00           | 01700 SOCIAL SERVICE                                    | 137, 249<br>182, 306                    | 1, 031, 883             | 1              |              | 0                           | 17. 00           |
| 22. 00           | 02200 I &R SERVICES-OTHER PRGM COSTS APPRV              | 54, 341                                 | 307, 579                | 1              |              | 0                           | 22. 00           |
| 22.00            | I NPATI ENT ROUTI NE SERVI CE COST CENTERS              | 34, 341                                 | 307, 377                | 10, 364        | 10, 677      | 0                           | 22.00            |
| 30. 00           | 03000 ADULTS & PEDIATRICS                               | 2, 684, 163                             | 15, 192, 882            | 522, 802       | 1, 646, 940  | 128, 763                    | 30.00            |
| 00.00            | ANCI LLARY SERVI CE COST CENTERS                        | 2,001,100                               | 10, 172, 002            |                | 1,010,710    | 120, 700                    | 00.00            |
| 50.00            | 05000 OPERATING ROOM                                    | 0                                       | 0                       | 0              | 0            | 0                           | 50.00            |
| 54. 00           | 05400 RADI OLOGY-DI AGNOSTI C                           | 46, 235                                 | 261, 699                | 9, 005         | 13, 020      | 0                           | 54. 00           |
| 60.00            | 06000 LABORATORY  | 80, 960                                 | 458, 247                | 1              |              | 0                           | 60.00            |
| 65.00            | 06500 RESPIRATORY THERAPY                               | 153, 669                                | 869, 794                | 29, 930        | 12, 289      | 0                           | 65. 00           |
| 66.00            | 06600 PHYSI CAL THERAPY                                 | 753, 384                                | 4, 264, 291             | 146, 739       | 280, 190     | 352                         | 66. 00           |
| 66. 01           | 06601 PHYSI CAL THERAPY - CARMEL                        | 0                                       | 0                       | 0              | 0            | 0                           | 66. 01           |
| 67.00            | 06700 OCCUPATI ONAL THERAPY                             | 613, 736                                | 3, 473, 855             | 119, 539       | 239, 666     | 219                         | 67. 00           |
| 68.00            | 06800 SPEECH PATHOLOGY                                  | 375, 563                                | 2, 125, 753             | 73, 149        | 137, 041     | 178                         | 68. 00           |
| 68. 01           | 06801 VI SI ON  | 0                                       | 0                       | 0              | 0            | 0                           | 68. 01           |
| 68. 02           | 06802 FAC RESOURCE                                      | 0                                       | 0                       | 0              | 0            | 0                           | 68. 02           |
| 69. 00           | 06900 ELECTROCARDI OLOGY                                | 0                                       | 0                       | 0              | 0            | 0                           | 69. 00           |
| 71. 00           | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT               | 46, 072                                 | 260, 775                | 8, 974         | 0            | 0                           | 71. 00           |
|                  | 07200 I MPL. DEV. CHARGED TO PATIENTS                   | 0                                       | 0                       | 0              | 0            | 0                           | 72. 00           |
| 73. 00           | 07300 DRUGS CHARGED TO PATIENTS                         | 280, 858                                | 1, 589, 707             | 54, 703        | 0            | 0                           | 73. 00           |
| 74. 00           | 07400 RENAL DIALYSIS                                    | 0                                       | 0                       | 0              | 0            | 0                           | 74.00            |
| 77. 00           | 07700 ALLOGENEIC HSCT ACQUISITION                       | 0                                       | 0                       | 1              | 0            | 0                           | 77. 00           |
| 78. 00           | 07800 CAR T-CELL IMMUNOTHERAPY                          | 0                                       | 0                       | ) 0            | 0            | 0                           | 78. 00           |
| 00.00            | OUTPATIENT SERVICE COST CENTERS                         | 02.705                                  | 4/0 100                 | 1/ 100         | 121 402      | 0                           | 00.00            |
| 90. 00<br>90. 01 | 09000   CLI NI C<br>  09001   SLEEP CENTER              | 82, 705                                 | 468, 123                |                |              | 0                           | 90.00            |
| 90.01            | 09100 EMERGENCY   | 0                                       | 0                       |                | 0            | 0                           | 90. 01<br>91. 00 |
| 91.00            | 09200 OBSERVATION BEDS (NON-DISTINCT PART               | ١                                       | 0                       | 1              | U            |                             | 92.00            |
| 72.00            | OTHER REIMBURSABLE COST CENTERS                         |   |                         | <u>′ </u>      |              |                             | 72.00            |
| 99. 00           | 09900 CMHC  | 0                                       | 0                       | 0              | 0            | 0                           | 99. 00           |
| 99. 10           | 09910 CORF  |   | Ö                       |                |              | -                           |                  |
|                  | 10200 OPI OI D TREATMENT PROGRAM                        |   | Ö                       | 1              |              |                             | 102.00           |
| .02.00           | SPECIAL PURPOSE COST CENTERS                            | <u> </u>                                |                         | ,              |              |                             | 102.00           |
| 118.00           |   | 7, 641, 809                             | 43, 254, 050            | 1, 433, 342    | 2, 828, 484  | 129, 512                    | 118. 00          |
|                  | NONREI MBURSABLE COST CENTERS                           | , |                         | ,              | ,            |                             |                  |
| 190.00           | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN                 | 0                                       | C                       | 0              | 0            | 0                           | 190. 00          |
|                  | 19200 PHYSICIANS PRIVATE OFFICES                        | 237, 872                                | 1, 346, 399             | 46, 331        | 26, 918      |                             | 192. 00          |
| 194.00           | 07950 FOUNDATI ON                                       | 235, 721                                | 1, 334, 222             |                | 54, 714      | 0                           | 194. 00          |
| 194. 01          | 07951 PUBLIC RELATIONS                                  | 51, 765                                 | 293, 001                | 10, 082        | 21, 542      | 0                           | 194. 01          |
|                  | 07952 ST. VINCENT - ARU                                 | 0                                       | 0                       | ) 0            | 0            |                             | 194. 02          |
|                  | 07953 MUNCI E - ARU                                     |   | 0                       | ) 0            | 0            |                             | 194. 03          |
|                  | 07954 RILEY - ARU                                       | 0                                       | 0                       | 0              | 0            |                             | 194. 04          |
|                  | 07955 RETAIL PHARMACY                                   | 332, 521                                | 1, 882, 128             | 64, 766        | 0            | 0                           | 194. 05          |
| 200.00           |   |   | 0                       | 2              |              |                             | 200. 00          |
| 201.00           |   | 0                                       | 40.433.55               | 0              | 0            |                             | 201.00           |
| 202.00           | TOTAL (sum lines 118 through 201)                       | 8, 499, 688                             | 48, 109, 800            | 1, 600, 433    | 2, 931, 658  | 129, 512                    | J2U2. UU         |
|                  |   |   |                         |                |              |                             |                  |

Heal th Financial Systems

REHABILITATION HOSPITAL OF INDIANA

In Lieu of Form CMS-2552-10

Provider CCN: 15-3028

Period:
From 01/01/2023
To 12/31/2023

Date/Time Prepared:
5/30/2024 8: 35 am

Cost Center Description

HOUSEKEEPING

DIETARY

CAFETERIA
ADMINISTRATION
SERVICES & SUPPLY

9. 00 10. 00 11. 00 13. 00 14. 00

GENERAL SERVICE COST CENTERS

1. 00 00100 CAP REL COSTS-BLDG & FIXT
2. 00 00200 CAP REL COSTS-MVBLE EQUIP

REHABILITATION HOSPITAL OF INDIANA

In Lieu of Form CMS-2552-10

Worksheet B
Part I
From 01/01/2023
Date/Time Prepared:
5/30/2024 8: 35 am

ADMINISTRATION SERVICES & SUPPLY

1. 00 00100 CAP REL COSTS-BLDG & FIXT
2. 00 00200 CAP REL COSTS-BLDG & FIXT
2. 00 00200 CAP REL COSTS-MVBLE EQUIP

|                                     | Cost Center Description  | HOUSEKEEPI NG       | DI ETARY    | CAFETERI A         | NURSI NG<br>ADMI NI STRATI ON | CENTRAL<br>SERVI CES &<br>SUPPLY |   |
|-------------------------------------|--|---------------------|-------------|--------------------|-------------------------------|----------------------------------|---|
|                                     |  | 9. 00               | 10.00       | 11. 00             | 13. 00                        | 14. 00                           |   |
|                                     | ERAL SERVICE COST CENTERS  |                     |             |                    |                               |                                  |   |
| 2. 00 002<br>4. 00 004<br>5. 01 005 | 00  CAP REL COSTS-BLDG & FIXT 000  CAP REL COSTS-MYBLE EQUIP 000  EMPLOYEE BENEFITS DEPARTMENT 191  ADMINISTRATIVE AND GENERAL 190  OTHER A&G - NON FOUNDATION |                     |             |                    |                               |                                  | 1. 00<br>2. 00<br>4. 00<br>5. 01<br>5. 02 |
| 7. 00 007<br>8. 00 008<br>9. 00 009 | 000 OPERATION OF PLANT 1000 LAUNDRY & LINEN SERVICE 1000 HOUSEKEEPING 1000 DIETARY   | 905, 234<br>29, 518 | 1, 307, 546 |                    |                               |                                  | 7. 00<br>8. 00<br>9. 00<br>10. 00         |
|                                     | OO CAFETERI A  | 19, 534             | 1, 307, 340 | 622, 615           |                               |                                  | 11.00                                     |
| 1                                   | NURSING ADMINISTRATION   | 5, 615              | 0           | 76, 570            | 3, 558, 317                   | ļ                                | 13. 00                                    |
|                                     | OO CENTRAL SERVI CES & SUPPLY  | 13, 255             | 0           | 4, 361             | 200 573                       | 728, 906                         | •   |
|                                     | 000 PHARMACY<br>000 MEDI CAL RECORDS & LI BRARY  | 19, 328<br>1, 086   | 0           | 25, 017<br>18, 553 |                               | 9, 313<br>0                      | 1   |
|                                     | OO SOCIAL SERVICE  | 3, 694              | Ö           | 15, 786            |                               | 1, 441                           | 17. 00                                    |
|                                     | 100 I&R SERVICES-OTHER PRGM COSTS APPRV  | 5, 284              | 0           | 0                  | 0                             | 0                                | 22. 00                                    |
|                                     | ATLENT ROUTINE SERVICE COST CENTERS  | F1F 00/             | 1 207 54/   | 220 5/1            | 2 750 001                     | 100 507                          | 1 20 00                                   |
|                                     | 100 ADULTS & PEDIATRICS<br>ILLARY SERVICE COST CENTERS   | 515, 006            | 1, 307, 546 | 229, 561           | 2, 758, 091                   | 189, 597                         | 30. 00                                    |
|                                     | OO OPERATING ROOM  | 0                   | 0           | 0                  | 0                             | 0                                | 50.00                                     |
|                                     | OO RADI OLOGY-DI AGNOSTI C   | 4, 071              | 0           | 4, 653             | 55, 901                       | 4, 186                           | ł   |
|                                     | 000 LABORATORY   | 6, 210              | 0           | 9, 571             | 0                             | 0                                | 60.00                                     |
|                                     | 000 RESPI RATORY THERAPY<br>000 PHYSI CAL THERAPY  | 3, 843<br>87, 616   | 0           | 18, 381<br>78, 353 | 220, 838                      | 120, 280<br>8, 047               | 65. 00<br>66. 00                          |
|                                     | 01 PHYSI CAL THERAPY - CARMEL  | 07,010              | 0           | 70, 333            |                               | 0, 047                           | 66. 01                                    |
|                                     | OO OCCUPATIONAL THERAPY  | 74, 944             | 0           | 61, 751            | 0                             | 10, 502                          | 67. 00                                    |
|                                     | SOO SPEECH PATHOLOGY   | 42, 853             | 0           | 39, 694            | 0                             | 10, 666                          | •   |
|                                     | 001 VISION<br>002 FAC RESOURCE   | 0                   | 0           | 0                  | 0                             | 0                                | 68. 01<br>68. 02                          |
|                                     | 000 ELECTROCARDI OLOGY   | 0                   | 0           | 0                  | 0                             | 0                                | 69.00                                     |
|                                     | 00 MEDICAL SUPPLIES CHARGED TO PATIENT   | O                   | 0           | 0                  | o                             | 348, 340                         | •   |
|                                     | 200 IMPL. DEV. CHARGED TO PATIENTS   | 0                   | 0           | 0                  | 0                             | 0                                | •   |
|                                     | OO DRUGS CHARGED TO PATIENTS OO RENAL DIALYSIS   | 0                   | 0           | 0                  | 0                             | 0                                | 73. 00<br>74. 00                          |
|                                     | OO ALLOGENEIC HSCT ACQUISITION   | 0                   | 0           | 0                  | 0                             | 0                                | 77.00                                     |
|                                     | OO CAR T-CELL IMMUNOTHERAPY  | o                   | Ö           | 0                  | O                             | 0                                | 78. 00                                    |
|                                     | PATIENT SERVICE COST CENTERS   |                     |             |                    |                               |                                  |   |
|                                     | 000 CLINIC   | 41, 115             | 0           | 10, 183            |                               | 5, 377                           | 90.00                                     |
|                                     | 001 SLEEP CENTER<br>00 EMERGENCY   | 0                   | 0           | 0                  | 0                             | 0                                | 90. 01<br>91. 00                          |
|                                     | OO OBSERVATION BEDS (NON-DISTINCT PART   |                     | J           | 0                  | , and the second              | ١                                | 92.00                                     |
|                                     | ER REIMBURSABLE COST CENTERS   |                     |             |                    |                               |                                  |   |
|                                     | OOO CMHC   | 0                   | 0           | 0                  |                               | 0                                |   |
|                                     | 210 CORF<br>200 OPLOLD TREATMENT PROGRAM   | 0                   | 0           | 0                  |                               | 0                                | 99. 10<br>102. 00                         |
|                                     | CIAL PURPOSE COST CENTERS  | <u> </u>            |             |                    | <u> </u>                      | - C                              | 102.00                                    |
| 118. 00                             | SUBTOTALS (SUM OF LINES 1 through 117)   | 872, 972            | 1, 307, 546 | 592, 434           | 3, 558, 317                   | 707, 749                         | 118. 00                                   |
|                                     | REIMBURSABLE COST CENTERS  |                     | 0           | 0                  |                               |                                  | 100.00                                    |
|                                     | 000 GIFT FLOWER COFFEE SHOP & CANTEEN  | 0<br>8, 417         | 0           | 0<br>18, 745       |                               | 17, 091                          | 190.00                                    |
|                                     | PSO FOUNDATION   | 17, 109             | 0           | 5, 606             |                               |                                  | 194. 00                                   |
|                                     | PUBLIC RELATIONS   | 6, 736              | 0           | 5, 830             |                               |                                  | 194. 01                                   |
|                                     | 252 ST. VINCENT - ARU  | 0                   | 0           | 0                  | 0                             |                                  | 194. 02                                   |
|                                     | 153 MUNCIE - ARU<br>154 RILEY - ARU  | 0                   | 0           | 0                  | 0                             |                                  | 194. 03<br>194. 04                        |
|                                     | 195 RETAIL PHARMACY  |                     | 0           | 0                  | 0                             |                                  | 194. 04                                   |
| 200. 00                             | Cross Foot Adjustments   |                     | J           |                    |                               |                                  | 200. 00                                   |
| 201. 00                             | Negative Cost Centers  | 0                   | 0           | 0                  | 0                             |                                  | 201. 00                                   |
| 202. 00                             | TOTAL (sum lines 118 through 201)  | 905, 234            | 1, 307, 546 | 622, 615           | 3, 558, 317                   | 728, 906                         | 202. 00                                   |

Health Financial Systems REHABILITATION HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-3028 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 8:35 am INTERNS & **RESI DENTS** Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE SERVICES-OTHER Subtotal RECORDS & PRGM COSTS 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 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 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 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 1, 571, 081 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 1,049,615 16.00 01700 SOCIAL SERVICE 17.00 0 1, 100, 125 17.00 02200 & SERVICES-OTHER PRGM COSTS APPRV 22 00 340, 344 22 00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 1, 049, 615 1, 100, 125 340, 344 24, 981, 272 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 0 0 0 50 00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 352, 535 54.00 06000 LABORATORY 0 0 509, 656 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 00000 0 0 0 1, 275, 355 65.00 06600 PHYSI CAL THERAPY 0 66.00 Ω 4, 865, 588 66.00 66. 01 06601 PHYSICAL THERAPY - CARMEL 0 0 66.01 06700 OCCUPATIONAL THERAPY 0 3, 980, 476 67.00 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 2, 429, 334 68.00 0 06801 VISION 68.01 0 68.01 0 68.02 06802 FAC RESOURCE 0 0 0 0 68.02 06900 ELECTROCARDI OLOGY 69 00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 618, 089 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 0 C Λ 72 00 07300 DRUGS CHARGED TO PATIENTS 1, 571, 081 0 3, 215, 491 73.00 73.00 07400 RENAL DIALYSIS 0 0 74.00 0 0 0 74.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 77.00 0 C 0 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 672, 389 90.00 90. 01 90.01 09001 SLEEP CENTER 0 C 0 0 Ω 91.00 09100 EMERGENCY 0 C 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 0 0 0 99.00 99. 10 09910 CORF 0 0 99.10 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 1, 571, 081 1, 049, 615 1, 100, 125 340, 344 42, 900, 185 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GLFT FLOWER COFFEE SHOP & CANTEEN 0 190, 00 0 0 192.00 19200 PHYSICIANS PRIVATE OFFICES C 0 1, 463, 901 192. 00 194. 00 07950 FOUNDATION 0 0 0 0 1, 460, 360 194. 00

0 0

0

0

1, 571, 081

Ω

0

1, 049, 615

0

0

0

0

0

o

340, 344

0

0

0

0

0

1, 100, 125

338, 460 194. 01

1, 946, 894 194, 05

48, 109, 800 202. 00

0 194, 02

0 194, 03

0 194. 04

0|200 00

0 201.00

194. 01 07951 PUBLIC RELATIONS

194. 05 07955 RETAIL PHARMACY

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

194. 03 07953 MUNCI E - ARU

194. 04 07954 RILEY - ARU

200 00

201.00

202.00

194. 02 07952 ST. VINCENT - ARU

Health Financial Systems REHABILITATION HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-3028 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 8:35 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 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 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 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 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 -340, 344 24, 640, 928 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 50 00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 352, 535 54.00 06000 LABORATORY 509, 656 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 0000000000000 1, 275, 355 65.00 06600 PHYSI CAL THERAPY 66.00 4, 865, 588 66.00 66.01 06601 PHYSI CAL THERAPY - CARMEL 66.01 06700 OCCUPATIONAL THERAPY 3, 980, 476 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 2, 429, 334 68.00 06801 VI SI ON 68.01 Ω 68.01 68.02 06802 FAC RESOURCE 68.02 0 06900 ELECTROCARDI OLOGY 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 618, 089 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 72 00 07300 DRUGS CHARGED TO PATIENTS 3, 215, 491 73.00 73.00 07400 RENAL DIALYSIS 74.00 C 74.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 672, 389 90.00 0 90.01 09001 SLEEP CENTER 90.01 C 91.00 09100 EMERGENCY 0 C 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 99.00 99. 10 09910 CORF 0 99.10 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) -340, 344 42, 559, 841 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GLFT FLOWER COFFEE SHOP & CANTEEN 190.00 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 1, 463, 901 192.00 194. 00 07950 FOUNDATION 0 1, 460, 360 194. 00 194. 01 07951 PUBLIC RELATIONS 194. 01 0 0 0 338, 460 194. 02 07952 ST. VINCENT - ARU 194. 03 07953 MUNCIE - ARU 194. 02 Ω 0 194. 03 194. 04 07954 RILEY - ARU 194. 04

0

-340, 344

1, 946, 894

47, 769, 456

194.05

200 00

201.00

202.00

194. 05 07955 RETAIL PHARMACY

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

200 00

201.00

202.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS REHABILITATION HOSPITAL OF INDIANA

Provider CCN: 15-3028

|   |                    |   | To           | 12/31/2023         | Date/Time Pre 5/30/2024 8:3 |                    |
|---|--------------------|---|--------------|--------------------|-----------------------------|--------------------|
|   |                    | CAPI TAL REI                            | LATED COSTS  |                    | 3/30/2024 8.3               | 3 alli             |
| Cost Center Description   | Directly           | BLDG & FIXT                             | MVBLE EQUIP  | Subtotal           | EMPLOYEE                    |                    |
| Sout Senter Description   | Assigned New       | DEDO G TTAT                             | MIVBEE EGOTT | Subtotal           | BENEFITS                    |                    |
|   | Capi tal           |   |              |                    | DEPARTMENT                  |                    |
|   | Related Costs<br>0 | 1.00                                    | 2.00         | 2A                 | 4. 00                       |                    |
| GENERAL SERVICE COST CENTERS  |                    |   |              | ,                  |                             |                    |
| 1.00 O0100 CAP REL COSTS-BLDG & FIXT  |                    |   |              |                    |                             | 1.00               |
| 2.00   00200   CAP REL COSTS-MVBLE EQUIP<br>4.00   00400   EMPLOYEE BENEFITS DEPARTMENT | 0                  | 17, 154                                 | 8, 189       | 25, 343            | 25, 343                     | 2. 00<br>4. 00     |
| 5. 01   00591   ADMINISTRATIVE AND GENERAL  | 0                  | 35, 883                                 |              | 53, 013            | 3, 577                      | 5. 01              |
| 5. 02 00590 OTHER A&G - NON FOUNDATION  | 0                  | 24, 047                                 |              | 35, 527            | 897                         | 5. 02              |
| 7.00 00700 OPERATION OF PLANT   | 0                  | 356, 442                                |              | 526, 606           | 56                          | 7. 00              |
| 8.00   00800   LAUNDRY & LINEN SERVICE  | 0                  | 14 520                                  | 1            | 21 470             | 0                           | 8.00               |
| 9. 00   00900   HOUSEKEEPI NG<br>10. 00   01000   DI ETARY                              | 0                  | 14, 538<br>37, 299                      | 1            | 21, 478<br>55, 105 | 446<br>43                   | 9. 00<br>10. 00    |
| 11. 00 01100 CAFETERI A   | 0                  | 24, 683                                 | 1            | 36, 466            | 28                          | 11. 00             |
| 13.00 01300 NURSING ADMINISTRATION  | 0                  | 7, 096                                  | 1            | 10, 483            | 2, 156                      | 13. 00             |
| 14. 00 01400 CENTRAL SERVICES & SUPPLY  | 0                  | 16, 749                                 | 1            | 24, 745            | 65                          | 14.00              |
| 15. 00   01500   PHARMACY<br>16. 00   01600   MEDI CAL RECORDS & LI BRARY               | 0                  | 24, 423<br>1, 373                       | 1            | 36, 082<br>2, 028  | 674<br>470                  | 15. 00<br>16. 00   |
| 17. 00 01700 SOCI AL SERVI CE   | 0                  | 4, 668                                  | 1            | 6, 896             | 591                         | 17. 00             |
| 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV  | 0                  | l                                       | 1            | 9, 864             | 0                           | 22. 00             |
| INPATIENT ROUTINE SERVICE COST CENTERS  |                    | /50 755                                 | 1 040 (74)   | 0/4 /0/            |                             |                    |
| 30. 00 03000 ADULTS & PEDIATRICS ANCI LLARY SERVICE COST CENTERS                        | 0                  | 650, 755                                | 310, 671     | 961, 426           | 8, 114                      | 30.00              |
| 50. 00 05000 OPERATING ROOM   | 0                  | 0                                       | 0            | ol                 | 0                           | 50.00              |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C  | 0                  | 5, 145                                  | 2, 456       | 7, 601             | 154                         | 54.00              |
| 60. 00   06000   LABORATORY   | 0                  | 7, 847                                  |              | 11, 593            | 0                           | 60. 00             |
| 65. 00 06500 RESPIRATORY THERAPY  | 0                  | .,                                      | 1            | 7, 174             | 584                         | 65. 00             |
| 66. 00   06600   PHYSI CAL THERAPY<br>66. 01   06601   PHYSI CAL THERAPY - CARMEL       | 0                  | 110, 712                                | 52, 853<br>0 | 163, 565<br>0      | 2, 522<br>0                 | 66. 00<br>66. 01   |
| 67. 00 06700 OCCUPATI ONAL THERAPY  | o o                | 94, 699                                 | _            | 139, 908           | 2, 158                      | 67. 00             |
| 68.00 06800 SPEECH PATHOLOGY  | 0                  | 54, 149                                 | 25, 851      | 80, 000            | 1, 342                      | 68. 00             |
| 68. 01   06801   VI SI ON   | 0                  | 0                                       | 0            | 0                  | 0                           | 68. 01             |
| 68. 02   06802   FAC RESOURCE<br>69. 00   06900   ELECTROCARDI OLOGY                    | 0                  | 0                                       | 0            | 0                  | 0                           | 68. 02<br>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                  | 0                           | 72. 00             |
| 73.00 07300 DRUGS CHARGED TO PATIENTS   | 0                  | 0                                       | 0            | 0                  | 0                           | 73. 00             |
| 74. 00   07400   RENAL DI ALYSI S   | 0                  | 0                                       | 0            | 0                  | 0                           | 74.00              |
| 77.00   07700   ALLOGENEIC HSCT ACQUISITION 78.00   07800   CAR T-CELL IMMUNOTHERAPY    | 0                  | 0                                       | 0            | 0                  | 0                           | 77. 00<br>78. 00   |
| OUTPATIENT SERVICE COST CENTERS   |                    |   | 1 0          | <u>0</u>           |                             | 70.00              |
| 90. 00 09000 CLI NI C   | 0                  | 51, 952                                 | 24, 802      | 76, 754            | 236                         | 90.00              |
| 90. 01 09001 SLEEP CENTER   | 0                  |   | 0            | 0                  | 0                           | 90. 01             |
| 91. 00   09100   EMERGENCY<br>92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART     | 0                  | 0                                       | 0            | 0                  | 0                           | 91. 00<br>92. 00   |
| OTHER REIMBURSABLE COST CENTERS   |                    |   |              | <u> </u>           |                             | 72.00              |
| 99. 00 09900 CMHC   | 0                  | 0                                       | 0            | 0                  | 0                           | 99. 00             |
| 99. 10   09910   CORF   | 0                  | ł                                       | 0            | 0                  | 0                           | 1                  |
| 102. 00 10200 OPIOLD TREATMENT PROGRAM  SPECIAL PURPOSE COST CENTERS                    | 0                  | 0                                       | 0            | O                  | 0                           | 102. 00            |
| 118. 00 SUBTOTALS (SUM OF LINES 1 through 117)  | 0                  | 1, 551, 147                             | 740, 510     | 2, 291, 657        | 24, 113                     | 118.00             |
| NONREI MBURSABLE COST CENTERS   |                    | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |              |                    | ,                           |                    |
| 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN  | 0                  |   | 0            | 0                  |                             | 190. 00            |
| 192. 00 19200 PHYSICIANS PRIVATE OFFICES<br>194. 00 07950 FOUNDATION                    | 0                  |   | 1            | 15, 714<br>31, 940 |                             | 192. 00<br>194. 00 |
| 194. 01 07950 FOUNDATTON<br>194. 01 07951 PUBLI C RELATI ONS                            |                    | 21, 619<br>8, 512                       | 1            | 12, 576            |                             | 194. 00            |
| 194. 02 07952 ST. VINCENT - ARU   | 0                  | 0, 312                                  | 0            | 0                  |                             | 194. 02            |
| 194. 03 07953 MUNCIE - ARU  | 0                  | 0                                       | 0            | o                  |                             | 194. 03            |
| 194. 04 07954 RILEY - ARU   | 0                  | 0                                       | 0            | o                  |                             | 194. 04            |
| 194.05 07955 RETAIL PHARMACY<br>200.00  Cross Foot Adjustments                          |                    | 0                                       |              | 0                  | 253                         | 194. 05<br>200. 00 |
| 201.00 Negative Cost Centers  |                    | 0                                       | o            | ol                 | 0                           | 200.00             |
| 202.00 TOTAL (sum lines 118 through 201)  | 0                  | 1, 591, 914                             | 759, 973     | 2, 351, 887        | 25, 343                     |                    |
|   |                    |   |              |                    |                             |                    |

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 01/2024 | Part | From 01/2024 | Part | Par

|  |                   |                | 1            | 0 12/31/2023  | 5/30/2024 8: 3 |                    |
|--|-------------------|----------------|--------------|---------------|----------------|--------------------|
| Cost Center Description  | ADMI NI STRATI VE | OTHER A&G -    | OPERATION OF | LAUNDRY &     | HOUSEKEEPI NG  |                    |
|  |                   | NON FOUNDATION |              | LINEN SERVICE |                |                    |
| OFWERN OFFICE COOT OFWERN  | 5. 01             | 5. 02          | 7. 00        | 8. 00         | 9. 00          |                    |
| GENERAL SERVICE COST CENTERS   | 1                 |                | T            |               |                | 1 1 00             |
| 1.00   00100   CAP REL COSTS-BLDG & FLXT<br>2.00   00200   CAP REL COSTS-MVBLE EQUIP |                   |                |              |               |                | 1. 00<br>2. 00     |
| 4.00   00400 EMPLOYEE BENEFITS DEPARTMENT  |                   |                |              |               |                | 4.00               |
| 5. 01   00591 ADMINISTRATIVE AND GENERAL   | 56, 590           |                |              |               |                | 5. 01              |
| 5. 02 00590 OTHER A&G - NON FOUNDATION   | 1, 883            | 38, 307        |              |               |                | 5. 02              |
| 7. 00   00700   OPERATION OF PLANT   | 3, 334            | 2, 335         |              |               |                | 7. 00              |
| 8. 00   00800 LAUNDRY & LINEN SERVICE  | 147               | 103            |              | 250           |                | 8.00               |
| 9. 00   00900   HOUSEKEEPI NG  | 988               | 692            |              | 0             | 30, 285        | 9. 00              |
| 10. 00   01000 DI ETARY  | 1, 346            | 943            |              | 0             | 988            | 10.00              |
| 11. 00   01100   CAFETERI A  | 615               | 431            |              |               | 654            | 11. 00             |
| 13.00 01300 NURSING ADMINISTRATION   | 3, 933            | 2, 755         | 3, 261       | 0             | 188            | 13. 00             |
| 14.00 01400 CENTRAL SERVICES & SUPPLY  | 761               | 533            | 7, 697       | 0             | 443            | 14. 00             |
| 15. 00 01500 PHARMACY  | 1, 314            | 920            | 11, 223      | 0             | 647            | 15. 00             |
| 16.00 01600 MEDICAL RECORDS & LIBRARY  | 914               | 640            | 631          | 0             | 36             | 16. 00             |
| 17.00 01700 SOCIAL SERVICE   | 1, 214            | 850            |              |               | 124            | 17. 00             |
| 22.00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV                                    | 362               | 253            | 3, 068       | 0             | 177            | 22. 00             |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS   |                   |                |              |               |                |                    |
| 30. 00   03000  ADULTS & PEDI ATRI CS  | 17, 863           | 12, 502        | 299, 052     | 249           | 17, 228        | 30. 00             |
| ANCILLARY SERVICE COST CENTERS   |                   | 0              | 1            |               | 0              | <br>               |
| 50. 00   05000   OPERATING ROOM  | 308               | 0              | 0            | -             | 0              | 50.00              |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C<br>60. 00   06000   LABORATORY              | 539               | 216<br>378     |              |               | 136<br>208     | 54. 00<br>60. 00   |
| 65. 00   06500   RESPI RATORY   THERAPY  | 1, 023            | 717            |              |               | 129            | 65.00              |
| 66. 00   06600   PHYSI CAL THERAPY   | 5, 017            | 3, 514         | 50, 877      | 1             | 2, 931         | 66.00              |
| 66. 01 06601 PHYSI CAL THERAPY - CARMEL  | 3,017             | 3, 314         | 30, 077      | 0             | 2, 751         | 66. 01             |
| 67. 00 06700 OCCUPATI ONAL THERAPY   | 4, 087            | 2, 862         |              | 0             | 2, 507         | 67.00              |
| 68. 00 06800 SPEECH PATHOLOGY  | 2, 501            | 1, 752         |              |               | 1, 434         | 68. 00             |
| 68. 01   06801   VI SI ON  | 0                 | 0              | 0            | 0             | 0              | 68. 01             |
| 68. 02   06802   FAC   RESOURCE  | 0                 | 0              | 0            | 0             | 0              | 68. 02             |
| 69. 00 06900 ELECTROCARDI OLOGY  | 0                 | 0              | 0            | 0             | 0              | 69. 00             |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                                      | 307               | 215            | 0            | 0             | 0              | 71. 00             |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS   | 0                 | 0              | 0            | 0             | 0              | 72. 00             |
| 73.00 07300 DRUGS CHARGED TO PATIENTS  | 1, 870            | 1, 310         | 0            | 0             | 0              | 73. 00             |
| 74. 00   07400   RENAL DI ALYSI S  | 0                 | 0              | 0            | 0             | 0              | 74. 00             |
| 77. 00 07700 ALLOGENEIC HSCT ACQUISITION   | 0                 | 0              | 0            | 0             | 0              | 77. 00             |
| 78. 00 07800 CAR T-CELL IMMUNOTHERAPY  | 0                 | 0              | 0            | 0             | 0              | 78. 00             |
| OUTPATIENT SERVICE COST CENTERS  | EE1               | 207            | 22.074       |               | 1 27/          | 00 00              |
| 90. 00   09000   CLI NI C<br>90. 01   09001   SLEEP CENTER                           | 551<br>0          | 386<br>0       |              |               | 1, 376<br>0    | 90. 00<br>90. 01   |
| 91. 00   09100   BMERGENCY   | 0                 | 0              |              | 0             | 0              | 91.00              |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART                                     |                   | 0              |              |               | O              | 92.00              |
| OTHER REIMBURSABLE COST CENTERS  |                   |                |              |               |                | 72.00              |
| 99. 00 09900 CMHC  | 0                 | 0              | 0            | 0             | 0              | 99. 00             |
| 99. 10 09910 CORF  | 0                 | 0              | 0            | 0             | 0              | 99. 10             |
| 102.00 10200 OPIOID TREATMENT PROGRAM  | 0                 | 0              | 0            | 0             | 0              | 102. 00            |
| SPECIAL PURPOSE COST CENTERS   |                   |                |              |               |                |                    |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)  | 50, 877           | 34, 307        | 513, 596     | 250           | 29, 206        | 118. 00            |
| NONREI MBURSABLE COST CENTERS  |                   |                |              |               |                |                    |
| 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN                                       | 0                 | 0              | 0            | 0             |                | 190. 00            |
| 192.00 19200 PHYSI CLANS PRI VATE OFFI CES   | 1, 584            | 1, 109         |              |               |                | 192. 00            |
| 194. 00 07950 FOUNDATION   | 1, 570            | 1, 099         |              |               |                | 194. 00            |
| 194. 01 07951 PUBLIC RELATIONS   | 345               | 241            |              |               |                | 194. 01            |
| 194. 02 07952 ST. VINCENT - ARU  | 0                 | 0              | 0            |               |                | 194. 02            |
| 194. 03 07953 MUNCI E - ARU<br>194. 04 07954 RILEY - ARU                             | 0                 | 0              | 0            |               |                | 194. 03<br>194. 04 |
| 194. 05 07955 RETAIL PHARMACY  | 2, 214            | 1, 551         |              |               |                | 194. 04            |
| 200.00 Cross Foot Adjustments  | 2,214             | 1, 331         | ١            |               | U              | 200.00             |
| 201.00 Negative Cost Centers   |                   | 0              | _            | n             | Λ              | 200.00             |
| 202.00 TOTAL (sum lines 118 through 201)   | 56, 590           | 38, 307        | 532, 331     | 250           |                |                    |
| (  |                   | ,,             | , 552, 561   |               | , -00          |                    |
|  |                   |                |              |               |                |                    |

0 201.00

55, 730 202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3028 Peri od: Worksheet B From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/30/2024 8:35 am Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI ON SERVICES & **SUPPLY** 10.00 11.00 13.00 15.00 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 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 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 75, 565 10.00 01100 CAFETERI A 49, 537 11.00 11.00 01300 NURSING ADMINISTRATION 0 13.00 6,092 28,868 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 347 34, 591 14.00 15.00 01500 PHARMACY 0 1, 990 2, 438 55, 730 15.00 442 01600 MEDICAL RECORDS & LIBRARY 0 1, 476 1, 808 16.00 16.00 0 01700 SOCIAL SERVICE 17.00 0 1, 256 C 68 0 17.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 75, 565 18, 266 22, 376 8, 998 30.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 0 05400 RADI OLOGY-DI AGNOSTI C 370 199 54.00 454 0 54.00 06000 LABORATORY 60.00 762  $\cap$ 0 60.00 65.00 06500 RESPIRATORY THERAPY 0 1, 462 1, 792 5, 708 0 65.00 06600 PHYSI CAL THERAPY 66.00 00000000000 6, 234 0 382 66.00 66 01 06601 PHYSI CAL THERAPY - CARMEL 0 66 01 0 0 06700 OCCUPATIONAL THERAPY 4, 913 0 67.00 498 0 67.00 68.00 06800 SPEECH PATHOLOGY 3, 158 0 506 0 68.00 68.01 06801 VI SI ON C 0 0 0 68.01 06802 FAC RESOURCE 0 68.02 C 0 0 68.02 69.00 06900 ELECTROCARDI OLOGY C 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 0 16, 531 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS Ω 0 0 72 00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 55, 730 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 74.00 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 o 0 77.00 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 Ω 0 Ω 78.00 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 0 810 0 255 0 90.00 90.01 09001 SLEEP CENTER 0 0 0 0 90.01 C 09100 EMERGENCY 0 0 91.00 91.00 C 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 99.00 0 0 0 99. 10 09910 CORF 0 99. 10 0 C 0 Ω 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 75, 565 55, 730 118. 00 47, 136 28, 868 33, 587 118.00 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190. 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 1, 491 811 0 192.00 0 194. 00 07950 FOUNDATI ON 0 0 194, 00 446 133 0 194. 01 194. 01 07951 PUBLIC RELATIONS 464 0 60 0 194. 02 07952 ST. VINCENT - ARU C 0 0 0 194. 02 194. 03 07953 MUNCIE - ARU 0 194. 03 0 C 0 0 0 194. 04 194. 04 07954 RILEY - ARU 0 C 0 194. 05 07955 RETAIL PHARMACY 0 0 0 194. 05 C 200.00 Cross Foot Adjustments 200.00

75.565

49, 537

28, 868

34, 591

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3028 Period:
From 01/01/2023 Part II
Date/Time Prepared:
5/30/2024 8: 35 am

|         |        |  |                      |                | 10                        | ) 12/31/2023         | 5/30/2024 8:3              |                    |
|---------|--------|--|----------------------|----------------|---------------------------|----------------------|----------------------------|--------------------|
|         |        |  |                      |                | INTERNS &                 |                      | 7 07 007 202 1 010         | <u> </u>           |
|         |        |  |                      |                | RESI DENTS                |                      |                            |                    |
|         |        | Cost Center Description  | MEDICAL<br>RECORDS & | SOCIAL SERVICE | SERVICES-OTHER PRGM COSTS | Subtotal             | Intern &<br>Residents Cost |                    |
|         |        |  | LI BRARY             |                | APPRV                     |                      | & Post                     |                    |
|         |        |  |                      |                |                           |                      | Stepdown                   |                    |
|         |        |  |                      |                |                           |                      | Adjustments                |                    |
|         | CENED  | AL CEDVICE COST CENTERS  | 16. 00               | 17. 00         | 22.00                     | 24. 00               | 25. 00                     |                    |
|         |        | AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT              |                      |                |                           |                      |                            | 1. 00              |
|         |        | CAP REL COSTS-MVBLE EQUIP                                      |                      |                |                           |                      |                            | 2. 00              |
| 1       |        | EMPLOYEE BENEFITS DEPARTMENT                                   |                      |                |                           |                      |                            | 4. 00              |
|         |        | ADMINISTRATIVE AND GENERAL                                     |                      |                |                           |                      |                            | 5. 01              |
|         |        | OTHER A&G - NON FOUNDATION                                     |                      |                |                           |                      |                            | 5. 02              |
|         |        | OPERATION OF PLANT<br>LAUNDRY & LINEN SERVICE                  |                      |                |                           |                      |                            | 7. 00<br>8. 00     |
|         |        | HOUSEKEEPI NG  |                      |                |                           |                      |                            | 9. 00              |
|         |        | DIETARY  |                      |                |                           |                      |                            | 10.00              |
| 11. 00  | 01100  | CAFETERI A   |                      |                |                           |                      |                            | 11. 00             |
| 1       |        | NURSI NG ADMI NI STRATI ON                                     |                      |                |                           |                      |                            | 13. 00             |
|         |        | CENTRAL SERVICES & SUPPLY PHARMACY                             |                      |                |                           |                      |                            | 14.00              |
|         |        | MEDICAL RECORDS & LIBRARY                                      | 8, 003               |                |                           |                      |                            | 15. 00<br>16. 00   |
| 1       |        | SOCIAL SERVICE   | 0,009                | 13, 144        |                           |                      |                            | 17. 00             |
| 4       |        | I&R SERVICES-OTHER PRGM COSTS APPRV                            | 0                    | 0              | i I                       |                      |                            | 22. 00             |
| -       |        | ENT ROUTINE SERVICE COST CENTERS                               |                      |                |                           |                      |                            |                    |
|         |        | ADULTS & PEDI ATRI CS  | 8, 003               | 13, 144        |                           | 1, 462, 786          | 0                          | 30. 00             |
|         |        | _ARY SERVICE COST CENTERS OPERATING ROOM                       | 0                    | 0              |                           | 0                    | 0                          | 50. 00             |
|         |        | RADI OLOGY-DI AGNOSTI C  | 0                    | 0              |                           | 11, 802              | 0                          | 54. 00             |
| 1       |        | LABORATORY   | 0                    | Ö              |                           | 17, 086              | Ö                          | 60.00              |
|         |        | RESPI RATORY THERAPY   | 0                    | 0              |                           | 20, 820              | 0                          | 65. 00             |
|         |        | PHYSI CAL THERAPY  | 0                    | 0              |                           | 235, 043             | 0                          | 66. 00             |
| 1       |        | PHYSICAL THERAPY - CARMEL                                      | 0                    | 0              |                           | 0                    | 0                          | 66. 01             |
|         |        | OCCUPATIONAL THERAPY SPEECH PATHOLOGY                          | 0                    | 0              |                           | 200, 452<br>115, 577 | 0                          | 67. 00<br>68. 00   |
|         |        | VISION   | 0                    | 0              |                           | 115, 577             |                            | 68. 01             |
|         |        | FAC RESOURCE   | 0                    | Ö              |                           | 0                    | Ö                          | 68. 02             |
| 69. 00  | 06900  | ELECTROCARDI OLOGY   | 0                    | 0              |                           | 0                    | 0                          | 69. 00             |
|         |        | MEDICAL SUPPLIES CHARGED TO PATIENT                            | 0                    | 0              |                           | 17, 053              | 0                          | 71. 00             |
|         |        | IMPL. DEV. CHARGED TO PATIENTS                                 | 0                    | 0              |                           | 0                    | 0                          | 72.00              |
|         |        | DRUGS CHARGED TO PATIENTS RENAL DIALYSIS                       | 0                    | 0              |                           | 58, 910              | 0<br>0                     | 73. 00<br>74. 00   |
| 1       |        | ALLOGENEIC HSCT ACQUISITION                                    | 0                    | 0              |                           | 0                    | 0                          | 77. 00             |
| 1       |        | CAR T-CELL IMMUNOTHERAPY                                       | 0                    | 0              |                           | 0                    | 0                          | 78. 00             |
| -       |        | TIENT SERVICE COST CENTERS                                     |                      |                |                           |                      |                            |                    |
|         |        | CLINIC   | 0                    |                | 1                         | 104, 242             | 0                          |                    |
|         |        | SLEEP CENTER<br>EMERGENCY                                      | 0                    | 0              |                           | 0                    | 0<br>0                     | 90. 01<br>91. 00   |
| 4       |        | OBSERVATION BEDS (NON-DISTINCT PART                            | U                    |                |                           | 0                    |                            | 91.00              |
|         |        | REI MBURSABLE COST CENTERS                                     |                      |                |                           |                      |                            | 72.00              |
|         | 09900  |  | 0                    | 0              |                           | 0                    | 0                          |                    |
|         | 09910  |  | 0                    | 0              |                           | 0                    | 0                          |                    |
|         |        | OPLOID TREATMENT PROGRAM                                       | 0                    | 0              |                           | 0                    | 0                          | 102. 00            |
| 118. 00 | SPECIA | AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) | 8, 003               | 13, 144        | 0                         | 2, 243, 771          | 0                          | 118. 00            |
|         | NONRE  | MBURSABLE COST CENTERS   | 0,003                | 15, 144        |                           | 2, 243, 771          |                            | 110.00             |
|         |        | GIFT FLOWER COFFEE SHOP & CANTEEN                              | 0                    | 0              |                           | 0                    | 0                          | 190. 00            |
|         |        | PHYSICIANS PRIVATE OFFICES                                     | 0                    | 0              |                           | 26, 467              |                            | 192. 00            |
|         |        | FOUNDATION   | 0                    | 0              |                           | 45, 939              |                            | 194. 00            |
|         |        | PUBLIC RELATIONS<br>ST. VINCENT - ARU                          | 0                    | 0              |                           | 17, 968              | l                          | 194. 01            |
| 4       |        | MUNCIE - ARU   | 0                    |                |                           | 0                    |                            | 194. 02<br>194. 03 |
|         |        | RILEY - ARU  | 0                    | Ö              |                           | 0                    | l                          | 194. 04            |
| 194. 05 |        | RETAIL PHARMACY  | 0                    | 0              |                           | 4, 018               | 0                          | 194. 05            |
| 200.00  |        | Cross Foot Adjustments   |                      |                | 13, 724                   | 13, 724              |                            | 200. 00            |
| 201.00  |        | Negative Cost Centers  | 0 003                | 0              | 0                         | 0 251 007            |                            | 201. 00            |
| 202. 00 |        | TOTAL (sum lines 118 through 201)                              | 8, 003               | 13, 144        | 13, 724                   | 2, 351, 887          | ı <sup>0</sup>             | 202. 00            |
|         |        |  |                      |                |                           |                      |                            |                    |

REHABILITATION HOSPITAL OF INDIANA
Provider CCN: 15-3028 | In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To | 12/31/2023 | Date/Time Prepared: | 5/30/2024 8:35 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

|        |  |              | 5/30/2024 8:3 | ss am   |
|--------|--|--------------|---------------|---------|
|        | Cost Center Description                    | Total 26. 00 |               |         |
|        | GENERAL SERVICE COST CENTERS               | 20.00        |               |         |
| 1 00   |  |              |               | 1 00    |
| 1.00   | 00100 CAP REL COSTS-BLDG & FLXT            |              |               | 1.00    |
| 2.00   | 00200 CAP REL COSTS-MVBLE EQUI P           |              |               | 2.00    |
| 4.00   | 00400 EMPLOYEE BENEFITS DEPARTMENT         |              |               | 4. 00   |
| 5. 01  | 00591 ADMI NI STRATI VE AND GENERAL        |              |               | 5. 01   |
| 5. 02  | 00590 OTHER A&G - NON FOUNDATION           |              |               | 5. 02   |
| 7. 00  | 00700 OPERATION OF PLANT                   |              |               | 7. 00   |
| 8.00   | 00800 LAUNDRY & LINEN SERVICE              |              |               | 8. 00   |
| 9.00   | 00900 HOUSEKEEPI NG                        |              |               | 9. 00   |
| 10.00  | 01000 DI ETARY                             |              |               | 10.00   |
| 11. 00 | 01100  CAFETERI A                          |              |               | 11. 00  |
| 13.00  | 01300 NURSI NG ADMI NI STRATI ON           |              |               | 13.00   |
| 14.00  | 01400 CENTRAL SERVICES & SUPPLY            |              |               | 14. 00  |
| 15.00  | 01500 PHARMACY                             |              |               | 15. 00  |
| 16.00  | 01600 MEDICAL RECORDS & LIBRARY            |              |               | 16. 00  |
|        | 01700 SOCIAL SERVICE                       |              |               | 17. 00  |
| 22. 00 | 02200 I &R SERVICES-OTHER PRGM COSTS APPRV |              |               | 22. 00  |
| 22.00  | I NPATI ENT ROUTI NE SERVI CE COST CENTERS |              |               | 22.00   |
| 30. 00 | 03000 ADULTS & PEDI ATRI CS                | 1, 462, 786  |               | 30.00   |
| 30.00  | ANCI LLARY SERVI CE COST CENTERS           | 1,402,700    |               | 30.00   |
| EO 00  | 05000 OPERATING ROOM                       | O            |               | 50.00   |
| 50.00  |  | 1            |               | 1       |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C              | 11, 802      |               | 54.00   |
| 60. 00 | 06000 LABORATORY                           | 17, 086      |               | 60. 00  |
| 65. 00 | 06500 RESPI RATORY THERAPY                 | 20, 820      |               | 65. 00  |
| 66. 00 | 06600 PHYSI CAL THERAPY                    | 235, 043     |               | 66. 00  |
| 66. 01 | 06601 PHYSI CAL THERAPY - CARMEL           | 0            |               | 66. 01  |
| 67.00  | 06700 OCCUPATI ONAL THERAPY                | 200, 452     |               | 67. 00  |
| 68.00  | 06800 SPEECH PATHOLOGY                     | 115, 577     |               | 68. 00  |
| 68. 01 | 06801 VI SI ON                             | 0            |               | 68. 01  |
| 68. 02 | 06802 FAC RESOURCE                         | o            |               | 68. 02  |
| 69. 00 | 06900 ELECTROCARDI OLOGY                   | 0            |               | 69.00   |
|        | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 17, 053      |               | 71. 00  |
|        | 07200 I MPL. DEV. CHARGED TO PATIENTS      | 0            |               | 72. 00  |
|        | 07300 DRUGS CHARGED TO PATIENTS            | 58, 910      |               | 73. 00  |
| 74. 00 | 07400 RENAL DIALYSIS                       | 30, 710      |               | 74. 00  |
|        | 07700 ALLOGENEIC HSCT ACQUISITION          |              |               | 77. 00  |
|        | 1  |              |               | 1       |
| 76.00  | 07800 CAR T-CELL IMMUNOTHERAPY             | U            |               | 78. 00  |
| 00.00  | OUTPATIENT SERVICE COST CENTERS            | 104 242      |               | 00.00   |
| 90.00  | 09000 CLINIC                               | 104, 242     |               | 90.00   |
| 90. 01 | 09001 SLEEP CENTER                         | 0            |               | 90. 01  |
| 91. 00 | 09100 EMERGENCY                            | 0            |               | 91. 00  |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART  |              |               | 92. 00  |
|        | OTHER REIMBURSABLE COST CENTERS            |              |               |         |
|        | 09900 CMHC                                 | 0            |               | 99. 00  |
|        | 09910  CORF                                | 0            |               | 99. 10  |
| 102.00 | 10200 OPIOID TREATMENT PROGRAM             | 0            |               | 102. 00 |
|        | SPECIAL PURPOSE COST CENTERS               |              |               |         |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117)     | 2, 243, 771  |               | 118. 00 |
|        | NONREI MBURSABLE COST CENTERS              |              |               |         |
| 190.00 | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN    | 0            |               | 190. 00 |
|        | 19200 PHYSICIANS PRIVATE OFFICES           | 26, 467      |               | 192.00  |
|        | 07950 FOUNDATION                           | 45, 939      |               | 194. 00 |
|        | 07951 PUBLIC RELATIONS                     | 17, 968      |               | 194. 01 |
|        | 07952 ST. VINCENT - ARU                    | 17,700       |               | 194. 02 |
|        | 1 1  |              |               | 194. 02 |
|        | 07953 MUNCI E - ARU                        |              |               |         |
|        | 07954 RILEY - ARU                          | 4 010        |               | 194. 04 |
|        | 07955 RETAIL PHARMACY                      | 4, 018       |               | 194. 05 |
| 200.00 | 1 1  | 13, 724      |               | 200. 00 |
| 201.00 |  | 0            |               | 201. 00 |
| 202.00 | TOTAL (sum lines 118 through 201)          | 2, 351, 887  |               | 202. 00 |
|        |  |              |               |         |

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 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 8:35 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SQUARE FEET) (SQUARE FEET) BENEFITS AND GENERAL DEPARTMENT (ACCUM. COST) (GROSS SALARI ES) 1.00 2.00 5A. 01 5. 01 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 110 157 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 110, 157 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 187 1, 187 22, 204, 979 4.00 00591 ADMINISTRATIVE AND GENERAL 3, 135, 365 2, 483 2, 483 -8, 499, 688 39, 610, 112 5 01 5 01 5.02 00590 OTHER A&G - NON FOUNDATION 1,664 1,664 786, 101 1, 317, 680 5.02 2, 333, 419 7.00 00700 OPERATION OF PLANT 24,665 24, 665 49, 443 7.00 00800 LAUNDRY & LINEN SERVICE 0 103, 084 8.00 8.00 Ó 00900 HOUSEKEEPI NG 1 006 1,006 390, 678 9 00 691, 225 9 00 10.00 01000 DI ETARY 2,581 2, 581 37, 591 0 942, 098 10.00 01100 CAFETERI A 11.00 1,708 1, 708 24, 875 0 430, 295 11.00 01300 NURSING ADMINISTRATION 1, 889, 709 2, 752, 492 13.00 491 491 13.00 532, 404 14.00 01400 CENTRAL SERVICES & SUPPLY 1.159 1, 159 56, 895 14 00 15.00 01500 PHARMACY 1,690 1,690 591,069 0 919, 341 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 95 95 412, 233 639, 607 16.00 01700 SOCIAL SERVICE 0 323 849, 577 17.00 17.00 323 517, 562 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 462 462 253, 238 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 45, 031 45, 031 7, 102, 500 0 12, 508, 719 30 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50 00  $\cap$ 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 356 356 135, 308 215, 464 54.00 0 60.00 06000 LABORATORY 543 543 377, 287 60.00 65.00 06500 RESPIRATORY THERAPY 512,068 716, 125 336 336 65.00 66.00 0 06600 PHYSI CAL THERAPY 7,661 7,661 2, 210, 684 3, 510, 907 66.00 06601 PHYSI CAL THERAPY - CARMEL 66.01 0 66.01 67.00 06700 OCCUPATIONAL THERAPY 6,553 6, 553 1, 890, 896 2, 860, 119 67.00 68.00 06800 SPEECH PATHOLOGY 3,747 3, 747 1, 176, 481 1, 750, 190 68.00 06801 VI SI ON 68.01 68.01 68.02 06802 FAC RESOURCE 0 C 0 0 68.02 06900 ELECTROCARDI OLOGY 0 0 69 00 C Ω 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 C 0 214, 703 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 308, 849 73.00 0 73.00 0 07400 RENAL DIALYSIS 0 0 0 74.00 Λ 74.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 C 0 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 3,595 3, 595 206, 725 0 385, 418 90.00 90.01 09001 SLEEP CENTER C 0 0 90.01 91.00 09100 EMERGENCY 0 C 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 00 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 0 0 99.00 09900 CMHC 0 0 0 99. 10 09910 CORF 0 0 0 0 99.10 0 102.00 10200 OPIOID TREATMENT PROGRAM 0 Ω O 0 0 102, 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) -8, 499, 688 107, 336 107, 336 21, 126, 183 35, 612, 241 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 736 736 515, 769 1, 108, 527 192. 00 194. 00 07950 FOUNDATI ON 0 1, 098, 501 194. 00 1, 496 1, 496 214, 182 194. 01 07951 PUBLIC RELATIONS 0 241, 236 194. 01 589 127, 182 589 194. 02 07952 ST. VINCENT - ARU 0 0 194. 02 C 194. 03 07953 MUNCIE - ARU 0 0 0 194. 03 C 0 194. 04 07954 RILEY - ARU 0 0 194, 04 C C 194. 05 07955 RETAIL PHARMACY 1, 549, 607 194. 05 0 C 221, 663 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 8, 499, 688 202. 00 6, 292, 108 202.00 Cost to be allocated (per Wkst. B, 1, 591, 914 759, 973 Part I) 0. 214584 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 14. 451319 6.898999 0.283365 204.00 Cost to be allocated (per Wkst. B, 56, 590 204. 00 25.343 Part II) 0.001141 0.001429 205.00 205.00 Unit cost multiplier (Wkst. B, Part II)NAHE adjustment amount to be allocated 206.00 206.00 (per Wkst. B-2)

| Health Financial Systems REH                                 | REHABILITATION HOSPITAL OF INDIANA |                              |   | In Lieu of Form CMS-2552-10 |  |         |  |
|--|------------------------------------|------------------------------|---|-----------------------------|--|---------|--|
| COST ALLOCATION - STATISTICAL BASIS                          |                                    | Provi der CC                 |   | Period:<br>From 01/01/2023  | Worksheet B-1                                  |         |  |
|  |                                    |                              |   | To 12/31/2023               |  |         |  |
|  | CAPITAL REL                        | ATED COSTS                   |   |                             |  |         |  |
| Cost Center Description                                      | BLDG & FIXT<br>(SQUARE FEET)       | MVBLE EQUIP<br>(SQUARE FEET) | EMPLOYEE<br>BENEFITS<br>DEPARTMENT<br>(GROSS<br>SALARIES) | Reconciliation              | ADMINISTRATIVE<br>AND GENERAL<br>(ACCUM. COST) |         |  |
|  | 1. 00                              | 2. 00                        | 4. 00   | 5A. 01                      | 5. 01  |         |  |
| 207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV) |                                    |                              |   |                             |  | 207. 00 |  |

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: From 01/01/2023 Provider CCN: 15-3028

|                  |  |                   |                         |                        | rom 01/01/2023<br>o 12/31/2023 | Date/Time Pre<br>5/30/2024 8:3 |                    |
|------------------|--|-------------------|-------------------------|------------------------|--------------------------------|--------------------------------|--------------------|
|                  | Cost Center Description  | Reconciliation    |                         | OPERATION OF           | LAUNDRY &                      | HOUSEKEEPI NG                  | 3 alli             |
|                  |  |                   | NON FOUNDATION          | PLANT<br>(SQUARE FEET) | LINEN SERVICE<br>(POUNDS OF    | (SQUARE FEET)                  |                    |
|                  |  | FA 02             | (ACCUM. COST)           | 7.00                   | LAUNDRY)                       | 0.00                           |                    |
|                  | GENERAL SERVICE COST CENTERS   | 5A. 02            | 5. 02                   | 7. 00                  | 8. 00                          | 9. 00                          |                    |
| 1.00             | 00100 CAP REL COSTS-BLDG & FIXT  |                   |                         |                        |                                |                                | 1.00               |
| 2.00             | 00200 CAP REL COSTS-MVBLE EQUIP  |                   |                         |                        |                                |                                | 2. 00              |
| 4.00             | 00400 EMPLOYEE BENEFITS DEPARTMENT   |                   |                         |                        |                                |                                | 4. 00              |
| 5. 01            | OO591   ADMINISTRATIVE AND GENERAL   OO590   OTHER A&G - NON FOUNDATION    | 1 (00 422         | 44 500 247              |                        |                                |                                | 5. 01              |
| 5. 02<br>7. 00   | 00700 OPERATION OF PLANT   | -1, 600, 433<br>0 |                         | 1                      |                                |                                | 5. 02<br>7. 00     |
| 8. 00            | 00800 LAUNDRY & LINEN SERVICE  | 0                 |                         | 1                      | 153, 181                       |                                | 8. 00              |
| 9.00             | 00900 HOUSEKEEPI NG  | 0                 | 839, 551                | 1                      |                                | 79, 152                        | 9. 00              |
| 10.00            | 01000 DI ETARY   | 0                 | , , , , , ,             | 1                      | 0                              | _, -,                          | 10. 00             |
| 11.00            | 01100 CAFETERI A   | 0                 | 522, 629                | 1                      | 0                              | 1, 708                         | 1                  |
| 13. 00<br>14. 00 | 01300   NURSI NG ADMI NI STRATI ON<br>  01400   CENTRAL SERVI CES & SUPPLY | 0                 | 3, 343, 133<br>646, 649 | l .                    | 0                              | 491<br>1, 159                  | 13. 00<br>14. 00   |
| 15. 00           | 01500 PHARMACY   |                   | 1, 116, 617             |                        |                                | 1, 690                         | 1                  |
| 16. 00           | 01600 MEDICAL RECORDS & LIBRARY  | 0                 | 776, 856                | 1                      |                                | 95                             | ı                  |
| 17. 00           | 01700 SOCIAL SERVICE   | 0                 | ,                       | 323                    | 0                              | 323                            | 17. 00             |
| 22. 00           | 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV                                | 0                 | 307, 579                | 462                    | 0                              | 462                            | 22. 00             |
| 30. 00           | I NPATI ENT ROUTI NE SERVI CE COST CENTERS  03000 ADULTS & PEDI ATRI CS    | 0                 | 15, 192, 882            | 45, 031                | 152, 295                       | 45, 031                        | 30.00              |
| 30.00            | ANCI LLARY SERVI CE COST CENTERS   |                   | 13, 172, 002            | 45, 051                | 132, 273                       | 45,031                         | 30.00              |
| 50.00            | 05000 OPERATI NG ROOM  | 0                 | 0                       | 0                      | 0                              | 0                              | 50.00              |
| 54.00            | 05400 RADI OLOGY-DI AGNOSTI C  | 0                 | 261, 699                | 356                    | 0                              | 356                            | 54.00              |
| 60.00            | 06000 LABORATORY   | 0                 | 458, 247                |                        |                                | 543                            | 1                  |
| 65. 00           | 06500 RESPI RATORY THERAPY   | 0                 | 869, 794                | ı                      |                                | 336                            | 1                  |
| 66. 00<br>66. 01 | 06600   PHYSI CAL THERAPY   06601   PHYSI CAL THERAPY   CARMEL             | 0                 | 4, 264, 291<br>0        | 1                      | 416<br>0                       | 1                              | 66. 00<br>66. 01   |
| 67. 00           | 06700 OCCUPATI ONAL THERAPY  |                   |                         | 1                      | _                              | 1                              | 1                  |
| 68. 00           | 06800 SPEECH PATHOLOGY   | 0                 |                         | 1                      | 211                            | 3, 747                         | 68. 00             |
| 68. 01           | 06801 VI SI 0N   | 0                 | 0                       | 0                      | 0                              | 0                              | 68. 01             |
| 68. 02           | 06802 FAC RESOURCE   | 0                 | 0                       | 0                      | 0                              | 0                              | 68. 02             |
| 69. 00<br>71. 00 | 06900  ELECTROCARDIOLOGY<br>  07100  MEDICAL SUPPLIES CHARGED TO PATIENT   | 0                 | 260, 775                | 0                      | 0                              | 0                              | 69. 00<br>71. 00   |
| 71.00            | 07200 IMPL. DEV. CHARGED TO PATIENTS                                       | 0                 | 200,773                 |                        | 0                              | 0                              | 72.00              |
| 73. 00           | 07300 DRUGS CHARGED TO PATIENTS  | 0                 | 1, 589, 707             | O                      | 0                              | 0                              | ı                  |
| 74. 00           | 07400 RENAL DIALYSIS   | 0                 | 1                       | •                      | 0                              | 0                              |                    |
| 77. 00           | 07700 ALLOGENEIC HSCT ACQUISITION  | 0                 | _                       | 0                      | 0                              | 0                              | 77. 00             |
| 78. 00           | 07800  CAR T-CELL IMMUNOTHERAPY<br>  OUTPATIENT SERVICE COST CENTERS       | 0                 | 0                       | 0                      | 0                              | 0                              | 78. 00             |
| 90. 00           | 09000 CLINIC   | 0                 | 468, 123                | 3, 595                 | 0                              | 3, 595                         | 90.00              |
| 90. 01           | 09001 SLEEP CENTER   | 0                 |                         | 1                      |                                | 0                              | 90. 01             |
| 91. 00           | 09100 EMERGENCY  | 0                 | 0                       | 0                      | 0                              | 0                              |                    |
| 92. 00           | 09200 OBSERVATION BEDS (NON-DISTINCT PART                                  |                   |                         |                        |                                |                                | 92.00              |
| 99 00            | OTHER REIMBURSABLE COST CENTERS O9900 CMHC                                 | 0                 | 0                       | 0                      | 0                              | 0                              | 99. 00             |
|                  | 09910 CORF   | 0                 |                         |                        |                                | l                              |                    |
| 102.00           | 10200 OPIOID TREATMENT PROGRAM   | 0                 | 0                       | 0                      | 0                              | 0                              | 102. 00            |
|                  | SPECIAL PURPOSE COST CENTERS   |                   |                         |                        |                                |                                |                    |
| 118. 00          | SUBTOTALS (SUM OF LINES 1 through 117)<br>  NONREIMBURSABLE COST CENTERS   | -1, 600, 433      | 41, 653, 617            | 77, 337                | 153, 181                       | 76, 331                        | 118. 00            |
| 190.00           | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN                                    | 0                 | 0                       | 0                      | 0                              | 0                              | 190. 00            |
|                  | 19200 PHYSI CI ANS PRI VATE OFFI CES                                       | 0                 | l .                     |                        |                                |                                | 192. 00            |
|                  | 07950 FOUNDATI ON  | 0                 | ,                       | 1                      |                                |                                | 194. 00            |
|                  | 07951 PUBLIC RELATIONS   | 0                 | 293, 001                | 589                    | 0                              |                                | 194. 01            |
|                  | 07952  ST. VINCENT - ARU<br>  07953  MUNCIE - ARU                          | 0                 | 0                       |                        | 0                              | <b>l</b>                       | 194. 02<br>194. 03 |
|                  | 07954 RI LEY - ARU   |                   | 0                       |                        | 0                              | <b>l</b>                       | 194. 03            |
|                  | 07955 RETAIL PHARMACY  | 0                 |                         | Ö                      | 0                              | <b>l</b>                       | 194. 05            |
| 200.00           | Cross Foot Adjustments   |                   |                         |                        |                                |                                | 200. 00            |
| 201.00           |  |                   |                         |                        |                                |                                | 201. 00            |
| 202.00           |  |                   | 1, 600, 433             | 2, 931, 658            | 129, 512                       | 905, 234                       | 202. 00            |
| 203. 00          | Part I)<br>  Unit cost multiplier (Wkst. B, Part I)                        |                   | 0. 034411               | 36. 573492             | 0. 845483                      | 11. 436654                     | 203. 00            |
| 204.00           |  |                   | 38, 307                 | 1                      |                                |                                | 204. 00            |
|                  | Part II)   |                   |                         |                        |                                |                                |                    |
| 205.00           |  |                   | 0. 000824               | 6. 641021              | 0. 001632                      | 0. 382618                      | 205. 00            |
| 206.00           |  | 1                 |                         |                        |                                |                                | 206. 00            |
|                  | (per Wkst. B-2)  |                   |                         |                        |                                |                                |                    |
| 207.00           |  |                   |                         |                        |                                |                                | 207. 00            |
|                  | Parts III and IV)  | 1                 | I                       | I                      | I                              | I                              | I                  |

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3028 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 8:35 am Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** (MEALS SERVED) (HOURS PALD) ADMI NI STRATI ON SERVICES & (COSTED SUPPLY REQUIS.) (DIRECT NRSING (COSTED REQUIS.) HRS) 10.00 11.00 13.00 14.00 15.00 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 56. 439 10 00 10 00 11.00 01100 CAFETERI A 454, 172 11.00 13.00 01300 NURSING ADMINISTRATION 0 55, 855 216, 040 13.00 01400 CENTRAL SERVICES & SUPPLY 0 14.00 3, 181 449, 268 14.00 100 01500 PHARMACY 18, 249 18 249 15 00 5, 740 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 13, 534 13, 534 0 0 16.00 01700 SOCIAL SERVICE 0 17.00 11, 515 888 0 17.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22 00 0 22 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 56, 439 167, 455 167, 455 116, 860 0 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM n 50 00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 394 3, 394 2, 580 0 54.00 06000 LABORATORY 0 6, 982 60.00 60.00 0 65.00 06500 RESPIRATORY THERAPY 0000000000000 13, 408 13, 408 74.136 0 65.00 06600 PHYSI CAL THERAPY 66.00 57, 155 C 4, 960 0 66.00 66. 01 06601 PHYSICAL THERAPY - CARMEL 0 0 66.01 06700 OCCUPATIONAL THERAPY 45, 045 6, 473 67.00 0 0 67.00 06800 SPEECH PATHOLOGY 68.00 28, 955 0 6,574 0 68.00 0 06801 VI SI ON 68.01 C 0 0 68.01 06802 FAC RESOURCE 0 0 0 68.02 68.02 C 06900 ELECTROCARDI OLOGY 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 0 214, 703 0 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72 00 C 0 Λ 72 00 07300 DRUGS CHARGED TO PATIENTS 100 73.00 0 74.00 07400 RENAL DIALYSIS C 0 0 74.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 C 0 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 3, 314 0 90.00 7. 428 90.01 09001 SLEEP CENTER 0 0 90.01 C Λ 91.00 09100 EMERGENCY 0 C 0 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 0 0 0 0 99. 10 09910 CORF 0 0 99. 10 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 56, 439 432, 156 216, 040 436, 228 100 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GLFT FLOWER COFFEE SHOP & CANTEEN 0 190, 00 0 0 0 192.00 192.00 19200 PHYSICIANS PRIVATE OFFICES 13, 674 10, 534 194. 00 07950 FOUNDATION 0 4,089 0 1,724 0 194.00 194. 01 07951 PUBLIC RELATIONS 0 194. 01 0 0 4, 253 0 782 194. 02 07952 ST. VINCENT - ARU 194. 03 07953 MUNCIE - ARU 0 0 194.02 C 0 0 C 0 0 194, 03 194. 04 07954 RILEY - ARU 0 0 0 0 194. 04 194. 05 07955 RETAIL PHARMACY 0 0 0 0 194. 05 C 200 00 Cross Foot Adjustments 200 00 201.00 Negative Cost Centers 201.00 1, 307, 546 622, 615 3, 558, 317 728, 906 1, 571, 081 202. 00 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 1. 370879 16. 470640 1. 622430 15, 710. 810000 203. 00 23. 167420 204.00 Cost to be allocated (per Wkst. B, 75, 565 49, 537 28, 868 34, 591 55, 730 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 1. 338879 0.109071 0.133623 0.076994 557. 300000 205. 00 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)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS REHABILITATION HOSPITAL OF INDIANA

Provider CCN: 15-3028

Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: Worksheet B-1

|  |  |  |  | 5/30/2024 8: |  |
|--|--|--|--|--------------|--|
| Cost Center Description  | MEDICAL<br>RECORDS &<br>LIBRARY<br>(TOTAL PATI<br>ENT DAYS)<br>16.00 | SOCIAL SERVICE  (TOTAL PATI ENT DAYS)  17.00 | INTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV (ASSI GNED TI ME) 22. 00 |              |  |
| GENERAL SERVICE COST CENTERS   |  |  |  |              |  |
| 1. 00  | 100<br>0   | 100<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>17. 00<br>22. 00 |
| INPATIENT ROUTINE SERVICE COST CENTERS   | 1  |  |  |              |  |
| 30. 00 03000 ADULTS & PEDIATRICS ANCI LLARY SERVICE COST CENTERS   | 100  | 100  | 100  |              | 30.00  |
| 50. 00   05000   OPERATI NG ROOM   54. 00   05400   RADI OLOGY - DI AGNOSTI C   60. 00   06000   LABORATORY   65. 00   06500   RESPI RATORY THERAPY   66. 01   06601   PHYSI CAL THERAPY - CARMEL   67. 00   06700   OCCUPATI ONAL THERAPY   68. 00   06800   SPEECH PATHOLOGY   68. 01   06801   VI SI ON   68. 02   06802   FAC RESOURCE   OST CENTERS   CENTERS | 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              | 1  |              | 50. 00<br>54. 00<br>60. 00<br>65. 00<br>66. 00<br>66. 01<br>67. 00<br>68. 00<br>68. 01<br>68. 02   |
| 69. 00 06900 ELECTROCARDIOLOGY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 00TPATIENT SERVICE COST CENTERS  | 0<br>0<br>0<br>0<br>0<br>0   | 0<br>0<br>0<br>0<br>0<br>0                   | 000000000000000000000000000000000000000  |              | 69. 00<br>71. 00<br>72. 00<br>73. 00<br>74. 00<br>77. 00<br>78. 00   |
| 90. 00 09000 CLI NI C  | 0  | 0  | 0  |              | 90.00  |
| 90. 01   09001   SLEEP CENTER<br>91. 00   09100   EMERGENCY<br>92. 00   09200   OBSERVATION   BEDS   (NON-DISTINCT   PART<br>  OTHER   REIMBURSABLE   COST   CENTERS   | 0  | 0  | 0  |              | 90. 01<br>91. 00<br>92. 00   |
| 99. 00 09900 CMHC  | 0  | 0  | 0  |              | 99. 00   |
| 99. 10   09910   CORF<br>102. 00   10200   OPI 0I D TREATMENT PROGRAM<br>  SPECIAL PURPOSE COST CENTERS  | 0  | 0  | 1  |              | 99. 10<br>102. 00  |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)  | 100  | 100  | 100  |              | 118. 00  |
| NONREI MBURSABLE COST CENTERS  190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN  192. 00 19200 PHYSICIANS PRIVATE OFFICES  194. 00 07950 FOUNDATION   | 0 0  | 0 0  | 0 0  |              | 190. 00<br>192. 00<br>194. 00  |
| 194. 01 07951 PUBLI C RELATI ONS   | 0  | 0  | 0  |              | 194. 01<br>194. 02   |
| 194. 02 07952 ST. VI NCENT - ARU<br>194. 03 07953 MUNCI E - ARU  | 0  | 0  | 0  |              | 194. 02  |
| 194. 04 07954 RI LEY - ARU   | 0  | 0  | 0  |              | 194. 04  |
| 194.05 07955 RETAIL PHARMACY<br>200.00  Cross Foot Adjustments   | 0  | 0  | 0  |              | 194. 05<br>200. 00   |
| 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I)   | 1, 049, 615  | 1, 100, 125                                  | 340, 344   |              | 201. 00  |
| 203.00 Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)  | 10, 496. 150000<br>8, 003  | 11, 001. 250000<br>13, 144                   |  |              | 203. 00<br>204. 00   |
| Part II) Unit cost multiplier (Wkst. B, Part   | 80. 030000   | 131. 440000                                  | 137. 240000  |              | 205. 00  |
| 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)  |  |  |  |              | 206. 00  |

| Health Financial Systems REH                                 | IABILITATION HOS | PITAL OF INDIA | In Lieu of Form CMS-2552-10 |                             |                                |         |
|--|------------------|----------------|-----------------------------|-----------------------------|--------------------------------|---------|
| COST ALLOCATION - STATISTICAL BASIS                          |                  | Provi der Co   |                             | Peri od:<br>From 01/01/2023 | Worksheet B-1                  |         |
|  | _                |                |                             | To 12/31/2023               | Date/Time Pre<br>5/30/2024 8:3 |         |
|  |                  |                | INTERNS &                   |                             |                                |         |
|  |                  |                | RESI DENTS                  |                             |                                |         |
| Cost Center Description                                      | MEDI CAL         | SOCIAL SERVICE | SERVI CES-OTHE              | ER .                        |                                |         |
|  | RECORDS &        |                | PRGM COSTS                  |                             |                                |         |
|  | LI BRARY         | (TOTAL PATI    | APPRV                       |                             |                                |         |
|  | (TOTAL PATI      | ENT DAYS)      | (ASSI GNED                  |                             |                                |         |
|  | ENT DAYS)        | ŕ              | TIME)                       |                             |                                |         |
|  | 16.00            | 17. 00         | 22. 00                      |                             |                                |         |
| 207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV) |                  |                |                             |                             |                                | 207. 00 |

| Health Financial Systems REH.            | ABILITATION HOS              | In Lie                | u of Form CMS-2 | 2552-10  |             |                |
|--|------------------------------|-----------------------|-----------------|--|-------------|----------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES |                              |                       |                 | Period: Worksheet C<br>From 01/01/2023 Part I<br>To 12/31/2023 Date/Time Pro<br>5/30/2024 8: |             | pared:<br>5 am |
|  |                              | Title                 | XVIII           | Hospi tal  | PPS         |                |
|  |                              |                       |                 | Costs  |             |                |
| Cost Center Description                  | Total Cost<br>(from Wkst. B, | Therapy Limit<br>Adj. | Total Costs     | RCE<br>Di sal I owance   | Total Costs |                |

|             |  |                |               |              |                 | 5/30/2024 8:3 | <u>s am</u> |
|-------------|--|----------------|---------------|--------------|-----------------|---------------|-------------|
|             |  |                | Title         | XVIII        | Hospi tal       | PPS           |             |
|             | ·                                      |                |               |              | Costs           |               |             |
|             | Cost Center Description                | Total Cost     | Therapy Limit | Total Costs  | RCE             | Total Costs   |             |
|             | ·                                      | (from Wkst. B, | Adj.          |              | Di sal I owance |               |             |
|             |  | Part I, col.   |               |              |                 |               |             |
|             |  | 26)            |               |              |                 |               |             |
|             |  | 1.00           | 2.00          | 3.00         | 4. 00           | 5. 00         |             |
| I NPA       | TIENT ROUTINE SERVICE COST CENTERS     |                |               |              |                 |               |             |
| 30.00 0300  | 00 ADULTS & PEDIATRICS                 | 24, 640, 928   |               | 24, 640, 928 | 0               | 24, 640, 928  | 30. 00      |
| ANCI        | LLARY SERVICE COST CENTERS             |                |               |              |                 |               |             |
| 50.00 0500  | OO OPERATING ROOM                      | 0              |               | 0            | 0               | 0             | 50.00       |
| 54. 00 0540 | OO RADI OLOGY-DI AGNOSTI C             | 352, 535       |               | 352, 535     | 0               | 352, 535      | 54.00       |
| 60.00 0600  | OO LABORATORY                          | 509, 656       |               | 509, 656     | 0               | 509, 656      | 60.00       |
| 65. 00 0650 | OO RESPI RATORY THERAPY                | 1, 275, 355    | 0             | 1, 275, 355  | 0               | 1, 275, 355   | 65. 00      |
| 66.00 0660  | OO PHYSI CAL THERAPY                   | 4, 865, 588    | 0             | 4, 865, 588  | 0               | 4, 865, 588   | 66. 00      |
| 66. 01 0660 | 01 PHYSICAL THERAPY - CARMEL           | 0              | 0             | 0            | 0               | 0             | 66. 01      |
| 67.00 0670  | OO OCCUPATI ONAL THERAPY               | 3, 980, 476    | 0             | 3, 980, 476  | 0               | 3, 980, 476   | 67. 00      |
| 68. 00 0680 | OO SPEECH PATHOLOGY                    | 2, 429, 334    | 0             | 2, 429, 334  | 0               | 2, 429, 334   | 68. 00      |
| 68. 01 0680 | O1 VISION                              | 0              | 0             | 0            | 0               | 0             | 68. 01      |
| 68. 02 0680 | 2 FAC RESOURCE                         | 0              | 0             | 0            | 0               | 0             | 68. 02      |
| 69.00 0690  | 00 ELECTROCARDI OLOGY                  | 0              |               | 0            | 0               | 0             | 69. 00      |
| 71.00 0710  | MEDICAL SUPPLIES CHARGED TO PATIENT    | 618, 089       |               | 618, 089     | 0               | 618, 089      | 71. 00      |
| 72.00 0720  | OO IMPL. DEV. CHARGED TO PATIENTS      | 0              |               | 0            | 0               | 0             | 72. 00      |
| 73.00 0730  | DO DRUGS CHARGED TO PATIENTS           | 3, 215, 491    |               | 3, 215, 491  | 0               | 3, 215, 491   | 73. 00      |
| 74.00 0740  | OO RENAL DIALYSIS                      | 0              |               | 0            | 0               | 0             | 74. 00      |
| 77.00 0770  | OO ALLOGENEIC HSCT ACQUISITION         | 0              |               | 0            | 0               | 0             | 77. 00      |
| 78. 00 0780 | OO CAR T-CELL IMMUNOTHERAPY            | 0              |               | 0            | 0               | 0             | 78. 00      |
| OUTP        | PATIENT SERVICE COST CENTERS           |                |               |              |                 |               |             |
| 90. 00 0900 | OO CLI NI C                            | 672, 389       |               | 672, 389     | 0               | 672, 389      | 90.00       |
| 90. 01 0900 | 01 SLEEP CENTER                        | 0              |               | 0            | 0               | 0             | 90. 01      |
| 91.00 0910  | OO EMERGENCY                           | 0              |               | 0            | 0               | 0             | 91.00       |
| 92. 00 0920 | OO OBSERVATION BEDS (NON-DISTINCT PART | 0              |               | 0            |                 | 0             | 92.00       |
|             | R REIMBURSABLE COST CENTERS            |                |               |              |                 |               |             |
| 99. 00 0990 |  | 0              |               | 0            |                 | 0             | 99. 00      |
| 99. 10 0991 |  | 0              |               | 0            |                 | 0             | 1           |
|             | OO OPLOLD TREATMENT PROGRAM            | 0              |               | 0            |                 | 0             | 102.00      |
| 200.00      | Subtotal (see instructions)            | 42, 559, 841   | 0             | 42, 559, 841 | 0               | 42, 559, 841  |             |
| 201.00      | Less Observation Beds                  | 0              |               | 0            |                 |               | 201. 00     |
| 202.00      | Total (see instructions)               | 42, 559, 841   | 0             | 42, 559, 841 | 0               |               |             |
| · ·         |  |                |               |              | 1               |               |             |

| Heal th | Financial Systems REH                     | ABILITATION HOSE | <u> ITAL OF INDIA</u> | NA           | In Lie          | u of Form CMS-2       | <u> 2552-10</u> |
|---------|---|------------------|-----------------------|--------------|-----------------|-----------------------|-----------------|
| COMPUT  | ATION OF RATIO OF COSTS TO CHARGES        |                  | Provi der CC          |              | Peri od:        | Worksheet C           |                 |
|         |   |                  |                       |              | From 01/01/2023 | Part I                |                 |
|         |   |                  |                       |              | To 12/31/2023   | Date/Time Pre         | pared:          |
|         |   |                  | Title                 | VVIII        | Hospi tal       | 5/30/2024 8: 3<br>PPS | 5 am            |
|         |   |                  | Charges               | AVIII        | поѕрітаі        | PPS                   |                 |
|         | Coot Conton Doppnintion                   | Innotiont        |                       | Total (ool ) | Cost on Other   | TEFRA                 |                 |
|         | Cost Center Description                   | I npati ent      | Outpati ent           |              | Cost or Other   |                       |                 |
|         |   |                  |                       | + col. 7)    | Ratio           | Inpatient             |                 |
|         |   | 6.00             | 7. 00                 | 8. 00        | 9. 00           | Rati o<br>10. 00      |                 |
|         | INPATIENT ROUTINE SERVICE COST CENTERS    | 6.00             | 7.00                  | 8.00         | 9.00            | 10.00                 |                 |
| 30. 00  | 03000 ADULTS & PEDIATRICS                 | 47, 010, 303     |                       | 47, 010, 30  | 2               |                       | 30.00           |
| 30.00   | ANCILLARY SERVICE COST CENTERS            | 47,010,303       |                       | 47,010,30    | ار              |                       | 30.00           |
| 50. 00  | 05000 OPERATING ROOM                      |                  | 0                     |              | 0. 000000       | 0. 000000             | 50.00           |
|         | 05400 RADI OLOGY-DI AGNOSTI C             | 2 221 751        | 12 110                | 2 242 04     |                 | 0.000000              | 1               |
| 54. 00  |   | 2, 331, 751      | 12, 110               | 2, 343, 86   |                 |                       |                 |
| 60.00   | 06000 LABORATORY                          | 1, 772, 571      | 0                     | 1, 772, 57   |                 | 0.000000              |                 |
| 65.00   | 06500 RESPIRATORY THERAPY                 | 3, 387, 692      | 204                   | 3, 387, 89   |                 | 0.000000              |                 |
| 66. 00  | 06600 PHYSI CAL THERAPY                   | 14, 211, 127     | 7, 430, 949           | 21, 642, 07  |                 | 0. 000000             |                 |
| 66. 01  | 06601 PHYSI CAL THERAPY - CARMEL          | 0                | 0                     |              | 0. 000000       | 0. 000000             |                 |
| 67. 00  | 06700 OCCUPATI ONAL THERAPY               | 14, 750, 518     | 3, 761, 822           | 18, 512, 34  |                 | 0. 000000             |                 |
| 68. 00  | 06800 SPEECH PATHOLOGY                    | 7, 696, 343      | 2, 889, 342           | 10, 585, 68  |                 | 0. 000000             |                 |
| 68. 01  | 06801 VI SI ON                            | 0                | 0                     |              | 0. 000000       | 0.000000              |                 |
| 68. 02  | 06802 FAC RESOURCE                        | 0                | 0                     |              | 0. 000000       | 0.000000              |                 |
| 69. 00  | 06900 ELECTROCARDI OLOGY                  | 0                | 0                     |              | 0. 000000       | 0.000000              |                 |
| 71. 00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 2, 149, 777      | 84, 456               | 2, 234, 23   |                 | 0.000000              |                 |
| 72.00   | 07200 I MPL. DEV. CHARGED TO PATIENTS     | 0                | 0                     |              | 0. 000000       | 0.000000              |                 |
| 73.00   | 07300 DRUGS CHARGED TO PATIENTS           | 8, 757, 254      | 4, 679, 277           | 13, 436, 53  | 1 0. 239310     | 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          |
| 78.00   | 07800 CAR T-CELL IMMUNOTHERAPY            | 0                | 0                     |              | 0. 000000       | 0.000000              | 78. 00          |
|         | OUTPATIENT SERVICE COST CENTERS           |                  |                       |              |                 |                       |                 |
| 90.00   | 09000 CLI NI C                            | 0                | 1, 939, 905           | 1, 939, 90   | 5 0. 346609     | 0.000000              | 90.00           |
| 90. 01  | 09001 SLEEP CENTER                        | 0                | 0                     |              | 0. 000000       | 0.000000              | 90. 01          |
| 91.00   | 09100 EMERGENCY                           | O                | 0                     |              | 0. 000000       | 0.000000              | 91.00           |
| 92.00   | 09200 OBSERVATION BEDS (NON-DISTINCT PART | o                | 0                     |              | 0. 000000       | 0.000000              | 92.00           |
|         | OTHER REIMBURSABLE COST CENTERS           | <u>'</u>         |                       |              |                 |                       | 1               |
| 99.00   | 09900 CMHC                                | 0                | 0                     |              | 0               |                       | 99. 00          |
| 99. 10  | 09910 CORF                                | ol               | 0                     |              | o               |                       | 99. 10          |
|         | 10200 OPI OI D TREATMENT PROGRAM          | 0                | 0                     |              | 0               |                       | 102. 00         |
| 200.00  |   | 102, 067, 336    | 20, 798, 065          | 122, 865, 40 | 1               |                       | 200.00          |
| 201.00  |   | .52,557,550      | 25, 5, 000            | .22,000,10   |                 |                       | 201. 00         |
| 202.00  |   | 102, 067, 336    | 20, 798, 065          | 122, 865, 40 | 1               |                       | 202. 00         |
| 202.00  | 1 1 1 2 1 2 1 1 2 2 2 2 2 2 2 2 2 2 2 2   |                  | 20, 0, 000            | .22, 333, 10 | -1              |                       | 1-32. 33        |

| Title XVIII   Hospital   PPS   Total   Total   Hospital   PPS   Total   Hospital   PPS   Total   |   |           |             | 10 12/01/2020 | 5/30/2024 8: 35 am |
|--|---|-----------|-------------|---------------|--------------------|
| NPATIENT ROUTINE SERVICE COST CENTERS   11.00  |   |           | Title XVIII | Hospi tal     | PPS                |
| INPATI ENT ROUTI NE SERVI CE COST CENTERS   30.00   03000   ADULTS & PEDI ATRI CS  | Cost Center Description                         |           |             |               |                    |
| INPATI ENT ROUTH NE SERVICE COST CENTERS   30.00   |   | Ratio     |             |               |                    |
| 30.00  |   | 11.00     |             |               |                    |
| ANCILLARY SERVICE COST CENTERS   |   |           |             |               |                    |
| 50. 00   05000   OPERATI NG ROOM   0. 000000   50. 00  |   |           |             |               | 30.00              |
| 54. 00   |   |           |             |               |                    |
| 60. 00   06000   LABORATORY   0. 287524   66. 00   06500   RESPI RATORY THERAPY   0. 376445   66. 00   06500   RESPI RATORY THERAPY   0. 224821   66. 00   06600   PHYSI CAL THERAPY   0. 224821   66. 00   06601   PHYSI CAL THERAPY   0. 224821   66. 00   06601   PHYSI CAL THERAPY   0. 215017   67. 00   06700   0CCUPATI ONAL THERAPY   0. 215017   68. 00   06800   SPEECH PATHOLOGY   0. 229492   68. 00   06800   SPEECH PATHOLOGY   0. 229492   68. 00   06800   SPEECH PATHOLOGY   0. 200000   68. 01   06801   VI SI ON   0. 000000   68. 01   06801   VI SI ON   0. 000000   69. 00   06900   ELECTROCARDI OLOGY   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000   |   |           |             |               |                    |
| 65. 00   06500   RESPIRATORY THERAPY   0. 376445   66. 00   06600   PHYSI CAL THERAPY   0. 224821   66. 00   06600   PHYSI CAL THERAPY   0. 224821   66. 01   06601   PHYSI CAL THERAPY   0. 200000   66. 01   06601   PHYSI CAL THERAPY   0. 215017   67. 00   06700   0CCUPATI ONAL THERAPY   0. 215017   67. 00   08800   SPEECH PATHOLOGY   0. 229492   68. 00   08800   SPEECH PATHOLOGY   0. 2000000   68. 01   08801   VISI ON   0. 0000000   68. 01   08801   VISI ON   0. 0000000   68. 02   69. 00   06900   ELECTROCARDI OLOGY   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000  |   | 1         |             |               |                    |
| 66. 00   |   | 0. 287524 |             |               | 60.00              |
| 66. 01 06601 PHYSI CAL THERAPY - CARMEL 0. 000000 67.0 0 0CCUPATI ONAL THERAPY 0. 215017 67. 00 68.0 0 0CCUPATI ONAL THERAPY 0. 215017 67. 00 68.0 0 06800 SPECCH PATHOLOGY 0. 0. 229492 68. 01 06801 VI SI ON 0. 000000 68. 01 068. 01 06801 VI SI ON 0. 000000 68. 01 068. 01 06802 FAC RESOURCE 0. 000000 68. 01 07. 00 06900 ELECTROCARDI OLOGY 0. 000000 68. 02 06900 ELECTROCARDI OLOGY 0. 000000 69. 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 276645 71. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 000000 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 239310 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 239310 72. 00 07400 RENAL DI ALYSI S 0. 000000 77. 00 07400 RENAL DI ALYSI S 0. 000000 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0. 000000 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0. 000000 77. 00 07000 CAR T-CELL IMMUNOTHERAPY 0. 0000000 77. 00 00000 CLI NI C 0. 000000 00000 00000 00000 00000 00000 0000   |   | 0. 376445 |             |               | 65. 00             |
| 67. 00   06700   OCCUPATI ONAL THERAPY   0. 215017   68. 00   68. 00   O6800   SPEECH PATHOLOGY   0. 229492   68. 00   68. 00   O6800   VI SI ON   0. 000000   68. 01   O6800   VI SI ON   0. 000000   68. 01   O6800   ELECTROCARDI OLOGY   0. 000000   69. 00   O6900   ELECTROCARDI OLOGY   0. 000000   69. 00   O7100   MEDI CAB SUPPLIES CHARGED TO PATIENT   0. 276645   71. 00   O7100   MEDI CAB SUPPLIES CHARGED TO PATIENTS   0. 000000   72. 00   O7300   DRUGS CHARGED TO PATIENTS   0. 000000   73. 00   O7400   RENAL DIALYSIS   0. 0000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000    |   | 0. 224821 |             |               |                    |
| 68. 00   | 66. 01   06601   PHYSI CAL THERAPY - CARMEL     | 0. 000000 |             |               | 66. 01             |
| 68. 01   | 67. 00 06700 OCCUPATI ONAL THERAPY              | 0. 215017 |             |               | 67. 00             |
| 68. 02   06802   FAC RESOURCE   0.000000   68. 02  | 68. 00 06800 SPEECH PATHOLOGY                   | 0. 229492 |             |               | 68. 00             |
| 69. 00   | 68. 01   06801   VI SI ON                       | 0. 000000 |             |               | 68. 01             |
| 71. 00   | 68. 02   06802   FAC   RESOURCE                 | 0. 000000 |             |               | 68. 02             |
| 72. 00   | 69. 00 06900 ELECTROCARDI OLOGY                 | 0. 000000 |             |               | 69. 00             |
| 73. 00   | 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 276645 |             |               | 71. 00             |
| 74. 00   | 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS      | 0. 000000 |             |               | 72. 00             |
| 77. 00   07700   ALLOGENEI C HSCT ACQUI SITION   0.000000   77.00   78.00   07800   CAR T-CELL IMMUNOTHERAPY   0.000000   78.00   000000   000000   000000   000000   000000   | 73.00 07300 DRUGS CHARGED TO PATIENTS           | 0. 239310 |             |               | 73. 00             |
| 78. 00   | 74. 00   07400   RENAL DI ALYSI S               | 0.000000  |             |               | 74. 00             |
| OUTPATIENT SERVICE COST CENTERS   O  | 77.00 07700 ALLOGENEIC HSCT ACQUISITION         | 0. 000000 |             |               | 77. 00             |
| 90. 00   09000   CLINI C   0. 346609   90. 00   90. 01   91. 00   99. 01   91. 00   91. 00   92. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART   0. 000000   92. 00   0THER REIMBURSABLE COST CENTERS   99. 00   09900   CMHC   99. 10   09910   CORF   99. 10   00910   CORF   99. 10   00900   CORF   99. 10   000000   000000   000000   000000   000000  |   | 0. 000000 |             |               | 78. 00             |
| 90. 01   09001   SLEEP CENTER   0. 000000   91. 00   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STINCT PART   0. 0000000   92. 00   OTHER REI MBURSABLE COST CENTERS   99. 00   09900   CMRC   99. 10   09910   CORF   99. 10   102. 00   10200   OPI OI D TREATMENT PROGRAM   102. 00   10200   OPI OI D TREATMENT PROGRAM   200. 00   Subtotal (see instructions)   Less Observation Beds   201. 00   | OUTPATIENT SERVICE COST CENTERS                 |           |             |               |                    |
| 91. 00   09100   EMERGENCY   0. 000000   92. 00   09200   OBSERVATI ON BEDS (NON-DI STINCT PART   0. 0000000   92. 00   07400  | 90. 00   09000   CLI NI C                       | 0. 346609 |             |               | 90.00              |
| 92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   0.000000   92.00   OTHER REIMBURSABLE COST CENTERS   99.00   09910   CMHC   99.10   09910   CORF   99.10   10200   OPI OI D TREATMENT PROGRAM   99.10   200.00   Subtotal (see instructions)   Less Observation Beds   201.00   20 | 90. 01   09001   SLEEP CENTER                   | 0. 000000 |             |               | 90. 01             |
| OTHER REIMBURSABLE COST CENTERS   99.00   09900   CMHC   99.10   09910   CORF   99.10   102.00   10200   OPI OI D TREATMENT PROGRAM   102.00   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00   | 91. 00   09100   EMERGENCY                      | 0. 000000 |             |               | 91.00              |
| 99. 00   09900   CMHC   99. 00   09910   CORF   99. 10   102.00   10200   OPI OI D TREATMENT PROGRAM   102. 00   200. 00   Subtotal (see instructions)   Less Observation Beds   201. 00   | 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0. 000000 |             |               | 92. 00             |
| 99. 10   09910   CORF   99. 10   10200   OPI OI D TREATMENT PROGRAM   102. 00   200. 00   Subtotal (see instructions)   Less Observation Beds   201. 00  | OTHER REIMBURSABLE COST CENTERS                 |           |             |               |                    |
| 102. 00   10200   OPI 0I D TREATMENT PROGRAM   102. 00   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00   |   |           |             |               | 99. 00             |
| 200.00       Subtotal (see instructions)       200.00         201.00       Less Observation Beds       201.00  |   |           |             |               |                    |
| 201. 00 Less Observation Beds 201. 00  | 102.00 10200 OPIOID TREATMENT PROGRAM           |           |             |               | 102. 00            |
|  | 200.00 Subtotal (see instructions)              |           |             |               | 200. 00            |
| 202.00   Total (see instructions)   202.00   | 201.00 Less Observation Beds                    |           |             |               | 201. 00            |
|  | 202.00 Total (see instructions)                 |           |             |               | 202. 00            |

| Health Financial Systems RE              | SPITAL OF INDIA              | TAL OF INDIANA In Lie |                       |                        | 2552-10   |  |
|--|------------------------------|-----------------------|-----------------------|------------------------|---|--|
| COMPUTATION OF RATIO OF COSTS TO CHARGES |                              | Provider CO           | Provider CCN: 15-3028 |                        | Worksheet C<br>Part I<br>Date/Time Pre<br>5/30/2024 8:3 |  |
|  |                              | Ti tl                 | e XIX                 | Hospi tal              | PPS   |  |
|  |                              | ·                     |                       | Costs                  |   |  |
| Cost Center Description                  | Total Cost<br>(from Wkst. B, | Therapy Limit Adj.    | Total Costs           | RCE<br>Di sal I owance | Total Costs   |  |

|        |   |                | Titl          | e XIX        | Hospi tal       | PPS          |         |
|--------|---|----------------|---------------|--------------|-----------------|--------------|---------|
|        | ·   |                |               |              | Costs           |              |         |
|        | Cost Center Description                   | Total Cost     | Therapy Limit | Total Costs  | RCE             | Total Costs  |         |
|        |   | (from Wkst. B, | Adj .         |              | Di sal I owance |              |         |
|        |   | Part I, col.   |               |              |                 |              |         |
|        |   | 26)            |               |              |                 |              |         |
|        |   | 1.00           | 2. 00         | 3. 00        | 4. 00           | 5. 00        |         |
|        | INPATIENT ROUTINE SERVICE COST CENTERS    |                |               |              |                 |              |         |
| 30.00  | 03000 ADULTS & PEDIATRICS                 | 24, 640, 928   |               | 24, 640, 928 | 0               | 24, 640, 928 | 30. 00  |
|        | ANCILLARY SERVICE COST CENTERS            |                |               |              |                 |              |         |
| 50.00  | 05000 OPERATING ROOM                      | 0              |               | 0            | 0               | 0            |         |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C             | 352, 535       |               | 352, 535     | 0               | 352, 535     | 54.00   |
| 60.00  | 06000 LABORATORY                          | 509, 656       |               | 509, 656     | 0               | 509, 656     | 60.00   |
| 65.00  | 06500 RESPIRATORY THERAPY                 | 1, 275, 355    | 0             | 1, 275, 355  | 0               | 1, 275, 355  | 65.00   |
| 66.00  | 06600 PHYSI CAL THERAPY                   | 4, 865, 588    | 0             | 4, 865, 588  | 0               | 4, 865, 588  | 66. 00  |
| 66. 01 | 06601 PHYSI CAL THERAPY - CARMEL          | 0              | 0             | 0            | 0               | 0            | 66. 01  |
| 67.00  | 06700 OCCUPATIONAL THERAPY                | 3, 980, 476    | 0             | 3, 980, 476  | 0               | 3, 980, 476  | 67.00   |
| 68.00  | 06800 SPEECH PATHOLOGY                    | 2, 429, 334    | 0             | 2, 429, 334  | 0               | 2, 429, 334  | 68. 00  |
| 68. 01 | 06801 VI SI ON                            | 0              | 0             | 0            | 0               | 0            | 68. 01  |
| 68. 02 | 06802 FAC RESOURCE                        | 0              | 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 | 618, 089       |               | 618, 089     | 0               | 618, 089     | 71. 00  |
| 72.00  | 07200 IMPL. DEV. CHARGED TO PATIENTS      | 0              |               | 0            | 0               | 0            | 72. 00  |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS           | 3, 215, 491    |               | 3, 215, 491  | 0               | 3, 215, 491  | 73. 00  |
| 74.00  | 07400 RENAL DIALYSIS                      | 0              |               | 0            | 0               | 0            | 74. 00  |
| 77. 00 | 07700 ALLOGENEIC HSCT ACQUISITION         | 0              |               | 0            | 0               | 0            | 77. 00  |
| 78.00  | 07800 CAR T-CELL IMMUNOTHERAPY            | 0              |               | 0            | 0               | 0            | 78. 00  |
|        | OUTPATIENT SERVICE COST CENTERS           | •              |               |              |                 |              |         |
| 90.00  | 09000 CLI NI C                            | 672, 389       |               | 672, 389     | 0               | 672, 389     | 90.00   |
| 90. 01 | 09001 SLEEP CENTER                        | 0              |               | 0            | 0               | 0            | 90. 01  |
| 91.00  | 09100 EMERGENCY                           | 0              |               | 0            | 0               | 0            | 91.00   |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0              |               | 0            |                 | 0            | 92.00   |
|        | OTHER REIMBURSABLE COST CENTERS           |                | <u> </u>      | <u>'</u>     |                 |              |         |
| 99. 00 | 09900 CMHC                                | 0              |               | 0            |                 | 0            | 99. 00  |
| 99. 10 | 09910 CORF                                | 0              |               | 0            |                 | 0            | 99. 10  |
|        | 10200 OPIOID TREATMENT PROGRAM            | 0              |               | 0            |                 | 0            | 102.00  |
| 200.0  |   | 42, 559, 841   | 0             | 42, 559, 841 | 0               |              |         |
| 201.0  |   | 0              |               | 0            |                 |              | 201.00  |
| 202.0  | Total (see instructions)                  | 42, 559, 841   | 0             | 42, 559, 841 | 0               | 42, 559, 841 | 202. 00 |

102, 067, 336

102, 067, 336

20, 798, 065

20, 798, 065

122, 865, 401

122, 865, 401

200. 00

201 00

202.00

200.00

201 00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

|   |               |           | 10 12/31/2023 | 5/30/2024 8:35 am |
|---|---------------|-----------|---------------|-------------------|
|   |               | Title XIX | Hospi tal     | PPS               |
| Cost Center Description                         | PPS Inpatient | ·         |               |                   |
|   | Ratio         |           |               |                   |
|   | 11. 00        |           |               |                   |
| INPATIENT ROUTINE SERVICE COST CENTERS          |               |           |               |                   |
| 30. 00 03000 ADULTS & PEDIATRICS                |               |           |               | 30.00             |
| ANCILLARY SERVICE COST CENTERS                  |               |           |               |                   |
| 50.00   05000   OPERATING ROOM                  | 0. 000000     |           |               | 50.00             |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C        | 0. 150408     |           |               | 54. 00            |
| 60. 00   06000   LABORATORY                     | 0. 287524     |           |               | 60. 00            |
| 65. 00 06500 RESPI RATORY THERAPY               | 0. 376445     |           |               | 65. 00            |
| 66. 00   06600 PHYSI CAL THERAPY                | 0. 224821     |           |               | 66. 00            |
| 66.01 06601 PHYSI CAL THERAPY - CARMEL          | 0. 000000     |           |               | 66. 01            |
| 67. 00  06700 OCCUPATI ONAL THERAPY             | 0. 215017     |           |               | 67. 00            |
| 68.00 06800 SPEECH PATHOLOGY                    | 0. 229492     |           |               | 68. 00            |
| 68. 01   06801   VI SI ON                       | 0. 000000     |           |               | 68. 01            |
| 68. 02   06802   FAC   RESOURCE                 | 0. 000000     |           |               | 68. 02            |
| 69. 00   06900   ELECTROCARDI OLOGY             | 0. 000000     |           |               | 69. 00            |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 276645     |           |               | 71. 00            |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS      | 0. 000000     |           |               | 72. 00            |
| 73.00 07300 DRUGS CHARGED TO PATIENTS           | 0. 239310     |           |               | 73. 00            |
| 74.00 07400 RENAL DIALYSIS                      | 0. 000000     |           |               | 74. 00            |
| 77.00 07700 ALLOGENEIC HSCT ACQUISITION         | 0. 000000     |           |               | 77. 00            |
| 78.00 07800 CAR T-CELL IMMUNOTHERAPY            | 0. 000000     |           |               | 78. 00            |
| OUTPATIENT SERVICE COST CENTERS                 |               |           |               |                   |
| 90. 00  09000   CLI NI C                        | 0. 346609     |           |               | 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 OPIOLD 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           |

Heal th Financial Systems REHABILITATION HOSPITAL OF INDIANA CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Provider CCN: REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: Provi der CCN: 15-3028

|              |   |                |                |               |             | 5/30/2024 8: 3 | 5 am    |
|--------------|---|----------------|----------------|---------------|-------------|----------------|---------|
|              |   |                |                | e XIX         | Hospi tal   | PPS            |         |
|              | Cost Center Description                 | Total Cost     |                | Operating Cos |             | Operating Cost |         |
|              |   | (Wkst. B, Part | (Wkst. B, Part | Net of Capita | l Reduction | Reduction      |         |
|              |   | I, col. 26)    | II col. 26)    | Cost (col. 1  | -           | Amount         |         |
|              |   |                |                | col . 2)      |             |                |         |
|              |   | 1.00           | 2. 00          | 3. 00         | 4. 00       | 5. 00          |         |
|              | CILLARY SERVICE COST CENTERS            |                |                |               |             |                |         |
|              | OOO OPERATING ROOM                      | 0              | 0              | )             | 0           | 0              | 50.00   |
|              | 400 RADI OLOGY-DI AGNOSTI C             | 352, 535       | 11, 802        |               |             | 0              | 54.00   |
|              | 000 LABORATORY                          | 509, 656       | 17, 086        |               | 0           | 0              | 60.00   |
|              | 500 RESPI RATORY THERAPY                | 1, 275, 355    | 20, 820        | 1, 254, 53    | 5 0         | 0              | 65.00   |
|              | 600 PHYSI CAL THERAPY                   | 4, 865, 588    | 235, 043       | 4, 630, 54    | 5 0         | 0              | 66. 00  |
|              | 601 PHYSICAL THERAPY - CARMEL           | 0              | 0              | 1             | 0           | 0              | 66. 01  |
| 67. 00 067   | 700 OCCUPATI ONAL THERAPY               | 3, 980, 476    | 200, 452       | 3, 780, 02    | 4 0         | 0              | 67.00   |
| 68. 00 068   | 800 SPEECH PATHOLOGY                    | 2, 429, 334    | 115, 577       | 2, 313, 75    | 7 0         | 0              | 68.00   |
| 68. 01 068   | 801 VISION                              | 0              | 0              | )             | 0           | 0              | 68. 01  |
| 68. 02   068 | 802 FAC RESOURCE                        | 0              | 0              | )             | 0           | 0              | 68. 02  |
| 69. 00 069   | 900 ELECTROCARDI OLOGY                  | 0              | 0              | )             | 0           | 0              | 69. 00  |
| 71.00 07     | 100 MEDICAL SUPPLIES CHARGED TO PATIENT | 618, 089       | 17, 053        | 601, 03       | 6 0         | 0              | 71.00   |
| 72.00 072    | 200 IMPL. DEV. CHARGED TO PATIENTS      | 0              | 0              | )             | 0           | 0              | 72.00   |
| 73.00 073    | 300 DRUGS CHARGED TO PATIENTS           | 3, 215, 491    | 58, 910        | 3, 156, 58    | 1 0         | 0              | 73.00   |
| 74. 00   074 | 400 RENAL DIALYSIS                      | 0              | 0              | )             | 0           | 0              | 74.00   |
| 77. 00   07  | 700 ALLOGENEIC HSCT ACQUISITION         | 0              | 0              | )             | 0           | 0              | 77. 00  |
| 78. 00   078 | 800 CAR T-CELL IMMUNOTHERAPY            | 0              | 0              | )             | 0           | 0              | 78. 00  |
| OUT          | TPATIENT SERVICE COST CENTERS           |                |                |               |             |                |         |
| 90.00 090    | 000 CLI NI C                            | 672, 389       | 104, 242       | 568, 14       | 7 0         | 0              | 90.00   |
| 90. 01   090 | 001 SLEEP CENTER                        | 0              | 0              | )             | 0           | 0              | 90. 01  |
| 91.00 09     | 100 EMERGENCY                           | O              | 0              | )             | 0           | 0              | 91.00   |
| 92. 00 092   | 200 OBSERVATION BEDS (NON-DISTINCT PART | o              | Ō              | 1             | 0           | 0              | 92.00   |
| OTH          | HER REIMBURSABLE COST CENTERS           |                |                |               | <u> </u>    |                |         |
| 99. 00 099   | 900 CMHC                                | 0              | O              |               | 0 0         | 0              | 99. 00  |
| 99. 10   099 | 910 CORF                                | o              | 0              | )             | 0           | 0              | 99. 10  |
| 102.00 102   | 200 OPIOID TREATMENT PROGRAM            | o              | Ō              | 1             | 0           | 0              | 102.00  |
| 200.00       | Subtotal (sum of lines 50 thru 199)     | 17, 918, 913   | 780, 985       | 17, 137, 92   | 8 0         | 0              | 200. 00 |
| 201.00       | Less Observation Beds                   | O              | 0              |               | 0 0         | 0              | 201. 00 |
| 202.00       | Total (line 200 minus line 201)         | 17, 918, 913   | 780, 985       | 17, 137, 92   | 8 0         | 0              | 202. 00 |
| !            |   |                |                | •             | •           | . '            | •       |

Peri od: Worksheet C From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared: 5/30/2024 8:35 am Provider CCN: 15-3028 REDUCTIONS FOR MEDICALD ONLY

|            |  |                |                |               |           | 5/30/2024 8: 35 | am      |
|------------|--|----------------|----------------|---------------|-----------|-----------------|---------|
|            |  |                | Ti tl          | e XIX         | Hospi tal | PPS             |         |
|            | Cost Center Description                | Cost Net of    | Total Charges  | Outpati ent   |           |                 |         |
|            |  | Capital and    | (Worksheet C,  | Cost to Charg | ge        |                 |         |
|            |  | Operating Cost | Part I, column | Ratio (col.   | 6         |                 |         |
|            |  | Reducti on     | 8)             | / col . 7)    |           |                 |         |
|            |  | 6. 00          | 7. 00          | 8. 00         |           |                 |         |
| ANC        | ILLARY SERVICE COST CENTERS            |                |                |               |           |                 |         |
| 50.00 050  | OO OPERATING ROOM                      | 0              | 0              | 0.00000       | 00        |                 | 50.00   |
| 54.00 054  | 00 RADI OLOGY-DI AGNOSTI C             | 352, 535       | 2, 343, 861    | 0. 15040      | 08        |                 | 54.00   |
| 60.00 060  | 000 LABORATORY                         | 509, 656       | 1, 772, 571    | 0. 28752      | 24        |                 | 60.00   |
| 65.00 065  | 00 RESPI RATORY THERAPY                | 1, 275, 355    | 3, 387, 896    | 0. 37644      | 15        |                 | 65.00   |
| 66.00 066  | 00 PHYSI CAL THERAPY                   | 4, 865, 588    | 21, 642, 076   | 0. 22482      | 21        |                 | 66.00   |
| 66. 01 066 | 01 PHYSICAL THERAPY - CARMEL           | 0              | 0              | 0.00000       | 00        |                 | 66. 01  |
| 67. 00 067 | 00 OCCUPATIONAL THERAPY                | 3, 980, 476    | 18, 512, 340   | 0. 2150°      | 17        |                 | 67.00   |
| 68. 00 068 | OO SPEECH PATHOLOGY                    | 2, 429, 334    | 10, 585, 685   | 0. 22949      | 92        |                 | 68.00   |
| 68. 01 068 | O1 VISION                              | 0              | 0              | 0.00000       | 00        |                 | 68. 01  |
| 68. 02 068 | 02 FAC RESOURCE                        | 0              | 0              | 0.00000       | 00        |                 | 68. 02  |
| 69.00 069  | OO ELECTROCARDI OLOGY                  | 0              | 0              | 0.00000       | 00        |                 | 69.00   |
| 71.00 071  | 00 MEDICAL SUPPLIES CHARGED TO PATIENT | 618, 089       | 2, 234, 233    | 0. 27664      | 15        |                 | 71.00   |
| 72.00 072  | OO IMPL. DEV. CHARGED TO PATIENTS      | 0              | 0              | 0.00000       | 00        |                 | 72.00   |
| 73.00 073  | OO DRUGS CHARGED TO PATIENTS           | 3, 215, 491    | 13, 436, 531   | 0. 2393       | 10        |                 | 73.00   |
| 74.00 074  | 00 RENAL DIALYSIS                      | 0              | 0              | 0.00000       | 00        |                 | 74.00   |
| 77. 00 077 | OO ALLOGENEIC HSCT ACQUISITION         | 0              | 0              | 0. 00000      | 00        |                 | 77.00   |
| 78. 00 078 | OO CAR T-CELL IMMUNOTHERAPY            | 0              | 0              | 0. 00000      | 00        |                 | 78.00   |
| OUT        | PATIENT SERVICE COST CENTERS           | ,              |                | •             |           |                 |         |
| 90. 00 090 | OO CLI NI C                            | 672, 389       | 1, 939, 905    | 0. 34660      | )9        |                 | 90.00   |
| 90. 01 090 | 01 SLEEP CENTER                        | 0              | 0              | 0. 00000      | 00        |                 | 90. 01  |
| 91. 00 091 | OO EMERGENCY                           | 0              | 0              | 0. 00000      | 00        |                 | 91.00   |
|            | OO OBSERVATION BEDS (NON-DISTINCT PART | 0              | 0              | 0.00000       |           |                 | 92. 00  |
|            | ER REIMBURSABLE COST CENTERS           | _              | -              |               |           |                 |         |
|            | OO CMHC                                | 0              | 0              | 0.00000       | 00        |                 | 99. 00  |
|            | 10 CORF                                | 0              | 0              | 0.00000       |           |                 | 99. 10  |
|            | OO OPIOID TREATMENT PROGRAM            | 0              | ا م            | 0. 00000      |           | Į.              | 102. 00 |
| 200. 00    | Subtotal (sum of lines 50 thru 199)    | 17, 918, 913   | 75, 855, 098   |               |           |                 | 200. 00 |
| 201. 00    | Less Observation Beds                  | 0              | 0              |               |           |                 | 201. 00 |
| 202.00     | Total (line 200 minus line 201)        | 17, 918, 913   | 75, 855, 098   |               |           | ı               | 202. 00 |

| Health Financial Systems F                                       | REHABILITATION HOS                        | PITAL OF INDIA                                   | NA                                  | In Li€                                      | eu of Form CMS-               | 2552-10           |
|--|---|--|-------------------------------------|---|-------------------------------|-------------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA                | AL COSTS                                  | Provi der C                                      |                                     | Period:<br>From 01/01/2023<br>To 12/31/2023 |                               | pared:<br>5 am    |
|  |   | Titl∈  | XVIII                               | Hospi tal                                   | PPS                           |                   |
| Cost Center Description  | Capital<br>Related Cost<br>(from Wkst. B, | Swing Bed<br>Adjustment                          | Reduced<br>Capi tal<br>Related Cost | Days  | Per Diem (col.<br>3 / col. 4) |                   |
|  | Part II, col.<br>26)                      |  | (col . 1 - col<br>2)                |   |                               |                   |
|  | 1.00                                      | 2. 00  | 3. 00                               | 4. 00                                       | 5. 00                         |                   |
| INPATIENT ROUTINE SERVICE COST CENTERS                           |   |  |                                     |   |                               |                   |
| 30.00 ADULTS & PEDIATRICS  | 1, 462, 786                               | 0  | 1, 462, 78                          | 6 18, 813                                   | 77. 75                        | 30.00             |
| 200.00 Total (lines 30 through 199)                              | 1, 462, 786                               |  | 1, 462, 78                          | 6 18, 813                                   |                               | 200. 00           |
| Cost Center Description  |   | 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, 231<br>5, 231                          | 1  |                                     |   |                               | 30. 00<br>200. 00 |

| ncial Systems | REHABILITATION HOSPITAL OF INDIANA | In Lieu of Form ( |
|---------------|------------------------------------|-------------------|
|               |                                    |                   |

| Health Financial Systems REH                        | ABILITATION HOS | PITAL OF INDIA | NA      | In Li                                      | eu of Form CMS-                  | 2552-10 |
|---|-----------------|----------------|---------|--|----------------------------------|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | L COSTS         | Provider Co    |         | Peri od:<br>From 01/01/202<br>To 12/31/202 | 3 Date/Time Pre<br>5/30/2024 8:3 |         |
|   |                 |                | XVIII   | Hospi tal                                  | PPS                              |         |
| Cost Center Description                             | Capi tal        | Total Charges  |         |  | Capital Costs                    |         |
|   |                 | (from Wkst. C, |         |  | (column 3 x                      |         |
|   | (from Wkst. B,  |                |         | I. Charges                                 | column 4)                        |         |
|   | Part II, col.   | 8)             | 2)      |  |                                  |         |
|   | 26)             |                |         |  |                                  |         |
|   | 1.00            | 2. 00          | 3. 00   | 4. 00                                      | 5. 00                            |         |
| ANCILLARY SERVICE COST CENTERS                      |                 | Г              | T       | T  | T                                |         |
| 50. 00   05000   OPERATI NG ROOM                    | 0               | 0              | 0.0000  |  | 0                                | 50. 00  |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C            | 11, 802         |                |         |  |                                  |         |
| 60. 00   06000   LABORATORY                         | 17, 086         |                |         |  |                                  |         |
| 65. 00 06500 RESPIRATORY THERAPY                    | 20, 820         |                | 1       |  |                                  |         |
| 66. 00 06600 PHYSI CAL THERAPY                      | 235, 043        | 1              |         |  |                                  |         |
| 66. 01 06601 PHYSI CAL THERAPY - CARMEL             | 0               | "              | 0.0000  |  | 0                                | 66. 01  |
| 67. 00 06700 OCCUPATI ONAL THERAPY                  | 200, 452        |                |         |  |                                  | 67. 00  |
| 68. 00   06800   SPEECH PATHOLOGY                   | 115, 577        | 10, 585, 685   |         |  | 8 23, 094                        | 68. 00  |
| 68. 01   06801   VI SI ON                           | 0               | 0              | 0.0000  |  | 0                                | 68. 01  |
| 68. 02   06802   FAC   RESOURCE                     | 0               | 0              | 0.0000  |  | 0                                | 68. 02  |
| 69. 00   06900   ELECTROCARDI OLOGY                 | 0               | 0              | 0.0000  |  | 0                                | 69. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 17, 053         | 2, 234, 233    | 0. 0076 | 33 666, 27                                 | 1 5, 086                         | 71. 00  |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 0               | 0              | 0.0000  | 00   | 0                                | 72. 00  |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 58, 910         | 13, 436, 531   | 0.0043  | 84 2, 252, 21                              | 7 9, 874                         | 73. 00  |
| 74.00 07400 RENAL DIALYSIS                          | 0               | 0              | 0.0000  | 00   | 0                                | 74. 00  |
| 77.00 07700 ALLOGENEIC HSCT ACQUISITION             | 0               | 0              | 0.0000  | 00   | 0                                | 77. 00  |
| 78.00 07800 CAR T-CELL IMMUNOTHERAPY                | 0               | 0              | 0.0000  | 00   | 0 0                              | 78. 00  |
| OUTPATIENT SERVICE COST CENTERS                     |                 |                |         |  |                                  |         |
| 90. 00 09000 CLINIC                                 | 104, 242        | 1, 939, 905    | 0. 0537 | 36   | 0                                | 90.00   |
| 90. 01   09001   SLEEP CENTER                       | 0               | 0              | 0.0000  | 00   | 0                                | 90. 01  |
| 91. 00   09100   EMERGENCY                          | 0               | 0              | 0.0000  | 00   | 0                                | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART     | 0               | 0              | 0.0000  | 00   | 0 0                              | 92. 00  |
| 200.00   Total (lines 50 through 199)               | 780, 985        | 75, 855, 098   |         | 15, 246, 51                                | 6 138, 199                       | 200. 00 |

| Health Financial Systems   | REHABILITATION HOS   | PITAL OF INDIA  | NA  | In Lie                                      | u of Form CMS-  | 2552-10           |
|--|--|---|---|---|---|-------------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OT                          | HER PASS THROUGH COST                                      |   | F   | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet D<br>Part III<br>Date/Time Pre<br>5/30/2024 8:3 |                   |
|  |  |   | XVIII   | Hospi tal                                   | PPS   |                   |
| Cost Center Description  | Nursi ng<br>Program<br>Post-Stepdown<br>Adj ustments       | Nursi ng<br>Program   | Allied Health<br>Post-Stepdown<br>Adjustments |   | All Other<br>Medical<br>Education Cost                    |                   |
|  | 1A   | 1. 00   | 2A  | 2. 00                                       | 3. 00   |                   |
| INPATIENT ROUTINE SERVICE COST CENTERS                                 |  |   |   |   |   |                   |
| 30. 00 03000 ADULTS & PEDIATRICS                                       | 0  | 0   | (   | 0   | 0   |                   |
| 200. 00   Total (lines 30 through 199)                                 | 0  | 0   | (   | 0   |   | 200. 00           |
| Cost Center Description  | Swing-Bed Adjustment Amount (see instructions)             | Total Costs<br>(sum of cols.<br>1 through 3,<br>minus col. 4) | Total Patient<br>Days                         | Per Diem (col.<br>5 ÷ col. 6)               | Inpatient<br>Program Days                                 |                   |
|  | 4.00   | 5. 00   | 6. 00   | 7. 00                                       | 8. 00   |                   |
| INPATIENT ROUTINE SERVICE COST CENTERS                                 | <u> </u>   |   |   |   |   |                   |
| 30.00 03000 ADULTS & PEDIATRICS<br>200.00 Total (lines 30 through 199) | 0  | 0   | 18, 813<br>18, 813                            |   |   | 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 |

THROUGH COSTS

|  |               |               |          | 12, 01, 2020  | 5/30/2024 8: 3 |         |
|--|---------------|---------------|----------|---------------|----------------|---------|
|  |               |               | XVIII    | Hospi tal     | PPS            |         |
| Cost Center Description                          | Non Physician | Nursi ng      | Nursi ng |               | Allied Health  |         |
|  | Anestheti st  | Program       | Program  | Post-Stepdown |                |         |
|  | Cost          | Post-Stepdown |          | Adjustments   |                |         |
|  |               | Adjustments   |          |               |                |         |
|  | 1.00          | 2A            | 2. 00    | 3A            | 3. 00          |         |
| ANCI LLARY SERVI CE COST CENTERS                 |               | _             | l        | _1            | _              |         |
| 50. 00   05000   OPERATI NG ROOM                 | 0             | 0             |          | 0             | 0              |         |
| 54. 00   05400   RADI OLOGY - DI AGNOSTI C       | 0             | 0             |          | 0             | 0              | 54. 00  |
| 60. 00   06000   LABORATORY                      | 0             | 0             |          | 0             | 0              | 60. 00  |
| 65. 00 06500 RESPI RATORY THERAPY                | 0             | 0             |          | 0             | 0              | 65. 00  |
| 66. 00 06600 PHYSI CAL THERAPY                   | 0             | 0             |          | 0             | 0              | 66. 00  |
| 66. 01 06601 PHYSI CAL THERAPY - CARMEL          | 0             | 0             |          | 0             | 0              | 66. 01  |
| 67. 00 06700 OCCUPATI ONAL THERAPY               | 0             | 0             |          | 0             | 0              | 67. 00  |
| 68. 00 06800 SPEECH PATHOLOGY                    | 0             | 0             |          | 0             | 0              | 68. 00  |
| 68. 01   06801   VI SI ON                        | 0             | 0             |          | 0             | 0              | 68. 01  |
| 68. 02   06802   FAC   RESOURCE                  | 0             | 0             |          | 0             | 0              | 68. 02  |
| 69. 00 06900 ELECTROCARDI OLOGY                  | 0             | 0             |          | 0             | 0              | 69. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 0             | 0             |          | 0             | 0              | 71. 00  |
| 72. 00 07200 I MPL. 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  |
| 78. 00 07800 CAR T-CELL IMMUNOTHERAPY            | 0             | 0             |          | 0 0           | 0              | 78. 00  |
| OUTPATIENT SERVICE COST CENTERS                  |               |               |          |               |                |         |
| 90. 00   09000   CLI NI C                        | 0             | 0             |          | 0             | 0              | 90. 00  |
| 90. 01  09001   SLEEP CENTER                     | 0             | 0             |          | 0             | 0              | 90. 01  |
| 91. 00   09100   EMERGENCY                       | 0             | 0             |          | 0             | 0              | 91. 00  |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0             |               |          | 0             | 0              | 92. 00  |
| 200.00   Total (lines 50 through 199)            | 0             | 0             |          | 0 0           | 0              | 200. 00 |
|  |               |               |          |               |                |         |

| Health Financial Systems REF                                     | IABILITATION HOSP    | ITAL OF INDIA               | NA          | In Lie                      | u of Form CMS-2                         | 2552-10 |
|--|----------------------|-----------------------------|-------------|-----------------------------|---|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS | RVICE OTHER PASS     | Provi der Co                | CN: 15-3028 | Peri od:<br>From 01/01/2023 |   |         |
|  |                      | Title                       | : XVIII     | Hospi tal                   | Date/Time Prep<br>5/30/2024 8:35<br>PPS |         |
| Cost Center Description  | All Other<br>Medical | Total Cost<br>(sum of cols. | Total       |                             | Ratio of Cost                           |         |

|             |                                     |                |               |              | 0 12/31/2023   | 5/30/2024 8:3  |         |
|-------------|-------------------------------------|----------------|---------------|--------------|----------------|----------------|---------|
|             |                                     |                | Title         | XVIII        | Hospi tal      | PPS            |         |
|             | Cost Center Description             | All Other      | Total Cost    | Total        | Total Charges  | Ratio of Cost  |         |
|             |                                     | Medi cal       | (sum of cols. | Outpati ent  | (from Wkst. C, | to Charges     |         |
|             |                                     | Education Cost | 1, 2, 3, and  | Cost (sum of | Part I, col.   | (col. 5 ÷ col. |         |
|             |                                     |                | 4)            | col s. 2, 3, | 8)             | 7)             |         |
|             |                                     |                |               | and 4)       |                | (see           |         |
|             |                                     |                |               |              |                | instructions)  |         |
|             |                                     | 4. 00          | 5. 00         | 6. 00        | 7. 00          | 8. 00          |         |
|             | LARY SERVICE COST CENTERS           |                |               | T            | .T _           |                |         |
|             | OPERATING ROOM                      | 0              | 0             | (            | 0              | 0. 000000      | 1       |
|             | RADI OLOGY-DI AGNOSTI C             | 0              | 0             | (            | 2, 343, 861    | 0. 000000      | 1       |
|             | LABORATORY                          | 0              | 0             | (            | 1, 772, 571    | 0. 000000      | 1       |
|             | RESPI RATORY THERAPY                | 0              | 0             | (            | 3, 387, 896    |                |         |
|             | PHYSI CAL THERAPY                   | 0              | 0             | (            | 21, 642, 076   |                | 1       |
|             | PHYSICAL THERAPY - CARMEL           | 0              | 0             | (            | 0              | 0. 000000      |         |
|             | OCCUPATIONAL THERAPY                | 0              | 0             | (            | 18, 512, 340   | 0. 000000      |         |
|             | SPEECH PATHOLOGY                    | 0              | 0             | (            | 10, 585, 685   |                |         |
|             | VISION                              | 0              | 0             | (            | 0              | 0. 000000      | 1       |
|             | FAC RESOURCE                        | 0              | 0             | (            | 0              | 0. 000000      | 1       |
|             | ELECTROCARDI OLOGY                  | 0              | 0             | (            | 0              | 0. 000000      |         |
|             | MEDICAL SUPPLIES CHARGED TO PATIENT | 0              | 0             | (            | 2, 234, 233    | 0. 000000      | 1       |
|             | IMPL. DEV. CHARGED TO PATIENTS      | 0              | 0             | (            | 0              | 0. 000000      | 1       |
|             | DRUGS CHARGED TO PATIENTS           | 0              | 0             | (            | 13, 436, 531   | 0. 000000      | 1       |
|             | RENAL DIALYSIS                      | 0              | 0             | (            | 0              | 0. 000000      | 1       |
|             | ALLOGENEIC HSCT ACQUISITION         | 0              | 0             | (            | 0              | 0. 000000      | 1       |
|             | CAR T-CELL IMMUNOTHERAPY            | 0              | 0             | (            | 0              | 0. 000000      | 78. 00  |
|             | ATIENT SERVICE COST CENTERS         | , ,            |               | T            |                |                | 1       |
| 90.00 09000 |                                     | 0              | 0             | (            | 1, 939, 905    | 0. 000000      |         |
|             | SLEEP CENTER                        | 0              | 0             | (            | 0              | 0. 000000      |         |
|             | EMERGENCY                           | 0              | 0             | (            | 0              | 0. 000000      |         |
|             | OBSERVATION BEDS (NON-DISTINCT PART | 0              | 0             | (            | 0              | 0. 000000      | 1       |
| 200.00      | Total (lines 50 through 199)        | 0              | 0             | (            | 75, 855, 098   |                | 200. 00 |

| Health Financial Systems REHABILITATION HOSPITAL OF INDIANA In L    |   |                                 |                                      |   | u of Form CMS-2  | 2552-10 |
|---|---|---------------------------------|--------------------------------------|---|--|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE<br>THROUGH COSTS | RVICE OTHER PASS                          | Provi der Co                    |                                      | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet D<br>Part IV<br>Date/Time Pre<br>5/30/2024 8:3 |         |
|   |   | Title                           | : XVIII                              | Hospi tal                                   | PPS  |         |
| Cost Center Description   | Outpatient<br>Ratio of Cost<br>to Charges | Inpatient<br>Program<br>Charges | Inpatient<br>Program<br>Pass-Through | Outpatient<br>Program<br>Charges            | Outpatient<br>Program<br>Pass-Through                    |         |

|   |                |              |               |             | 5/30/2024 8:3 | <u>s am</u> |
|---|----------------|--------------|---------------|-------------|---------------|-------------|
|   |                | Title        | XVIII         | Hospi tal   | PPS           |             |
| Cost Center Description                         | Outpati ent    | I npati ent  | Inpati ent    | Outpati ent | Outpati ent   |             |
|   | Ratio of Cost  | Program      | Program       | Program     | Program       |             |
|   | to Charges     | Charges      | Pass-Through  | Charges     | Pass-Through  |             |
|   | (col. 6 ÷ col. |              | Costs (col. 8 |             | Costs (col. 9 |             |
|   | 7)             |              | x col. 10)    |             | x col. 12)    |             |
|   | 9. 00          | 10.00        | 11. 00        | 12.00       | 13. 00        |             |
| ANCILLARY SERVICE COST CENTERS                  |                |              |               |             |               |             |
| 50. 00   05000   OPERATI NG ROOM                | 0. 000000      | 0            | (             | ·           | 0             | 50.00       |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C        | 0. 000000      | 766, 311     | (             | 1, 869      | 0             | 54.00       |
| 60. 00   06000   LABORATORY                     | 0. 000000      | 490, 780     | (             | 0           | 0             | 60.00       |
| 65. 00 06500 RESPIRATORY THERAPY                | 0. 000000      | 1, 182, 734  | C             | 0           | 0             | 65. 00      |
| 66. 00   06600   PHYSI CAL THERAPY              | 0. 000000      | 3, 810, 394  | C             | 0           | 0             | 66. 00      |
| 66. 01 06601 PHYSI CAL THERAPY - CARMEL         | 0. 000000      | 0            | C             | 0           | 0             | 66. 01      |
| 67. 00 06700 OCCUPATI ONAL THERAPY              | 0. 000000      | 3, 962, 571  | C             | 2, 440      | 0             | 67. 00      |
| 68. 00 06800 SPEECH PATHOLOGY                   | 0. 000000      | 2, 115, 238  | C             | 0           | 0             | 68. 00      |
| 68. 01   06801   VI SI ON                       | 0. 000000      | 0            | C             | 0           | 0             | 68. 01      |
| 68. 02   06802   FAC RESOURCE                   | 0. 000000      | 0            | C             | 0           | 0             | 68. 02      |
| 69. 00 06900 ELECTROCARDI OLOGY                 | 0. 000000      | 0            | C             | 0           | 0             | 69. 00      |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 000000      | 666, 271     | C             | 18, 886     | 0             | 71. 00      |
| 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS     | 0. 000000      | 0            | C             | 0           | 0             | 72. 00      |
| 73.00 07300 DRUGS CHARGED TO PATIENTS           | 0. 000000      | 2, 252, 217  | C             | 1, 860, 335 | 0             | 73.00       |
| 74. 00 07400 RENAL DIALYSIS                     | 0. 000000      | 0            | C             | 0           | 0             | 74.00       |
| 77. 00 07700 ALLOGENEIC HSCT ACQUISITION        | 0. 000000      | 0            | (             | 0           | 0             | 77. 00      |
| 78. 00 07800 CAR T-CELL IMMUNOTHERAPY           | 0. 000000      | 0            | (             | 0           | 0             | 78. 00      |
| OUTPATIENT SERVICE COST CENTERS                 |                |              |               |             |               |             |
| 90. 00 09000 CLI NI C                           | 0. 000000      | 0            | (             | 492, 366    | 0             | 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 Total (lines 50 through 199)             | 1              | 15, 246, 516 | C             | 2, 375, 896 | 0             | 200.00      |
|   |                |              | •             |             |               | •           |

Health Financial Systems REHABILITATION HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-3028 Peri od: Worksheet D From 01/01/2023 Part V 12/31/2023 Date/Time Prepared: 5/30/2024 8:35 am Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.150408 1,869 0 0 281 54.00 06000 LABORATORY 0. 287524 0 60 00 60 00 0 0 06500 RESPIRATORY THERAPY 65.00 0.376445 C 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 0. 224821 0 0 66.00 0 66. 01 06601 PHYSI CAL THERAPY - CARMEL 0.000000 0 0 0 0 0 0 0 0 0 0 66 01 0 06700 OCCUPATIONAL THERAPY 67.00 0.215017 2, 440 525 67.00 68.00 06800 SPEECH PATHOLOGY 0. 229492 0 68.00 06801 VI SI ON 0 68.01 0.000000 0 0 68.01 0 06802 FAC RESOURCE 0.000000 68 02 68 02 C 0 06900 ELECTROCARDI OLOGY 69.00 0.000000 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 276645 18, 886 0 5, 225 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 1, 860, 335 445, 197 73.00 0.239310 74.00 07400 RENAL DIALYSIS 0.000000 0 0 74.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 77.00 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 346609 492, 366 0 0 170, 658 90.00 09001 SLEEP CENTER 0.000000 0 0 90.01 90.01 0 0 0 09100 EMERGENCY 91.00 91.00 0.000000 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 Ω 0 200.00 Subtotal (see instructions) 2, 375, 896 0 621, 886 200. 00 Less PBP Clinic Lab. Services-Program 0 201.00 201. 00 Only Charges

0

0

621, 886 202. 00

2, 375, 896

202.00

Net Charges (line 200 - line 201)

Health Financial Systems In Lieu of Form CMS-2552-10 REHABILITATION HOSPITAL OF INDIANA APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-3028 Peri od: Worksheet D From 01/01/2023 To 12/31/2023 Part V Date/Time Prepared: 5/30/2024 8:35 am Title XVIII Hospi tal PPS Costs 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 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 54.00 60. 00 06000 LABORATORY 0 60.00 06500 RESPIRATORY THERAPY 0 65.00 65.00 66. 00 06600 PHYSI CAL THERAPY 0 66.00 0 66. 01 06601 PHYSI CAL THERAPY - CARMEL 66.01 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06801 VI SI ON 0 68.01 68.01 06802 FAC RESOURCE 0 68 02 68 02 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 90. 01 09001 SLEEP CENTER 0 0 0 0 0 90.01

0

0

0

0

0

91.00

92.00

200.00

201. 00

202.00

91. 00 09100 EMERGENCY

200.00

201.00

202.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

| Health Financial Systems REH.                                    | ABILITATION HOS  | PITAL OF INDIA                                   | NA  | In Li€                                      | eu of Form CMS-               | 2552-10           |
|--|--|--|---|---|-------------------------------|-------------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL               | COSTS  | Provider Co                                      |   | Period:<br>From 01/01/2023<br>To 12/31/2023 |                               | pared:<br>5 am    |
|  |  | Titl   | e XIX   | Hospi tal                                   | PPS                           |                   |
| Cost Center Description  | Capital<br>Related Cost<br>(from Wkst. B,<br>Part II, col. | Swing Bed<br>Adjustment                          | Reduced<br>Capital<br>Related Cost<br>(col. 1 - col | Days  | Per Diem (col.<br>3 / col. 4) |                   |
|  | 26)<br>1.00  | 2.00   | 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, 462, 786  | 0  | 1, 462, 78  | 6 18, 813                                   | 77. 75                        | 30.00             |
| 200.00 Total (lines 30 through 199)                              | 1, 462, 786  |  | 1, 462, 78  | 6 18, 813                                   |                               | 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) | 751<br>751   |  | 1   |   |                               | 30. 00<br>200. 00 |

| th Financial Systems | REHABILITATION HOSPITAL OF | I NDI ANA | In Lie | u of Form CMS-25 |
|----------------------|----------------------------|-----------|--------|------------------|
|                      |                            |           |        |                  |

| Health Financial Systems REHA                       | ABILITATION HOS | SPITAL OF INDIA                       | NA            | In Lie                                      | eu of Form CMS-2 | 2552-10 |
|---|-----------------|---------------------------------------|---------------|---|------------------|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | L COSTS         | Provider Co                           |               | Period:<br>From 01/01/2023<br>To 12/31/2023 |                  |         |
|   |                 | Ti tl                                 | e XIX         | Hospi tal                                   | PPS              |         |
| Cost Center Description                             | Capi tal        | Total Charges                         | Ratio of Cos  | t Inpatient                                 | Capital Costs    |         |
|   | Related Cost    | (from Wkst. C,                        | to Charges    | Program                                     | (column 3 x      |         |
|   | (from Wkst. B,  |                                       | (col. 1 ÷ col | . Charges                                   | column 4)        |         |
|   | Part II, col.   | 8)                                    | 2)            |   |                  |         |
|   | 26)             |                                       |               |   |                  |         |
|   | 1. 00           | 2.00                                  | 3. 00         | 4. 00                                       | 5. 00            |         |
| ANCILLARY SERVICE COST CENTERS                      |                 |                                       |               |   |                  |         |
| 50. 00   05000 OPERATING ROOM                       | 0               | 0                                     | 0. 00000      |   | 0                |         |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C            | 11, 802         |                                       |               |   |                  |         |
| 60. 00   06000   LABORATORY                         | 17, 086         |                                       |               |   |                  |         |
| 65. 00 06500 RESPI RATORY THERAPY                   | 20, 820         |                                       |               |   |                  |         |
| 66. 00 06600 PHYSI CAL THERAPY                      | 235, 043        |                                       |               |   |                  |         |
| 66. 01 06601 PHYSI CAL THERAPY - CARMEL             | 0               | · · · · · · · · · · · · · · · · · · · | 0.00000       |   | 0                | 66. 01  |
| 67. 00 06700 OCCUPATI ONAL THERAPY                  | 200, 452        |                                       |               |   |                  |         |
| 68. 00   06800   SPEECH PATHOLOGY                   | 115, 577        | 10, 585, 685                          |               |   | 3, 065           |         |
| 68. 01  06801  VI SI ON                             | 0               | 0                                     | 0.00000       |   | 0                | 68. 01  |
| 68. 02   06802   FAC   RESOURCE                     | 0               | 0                                     | 0.00000       |   | 0                | 68. 02  |
| 69. 00   06900   ELECTROCARDI OLOGY                 | 0               | 0                                     | 0.00000       |   | 0                | 69. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 17, 053         | 2, 234, 233                           | 0. 00763      | 3 53, 854                                   | 411              | 71. 00  |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 0               | 0                                     | 0.00000       | 0   | 0                | 72. 00  |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 58, 910         | 13, 436, 531                          | 0. 00438      | 4 296, 564                                  | 1, 300           | 73. 00  |
| 74.00   07400   RENAL DIALYSIS                      | 0               | 0                                     | 0.00000       | 0 0   | 0                | 74. 00  |
| 77.00 07700 ALLOGENEIC HSCT ACQUISITION             | 0               | 0                                     | 0.00000       | 0 0   | 0                | 77. 00  |
| 78.00 07800 CAR T-CELL IMMUNOTHERAPY                | 0               | 0                                     | 0.00000       | 0 0   | 0                | 78. 00  |
| OUTPATIENT SERVICE COST CENTERS                     |                 |                                       |               |   |                  |         |
| 90. 00  09000 CLI NI C                              | 104, 242        | 1, 939, 905                           | 0. 05373      | 6 0   | 0                | 90.00   |
| 90. 01   09001   SLEEP CENTER                       | 0               | 0                                     | 0.00000       | 0 0   | 0                | 90. 01  |
| 91. 00   09100   EMERGENCY                          | 0               | 0                                     | 0.00000       | 0 0   | 0                | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART     | 0               | 0                                     | 0.00000       | 0   | 0                | 1 ,2.00 |
| 200.00   Total (lines 50 through 199)               | 780, 985        | 75, 855, 098                          |               | 1, 939, 062                                 | 18, 008          | 200. 00 |

| Health Financial Systems   | REHABILITATION HOSE  | PITAL OF INDIA                                 | NA  | In Lie                                      | u of Form CMS-  | 2552-10           |
|--|--|--|---|---|---|-------------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OT                          | THER PASS THROUGH COST                                     |  | F   | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet D<br>Part III<br>Date/Time Pre<br>5/30/2024 8:3 |                   |
|  |  |  | e XIX   | Hospi tal                                   | PPS   |                   |
| Cost Center Description  | Nursi ng<br>Program<br>Post-Stepdown<br>Adj ustments       | Nursi ng<br>Program                            | Allied Health<br>Post-Stepdown<br>Adjustments |   | All Other<br>Medical<br>Education Cost                    |                   |
|  | 1A   | 1. 00  | 2A  | 2. 00                                       | 3. 00   |                   |
| INPATIENT ROUTINE SERVICE COST CENTERS                                 |  |  |   |   |   |                   |
| 30.00 03000 ADULTS & PEDIATRICS<br>200.00 Total (lines 30 through 199) | 0  | 0  | (   | 0   | 0   | 30. 00<br>200. 00 |
| 200.00 Total (lines 30 through 199)  Cost Center Description           | Swi ng-Bed   | Total Costs                                    | Total Dationt                                 | Per Diem (col.                              | Inpati ent  | 200.00            |
| cost center bescription  | Adjustment<br>Amount (see                                  | (sum of cols.<br>1 through 3,<br>minus col. 4) | Days  | 5 ÷ col . 6)                                | Program Days  |                   |
|  | 4.00   | 5.00   | 6, 00   | 7. 00                                       | 8. 00   |                   |
| INPATIENT ROUTINE SERVICE COST CENTERS                                 |  |  |   | 1   | 9.00  |                   |
| 30.00 03000 ADULTS & PEDIATRICS<br>200.00 Total (lines 30 through 199) | 0  | 0  | 18, 813<br>18, 813                            |   |   | 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 |

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: THROUGH COSTS

|                   |                                   |               |               |          | 10 12/31/2023 | 5/30/2024 8: 3 |         |
|-------------------|-----------------------------------|---------------|---------------|----------|---------------|----------------|---------|
|                   |                                   |               | Ti tl         | e XIX    | Hospi tal     | PPS            |         |
| Co                | st Center Description             | Non Physician | Nursi ng      | Nursi ng |               | Allied Health  |         |
|                   |                                   | Anesthetist   | Program       | Program  | Post-Stepdown |                |         |
|                   |                                   | Cost          | Post-Stepdown |          | Adjustments   |                |         |
|                   |                                   |               | Adjustments   |          |               |                |         |
|                   |                                   | 1.00          | 2A            | 2. 00    | 3A            | 3. 00          |         |
|                   | RY SERVICE COST CENTERS           |               |               | 1        |               |                |         |
|                   | ERATING ROOM                      | 0             | 0             | 1        | 0             | 0              | 50. 00  |
|                   | DI OLOGY-DI AGNOSTI C             | 0             | 0             | 1        | 0             | 0              | 54. 00  |
| 60. 00   06000 LA |                                   | 0             | 0             | 1        | 0             | 0              | 60. 00  |
| 1 1               | SPI RATORY THERAPY                | 0             | 0             | 1        | 0             | 0              | 65. 00  |
|                   | YSI CAL THERAPY                   | 0             | 0             | 1        | 0             | 0              | 66. 00  |
|                   | YSICAL THERAPY - CARMEL           | 0             | 0             | 1        | 0             | 0              | 66. 01  |
|                   | CUPATI ONAL THERAPY               | 0             | 0             | 1        | 0             | 0              | 67. 00  |
|                   | EECH PATHOLOGY                    | 0             | 0             | 1        | 0             | 0              | 68. 00  |
| 68. 01   06801 VI |                                   | 0             | 0             | 1        | 0             | 0              | 68. 01  |
|                   | C RESOURCE                        | 0             | 0             | 1        | 0             | 0              | 68. 02  |
| 1 1               | ECTROCARDI OLOGY                  | 0             | 0             | 1        | 0             | 0              | 69. 00  |
|                   | DICAL SUPPLIES CHARGED TO PATIENT | 0             | 0             | 1        | 0             | 0              | 71. 00  |
|                   | PL. DEV. CHARGED TO PATIENTS      | 0             | 0             | 1        | 0             | 0              | 72. 00  |
|                   | UGS CHARGED TO PATIENTS           | 0             | 0             | 1        | 0             | 0              | 73. 00  |
| 74. 00   07400 RE |                                   | 0             | 0             | 1        | 0             | 0              | 74. 00  |
| 1 1               | LOGENEIC HSCT ACQUISITION         | 0             | 0             | 1        | 0             | 0              | 77. 00  |
|                   | R T-CELL IMMUNOTHERAPY            | 0             | 0             |          | 0 0           | 0              | 78. 00  |
|                   | NT SERVICE COST CENTERS           |               |               |          |               |                |         |
| 90. 00 09000 CL   |                                   | 0             | 0             | 1        | 0             | 0              | 90. 00  |
|                   | EEP CENTER                        | 0             | 0             | 1        | 0             | 0              | 90. 01  |
| 91.00 09100 EM    |                                   | 0             | 0             | 1        | 0             | 0              | 91. 00  |
| 1 1               | SERVATION BEDS (NON-DISTINCT PART | 0             |               |          | 0             | 0              | 92. 00  |
| 200. 00 To        | tal (lines 50 through 199)        | 0             | ] 0           | 1        | 0             | 0              | 200. 00 |

| Health Financial Systems                            | REHABILITATION HOSPIT        | TAL OF INDIANA         | In Lie                                       | u of Form CMS-2552-10  |
|---|------------------------------|------------------------|--|--|
| APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS | ANCILLARY SERVICE OTHER PASS | Provi der CCN: 15-3028 | Peri od:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet D<br>Part IV<br>Date/Time Prepared:<br>5/30/2024 8:35 am |
|   |                              |                        |  |  |

| THROUGH COST | S                                   |                |               |              | From 01/01/2023<br>To 12/31/2023 | Date/Time Pre  | nared.  |
|--------------|-------------------------------------|----------------|---------------|--------------|----------------------------------|----------------|---------|
|              |                                     |                |               |              | 10 12/31/2023                    | 5/30/2024 8: 3 |         |
|              |                                     |                | Ti tl         | e XIX        | Hospi tal                        | PPS            |         |
|              | Cost Center Description             | All Other      | Total Cost    | Total        | Total Charges                    | Ratio of Cost  |         |
|              |                                     | Medi cal       | (sum of cols. | Outpati ent  | (from Wkst. C,                   | to Charges     |         |
|              |                                     | Education Cost | 1, 2, 3, and  | Cost (sum of | Part I, col.                     | (col. 5 ÷ col. |         |
|              |                                     |                | 4)            | col s. 2, 3, | 8)                               | 7)             |         |
|              |                                     |                |               | and 4)       |                                  | (see           |         |
|              |                                     |                |               |              |                                  | instructions)  |         |
|              |                                     | 4. 00          | 5. 00         | 6. 00        | 7. 00                            | 8. 00          |         |
|              | LARY SERVICE COST CENTERS           |                |               | ı            |                                  |                |         |
|              | OPERATING ROOM                      | 0              | 0             |              | 0 0                              | 0. 000000      |         |
|              | RADI OLOGY-DI AGNOSTI C             | 0              | 0             |              | 0 2, 343, 861                    | 0. 000000      |         |
|              | LABORATORY                          | 0              | 0             |              | 0 1, 772, 571                    | 0. 000000      |         |
|              | RESPI RATORY THERAPY                | 0              | 0             |              | 0 3, 387, 896                    |                |         |
|              | PHYSI CAL THERAPY                   | 0              | 0             |              | 0 21, 642, 076                   |                |         |
|              | PHYSICAL THERAPY - CARMEL           | 0              | 0             |              | 0                                | 0. 000000      | 1       |
|              | OCCUPATIONAL THERAPY                | 0              | 0             |              | 0 18, 512, 340                   | 0. 000000      |         |
|              | SPEECH PATHOLOGY                    | 0              | 0             |              | 0 10, 585, 685                   | 0. 000000      |         |
|              | VISION                              | 0              | 0             |              | 0 0                              | 0. 000000      |         |
|              | FAC RESOURCE                        | 0              | 0             |              | 0 0                              | 0. 000000      |         |
|              | ELECTROCARDI OLOGY                  | 0              | 0             |              | 0                                | 0. 000000      |         |
|              | MEDICAL SUPPLIES CHARGED TO PATIENT | 0              | 0             |              | 0 2, 234, 233                    | 0. 000000      |         |
|              | IMPL. DEV. CHARGED TO PATIENTS      | 0              | 0             |              | 0                                | 0. 000000      |         |
|              | DRUGS CHARGED TO PATIENTS           | 0              | 0             |              | 0 13, 436, 531                   | 0. 000000      |         |
| 1 1          | RENAL DI ALYSI S                    | 0              | 0             |              | 0                                | 0. 000000      |         |
| 1 1          | ALLOGENEIC HSCT ACQUISITION         | 0              | 0             |              | 0 0                              | 0. 000000      |         |
|              | CAR T-CELL IMMUNOTHERAPY            | 0              | 0             |              | 0 0                              | 0. 000000      | 78. 00  |
|              | TIENT SERVICE COST CENTERS          |                |               | T            |                                  |                | 4       |
|              | CLINIC                              | 0              | 0             |              | 0 1, 939, 905                    | 0.000000       |         |
|              | SLEEP CENTER                        | 0              | 0             |              | 0                                | 0.000000       |         |
|              | EMERGENCY                           | 0              | 0             |              | 0                                | 0. 000000      |         |
|              | OBSERVATION BEDS (NON-DISTINCT PART | 0              | 0             |              | 0 0                              | 0. 000000      |         |
| 200. 00      | Total (lines 50 through 199)        | 0              | 0             |              | 0 75, 855, 098                   |                | 200. 00 |

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

| Cost Center Description  | APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET<br>THROUGH COSTS | RVICE OTHER PASS | Provi der CO | !      | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet D<br>Part IV<br>Date/Time Pre<br>5/30/2024 8:3 |        |
|--|--|------------------|--------------|--------|---|--|--------|
| Ratio of Cost to Charges to Charges (col. 6 + col. 7)   Program Charges (col. 6 + col. 7)   Program Charges (col. 6 + col. 7)   Program Charges (col. 8 + col. 10)   Program Charges (col. 10)   Program Charg   |  |                  |              | e XIX  | Hospi tal                                   |  |        |
| to Charges (col. 6 ÷ col. 7)   | Cost Center Description  |                  |              |        |   |  |        |
| Col. 6   |  |                  |              |        |   |  |        |
| 7)   x col. 10)   x col. 12  |  |                  | Charges      |        |   |  |        |
| ANCI LLARY SERVICE COST CENTERS   9.00   10.00   11.00   12.00   13.00   |  | (col. 6 ÷ col.   |              |        | 3   |  |        |
| ANCI LLARY SERVICE COST CENTERS  |  | - /              |              |        |   |  |        |
| 50. 00   05000   OPERATI NG ROOM   |  | 9. 00            | 10. 00       | 11. 00 | 12. 00                                      | 13. 00   |        |
| 54. 00   |  |                  |              |        |   |  |        |
| 60. 00 06000 LABORATORY 0. 000000 57, 499 0 0 0 0 60. 00 65. 00 650. 00 RESPI RATORY THERAPY 0. 000000 113, 129 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 000000 528, 611 0 0 0 0 66. 00 66. 01 06601 PHYSI CAL THERAPY - CARMEL 0. 000000 0 0 0 0 0 0 0 66. 00 67. 00 067. 00 067. 00 067. 00 067. 00 067. 00 067. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  |  |                  | 0            |        | 0   | 0  |        |
| 65. 00   | 54. 00   05400   RADI OLOGY-DI AGNOSTI C                             | 0. 000000        | 60, 181      |        | 0   | 0  | 54. 00 |
| 66. 00   06600   PHYSI CAL THERAPY   0.000000   528, 611   0 0 0 0   066. 00   66. 01   06601   PHYSI CAL THERAPY - CARMEL   0.000000   0 0 0 0 0   67. 00   06700   0CCUPATI ONAL THERAPY   0.000000   548, 450   0 0 0   68. 00   06800   SPEECH PATHOLOGY   0.000000   280, 774   0 0 0   0   68. 01   06801   VI SI ON   0.000000   0 0 0 0   0   68. 02   06802   FAC RESOURCE   0.000000   0 0 0   0   69. 00   06900   ELECTROCARDI OLOGY   0.000000   0 0 0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0.000000   53, 854   0 0 0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0.000000   0 0 0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   0 0   0   0   74. 00   07400   RENAL DI ALYSI S   0.000000   0 0   0   0   77. 00   07700   ALLOGENEIC HSCT ACQUI SI TI ON   0.000000   0   0   0   78. 00   07800   CAR T-CELL I IMMUNOTHERAPY   0.000000   0   0   0   78. 00   07800   CAR T-CELL I IMMUNOTHERAPY   0.000000   0   0   0   78. 00   079000   CAR T-CELL I IMMUNOTHERAPY   0.000000   0   0   0   790. 01   09001   SLEEP CENTER   0.000000   0   0   0   0   791. 00   09100   EMERGENCY   0.000000   0   0   0   792. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   0.000000   0   0   0   792. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   0.000000   0   0   792. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   0.000000   0   0   792. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0.000000   0   0   793. 00   000000   000000000   0   0   794. 00   00000000000000000000000000000000   |  |                  | 57, 499      |        | 0   | 0  | 60.00  |
| 66. 01   | 65. 00 06500 RESPIRATORY THERAPY                                     | 0. 000000        | 113, 129     |        | 0   | 0  | 65. 00 |
| 67. 00   | 66. 00 06600 PHYSI CAL THERAPY                                       | 0. 000000        | 528, 611     |        | 0   | 0  | 66. 00 |
| 68. 00   | 66. 01   06601 PHYSI CAL THERAPY - CARMEL                            | 0.000000         | 0            |        | 0   | 0  | 66. 01 |
| 68. 01   | 67. 00 06700 OCCUPATI ONAL THERAPY                                   | 0.000000         | 548, 450     |        | 0   | 0  | 67.00  |
| 68. 02   | 68. 00 06800 SPEECH PATHOLOGY  | 0. 000000        | 280, 774     |        | 0   | 0  | 68. 00 |
| 69. 00   06900   ELECTROCARDI OLOGY   0.000000   0   0   0   0   69. 00   0   0   0   0   0   0   0   0   0  | 68. 01   06801   VI SI ON  | 0. 000000        | 0            |        | 0   | 0  | 68. 01 |
| 71. 00   | 68. 02   06802   FAC   RESOURCE                                      | 0. 000000        | 0            |        | 0   | 0  | 68. 02 |
| 72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.000000   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   296, 564   0   0   0   73. 00   74. 00   07400   RENAL DIALYSIS   0.000000   0   0   0   0   0   77. 00   07700   ALLOGENEI C HSCT ACQUISITION   0.000000   0   0   0   0   0   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0.000000   0   0   0   0   00   078. 00   07800   07800   07800   07800   0   0   0   00   078. 00   07800   07800   07800   0   0   0   00   078. 00   07800   07800   0   0   0   00   078. 00   07800   07800   07800   0   0   00   07800   07800   07800   0   0   00   07800   0   0   0   00   07800   0   0   00   0   0   0   00   0   0  | 69. 00 06900 ELECTROCARDI OLOGY                                      | 0. 000000        | 0            |        | 0   | 0  | 69. 00 |
| 73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   296, 564   0   0   0   73. 00   74. 00   07400   RENAL DIALYSIS   0.000000   0   0   0   0   74. 00   77. 00   07700   ALLOGENEI C HSCT ACQUISITION   0.000000   0   0   0   0   0   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0.000000   0   0   0   0   00TPATIENT SERVICE COST CENTERS   0.000000   0   0   0   0   90. 01   09001   SLEEP CENTER   0.000000   0   0   0   0   0   91. 00   09100   EMERGENCY   0.000000   0   0   0   0   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0.000000   0   0   0   0   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0.000000   0   0   0   0   94. 00   09200   00000000   0   0   0   0   95. 00   09200   00000000000000000000000000  | 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                      | 0. 000000        | 53, 854      |        | 0   | 0  | 71.00  |
| 74. 00   | 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS                           | 0. 000000        | 0            |        | 0   | 0  | 72. 00 |
| 77. 00   07700   ALLOGENEI C HSCT ACQUI SITION   0.000000   0   0   0   0   0   77. 00   0   0   0   0   0   0   0   0   0   | 73.00 07300 DRUGS CHARGED TO PATIENTS                                | 0. 000000        | 296, 564     |        | 0   | 0  | 73. 00 |
| 78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0.000000   0   0   0   0   78. 00  | 74. 00   07400   RENAL DI ALYSI S                                    | 0. 000000        | 0            |        | 0   | 0  | 74.00  |
| OUTPATIENT SERVICE COST CENTERS           90. 00         09000 CLINIC         0.000000         0         0         0         0         90. 00           90. 01         09001 SLEEP CENTER         0.000000         0         0         0         0         0         90. 01           91. 00         09100 EMERGENCY         0.000000         0         0         0         0         91. 00           92. 00         09200 OBSERVATI ON BEDS (NON-DI STINCT PART         0.000000         0         0         0         0         92. 00  | 77.00 07700 ALLOGENEIC HSCT ACQUISITION                              | 0. 000000        | 0            |        | 0   | 0  | 77. 00 |
| 90. 00   09000   CLINI C   0.000000   0   0   0   0   90. 00   90. 01   90. | 78.00 07800 CAR T-CELL IMMUNOTHERAPY                                 | 0. 000000        | 0            |        | 0   | 0  | 78. 00 |
| 90. 01   09001   SLEEP CENTER  | OUTPATIENT SERVICE COST CENTERS                                      | <u> </u>         |              |        |   |  |        |
| 91. 00   09100   EMERGENCY   | 90. 00 09000 CLI NI C  | 0. 000000        | 0            |        | 0 0   | 0  | 90.00  |
| 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0.000000   0   0   0   0   92.00  | 90. 01   09001   SLEEP CENTER  | 0. 000000        | 0            |        | 0   | 0  | 90. 01 |
| 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0.000000   0   0   0   0   92.00  | 91. 00  09100 EMERGENCY  | 0. 000000        | 0            |        | o o   | 0  | 91.00  |
|  |  |                  | 0            |        | o   | 0  |        |
|  |  |                  | 1, 939, 062  |        | 0 0   | 0  |        |

0.000000

0.000000

0

0

0

0

0

0

1, 141, 761

1, 141, 761

91.00

92.00

201.00

0 202.00

0

Ω

0 200.00

0

09100 EMERGENCY

Only Charges

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

91.00

200.00

201.00

202.00

Health Financial Systems In Lieu of Form CMS-2552-10 REHABILITATION HOSPITAL OF INDIANA APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-3028 Peri od: Worksheet D From 01/01/2023 To 12/31/2023 Part V Date/Time Prepared: 5/30/2024 8:35 am Title XIX Hospi tal PPS Costs 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 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 130 0 54.00 60.00 06000 LABORATORY 0 60.00 0 06500 RESPIRATORY THERAPY 0 65.00 0 65.00 66. 00 06600 PHYSI CAL THERAPY 91, 689 66.00 66. 01 06601 PHYSI CAL THERAPY - CARMEL 0 66.01 06700 OCCUPATIONAL THERAPY 0 67.00 57, 549 67.00 68.00 06800 SPEECH PATHOLOGY 47, 638 0 68.00 06801 VI SI ON 0 68.01 0 68.01 06802 FAC RESOURCE 0 68 02 68 02 0 06900 ELECTROCARDI OLOGY 69.00 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 352 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 20, 322 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 58, 242 0 90.00 90. 01 09001 SLEEP CENTER 0 90.01 09100 EMERGENCY 91.00 0 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 200.00 Subtotal (see instructions) 276, 922 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201. 00 Only Charges

276, 922

0

202.00

202.00

Net Charges (line 200 - line 201)

| Health Financial Systems                | REHABILITATION HOSPITAL OF INDIANA | In Lie          | eu of Form CMS-2                            | 2552-10 |
|---|------------------------------------|-----------------|---|---------|
| COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15                   | From 01/01/2023 | Worksheet D-1 Date/Time Prep 5/30/2024 8:35 |         |
|   | Title XVII                         | I Hospi tal     | PPS   |         |
| Cost Center Description                 |                                    |                 |   |         |

|                  |  | T: +1 o V/// / /                 | Haani tal        | 5/30/2024 8: 3   | <u>5 am</u>      |
|------------------|--|----------------------------------|------------------|--|------------------|
|                  | Cost Center Description  | Title XVIII                      | Hospi tal        | PPS  |                  |
|                  | <u> </u>   |                                  |                  | 1. 00  |                  |
|                  | PART I - ALL PROVIDER COMPONENTS   |                                  |                  |  |                  |
| 1. 00            | INPATIENT DAYS Inpatient days (including private room days and swing-bed days  | s excluding newborn)             |                  | 18, 813  | 1.00             |
| 2. 00            | Inpatient days (including private room days, excluding swing-  |                                  |                  | 18, 813  | 1                |
| 3.00             | Private room days (excluding swing-bed and observation bed day   | ys). If you have only pr         | vate room days,  | 0  | 3. 00            |
| 4. 00            | do not complete this line.<br>Semi-private room days (excluding swing-bed and observation by                                     | ad days)                         |                  | 10 012   | 4. 00            |
| 5. 00            | Total swing-bed SNF type inpatient days (including private ro  |                                  | 31 of the cost   | 18, 813<br>0   | 1                |
| 0.00             | reporting period   | siii days) tiii dagii beeciiibei | 01 01 110 0031   | Ŭ  | 0.00             |
| 6.00             | Total swing-bed SNF type inpatient days (including private roof  | 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 room         | m days) through Dosombor         | 21 of the cost   | 0  | 7. 00            |
| 7.00             | reporting period   | ii days) tiii ougii beceiibei    | 31 Of the Cost   | 0  | 7.00             |
| 8.00             | Total swing-bed NF type inpatient days (including private room   | m days) after December 3         | 1 of the cost    | 0  | 8. 00            |
|                  | reporting period (if calendar year, enter 0 on this line)  | 5                                |                  |  |                  |
| 9. 00            | Total inpatient days including private room days applicable to newborn days) (see instructions)                                  | the Program (excluding           | swing-bed and    | 5, 231   | 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  |                                  | ,                |  |                  |
| 11. 00           | Swing-bed SNF type inpatient days applicable to title XVIII or   |                                  | oom days) after  | 0  | 11. 00           |
| 12. 00           | December 31 of the cost reporting period (if calendar year, en<br>Swing-bed NF type inpatient days applicable to titles V or XIX |                                  | e room days)     | 0  | 12. 00           |
| .2.00            | through December 31 of the cost reporting period   | t omy (mer daring private        | s room dayoy     | , and the second | 12.00            |
| 13. 00           | Swing-bed NF type inpatient days applicable to titles V or XIX   |                                  |                  | 0  | 13. 00           |
| 14. 00           | after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra   |                                  |                  | 0  | 14. 00           |
| 15. 00           | Total nursery days (title V or XIX only)   | all (excluding swing-bed to      | lays)            | 0  | 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 o         | 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 services   | s through December 31 of         | the cost         | 266. 32  | 19. 00           |
| 20. 00           | reporting period Medicaid rate for swing-bed NF services applicable to services  | s after December 31 of t         | ne cost          | 0.00   | 20. 00           |
| 20.00            | reporting period   | s arter becomber or or the       | 10 0031          | 0.00   | 20.00            |
| 21. 00           | Total general inpatient routine service cost (see instructions   |                                  |                  | 24, 640, 928   | 1                |
| 22. 00           | Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)   | er 31 of the cost report         | ng period (line  | 0  | 22. 00           |
| 23. 00           | Swing-bed cost applicable to SNF type services after December  | 31 of the cost reporting         | period (line 6   | 0  | 23. 00           |
|                  | x line 18)   |                                  |                  |  |                  |
| 24. 00           | ] 3 11 31  | r 31 of the cost reporti         | ng period (line  | 0  | 24. 00           |
| 25. 00           | 7 x line 19) Swing-bed cost applicable to NF type services after December 3  | 31 of the cost reporting         | neriod (line 8   | 0  | 25. 00           |
| 20.00            | x line 20)   | or the cost reporting            | perrod (rriie o  | Ŭ  | 20.00            |
| 26. 00           | Total swing-bed cost (see instructions)  |                                  |                  | 0  | 26. 00           |
| 27. 00           | General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT                                | (line 21 minus line 26)          |                  | 24, 640, 928   | 27. 00           |
| 28. 00           | General inpatient routine service charges (excluding swing-bed   | d and observation bed ch         | arges)           | 0  | 28. 00           |
| 29. 00           | Pri vate room charges (excluding swing-bed charges)  |                                  |                  | 0  |                  |
| 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   | 1                |
| 32. 00<br>33. 00 | Average private room per diem charge (line 29 ÷ line 3)<br>Average semi-private room per diem charge (line 30 ÷ line 4)          |                                  |                  | 0. 00<br>0. 00   | 1                |
| 34. 00           | Average per diem private room charge differential (line 32 mi)   | nus line 33)(see instruc         | tions)           | 0.00   | 1                |
| 35.00            | Average per diem private room cost differential (line 34 x li  |                                  |                  | 0.00   | 35. 00           |
| 36.00            | Private room cost differential adjustment (line 3 x line 35)   |                                  | 56               | 0  | 36.00            |
| 37. 00           | General inpatient routine service cost net of swing-bed cost a 27 minus line 36)   | and private room cost di         | rrerential (line | 24, 640, 928   | 37. 00           |
|                  | PART II - HOSPITAL AND SUBPROVIDERS ONLY   |                                  |                  |  |                  |
|                  | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU   |                                  |                  |  |                  |
| 38. 00           | Adjusted general inpatient routine service cost per diem (see  | *                                |                  | 1, 309. 78   |                  |
| 39. 00<br>40. 00 | Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program    | •                                |                  | 6, 851, 459<br>0   | 39. 00<br>40. 00 |
|                  | Total Program general inpatient routine service cost (line 39  | ,                                |                  | 6, 851, 459  | 1                |
|                  |  | •                                | '                |  |                  |

| OMPUT          | ATION OF INPATIENT OPERATING COST   |                                | Provi der       |                              | Period:<br>From 01/01/2023 | Worksheet D-1               |                |
|----------------|---|--------------------------------|-----------------|------------------------------|----------------------------|-----------------------------|----------------|
|                |   |                                |                 |                              | To 12/31/2023              | Date/Time Pre               |                |
|                |   |                                | Ti tl           | e XVIII                      | Hospi tal                  | 5/30/2024 8: 3<br>PPS       | is am          |
|                | Cost Center Description   | Total                          | Total           | Average Per<br>sDiem (col. 1 | Program Days               | Program Cost (col. 3 x col. |                |
|                |   | impatrent cost                 | прастепт вау    | col . 2)                     | -                          | 4)                          |                |
| 2. 00          | NURSERY (title V & XIX only)  | 1.00                           | 2. 00           | 3. 00                        | 4. 00                      | 5. 00                       | 42.            |
| 00             | Intensive Care Type Inpatient Hospital Units  |                                |                 |                              |                            |                             | 42.            |
| 3. 00          | INTENSIVE CARE UNIT CORONARY CARE UNIT  |                                |                 |                              |                            |                             | 43.<br>44.     |
|                | BURN INTENSIVE CARE UNIT  |                                |                 |                              |                            |                             | 45.            |
|                | SURGICAL INTENSIVE CARE UNIT  |                                |                 |                              |                            |                             | 46.            |
| 7.00           | OTHER SPECIAL CARE (SPECIFY)  Cost Center Description   |                                |                 |                              |                            |                             | 47.            |
| 2 00           | Program inpatient ancillary service cost (Wks   | rt D 2 col 3                   | Line 200)       |                              |                            | 1. 00<br>3, 619, 010        | 48.            |
| 3. 00<br>3. 01 | Program inpatient cellular therapy acquisition  |                                |                 | III, line 10,                | column 1)                  | 3, 619, 010                 | 1              |
| 0. 00          | Total Program inpatient costs (sum of lines   | 11 through 48.C                | 1)(see instru   | ctions)                      | ·                          | 10, 470, 469                | 49.            |
| . 00           | PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpa                      | atient routine                 | services (fro   | m Wkst. D, sum               | of Parts I and             | 406, 710                    | 50.            |
| . 00           |   | ationt andillar                |                 | From What D. o.              | um of Dorsto II            | 120 100                     | 51.            |
| . 00           | Pass through costs applicable to Program inpa<br>and IV)  | atrent anciliar                | y services (i   | TOIII WKSt. D, St            | um of Parts II             | 138, 199                    | 51.            |
| . 00           | Total Program excludable cost (sum of lines 5   | ,                              | loted man ab    | uciaian anaath               | atiot and                  | 544, 909                    |                |
| 8. 00          | Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5      |                                | nated, non-pr   | iysi ci an-anestne           | etist, and                 | 9, 925, 560                 | 53.            |
|                | TARGET AMOUNT AND LIMIT COMPUTATION   |                                |                 |                              |                            | 0                           | 54.            |
|                | Program discharges Target amount per discharge  |                                |                 |                              |                            | 0<br>0. 00                  |                |
|                | Permanent adjustment amount per discharge   |                                |                 |                              |                            | 0.00                        |                |
|                | Adjustment amount per discharge (contractor u<br>Target amount (line 54 x sum of lines 55, 55.    |                                |                 |                              |                            | 0. 00<br>0                  |                |
| . 00           | Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)    |                                |                 |                              |                            | 0                           | 57.            |
| . 00           |   |                                |                 |                              |                            | 0<br>0. 00                  | 1              |
| 00             | updated and compounded by the market basket)  |                                | ·               | 0 1                          |                            | 0.00                        |                |
| . 00           | Expected costs (lesser of line 53 ÷ line 54, market basket)                                       | or time 55 ffc                 | ılı prior year  | cost report, up              | dated by the               | 0.00                        | 60.            |
| . 00           | Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less       |                                |                 |                              |                            | 0                           | 61.            |
|                | 53) are less than expected costs (lines 54 x  |                                |                 |                              |                            |                             |                |
| 2. 00          | enter zero. (see instructions) Relief payment (see instructions)                                  |                                |                 |                              |                            | 0                           | 62.            |
| 3. 00          | Allowable Inpatient cost plus incentive payme   | ent (see instru                | ctions)         |                              |                            | 0                           | 1              |
|                | PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost            | ts through Docs                | mbor 21 of th   | no cost roporti              | ag pariod (Saa             | 0                           | 64.            |
| . 00           | instructions) (title XVIII only)  | ts till ough bece              | iliber 31 of tr | le cost reportir             | ig per rou (see            | 0                           | 04.            |
| . 00           | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)                     | ts after Decemb                | er 31 of the    | cost reporting               | period (See                | 0                           | 65.            |
| . 00           | Total Medicare swing-bed SNF inpatient routin   | ne costs (line                 | 64 plus line    | 65)(title XVIII              | only); for                 | 0                           | 66.            |
| . 00           | CAH, see instructions<br>  Title V or XIX swing-bed NF inpatient routine                          | e costs through                | December 31     | of the cost re               | porting period             | 0                           | 67             |
|                | (line 12 x line 19)   | · ·                            |                 | ·                            |                            |                             |                |
| . 00           | Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)                                 | e costs arter L                | ecember 31 or   | the cost repor               | rting period               | 0                           | 68.            |
| . 00           | Total title V or XIX swing-bed NF inpatient r   |                                |                 |                              |                            | 0                           | 69.            |
| . 00           | PART III - SKILLED NURSING FACILITY, OTHER NU<br>Skilled nursing facility/other nursing facili    |                                |                 |                              |                            |                             | 70.            |
|                | Adjusted general inpatient routine service co   |                                | ine 70 ÷ line   | 2)                           |                            |                             | 71.            |
| . 00           | Program routine service cost (line 9 x line 7 Medically necessary private room cost applications) |                                | (line 14 x l    | ine 35)                      |                            |                             | 72.            |
| . 00           | Total Program general inpatient routine servi   | ce costs (line                 | 72 + line 73    | 5)                           | ant II ani                 |                             | 74.            |
| . 00           | Capital-related cost allocated to inpatient r 26, line 45)  | outine service                 | costs (Trom     | worksneet B, Pa              | artii, COIUMN              |                             | 75.            |
|                | Per diem capital-related costs (line 75 ÷ lir   |                                |                 |                              |                            |                             | 76             |
|                | Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus        |                                |                 |                              |                            |                             | 77.            |
| . 00           |   |                                |                 |                              |                            |                             |                |
| . 00           | Aggregate charges to beneficiaries for excess   | s costs (from p                |                 | *.                           |                            |                             | 79             |
|                | Aggregate charges to beneficiaries for excess   | s costs (from parison to the c |                 | *.                           | us line 79)                |                             | 79<br>80<br>81 |

83.00

84.00

85.00

86.00

87.00 0.00 88.00 0 89.00

85.00

86.00

83.00 Reasonable inpatient routine service costs (see instructions)

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

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

84.00 Program inpatient ancillary services (see instructions)

| Health Financial Systems REHA                 | ABILITATION HOS | PITAL OF INDIA | NA         | In Lie                     | eu of Form CMS-2 | 2552-10        |
|---|-----------------|----------------|------------|----------------------------|------------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST       |                 | Provi der CC   |            | Period:<br>From 01/01/2023 | Worksheet D-1    |                |
|   |                 |                |            | To 12/31/2023              |                  | pared:<br>5 am |
|   |                 | Title          | XVIII      | Hospi tal                  | PPS              |                |
| Cost Center Description                       | Cost            | Routine Cost   | column 1 ÷ | Total                      | Observation      |                |
|   |                 | (from line 21) | column 2   | Observati on               | Bed Pass         |                |
|   |                 |                |            | Bed Cost (from             | Through Cost     |                |
|   |                 |                |            | line 89)                   | (col. 3 x col.   |                |
|   |                 |                |            |                            | 4) (see          |                |
|   |                 |                |            |                            | instructions)    |                |
|   | 1.00            | 2.00           | 3. 00      | 4. 00                      | 5. 00            |                |
| COMPUTATION OF OBSERVATION BED PASS THROUGH ( | COST            |                |            |                            |                  |                |
| 90.00 Capital -related cost                   | 1, 462, 786     | 24, 640, 928   | 0. 05936   | 4 0                        | 0                | 90. 00         |
| 91.00 Nursing Program cost                    | 0               | 24, 640, 928   | 0.00000    | 0                          | 0                | 91.00          |
| 92.00 Allied health cost                      | 0               | 24, 640, 928   | 0.00000    | 0                          | 0                | 92. 00         |
| 93.00 All other Medical Education             | o               | 24, 640, 928   | 0. 00000   | 0 0                        | 0                | 93. 00         |

| Health Financial Systems                | REHABILITATION HOSPITAL OF INDIANA | In Lie                      | u of Form CMS-              | 2552-10        |
|---|------------------------------------|-----------------------------|-----------------------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 15-3028             | Peri od:<br>From 01/01/2023 | Worksheet D-1               |                |
|   |                                    | To 12/31/2023               | Date/Time Pre 5/30/2024 8:3 | pared:<br>5 am |
|   | Title XIX                          | Hospi tal                   | PPS                         |                |
| Cost Center Description                 |                                    |                             |                             |                |
|   |                                    |                             | 1. 00                       |                |
| PART I - ALL PROVIDER COMPONENTS        |                                    |                             |                             |                |

|                  |  | Title XIX                 | Hospi tal       | PPS          | <u> </u>         |  |
|------------------|--|---------------------------|-----------------|--------------|------------------|--|
|                  | Cost Center Description  |                           |                 |              |                  |  |
|                  | DADT I ALL DROWLDED COMPONENTS   |                           |                 | 1.00         |                  |  |
|                  | PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS  |                           |                 |              |                  |  |
| 1.00             | Inpatient days (including private room days and swing-bed days, excluding newborn)   |                           |                 |              | 1. 00            |  |
| 2.00             | Inpatient days (including private room days, excluding swing-bed and newborn days)   |                           |                 |              | 2. 00            |  |
| 3.00             | Private room days (excluding swing-bed and observation bed day   | /s). If you have only pri | vate room days, | 0            | 3. 00            |  |
| 4. 00            | do not complete this line.<br>Semi-private room days (excluding swing-bed and observation be   | d days)                   |                 | 18, 813      | 4. 00            |  |
| 5.00             | Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost                                |                           |                 |              | 5. 00            |  |
|                  | reporting period   |                           |                 |              |                  |  |
| 6.00             | Total swing-bed SNF type inpatient days (including private room  | 0                         | 6. 00           |              |                  |  |
| 7. 00            | reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room             | days) through December    | 31 of the cost  | 0            | 7. 00            |  |
| 7.00             | reporting period   | or the cost               | Ö               | 7.00         |                  |  |
| 8.00             | Total swing-bed NF type inpatient days (including private room   | n 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 to the Program (excluding swing-bed and newborn days) (see instructions) |                           |                 |              | 9. 00            |  |
| 10. 00           | Swing-bed SNF type inpatient days applicable to title XVIII or   | nly (including private ro | oom days)       | 0            | 10. 00           |  |
|                  | through December 31 of the cost reporting period (see instruct   | i ons)                    |                 |              |                  |  |
| 11. 00           | Swing-bed SNF type inpatient days applicable to title XVIII or   |                           | oom days) after | 0            | 11. 00           |  |
| 12. 00           | December 31 of the cost reporting period (if calendar year, er 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   | Comy (Therearing private  | 3 1 00m days)   | Ö            | 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 ye   |                           |                 | 0            | 14.00            |  |
| 14. 00<br>15. 00 | Medically necessary private room days applicable to the Progra<br>Total nursery days (title V or XIX only)                           | am (excluding swing-bed o | lays)           | 0            | 14. 00<br>15. 00 |  |
| 16. 00           |  |                           |                 |              | 16. 00           |  |
|                  | SWING BED ADJUSTMENT   |                           |                 |              |                  |  |
| 17. 00           | Medicare rate for swing-bed SNF services applicable to service   | es through December 31 o  | 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   |                           |                 | 0.00         |                  |  |
| 19. 00           | Medicaid rate for swing-bed NF services applicable to services   | s through December 31 of  | the cost        | 266. 32      | 19. 00           |  |
| 20. 00           | reporting period Medicaid rate for swing-bed NF services applicable to services  | after December 31 of th   | ne cost         | 0.00         | 20. 00           |  |
| 20.00            | reporting period   | ditter becomber of the    | 10 0031         | 0.00         | 20.00            |  |
| 21. 00           | Total general inpatient routine service cost (see instructions   |                           |                 | 24, 640, 928 |                  |  |
| 22. 00           | Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)   | er 31 of the cost reporti | ng period (line | 0            | 22. 00           |  |
| 23. 00           | Swing-bed cost applicable to SNF type services after December  | 31 of the cost reporting  | period (line 6  | 0            | 23. 00           |  |
|                  | x line 18)   | ,                         |                 |              |                  |  |
| 24. 00           | Swing-bed cost applicable to NF type services through December   | 31 of the cost reporti    | ng period (line | 0            | 24. 00           |  |
| 25. 00           | <pre>  7 x line 19)   Swing-bed cost applicable to NF type services after December 3</pre>   | 31 of the cost reporting  | period (line 8  | 0            | 25. 00           |  |
| 20.00            | x line 20)   | or the cost reporting     | perrou (rine o  | o l          | 20.00            |  |
| 26. 00           | Total swing-bed cost (see instructions)  |                           |                 | 0            |                  |  |
| 27. 00           | General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT                                  | (line 21 minus line 26)   |                 | 24, 640, 928 | 27. 00           |  |
| 28. 00           | General inpatient routine service charges (excluding swing-bed   | and observation bed cha   | arges)          | 0            | 28. 00           |  |
| 29. 00           | Private room charges (excluding swing-bed charges)   |                           | a. goo)         | Ö            |                  |  |
| 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     | 31.00            |  |
| 32.00            | Average private room per diem charge (line 29 ÷ line 3)  |                           |                 | 0. 00        | 32.00            |  |
| 33. 00           | Average semi-private room per diem charge (line 30 ÷ line 4)   |                           |                 | 0. 00        |                  |  |
| 34. 00           | Average per diem private room charge differential (line 32 mir   |                           | tions)          | 0. 00        |                  |  |
| 35. 00           | Average per diem private room cost differential (line 34 x lin   | ne 31)                    |                 | 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 (line 24,640,928 27 minus line 36)   |                           |                 |              | 37. 00           |  |
|                  | PART II - HOSPITAL AND SUBPROVIDERS ONLY   |                           |                 |              |                  |  |
|                  | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  |                           |                 |              |                  |  |
| 38. 00           | Adjusted general inpatient routine service cost per diem (see  |                           |                 | 1, 309. 78   | 38. 00           |  |
| 39. 00           | Program general inpatient routine service cost (line 9 x line  | ,                         |                 | 983, 645     |                  |  |
| 40.00            | Medically necessary private room cost applicable to the Progra   | •                         |                 | 002 (45      | 40.00            |  |
| 41. 00           | Total Program general inpatient routine service cost (line 39  | + ITHE 40)                |                 | 983, 645     | 41.00            |  |

| COMPUT         | ATION OF INPATIENT OPERATING COST  |                         | Provi der (             | CCN: 15-3028                      | Peri od:<br>From 01/01/2023 | Worksheet D-1                        |                  |
|----------------|--|-------------------------|-------------------------|-----------------------------------|-----------------------------|--------------------------------------|------------------|
|                |  |                         |                         |                                   | To 12/31/2023               | Date/Time Pre 5/30/2024 8:3          |                  |
|                |  |                         |                         | le XIX                            | Hospi tal                   | PPS                                  |                  |
|                | Cost Center Description  | Total<br>Inpatient Cost | Total<br>Inpatient Days | Average Pers Diem (col. 1 col. 2) |                             | Program Cost<br>(col. 3 x col.<br>4) |                  |
| 10.00          | AUDOEDY (11 11 A A VIV   | 1. 00                   | 2. 00                   | 3. 00                             | 4. 00                       | 5. 00                                | 10.00            |
| 42. 00         | NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units  |                         |                         |                                   |                             |                                      | 42. 00           |
| 43. 00         | INTENSIVE CARE UNIT  |                         |                         |                                   |                             |                                      | 43.00            |
|                | CORONARY CARE UNIT   |                         |                         |                                   |                             |                                      | 44.00            |
|                | BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT  |                         |                         |                                   |                             |                                      | 45. 00<br>46. 00 |
|                | OTHER SPECIAL CARE (SPECIFY)   |                         |                         |                                   |                             |                                      | 47. 00           |
|                | Cost Center Description  |                         |                         |                                   |                             |                                      |                  |
| 18. 00         | Program inpatient ancillary service cost (Wk:  | s+ D 2 col 2            | Line 200)               |                                   |                             | 1. 00<br>455, 244                    | 48. 00           |
|                | Program inpatient cellular therapy acquisition   |                         |                         | III. line 10.                     | column 1)                   | 455, 244                             | 48. 01           |
|                | Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS  |                         |                         |                                   |                             | 1, 438, 889                          | 1                |
| 0.00           | Pass through costs applicable to Program inpa  | atient routine          | services (fro           | m Wkst. D, sur                    | n of Parts I and            | 58, 390                              | 50. 00           |
| 1. 00          | <pre>III) Pass through costs applicable to Program inpa and IV)</pre>  | atient ancillar         | y services (f           | rom Wkst. D, s                    | sum of Parts II             | 18, 008                              | 51.00            |
| 2. 00          | Total Program excludable cost (sum of lines!   | ,                       |                         |                                   |                             | 76, 398                              | 1                |
| 3. 00          | Total Program inpatient operating cost exclud  |                         | lated, non-ph           | ysician anestl                    | netist, and                 | 1, 362, 491                          | 53.00            |
|                | medical education costs (line 49 minus line !<br>TARGET AMOUNT AND LIMIT COMPUTATION   | 02)                     |                         |                                   |                             |                                      |                  |
|                | Program di scharges  |                         |                         |                                   |                             | 0                                    | 54.00            |
|                | Target amount per discharge  |                         |                         |                                   |                             |                                      | 55. 00           |
|                | Permanent adjustment amount per discharge  |                         |                         |                                   |                             |                                      | 55. 01           |
|                | Adjustment amount per discharge (contractor use only) Target amount (line 54 x sum of lines 55, 55.01, and 55.02)                                |                         |                         |                                   |                             |                                      | 55. 02<br>56. 00 |
|                | Difference between adjusted inpatient operati  |                         |                         | line 56 minus                     | line 53)                    | 0                                    |                  |
| 8. 00          | Bonus payment (see instructions)   |                         |                         |                                   |                             |                                      | 58.00            |
| 9. 00          | Trended costs (lesser of line 53 ÷ line 54,  | or line 55 from         | the cost rep            | orting period                     | endi ng 1996,               | 0. 00                                | 59.00            |
| 0. 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 |                         |                         |                                   |                             | 0.00                                 | 60.00            |
| 1. 00          | market basket) 00   Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus                          |                         |                         |                                   |                             | 0                                    | 61.00            |
| 1. 00          | 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line  |                         |                         |                                   |                             |                                      | 01.00            |
|                | 53) are less than expected costs (lines 54 $\times$  | 60), or 1 % of          | the target a            | mount (line 5                     | 5), otherwise               |                                      |                  |
| 52. 00         | enter zero. (see instructions)   |                         |                         |                                   |                             | 0                                    | 62. 00           |
|                | Relief payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions)   |                         |                         |                                   |                             | 0                                    |                  |
|                | PROGRAM INPATIENT ROUTINE SWING BED COST   |                         |                         |                                   |                             |                                      |                  |
| 4. 00          | Medicare swing-bed SNF inpatient routine cos   | ts through Dece         | mber 31 of th           | e cost reporti                    | ng period (See              | 0                                    | 64.00            |
| 55. 00         | <pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>  | ts after Decemb         | er 31 of the            | cost reporting                    | neriod (See                 | 0                                    | 65.00            |
| .0. 00         | instructions)(title XVIII only)  |                         | 0. 0. 0                 | 000t . opo. t                     | g po ou (000                |                                      | 00.00            |
| 6. 00          | Total Medicare swing-bed SNF inpatient routin  | ne costs (line          | 64 plus line            | 65)(title XVI                     | <pre>II only); for</pre>    | 0                                    | 66. 00           |
| 7. 00          | CAH, see instructions Title V or XIX swing-bed NF inpatient routine  | e costs through         | December 31             | of the cost re                    | eporting period             | 0                                    | 67. 00           |
| 8. 00          | (line 12 x line 19) Title V or XIX swing-bed NF inpatient routing  | a costs after D         | ecember 31 of           | the cost ren                      | orting period               | 0                                    | 68. 00           |
| 0.00           | (line 13 x line 20)  |                         | ccciiioci 31 01         | the cost rep                      | or tring period             |                                      | 00.00            |
| 9. 00          | Total title V or XIX swing-bed NF inpatient (<br>PART III - SKILLED NURSING FACILITY, OTHER NU   |                         |                         |                                   |                             | 0                                    | 69. 00           |
| 0. 00          | Skilled nursing facility/other nursing facili  |                         |                         |                                   | )                           |                                      | 70.00            |
| 1. 00          | Adjusted general inpatient routine service co  | ost per diem (I         |                         |                                   |                             |                                      | 71.00            |
|                | Program routine service cost (line 9 x line 71)  |                         |                         |                                   |                             |                                      | 72.00            |
| 3. 00<br>4. 00 | Medically necessary private room cost application<br>Total Program general inpatient routine servi   |                         | •                       |                                   |                             |                                      | 73.00            |
| 5. 00          | Capital -related cost allocated to inpatient   |                         |                         | •                                 | Part II, column             |                                      | 75. 00           |
|                | 26, line 45)   |                         |                         |                                   |                             |                                      |                  |
|                | Per diem capital-related costs (line 75 ÷ lin  |                         |                         |                                   |                             |                                      | 76.00            |
|                | Program capital -related costs (line 9 x line  |                         |                         |                                   |                             |                                      | 77. 00           |
| 8. 00<br>9. 00 | Inpatient routine service cost (line 74 minus<br>Aggregate charges to beneficiaries for excess   |                         | rovi den irecon         | ds)                               |                             |                                      | 79.00            |
| 80.00          | Total Program routine service costs for compa  |                         |                         | *.                                | nus line 79)                |                                      | 80.00            |
|                | Inpatient routine service cost per diem limit  |                         |                         |                                   | •                           | 1                                    | 81.00            |

| Health Financial Systems REH                     | ABILITATION HOSPITAL OF INDIANA |                |            | In Lieu of Form CMS-2552-10      |                |        |
|--|---------------------------------|----------------|------------|----------------------------------|----------------|--------|
| COMPUTATION OF INPATIENT OPERATING COST          |                                 | Provi der CC   |            | Peri od:                         | Worksheet D-1  |        |
|  |                                 |                |            | From 01/01/2023<br>To 12/31/2023 |                |        |
|  |                                 | Titl           | Title XIX  |                                  | PPS            |        |
| Cost Center Description                          | Cost                            | Routine Cost   | column 1 ÷ | Total                            | Observation    |        |
|  |                                 | (from line 21) | column 2   | Observati on                     | Bed Pass       |        |
|  |                                 |                |            | Bed Cost (from                   | Through Cost   |        |
|  |                                 |                |            | line 89)                         | (col. 3 x col. |        |
|  |                                 |                |            |                                  | 4) (see        |        |
|  |                                 |                |            |                                  | instructions)  |        |
|  | 1.00                            | 2.00           | 3. 00      | 4. 00                            | 5. 00          |        |
| COMPUTATION OF OBSERVATION BED PASS THROUGH COST |                                 |                |            |                                  |                |        |
| 90.00 Capital -related cost                      | 1, 462, 786                     | 24, 640, 928   | 0. 05936   | 4 0                              | 0              | 90. 00 |
| 91.00 Nursing Program cost                       | 0                               | 24, 640, 928   | 0.00000    | 0                                | 0              | 91.00  |
| 92.00 Allied health cost                         | 0                               | 24, 640, 928   | 0.00000    | 0                                | 0              | 92. 00 |
| 93.00 All other Medical Education                | 0                               | 24, 640, 928   | 0. 00000   | 0 0                              | 0              | 93. 00 |

| ANCILLARY SERVICE COST CENTERS   |   | HOSPITAL OF INDIA |               |              | eu of Form CMS-1 |                  |
|--|---|-------------------|---------------|--------------|------------------|------------------|
| To   12/31/2023   Date/Time Prepare   To   12/31/2023   S35 am   Title XVIII   Hospital   PPS  | INPATIENT ANCILLARY SERVICE COST APPORTIONMENT  | Provi der C       |               |              | Worksneet D-3    |                  |
| Title XVIII  |   |                   |               |              | Date/Time Pre    | pared.           |
| NPATI ENT ROUTINE SERVICE COST CENTERS   1,00  |   |                   |               |              |                  |                  |
| No Charges   |   | Titl∈             | XVIII         | Hospi tal    | PPS              | _                |
| NPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.   | Cost Center Description   |                   | Ratio of Cost | Inpati ent   | Inpati ent       |                  |
| NAME      |   |                   | To Charges    |              |                  |                  |
| NPATI ENT ROUTINE SERVICE COST CENTERS   12, 485, 556   30. 00   3.0000   3.0000   3.0000   3.0000   3.0000   3.0000   3.0000   3.0000   3.00000   3.0000   3.00000   3.0000   3.00000   3.00000   3   |   |                   |               | Charges      |                  |                  |
| NPATI ENT ROUTI NE SERVICE COST CENTERS   12, 485, 556   30.      |   |                   |               |              |                  |                  |
| 30.00  |   |                   | 1.00          | 2. 00        | 3. 00            |                  |
| ANCILLARY SERVICE COST CENTERS   |   |                   |               |              |                  | 1                |
| 50. 00         05000   OPERATI NG ROOM         0.000000   O.000000   O.0000000   O.0000000   O.0000000   O.0000000   O.0000000   O.000000   O.0000000   O.0000000   O.00  |   |                   |               | 12, 485, 556 |                  | 30.00            |
| 54.00         05400         RADI OLOGY-DI AGNOSTI C         0.150408         766, 311         115, 259         54.           60.00         06000         LABORATORY         0.287524         490, 780         141, 111         60.           65.00         06500         RESPI RATORY THERAPY         0.376445         1, 182, 734         445, 234         65.           66.01         06600         PHYSI CAL THERAPY         0.224821         3, 810, 394         856, 657         66.           66.01         06601         PHYSI CAL THERAPY         0.215017         3, 962, 571         852, 020         67.           67.00         06700         OCUPATI ONAL THERAPY         0.215017         3, 962, 571         852, 020         67.           68.01         06800         SPEECH PATHOLOGY         0.29492         2, 115, 238         485, 430         68.           68.01         06801         VI SI ON         0.000000         0         0         68.           68.02         JEAC RESOURCE         0.000000         0         0         68.           68.01         O6802         FAC RESOURCE         0.000000         0         0         69.           71.00         O7100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS   |   |                   | 1             |              |                  |                  |
| 60. 00   |   |                   |               |              |                  |                  |
| 65. 00   06500   RESPI RATORY THERAPY   0. 376445   1, 182, 734   445, 234   65. 66. 00   06600   PHYSI CAL THERAPY   0. 224821   3, 810, 394   856, 657   66. 60. 01   06601   PHYSI CAL THERAPY - CARMEL   0. 000000   0   0. 06. 00. 000000   0. 00. 000000   0. 00. 00   |   |                   |               |              |                  |                  |
| 66. 00   06600   PHYSI CAL THERAPY   0. 0600   PHYSI CAL THERAPY - CARMEL   0. 000000   0   0   66. 66. 01   06601   PHYSI CAL THERAPY - CARMEL   0. 000000   0   0   66. 67. 00   06700   0CCUPATI ONAL THERAPY   0. 215017   3, 962, 571   852, 020   67. 68. 00   06800   SPEECH PATHOLOGY   0. 229492   2, 115, 238   485, 430   68. 68. 01   06801   VI SI ON   0. 000000   0   0   0   68. 68. 02   06802   FAC RESOURCE   0. 000000   0   0   0   68. 69. 00   06900   ELECTROCARDI OLOGY   0. 000000   0   0   0   69. 69. 69. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 276645   666, 271   184, 321   71. 72. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 000000   0   0   0   74. 73. 00   07400   RENAL DI ALYSI S   0. 000000   0   0   0   74. 74. 00   07400   RENAL DI ALYSI S   0. 000000   0   0   0   77. 75. 00   07600   ALLOGENEIC HSCT ACQUI SI TI ON   0. 000000   0   0   0   77. 75. 00   07600   CAR T-CELL IMMUNOTHERAPY   0. 0000000   0   0   0   77. 78. 00   07900   CAR T-CELL IMMUNOTHERAPY   0. 0000000   0   0   0   0   0   0  |   |                   | 1             |              |                  |                  |
| 66. 01   06601   PHYSI CAL THERAPY - CARMEL   0.000000   0   0   0   66. 67. 00   06700   0CCUPATI ONAL THERAPY   0.215017   3,962,571   852,020   67. 68. 00   06800   SPEECH PATHOLOGY   0.229492   2,115,238   485,430   68. 68. 01   06801   VI SI ON   0.000000   0   0   0   68. 68. 02   06802   FAC RESOURCE   0.000000   0   0   0   68. 69. 00   06900   ELECTROCARDI OLOGY   0.000000   0   0   0   69. 69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0.276645   666,271   184,321   71. 72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.000000   0   0   72. 73. 00   07300   DRUGS CHARGED TO PATIENTS   0.239310   2,252,217   538,978   73. 74. 00   07400   DRUGS CHARGED TO PATIENTS   0.000000   0   0   74. 77. 00   07700   ALLOGENEIC HSCT ACQUISITION   0.000000   0   0   0   77. 78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0.000000   0   0   0   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0.000000   0   0   0   0   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0.000000   0   0   0   0   0   0   0  |   |                   | 1             |              |                  |                  |
| 67. 00   06700   0CCUPATI ONAL THERAPY   0. 215017   3, 962, 571   852, 020   67. 68. 00   06800   SPEECH PATHOLOGY   0. 229492   2, 115, 238   485, 430   68. 68. 01   06801   VI SI ON   0. 0000000   0   0   0   68. 68. 02   06802   FAC RESOURCE   0. 0000000   0   0   0   68. 69. 00   06900   ELECTROCARDI OLOGY   0. 0000000   0   0   0   69. 69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0. 276645   666, 271   184, 321   71. 72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 000000   0   0   0   72. 73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 239310   2, 252, 217   538, 978   73. 74. 00   07400   RENAL DI ALYSI S   0. 000000   0   0   0   74. 70. 00   07700   ALLOGENEI C HSCT ACQUI SITI ON   0. 000000   0   0   0   77. 78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0. 000000   0   0   0   78. 00   07900   CLI NI C   0. 346609   0   0. 000000   0   0   0   90. 000000   0   0   0   0   90. 000000   0   0   0   0   90. 000000   0   0   0   0   90. 000000   0   0   0   0   90. 000000   0   0   0   0   90. 000000   0   0   0   0   90. 0000000   0   0   0   0   90. 0000000   0   0   0   0   90. 0000000   0   0   0   90. 0000000   0   0   0   90. 0000000   0   0   0   0   90. 0000000   0   0   0   90. 0000000   0   0   0   90. 0000000   0   0   0   90. 0000000   0   0   0   90. 00000000   0   0   0   90. 000000000   0   0   0   90. 0000000000  |   |                   | 1             |              |                  |                  |
| 68. 00       06800   06800   06800   06801   06801   06801   06801   06801   06801   06801   06801   06801   06801   06801   06801   06802   FAC RESOURCE   0.0000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000  |   |                   | 1             |              | 1                | 66. 01           |
| 68. 01   |   |                   |               |              |                  |                  |
| 68. 02       06802   FAC RESOURCE       0.00000000  |   |                   |               |              |                  |                  |
| 69. 00 06900   ELECTROCARDI OLOGY  |   |                   |               |              | ľ                | 00.0.            |
| 71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0. 276645   666, 271   184, 321   71.     72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 0000000   0   0   72.     73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 239310   2, 252, 217   538, 978   73.     74. 00   07400   RENAL DIALYSIS   0. 000000   0   0   0   74.     77. 00   07700   ALLOGENEI C HSCT ACQUISITION   0. 000000   0   0   0   77.     78.   |   |                   | 1             |              | · ·              | 68. 02           |
| 72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.000000   0   0   72.    73. 00   07300   DRUGS CHARGED TO PATIENTS   0.239310   2,252,217   538,978   73.    74. 00   07400   RENAL DIALYSIS   0.000000   0   0   0   74.    77. 00   07700   ALLOGENEI C HSCT ACQUISITION   0.000000   0   0   0   77.    78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0.000000   0   0   0   78.    78.    0000000   0   0   0   0   0   0   0  |   |                   |               |              |                  | 69.00            |
| 73. 00     07300     DRUGS CHARGED TO PATIENTS     0. 239310     2, 252, 217     538, 978     73.       74. 00     07400     RENAL DI ALYSIS     0. 000000     0     0     74.       77. 00     07700     ALLOGENEI C HSCT ACQUISITION     0. 000000     0     0     0     77.       78. 00     07800     CAR T-CELL IMMUNOTHERAPY     0. 000000     0     0     0     78.       90. 01     09000     CLINIC     0. 346609     0     0     90.       90. 01     09001     SLEEP CENTER     0. 000000     0     0     97.       91. 00     09100     EMERGENCY     0. 000000     0     0     97.       92. 00     09200     OBSERVATION BEDS (NON-DISTINCT PART Total (sum of lines 50 through 94 and 96 through 98)     15, 246, 516     3, 619, 010     200.  |   |                   | 1             |              |                  | 71.00            |
| 74. 00       07400 RENAL DIALYSIS       0.000000 0 0 0 0 0 0 74.         77. 00 07700 ALLOGENEI C HSCT ACQUISITION       0.000000 0 0 0 0 77.         78. 00 07800 CAR T-CELL IMMUNOTHERAPY       0.000000 0 0 0 0 78.         00 UTPATIENT SERVICE COST CENTERS       0.346609 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  |   |                   | 1             |              |                  |                  |
| 77. 00   |   |                   | 1             |              |                  |                  |
| 78. 00   |   |                   |               |              | · -              |                  |
| OUTPATIENT SERVICE COST CENTERS   O9000   CLINIC   O. 346609   O   O   O9000   O90000   O90000   O90000   O90000   O90000   O90000   O900000   O900000   O900000   O900000   O9000000   O9000000   O9000000   O9000000   O9000000   O9000000   O90000000   O90000000   O90000000   O90000000   O90000000   O900000000   O900000000   O9000000000   O900000000   O9000000000   O9000000000   O9000000000   O90000000000   |   |                   |               |              | ľ                | 1                |
| 90. 00   |   |                   | 0.00000       | 0 0          | 0                | 78. 00           |
| 90. 01   |   |                   | 0.24//0       |              | 0                | 00 00            |
| 91. 00   |   |                   | 1             |              | 1                |                  |
| 92. 00   09200 |   |                   | 1             |              | ľ                | 90. 01<br>91. 00 |
| 200.00 Total (sum of lines 50 through 94 and 96 through 98) 15,246,516 3,619,010 200.  |   |                   | 1             |              | ľ                | 91.00            |
|  |   | 2)                | 0.00000       |              |                  |                  |
|  | 200.00   Total (sum of fines 50 through 94 and 96 through 98 201.00   Less PBP Clinic Laboratory Services-Program only ch |                   |               | 15, 246, 516 |                  | 200.00           |

201. 00 202. 00

15, 246, 516

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

201.00 202.00

| Health Financial Systems   REHABILITATION HOSPITAL OF INDIANA   In Lieu of Form CMS-2552  | -10      |
|---|----------|
| To 12/31/2023 Date/Time Prepare 5/30/2024 8: 35 am  Title XIX Hospital PPS  Cost Center Description Ratio of Cost To Charges Charges (col. 1 x col. 2)  To 12/31/2023 Date/Time Prepare 5/30/2024 8: 35 am  PPS  Cost Center Description Ratio of Cost To Charges (col. 1 x col. 2) |          |
| Cost Center Description  Cost Center Description  Title XIX  Hospital  PPS  Ratio of Cost To Charges  Charges  Cost Center Description  Ratio of Cost To Charges Charges Charges Col. 1 x col. 2)   |          |
| Cost Center Description  Ratio of Cost Inpatient Program Program Costs Charges (col. 1 x col. 2)  Title XIX Hospital PPS  Ratio of Cost Inpatient Program Costs (col. 1 x col. 2)   | ∌d:<br>n |
| Cost Center Description  Ratio of Cost Inpatient Program Program Costs Charges (col. 1 x col. 2)  | <u>'</u> |
| To Charges Program Program Costs Charges (col. 1 x col. 2)  |          |
|   |          |
|   |          |
| 1.00   2.00   3.00  |          |
|   |          |
| INPATIENT ROUTINE SERVICE COST CENTERS  |          |
|   | . 00     |
| ANCILLARY SERVICE COST CENTERS  |          |
| 50. 00   05000   OPERATI NG ROOM   0. 000000   0   50.  |          |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C   0. 150408   60, 181   9, 052   54.   |          |
| 60. 00   06000   LABORATORY   0. 287524   57, 499   16, 532   60.   |          |
| 65. 00   06500   RESPI RATORY THERAPY   0. 376445   113, 129   42, 587   65.  |          |
| 66. 00   06600   PHYSI CAL THERAPY 0. 224821 528, 611 118, 843   66.  |          |
| 66. 01   06601   PHYSI CAL THERAPY - CARMEL   0. 000000   0   66.   |          |
| 67. 00   06700   0CCUPATI ONAL THERAPY  |          |
| 68. 00   06800   SPEECH PATHOLOGY   0. 229492   280, 774   64, 435   68.  |          |
|   | . 01     |
|   | . 02     |
|   | . 00     |
| 71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   0. 276645   53, 854   14, 898   71.  |          |
| 72. 00   07200   I MPL. DEV. CHARGED TO PATI ENTS   0. 000000   0   0   72.   |          |
| 73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 239310   296, 564   70, 971   73.   |          |
| 74. 00   07400   RENAL DI ALYSI S   0. 000000   0   0   74.   |          |
|   | . 00     |
|   | . 00     |
| OUTPATIENT SERVICE COST CENTERS   |          |
| 90. 00   09000   CLI NI C   0. 346609   0   0   90.   |          |
|   | . 01     |
| 91. 00   09100   EMERGENCY  |          |

0.000000

1, 939, 062

201. 00 202. 00

0 92.00

455, 244 200. 00

200.00

201.00 202.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

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)

Provider CCN: 15-3028

Peri od:

From 01/01/2023

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4

In Lieu of Form CMS-2552-10 Worksheet E

Part A Exhibit 4

12/31/2023 Date/Time Prepared: 5/30/2024 8:35 am Title XVIII Hospi tal Period Prior Total (Col 2 W/S E, Part A Amounts (from Pre/Post Peri od to 10/01 On/After 10/01 through 4) line Part A) Entitlement 4 00 0 1 00 2 00 3 00 5 00 1.00 DRG amounts other than outlier 1.00 1.00 1.01 DRG amounts other than outlier 1.01 1.01 payments for discharges occurring prior to October 1 1 02 DRG amounts other than outlier 1 02 1.02 payments for discharges occurring on or after October DRG for Federal specific 1.03 1.03 1.03 operating payment for Model 4 BPCI occurring prior to October 1 1.04 DRG for Federal specific 1.04 1.04 operating payment for Model 4 BPCI occurring on or after October 1 Outlier payments for 2.00 2 00 2.00 discharges (see instructions) 2.01 Outlier payments for 2.02 2.01 discharges for Model 4 BPCI Outlier payments for 2.02 2.03 2.02 discharges occurring prior to October 1 (see instructions) 2.03 Outlier payments for 2.04 2.03 discharges occurring on or after October 1 (see instructions) 3.00 3.00 Operating outlier 2.01 reconciliation 4.00 Managed care simulated 3.00 -2, 017, 266 2, 017, 266 4.00 payments Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part 21.00 0.000000 0.000000 0.000000 0.000000 5.00 A, line 21 (see instructions) IME payment adjustment (see 6.00 22.00 0 0 0 6.00 instructions) 6.01 IME payment adjustment for 22.01 6. 01 managed care (see instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor 27.00 0.000000 0.000000 0.000000 0.000000 7.00 (see instructions) 8.00 IME adjustment (see 28.00 8.00 instructions) IME payment adjustment add on 8.01 28.01 8.01 for managed care (see instructions) 9.00 Total IME payment (sum of 29.00 9.00 lines 6 and 8) Total IME payment for managed 9.01 29.01 9.01 care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate 33 00 0.0000 0.0000 0.0000 0.0000 10.00 share percentage (see instructions) Di sproporti onate share 0 11.00 34.00 0 11.00 adjustment (see instructions) 11. 01 Uncompensated care payments 36.00 0 0 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment 0 0 12.00 46.00 12.00 (see instructions) 13 00 47 00 0 Subtotal (see instructions) 0 0 13 00 Hospital specific payments 48.00 0 14.00 14.00 (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient 15.00 49 00 C 15.00 operating costs (see instructions) Payment for inpatient program 50.00 16.00 capital (from Wkst. L, Pt. I, if applicable)

100.00

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-3028 Peri od: Worksheet E From 01/01/2023 Part A Exhibit 4
Date/Time Prepared: 12/31/2023 5/30/2024 8:35 am Title XVIII Hospi tal W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od 0n/After 10/01 4.00 to 10/01 Part A) line Entitlement through 4) 0 1 00 2 00 3 00 5 00 17.00 Special add-on payments for 54.00 17.00 new technologies 17.01 Net organ aquisition cost 17.01 17.02 Credits received from 68.00 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 W/S L, line (Amounts from 0 1.00 2.00 3.00 4. 00 5.00 Capital DRG other than outlier 20.00 1.00 0 20.00 0 0 Model 4 BPCI Capital DRG other 0 0 0 20.01 1 01 20.01 than outlier 21.00 Capital DRG outlier payments 2.00 0 0 0 21.00 Model 4 BPCI Capital DRG 21.01 2.01 0 21.01 outlier payments Indirect medical education 22 00 5.00 0.0000 0.0000 0.0000 0.0000 22.00 percentage (see instructions) 23.00 Indirect medical education 6.00 0 0 23.00 adjustment (see instructions) 24.00 Allowable disproportionate 10.00 0.0000 0.0000 0.0000 0.0000 24.00 share percentage (see instructions) 0 25.00 Di sproporti onate share 11.00 0 C 25.00 0 adjustment (see instructions) 26.00 Total prospective capital 12.00 0 26.00 payments (see instructions) W/S E, Part A (Amounts to E, Part A) line 1.00 2.00 3.00 4.00 5. 00 0 27.00 Low volume adjustment factor 0.000000 0.000000 27.00 28.00 Low volume adjustment 70.96 28.00 (transfer amount to Wkst. E, Pt. A. line) 29.00 Low volume adjustment 29.00 70.97 0 (transfer amount to Wkst. E, Pt. A, line)

100.00 Transfer low volume

adjustments to Wkst. E, Pt. A.

Provider CCN: 15-3028

Peri od:

From 01/01/2023

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Part A Exhibit 5

Date/Time Prepared: 12/31/2023 5/30/2024 8:35 am Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 1.00 2.00 3. 00 4. 00 0 1.00 DRG amounts other than outlier payments 1.00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 0 0 1.01 discharges occurring prior to October 1 DRG amounts other than outlier payments for 1.02 1.02 0 0 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 0 1.03 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 O 2. 01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 O Ω 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 2.03 0 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 3.00 Managed care simulated payments 5, 260, 966 2.017.266 7, 278, 232 4.00 3.00 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 C 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 0 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.0000 0.0000 0.0000 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 0 0 0 11.00 instructions) 11.01 0 Uncompensated care payments 36 00 0 0 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 O 0 12.00 instructions) 13 00 47 00 0 Subtotal (see instructions) 0 13 00 0 14.00 Hospital specific payments (completed by SCH 48.00 0 0 0 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 0 0 15.00 15.00 (see instructions) 16.00 50 00 0 16.00 Payment for inpatient program capital (from 0 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 17.00 0 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 0 68.00 0 17.02 17.02 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 0 18.00 amount (see instructions) 19.00 **SUBTOTAL** 19.00

|        | Financial Systems REHAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA               | ABILITATION HOS<br>TION EXHIBIT 5 | Provider CO                      | CN: 15-3028 F | Period:<br>From 01/01/2023<br>To 12/31/2023 |                             | t 5<br>pared: |
|--------|--|-----------------------------------|----------------------------------|---------------|---|-----------------------------|---------------|
|        |  |                                   | Title                            | XVIII         | Hospi tal                                   | PPS                         |               |
|        |  | Wkst. L, line                     | (Amt. from<br>Wkst. L)           |               |   |                             |               |
|        |  | 0                                 | 1.00                             | 2.00          | 3. 00                                       | 4. 00                       |               |
| 20. 00 | Capital DRG other than outlier   | 1.00                              | 0                                | (             | 0   | 0                           | 20.00         |
| 20. 01 | Model 4 BPCI Capital DRG other than outlier                                      | 1. 01                             | 0                                | (             | 0   | 0                           | 20. 01        |
| 21. 00 | Capital DRG outlier payments   | 2.00                              | 0                                | (             | 0   | 0                           | 21.00         |
| 21. 01 | Model 4 BPCI Capital DRG outlier payments  | 2. 01                             | 0                                | (             | 0   | 0                           | 21. 01        |
|        | Indirect medical education percentage (see instructions)                         | 5. 00                             | 0. 0000                          | 0. 0000       | 0.0000                                      |                             | 22. 00        |
| 23. 00 | Indirect medical education adjustment (see instructions)                         | 6. 00                             | 0                                | (             | 0   | 0                           | 23. 00        |
|        | Allowable disproportionate share percentage (see instructions)                   | 10. 00                            | 0. 0000                          | 0. 0000       | 0. 0000                                     |                             | 24. 00        |
|        | Disproportionate share adjustment (see instructions)                             | 11. 00                            | 0                                | (             | 0   | 0                           | 25. 00        |
| 26. 00 | Total prospective capital payments (see instructions)                            | 12.00                             | 0                                | (             | 0   | 0                           | 26. 00        |
|        |  | Wkst. E, Pt.<br>A, line           | (Amt. from<br>Wkst. E, Pt.<br>A) |               |   |                             |               |
|        |  | 0                                 | 1. 00                            | 2.00          | 3. 00                                       | 4. 00                       |               |
| 27. 00 |  |                                   |                                  |               |   |                             | 27. 00        |
| 28. 00 | Low volume adjustment prior to October 1   | 70. 96                            | 0                                | (             |   | 0                           | 28. 00        |
| 29. 00 | Low volume adjustment on or after October 1                                      | 70. 97                            | 0                                |               | 0   | 0                           | 29.00         |
| 30.00  | HVBP payment adjustment (see instructions)                                       | 70. 93                            | 0                                | (             | o   | 0                           | 30.00         |
|        | HVBP payment adjustment for HSP bonus payment (see instructions)                 | 70. 90                            | 0                                | (             | 0   | 0                           | 30. 01        |
| 31. 00 | HRR adjustment (see instructions)  | 70. 94                            | 0                                | (             | 0   | 0                           | 31.00         |
| 31. 01 | HRR adjustment for HSP bonus payment (see instructions)                          | 70. 91                            | 0                                | (             | 0   | 0                           | 31. 01        |
|        |  |                                   |                                  |               |   | (Amt. to Wkst.<br>E, Pt. A) |               |
|        |  | 0                                 | 1. 00                            | 2.00          | 3. 00                                       | 4.00                        |               |
|        | HAC Reduction Program adjustment (see  | 70. 99                            | 1.00                             | 2.00          | 0   |                             | 32. 00        |
| 100.00 | instructions)<br>Transfer HAC Reduction Program adjustment to<br>Wkst. E, Pt. A. |                                   | N                                |               |   |                             | 100. 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             | Peri od:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet E<br>Part B<br>Date/Time Prepared:<br>5/30/2024 8:35 am |

| Multiple    |        | Ti +1.   | - V//                                   | Hooni tol         | 5/30/2024 8: 3 | 5 am   |
|--|--------|--|---|-------------------|----------------|--------|
| Next   No   Medical and other services (see instructions)  |        |  | e xviii                                 | Hospi tal         | PPS            |        |
| Nedical and other services (see instructions)  |        |  |   |                   | 1. 00          |        |
| Bedical and other services relationsed under DPVS (see Instructions)   |        | PART B - MEDICAL AND OTHER HEALTH SERVICES                             |   |                   |                |        |
| 0.00   Order or RPH payments   0.00   |        |  |   |                   | -              | 1. 00  |
| 0.00      |        | ,  |   |                   |                |        |
| 0.01   1   |        |  |   |                   |                |        |
| Enter the hospit full specific payment to cost ratio (see instructions)  |        | ,                                |   |                   |                |        |
|  |        | 1  |   |                   | -              | 5. 00  |
| Transit formal corridor payment (see instructions)   |        | Line 2 times line 5  |   |                   | -              | 6. 00  |
| Ancil lary service other pass through costs including REH direct graduate medical education costs from   Nest. D. Pt. IV, col. 13, line 200   0.00   |        |  |   |                   |                | 7. 00  |
| Wist, D. Pri, IV, col. 13, line 200  |        | ,                                |   |                   | -              |        |
| 10.00   Grgam acquist incis   10.00    | 9.00   |  | medical educa                           | ation costs from  | 0              | 9.00   |
| 11.00  | 10 00  |  |   |                   | 0              | 10 00  |
| COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable cost (Complete only If Fine 11 exceeds line 18)   Reasonable charges   Reasonable cost (Complete only If Fine 11 exceeds line 18)   Reasonable charges   Reasonable cost (Complete only If Fine 11 exceeds line 18)   Reasonable charges   Reasonable cost (Complete only If Fine 11 exceeds line 18)   Reasonable charges   Reasonable cost (Complete only If Fine 11 exceeds line 18)   Reasonable charges   Reasonable cost (Complete only If Fine 11 exceeds line 18)   Reasonable charges   |        |  |   |                   | -              |        |
| 12.00   Ancillary service charges   0   12.00  |        |  |   |                   | -              |        |
| 13.00   Organ acquisition charges (From Wist, D-4, Pt. III, col. 4, line 69)   |        |  |   |                   |                |        |
| 14.00   Initial reasonable charges (sum of lines 12 and 13)   14.00   14.00   15.00    |        |  |   |                   |                | 12. 00 |
| Customary_charges  |        |  |   |                   |                | 13. 00 |
| 15.00   Aggregate amount actually collected from patients Hable for payment for services on a charge basis   0   15.00   | 14. 00 |  |   |                   | 0              | 14. 00 |
| 16.00   Amount's that would have been real ized from patients liable for payment for services on a chargebasis   of 16.00   had such payment been made in accordance with 42 CFR \$413.13(e)   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.0000000   0.0000000   0.0000000   0.00000000   | 15 00  |  | 0021100000                              | a ahanga basi s   | 0              | 15 00  |
| had such payment been made in accordance with 42 CFR \$413.13(e)   |        | ,  |   |                   |                |        |
| 17.00  | 10.00  |  | JI Selvices of                          | ii a chargebasi's | O              | 10.00  |
| 19.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   0   19.00   | 17. 00 |  |   |                   | 0.000000       | 17. 00 |
| Instructions   | 18.00  | Total customary charges (see instructions)                             |   |                   | 0              | 18. 00 |
| 20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20.00   | 19. 00 |  | 18 exceeds li                           | ne 11) (see       | 0              | 19. 00 |
| Instructions   |        |  |   | 10) (             |                |        |
| 21.00   Lesser of cost or charges (see instructions)   0   21.00   | 20.00  |  | II exceeds III                          | ne 18) (see       | 0              | 20.00  |
| 22.00   Interns and residents (see instructions)   0.22.00   | 21 00  |  |   |                   | 0              | 21 00  |
| 23.00   Cost of physicians's services in a teaching hospital (see instructions)   0   23.00  |        | ,  |   |                   | -              | 22. 00 |
| COMPUTATION OF RELIMBURSEMENT SETTLEMENT   0   25.00   |        |  |   |                   | 0              | 23. 00 |
| 25.00   Deductibles and coinsurance amounts (for CAH, see instructions)   0   25.00  | 24. 00 | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)           |   |                   | 535, 951       | 24. 00 |
| 26. 00   Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   111, 318   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   424, 633   27. 00   1   1   1   1   1   1   1   1   1  |        |  |   |                   |                |        |
| Instructions   |        |  |   |                   |                |        |
| 28. 00   Direct graduate medical education payments (from Wkst. E-4, line 50)   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   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   28. 00   29. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   29. 00   28. 00   29. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   29. 00   28. 00. 00   28. 00. 00   28. 00. 00   28. 00. 00   28. 00. 00   28. 00. 00   28. 00. 00   28. 00. 00   28. 00. 00   28. 00. 00   29. 00    | 27.00  |  | n or tines 22                           | and 23] (see      | 424, 633       | 27.00  |
| 28.50   REH Facility payment amount (see instructions)   28.50   29.00   SbD direct medical education costs (from Wkst. E-4, line 36)   0.90.00   30.00   30.00   30.00   50   | 28. 00 |  |   |                   | 0              | 28. 00 |
| 29.00   ESRD direct medical education costs (From Wkst. E-4, line 36)   29.00   30.00   Subtotal (sum of lines 27, 28, 28.50 and 29)   424,633   30.00   31.00   Primary payer payments   424,633   32.00   31.00   ALUMABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   424,633   32.00   ALUMABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   424,633   32.00   33.00    |        |  |   |                   | _              | 28. 50 |
| 31.00   Subtotal (line 30 minus line 31)   | 29. 00 | , ,  |   |                   | 0              | 29. 00 |
| 32.00   Subtotal (line 30 minus line 31)   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   33.00   Allowable bad debts (see instructions)   68, 636   34.00   Allowable bad debts (see instructions)   44, 613   35.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   68, 636   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   68, 636   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   68, 636   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   68, 636   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   68, 636   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   68, 636   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   68, 636   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   68, 636   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   68, 636   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   68, 636   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   93.00   39.0   |        |  |   |                   |                |        |
| ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)  |        | 1 3 . 3 . 3  |   |                   | -              |        |
| 33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   33.00   34.00   All lowable bad debts (see instructions)   68,636   34.00   34.00   All lowable bad debts (see instructions)   44,613   35.00   35.00   All lowable bad debts (see instructions)   68,636   34.00   36.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   68,636   36.00   37.00   Subtotal (see instructions)   469,246   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.50   79.00   70   THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   79.00   70   Poneer ACO demonstration payment adjustment (see instructions)   0   39.75   70   Pomonstration payment adjustment amount before sequestration   0   39.75   70   Pomonstration payment adjustment amount before sequestration   0   39.97   70   70   70   70   70   70   70  | 32. 00 |  |   |                   | 424, 633       | 32.00  |
| 34.00  | 33 00  |  |   |                   | 0              | 33 00  |
| 35.00  |        |  |   |                   | -              |        |
| 37.00   Subtotal (see instructions)   469,246   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00      |        |  |   |                   |                |        |
| 38.00   MSP-LCC reconciliation amount from PS&R   0   38.00     39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00     39.50   39.75   90.00   39.75   90.00   90.00     39.75   90.00   90.00   90.00     39.75   90.00   90.00   90.00     39.75   90.00   90.00   90.00     39.75   90.00   90.00   90.00     39.75   90.00   90.00   90.00     39.75   90.00   90.00   90.00     39.75   90.00   90.00   90.00     39.75   90.00   90.00   90.00     39.75   90.00   90.00   90.00     39.75   90.00   90.00   90.00     39.75   90.00   90.00   90.00     39.75   90.00   90.00   90.00     39.75   90.00   90.00   90.00     39.75   90.00   90.00   90.00     39.75   90.00   90.00   90.00     39.75   90.90   90.00   90.00     39.75   90.90   90.00     40.01   40.02   40.00     40.02   40.00   40.02     40.01   40.02   40.00     40.02   40.00   40.02     40.01   40.02   40.00     40.02   40.00   40.02     40.01   40.02     40.01   40.02     40.01   40.02     40.01   40.02   | 36.00  | Allowable bad debts for dual eligible beneficiaries (see instructions) |   |                   | 68, 636        | 36. 00 |
| 39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.50   39.00   39.00   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.75   39.97   Demonstration payment adjustment amount (see instructions)   0 39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0 39.99   469.246   40.00   4   | 37. 00 |  |   |                   | 469, 246       | 37. 00 |
| 39.50   Pi oneer ACO demonstration payment adjustment (see instructions)   39.50   39.75   N95 respirator payment adjustment amount (see instructions)   0 39.75   39.97   Demonstration payment adjustment amount before sequestration   0 39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0 39.99   40.00   Subtotal (see instructions)   469.246   40.00   40.01   Sequestration adjustment (see instructions)   469.246   40.00   40.02   Demonstration payment adjustment amount after sequestration   0 40.02   40.03   Sequestration adjustment amount after sequestration   0 40.02   40.03   40.00     |        |  |   |                   |                | 38. 00 |
| 39.75       N95 respirator payment adjustment amount (see instructions)       0       39.75         39.97       Demonstrati on payment adjustment amount before sequestration       0       39.97         39.98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39.97         39.99       RECOVERY OF ACCELERATED DEPRECIATION       0       39.98         40.00       Subtotal (see instructions)       469, 246       40.00         40.01       Sequestration adjustment (see instructions)       9, 385       40.01         40.02       Sequestration adjustment amount after sequestration       0       40.02         40.03       Sequestration payment adjustment (see instructions)       9, 385       40.01         40.02       Sequestration adjustment (see instructions)       0       40.02         40.03       Sequestration adjustment amount after sequestration       0       40.02         41.00       Interim payments       469, 800       41.00         41.01       Interim payments-PARHM       41.00         42.01       Tentative settlement (for contractor use only)       0       42.00         43.00       Balance due provider/program (see instructions)       -9, 939       43.00         44.00       Sils.2 <td< td=""><td></td><td></td><td></td><td></td><td>0</td><td></td></td<>  |        |  |   |                   | 0              |        |
| 39. 97 Demonstration payment adjustment amount before sequestration 39. 97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 469, 246 40. 01 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment amount after sequestration 40. 04 Sequestration adjustment amount after sequestration 40. 05 Interim payments 40. 06 Interim payments 40. 07 Interim payments 40. 08 Interim payments 40. 09 Protested amounts (see instructions) 40. 01 Interim payments 40. 02 Interim payments 40. 03 Interim payments 40. 04 Interim payments 40. 05 Interim payments 40. 06 Interim payments 41. 01 Interim payments 42. 00 Interim payments 43. 01 Interim payments 44. 00 Interim payments 45. 00 Interim payments 469, 800 41. 00 Interim payments 42. 00 Interim payments 45. 00 Interim payments 469, 800 41. 00 Interim payments 41. 00 Interim payments 41. 00 Interim payments 42. 00 Interim payments 45. 00 Interim payments 469, 800 41. 00 Interim payments 469, 800 41. 00 Interim payments 469, 800 41. 00 Interim payments 41. 00 Interim payments 469, 800 41. 00 Interim payments 41. 00 Interim payments 41. 00 Interim payments 469, 800 41. 00 Interim payments 469, |        | ,                                |   |                   | 0              |        |
| 39. 98   |        |  |   |                   |                |        |
| 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 469, 246 40. 00 40. 01 Sequestration adjustment (see instructions) 9, 385 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 41. 00 Sequestration adjustment-PARHM pass-throughs 469, 800 41. 00 41. 01 Interim payments 469, 800 41. 00 41. 01 Interim payments-PARHM 41. 01 42. 00 Tentative settlement (for contractors use only) 42. 01 43. 00 Balance due provider/program (see instructions) 43. 01 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8, 244 45. 00 90. 00 Original outlier amount (see instructions) 90. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 92. 00 The rate used to calculate the Time Value of Money 0. 00 92. 00   |        |  | (see instruc                            | tions)            | -              | 39. 98 |
| 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement -PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8, 244 44. 00  90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 92. 00 The rate used to calculate the Time Value of Money 93. 00 The rate used to calculate the Time Value of Money 94. 00 To description of the value of Money 95. 00 The rate used to calculate the Time Value of Money 96. 00 The rate used to calculate the Time Value of Money 97. 00 The rate used to calculate the Time Value of Money 98. 00 The rate used to calculate the Time Value of Money 99. 00 The rate used to calculate the Time Value of Money  |        | ·  | , | ·                 |                | 39. 99 |
| 40. 02 Demonstration payment adjustment amount after sequestration  40. 03 Sequestration adjustment-PARHM pass-throughs  41. 00 Interim payments  469, 800 41. 00  41. 01 Interim payments-PARHM  42. 00 Tentative settlement (for contractors use only)  42. 01 Tentative settlement-PARHM (for contractor use only)  43. 00 Balance due provider/program (see instructions)  44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8, 244  44. 00 Original outlier amount (see instructions)  90. 00 Outlier reconciliation adjustment amount (see instructions)  79. 00 The rate used to calculate the Time Value of Money  0 40. 02 40. 03  40. 03  40. 03  40. 03  41. 00  41. 00  41. 01  42. 01  42. 01  42. 01  42. 01  43. 00  43. 01  44. 00  90. 00  90. 00  91. 00  91. 00  92. 00  10 469, 800  41. 00  41. 00  42. 01  44. 00  42. 01  42. 01  43. 01  44. 00  90. 00  90. 00  91. 00  92. 00  11 40. 02  44. 00  45. 01  469, 800  41. 00  41. 00  41. 00  42. 01  42. 01  42. 01  42. 01  42. 01  43. 01  44. 00  90. 00  91. 00  92. 00  11 40. 02  12 40. 03  13 41. 00  44. 00  44. 00  44. 00  44. 00  45. 01  46. 02  47. 01  48. 01  49. 00  49. 00  90. 00  91. 00  91. 00  92. 00   | 40.00  | Subtotal (see instructions)  |   |                   | 469, 246       | 40. 00 |
| 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 40. 03 Interim payments 40. 03 Interim payments 41. 00 Interim payments 469, 800 41. 00 41. 01 Tentative settlement (for contractors use only) 42. 00 Tentative settlement-PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8, 244 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8, 244 44. 00 Original outlier amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 90. 00 Oo 0 92. 00  |        |  |   |                   |                | 40. 01 |
| 41. 00   |        |  |   |                   | 0              |        |
| 41. 01 Interim payments-PARHM  42. 00 Tentative settlement (for contractors use only)  42. 01 Tentative settlement-PARHM (for contractor use only)  43. 00 Bal ance due provider/program (see instructions)  43. 01 Bal ance due provider/program-PARHM (see instructions)  43. 01 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8, 244  44. 00 Since Complete By Contractor Since Contracto |        |  |   |                   | 440. 900       |        |
| 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{\text{515.2}}{\text{10 BE COMPLETED BY CONTRACTOR}}  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money  0 42.00 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.00 43.00 43.01 43.00 43.01 43.00 43.01 43.00 43.01 43.00 43.01 43.00 43.01 43.00 43.01 43.00 43.01 43.00 43.01 43.00 43.01 43.00 43.01 43.00 43.01 43.00 43.01 43.00 43.00 43.01 43.00 43.01 43.00 43.01 43.00 43.01 43.00 43.01 43.00 43.00 43.01 43.00 43.00 43.01 44.00 8711 8715 8715 8715 8715 8715 8715 8715  |        | 1  |   |                   | 407, 600       |        |
| 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{\text{5115.2}}{\text{TO BE COMPLETED BY CONTRACTOR}}  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money  42.01 42.01 42.01 43.00 9.00 9.00 9.00 9.00 9.00 90.00 91.00 92.00  |        |  |   |                   | 0              | 42.00  |
| 43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8,244  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8,244  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8,244  45.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8,244  46.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8,244  47.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8,244  48.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8,244  49.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8,244  49.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8,244  49.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8,244  49.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8,244  49.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8,244  49.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8,244  49.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8,244  49.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8,244  49.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8,244  49.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 90,000  49.00 Protested amounts (nonallowable cost report items) in accordance with  |        |  |   |                   |                | 42. 01 |
| 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$8,244 A4.00 Protested amounts (see instructions) 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money   | 43.00  | ,  |   |                   | -9, 939        | 43. 00 |
| \$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money  93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 The rate used to calculate the Time Value of Money  95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)  |        |  |   |                   |                | 43. 01 |
| TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money  0.00 92.00   | 44. 00 |  | 3 Pub. 15-2, <i>i</i>                   | chapter 1,        | 8, 244         | 44. 00 |
| 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 0.00 99.00   |        |  |   |                   |                |        |
| 91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  0 91.00 0.00 92.00  | 90 00  |  |   |                   | 0              | 90 00  |
| 92.00 The rate used to calculate the Time Value of Money 0.00 92.00  |        |  |   |                   |                | 91.00  |
| 93.00   Time Value of Money (see instructions) 0   93.00   |        |  |   |                   |                | 92. 00 |
|  | 93. 00 | Time Value of Money (see instructions)                                 |   |                   | 0              | 93. 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             | Peri od:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet E<br>Part B<br>Date/Time Pre<br>5/30/2024 8:3 |         |
|   | Title XVIII                        | Hospi tal                                    | PPS   |         |
|   |                                    |  |   |         |
|   |                                    |  | 1. 00   |         |
| 94.00 Total (sum of lines 91 and 93)    |                                    |  | (   | 94.00   |
|   |                                    |  |   |         |
|   |                                    |  | 1. 00   |         |
| MEDICARE PART B ANCILLARY COSTS         |                                    |  |   |         |
| 200.00 Part B Combined Billed Days      |                                    |  | (   | 200. 00 |

Worksheet E-1 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 8:35 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 9, 480, 797 436, 300 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 08/30/2023 33, 500 3.01 0 3.02 3.02 3.03 0 3.03 0 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 3.51 0 0 3.52 3.52 0 3.53 3.53 0 0 3.54 Λ 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 33, 500 3.99 3.50-3.98) 9, 480, 797 469, 800 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 22, 984 0 6.01 6 02 SETTLEMENT TO PROGRAM 9, 939 6.02 7.00 Total Medicare program liability (see instructions) 9, 503, 781 459, 861 7.00 Contractor NPR Date (Mo/Day/Yr)

Provider CCN: 15-3028

Peri od:

Number

1 00

2 00

8.00

0

8.00 Name of Contractor

| Health Financial Systems                | REHABILITATION HOSPITAL OF INDIA | ANA         | In Lie                                       | u of Form CMS-2552-10   |
|---|----------------------------------|-------------|--|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der C                      | CN: 15-3028 | Peri od:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet E-3<br>Part III<br>Date/Time Prepared:<br>5/30/2024 8:35 am |
|   |                                  |             |  |   |

| PART III MEDICARE PART A SERVICES - IBF PRS     1.00  |          |   |                            |                   | 5/30/2024 8: 3 | 5 am     |
|---|----------|---|----------------------------|-------------------|----------------|----------|
| PART   11.1   |          |   | Title XVIII                | Hospi tal         | PPS            |          |
| PART   11.1   |          |   |                            |                   |                |          |
| Next Federal PPS Payment (see instructions)   |          |   |                            |                   | 1. 00          |          |
| Medicare SSI ratio (IRF PPS only) (see instructions)  |          | PART III - MEDICARE PART A SERVICES - IRF PPS   |                            |                   |                |          |
| Inpatt ent Rehabilitation II P Payments (see instructions)  | 1.00     | Net Federal PPS Payment (see instructions)  |                            |                   | 8, 991, 471    | 1.00     |
| 4.00   0utilifer Payments   93,880   4.00   5.01   10   10   10   10   10   10   10   | 2.00     | Medicare SSI ratio (IRF PPS only) (see instructions)  |                            |                   | 0. 0374        | 2.00     |
| Unweighted Intern and resident FIE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)   0.00   5.01  | 3.00     | Inpatient Rehabilitation LIP Payments (see instructions)  |                            |                   | 784, 056       | 3.00     |
| to November 15, 2004 (see instructions) 5.01 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 CPR \$412.424(d)(1)(III)(F(1)) (or (2) (see instructions) 7.00 Current year's unweighted FTE count for IRR excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 8.00 Current year's unweighted FTE count for IRR excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 8.00 Current year's unweighted FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 8.00 Current year's unweighted FTE Count for residents within the new program growth period of a "new teaching program" (see instructions) 9.00 Intern and resident count for IRR PPS medical education adjustment (see instructions) 9.01 (10.00 Page Daily Consus (see instructions) 11.00 Teaching Adjustment (see instructions) 12.00 Teaching Adjustment (see instructions) 13.00 Total PPS Payment (see instructions) 15.00 Total PPS Payment (see instructions) 16.00 Cost of physic clars' services in ateaching hospital (see instructions) 17.00 Subtotal (See instructions) 18.00 Primary payer payments 18.00 Primary payer paymen | 4.00     | Outlier Payments  |                            |                   | 93, 880        | 4.00     |
| 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 CFR §412.424(0)(1)(11)(1)(1) or (2) (see instructions)   | 5. 00    |   | ost reporting period end   | ding on or prior  | 0. 34          | 5. 00    |
| 0.00   New Teaching program adjustment. (see Instructions)   0.00   0.00   0.00   1.    | 5. 01    | Cap increases for the unweighted intern and resident FTE coun-<br>program or hospital closure, that would not be counted withou |                            |                   | 0.00           | 5. 01    |
| teaching program" (see Instructions)  | 6.00     |   |                            |                   | 0.00           | 6. 00    |
| Second   Current year's unweighted   LaR FTE count for residents within the new program growth period of a "new to be teaching program" (see instructions)   0.34 9.00  | 7. 00    |   | the new program growth pe  | eriod of a "new   | 2. 99          | 7. 00    |
| 10.00   Average Dail y Census (see instructions)   51.542466   10.00   15.00   15.00   15.00   16.00    | 8. 00    | Current year's unweighted I&R FTE count for residents within  | the new program growth po  | eriod of a "new   | 0.00           | 8. 00    |
| 11.00   Taaching Adjustment Factor (see instructions)   0.006705   11.00   0.00   10.00   Total PRS Payment (see instructions)   0.00    | 9.00     | Intern and resident count for IRF PPS medical education adjust  | tment (see instructions)   |                   | 0. 34          | 9. 00    |
| 12.00   Teaching Adjustment (see instructions)   6.0.288   12.00   13.00   Total PPS Payment (see instructions)   9,929,695   13.00   14.00   Nursing and Allied Health Managed Care payments (see instructions)   14.00   15.00   07gan acquisition (D0 NOT USE THIS LINE)   15.00   16.00   07gan acquisition (D0 NOT USE THIS LINE)   15.00   16.00   07gan acquisition (D0 NOT USE THIS LINE)   9,929,695   17.00   17.00   07gan acquisition (D0 NOT USE THIS LINE)   9,929,695   17.00   17.00   07gan acquisition (D0 NOT USE THIS LINE)   9,929,695   17.00   17.00   07gan acquisition (D0 NOT USE THIS LINE)   9,895,390   19.00   07gan acquisition (Line 17 less line 18).   9,885,390   19.00   07gan acquisition (Line 17 less line 18).   9,885,390   19.00   07gan acquisition (Line 17 less line 18).   9,885,390   19.00   07gan acquisition (Line 19 minus line 20)   9,832,678   21.00   07gan acquisition (Line 19 minus line 20)   9,832,678   21.00   07gan acquisition (Line 19 minus line 20)   9,665,878   23.00   07gan acquisition (Line 21 minus line 22)   9,665,878   23.00   07gan acquisition (Line 21 minus line 22)   9,665,878   23.00   07gan acquisition (Line 21 minus line 22)   9,665,878   23.00   07gan acquisition (Line 21 minus line 22)   9,665,878   23.00   07gan acquisition (Line 21 minus line 22)   9,665,878   23.00   07gan acquisition (Line 21 minus line 22)   9,665,878   23.00   07gan acquisition (Line 21 minus line 22)   9,665,878   23.00   07gan acquisition (Line 21 minus line 22)   9,665,878   23.00   07gan acquisition (Line 21 minus line 22)   9,665,878   23.00   07gan acquisition (Line 21 minus line 22)   9,665,878   23.00   07gan acquisition (Line 21 minus line 22)   9,665,878   23.00   07gan acquisition (Line 21 minus line 22)   9,665,878   23.00   07gan acquisition (Line 21 minus line 22)   9,665,878   23.00   07gan acquisition (Line 21 minus line 22)   9,665,878   23.00   07gan acquisition (Line 21 minus line 22)   9,665,878   23.00   07gan acquisition (Line 21 minus line 22)   9,665,878   23.00   07gan acquisiti    | 10. 00   | Average Daily Census (see instructions)   |                            |                   | 51. 542466     | 10.00    |
| 13.00   Total PPS Payment (see instructions)   9,929,695   13.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   14.00   15.00   14.00   15.00   1    | 11. 00   | Teaching Adjustment Factor (see instructions)   |                            |                   | 0. 006705      | 11. 00   |
| 14. 00   Nursing and Allied Heal th Managed Care payments (see instruction)   0   14. 00   15. 00   15. 00   16. 00   16. 00   16. 00   16. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00       | 12.00    | Teaching Adjustment (see instructions)  |                            |                   | 60, 288        | 12.00    |
| 15. 00  | 13.00    | Total PPS Payment (see instructions)  |                            |                   | 9, 929, 695    | 13.00    |
| 16. 00   Cost of physicians' services in a teaching hospital (see instructions)   9, 929, 695   17. 00   18. 00   19.     | 14.00    | Nursing and Allied Health Managed Care payments (see instructi  | on)                        |                   | 0              | 14.00    |
| 17.00   Subtotal (see instructions)   9,29,695   17.00   18.00   19.    | 15. 00   | Organ acquisition (DO NOT USE THIS LINE)  |                            |                   |                | 15.00    |
| 18.00   Primary payer payments  | 16. 00   | Cost of physicians' services in a teaching hospital (see inst   | ructions)                  |                   | 0              | 16.00    |
| 19.00   Subtotal (line 17 less line 18).   9,885,390   19.00   Deductibles   52.712   20.00   20.00   Subtotal (line 19 minus line 20)   9,832,678   21.00   22.00   Coinsurance   166,800   22.00   23.00   Subtotal (line 21 minus line 22)   166,800   22.00   All lowable bad debts (exclude bad debts for professional services) (see instructions)   49,013   24.00   All lowable bad debts (see instructions)   49,013   24.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   49,013   24.00   27.00   Subtotal (sum of lines 23 and 25)   9,667,736   27.00   28.00   07.00   29.00   07.00       | 17. 00   | Subtotal (see instructions)   |                            |                   | 9, 929, 695    | 17. 00   |
| 20. 00   Deductibles   52,712   20. 00   21. 00   Subtotal (line 19 minus line 20)   9,832,678   21. 00   22. 00   22. 00   23. 00   Subtotal (line 21 minus line 22)   166,800   22. 00   23. 00   Subtotal (line 21 minus line 22)   9,665,878   23. 00   23. 00   34. 00   3    | 18. 00   | Primary payer payments  |                            |                   | 44, 305        | 18.00    |
| 21.00   Subtotal (line 19 minus line 20)   9,832,678   21.00   22.00   23.00   20.00    | 19. 00   | Subtotal (line 17 less line 18).  |                            |                   | 9, 885, 390    | 19.00    |
| 22.00   Coinsurance   166,800   22.00   23.00   Subtotal (line 21 minus line 22)   9,665,878   23.00   24.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   49,013   24.00   25.00   Adjusted reimbursable bad debts (see instructions)   31,858   25.00   27.00   27.00   Subtotal (sum of lines 23 and 25)   9,697,736   27.00   28.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   9,697,736   27.00   29.00   Other pass through costs (see instructions)   0 29.00   29.00   0.0    |          |   |                            |                   | 52, 712        | 20.00    |
| 23.00   Subtotal (line 21 minus line 22)   9,665,878   23.00   24.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   49,013   24.00   24.00   Allowable bad debts (see instructions)   31,858   25.00   26.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   49,013   26.00   27.00   Subtotal (sum of lines 23 and 25)   9,697,736   27.00   28.00   Direct graduate medical education payments (from Wkst. E-4, line 49)   9,697,736   27.00   28.00   0 Other pass through costs (see instructions)   0 0 0 0 Other pass through costs (see instructions)   0 0 0 0 Other pass through costs (see instructions)   0 0 0 0 0 Other pass through costs (see instructions)   0 0 0 0 0 0 Other pass through costs (see instructions)   0 0 0 0 0 0 Other pass through costs (see instructions)   0 0 0 0 0 0 0 0 Other pass through costs (see instructions)   0 0 0 0 0 0 0 0 0 Other pass through costs (see instructions)   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   | 21. 00   | Subtotal (line 19 minus line 20)  |                            |                   | 9, 832, 678    | 21. 00   |
| 24. 00  | 22.00    | Coinsurance   |                            |                   | 166, 800       | 22. 00   |
| 25. 00 Adjusted reimbursable bad debts (see instructions) 26. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 27. 00 Subtotal (sum of lines 23 and 25) 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 49) 29. 00 Other pass through costs (see instructions) 30. 00 Outlier payments reconciliation 31. 00 Other ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 31. 50 Pioneer ACO demonstration payment adjustment (see instructions) 31. 98 Recovery of accelerated depreciation. 31. 99 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. 01 Interim payments 33. 00 Tentative settlement (for contractor use only) 34. 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, 334, 223 36. 00 Time Value of Money (see instructions) 37. 00 Outlier reconciliation adjustment amount (see instructions) 38. 00 Time Value of Money (see instructions) 39. 00 Time Value of Money (see instructions) 49. 00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 49. 00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.   | 23. 00   | Subtotal (line 21 minus line 22)  |                            |                   | 9, 665, 878    | 23. 00   |
| 26. 00 Allowable bad debts for dual eligible beneficiaries (see instructions)       49,013 (26.00 9.697.736 27.00 9.697.736 27.00 9.697.736 27.00 9.697.736 27.00 9.697.736 27.00 9.697.736 27.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0   | 24.00    | Allowable bad debts (exclude bad debts for professional service   | ces) (see instructions)    |                   | 49, 013        | 24. 00   |
| 27. 00       Subtotal (sum of lines 23 and 25)       9,697,736       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. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0 31. 50         31. 98       Recovery of accelerated depreciation.       0 31. 50         31. 99       Demonstration payment adjustment amount before sequestration       0 31. 90         32. 00       Total amount payable to the provider (see instructions)       9,697,736       32. 00         32. 01       Sequestration adjustment (see instructions)       193,955       32. 01         32. 02       Demonstration payment adjustment amount after sequestration       9,697,736       32. 00         33. 00       Interim payments       9,697,736       32. 00         34. 00       Tentative settlement (for contractor use only)       9,480,797       33. 00         35. 00       Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)       22,984       35. 00         50. 00       Driginal outlier amount from Wkst. E-3, Pt. III, line 4       93,880       50. 00         51. 00       Outlier reconcil  | 25.00    | Adjusted reimbursable bad debts (see instructions)  |                            |                   | 31, 858        | 25.00    |
| 28.00 Direct graduate medical education payments (from Wkst. E-4, line 49)  29.00 Other pass through costs (see instructions)  30.00 Outlier payments reconciliation  30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  31.50 Pioneer ACO demonstration payment adjustment (see instructions)  31.98 Recovery of accelerated depreciation.  31.99 Demonstration payment adjustment amount before sequestration  31.99 Demonstration payment adjustment amount before sequestration  31.99 Sequestration adjustment amount after sequestration  32.01 Sequestration adjustment (see instructions)  32.02 Demonstration payment adjustment amount after sequestration  32.02 Interim payments  32.02 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, 334, 223  36.00 The rate used to calculate the Time Value of Money  37.00 Time Value of Money (see instructions)  49.00 Time Value of Money (see instructions)  50.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  59.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  | 26.00    | Allowable bad debts for dual eligible beneficiaries (see insti  | ructions)                  |                   | 49, 013        | 26.00    |
| 29. 00   Other pass through costs (see instructions)  | 27. 00   | Subtotal (sum of lines 23 and 25)   |                            |                   | 9, 697, 736    | 27. 00   |
| 30. 00   Outlier payments reconciliation   0   30. 00   31. 00   31. 00   31. 00   31. 00   31. 00   31. 00   31. 00   31. 00   31. 00   31. 50   3  | 28.00    | Direct graduate medical education payments (from Wkst. E-4, li  | ne 49)                     |                   | 0              | 28. 00   |
| 31.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 31.90 Pioneer ACO demonstration payment adjustment (see instructions) 31.90 Pioneer ACO demonstration payment adjustment (see instructions) 31.98 Recovery of accelerated depreciation. 0 31.99 Demonstration payment adjustment amount before sequestration 0 31.99 Pioneer ACO demonstration payment adjustment of accelerated depreciation. 0 31.99 Demonstration payment adjustment descriptions of the provider (see instructions) 22.00 Total amount payable to the provider (see instructions) 23.00 Jemonstration adjustment (see instructions) 25.00 Demonstration payment adjustment amount after sequestration 26.00 Interim payments 27.00 Jemonstration payment adjustment amount after sequestration 28.00 Jemonstration payment adjustment amount after sequestration 38.00 Interim payments 39.480,797 33.00 Jemonstration payment adjustment amount sequestration and sequestra  | 29.00    | Other pass through costs (see instructions)   |                            |                   | 0              | 29. 00   |
| 31.50 31.98 Recovery of accelerated depreciation.  Demonstration payment adjustment (see instructions)  Demonstration payment adjustment amount before sequestration  Total amount payable to the provider (see instructions)  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment (see instructions)  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Demonstration payment adjustment (see instructions)  193.955 32.00  32.02  33.00  Interim payments  Tentative settlement (for contractor use only)  Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  334.223  36.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  334, 223  36.00  Original outlier amount from Wkst. E-3, Pt. III, line 4  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  Outlier reconciliation adjustment amount (see instructions)  FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  O.0000000  99.00  | 30.00    | Outlier payments reconciliation   |                            |                   | 0              | 30.00    |
| 31.98 Recovery of accelerated depreciation.  Demonstration payment adjustment amount before sequestration  10 31.99 31.99 32.00 Total amount payable to the provider (see instructions)  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstration adjustment amount after sequestration  Demonstrat  | 31.00    | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  |                            |                   | 0              | 31.00    |
| 31. 99 32. 00 32. 01 32. 02 32. 01 32. 02 32. 02 33. 02 32. 02 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 38. 00 38. 00 38. 00 39. 00 30  | 31. 50   | Pioneer ACO demonstration payment adjustment (see instructions  | s)                         |                   | 0              | 31. 50   |
| Total amount payable to the provider (see instructions)  Sequestration adjustment (see instructions)  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Interim payments  Tentative settlement (for contractor use only)  Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 334, 223 36.00  TO BE COMPLETED BY CONTRACTOR  TO BE COMPLETED BY CONTRACTOR  Original outlier amount from Wkst. E-3, Pt. III, line 4  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 ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00  Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   | 31. 98   | Recovery of accelerated depreciation.   |                            |                   | 0              | 31. 98   |
| 32.01 Sequestration adjustment (see instructions) 32.02 Demonstration payment adjustment amount after sequestration 32.03 Journal 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 (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 334, 223 36.00 Since Complete By Contractor 36.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 37.00 Outlier reconciliation adjustment amount (see instructions) 38.00 Outlier reconciliation adjustment amount (see instructions) 39.00 Time Value of Money (see instructions) 40.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 40.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 40.00 Occupants and subject to the cost reporting period immediately preceding February 29, 2020. 40.00 Occupants and subject to the cost reporting period immediately preceding February 29, 2020. 40.00 Occupants and subject to the cost reporting period immediately preceding February 29, 2020. 40.00 Occupants and subject to the cost reporting period immediately preceding February 29, 2020.   | 31. 99   | Demonstration payment adjustment amount before sequestration  |                            |                   | 0              | 31. 99   |
| 32.02 33.00 Interim payments 32.02 33.00 Interim payments 32.01 Interim payments 32.02 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 (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 334, 223 36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 334, 223 36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 334, 223 36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 334, 223 36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 334, 223 36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 334, 223 36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 334, 223 36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 334, 223 36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 334, 223 36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 334, 223 36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 334, 223 36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 334, 223 36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 334, 202 36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 334, 202 36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 202, 202, 202, 202, 202, 202, 202, 2  | 32.00    | Total amount payable to the provider (see instructions)   |                            |                   | 9, 697, 736    | 32.00    |
| 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, 334, 223 36.00    50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4  50.00 Outlier reconciliation adjustment amount (see instructions) 50.00 The rate used to calculate the Time Value of Money 50.00 Time Value of Money (see instructions) 50.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  94.00 33.00 34.00 3  | 32. 01   | Sequestration adjustment (see instructions)   |                            |                   | 193, 955       | 32. 01   |
| 34.00 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, 334, 223 TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 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 ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 36.00 50.00 36.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 60.0  | 32. 02   | Demonstration payment adjustment amount after sequestration   |                            |                   | 0              | 32. 02   |
| 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  22, 984 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 334, 223 36.00 \$\frac{\       | 33.00    | Interim payments  |                            |                   | 9, 480, 797    | 33.00    |
| 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 334, 223 36.00 \$\frac{\text{\$\frac{\text{\$\grace}{\text{\$\grace}}}}{\text{TO BE COMPLETED BY CONTRACTOR}}\$  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 93, 880 50.00 0utlier reconciliation adjustment amount (see instructions) 0 51.00 52.00 The rate used to calculate the Time Value of Money (see instructions) 0 52.00 53.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00  | 34.00    | Tentative settlement (for contractor use only)  |                            |                   | 0              | 34.00    |
| \$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)  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 ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0.000000 99.00   | 35.00    | Balance due provider/program (line 32 minus lines 32.01, 32.02  | 2, 33, and 34)             |                   | 22, 984        | 35.00    |
| TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4  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 ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0.000000 99.00   | 36.00    | Protested amounts (nonallowable cost report items) in accordan  | nce with CMS Pub. 15-2, o  | chapter 1,        | 334, 223       | 36.00    |
| 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 ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0.000000 99.00  |          |   |                            | ·                 |                |          |
| 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 ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0.000000 99.00   | 50 00    |   |                            |                   | 03 800         | 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 ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0.000000 99.00  |          |   |                            |                   | · _            |          |
| 53.00 Time Value of Money (see instructions) 0 53.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00  |          |   |                            |                   |                |          |
| FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0.000000 99.00  |          |   |                            |                   |                |          |
| THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00   | 55.00    |   | DECLINITING ON OD DEFORE A | MAV 11 2022 (TUE  |                | 55.00    |
| 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00  |          |   | DEGININING ON OK BEFORE    | MAT 11, 2023 (THE | LND UF         |          |
|   | 99 00    |   | diately preceding Enhance  | 2/ 20 2020        | 0 000000       | 99 00    |
| 77. or positionation reaching and ustillent ractor for the current year. (See Histractions)   |          |   |                            | y 27, 2020.       |                |          |
|   | , , . 01 | 1 carrow roughly may do thronk rabitor for the barrott year.  |                            | I                 | 3.000703       | ,,,,,,,, |

|                  | Financial Systems REHABILITATION HOSPITA   |               |                     | In Lie           | u of Form CMS-2<br>Worksheet F-4 |                  |  |
|------------------|--|---------------|---------------------|------------------|----------------------------------|------------------|--|
|                  | GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT  | Provi der CC  | N: 15-3028          | From 01/01/2023  |                                  |                  |  |
|                  |  |               |                     | To 12/31/2023    | Date/Time Prep 5/30/2024 8:3     |                  |  |
|                  |  | Title         | XVIII               | Hospi tal        | PPS                              |                  |  |
|                  |  |               |                     |                  | 1. 00                            |                  |  |
| 1. 00            | COMPUTATION OF TOTAL DIRECT GME AMOUNT  Unweighted resident FTE count for allopathic and osteopathic p   | rograms for   | cost reporti        | na neriods       | 0.00                             | 1.00             |  |
| 1.00             | ending on or before December 31, 1996.   | Ü             | cost reporti        | ing perious      | 0.00                             | 1.00             |  |
| 1.01             | FTE cap adjustment under §131 of the CAA 2021 (see instruction   |               | 1) ( !              |                  | 0.00                             |                  |  |
| 2. 00<br>2. 26   | Unweighted FTE resident cap add-on for new programs per 42 CFR Rural track program FTE cap limitation adjustment after the ca  |               |                     |                  | 0. 00<br>0. 00                   | 1                |  |
|                  | the CAA 2021 (see instructions)  |               |                     | 3                |                                  |                  |  |
| 3. 00<br>3. 01   | Amount of reduction to Direct GME cap under section 422 of MMA Direct GME cap reduction amount under ACA §5503 in accordance   |               | 8/12 70 (m)         | (600             | 0. 00<br>0. 00                   | 1                |  |
| 3.01             | instructions for cost reporting periods straddling 7/1/2011)   | WI til 42 CIR | 9413.74 (111).      | (366             | 0.00                             | 3.01             |  |
| 3. 02            | Adjustment (increase or decrease) to the hospital's rural trac   |               |                     |                  | 0.00                             | 3. 02            |  |
|                  | programs with a rural track Medicare GME affiliation agreement 49075 (August 10, 2022) (see instructions)  | in accordar   | nce with 413.       | 75(b) and 87 FR  |                                  |                  |  |
| 4.00             | Adjustment (plus or minus) to the FTE cap for allopathic and o   |               | orograms due        | to a Medicare    | 0.00                             | 4. 00            |  |
| 4. 01            | GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)) ACA Section 5503 increase to the Direct GME FTE Cap (see instr  |               | cost roporti        | na nori ode      | 0. 00                            | 4. 01            |  |
| 4.01             | straddling 7/1/2011)   | uctions for   | cost reporti        | ng perrous       | 0.00                             | 4.01             |  |
| 4. 02            | ACA Section 5506 number of additional direct GME FTE cap slots   | (see instr    | ructions for        | cost reporting   | 0.00                             | 4. 02            |  |
| 4. 21            | periods straddling 7/1/2011) The amount of increase if the hospital was awarded FTE cap slo  | its under 812 | 26 of the CAA       | 2021 (see        | 0.00                             | 4. 21            |  |
| 1. 21            | instructions)  | res under 312 | 20 01 1110 070      | ( 2021 ( 300     | 0.00                             | ' '              |  |
| 5.00             | FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus line   |               |                     | nus lines 3 and  | 0. 00                            | 5. 00            |  |
| 6. 00            | 3.01, plus or minus line 3.02, plus or minus line 4, plus line Unweighted resident FTE count for allopathic and osteopathic p  |               |                     | vear from vour   | 2. 99                            | 6. 00            |  |
|                  | records (see instructions)   |               |                     | , ,              |                                  |                  |  |
| 7. 00            | Enter the lesser of line 5 or line 6   |               | Primary Care        | e Other          | 0. 00<br>Total                   | 7. 00            |  |
|                  |  |               | 1. 00               | 2. 00            | 3. 00                            |                  |  |
| 8. 00            | Weighted FTE count for physicians in an allopathic and osteopa   | ithi c        | 0. 0                | 2. 70            | 2. 70                            | 8. 00            |  |
| 9. 00            | program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwi-   | se            | 0. 0                | 0. 00            | 0. 00                            | 9. 00            |  |
|                  | multiply line 8 times the result of line 5 divided by the amou   | ınt on line   |                     |                  |                                  |                  |  |
|                  | 6. For cost reporting periods beginning on or after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions.  | 2022, or      |                     |                  |                                  |                  |  |
| 10. 00           | Weighted dental and podiatric resident FTE count for the curre   | ent year      |                     | 0.00             |                                  | 10.00            |  |
| 10. 01           | Unweighted dental and podiatric resident FTE count for the cur   | rent year     |                     | 0.00             |                                  | 10. 01           |  |
| 11. 00<br>12. 00 | Total weighted FTE count Total weighted resident FTE count for the prior cost reporting  | vear (see     | 0. (<br>0. (        |                  |                                  | 11. 00<br>12. 00 |  |
| 12.00            | instructions)  | year (see     | 0. (                | 0.00             |                                  | 12.00            |  |
| 13. 00           | Total weighted resident FTE count for the penultimate cost rep   | orting        | 0.0                 | 0.00             |                                  | 13. 00           |  |
| 14. 00           | year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided  | by 3).        | 0. 0                | 0.00             |                                  | 14. 00           |  |
| 15. 00           | Adjustment for residents in initial years of new programs  |               | 0.0                 |                  |                                  | 15. 00           |  |
| 15. 01           | Unweighted adjustment for residents in initial years of new practice. Adjustment for residents displaced by program or hospital clos   |               | 0. (<br>0. (        |                  |                                  | 15. 01<br>16. 00 |  |
| 16. 00           | Unweighted adjustment for residents displaced by program or ho   |               | 0. (                |                  |                                  | 16. 00           |  |
|                  | closure  | .             |                     |                  |                                  |                  |  |
| 17. 00<br>18. 00 | Adjusted rolling average FTE count Per resident amount   |               | 0. 0<br>103, 607. 1 |                  |                                  | 17. 00<br>18. 00 |  |
| 18. 01           | Per resident amount under §131 of the CAA 2021   |               | 0. (                |                  |                                  | 18. 01           |  |
| 19. 00           | Approved amount for resident costs   |               |                     | 0 0              | 0                                | 19. 00           |  |
|                  |  |               |                     |                  |                                  |                  |  |
| 20. 00           |  | E resident o  | cap slots red       | cei ved under 42 | 1. 00                            | 20. 00           |  |
| 21. 00           | Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruc   | tions)        |                     |                  | 2 00                             | 21. 00           |  |
| 22. 00           | Allowable additional direct GME FTE Resident Count (see instructional direct GME FTE Resident Count (see instruct GME FTE Resi |               |                     |                  |                                  | 22. 00           |  |
|                  | Enter the locality adjustment national average per resident am   | ount (see in  | nstructions)        |                  |                                  | 23. 00           |  |
|                  | Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)   |               |                     |                  | 0                                | 24. 00<br>25. 00 |  |
| 20.00            | ا الله عال عال الله ع<br>الله عال الله عال ال  |               |                     |                  |                                  |                  |  |

|        | GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT                             | Provi der C  | CN: 15-3028        | Peri od:                         | Worksheet E-4               |        |
|--------|---|--------------|--------------------|----------------------------------|-----------------------------|--------|
| EDI CA | L EDUCATION COSTS   |              |                    | From 01/01/2023<br>To 12/31/2023 | Date/Time Pre 5/30/2024 8:3 |        |
|        |   |              | XVIII              | Hospi tal                        | PPS                         |        |
|        |   |              | Inpatient Par<br>A | rt Managed Care                  | Total                       |        |
|        |   |              | 1, 00              | 2, 00                            | 3. 00                       |        |
|        | COMPUTATION OF PROGRAM PATIENT LOAD   |              |                    |                                  |                             |        |
| 6. 00  | Inpatient Days (see instructions) (Title XIX - see S-2 Part I) 3.02, column 2)        | X, line      | 5, 23              | 4, 299                           |                             | 26. 00 |
| 7. 00  | Total Inpatient Days (see instructions)   |              | 18, 8              | 18, 813                          |                             | 27. 00 |
| 8. 00  | Ratio of inpatient days to total inpatient days                                       |              | 0. 2780            |                                  |                             | 28.00  |
| 9. 00  | Program di rect GME amount  |              |                    | 0 0                              | 0                           | 29.00  |
| 9. 01  | Percent reduction for MA DGME   |              |                    | 3. 27                            |                             | 29. 0° |
|        | Reduction for direct GME payments for Medicare Advantage                              |              |                    | 0                                | 0                           | 30.00  |
| 1. 00  | Net Program direct GME amount   |              |                    |                                  | 0                           | 31.0   |
|        |   |              |                    |                                  | 1. 00                       |        |
|        | DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE                        | XVIII ONLY   | ' (NURSING PRO     | GRAM AND PARAMED                 |                             |        |
|        | EDUCATION COSTS)  | Z XVIII ONEI | (NONOTHO TRO       | 7010 W 7114D 17110 WILL          | 71 0712                     |        |
| 2. 00  | Renal dialysis direct medical education costs (from Wkst. B, F                        | Pt. I, sum c | of col. 20 and     | 1 23, lines 74                   | 0                           | 32. 0  |
| 3. 00  | and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt. I                | l col 8 s    | um of lines 3      | 74 and 94)                       | 0                           | 33. 0  |
|        | Ratio of direct medical education costs to total charges (line                        |              |                    | + dild /+/                       | 0. 000000                   | 1      |
|        | Medicare outpatient ESRD charges (see instructions)                                   | 3 02 . 11110 | 00)                |                                  | 0. 000000                   |        |
|        | Medicare outpatient ESRD direct medical education costs (line                         | 34 x line 3  | 35)                |                                  | Ō                           |        |
|        | APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII                         |              | ,                  |                                  |                             |        |
|        | Part A Reasonable Cost  |              |                    |                                  |                             |        |
|        | Reasonable cost (see instructions)  |              |                    |                                  | 10, 470, 469                |        |
|        | Organ acquisition and HSCT acquisition costs (see instructions                        |              |                    |                                  | 0                           | 1      |
|        | Cost of physicians' services in a teaching hospital (see instr                        | ructions)    |                    |                                  | 0                           | 1      |
|        | Primary payer payments (see instructions)   |              |                    |                                  | 44, 305                     |        |
| 1. 00  | Total Part A reasonable cost (sum of lines 37 through 39 minus Part B Reasonable Cost | s line 40)   |                    |                                  | 10, 426, 164                | 41.0   |
| 2. 00  | Reasonable cost (see instructions)  |              |                    |                                  | 621, 886                    | 42.0   |
|        | Primary payer payments (see instructions)   |              |                    |                                  | 021,000                     |        |
|        | Total Part B reasonable cost (line 42 minus line 43)                                  |              |                    |                                  | 621, 886                    |        |
|        | Total reasonable cost (sum of lines 41 and 44)  |              |                    |                                  | 11, 048, 050                |        |
|        | Ratio of Part A reasonable cost to total reasonable cost (line                        | e 41 ÷ line  | 45)                |                                  | 0. 943711                   |        |
| 7. 00  | Ratio of Part B reasonable cost to total reasonable cost (line                        |              | 45)                |                                  | 0. 056289                   | 47.0   |
|        | ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR                        | RT B         |                    |                                  |                             |        |
|        | Total program GME payment (line 31)   |              |                    |                                  | 0                           | 1      |
|        | Part A Medicare GME payment (line 46 x 48) (title XVIII only)                         |              |                    |                                  | 0                           | 1      |
| J. 00  | Part B Medicare GME payment (line 47 x 48) (title XVIII only)                         | (see instru  | ICTI ONS)          |                                  | 0                           | 50.0   |

| Health Financial Systems REHABILITATION HOSPITAL OF INDIANA In Lieu o      |  |                         |                          |                                  | u of Form CMS-2                  | 552-10 |
|--|--|-------------------------|--------------------------|----------------------------------|----------------------------------|--------|
| OUTLIE   | OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT Provider CCN: 15-3028 Period: W |                         |                          |                                  |                                  |        |
|  |  |                         |                          | From 01/01/2023<br>To 12/31/2023 | Date/Time Prep<br>5/30/2024 8:35 |        |
|  |  |                         | Title XVIII              |                                  | PPS                              |        |
|  |  |                         |                          |                                  |                                  |        |
|  |  |                         |                          |                                  | 1. 00                            |        |
|  | TO BE COMPLETED BY CONTRACTOR  |                         |                          |                                  |                                  |        |
| 1.00   | Operating outlier amount from Wkst. E, F                                       | Pt. A, line 2, or sum o | of 2.03 plus 2.04 (see i | nstructions)                     | 0                                | 1.00   |
| 2.00   | Capital outlier from Wkst. L, Pt. I, lir                                       | ne 2                    |                          |                                  | 0                                | 2.00   |
| 3.00   | Operating outlier reconciliation adjustm                                       | nent amount (see instr  | uctions)                 |                                  | 0                                | 3.00   |
| 4.00   | Capital outlier reconciliation adjustmen                                       | nt amount (see instruc  | tions)                   |                                  | 0                                | 4.00   |
| 5.00 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 instruc   | tions)                   |                                  | o                                | 7. 00  |

Health Financial Systems REHABILITATION
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

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared:

| onl y)           |   |                            | '                    | 0 12/31/2023   | 5/30/2024 8: 3 |                  |
|------------------|---|----------------------------|----------------------|----------------|----------------|------------------|
|                  |   | General Fund               | Speci fi c           | Endowment Fund |                |                  |
|                  |   | 1. 00                      | Purpose Fund<br>2.00 | 3. 00          | 4. 00          |                  |
|                  | CURRENT ASSETS  |                            |                      |                |                |                  |
| 1.00             | Cash on hand in banks   | 2, 802, 438                |                      | -              | 0              | 1.00             |
| 2. 00<br>3. 00   | Temporary investments Notes receivable                                    | 0                          |                      | -              | 0              | 2. 00<br>3. 00   |
| 4. 00            | Accounts receivable   | 16, 430, 239               | 1                    | 0              | 0              | 4. 00            |
| 5. 00            | Other recei vable   | 836, 710                   |                      | 0              | 0              | 5. 00            |
| 6.00             | Allowances for uncollectible notes and accounts receivable                | -11, 281, 121              | 0                    | 0              | 0              | 6. 00            |
| 7.00             | Inventory   | 516, 750                   |                      | 0              | 0              | 7. 00            |
| 8.00             | Prepai d expenses   | 889, 344                   | 0                    | 0              | 0              | 1                |
| 9. 00<br>10. 00  | Other current assets Due from other funds                                 | 0                          |                      | 0              | 0              |                  |
| 11. 00           | Total current assets (sum of lines 1-10)                                  | 10, 194, 360               |                      |                | 0              | 11.00            |
| 11.00            | FIXED ASSETS  | 10, 174, 300               | ,,                   | 9              | 0              | 11.00            |
| 12.00            | Land  | 2, 506, 638                | C                    | 0              | 0              | 12. 00           |
| 13.00            | Land improvements   | 757, 042                   | 2 C                  | 0              | 0              | 13. 00           |
| 14. 00           | Accumul ated depreciation   | -427, 471                  | 1                    | 0              | 0              | 14. 00           |
| 15. 00           | Bui I di ngs  | 33, 661, 545               | 1                    | 0              | 0              | 15.00            |
| 16. 00<br>17. 00 | Accumulated depreciation Leasehold improvements                           | -17, 030, 086<br>205, 018  | 1                    | 0              | 0              | 16. 00<br>17. 00 |
| 18.00            | Accumulated depreciation  | -194, 263                  | 1                    | 0              | 0              | 18.00            |
| 19. 00           | Fi xed equipment  | 3, 580, 974                | •                    |                | 0              | 19.00            |
| 20. 00           | Accumulated depreciation  | -2, 167, 770               | •                    | 0              | 0              | 20.00            |
| 21. 00           | Automobiles and trucks  | 0                          | ) C                  | 0              | 0              | 21. 00           |
| 22. 00           | Accumul ated depreciation   | 0                          | 0                    | 0              | 0              | 22. 00           |
| 23. 00           | Major movable equipment   | 16, 206, 945               |                      | 0              | 0              | 23. 00           |
| 24. 00<br>25. 00 | Accumulated depreciation  | -14, 629, 071              |                      | 0              | 0              | 24. 00<br>25. 00 |
| 26. 00           | Minor equipment depreciable Accumulated depreciation                      | 105, 832<br>-105, 832      |                      | -              | 0              | 26.00            |
| 27. 00           | HIT designated Assets   | 0 103, 032                 |                      | -              | 0              | 27. 00           |
| 28. 00           | Accumulated depreciation  | 0                          | Ö                    | 0              | 0              | 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)                                   | 22, 469, 501               | C                    | 0              | 0              | 30. 00           |
| 21 00            | OTHER ASSETS  | 0                          | J 0                  | O              | 0              | 21 00            |
| 31. 00<br>32. 00 | Investments Deposits on Leases  | 0                          |                      |                | 0              | 31. 00<br>32. 00 |
| 33. 00           | Due from owners/officers  | 965, 144                   | 1                    | -              | 0              | 33.00            |
| 34. 00           | Other assets  | 135, 547                   |                      | 0              | 0              | 34. 00           |
| 35.00            | Total other assets (sum of lines 31-34)                                   | 1, 100, 691                | 0                    | 0              | 0              | 35. 00           |
| 36. 00           | Total assets (sum of lines 11, 30, and 35)                                | 33, 764, 552               | . C                  | 0              | 0              | 36. 00           |
| 07.00            | CURRENT LIABILITIES   | 4 4 (0 4 4 4               |                      |                |                | 07.00            |
| 37. 00<br>38. 00 | Accounts payable Salaries, wages, and fees payable                        | 4, 169, 141<br>2, 762, 697 | 1                    | 0              | 0              | 37. 00<br>38. 00 |
| 39. 00           | Payroll taxes payable   | 2,702,097                  |                      | 0              | 0              | 39.00            |
| 40. 00           | Notes and Loans payable (short term)                                      | 1, 053, 665                | 1                    | Ö              | 0              | 40.00            |
| 41.00            | Deferred income   | 0                          | o c                  | 0              | 0              | 41.00            |
| 42.00            | Accel erated payments   | 0                          |                      |                |                | 42. 00           |
| 43. 00           | Due to other funds  | 0                          | 0                    | 0              | 0              | 1                |
| 44. 00           | Other current liabilities   | 813, 917                   |                      | -              | 0              |                  |
| 45. 00           | Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES | 8, 799, 420                | ) C                  | 0              | 0              | 45. 00           |
| 46. 00           | Mortgage payable  | 0                          |                      | 0              | 0              | 46. 00           |
| 47. 00           | Notes payable   | 7, 001, 882                | 1                    | -              | 0              |                  |
| 48.00            | Unsecured Loans   | 0                          | 0                    | 0              | 0              |                  |
| 49.00            | Other long term liabilities   | 0                          | 0                    | 0              | 0              | 49. 00           |
| 50. 00           | Total long term liabilities (sum of lines 46 thru 49)                     | 7, 001, 882                |                      |                | 0              | 50.00            |
| 51. 00           | Total liabilities (sum of lines 45 and 50)                                | 15, 801, 302               | <u>:</u>   C         | 0              | 0              | 51.00            |
| 52. 00           | CAPITAL ACCOUNTS  General fund balance                                    | 17, 963, 250               | 1                    |                |                | 52.00            |
| 53. 00           | Specific purpose fund   | 17, 703, 230               | 1 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            | Governing body created - endowment fund balance                           |                            |                      | 0              |                | 56. 00           |
| 57. 00           | Plant fund balance - invested in plant                                    |                            |                      |                | 0              |                  |
| 58. 00           | Plant fund balance - reserve for plant improvement,                       |                            |                      |                | 0              | 58. 00           |
| 59. 00           | replacement, and expansion Total fund balances (sum of lines 52 thru 58)  | 17, 963, 250               |                      | 0              | 0              | 59. 00           |
| 60.00            | Total liabilities and fund balances (sum of lines 51 and                  | 33, 764, 552               |                      | o o            | 0              |                  |
|                  | 59)   |                            | 1                    |                |                |                  |
|                  |   |                            |                      | ·              |                |                  |

13.00

14.00

15.00

16.00

17.00

18.00

19.00

STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-3028 Peri od: Worksheet G-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 8:35 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 16, 702, 844 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 1, 260, 406 2.00 3.00 Total (sum of line 1 and line 2) 17, 963, 250 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 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) 10.00 17, 963, 250 Subtotal (line 3 plus line 10) 11.00 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 00000 13.00 13.00 14.00 14.00 0 15.00 0 15.00 16.00 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 17, 963, 250 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 11.00 0 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00

0

0

0

13. 00 14. 00

15. 00 16. 00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

Provider CCN: 15-3028

Peri od:

From 01/01/2023 Parts I & II Date/Time Prepared: 12/31/2023 5/30/2024 8:35 am Cost Center Description Outpati ent Inpati ent Total 1.00 2. 00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 47, 010, 303 47, 010, 303 1.00 2.00 SUBPROVIDER - IPF 2.00 3.00 SUBPROVIDER - IRF 3.00 4.00 SUBPROVI DER 4.00 Swing bed - SNF Swing bed - NF 5.00 0 0 5.00 6.00 0 6.00 SKILLED NURSING FACILITY 7.00 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) 47, 010, 303 47, 010, 303 10 00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 11.00 12.00 CORONARY CARE UNIT 12.00 BURN INTENSIVE CARE UNIT 13 00 13 00 SURGICAL INTENSIVE CARE UNIT 14.00 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 Total intensive care type inpatient hospital services (sum of lines 16, 00 0 16, 00 11 - 15) 17.00 Total inpatient routine care services (sum of lines 10 and 16) 47, 010, 303 47, 010, 303 17.00 18.00 Ancillary services 55, 057, 033 18, 858, 160 73, 915, 193 18.00 Outpatient services 2, 743, 044 2, 940, 801 19.00 197, 757 19.00 RURAL HEALTH CLINIC 20.00 C 0 20.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULANCE SERVICES 23.00 CMHC 24.00 0 Λ 24.00 24. 10 CORF 0 0 24. 10 AMBULATORY SURGICAL CENTER (D. P.) 25.00 25.00 26.00 26.00 HOSPI CE OTHER (SPECIFY) 27.00 Λ 27.00 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 102, 265, 093 21, 601, 204 123, 866, 297 28.00 line 1) PART II - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) 45, 535, 971 29 00 30.00 ADD (SPECIFY) 0 30.00 0 31.00 31.00 32.00 0 32.00 0 33.00 33.00 0 34.00 34.00 35.00 0 35.00 Total additions (sum of lines 30-35) 36, 00 0 36, 00 DEDUCT (SPECIFY) 37.00 37.00 38.00 0 38.00 39.00 39.00 0 40.00 40.00 0 41.00 41.00 42.00 Total deductions (sum of lines 37-41) 42.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 45, 535, 971 43.00 43.00

to Wkst. G-3, line 4)

|        | <u> </u>  |                       |                                  | eu of Form CMS-2552-10                |           |
|--------|---|-----------------------|----------------------------------|---------------------------------------|-----------|
| STATEM | ENT OF REVENUES AND EXPENSES  | Provider CCN: 15-3028 | Peri od:                         | Worksheet G-3                         |           |
|        |   |                       | From 01/01/2023<br>To 12/31/2023 | Doto/Timo Dro                         | narod     |
|        | 10 12/31/2023   |                       |                                  | Date/Time Prepared: 5/30/2024 8:35 am |           |
|        |   |                       |                                  | 07 007 202 1 0.0                      | O dill    |
|        |   |                       |                                  | 1. 00                                 |           |
| 1.00   | Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)        |                       |                                  | 123, 866, 297                         | 1, 00     |
| 2.00   | Less contractual allowances and discounts on patients' accounts           |                       |                                  | 79, 352, 887                          | 2.00      |
| 3.00   | Net patient revenues (line 1 minus line 2)                                |                       |                                  | 44, 513, 410                          | ı         |
| 4.00   | Less total operating expenses (from Wkst. G-2, Part II, line 43)          |                       |                                  | 45, 535, 971                          | 4.00      |
| 5.00   | Net income from service to patients (line 3 minus line 4)                 |                       |                                  | -1, 022, 561                          | 5. 00     |
|        | OTHER I NCOME   |                       |                                  |                                       |           |
| 6.00   | Contributions, donations, bequests, etc                                   |                       |                                  | 0                                     | 6.00      |
| 7.00   | Income from investments   |                       |                                  | 0                                     | 7. 00     |
| 8.00   | Revenues from telephone and other miscellaneous communication services    |                       |                                  | 0                                     | 8. 00     |
| 9.00   | Revenue from television and radio service                                 |                       |                                  | 0                                     | 9. 00     |
| 10.00  | Purchase di scounts   |                       |                                  | 0                                     | 10.00     |
| 11.00  | 0 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  | No Revenue from meals sold to employees and guests                        |                       |                                  | 0                                     | 14.00     |
| 15. 00 | 0 Revenue from rental of living quarters                                  |                       |                                  | 0                                     | 15. 00    |
| 16.00  | Revenue from sale of medical and surgical supplies to other than patients |                       |                                  | 0                                     | 16.00     |
| 17.00  | Revenue from sale of drugs to other than patients                         |                       |                                  | 0                                     | 17. 00    |
| 18.00  | Revenue from sale of medical records and abstracts                        |                       |                                  | 0                                     | 18. 00    |
| 19.00  | Tuition (fees, sale of textbooks, uniforms, etc.)                         |                       |                                  | 0                                     | 19. 00    |
| 20.00  | Revenue from gifts, flowers, coffee shops, and canteen                    |                       |                                  | 0                                     | 20. 00    |
| 21.00  | Rental of vending machines  |                       |                                  | 0                                     | 21. 00    |
| 22. 00 | Rental of hospital space  |                       |                                  | 0                                     | 22. 00    |
| 23.00  | Governmental appropriations   |                       |                                  | 0                                     | 23. 00    |
|        | MI SCELLANEOUS I NCOME  |                       |                                  | 2, 282, 967                           |           |
| 04 50  | 201/15 42 51/5 5 11   |                       |                                  |                                       | 1 0 4 - 6 |

24.00 MISCELLANEOUS INCOME
24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
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)

0 24. 50 25. 00

26.00 27. 00 0 0 28.00 1, 260, 406 29.00

2, 282, 967 1, 260, 406