This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-3028 Worksheet S Peri od: From 01/01/2019 Parts I-III AND SETTLEMENT SUMMARY 12/31/2019 Date/Time Prepared: 6/30/2020 7:23 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 6/30/2020 7:23 am Manually prepared cost report use only ] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended

## PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REHABILITATION HOSPITAL OF INDIANA (15-3028) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) MARJORIE BASEY
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)
Date

	·		Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-25, 529	58, 622	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-25, 529	58, 622	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3028 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/30/2020 7:23 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 4141 SHORE DRIVE 1.00 PO Box: 1.00 State: IN 2.00 City: INDIANAPOLIS Zip Code: 46254 County: MARION 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)
V | XVIII | XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 REHABILITATION HOSPITAL 153028 26900 5 01/07/1992 Ν 3.00 OF INDIANA Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 Hospital-Based (CMHC) I 17.00 17.00 17. 10 Hospital -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 19.00 Other From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2019 12/31/2019 20.00 21.00 Type of Control (see instructions) 21.00 4 1. 00 3.00 2.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this N N 22 01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N Ν N 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d pai d days Medi cai d eligible Medi cai d days unpai d paid days el i gi bl e unpai d days 1.00 3.00 4.00 5. 00 6.00 2.00 24.00 If this provider is an IPPS hospital, enter the 0 0 24 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provi der CC			/31/201	9 Pai 9 Da 6/	rt I te/Ti 30/20	et S-2 me Pre 20 7:2	pared:
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid 4.00	HMO	cai d days	Med d	ther i cai d ays . 00	_
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	850				0	3, 055			25. 00
					'Rural . 00	S Dat	e of 2.0		-
26.00 Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo		at the beg	ginning of	the		1			26. 00
7.00 Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassification.	age) status or "2" for r	rural. If ap	d of the compplicable,	st		1			27.00
5.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	ne number of	periods S	CH status i	n		0			35. 0
					nni ng: . 00		Endi i		
6.00 Enter applicable beginning and ending dates of SCH s		cript line	36 for numb		. 00		۷. ۷		36.0
of periods in excess of one and enter subsequent dat 7.00 If this is a Medicare dependent hospital (MDH), ente		er of period	ds MDH state	us		0			37.0
is in effect in the cost reporting period. 7.01 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" finstructions)									37.0
8.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.									38.0
					//N . 00		Y/I 2. C		
9.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)	), (ii), or the mileage ii)? Enter	(iii)? En requirement in column :	ter in colu nts in 2 "Y" for y	ume mn es	N		N		39.0
0.00 Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	er "Y" for			N		N		40.0
							VIII 2. 00	XI X 3. 00	-
Prospective Payment System (PPS)-Capital 5.00 Does this facility qualify and receive Capital payme	ent for disc	roporti ona	te share in	accordan	ce I	N T	N	N	45. 0
with 42 CFR Section §412.320? (see instructions) 6.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks	eption for	extraordi na	ary circums	tances		N	N	N	46. 00
Pt. III. 7.00 Is this a new hospital under 42 CFR §412.300(b) PPS 8.00 Is the facility electing full federal capital paymen Teaching Hospitals						N N	N N	N N	47. 0 48. 0
6.00 Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for	impacted by	CR 11642				Y	N		56.0
7.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	period duri or yes or "N oth of this Y", complet	ng which re I" for no in cost repor e Workshee	n column 1. ting period	If colum ? Enter	า 1 'Y"	N			57.0
8.00 $\mid$ If line 56 is yes, did this facility elect cost reim	bursement f	or physicia	ans' servic	es as		N			58.0
defined in CMS Pub. 15–1, chapter 21, §2148? If yes, 9.00 Are costs claimed on line 100 of Worksheet A? If ye				)	_	N D-			59. 0
			NAHE 413.8 Y/N		sheet A ne #	Qua			
0.00 Are you claiming pursing and allied health education	(NIAUE) cos	te for	1. 00	2	. 00		3. 0		60.0
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in col	8.85? (see Dlumn 1. lf CR) NAHE MA	column 1	N						60.00

lealth Financial Systems	REHABILITATION HOSPIT	AL OF INDIANA	In Lie	u of Form CMS-2552-10
				and the second s

ealth Financial Systems		Provider C	CN: 15-3028 Pe	eriod: rom 01/01/2019	u of Form CMS-2 Worksheet S-2 Part I	
			To		Date/Time Pre 6/30/2020 7:2	
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2. 00	3. 00	4. 00	5. 00	
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0. 00	0. 00	61
1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61
1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61
1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61
current cost reporting period. (see instructions).  1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61
61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61
	Pro	gram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 00	2. 00	3. 00	4. 00	
<ul> <li>1.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.</li> <li>1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,</li> </ul>				0. 00	0. 00	
the direct GME FTE unweighted count.						
					1. 00	-
ACA Provisions Affecting the Health Resources and Sei					1. 00	
2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruction 2.01 Enter the number of FTE residents that rotated from a	ctions)				0. 00	
during in this cost reporting period of HRSA THC progressions to the Teaching Hospitals that Claim Residents in Nonprovide 3.00 Has your facility trained residents in nonprovider se	er Setti	ngs		neriod2 Enter	N	63
"Y" for yes or "N" for no in column 1. If yes, comple					Ratio (col.	
			FTEs Nonprovi der Si te	FTEs in Hospital	1/ (col . 1 + col . 2))	
Coation FEOA of the ACA Dana Varia FTF Dani July 1	onn=:::	don Cott!	1. 00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and before		9	- mis base year	rs your cost i	eportring	
4.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	ty trair n-primar all nor d non-pr n columr	ned residents by care aprovider imary care a 3 the ratio	0.00	0.00	0. 000000	64

1103F1 1	AL AND HOSPITAL HEALTH CARE COMP	LEX TOENTITICATION D.	ATA TTOVICE S		om 01/01/2019 12/31/2019	Part I Date/Time Pre	
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3+ col. 4))	3 am
		1. 00	2. 00	3. 00	4. 00	5. 00	
65. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column			0.00	0.00	0. 000000	65.00
	4)). (see instructions)			Unwei ghted	Unweighted	Ratio (col.	
				FTEs Nonprovi der Si te	FTEs in Hospital	1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Current	Vaar ETE Daaidanta i	n Nannnavi dan Catti	1.00	2.00	3.00	
	beginning on or after July 1, 20		n wonprovider Setti	ngsEffective i	or cost report	ing perious	
66. 00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. Try care resident 3 the ratio of	0.00	Unwei ghted	Ratio (col.	66. 00
				FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
67. 00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	3.00	4.00	5. 00 0. 000000	67. 00
					1.00	2.00 3.00	
70. 00	Inpatient Psychiatric Facility F Is this facility an Inpatient Ps	ychiatric Facility (	IPF), or does it cor	ntain an IPF sub	provi der? N		70.00
	Enter "Y" for yes or "N" for no If line 70 is yes: Column 1: Did recent cost report filed on or b42 CFR 412.424(d)(1)(iii)(c)) Coprogram in accordance with 42 CFC Column 3: If column 2 is Y, indi (see instructions)	the facility have a efore November 15, 2 lumn 2: Did this fac R 412.424 (d)(1)(iii cate which program y	n approved GME teach 2004? Enter "Y" for Sility train resident )(D)? Enter "Y" for	ning program in yes or "N" for ts in a new teac yes or "N" for	the most no. (see hing no.	0	71. 00
75 00	Inpatient Rehabilitation Facilit	y PPS	y (IDE) or door !+	contain on LDF	V		75 00
/5.00	Is this facility an Inpatient Resubprovider? Enter "Y" for yes	กลมกากสนาดก Facilit and "N" for no.	y (IKF), Or does it	contain an IRF	Y		75. 00

Health Financial Systems REHABILITATION HOSPI			of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-3028	Peri od:	Worksheet S-2	2
		From 01/01/2019	Part I	onorod.
		To 12/31/2019	Date/Time Pre 6/30/2020 7:2	
			7 007 2020 711	
		1.00	2.00 3.00	
76.00 If line 75 is yes: Column 1: Did the facility have an approve	ed GME teaching program in	n the most Y	N O	76.00
recent cost reporting period ending on or before November 15,	, 2004? Enter "Y" for yes	or "N" for		
no. Column 2: Did this facility train residents in a new team	ching program in accordanc	ce with 42		
CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.				
indicate which program year began during this cost reporting	period. (see instructions	s)		
			1. 00	+
Long Term Care Hospital PPS				
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes	and "N" for no.		N	80.00
81.00 Is this a LTCH co-located within another hospital for part of	r all of the cost reportin	ng period? Enter	N	81.00
"Y" for yes and "N" for no.				
TEFRA Provi ders				
85.00   Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)	3		N	85.00
86.00 Did this facility establish a new Other subprovider (exclude	d unit) under 42 CFR Secti	on		86.00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				
87.00 Is this hospital an extended neoplastic disease care hospital	l classified under section	1	N	87.00
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		V	VIV	
		1. 00	XI X 2. 00	+
Title V and XIX Services		1.00	2.00	
90.00 Does this facility have title V and/or XIX inpatient hospital	I services? Enter "Y" for	N	Υ	90.00
yes or "N" for no in the applicable column.			-	
91.00 Is this hospital reimbursed for title V and/or XIX through the	he cost report either in	N	N	91.00
full or in part? Enter "Y" for yes or "N" for no in the appli	icable column.			
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dua	al certification)? (see		N	92.00
instructions) Enter "Y" for yes or "N" for no in the applical				
93.00 Does this facility operate an ICF/IID facility for purposes	of title V and XIX? Enter	N	N	93.00
"Y" for yes or "N" for no in the applicable column.				1
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for no in the	N	N	94.00
applicable column.	Li cabla, calumn	0.00	0.00	05.00
95.00   If line 94 is "Y", enter the reduction percentage in the appl 96.00   Does title V or XIX reduce operating cost? Enter "Y" for yes		0. 00 N	0. 00 N	95.00
applicable column.	or in for no fir the	IN	IN	90.00
97.00 If line 96 is "Y", enter the reduction percentage in the appl	Licable column	0. 00	0. 00	97.00
98.00 Does title V or XIX follow Medicare (title XVIII) for the in		N N	Υ Υ	98.00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" fo			•	
column 1 for title V, and in column 2 for title XIX.	3			
98.01 Does title V or XIX follow Medicare (title XVIII) for the re	porting of charges on Wks <sup>-</sup>	t. N	Υ	98. 01
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti	tle V, and in column 2 for	-		
title XIX.				
98.02 Does title V or XIX follow Medicare (title XVIII) for the cal		N	Υ	98. 02
bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o	r "N" for no in column 1			
for title V, and in column 2 for title XIX.	to the control of the			00.01
98.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for year			N	98. 03
for title V, and in column 2 for title XIX.	S OF IN TOT HO TH COLUMN	1		
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH	reimbursed 101% of	N	N	98. 04
outpatient services cost? Enter "Y" for yes or "N" for no in			IN	70.02
in column 2 for title XIX.	cordining from title v, and	1		
98.05 Does title V or XIX follow Medicare (title XVIII) and add bad	ck the RCE disallowance or	n N	Υ	98. 05
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co				70.00
column 2 for title XIX.				
98.06 Does title V or XIX follow Medicare (title XVIII) when cost	reimbursed for Wkst. D,	N	Υ	98.06
Pts. I through IV? Enter "Y" for yes or "N" for no in column	1 for title V, and in			
column 2 for title XIX.				
Rural Providers				4
105.00 Does this hospital qualify as a CAH?		N N		105.00
106.00 If this facility qualifies as a CAH, has it elected the all-	inclusive method of paymer	ודן		106.00
for outpatient services? (see instructions)	ct roimburcoment for LOD			107.00
107.00 Column 1: If line 105 is Y, is this facility eligible for contraining programs? Enter "Y" for years "N" for pa in column	st reimbursement for I&R			107.00
training programs? Enter "Y" for yes or "N" for no in column				1
Column 2: If column 1 is Y and line 70 or line 75 is Y, do y approved medical education program in the CAH's excluded IP				
Enter "Y" for yes or "N" for no in column 2. (see instruction				
108.00 Is this a rural hospital qualifying for an exception to the		2 N		108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		-		1.33.00
, , , , , , , , , , , , , , , , , , , ,		1	1	

Health Financial Systems REHABILITATION HOSPITA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 15-3028	Period: From 01/01/2019 To 12/31/2019		-2 repared:
	Physi cal	Occupati onal		Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1. 00 N	2. 00 N	3. 00 N	4.00 N	109. 00
				1.00	
10.00 Did this hospital participate in the Rural Community Hospital I Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, lines 200 through 218, and Workslapplicable.	for yes o	r "N" for no.	If yes,	N	110. 0
			1. 00	2. 00	
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to columntegration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	reporting nn 1 is Y, cipating i	period? Enter enter the n column 2.	N		111.0
		1. 00	2.00	3. 00	
12.00 Did this hospital participate in the Pennsylvania Rural Health demonstration for any portion of the current cost reporting per Enter "Y" for yes or "N" for no in column 1. If column 1 is "' in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	riod? Y", enter	N	2.00	3.00	112.00
Miscellaneous Cost Reporting Information 15.00 s this an all-inclusive rate provider? Enter "Y" for yes or "I	d" for no	N			0115.0
in column 1. If column 1 is yes, enter the method used (A, B, oin column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (incorpsychiatric, rehabilitation and long term hospitals providers) the definition in CMS Pub.15-1, chapter 22, §2208.1.	or E only) percent cludes based on				
16.00 Is this facility classified as a referral center? Enter "Y" for "N" for no.	r yes or	N			116. 0
17.00 Is this facility legally-required to carry malpractice insurance "Y" for yes or "N" for no.	ce? Enter	N			117. 0
18.00 Is the malpractice insurance a claims-made or occurrence policy			1		118. 0
if the policy is claim-made. Enter 2 if the policy is occurrent	se.	Premi ums	Losses	Insurance	
18.01 List amounts of malpractice premiums and paid losses:		1.00	2. 00	3. 00	0118.0
				0.00	
18.02 Are mal practice premiums and paid losses reported in a cost cer Administrative and General? If yes, submit supporting schedulo and amounts contained therein.			1.00 N	2.00	118. 0
19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with < 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments?	olumn 1, " fies for	Y" for yes or the Outpatient		N	119. 0 120. 0
Enter in column 2, "Y" for yes or "N" for no. 21.00Did this facility incur and report costs for high cost implanta	able devic	es charged to	N		121. 0
patients? Enter "Y" for yes or "N" for no.  22.00 Does the cost report contain healthcare related taxes as define     Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is     the Worksheet A line number where these taxes are included.					122. 0
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	ves and "N	" for no. If	N		125. 0
yes, enter certification date(s) (mm/dd/yyyy) below.					
26.00  f this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.			;		126. 0
07 00H C 111 1 1 1 M 11 1 1 1 1 1 1 1 1 1 1 1	the certi	fication date			127.0
127.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.	the certi				

Health Financial Systems	REHABILITATION HOSF	PITAL OF INDIA	NA		In Lie	u of Form CMS.	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		Provi der CC	CN: 15-3028	Peri od:		Worksheet S-	
					/01/2019 2/31/2019	Part     Date/Time Pr	epared.
				10 12	., 01, 201,	6/30/2020 7:	
					1 00	2.00	_
132.00 If this is a Medicare certified is	Let transplant center en	ter the certif	ication date		1. 00	2. 00	132.00
in column 1 and termination date,			reation date				132.00
133.00 Removed and reserved							133.00
134.00 If this is an organ procurement or		ne OPO number	in column 1				134.00
and termination date, if applicabl	e, in column 2.						-
140.00 Are there any related organization	or home office costs as o	defined in CMS	Pub. 15-1.		Υ	15H059	140.00
chapter 10? Enter "Y" for yes or "	N" for no in column 1. If	yes, and home	office costs	s			
are claimed, enter in column 2 the			tions)				
1.00 If this facility is part of a chai	n organization onter on		yugh 1/2 tho	namo and	3.00	of the home	
office and enter the home office of			Jugii 143 tile	name and	auui ess	of the nome	
141.00 Name: IU HEALTH	Contractor's Name: WPS		Contract	or's Nur	mber: 0810	)1	141.00
142.00 Street: 340 W 10TH STREET	PO Box:						142.00
143.00 Ci ty: I NDI ANAPOLI S	State: IN		Zi p Code	:	4620	)2	143. 00
						1.00	-
144.00 Are provider based physicians' cos	ts included in Worksheet /	۹?				N N	144.00
							111111
					1. 00	2.00	
145.00 If costs for renal services are cl	aimed on Wkst. A, line 74,	are the cost	s for				145. 00
inpatient services only? Enter "Y" no, does the dialysis facility inc	TOT YES OF N TOT NO IN	for this cost	column IIS				
period? Enter "Y" for yes or "N"		101 11113 0031	reporting				
146.00 Has the cost allocation methodolog		usly filed cos	st report?		N		146.00
Enter "Y" for yes or "N" for no in		15-2, chapter	40, §4020) I1	f			
yes, enter the approval date (mm/d	d/yyyy) in column 2.						
						1.00	-
147.00 Was there a change in the statisti	cal basis? Enter "Y" for y	yes or "N" for	no.			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? En					N	149.00
	-	Part A 1.00	Part B 2.00	_	tle V 3.00	Title XIX 4.00	-
Does this facility contain a provi	der that qualifies for an						
or charges? Enter "Y" for yes or "							
155. 00 Hospi tal		N	N		N	N	155.00
156.00 Subprovi der - IPF 157.00 Subprovi der - IRF		N N	l N N		N N	N N	156. 00 157. 00
158. OO SUBPROVI DER		IN	I IN		IN	IN IN	158. 00
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	161.00
161. 10 CORF			N N		N	N	161. 10
						1.00	
Mul ti campus							
165.00 Is this hospital part of a Multica	mpus hospital that has one	e or more camp	uses in diffe	erent CE	BSAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Name	County	State 7:	p Code	CBSA	FTE/Campus	
	0	1. 00		3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each					00		0166.00
campus enter the name in column							
O, county in column 1, state in column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
Hool the La-Garanti and Table 1 (1977)	) inconting to the A	on Doctor	nd Dollarus I	n+ ^-!		1. 00	
Health Information Technology (HIT 167.00 is this provider a meaningful user				nt Act		N	167. 00
168.00 If this provider is a CAH (line 10				), enter	the	IN	168.00
reasonable cost incurred for the H			,	,			
168.01 If this provider is a CAH and is n					lshi p		168. 01
exception under §413.70(a)(6)(ii)?					ontor the	0.0	0169. 00
transition factor. (see instruction		is not a CAH	(1116 100 15	IN ), €	anter tile	0.0	9107.00
	-/					1	1

Health Financial Systems	REHABILITATION HOSP	ITAL OF INDIANA	In Lie	In Lieu of Form CMS-2552-				
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CCN: 15-3028	Peri od:	Worksheet S-2				
			From 01/01/2019					
			To 12/31/2019	Date/Time Pre	pared:			
				6/30/2020 7: 2	3 am			
			Begi nni ng	Endi ng				
			1. 00	2. 00				
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)			170. 00					
per real respectivery (min day yyyy)								
					-			
			1. 00	2. 00				
171.00 If line 167 is "Y", does this pro-	vider have any days for ind	lividuals enrolled in	N	C	171.00			
section 1876 Medicare cost plans	reported on Wkst. S-3, Pt.	I, line 2, col. 6? Enter						
"Y" for yes and "N" for no in col	umn 1. If column 1 is yes,	enter the number of secti	on					
1876 Medicare days in column 2. (	see instructions)							

	n Financial Systems REHABILITATION HOSTAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Peri od: From 01/01/2019		
				To 12/31/2019	Date/Time Pro 6/30/2020 7:3	epared: 23 am
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO re	ocnoncos Ent	1.00	2.00	
	mm/dd/yyyy format.	I TOT ALL NO TO	esponses. Em	er arr dates in	trie	
	COMPLETED BY ALL HOSPITALS					
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	hoginning of	the cost	N	I	1.00
1.00	reporting period? If yes, enter the date of the change in a					1.00
		•	Y/N	Date	V/I	
2 00	Has the provider terminated participation in the Medicare F	Drogram? If	1.00 N	2. 00	3. 00	2.00
2. 00	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	nn 3, "V" for	IN.			2.00
3. 00	Is the provider involved in business transactions, including		Y			3. 00
	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of	of the board				
	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		T		Г	
4. 00	Column 1: Were the financial statements prepared by a Cera Accountant? Column 2: If yes, enter "A" for Audited, "C" 1		Y	A		4. 00
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
5. 00	Are the cost report total expenses and total revenues differenthese on the filed financial statements? If yes, submit reconstructions are the cost report total expenses and total revenues differenthese differenth		N			5. 00
	Those on the fired fridancial statements. If yes, submit rec	501101111111111111	I.	Y/N	Legal Oper.	
	Accord 51 and and Advistage			1. 00	2. 00	
6. 00	Approved Educational Activities  Column 1: Are costs claimed for pursing school 2 Column 2:	If ves is t	he provider i	s N		6.00
0.00	the legal operator of the program?					
7 00	Are costs claimed for Allied Health Programs? If "Y" see instructions.					
7.00						7.00
8. 00	Were nursing school and/or allied health programs approved		d during the	N N		7. 00 8. 00
	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved	and/or renewed	o o	N		
<ul><li>8. 00</li><li>9. 00</li></ul>	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	and/or renewed graduate medic ns.	cal educatior	N Y		8. 00 9. 00
8. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated of	and/or renewed graduate medic ns.	cal educatior	N		8.00
<ul><li>8. 00</li><li>9. 00</li><li>10. 00</li></ul>	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I	and/or renewed graduate medic ns. or renewed in	cal education	N Y		8. 00 9. 00
<ul><li>8. 00</li><li>9. 00</li><li>10. 00</li></ul>	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	and/or renewed graduate medic ns. or renewed in	cal education	N Y N	V/N	8. 00 9. 00 10. 00
<ul><li>8. 00</li><li>9. 00</li><li>10. 00</li></ul>	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I	and/or renewed graduate medic ns. or renewed in	cal education	N Y N	Y/N 1, 00	8. 00 9. 00 10. 00
<ul><li>8. 00</li><li>9. 00</li><li>10. 00</li></ul>	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts	and/or renewed graduate medic ns. or renewed in & R in an App	cal education the current proved	N Y N	1. 00	8. 00 9. 00 10. 00 11. 00
8. 00 9. 00 10. 00 11. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts Is the provider seeking reimbursement for bad debts? If yes	and/or renewed graduate medicals. or renewed in & R in an App	cal education the current proved tions.	N Y N N	1. 00 Y	8. 00 9. 00 10. 00 11. 00
8. 00 9. 00 10. 00 11. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection periods.	and/or renewed graduate medicals. or renewed in & R in an App	cal education the current proved tions.	N Y N N	1. 00	8. 00 9. 00 10. 00 11. 00
8. 00 9. 00 10. 00 11. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts  Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payments.	graduate medicis. or renewed in  & R in an App	cal education the current proved tions. during this c	N Y N N N Sost reporting	1. 00 Y	8. 00 9. 00 10. 00 11. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts  Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-paymed Bed Complement	graduate medicals. or renewed in & R in an Apple. s, see instructionality change cents waived? I	cal education the current proved tions. during this c	N Y N N N sost reporting	1. 00 Y N	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts  Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payments.	graduate medicals. or renewed in a R in an Apple. s, see instructional colory change of the colors change of the c	cal education the current proved tions. during this of yes, see in	N Y N N Sost reporting	1. 00 Y N	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts  Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-paymed Bed Complement	graduate medicals. or renewed in & R in an Apple. s, see instructionality change cents waived? In ng period? If Par Y/N	cal education the current proved  tions. during this c f yes, see in yes, see ins t A Date	N N N N Sost reporting structions.  Structions. Par	1.00  Y N N T B Date	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-paymed Bed Complement  Did total beds available change from the prior cost reportions.	and/or renewed graduate medicals. or renewed in & R in an Apple s, see instructional collections waived? If ng period? If Par	cal education the current proved tions. during this c f yes, see in	N Y N N sost reporting structions.	1.00 Y N N	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payme Bed Complement  Did total beds available change from the prior cost reporti	graduate medicals. or renewed in & R in an Apple. s, see instructionality change cents waived? In ng period? If Par Y/N	cal education the current proved  tions. during this of f yes, see inset A  Date 2.00	N N N N Sost reporting structions.  Structions. Par	1.00  Y N N  N  t B Date 4.00	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts  Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payme Bed Complement  Did total beds available change from the prior cost reportion 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	and/or renewed graduate medicals. or renewed in & R in an Apple s, see instructionality change of ents waived? If par Y/N 1.00	cal education the current proved  tions. during this c f yes, see in yes, see ins t A Date	N Y N N N N N N N N N N N N N N N N N N	1.00  Y N N T B Date	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts  Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-paymed Bed Complement  Did total beds available change from the prior cost reportion of 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	and/or renewed graduate medicals. or renewed in & R in an Apple s, see instructionality change of ents waived? If par Y/N 1.00	cal education the current proved  tions. during this of f yes, see inset A  Date 2.00	N Y N N N N N N N N N N N N N N N N N N	1.00  Y N N  N  t B Date 4.00	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 16. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payme Bed Complement  Did total beds available change from the prior cost reportion to 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)	and/or renewed graduate medicals. or renewed in  & R in an App  s, see instructional and the sents waived? If  par Y/N 1.00	cal education the current proved  tions. during this of f yes, see inset A  Date 2.00	N Y N N N N N N N N N N N N N N N N N N	1.00  Y N N  N  t B Date 4.00	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-payme Bed Complement  Did total beds available change from the prior cost reporting total beds available change from the prior cost reporting 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	and/or renewed graduate medicals. or renewed in & R in an Apple s, see instructionality change of ents waived? If par Y/N 1.00	cal education the current proved  tions. during this of f yes, see inset A  Date 2.00	N Y N N N N N N N N N N N N N N N N N N	1.00  Y N N  N  t B Date 4.00	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 16. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.  Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.  If line 12 is yes, were patient deductibles and/or co-paymed Bed Complement  Did total beds available change from the prior cost reportion to total beds available change from the prior cost reportion of the PS&R Report used in columns 2 and 4 (see instructions)  Was the cost report prepared using the PS&R Report for	and/or renewed graduate medicals. or renewed in  & R in an App  s, see instructional and the sents waived? If  par Y/N 1.00	cal education the current proved  tions. during this of f yes, see inset A  Date 2.00	N Y N N N N N N N N N N N N N N N N N N	1.00  Y N N  N  t B Date 4.00	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00

Ν

18.00

19.00

18.00 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.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems REHABILITATION HO	SPITAL OF INDIA	ANA	In Lie	u of Form CM	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der 0	CCN: 15-3028	Peri od: From 01/01/2019 To 12/31/2019		Prepared:
			iption	Y/N	Y/N	
00.00	1011 1/ 1011		0	1.00	3. 00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS	HOSPLTALS)		1.00	
	Capital Related Cost		,			
22.00	Have assets been relifed for Medicare purposes? If yes, se	ee instructions	5		Υ	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	e due to apprai	sals made du	ing the cost	N	23. 00
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter	red into during	this cost re	eporting period?	N	24.00
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	g the cost repo	orting period <sup>~</sup>	? If yes, see	N	25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during 1	the cost report	ing period? I	f yes, see	N	26. 00
27. 00	instructions. Has the provider's capitalization policy changed during th	f yes, submit	N	27. 00		
	copy. Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit eperiod? If yes, see instructions.	reporting	N	28. 00		
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst	N	29. 00			
30. 00	Has existing debt been replaced prior to its scheduled mat instructions.	s, see	N	30.00		
31. 00	Has debt been recalled before scheduled maturity without i instructions.	s, see	N	31.00		
32. 00	Purchased Services Have changes or new agreements occurred in patient care se	ervices furnish	ned through co	ontractual	N	32.00
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	ructions.	G			33.00
	Provi der-Based Physi ci ans					
34. 00		arrangement wit	th provider-ba	ased physicians?	N	34.00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex		ents with the	provi der-based		35.00
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date	
				1.00	2. 00	
24 00	Home Office Costs			V		24 00
36. 00 37. 00	If line 36 is yes, has a home office cost statement been p	orepared by the	e home office	? Y Y		36. 00 37. 00
38. 00	If yes, see instructions.  If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end of the home of the provider?			= N		38. 00
39. 00	1 1 3 .			s, Y		39. 00
40. 00	If line 36 is yes, did the provider render services to the	e home office?	If yes, see	N		40. 00
	i nstructi ons.					
		1.	. 00	2.	00	
	Cost Report Preparer Contact Information					
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		41.00
42. 00	respectively. Enter the employer/company name of the cost report	IU HEALTH				42. 00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-962-1093		RUTTER@I UHEALT	H. ORG	43.00
	1. 1. 1. p. opa. o oor annio i ana 2, i oopooti voi y.	1		1		П

Heal th	Financial Systems REHABILITATION HO	SPI	TAL OF INDIANA		In Lieu	ı of Form C	MS-2	552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der CCN: 15-3028		eriod: rom 01/01/2019	Worksheet Part II	S-2	
				To			Pre 7: 2:	oared: 3 am
			3. 00					
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position	DI	RECTOR					41.00
	held by the cost report preparer in columns 1, 2, and 3,							
	respectively.							
42.00	Enter the employer/company name of the cost report							42.00
	preparer.							
43.00	Enter the telephone number and email address of the cost							43.00
	report preparer in columns 1 and 2, respectively.							

Peri od:

From 01/01/2019 Part I 12/31/2019 Date/Time Prepared: 6/30/2020 7:23 am I/P Days / 0/P Visits / Trips CAH Hours Component Worksheet A No. of Beds Bed Days Title V Line Number Avai I abl e 1.00 2.00 3.00 4.00 5.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 33, 215 0.00 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 HMO IRF Subprovider 4.00 4 00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 Total Adults and Peds. (exclude observation 7.00 91 33, 215 0.00 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8 00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 91 14.00 Total (see instructions) 33, 215 0.00 0 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 17.00 SUBPROVIDER - IRF 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 24.00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 30.00 24.10 99.00 25.00 CMHC - CMHC 25.00 0 CMHC - CORF 25. 10 99.10 0 25.10 RURAL HEALTH CLINIC 26.00 26.00 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 26 25 26 25 91 27.00 Total (sum of lines 14-26) 27.00 28.00 Observation Bed Days 0 28.00 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) 30 00 30.00 31.00 Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) 0 32.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 32.01 33.00 LTCH non-covered days 33 00 33.01 LTCH site neutral days and discharges 33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-3028

Peri od: Worksheet S-3 From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared:

6/30/2020 7:23 am I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Title XIX Total All Component Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 Hospital Adults & Peds. (columns 5, 6, 7 and 21, 061 1.00 7, 119 850 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 3, 466 3, 461 2.00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 4 00 0 0 5.00 Hospital Adults & Peds. Swing Bed SNF 0 C 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 7, 119 850 21,061 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8 00 8 00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12 00 13.00 NURSERY 13.00 365. 79 14.00 Total (see instructions) 7, 119 850 21, 061 2. 59 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 17.00 SUBPROVIDER - IRF 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 24.00 24.00 24. 10 HOSPICE (non-distinct part) 0 24.10 0.00 CMHC - CMHC 0 0.00 25.00 25.00 CMHC - CORF 0 25. 10 0 0 0.00 0.00 25.10 RURAL HEALTH CLINIC 26.00 26.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 26 25 0 00 26 25 365.79 27.00 Total (sum of lines 14-26) 2. 59 27.00 28.00 Observation Bed Days 0 0 28.00 29.00 Ambulance Trips 0 29.00 Employee discount days (see instruction) 0 30 00 30.00 0 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) 0 32.00 Total ancillary labor & delivery room outpatient days (see instructions) 0 32.01 32.01 33 00 LTCH non-covered days 33 00 33.01 LTCH site neutral days and discharges 33.01

Provi der CCN: 15-3028

Peri od: Worksheet S-3 From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared:

							6/30/2020 7: 2	3 am
		Full Time Equivalents			Di sch	arges		
	Component	Nonpai d	Title V	1	Title XVIII	Title XIX	Total All	
		Workers 11.00	12. 00	_	13. 00	14. 00	Pati ents 15.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and			0	495	53	1, 350	1. 00
1.00	Respiral Addits areas. (Cordinates 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)				473	55	1, 330	1.00
2.00	HMO and other (see instructions)				210	204		2.00
3.00	HMO IPF Subprovider					o		3.00
4.00	HMO IRF Subprovider					o		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF							5.00
6.00	Hospital Adults & Peds. Swing Bed NF							6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)							7. 00
8.00	INTENSIVE CARE UNIT							8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13.00
14.00	Total (see instructions)	0.00		0	495	53	1, 350	14.00
15.00	CAH visits							15.00
16.00	SUBPROVIDER - IPF							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
	OTHER LONG TERM CARE							21.00
	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)							24. 10
25.00	CMHC - CMHC	0.00						25.00
25. 10	CMHC - CORF	0.00						25. 10
26. 00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00						26. 25
	Total (sum of lines 14-26)	0.00						27. 00
28. 00	Observation Bed Days							28. 00
29. 00	Ambul ance Trips							29. 00
	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31.00
	Labor & delivery days (see instructions)							32.00
32. 01	Total ancillary labor & delivery room							32. 01
22.00	outpatient days (see instructions)							22.00
	LTCH non-covered days				0			33.00
33. 01	LTCH site neutral days and discharges				0			33. 01

Heal th	Financial Systems REHA	BILITATION HOSP	ITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
					From 01/01/2019 To 12/31/2019	Date/Time Pre 6/30/2020 7:2	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cat	Reclassi fi ed	3 alli
	5551 551151 55551 Pt 1 511	our ur r oo	0 21.101	+ col . 2)	i ons (See	Tri al Bal ance	
					A-6)	(col. 3 +-	
						col. 4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FLXT		936, 503			936, 503	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		1, 067, 393			1, 067, 393	2. 00
3.00	00300 OTHER CAP REL COSTS		0	(	-	0	3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	155, 967	5, 710, 471	5, 866, 438		5, 859, 517	4.00
5. 01	00591 ADMINISTRATIVE AND GENERAL	3, 354, 147	2, 184, 471	5, 538, 618		5, 389, 166	5. 01
5. 02	00590 OTHER A&G - NON FOUNDATION	864, 345	254, 144			1, 118, 010	5. 02
7.00	00700 OPERATION OF PLANT	37, 830	1, 760, 887	1, 798, 717		1, 791, 023	7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE	200 400	112, 586			112, 586	8. 00 9. 00
10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	299, 699 63, 892	176, 997 996, 936			475, 952 719, 302	10.00
11. 00	01100 CAFETERI A	03, 692	990, 930 0	1,000,626		341, 459	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 477, 614	269, 000	1		1, 942, 457	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	66, 235	139, 978			486, 832	14.00
15. 00	01500 PHARMACY	588, 442	164, 241	752, 683		754, 522	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	338, 709	163, 935			502, 644	16. 00
17. 00	01700 SOCIAL SERVICE	302, 270	86, 570			388, 840	17. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	208, 091			208, 091	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-1				===, =	
30.00	03000 ADULTS & PEDIATRICS	7, 959, 286	1, 576, 863	9, 536, 149	-311, 707	9, 224, 442	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	131, 965	22, 784			151, 806	54.00
60.00	06000 LABORATORY	0	428, 524			428, 365	60.00
65. 00	06500 RESPI RATORY THERAPY	464, 994	143, 690			528, 100	65.00
66.00	06600 PHYSI CAL THERAPY	1, 841, 484	406, 888			2, 638, 002	66.00
66. 01	06601 PHYSI CAL THERAPY - CARMEL	160, 887	108, 008			279, 483	66. 01
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	2, 136, 019	363, 711	2, 499, 730		2, 405, 833	67.00
68. 01	06801 VI SI ON	892, 966 210, 322	119, 731 16, 070			1, 242, 562	68. 00 68. 01
68. 02	06802 FAC RESOURCE	1, 392, 369	411, 056			244, 271 1, 656, 096	68. 02
69. 00	06900 ELECTROCARDI OLOGY	1, 372, 307	411,030	1,003,420	147, 329	1, 030, 040	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9, 405	9, 405	243, 452	252, 857	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		7, <del>1</del> 03	7, 400	243, 432	232, 037	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	ol	1, 794, 723	1, 794, 723	0	1, 794, 723	73.00
74. 00	07400 RENAL DI ALYSI S	ol	0	(	o o	0	74.00
	OUTPATIENT SERVICE COST CENTERS	<u> </u>					
90.00	09000 CLI NI C	211, 061	66, 977	278, 038	-29, 395	248, 643	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)						92.00
	OTHER REIMBURSABLE COST CENTERS			1			
	09900 CMHC	0	0	1	0		99.00
99. 10	O9910   CORF   SPECIAL PURPOSE COST CENTERS	464, 505	187, 557	652, 062	-652, 062	0	99. 10
118. 00		23, 415, 008	19, 888, 190	43, 303, 198	-113, 718	43, 189, 480	118 00
110.00	NONREI MBURSABLE COST CENTERS	23, 413, 000	17, 000, 170	45, 303, 170	-113,710	43, 107, 400	110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	Ω	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	943, 011	555, 390				
	07950 FOUNDATION	219, 038	10, 850			241, 222	
	07951 PUBLIC RELATIONS	113, 124	285, 668			398, 792	
	07952 ST. VINCENT - ARU	0	0	(			194. 02
	07953 MUNCIE - ARU	83, 732	16, 152	99, 884	0	99, 884	
	07954 RI LEY - ARU	· ol	0		o		194. 04
194. 05	07955 RETAIL PHARMACY	172, 348	451, 364		-4, 266	619, 446	
200.00	TOTAL (SUM OF LINES 118 through 199)	24, 946, 261	21, 207, 614	46, 153, 875	0	46, 153, 875	200. 00

Peri od: Worksheet A From 01/01/2019 Date/Ti me Prepared: 4/20/2020 7:23 am

Cost Center Description					6/30/2020 7: 2	
All location		Cost Center Description	Adjustments	Net Expenses		
CENTRAL SERVICE COST CENTERS		·	(See A-8)	For		
GNERAL SERVICE COST CENTERS 1.00 00020 (CAR PELE COSTS-SHUBLE GUIP 1 238 705 1, 306, 338 2.0 0 2.00 00200 (CAR PELE COSTS-SHUBLE GUIP 1 238 705 1, 306, 338 2.0 0 2.00 00200 (CAR PELE COSTS-SHUBLE GUIP 1 238 705 1, 306, 338 2.0 0 2.00 00200 (CAR PELE COSTS-SHUBLE GUIP 1 238 705 1, 306, 338 2.0 0 2.00 00400 (CHER CAP PELE COSTS-SHUBLE GUIP 1 228 705 1, 306, 338 2.0 0 2.00 00400 (CHER CAP PELE SHEPE TS DEPARTMENT 2.66, 854 1, 855, 000 4.0 0 2.00 00700 (OHER CAP PELE SHEPE TS DEPARTMENT 2.46), 854 1, 767, 137 7.0 0 2.00 00700 (OHER CAP PELE SHEPE TS DEPARTMENT 2.46), 854 1, 767, 137 7.0 0 2.00 00700 (OHER CAP PELE SHEPE TS DEPARTMENT 2.46), 854 1, 767, 137 7.0 0 2.00 00700 (OHER CAP PELE SHEPE TS DEPARTMENT 2.46), 854 1, 767, 137 7.0 0 2.00 00700 (OHUSEKEEP ING 0 475, 952 9.0 0 2.00 00700 (DEDARTM IN STRATION 1 - 23, 886 1, 767, 137 97 1.0 0 2.00 00700 (DETARTM IN STRATION 1 - 10, 10, 10, 10, 10, 10, 10, 10, 10, 10,				Allocation		
1.00			6. 00	7. 00		
2.00 002000 CAP REL COSTS-WUBLE FOULP 288, 965 1,306,358 2.00 3.30 0.40 00300 OTHER CAP REL COSTS 0 3.30 0.40 00300 OTHER CAP REL COSTS 0 3.30 0.40 00400 EMPLOYEE BENEFITS DEPARTMENT 2.2,699 5,866,818 4.00 5.01 0.0590 OTHER CAP REL COSTS 0 5.01 0.0590 OTHER CAP REL COSTS 0 5.01 0.0590 OTHER CAP REL COSTS 0 5.01 0.0590 OTHER AGS - MON FOUNDATION 5 0 1,118,010 5.02 0.00 0000 OTHER CAP REL COSTS 0 5.00 0.00 0.00 0.00 0.00 0.00 0.00 0		GENERAL SERVICE COST CENTERS				
3.00 003000 OTHER CAP REL COSTS	1.00	00100 CAP REL COSTS-BLDG & FLXT	-116, 949	819, 554	1	1.00
4.00	2.00	00200 CAP REL COSTS-MVBLE EQUIP	238, 965	1, 306, 358	3	2.00
5.01   00599   JADMIN STRATIVE AND GENERAL   2, 462, 864   7, 852, 020   5.01   5.02   00590   OTHER ASG - NON FOUNDATION   -23, 886   1, 767, 137   7.00   00700   OTHER ASG - NON FOUNDATION   -23, 886   1, 767, 137   7.00   00700   OTHER ASG - NON FOUNDATION   -23, 886   1, 767, 137   7.00   00700   OTHER ASG - NON FOUNDATION   -23, 886   1, 767, 137   7.00   00700   OTHER ASG - NON FOUNDATION   -23, 886   1, 767, 137   7.00   00700   OTHER ASG - NON FOUNDATION   -3, 75, 75, 75, 75   7.00   0.00   00700   DETARY   -305   718, 997   10.00   0.00	3.00	00300 OTHER CAP REL COSTS	0	0		3.00
5.00   0.00590   OTHER AGC - NON FOUNDATION	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 699	5, 856, 818	3	4. 00
7. 00 00700   OPERATION OF PLANT	5. 01	00591 ADMINISTRATIVE AND GENERAL	2, 462, 854	7, 852, 020		5. 01
8. 00   005000   LANDRY % LINEN SERVICE   0	5. 02	00590 OTHER A&G - NON FOUNDATION	0	1, 118, 010		5. 02
9,00   000900   0005EKEEPI NG	7.00	00700 OPERATION OF PLANT	-23, 886	1, 767, 137	7	7.00
10.00   01000   01EARY   -305   718, 997   10.00   13.00   13.00   01300   AURTS INFO ADMINISTRATION   -161, 915   179, 544   13.00   14.00   1400   CENTEAL SERVICES & SUPPLY   0 486, 832   14.00   1400   1400   01400   CENTEAL SERVICES & SUPPLY   -21, 709   732, 813   15.00   15.00   15.00   HEADMACY   -74   502, 570   16.00   16.00   1000   MEDICAL RECORDS & LIBRARY   -74   502, 570   16.00   17.00   1700   SOCIAL SERVICE   0 388, 840   17.00   17.00   17.00   1800   AURTS SERVICE COST CENTERS   -74   502, 907   1800	8.00	00800 LAUNDRY & LINEN SERVICE	0	112, 586	b contract of the contract of	8.00
11.00   01100   CAPETERIA A   11.00   11.00   CAPETERIA A   13.00   11.00   01400   CENTRAL SERVI CES & SUPPLY   0   486, 832   11.4			0			
13.0   01300   NURSING ADMINISTRATION   -3   1,942,454   114.00     14.0   01400   CENTRAL SERVICES & SUPPLY   0   486,832   114.00     15.0   01500   PHARMACY   -21,709   732,813   15.00     16.0   01600   MEDICAL RECORDS & LIBRARY   -74   502,570   16.00     16.0   01600   MEDICAL RECORDS & LIBRARY   -74   502,570   16.00     17.0   01700   SOCIAL SERVICE   REGULATOR   0   388,840   17.00     17.0   01700   SOCIAL SERVICE   COST CENTERS   -20,000   17.00     18   18   18   18   18   18   18     18   18	10.00	01000 DI ETARY	-305	718, 997	7	10.00
14. 00   01400   CONTRAL SERVI CES & SUPPLY   0   446, 832   15. 00   15. 00   01500   PHARMACY   -21, 709   73.2, 813   15. 00   16. 00   01600   MEDICAL RECORDS & LIBRARY   -21, 709   73.2, 813   15. 00   10. 00   1	11. 00	01100 CAFETERI A	-161, 915	179, 544	1	
15.00   01500   PHARMACY   -21,709   732,813   15.00   16.00   16.00   17.00			-3	1, 942, 454	1	
16.00   01600   MEDICAL RECORDS & LIBRARY   7-4   502,570   17.00	14. 00	01400 CENTRAL SERVICES & SUPPLY	0	486, 832	2	14.00
17. 00   01700   SOCI AL SERVICE   0   388, 840   27. 00   22. 00	15. 00		-21, 709	732, 813	3	15. 00
22.00	16. 00	01600 MEDICAL RECORDS & LIBRARY	-74	502, 570		16. 00
INPATI ENT ROUTINE SERVICE COST CENTERS   0   9, 224, 442   30.00   ANCIL LARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   0	17. 00		0	388, 840		17. 00
30. 00   03000   ADULTS & PEDIATRICS   0   9, 224, 442     30. 00   ANCILLARY SERVICE COST CENTERS	22. 00		0	208, 091		22. 00
ANCELLARY SERVICE COST CENTERS   S0. 00		INPATIENT ROUTINE SERVICE COST CENTERS			,	
50.00	30.00		0	9, 224, 442	2	30.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0   151, 806   60. 00   60. 00   60000   LABORATORY   -128, 796   299, 559   60. 00					,	
60.00   06000   LABORATORY   -128, 796   299, 569   60.00   65.00   065000   RESPI RATORY THERAPY   0 528, 100   65.00   66.01   06600   PHYSI CAL THERAPY   0 2, 638, 002   66.00   66.01   06601   PHYSI CAL THERAPY   0 2, 638, 002   66.00   66.01   06601   PHYSI CAL THERAPY   0 2, 638, 002   66.01   67.00   06700   0CCUPATI ONAL THERAPY   0 2, 638, 002   67.00   68.00   06800   SPECH PATHOLOGY   0 1, 242, 562   68.00   68.01   06801   VISI ON   -2, 850 2, 241, 421   68.01   68.02   06802   FAC RESOURCE   -279 1, 655, 817   69.00   69.00   69.00   06900   ELECTROCARDIOLOGY   0 0   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0 0 0   72.00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0 0 0   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   0 0 0   74.00   74.00   07400   RENAL. DI ALYSI S   0 0   0   74.00   07400   RENAL. DI ALYSI S   0 0   0   74.00   07400   RENAL. DI ALYSI S   0 0   0   75.00   07900   CLI NI C   0 248, 643   99.00   76.00   09000   CLI NI C   0 0 0   99.00   77.00   09000   CLI NI C   0 0 0   99.00   78.00   09000   CLI NI C   0 0 0   79.00   09000   CLI NI C   0 0 0		1			1	
65. 00 06500 RESPIRATORY THERAPY 0 52,83,002 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 2,638,002 66. 00 66. 01 06601 PHYSI CAL THERAPY 0 0 279,483 66. 01 67. 00 06700 0CUPATI ONAL THERAPY 0 0 1,242,562 68. 00 68. 00 06800 SPEECH PATHOLOGY 0 1,242,562 68. 00 68. 01 06801 VI SI ON -2,850 241, 421 68. 02 68. 01 06801 VI SI ON -2,850 241, 421 68. 02 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 72. 00 07200 IMPL DEV CHARGED TO PATI ENTS 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 1,794, 723 73. 00 74. 00 07400 IRENAL DI ALYSIS 0 0 0 0 70. 00 09000 CLI NI C 90. 00 09000 CLI NI C 90. 01 090001 SLEEP CENTER 0 0 0 0 91. 00 090001 SLEEP CENTER 0 0 0 0 91. 00 09000 CLIN IS C 99. 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54.00					
66. 00   06600   PHYSICAL THERAPY   0   2,638,002   66. 00	60.00		-128, 796	299, 569		60.00
66. 01   06601   PHYSICAL THERAPY - CARMEL   0   279, 483   66. 01   67. 00   06700   0CCUPATI ONAL THERAPY   0   2, 405, 833   67. 00   68. 01   06800   SPEECH PATHOLOGY   0   1, 242, 562   68. 00   68. 01   06801   VI SI ON   -2, 850   241, 421   68. 01   68. 02   06802   FAC RESOURCE   -279   1, 655, 817   68. 02   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   252, 857   71. 00   72. 00   07200   IMPL DEV. CHARGED TO PATIENTS   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   1, 794, 723   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   74. 00    00   07000   SUEGE P CENTER   0   0   0   90. 01   09001   SLEEP CENTER   0   0   0   90. 01   09001   SLEEP CENTER   0   0   0   90. 01   09000   SHERGENCY   0   0   0   90. 00   09000   OMBRO CENTERS    99. 10   09000   OMBRO CENTERS   0   0   0   99. 10   09000   OMBRO CENTERS   118. 00   SPECIAL PURPOSE COST CENTERS   119. 00   01000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   194. 00   07950   FOUNDATION   337, 690   578, 912   194. 00   194. 00   07950   FOUNDATION   337, 690   578, 912   194. 00   194. 01   07951   PUBLIC RELATIONS   0   398, 792   194. 01   194. 02   07950   FOUNDATION   340, 690   578, 912   194. 00   194. 03   07954   RILEY - ARU   0   0   99, 884   194. 03   194. 04   07954   RILEY - ARU   0   0   0   194. 05   194. 05   07955   RETAIL PHARMACY   0   619, 446   194. 05   194. 05   194. 06   07955   RETAIL PHARMACY   0   619, 446   194. 05   194. 05   194. 06   07955   RETAIL PHARMACY   0   619, 446   194. 05			0			
67.00   06700   0CCUPATI (DNAL THERAPY   0   2, 405, 833   67.00   68.00   68.00   68.00   68.00   68.00   68.00   68.00   68.00   68.00   68.00   68.00   68.00   68.00   68.00   68.00   68.01   68.			0		1	
68. 00   06800   SPEECH PATHOLOGY			0	1	1	
68. 01		1	0		1	
68. 02   06802 FAC RESOURCE		+ I	_		2	
69. 00   06900   ELECTROCARDIOLOGY   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   252,857   71. 00   72. 00   72. 00   73. 00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   73. 00   73. 00   74.00   RINAL DI ALYSIS   0   0   0   0   0   0   0   0   0		1			1	
71. 00		I I				
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 1,794,723 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 1,794,723 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0  OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 0 0 248,643 90. 00 90. 01 99001 SLEEP CENTER 0 0 0 91. 00 91. 00 09100 EMERGENCY 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 099. 00 09900 CMHC 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 99. 10 SPECIAL PURPOSE COST CENTERS  118. 00 SPECIAL PURPOSE COST CENTERS  119. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 1,605,051 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 1,605,051 192. 00 194. 00 07950 FOUNDATION 337,690 578, 912 194. 01 194. 02 07952 ST. VI NCENT - ARU 0 99,884 194. 03 194. 03 07953 MUNCIE - ARU 0 99,884 194. 03 194. 05 07955 RETAIL PHARMACY 0 619,446		I I		_	1	
73. 00				252, 857	7	
74. 00   07400   RENAL DIALYSIS   0   0   0   0   0   0   0   0   0				0		
90. 00   09000   CLI NI C   0   248, 643   90. 00   90. 01   90.						
90. 00   09000   CLINIC   0   248,643   90. 00   90. 01   90. 01   90. 01   90. 01   90. 01   90. 01   90. 01   90. 01   90. 01   90. 01   90. 01   90. 01   90. 01   90. 01   90. 01   90. 00	74. 00		0	0	)	74.00
90. 01   09001   SLEEP CENTER   0   0   0   0   91. 00   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   92. 00   OTHER REIMBURSABLE COST CENTERS   99. 00   0   0   0   0   0   99. 00   99. 10   OTHER PREIMBURSABLE COST CENTERS   118. 00   OTHER PREIMBURSABLE COST CENTERS   OTHER PREIMBURSABLE C			_			
91. 00   09100   EMERGENCY   0   0   0   0   0   92. 00				· ·	1	
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   92. 00   OTHER REIMBURSABLE COST CENTERS   99. 00   O9910   CORF   0   0   0   99. 10   SPECIAL PURPOSE COST CENTERS   99. 10   SUBTOTALS (SUM OF LINES 1 through 117)   2, 242, 354   45, 431, 834   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   190. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   1, 605, 051   192. 00   194. 00   07950   FOUNDATI ON   337, 690   578, 912   194. 00   194. 01   07951   PUBLI C RELATI ONS   0   398, 792   194. 01   194. 02   07952   ST. VINCENT - ARU   0   0   0   194. 02   194. 03   07953   MUNCI E - ARU   0   99, 884   194. 03   194. 04   07954   RI LEY - ARU   0   0   0   194. 04   194. 05   07955   RETAI L PHARMACY   0   619, 446   194. 05					1	1
OTHER REIMBURSABLE COST CENTERS   99.00   09910   CMHC   0 0 0   0 0   0 0   0 0 0   0 0 0   0 0 0 0   0			0	0		
99. 00 99. 10 09900 CMHC 09910 CORF SPECIAL PURPOSE COST CENTERS  118. 00 NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194. 00 07950 FOUNDATI ON 194. 01 07951 PUBLI C RELATI ONS 194. 02 07952 ST. VI NCENT - ARU 194. 03 07953 MUNCI E - ARU 194. 04 07954 RI LEY - ARU 194. 05 195. 00 196. 00 197. 00 1	92.00					92.00
99. 10   SPECIAL PURPOSE COST CENTERS   99. 10   SPECIAL PURPOSE COST CENTERS   99. 10   SUBTOTALS (SUM OF LINES 1 through 117)   2, 242, 354   45, 431, 834   99. 10   NONREI MBURSABLE COST CENTERS   190. 00   1920	00.00					
SPECIAL PURPOSE COST CENTERS   118.00   SUBTOTALS (SUM OF LINES 1 through 117)   2,242,354   45,431,834   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   1,605,051   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   1,605,051   192.00   194.00   19700					1	
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   2, 242, 354   45, 431, 834   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   1, 605, 051   192. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   1, 605, 051   192. 00   194. 00   195	99. 10		0	0	J	99. 10
NONRE   MBURSABLE   COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   190. 00   192. 00   192. 00   192.00	110 0		2 242 254	45 421 024	4	110 00
190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   1,605,051   192. 00   192.00	118.0		2, 242, 354	45, 431, 834	+	1118.00
192. 00	100.0					100.00
194. 00   07950   FOUNDATION   337, 690   578, 912   194. 00   194. 01   194. 02   194. 02   194. 03   194. 04   194. 04   194. 05   194. 05   194. 05   194. 06   194. 08   194					1	
194. 01 07951 PUBLI C RELATI ONS 0 398, 792 194. 01 194. 02 07952 ST. VI NCENT - ARU 0 0 99, 884 194. 03 07953 MUNCI E - ARU 0 99, 884 194. 04 07954 RI LEY - ARU 0 0 0 194. 04 194. 05 07955 RETAIL PHARMACY 0 619, 446 194. 05			_	.,,	1	
194. 02     07952     ST. VI NCENT - ARU     0     0     194. 02       194. 03     07953     MUNCI E - ARU     0     99, 884     194. 03       194. 04     07954     RI LEY - ARU     0     0     194. 04       194. 05     07955     RETAI L PHARMACY     0     619, 446     194. 05			337, 690	1	1	
194. 03     07953     MUNCI E - ARU     0     99, 884     194. 03       194. 04     07954     RI LEY - ARU     0     0     194. 04       194. 05     07955     RETAI L PHARMACY     0     619, 446     194. 05				398, 792		
194. 04 07954 RI LEY - ARU 0 0 194. 05 194. 05 07955 RETAIL PHARMACY 0 619, 446 194. 05				00.004		
194. 05 07955 RETAIL PHARMACY 0 619, 446 194. 05				79, 884	† 	
				610 114		
200.00     1017L (30m of LINES 110 till ough 177)   2,300,044  40,733,717			_		1	
	200.0	1. OTTLE (Som of ETHES 110 through 177)	2, 300, 044	10,700,717	1	1-00.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Provi der CCN: 15-3028

					10 12/31/20	6/30/2020 7:23 am
		Increases			' ·	07 307 2020 7 . 23 dill
	Cost Center	Li ne #	Sal ary	Other		
	2.00	3. 00	4. 00	5. 00		
	A - CAFETERIA					
1.00	CAFETERI A	1100	20, 567	320, 892		1.00
	0		20, 567	320, 892		
	B - NURSING ADMINISTRATION					
1.00	NURSING ADMINISTRATION	1300	16 <u>3, 3</u> 78	0		1.00
	0		163, 378	0		
	C - NCR (CORF)					
1.00	PHYSI CAL THERAPY	66. 00	129, 907	52, 401		1.00
2.00	OCCUPATI ONAL THERAPY	67. 00	239, 962	96, 796		2.00
3.00	SPEECH PATHOLOGY	6800	9 <u>4, 6</u> 36	3 <u>8, 1</u> 74		3.00
	0		464, 505	187, 371		
	D - MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	312, 460		1.00
2. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	243, 452		2.00
	PATI ENTS					
3. 00	PHARMACY	15. 00	0	1, 839		3.00
4.00		0. 00	0	0		4.00
5.00		0. 00	0	0		5. 00
6.00		0. 00	0	0		6.00
7.00		0. 00	0	0		7.00
8.00		0. 00	0	0		8.00
9.00		0. 00	0	0		9.00
10.00		0. 00	0	0		10.00
11. 00		0. 00	0	0		11.00
12.00		0. 00	0	0		12.00
13.00		0. 00	0	0		13.00
14.00		0. 00	0	0		14.00
15. 00		0. 00	0	0		15. 00
16. 00		0. 00	0	0		16. 00
17. 00		0. 00	0	0		17. 00
18. 00		0. 00	0	0		18. 00
19. 00		0. 00	0	0		19. 00
20.00		0. 00	0	0		20.00
21. 00		0. 00	0	0		21. 00
22. 00		000	0_	0		22. 00
	0		0	557, 751		
4 00	E - THERAPY ADMIN		40 (55			
1.00	ADMINISTRATIVE AND GENERAL	5. 01	12, 482	1, 621		1.00
2.00	NURSI NG ADMI NI STRATI ON	13. 00	53, 768	6, 982		2.00
3. 00	PHYSI CAL THERAPY	66. 00	184, 046	23, 899		3.00
4.00	PHYSICAL THERAPY - CARMEL	66. 01	10, 695	1, 389		4.00
5.00	SPEECH PATHOLOGY	68. 00	87, 972	11, 424		5.00
6.00	VISION	68. 01	15, 901	2, 065		6.00
7. 00	FOUNDATI ON	1 <u>94.</u> 00	10, 031	1, 303		7. 00
	TOTALS		374, 895	48, 683		
4 00	F - RTOC ADMIN	400 00	400 054	44.044		1.00
1. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	120, 051	14,014		1.00
F00 00	TOTALS		120, 051	14, 014		500.00
500.00	Grand Total: Increases		1, 143, 396	1, 128, 711		500.00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: Provider CCN: 15-3028

					6/30/2020 7:23 am
	Decreases				
Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.	
6. 00	7. 00	8. 00	9. 00	10. 00	
A - CAFETERIA					
. 00 <u>DI ETARY</u>	10.00	2 <u>0, 5</u> 67	32 <u>0,</u> 892		1. 0
0		20, 567	320, 892	2	
B - NURSING ADMINISTRATION					
. 00 ADMINISTRATIVE AND GENERAL	501	16 <u>3, 3</u> 78		0 0	1.0
0		163, 378		)	
C - NCR (CORF)					
. 00 CORF	99. 10	464, 505	187, 371		1.0
. 00	0. 00	0	C	0	2.0
. 00	0.00				3.0
0		464, 505	187, 371		
D - MEDICAL SUPPLIES					
. 00 EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	6, 921		1.0
OO ADMINISTRATIVE AND GENERAL	5. 01	0	177		2.0
OO OTHER A&G - NON FOUNDATION	5. 02	0	479	0	3.0
.00 OPERATION OF PLANT	7. 00	0	7, 694	0	4.0
. 00 HOUSEKEEPI NG	9. 00	0	744	0	5. (
00 DI ETARY	10. 00	0	67	0	6. (
OO NURSING ADMINISTRATION	13. 00	0	28, 285	0	7.0
OO CENTRAL SERVICES & SUPPLY	14. 00	O	31, 841	0	8. (
OO ADULTS & PEDIATRICS	30. 00	O	311, 707	0	9. (
D. OO RADI OLOGY-DI AGNOSTI C	54.00	O	2, 943	0	10.0
1. 00 LABORATORY	60.00	O	159	0	11. (
2. 00 RESPIRATORY THERAPY	65. 00	O	80, 584	0	12.0
3. 00 PHYSI CAL THERAPY	66. 00	O	623	0	13.
4.00 PHYSICAL THERAPY - CARMEL	66. 01	O	1, 496	0	14.0
5. 00 OCCUPATIONAL THERAPY	67. 00	o	7, 077		15.0
6. 00 SPEECH PATHOLOGY	68. 00	o	2, 341		16.
7.00 VISION	68. 01	o	87		17.
B. 00 FAC RESOURCE	68. 02	o	13, 264		18.
P. OO CLINIC	90.00	0	29, 395		19.
0. 00 CORF	99. 10	ol	186		20.
1.00 PHYSICIANS' PRIVATE OFFICES	192. 00	ol	27, 415		21.
2. 00 RETAIL PHARMACY	194. 05	ol	4, 266		22.
0			<u>,,</u> 557, 751		
E - THERAPY ADMIN		<u> </u>	33,7,73		
OO OCCUPATIONAL THERAPY	67.00	374, 895	48, 683	8 0	1. (
00	0.00	0, 1, 0, 0	.0, 000		2.0
00	0.00	o o	(		3.0
00	0.00		(	1	4.
00	0.00	0		1	5.0
00	0.00	0		-	6.0
00	0.00	0	(		7.0
TOTALS — — — —	— — <del>" " "  </del>	374, 895	48, 683		7.0
F - RTOC ADMIN		3/4,073	40, 003	, <u> </u>	
00 FAC RESOURCE	68. 02	120, 051	14, 014	0	1. (
TOTALS	— — <del>00.02</del>	120, 051	14, 014		1.0
00.00 Grand Total: Decreases					500.0
Jo. oo pi and Total. Decleases		1, 143, 396	1, 128, 711	ı I	500.

6.00

7.00

8.00

9.00

Movable Equipment

Reconciling Items

HIT designated Assets

10.00 Total (line 8 minus line 9)

Subtotal (sum of lines 1-7)

6.00

7.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-3028 Peri od: Worksheet A-7 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/30/2020 7:23 am Acqui si ti ons Begi nni ng Purchases Disposals and Donati on Total Bal ances Retirements 2.00 3.00 4.00 5.00 1.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2, 506, 638 0 0 1.00 0 370, 910 2.00 Land Improvements 0 2.00 3.00 3.00 Buildings and Fixtures 15, 847, 816 2, 190, 462 2, 190, 462 0 0 4.00 Building Improvements 205, 018 0 4.00 Fi xed Equi pment 2, 265, 857 0 5.00 0 5.00 0 6.00 Movable Equipment 13, 830, 024 860, 071 860, 071 1, 752 6.00 0 7.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 35, 026, 263 3, 050, 533 0 3, 050, 533 1, 752 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 35, 026<u>, 263</u> 3, 050, 533 1, 752 3, 050, 533 10.00 0 10.00 Endi ng Ful I y Bal ance Depreciated Assets 6. 00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2, 506, 638 1.00 2.00 370, 910 154, 837 Land Improvements 2.00 18, 038, 278 852, 150 3.00 Buildings and Fixtures 3.00 4.00 Building Improvements 205, 018 95, 017 4.00 5.00 Fixed Equipment 2, 265, 857 1, 508, 400 5.00

14, 688, 343

38, 075, 044

38, 075, 044

6, 809, 022

9, 419, 426

9, 419, 426

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: From 01/01/2019	Worksheet A-7 Part II

					o 12/31/2019		
			SL	JMMARY OF CAPIT	AL		
	Cost Center Description	Depreciation	Lease	Interest	I nsurance (see	Taxes (see instructions)	
		9. 00	10. 00	11.00	instructions) 12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2	12.00	13.00	
1. 00	CAP REL COSTS-BLDG & FLXT	647, 382		257, 200	31, 921	0	1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	1, 044, 796		0	9, 267	0	2. 00
3. 00	Total (sum of lines 1-2)	1, 692, 178		257, 200		Ö	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Relat					
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI					
1. 00	CAP REL COSTS-BLDG & FIXT	0	936, 503	1			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13, 330		1			2.00
3. 00	Total (sum of lines 1-2)	13, 330	2, 003, 896				3. 00

Health Financial Systems REHA	ABILITATION HOS	SPITAL OF INDIA	ıNA	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
				From 01/01/2019 To 12/31/2019		narod:
				10 12/31/2019	6/30/2020 7: 2	3 am
	COME	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col. 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	0.00	1.00	0.00	
1. 00 CAP REL COSTS-BLDG & FLXT	38, 075, 044	0	38, 075, 04	4 1. 000000	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	)	0. 000000	0	2.00
3.00 Total (sum of lines 1-2)	38, 075, 044		38, 075, 04			3.00
	ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at	cols. 5	'		
		ed Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	1	T	T			
1. 00 CAP REL COSTS-BLDG & FLXT	0	1	1	773, 451	0	1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	0		1	0 1, 283, 761	0	2.00
3.00 Total (sum of lines 1-2)	0	J	JMMARY OF CAPI	0 2, 057, 212	0	3.00
		30	JIMIMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see	9 through 14)	
	11.00	10.00	10.00	instructions)	45.00	
DART III DECONCILIATION OF CARLTAL COSTS O	11. 00	12. 00	13. 00	14. 00	15. 00	

259 0 259

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

Total (sum of lines 1-2)

31, 921 9, 267 41, 188

0 0 0

13, 923 13, 330 27, 253

819, 554 1. 00 1, 306, 358 2. 00 2, 125, 912 3. 00

1. 00 2. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 15-3028

				Fr To	om 01/01/2019 12/31/2019	Date/Time Pre	
				Expense Classification on	Worksheet A	6/30/2020 7: 2	3 am
				To/From Which the Amount is t			
	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	
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-256, 941	CAP REL COSTS-BLDG & FIXT	1. 00	11	1. 00
2. 00	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		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
	suppliers (chapter 8)		40.000	ODERATION OF BLANT			
7. 00	Tel ephone services (pay stations excluded) (chapter	A	- 10, 823	OPERATION OF PLANT	7. 00	0	7. 00
0.00	21)	^	12.042	OPERATION OF PLANT	7 00	0	0.00
8. 00	Television and radio service (chapter 21)	А	-13,003	OPERATION OF PLANT	7. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0		0. 00	0	9. 00 10. 00
10.00	adjustment	A-0-2	Ü			U	10.00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization	A-8-1	2, 757, 453			0	12.00
13. 00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13. 00
14.00	Cafeteria-employees and guests		-161, 915	CAFETERI A	11. 00	0	14.00
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	-21, 247	PHARMACY	15. 00	0	17. 00
18. 00	Sale of medical records and	В	-74	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees,						
20. 00	books, etc.) Vending machines		0		0. 00	0	20. 00
	Income from imposition of		0		0. 00	0	
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
0.4.00	(chapter 21)			0.15 DEL 000TO DI DO 0 ELVE	4 00		0, 00
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
50.00	therapy costs in excess of	A-0-3	0	TOOGOTATIONAL ITIENAFT	37.00		50.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
•	i nstructi ons)		_				

Provi der CCN: 15-3028 Peri od: Worksheet A-8 From 01/01/2019
To 12/31/2019 Date/Time Prepared:

						6/30/2020 7:2	3 am
	·			Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					•		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	cost center bescription		Allourt	Cost Center	LITTE #		
		(2)	2.00	3.00	4.00	Ref.	
01.00		1. 00	2. 00	3.00	4. 00	5. 00	01.00
31. 00		A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00			0		0. 00	0	32.00
	Depreciation and Interest						
33.00	MI SCELLANEOUS REVENUE	В	-2, 699	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33.00
33. 01	MI SCELLANEOUS REVENUE	В	-58, 243	ADMINISTRATIVE AND GENERAL	5. 01	0	33. 01
33. 02	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 02
	(3)						
33. 03			0		0.00	0	33. 03
	(3)						
33. 04			0		0. 00	0	33. 04
	(3)		_			_	
33. 05		В	-2 850	VISION	68. 01	0	33. 05
33. 06		В		FAC RESOURCE	68. 02	o O	33.06
33. 07	RHI FOUNDATION	A		FOUNDATION	194. 00	0	33. 07
33. 08	ADVERTI SI NG	A		DI ETARY	10.00	0	
33. 09		A		1		0	
				NURSI NG ADMI NI STRATI ON	13.00	Ĭ.	
33. 10		A		FAC RESOURCE	68. 02	0	
33. 11	TAXES	A		ADMINISTRATIVE AND GENERAL	5. 01	0	33. 11
33. 12	· ·	A		PHARMACY	15. 00	0	
33. 13		A	14, 182	CAP REL COSTS-BLDG & FLXT	1. 00	14	33. 13
	AMORTIZATION CARR						
33. 14		A	-259	CAP REL COSTS-BLDG & FLXT	1. 00	14	
33. 15	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 15
	(3)						
33. 16	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 16
	(3)						
33. 17			0		0.00	0	33. 17
	(3)						
50.00			2, 580, 044				50.00
	(Transfer to Worksheet A,		, ,				
	column 6, line 200.)						

column 6, line 200.)

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

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

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

B. Amount Received - if cost cannot be determined.

(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.

Peri od: Worksheet A-8-1 From 01/01/2019 12/31/2019 Date/Time Prepared:

					6/30/2020 7: 2	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4.00	5. 00	
	OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OF	CLAIMED HOME	
1. 00		CAP REL COSTS-BLDG & FLXT	ALLOCATION FROM HO REPORT	126, 069	0	1. 00
2. 00			ALLOCATION FROM HO REPORT	238, 965		2. 00
3.00			ALLOCATION FROM HO REPORT	2, 521, 215		3.00
4. 00			RELATED PARTY FEES	6, 268		4. 00
4. 01	1		ALLOCATION FROM RELATED PART			4. 01
4. 02	5. 01	ADMINISTRATIVE AND GENERAL	RELATED PARTY FEES	233, 796		4. 02
4.03	54.00	RADI OLOGY-DI AGNOSTI C	RELATED PARTY FEES	2, 474	2, 474	4.03
4.04	66.00	PHYSI CAL THERAPY	RELATED PARTY FEES	1, 970	1, 970	4.04
4.05	15.00	PHARMACY	RELATED PARTY FEES	8, 562	8, 562	4.05
4.06	192. 00	PHYSICIANS' PRIVATE OFFICES	RELATED PARTY FEES	354, 547	354, 547	4.06
4.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY FEES	8, 374	8, 374	4. 07
4.08	0.00			0	0	4.08
4.09	0.00			0	0	4. 09
5.00	TOTALS (sum of lines 1-4).			3, 882, 414	1, 124, 961	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/	or Home Office	i
			•		i
					1
					i
					i
Symbol (1)	Name	Percentage of	Name	Percentage of	
•		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

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

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

					12/01/201/	6/30/2020 7: 2	23 am
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF TR	RANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:						
1.00	126, 069	9					1.00
2.00	238, 965	9					2.00
3.00	2, 521, 215	0					3.00
4.00	0	0					4.00
4. 01	-128, 796	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, 757, 453						5. 00

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

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

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

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

6. 00	HOME OFFICE	6.00
	MGMT COMPANY	7.00
8. 00 9. 00		8.00
9. 00		9.00
10. 00 100. 00		10.00
100.00		100.00

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

Period: Worksheet B
From 01/01/2019 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-3028

				To	12/31/2019	Date/Time Pre 6/30/2020 7:2	pared:
			CAPI TAL REI	LATED COSTS		6/30/2020 7:2	3 alli
	Coat Contar Decement on	Not Evnences	DIDC 0 FLVT	MVBLE EQUIP	EMDL OVEE	Cubtatal	
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	WVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
		0	1.00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	819, 554 1, 306, 358	819, 554	1, 306, 358			1.00 2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 856, 818	13, 870		5, 892, 796		4.00
5. 01	00591 ADMINISTRATIVE AND GENERAL	7, 852, 020	26, 022		761, 432	8, 680, 952	5. 01
5. 02	00590 OTHER A&G - NON FOUNDATION	1, 118, 010	17, 208		205, 460	1, 368, 108	
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 767, 137 112, 586	10, 621 0		8, 992 0	1, 803, 679 112, 586	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	475, 952	6, 926	-	71, 240	565, 158	9.00
10.00	01000 DI ETARY	718, 997	28, 719		10, 299	803, 793	1
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	179, 544	13, 638		4, 889	219, 811	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 942, 454 486, 832	5, 644 7, 060		402, 855 15, 744	2, 359, 950 520, 889	1
15. 00	01500 PHARMACY	732, 813	3, 490		139, 876	881, 742	1
16.00	01600 MEDICAL RECORDS & LIBRARY	502, 570	9, 312		80, 513	607, 238	1
17. 00 22. 00	01700 SOCIAL SERVICE 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	388, 840 208, 091	2, 475 0		71, 851 0	467, 111 208, 091	17. 00 22. 00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	200, 071	0			200, 071	22.00
30.00	03000 ADULTS & PEDIATRICS	9, 224, 442	356, 710	568, 591	1, 891, 966	12, 041, 709	30.00
E0.00	ANCILLARY SERVICE COST CENTERS	0	0		ما	0	F0 00
50. 00 54. 00	O5000   OPERATI NG ROOM   O5400   RADI OLOGY-DI AGNOSTI C	0 151, 806	0 4, 674		0 31, 369	0 195, 299	50.00 54.00
60.00	06000 LABORATORY	299, 569	2, 680		0.,007	306, 520	60.00
65. 00	06500 RESPI RATORY THERAPY	528, 100	10, 629		110, 532	666, 204	1
66. 00 66. 01	06600 PHYSI CAL THERAPY 06601 PHYSI CAL THERAPY - CARMEL	2, 638, 002 279, 483	128, 061 0		512, 360 40, 786	3, 482, 550 320, 269	1
67. 00	06700 OCCUPATI ONAL THERAPY	2, 405, 833	109, 811	175, 037	475, 670	3, 166, 351	67.00
68. 00	06800 SPEECH PATHOLOGY	1, 242, 562	16, 024		255, 670	1, 539, 799	1
68. 01	06801   VI SI 0N	241, 421	0	7 010	53, 775	295, 196	1
68. 02 69. 00	06900 ELECTROCARDI OLOGY	1, 655, 817 0	4, 968 0	7, 918 0	302, 438 0	1, 971, 141 0	68. 02 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	252, 857	Ö	1	Ö	252, 857	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	1, 794, 723 0	0	_	0	1, 794, 723 0	73.00 74.00
74.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	0	<u> </u>		74.00
	09000 CLI NI C	248, 643	27, 134	43, 252	50, 170	369, 199	
90. 01	09001 SLEEP CENTER	0	0		0	0	90.01
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	U	0	0	U U	0	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS						
	09900 CMHC	0			1	0	
99. 10	09910 CORF SPECI AL PURPOSE COST CENTERS	0	0	0	0	0	99. 10
118. 00		45, 431, 834	805, 676	1, 284, 236	5, 497, 887	45, 000, 925	118. 00
	NONREI MBURSABLE COST CENTERS		·				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 (05 051	12.454		0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES	1, 605, 051 578, 912	12, 454 1, 424		252, 696 54, 451	1, 890, 053 637, 057	
	07951 PUBLIC RELATIONS	398, 792	0		26, 890	425, 682	
	07952 ST. VINCENT - ARU	0	0	1	О		194. 02
	07953 MUNCIE - ARU 07954 RILEY - ARU	99, 884	0	0	19, 904	119, 788	194. 03 194. 04
	07954 RILEY - ARU 07955 RETAIL PHARMACY	619, 446	0	0	40, 968	660, 414	
200.00	Cross Foot Adjustments		_		·	0	200. 00
201.00		40 700 040	010 554	0	0 E 002 704		201.00
202.00	TOTAL (sum lines 118 through 201)	48, 733, 919	819, 554	1, 306, 358	5, 892, 796	48, 733, 919	J2U2. UU

Provider CCN: 15-3028

				1	0 12/31/2019	6/30/2020 7: 2	
	Cost Center Description	ADMI NI STRATI V	Subtotal	OTHER A&G -	OPERATION OF	LAUNDRY &	<u> </u>
	·	E AND GENERAL		NON	PLANT	LINEN SERVICE	
				FOUNDATI ON			
		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, 680, 952					5. 01
5. 02	00590 OTHER A&G - NON FOUNDATION	296, 520	1, 664, 628				5. 02
7.00	00700 OPERATION OF PLANT	390, 924	2, 194, 603	77, 612	2, 272, 215		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	24, 402	136, 988	4, 845	0	141, 833	8. 00
9. 00	00900 HOUSEKEEPI NG	122, 491	687, 649				9. 00
10. 00	01000 DI ETARY	174, 212	978, 005	34, 587	86, 796		10.00
11. 00	01100  CAFETERI A	47, 641	267, 452	9, 458	·		11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	511, 488	2, 871, 438		·		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	112, 896	633, 785	22, 414			14.00
15. 00	01500 PHARMACY	191, 106	1, 072, 848		10, 547	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	131, 611	738, 849	26, 129			16. 00
17. 00	01700 SOCIAL SERVICE	101, 240	568, 351				17. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	45, 101	253, 192	8, 954	0	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	2, 609, 878	14, 651, 587	518, 175	1, 078, 058	139, 986	30.00
	ANCILLARY SERVICE COST CENTERS			_			
50.00	05000 OPERATING ROOM	0	0	0			50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	42, 329	237, 628	8, 404	14, 125		54.00
60.00	06000 LABORATORY	66, 434	372, 954	13, 190	8, 098		60.00
65.00	06500 RESPI RATORY THERAPY	144, 391	810, 595	28, 667	32, 125		65.00
66.00	06600 PHYSI CAL THERAPY	754, 797	4, 237, 347	149, 854			66.00
66. 01	06601 PHYSI CAL THERAPY - CARMEL	69, 414	389, 683	13, 781	0	1, 342	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	686, 265	3, 852, 616	136, 248			67.00
68.00	06800 SPEECH PATHOLOGY	333, 731	1, 873, 530	66, 257	48, 429		68.00
68. 01	06801 VI SI ON	63, 980	359, 176	12, 702	15 013	0	68. 01
68. 02	06802 FAC RESOURCE	427, 219	2, 398, 360	84, 818	15, 013		68. 02
69.00	06900 ELECTROCARDI OLOGY	E4 003	207.440	10.000	0	0	69. 00 71. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	54, 803	307, 660	10, 880	0	0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	388, 983	2 102 704	U 77 227	0		72. 00 73. 00
74.00	07400 RENAL DI ALYSI S	300, 903	2, 183, 706	77, 227 0	0		74.00
74.00	OUTPATIENT SERVICE COST CENTERS	U U	U		U		74.00
90. 00	09000 CLINIC	80, 019	449, 218	15, 887	82, 007	0	90.00
90. 00	09001 SLEEP CENTER	00,019	447, 210	13,007	02,007		90.00
91. 00	09100 EMERGENCY	0	0	0	0		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		0	١	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	o o	Ö	0			99. 10
77. 10	SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>				77.10
118.00		7, 871, 875	44, 191, 848	1, 503, 997	2, 230, 270	141, 833	118 00
110.00	NONREI MBURSABLE COST CENTERS	7,071,070	11, 171, 010	1,000,777	2,200,210	111,000	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	409, 644	2, 299, 697	81, 329			192.00
	07950 FOUNDATI ON	138, 074	775, 131	27, 413			194.00
	07951 PUBLIC RELATIONS	92, 261	517, 943	18, 317	0		194. 01
194. 02	07952 ST. VINCENT - ARU	o	0	0	0	0	194. 02
	07953 MUNCIE - ARU	25, 962	145, 750	5, 154	0	0	194. 03
	07954 RI LEY - ARU	o	0	0	0		194. 04
	07955 RETAIL PHARMACY	143, 136	803, 550	28, 418	0	0	194. 05
200.00	Cross Foot Adjustments		o				200. 00
201.00	Negative Cost Centers	0	o	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	8, 680, 952	48, 733, 919	1, 664, 628	2, 272, 215	141, 833	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-3028

Period: Worksheet B From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared:

6/30/2020 7:23 am Cost Center Description HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL ADMI NI STRATI O SERVICES & Ν **SUPPLY** 9. 00 10.00 11 00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.01 00591 ADMINISTRATIVE AND GENERAL 5.01 00590 OTHER A&G - NON FOUNDATION 5.02 5.02 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 732, 900 9.00 10.00 01000 DI ETARY 28, 256 1, 127, 644 10.00 01100 CAFETERI A 13, 419 331, 548 11.00 11.00 01300 NURSING ADMINISTRATION 5, 553 3, 028, 821 13.00 C 33, 224 13.00 6, 946 14.00 01400 CENTRAL SERVICES & SUPPLY C 2, 165 686, 646 14.00 15.00 01500 PHARMACY 3, 433 0 10, 150 203, 080 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16.00 6, 667 16.00 C 133, 406 9.162 0 17.00 01700 SOCIAL SERVICE 2, 435 4,821 0 17.00 02200 | &R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 350, 961 1, 127, 644 125, 002 172, 751 30.00 2, 501, 162 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM n 50.00 05400 RADI OLOGY-DI AGNOSTI C 4.598 46, 851 54.00 0 2, 342 3, 785 54.00 60.00 06000 LABORATORY 2,636 0 4, 142 207 60.00 65.00 06500 RESPIRATORY THERAPY 10, 458 0 7, 213 144, 322 100, 598 65.00 66.00 06600 PHYSI CAL THERAPY 125, 997 0 32, 625 832 66.00 06601 PHYSICAL THERAPY - CARMEL 66.01 Ω 0 1.896 0 1.951 66.01 67.00 06700 OCCUPATI ONAL THERAPY 108, 041 C 31, 590 0 2, 181 67.00 06800 SPEECH PATHOLOGY 15, 594 68.00 15, 766 0 2, 489 68.00 06801 VI SI ON 0 2.819 0 68.01 0 163 68.01 0 06802 FAC RESOURCE 68.02 4,887 C 22, 726 17, 295 68.02 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 329, 698 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 O 72 00 0 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 0 0 0 73.00 07400 RENAL DIALYSIS 0 0 74.00 74.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 90.00 0 4, 256 0 13.388 26, 697 09001 SLEEP CENTER 90.01 0 0 0 0 90.01 09100 EMERGENCY 0 0 0 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00 92 00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 0 99.00 0 99.10 09910 CORF 0 0 ol 0 99.10 0 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 719, 245 1, 127, 644 307, 232 3, 028, 821 645, 338 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 35, 746 192. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 12, 254 16, 659 0 0 194. 00 07950 FOUNDATI ON 1, 401 0 5,703 0 0 194.00 194. 01 07951 PUBLIC RELATIONS 1, 954 0 0 194. 01 0 0 194. 02 07952 ST. VINCENT - ARU 0 0 0 194. 02 0 0 194. 03 07953 MUNCI E - ARU 0 Ω 0 0 0 194 03 194. 04 07954 RILEY - ARU 0 0 0 0 0 194.04 194. 05 07955 RETAIL PHARMACY 0 0 0 5, 562 194. 05 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers  $\cap$ 0 201.00 202.00 TOTAL (sum lines 118 through 201) 331, 548 3, 028, 821 686, 646 202. 00 732, 900 1, 127, 644

| Peri od: | Worksheet B | From 01/01/2019 | Part | | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS REHABILITATION HOSPITAL OF INDIANA Provider CCN: 15-3028

				Т	o 12/31/2019	Date/Time Pre 6/30/2020 7:2	
					INTERNS &	0/30/2020 7.2	J alli
					RESI DENTS		
	Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	SERVI CES-OTHE	Subtotal	
			RECORDS & LI BRARY	SERVI CE	R PRGM COSTS		
		15. 00	16. 00	17. 00	22.00	24. 00	
G	ENERAL SERVICE COST CENTERS	10100	10.00	171.00		21100	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
1	00591 ADMI NI STRATI VE AND GENERAL						5. 01
1	00590 OTHER A&G - NON FOUNDATION 00700 OPERATION OF PLANT						5. 02 7. 00
	00800 LAUNDRY & LINEN SERVICE						8.00
1	00900 HOUSEKEEPI NG						9.00
1	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11. 00
	01300 NURSING ADMINISTRATION						13.00
1	01400 CENTRAL SERVICES & SUPPLY						14.00
- 1	01500 PHARMACY	1, 337, 999	0.40 05.4				15.00
	01600 MEDICAL RECORDS & LIBRARY	0	942, 356				16.00
	01700 SOCIAL SERVICE 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	· ·			17. 00 22. 00
	NPATIENT ROUTINE SERVICE COST CENTERS	U <sub>I</sub>	U	C	262, 146		22.00
	33000 ADULTS & PEDIATRICS	0	942, 356	603, 187	262, 146	22, 473, 015	30.00
	NCILLARY SERVICE COST CENTERS	<u> </u>	7 127 000	000/10/	2027 1 10	22, 170, 010	00.00
	05000 OPERATING ROOM	0	0	C	0	0	50.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	317, 733	54.00
	06000 LABORATORY	0	0	0	0	401, 227	60.00
1	06500 RESPI RATORY THERAPY	0	0	0	0	1, 133, 978	•
	06600 PHYSI CAL THERAPY	0	0	0	0	4, 933, 826	•
1	06601 PHYSI CAL THERAPY - CARMEL 06700 OCCUPATI ONAL THERAPY	0	0		0	408, 653 4, 462, 811	
1	06800 SPEECH PATHOLOGY	0	0			2, 022, 168	•
1	06801 VI SI ON	ő	Ö	Ö	١	374, 860	
1	06802 FAC RESOURCE	o	0	O	Ö	2, 543, 099	68. 02
69.00	06900 ELECTROCARDI OLOGY	О	0	O	O	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	648, 238	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72.00
1	07300 DRUGS CHARGED TO PATIENTS	1, 337, 999	0			3, 598, 932	
	07400 RENAL DIALYSIS DUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	74. 00
	09000 CLINIC	0	0	О	O	591, 453	90.00
	99001 SLEEP CENTER	o	Ö	Ö		0	90.01
	09100 EMERGENCY	o	0	O		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	THER REIMBURSABLE COST CENTERS						
1	09900 CMHC	0	0			0	
_	09910 CORF	0	0	0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS	1 227 000	042.254	(02.107	262 146	42 000 002	110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 337, 999	942, 356	603, 187	262, 146	43, 909, 993	118.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	9200 PHYSI CI ANS' PRI VATE OFFI CES	o	0		o	2, 483, 325	
	07950 FOUNDATI ON	O	0	C	O	813, 953	•
194. 01 0	07951 PUBLIC RELATIONS	О	0	0	O	538, 214	194. 01
	07952 ST. VINCENT - ARU	0	0	0	1		194. 02
	07953 MUNCIE - ARU	0	0	0		150, 904	
	77954 RILEY - ARU	0	0	0	0		194. 04
200. 00	07955 RETAIL PHARMACY Cross Foot Adjustments	o	O			837, 530	194. 05 200. 00
200.00	Negative Cost Centers	n	n	n			200.00
202.00	TOTAL (sum lines 118 through 201)	1, 337, 999	942, 356	603, 187	262, 146	48, 733, 919	
1	, (2.2 2.2 2.2 2.2 2.2 2.2 2.2 2.2 2.2 2.		, 200	,,			

Health Financial Systems In Lieu of Form CMS-2552-10 REHABILITATION HOSPITAL OF INDIANA COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-3028 Peri od: Worksheet B From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/30/2020 7:23 am Cost Center Description Intern & Total Resi dents 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 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 9.00 00900 HOUSEKEEPI NG 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 17.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 INPATIENT ROUTINE SERVICE COST CENTERS

8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 22.00 03000 ADULTS & PEDIATRICS 30.00 -262, 146 22, 210, 869 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 317, 733 54.00 06000 LABORATORY 60.00 000000000000 401, 227 60.00 65 00 06500 RESPIRATORY THERAPY 1, 133, 978 65.00 06600 PHYSI CAL THERAPY 66.00 4, 933, 826 66.00 66.01 06601 PHYSI CAL THERAPY - CARMEL 408, 653 66.01 06700 OCCUPATI ONAL THERAPY 67.00 4, 462, 811 67.00 06800 SPEECH PATHOLOGY 68 00 2, 022, 168 68 00 68.01 06801 VLSL0N 374, 860 68.01 06802 FAC RESOURCE 2, 543, 099 68.02 68.02 69.00 06900 ELECTROCARDI OLOGY Ω 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 648, 238 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 C 0 3, 598, 932 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS 0 74.00 0 74.00 90.00 09000 CLI NI C 0 591, 453 90.00 90.01 09001 SLEEP CENTER 0 C 90.01 09100 EMERGENCY 0 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 99.00 0 99. 10 09910 CORF 99. 10 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) -262, 146 43, 647, 847 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN l190 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 2, 483, 325 192.00 194. 00 07950 FOUNDATI ON 813, 953 194.00 194. 01 07951 PUBLIC RELATIONS 194. 01 538, 214

0 0 194. 02 07952 ST. VINCENT - ARU r 194.02 194. 03 07953 MUNCIE - ARU 150, 904 194. 03 0 0 194. 04 07954 RILEY - ARU 194.04 C 194. 05 07955 RETAIL PHARMACY 194. 05 837, 530 200.00 Cross Foot Adjustments 0 C 200.00 Negative Cost Centers 201.00 201.00 TOTAL (sum lines 118 through 201) 48, 471, 773 202.00 202.00 -262, 146

| Peri od: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3028

				То	12/31/2019	Date/Time Pre 6/30/2020 7:2	
			CAPI TAL REI	LATED COSTS		0/30/2020 7.2	Jaiii
	Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assi gned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4. 00	
	00100 CAP REL COSTS-BLDG & FLXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	13, 870	22, 108	35, 978	35, 978	4.00
5. 01	00591 ADMINISTRATIVE AND GENERAL	0	26, 022		67, 500	4, 648	5. 01
5. 02	00590 OTHER A&G - NON FOUNDATION	0	17, 208		44, 638	1, 254	5. 02
7.00	00700 OPERATION OF PLANT	0	10, 621	16, 929	27, 550	55	7.00
	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8. 00
	00900 HOUSEKEEPI NG	0	6, 926		17, 966	435	9. 00
	01000 DI ETARY	0	28, 719		74, 497	63	10.00
	01100 CAFETERI A	0	13, 638		35, 378	30	11.00
	01300 NURSI NG ADMI NI STRATI ON	0	5, 644		14, 641	2, 459	13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	7, 060 3, 490		18, 313 9, 053	96 854	14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	9, 312		24, 155	491	16.00
	01700 SOCIAL SERVICE	0	2, 475		6, 420	439	17. 00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	2, 473		0, 420	0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS			<u> </u>			22.00
	03000 ADULTS & PEDIATRICS	0	356, 710	568, 591	925, 301	11, 556	30.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0		0	0	50.00
	05400 RADI OLOGY-DI AGNOSTI C	0	4, 674		12, 124	191	54.00
60.00	06000 LABORATORY	0	2, 680		6, 951	0	60.00
	06500 RESPI RATORY THERAPY	0	10, 629		27, 572	675	65.00
	06600 PHYSI CAL THERAPY	0	128, 061	204, 127	332, 188	3, 128	66.00
66. 01 67. 00	06601 PHYSI CAL THERAPY - CARMEL 06700 OCCUPATI ONAL THERAPY	0	0 109, 811	_	0 284, 848	249 2, 904	66. 01 67. 00
68.00	06800 SPEECH PATHOLOGY	0	16, 024		41, 567	1, 561	68.00
	06801 VI SI ON	0	10,024		41, 307	328	68. 01
	06802 FAC RESOURCE	0	4, 968	_	12, 886	1, 846	68. 02
	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS	1		10.050	70.00/	221	
	09000 CLINIC	0	27, 134		70, 386	306	90.00
	09001 SLEEP CENTER 09100 EMERGENCY	0	0		0	0	90. 01 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	U	92.00
	OTHER REIMBURSABLE COST CENTERS				<u> </u>		72.00
	09900 CMHC	0	0	0	0	0	99. 00
99. 10	09910 CORF	0	0	О	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS						
118.00		0	805, 676	1, 284, 236	2, 089, 912	33, 568	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	12, 454		32, 306		192.00
	07950 FOUNDATION 07951 PUBLIC RELATIONS		1, 424 0		3, 694 0		194. 00 194. 01
	07952 ST. VINCENT - ARU	0	0		0		194. 01
	07953 MUNCIE - ARU		0		n		194. 02
	07954 RI LEY - ARU	0	0	l ő	ő		194. 04
	07955 RETAIL PHARMACY	0	Ö	Ö	Ö		194. 05
200.00	Cross Foot Adjustments				o		200. 00
201.00	Negative Cost Centers		0	0	o		201.00
202. 00	TOTAL (sum lines 118 through 201)	0	819, 554	1, 306, 358	2, 125, 912	35, 978	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3028

| Peri od: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared:

				1	o 12/31/2019	Date/Time Pre 6/30/2020 7:2	
	Cost Center Description	ADMI NI STRATI V	OTHER A&G -	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	Jani
		E AND GENERAL	NON	PLANT	LINEN SERVICE		
			FOUNDATI ON				
		5. 01	5. 02	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FLXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
1	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00591 ADMI NI STRATI VE AND GENERAL	72, 148	40.057				5. 01
	00590 OTHER A&G - NON FOUNDATION	2, 464	48, 356				5.02
	00700 OPERATION OF PLANT	3, 248	2, 254		244		7.00
	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	203	141 706	0 305	344 0	20, 420	8. 00 9. 00
	01000 DI ETARY	1, 018 1, 448	1, 004		0	20, 430 788	1
	01100 CAFETERI A	396	275		0	374	ł
1	01300 NURSI NG ADMI NI STRATI ON	4, 250	2, 949		0	155	•
1	01400 CENTRAL SERVICES & SUPPLY	938	651	311	0	194	•
	01500 PHARMACY	1, 588	1, 102		0	96	1
	01600 MEDICAL RECORDS & LIBRARY	1, 094	759		0	255	•
	01700 SOCI AL SERVI CE	841	584		0	68	17. 00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	375	260		0	0	•
	INPATIENT ROUTINE SERVICE COST CENTERS				- "		
30. 00	03000 ADULTS & PEDIATRICS	21, 699	15, 062	15, 705	340	9, 783	30.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0		0	0	50.00
1	05400 RADI OLOGY-DI AGNOSTI C	352	244		0	128	•
1	06000 LABORATORY	552	383		0	73	60.00
	06500 RESPIRATORY THERAPY	1, 200	832		0	292	•
1	06600 PHYSI CAL THERAPY	6, 272	4, 352		0	3, 512	•
	06601 PHYSI CAL THERAPY - CARMEL 06700 OCCUPATI ONAL THERAPY	577	400		3	0	66. 01 67. 00
	06800 SPEECH PATHOLOGY	5, 703 2, 773	3, 957 1, 924		1	3, 012 439	68.00
	06801 VI SI ON	532	369		0	0	68. 01
1	06802 FAC RESOURCE	3, 550	2, 463		0	136	ł
	06900 ELECTROCARDI OLOGY	3, 330	2, 403		0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	455	316		0	0	ł
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	3, 232	2, 243		0	0	73.00
	07400 RENAL DIALYSIS	0	0		0	0	74.00
[	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	665	461	1, 195	0	744	•
	09001 SLEEP CENTER	0	0		0	0	90. 01
	09100 EMERGENCY	0	0	0	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
	09900 CMHC	0	0	0	0	0	99. 00
	09910 CORF	0	0		0	0	1
	SPECIAL PURPOSE COST CENTERS						
118. 00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	65, 425	43, 691	32, 496	344	20, 049	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	J	l ~	٥	U	190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 FOUNDATION	3, 404 1, 147	2, 362 796		0		192. 00 194. 00
4	07950 POUNDATION 07951 PUBLIC RELATIONS	767	532		0		194. 00
	07952 ST. VINCENT - ARU	0	0		0		194. 01
	07953 MUNCI E - ARU	216	150		0		194. 03
	07954 RILEY - ARU		0		ol		194. 04
	07955 RETAIL PHARMACY	1, 189	825		o		194. 05
200.00	Cross Foot Adjustments						200. 00
201. 00		0	0		0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	72, 148	48, 356	33, 107	344	20, 430	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3028

COST CENTER DESCRIPTION							6/30/2020 7: 2	23 am
CENTRAL SERVICE COST CENTERS		Cost Center Description	DI ETARY	CAFETERI A	ADMI NI STRATI O	SERVICES &	PHARMACY	
GENERAL SERVICE COST CENTERS 1.00   001002   CAP REL COSTS-BLIG & FIXT 2.00   002002   CAP REL COSTS-BLIG & FIXT 3.00   002002   CAP REL COSTS-BURDE E DUIP   4.00   004002   CAP REL COSTS-BURDE E DUIP   5.01   00591   ADMINISTRATI VE AND CEREPAU. 5.01   05901   ADMINISTRATI VE AND CEREPAU. 6.00   009002   LANDROY & LINEN SERVICE   9.00   009002   LANDROY & LINEN S			10.00	11. 00			15. 00	
2.00	-	GENERAL SERVICE COST CENTERS	1			'		
4.00	1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
5.01   00599   ADMIN INSTRATIVE AND GENERAL     5.01   7.00   00700 (PERATION OF PLANT   8.00   00800 (DHER AGE - NON FOUNDATION   9.00   00900 (DHER AGE - NON FOUNDATION   9.00   10.00   00900 (DHERATION OF PLANT   10.00   11.00   01000 (DHERATION OF PLANT   11.00   01000 (DHERA	2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
5.00   COSPO   OTHER AGG - NON FOUNDATION	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
7. 00 00700   OPERATION OF PLANT   8. 00 0900   LAUNDRY & LINEN SERVICE   9. 00   0.00	5. 01	00591 ADMINISTRATIVE AND GENERAL						5. 01
8.00   00800   LAUNDRY & LINEN SERVICE	5.02	00590 OTHER A&G - NON FOUNDATION						5. 02
9,00 00000 HOUSEKEPING	7.00	00700 OPERATION OF PLANT						7.00
10, 00   10000   0   17ARY   79, 065   11, 00   110, 00   13, 00   1300   0   1300   0   1400   131, 00   1300   0   1300   0   1300   0   1300   0   1300   0   1300   0   1300   0   1300	8.00	00800 LAUNDRY & LINEN SERVICE						8.00
11. 00   01100   CAFETERIA	9.00	00900 HOUSEKEEPI NG						9.00
13. 00   01300   NURSIN CADMINI STRATION   0   3,713   28,416   13. 00   15. 00   01500   PARAMACY   0   1.134   1,905   0   15,806   15. 00   16. 00   01500   PARAMACY   0   1.134   1,905   0   0   17. 00   01700   01700   SOCIAL SERVICE   0   539   0   0   0   0   0   0   0   0   0	10.00	01000 DI ETARY	79, 065					10.00
14. 00   O14000   CAUTRAL SERVICES & SUPPLY   0   24.2   0   20.745   14. 00     15. 00   O1500   PHARMACY   0   0   1.344   1,905   0   15.886   15.00     16. 00   O1600   MEDICAL RECORDS & LI BRARY   0   74.5   1,252   0   0   0   16. 00     10. 00   O1700   O2700   SOCIAL SERVICE   0   0   0   0   0   0   0   22.00     10. 00   O1700   SOCIAL SERVICES OTHER PREM COSTS APPRVD   0   0   0   0   0   0   22.00     10. 00   O1700   SOCIAL SERVICES OTHER PREM COSTS APPRVD   0   0   0   0   0   0   0   0     10. 00   O1700   O1700   O1700   O1700   O1700   O1700     10. 00   O1700   O1700   O1700   O1700   O1700   O1700   O1700     10. 00   O1700   O1700   O1700   O1700   O1700   O1700   O1700     10. 00   O1700   O1700   O1700   O1700   O1700   O1700   O1700   O1700     10. 00   O1700   O1700   O1700   O1700   O1700   O1700   O1700   O1700     10. 00   O1700	11.00	01100 CAFETERI A	0	37, 054				11.00
15.00   01500   PHARMACY	13.00	01300 NURSING ADMINISTRATION	0	3, 713	28, 416			13.00
16. 00   01600   MEDICAL RECORDS & LI BRARY   0   745   1,252   0   0   16. 00	14.00	01400 CENTRAL SERVICES & SUPPLY	0	242	0	20, 745		14.00
17. 00   01700   SOCIAL SERVICE   0   5.99   0   0   0   0   22. 00   22. 00   22.00   1   17. 00   0   0   0   0   22. 00   22. 00   1   18. ERVICE COST CENTERS	15.00	01500 PHARMACY	0	1, 134	1, 905	0	15, 886	15. 00
22.00	16.00	01600 MEDICAL RECORDS & LIBRARY	0	745	1, 252	0	0	16.00
INPATI ENT ROUTINE SERVICE COST CENTERS   79,065   13,971   23,465   5,219   0 0 0.0	17.00	01700 SOCI AL SERVI CE	0	539	0	0	0	17.00
30.00	22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
ANCILLARY SERVICE COST CENTERS								
50.00   05000   05000   05000   0   0   0	30.00		79, 065	13, 971	23, 465	5, 219	0	30.00
54.00   05400   RADIOLOGY-DI AGNOSTIC   0   262   440   114   0   54.00								
60.0   06000   LABORATORY   0   06000   1,354   3,039   065,00   065,00   06500   RESPIRATORY THERAPY   0   8066   1,354   3,039   0   65,00   06000   06000   07,000		1 1	0				0	
65.00   06500   RESPI RATORY THERAPY   0   806   1,354   3,039   0   65.00   66.01   06600   PHYSI CAL THERAPY   0   3,646   0   255   0   66.00   66.01   06601   PHYSI CAL THERAPY   0   3,530   0   66   0   67.00   67.00   06700   OCUPATI ONAL THERAPY   0   3,530   0   66   0   67.00   68.01   06800   SPEECH PATHOLOGY   0   1,743   0   75   0   68.00   68.01   06800   SPEECH PATHOLOGY   0   315   0   5   0   68.01   68.01   06800   SPEECH PATHOLOGY   0   315   0   5   0   68.01   68.02   06802   FAC RESOURCE   0   2,540   0   523   0   68.02   69.00   06900   ELECTROCARDIOLOGY   0   0   0   0   0   0   0   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   72.00   07200   IMPL DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   73.00   07300   ROUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   74.00   07400   RENALD INLYSIS   0   0   0   0   0   0   0   74.00   07400   RENALD INLYSIS   0   0   0   0   0   0   0   74.00   07400   RENALD INLYSIS   0   0   0   0   0   0   0   79.00   09000   CLINIC C   0   476   0   404   0   90.00   79.00   09000   CLINIC C   0   476   0   404   0   90.00   79.00   09000   ERERGENCY   0   0   0   0   0   0   99.00   79.00   09000   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   99.00   79.00   09000   OMBURSABLE COST CENTERS   0   0   0   0   0   0   99.00   79.00   09000   OMBURSABLE COST CENTERS   0   0   0   0   0   0   0   79.00   09000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   0   79.00   09000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   0   79.00   192.00   19200   PHYSI CLANS' PRI VATE OFFI CES   0   1,862   0   1,862   0   0   0   0   79.40   07954   RILEY - ARU   0   0   0   0   0   0   0   0   79.40   07954   RILEY - ARU   0   0   0   0   0   0   0   79.00   07055   ETAIL FUNCART - ARU   0   0   0   0   0   0   0   79.00   07055   RITAL FUNCART - ARU   0   0   0   0   0   0   0   79.00   07055   RITAL FUNCART - ARU   0   0   0   0   0   0   0   79.00   07050   CLINIC COST			0			114	0	1
66. 00   06600   PHYSICAL THERAPY   0   0   3, 646   0   25   0   66, 00   67. 00   06601   PHYSICAL THERAPY - CARMEL   0   212   0   59   0   66, 01   67. 00   06700   OCCUPATIONAL THERAPY   0   3, 530   0   66   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   1,743   0   75   0   68. 00   68. 01   06801   VISION   0   315   0   5   0   68. 00   68. 02   06801   VISION   0   315   0   5   0   68. 00   68. 02   06802   FAC RESOURCE   0   2,540   0   523   0   68. 02   69. 00   06900   ELECTROCARDIOLOGY   0   0   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   07300   PRUSS CHARGED TO PATIENTS   0   0   0   0   0   0   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   75. 80   07400   RENAL DI ALYSIS   0   0   0   0   0   0   76. 00   07400   RENAL DI BEES (NON-DISTINCT PART)   0   77. 00   07900   CHERGES COST CENTERS   0   0   0   0   0   0   77. 00   07900   CHERGES COST CENTERS   0   0   0   0   0   0   77. 00   07900   CHERGES COST CENTERS   0   0   0   0   0   0   77. 00   07900   CHERGES COST CENTERS   0   0   0   0   0   0   77. 00   07900   CHERGES COST CENTERS   0   0   0   0   0   0   77. 00   07900   CHERGES COST CENTERS   0   0   0   0   0   0   78. 00   07900   CHERGE COST CENTERS   0   0   0   0   0   0   79. 10   07900   0			0			6	0	1
66.01   06601   PHYSICAL THERAPY - CARMEL   0   212   0   59   0   66.01   67.00   06700   OCCUPATIONAL THERAPY   0   3,530   0   66   0   67.00   68.00   06800   SPEECH PATHOLOGY   0   1,743   0   75   0   68.00   68.01   06801   VISION   0   315   0   55   0   68.00   68.02   68602   FAC RESOURCE   0   0   2,540   0   523   0   68.02   69.00   06900   ELECTROCARDIOLOGY   0   0   0   0   0   0   0   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   72.00   07200   IMPL DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   79.01   099000   CLINIC   COST CENTERS   79.00   099000   CLINIC   COST CENTERS   79.00   099000   CHINIC   COST CENTERS   79.00   09900   CMBCERCHY   O   0   0   0   0   0   79.10   09910   CMBCERCHY   O   0   0   0   0   0   79.10   09910   CMBCERCHY   O   0   0   0   0   0   79.10   09910   CMBCERCHY   O   0   0   0   0   0   79.10   09910   CMBCERCHY   O   0   0   0   0   79.		· · ·	0				0	1
67. 00   06700   05CUPATI ONAL THERAPY   0   3,530   0   66   0   67. 00   88. 00   06800   SPECH PATHOLOGY   0   1,743   0   75   0   68. 01   88. 01   06801   VI SI ON   0   315   0   5   0   68. 01   86. 02   06802   FAC RESOURCE   0   2,540   0   523   0   68. 02   86. 02   06802   FAC RESOURCE   0   0   0   0   0   0   0   87. 00   0710.00   O7100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   9,962   0   71. 00   87. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   87. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   87. 00   07400   RENAL DI ALYSI   S   0   0   0   0   0   0   0   89. 01   09000   CLI NI C   0   0   0   0   0   0   0   89. 01   09000   SLEEP CENTER   0   0   0   0   0   0   0   0   89. 00   09000   SLEEP CENTER   0   0   0   0   0   0   0   0   89. 00   09200   DSSERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   89. 00   09900   CUHC   0   0   0   0   0   0   0   0   0   89. 01   O9901   CURF   CENTERS   0   0   0   0   0   0   0   0   0   89. 02   O9901   CURF   CENTERS   0   0   0   0   0   0   0   0   0   89. 01   O9901   CURF   CENTERS   0   0   0   0   0   0   0   0   0   89. 02   O9901   CURF   CENTERS   0   0   0   0   0   0   0   0   0   89. 02   O9901   CURF   CENTERS   0   0   0   0   0   0   0   0   0		1 1	0			1	0	1
68. 00   06800   SPECH PATHOLOGY   0   1,743   0   75   0   68. 01   68. 01   06801   VISION   0   315   0   5   0   68. 01   68. 02   06802   FAC RESOURCE   0   2,540   0   523   0   68. 01   69. 00   06900   ELECTROCARDIOLOGY   0   0   0   0   0   0   69. 00   06900   CLECTROCARDIOLOGY   0   0   0   0   0   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   74. 00   07400   RENALD ID ALLYSIS   0   0   0   0   0   75. 806   73. 00   76. 00   07400   RENALD ID ALLYSIS   0   0   0   0   0   77. 00   07900   CLINIC   0   0   0   0   0   79. 01   09001   SLEEP CENTER   0   0   0   0   0   0   79. 00   09000   CLINIC   0   0   0   0   0   0   79. 00   09100   BERGENCY   0   0   0   0   0   0   79. 00   09900   CMHC   0   0   0   0   0   79. 00   09900   08DERVATION BEDS (NON-DISTINCT PART)   0   79. 10   09901   CORF   0   0   0   0   0   79. 10   09901   CORF   0   0   0   0   0   79. 10   09901   CORF   0   0   0   0   79. 10   09900   05DERVATION BEDS (NON-DISTINCT PART)   0   79. 10   09900   05DERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   79. 10   09900   05DERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   79. 10   09900   05DERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   79. 10   09900   05DERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   79. 10   09900   05DERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   79. 10   09900   05DERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   79. 10   09900   05DERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   79. 10   09900   05DERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   79. 10   09900   05DERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   79. 10   09900   05DERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   79. 10   09900   05DERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   79. 10   09900   05DERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   79. 10   09900   05DERVATION BE		1 1	0		-	1	0	1
68. 01   06801   VI SI ON   0   315   0   5   0   68. 01   68. 02   06802   FAC RESOURCE   0   0   2,540   0   523   0   68. 01   68. 02   06800   ELECTROCARDIOLOGY   0   0   0   0   0   0   69. 00   06900   ELECTROCARDIOLOGY   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   9,962   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   75. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   76. 00   09000   CLI NI C   0   476   0   404   0   90. 00   79. 01   09000   SLEEP CENTER   0   0   0   0   0   0   79. 00   09000   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   79. 00   09000   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   79. 00   09000   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   70. 00   09000   CLI NI C   0   476   0   404   0   90. 00   70. 00   09000   CLI NI C   0   476   0   404   0   90. 00   70. 00   09001   SLEEP CENTER   0   0   0   0   0   0   0   70. 00   09000   DRUGS CHARGED   0   0   0   0   0   70. 00   09000   DRUGS CHARGED   0   0   0   0   0   71. 00   09000   DRUGS CHARGED   0   0   0   0   0   72. 00   09000   DRUGS CHARGED   0   0   0   0   0   74. 00   09000   DRUGS CHARGED   0   0   0   0   0   75. 00   09000   DRUGS CHARGED   0   0   0   0   76. 00   09000   DRUGS CHARGED   0   0   0   0   77. 00   09000   DRUGS CHARGED   0   0   0   0   78. 00   09000   DRUGS CHARGED   0   0   0   0   79. 00   09000   DRUGS CHARGED   0   0   0   0   79. 00   09000   DRUGS CHARGED   0   0   0   0   79. 00   09000   DRUGS CHARGED   0   0   0   0   79. 00   09000   DRUGS CHARGED   0   0   0   0   79. 00   09000   DRUGS CHARGED   0   0   0   0   79. 00   09000   DRUGS CHARGED   0   0   0   0   79. 00   09000   DRUGS CHARGED   0   0   0   79. 00   09000			0					1
68 D2   06802   FAC RESOURCE   0   2,540   0   523   0   68 D2   69 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   71 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   72 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   73 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   74 00   07400   RENAL DI ALYSIS   0   0   0   0   0   75 00   07400   RENAL DI ALYSIS   0   0   0   0   0   76 00   09000   CLINI C   0   0   0   0   0   77 00   07400   RENAL DI ALYSIS   0   0   0   0   0   78 00   09000   CLINI C   0   0   0   0   0   0   79 0.00   09000   CLINI C   0   0   0   0   0   0   70 00   09000   CLINI C   0   0   0   0   0   0   70 00   09000   CLINI C   0   0   0   0   0   0   71 00   09100   EMERGENCY   0   0   0   0   0   0   72 00   09200   DESERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0   0   79 00   09900   CMHC   0   0   0   0   0   0   79 00   09910   CORF   0   0   0   0   0   79 00   09910   CORF   0   0   0   0   0   79 00   09910   CORF   0   0   0   0   0   79 00   09910   0   0   0   0   0   79 00   0   0   0   0   0   79 00   0   0   0   0   0   79 00   0   0   0   0   79 00   0   0   0   0   70 00   0   0   0   0   70 00   0   0   0   71 00   0   0   0   72 00   0   0   0   74 00   0   0   0   75 00   0   0   0   76 00   0   0   0   77 00   0   0   0   78 00   0   0   0   79 00   0   0   0   79 00   0   0   0   70 00   0   0   0   70 00   0   0   70 00   0   0   0   70 00   0   0   70 00   0   0   0   70 00   0   0   70 00   0   0   0   70 00   0   0   70 00   0   0   0   70 00   0   0   70 00   0   0   0   70 00   0   0   70 00   0   0   0   70 00   0   0   0   70 00   0   0   0   70 00   0   0   0   70 00   0   0   0   70 00   0   0   0   70 00   0   0   0   70 00   0   0   0   70 00   0   0   70 00   0   0   0   70 00   0   0   0   70 00   0   0   0   70 00   0   0   0   70 00   0   0   0   70 00   0   0   0   70 00   0   0   0   70 00   0   0   0   70 00   0   0   70 00   0   0   0   70 00   0   0   70 00   0   0   0   70 00   0		1 1	0			75		
69.00   69900   ELECTROCARDI OLOGY   0   0   0   0   0   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0UTPATIENT SERVICE COST CENTERS  90.00   09000   CLI INI C   0   476   0   404   0   90.00   90.01   09000   CLI INI C   0   0   0   0   0   0   0   91.00   09100   EMERGENCY   0   0   0   0   0   0   0   91.00   09200   DRISER VATION BEDS (NON-DISTINCT PART)   92.00   92.00   09200   DRISER VATION BEDS (NON-DISTINCT PART)   99.10   99.10   09900   CMBC   0   0   0   0   0   0   99.10   99.10   SUBTOTALS (SUM OF LINES 1 through 117)   79,065   34,337   28,416   19,497   15,886   118.00   191.00   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   1,862   0   1,080   0   192.00   194.00   07950   FOUNDATION   0   0   0   0   0   0   0   194.00   194.00   07950   FOUNDATION   0   0   0   0   0   0   0   194.00   194.00   07950   FOUNDATION   0   0   0   0   0   0   0   194.00   194.00   07950   FOUNDATION   0   0   0   0   0   0   0   0   0   194.01   07950   FOUNDATION   0   0   0   0   0   0   0   0   0   194.02   07952   ST. VINCENT - ARU   0   0   0   0   0   0   0   0   194.03   07953   RETAIL PHARMACY   0   0   0   0   0   0   0   0   194.05   07955   FETAIL PHARMACY   0   0   0   0   0   0   0   194.05   07955   RETAIL PHARMACY   0   0   0   0   0   0   0   194.05   07955   RETAIL PHARMACY   0   0   0   0   0   0   0   0   194.05   07955   RETAIL PHARMACY   0   0   0   0   0   0   0   0   0   194.05   07955   RETAIL PHARMACY   0   0   0   0   0   0   0   0   0   194.06   07950   FETAIL PHARMACY   0   0   0   0   0   0   0   0   0   194.07   07950   PURITOR   0   0   0   0   0   0   0   0   0			0			5	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 9,962 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 15,886 73. 00 74. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 15,886 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 0 74. 00  00TPATIENT SERVICE COST CENTERS  90. 00 9000 CLINC 0 476 0 404 0 90. 00 90. 01 99001 SLEEP CENTER 0 0 0 0 0 0 0 0 90. 01 91. 00 09100 EMERGENCY 0 0 0 0 0 0 0 0 90. 01 92. 00 09200 DEMERGENCY 0 0 0 0 0 0 0 0 91. 00 99. 10 07HER REIMBURSABLE COST CENTERS  99. 10 09901 CORF  99. 10 SPECIAL PURPOSE COST CENTERS  118. 00 SPECIAL PURPOSE COST CENTERS  119. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 1,862 0 1,080 0 192. 00 194. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 1,862 0 1,080 0 192. 00 194. 00 19750 FOUNDATION 0 0 637 0 0 0 194. 00 194. 01 07951 PUBLIC RELATIONS 0 218 0 0 0 0 194. 01 194. 02 07952 ST. VINCENT - ARU 0 0 0 0 0 0 0 194. 01 194. 03 07953 RETAIL PHARMACY 0 0 0 0 0 0 0 0 194. 02 194. 05 07955 RETAIL PHARMACY 0 0 0 0 0 0 0 0 0 0 194. 03 194. 06 07955 RETAIL PHARMACY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	2, 540	0	523	0	1
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   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0    00   074. 00   07400   RENAL DI ALYSI S   0   0   0   0   0    00   074. 00   07400   RENAL DI ALYSI S   0   0   0   0   0    00   074. 00   07400   RENAL DI ALYSI S   0   0   0   0   0    00   074. 00   09000   CLINI C   0   476   0   404   0   90. 00    90. 01   09001   SLEEP CENTER   0   0   0   0   0   0   0   0    91. 00   09100   EMERGENCY   0   0   0   0   0   0   0    92. 00   09200   DESERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   0   0   0    99. 00   09900   CMHC   0   0   0   0   0   0   0    99. 00   09900   CMHC   0   0   0   0   0   0   0    99. 10   09900   CMHC   0   0   0   0   0   0   0    99. 10   09910   CORF   SUBTOTALS (SUM OF LINES 1 through 117)   79, 065   34, 337   28, 416   19, 497   15, 886   118. 00    190. 00   19000   GHETR, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   190. 00    192. 00   19200   PHYSI CLANS' PRI VATE OFFI CES   0   1, 862   0   1, 080   0   192. 00    194. 01   07951   PUBLI C RELATIONS   0   218   0   0   0   0   194. 01    194. 02   07952   ST. VI NCENT - ARU   0   0   0   0   0   0   194. 01    194. 03   07953   MUNCIE - ARU   0   0   0   0   0   0   194. 01    194. 05   07955   RETAI L PHARMACY   0   0   0   0   0   0   0    100   00		1 1	0	0	0	0	0	1
73. 00 07300   DRUGS CHARGED TO PATIENTS   0 0 0 0 0 0 15,886 73. 00 74. 00 07400   RANAL DI ALYSIS   0 0 0 0 0 0 0 0 74.00  OUTPATIENT SERVI CE COST CENTERS  90. 00 09000   CLINIC   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	0	0	0	9, 962		1
74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   74. 00		1 1	0	0	0	0	-	1
OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE COST CENTER   OUTPATIENT SERVICE COST CENTER   OUTPATIENT SERVICE COST CENTER   OUTPATIENT SERVICE COST CENTER   OUTPATIENT SERVICE COST CENTERS   OUTPATIE			· · · · · · · · · · · · · · · · · · ·		- 1	-1		
90. 00	74.00		l U	0	l 0	U	0	74.00
90. 01	00 00			174		404	^	00.00
91. 00			l .			1		1
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   0   0   0   0   0   0			· · · · · · · · · · · · · · · · · · ·		- 1	-1		1
OTHER REIMBURSABLE COST CENTERS   O		1 1	o o	O	O O	o <sub>l</sub>	O	1
99. 00   09900   CMHC   0   0   0   0   0   0   99. 00   99. 10   99. 10   99. 10   SPECIAL PURPOSE COST CENTERS  118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   79, 065   34, 337   28, 416   19, 497   15, 886   118. 00   NONREI MBURSABLE COST CENTERS  190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   190. 00   190. 00   192. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   1, 862   0   1, 080   0   192. 00   194. 00   194. 01   194. 01   194. 01   194. 01   194. 02   194. 02   194. 03   194. 04   194. 05   194. 04   194. 05   1955   RETAIL PHARMACY   0   0   0   0   0   168   0   194. 05   1955   ROTAL PURPOSE COST CENTERS   0   0   0   0   0   0   194. 05   1955   ROTAL PURPOSE COST CENTERS   0   0   0   0   0   194. 05   194. 05   1955   RETAIL PHARMACY   0   0   0   0   0   194. 05   1955   ROTAL PURPOSE COST CENTERS   0   0   0   0   0   0   194. 05   1955   ROTAL PHARMACY   0   0   0   0   0   0   194. 05   1955   ROTAL PHARMACY   0   0   0   0   0   0   0   194. 05   1955   ROTAL PHARMACY   0   0   0   0   0   0   0   0   0	72.00				l.	l		72.00
99. 10	99 00		n	0		n	0	99 00
SPECIAL PURPOSE COST CENTERS   118.00   SUBTOTALS (SUM OF LINES 1 through 117)   79,065   34,337   28,416   19,497   15,886   118.00   NONREI MBURSABLE COST CENTERS		1 1						
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   79,065   34,337   28,416   19,497   15,886   118.00	77. 10		<u>ا</u>		<u> </u>	<u> </u>		//. 10
NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   190.00   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   1,862   0   1,080   0   192.00   194.00   07950   FOUNDATI ON   0   637   0   0   0   194.00   194.01   07951   PUBLI C RELATI ONS   0   218   0   0   0   194.01   194.02   07952   ST. VI NCENT - ARU   0   0   0   0   0   194.02   194.03   07953   MUNCI E - ARU   0   0   0   0   0   194.03   194.04   07954   RI LEY - ARU   0   0   0   0   0   194.04   194.05   07955   RETAI L PHARMACY   0   0   0   0   168   0   194.05   200.00   Cross Foot Adjustments   0   0   0   0   0   0   201.00   Negati ve Cost Centers   0   0   0   0   0   0   201.00   Negati ve Cost Centers   0   0   0   0   0   0   201.00   192.00   0   0   0   0   0   201.00   193.00   0   0   0   0   0   201.00   0   0   0   0   0   201.00   0   0   0   0   0   201.00   0   0   0   0   0   201.00   0   0   0   0   0   201.00   0   0   0   0   201.00   0   0   0   0   201.00   0   0   0   0   201.00   0   0   0   0   201.00   0   0   0   0   201.00   0   0   0   0   201.00   0   0   0   0   201.00   0   0   0   0   201.00   0   0   0   201.00   0   0   0   201.00   0   0   0   201.00   0   0   0   201.00   0   0   0   201.00   0   0   0   201.00   0   0   0   201.00   0   0   0   201.00   0   0   0   201.00   0   0   0   201.00   0   0   0   201.00   0   0   201.00   0   0   0   201.00   0   0   0   201.00   0   0   201.00   0   0   201.00   0   0   0   201.00   0   0   201.00   0   0   201.00   0   0   201.00   0   0   201.00   0   0   201.00   0   0   201.00   0   0   201.00   0   0   201.00   0   0   201.00   0   0   201.00   0   0   201.00   0   0   201.00   0   201.00   0   0   201.00   0   0   201.00   0   0   201.00   0   201.00   0   0   201.00   0   0   201.00   0   0   201.00   0   201.00   0   0   201.00   0   201.00   0   0   201.00   0   0   201.00   0   0   201.00   0   0   201.00   0   0   201.00   0   201.00   0   0   201.00   0   201.00   0   201.00   0   201.00	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	79, 065	34. 337	28, 416	19. 497	15, 886	118.00
192. 00     19200     PHYSI CI ANS' PRI VATE OFFI CES     0     1,862     0     1,080     0     192. 00       194. 00     07950     FOUNDATI ON     0     637     0     0     0     194. 00       194. 01     07951     PUBLI C RELATI ONS     0     218     0     0     0     194. 01       194. 02     07952     ST. VI NCENT - ARU     0     0     0     0     0     194. 02       194. 03     07953     MUNCI E - ARU     0     0     0     0     0     0     194. 03       194. 05     07954     RI LEY - ARU     0     0     0     0     0     0     194. 04       194. 05     07955     RETAI L PHARMACY     0     0     0     168     0     194. 05       200. 00     Cross Foot Adj ustments     0     0     0     0     0     0     0     201. 00			,			,	.,	
194. 00   07950   FOUNDATION   0   637   0   0   194. 00   194. 01   07951   PUBLIC RELATIONS   0   218   0   0   194. 01   194. 02   07952   ST. VINCENT - ARU   0   0   0   0   194. 03   07953   MUNCI E - ARU   0   0   0   0   194. 04   07954   RI LEY - ARU   0   0   0   0   194. 05   07955   RETAIL PHARMACY   0   0   0   200. 00   Cross Foot Adjustments   200. 00   201. 00   Negative Cost Centers   0   0   0   0   218   0   0   0   0   218   0   0   0   0   0   0   0   0   0   0	190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
194. 00   07950   FOUNDATION   0   637   0   0   194. 00   194. 01   07951   PUBLIC RELATIONS   0   218   0   0   194. 01   194. 02   07952   ST. VINCENT - ARU   0   0   0   0   194. 02   194. 03   07953   MUNCIE - ARU   0   0   0   0   0   194. 04   07954   RI LEY - ARU   0   0   0   0   194. 05   07955   RETAIL PHARMACY   0   0   0   168   0   200. 00   Cross Foot Adjustments   200. 00   201. 00   Negative Cost Centers   0   0   0   0   201. 00   Negative Cost Centers   0   0   0   0   201. 00   194. 05   0   0   0   201. 00   0   0   0   0   201. 00   0   0   0   201. 00   0   0   0   201. 00   0   0   0   201. 00   0   0   0   201. 00   0   0   0   201. 00   0   0   201. 00   0   0   201. 00   0   0   201. 00   0   0   201. 00   0   0   201. 00   0   0   201. 00   0   0   201. 00   0   0   201. 00   0   0   201. 00   0   0   201. 00   0   0   201. 00   0   201. 00   0   201. 00   0   201. 00   0   201. 00   0   201. 00   0   201. 00   0   201. 00   0   201. 00   0   201. 00   0   201. 00   0   201. 00   201. 00   0   201. 00	192.00	19200 PHYSICIANS' PRIVATE OFFICES	o	1, 862	0	1, 080	0	192.00
194. 02 07952 ST. VINCENT - ARU  194. 03 07953 MUNCIE - ARU  194. 04 07954 RI LEY - ARU  194. 05 07955 RETAIL PHARMACY  200. 00 Cross Foot Adjustments  201. 00 Negative Cost Centers  0 0 0 0 0 0 194. 02  0 0 0 0 0 0 194. 05  0 0 0 0 0 0 0 194. 05  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	637	0			
194. 03 07953 MUNCIE - ARU 0 0 0 0 194. 03 194. 04 07954 RI LEY - ARU 0 0 0 0 0 194. 04 194. 05 07955 RETAIL PHARMACY 0 0 0 168 0 194. 05 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 201. 00	194. 01	07951 PUBLIC RELATIONS	o	218	0	0	0	194. 01
194. 04 07954 RILEY - ARU 0 0 0 0 194. 04 194. 05 07955 RETAIL PHARMACY 0 0 0 168 0 194. 05 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 201. 00	194. 02	07952 ST. VINCENT - ARU	O	0	0	o	0	194. 02
194. 05 07955 RETAIL PHARMACY 0 0 0 168 0 194. 05 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00	194. 03	07953 MUNCIE - ARU	o	0	0	o	0	194. 03
200.00   Cross Foot Adjustments   200.00   201.00   Negative Cost Centers   0   0   0   0   201.00			0	0	0	o		
201.00   Negative Cost Centers   0   0   0   0   201.00	194.05	07955 RETAIL PHARMACY	0	0	0	168	0	
201.00     Negative Cost Centers     0     0     0     0     0     201.00       202.00     TOTAL (sum lines 118 through 201)     79,065     37,054     28,416     20,745     15,886     202.00	200.00	Cross Foot Adjustments						
202.00   TOTAL (sum lines 118 through 201)   79,065  37,054  28,416  20,745  15,886 202.00			0	-		0		
	202.00	TOTAL (sum lines 118 through 201)	79, 065	37, 054	28, 416	20, 745	15, 886	202.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3028 Peri od: Worksheet B From 01/01/2019 Part II Date/Time Prepared: 12/31/2019 6/30/2020 7:23 am INTERNS & **RESI DENTS** Cost Center Description MEDI CAL SOCI AL SERVI CES-OTHE Subtotal Intern & R PRGM COSTS RECORDS & **SERVICE** Resi dents LI BRARY Cost & Post Stepdown Adjustments 16. 00 17. 00 22.00 24.00 25. 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.01 00591 ADMINISTRATIVE AND GENERAL 5.01 5.02 00590 OTHER A&G - NON FOUNDATION 5.02 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 29.161 01700 SOCIAL SERVICE 17.00 9,000 17.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 635 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 9, 000 1, 159, 327 n 30 00 29, 161 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 14,061 0 54.00 60 00 06000 LABORATORY 8, 546 60.00 0 0 06500 RESPIRATORY THERAPY 65.00 0 36, 238 0 65.00 06600 PHYSI CAL THERAPY 0000000000 0 66.00 358, 762 0 66.00 06601 PHYSI CAL THERAPY - CARMEL 66.01 0 1.500 0 66.01 06700 OCCUPATIONAL THERAPY 308, 857 0 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 50, 788 0 68.00 06801 VI SI ON 68 01 1,549 68.01 68.02 06802 FAC RESOURCE 0 24, 163 0 68.02 06900 ELECTROCARDI OLOGY 69 00 C  $\cap$ 0 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 10,733 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 73.00 21, 361 07400 RENAL DIALYSIS 74.00 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 74.637 09001 SLEEP CENTER 90.01 90.01 0 C Λ 91.00 09100 EMERGENCY 0 C 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 99.00 0 0 0 99.10 09910 CORF 0 99.10 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 9, 000 0 29, 161 2, 070, 522 0 118.00 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 190. 00 0 43.447 0 192.00 0 194. 00 07950 FOUNDATI ON 0 6, 708 0 194.00 0 194. 01 07951 PUBLIC RELATIONS 0 0 1,681 0 194. 01 194. 02 07952 ST. VINCENT - ARU 0 0 194.02 0 194. 03 07953 MUNCI E - ARU 0 0 487 0 194.03 194. 04 07954 RILEY - ARU 0 0 194, 04 C 0 194. 05 07955 RETAIL PHARMACY 0 2, 432 0 194.05

0

9,000

29, 161

0 200. 00

0 201.00

0 202.00

635

635

0

635

2, 125, 912

0

200.00

201 00

202.00

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

| Peri od: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-3028

	Cost Center Description	Total	07 007 2020 7.2	- Calif
	<u>'</u>	26. 00		
	GENERAL SERVICE COST CENTERS			
1. 00	00100 CAP REL COSTS-BLDG & FLXT			1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 01	00591 ADMINISTRATIVE AND GENERAL			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 NURSING ADMINISTRATION			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY			14.00
15. 00	01500 PHARMACY			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY			16. 00
17. 00	01700 SOCI AL SERVI CE			17. 00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD			22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00	03000 ADULTS & PEDI ATRI CS	1, 159, 327		30.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0		50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	14, 061		54.00
60.00	06000 LABORATORY	8, 546		60.00
65.00	06500 RESPI RATORY THERAPY	36, 238		65.00
66.00	06600 PHYSI CAL THERAPY	358, 762		66.00
66. 01	06601 PHYSI CAL THERAPY - CARMEL	1, 500		66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	308, 857		67.00
68. 00	06800 SPEECH PATHOLOGY	50, 788		68.00
68. 01	06801 VI SI ON	1, 549		68. 01
68. 02	06802 FAC RESOURCE	24, 163		68. 02
69. 00	06900 ELECTROCARDI OLOGY	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 733		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	21, 361		73.00
74. 00	07400 RENAL DIALYSIS	0		74. 00
90. 00	OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC	74, 637		90.00
90.00	09001 SLEEP CENTER	74, 037		90.00
91. 00	09100 EMERGENCY	0		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
72.00	OTHER REIMBURSABLE COST CENTERS			72.00
99. 00	09900 CMHC	0		99. 00
	09910 CORF	O		99. 10
	SPECIAL PURPOSE COST CENTERS	-1		
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	2, 070, 522		118. 00
	NONREI MBURSABLE COST CENTERS			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES	43, 447		192. 00
	07950 FOUNDATI ON	6, 708		194. 00
	07951 PUBLIC RELATIONS	1, 681		194. 01
	07952 ST. VINCENT - ARU	0		194. 02
194. 03	07953 MUNCIE - ARU	487		194. 03
194. 04	07954 RI LEY - ARU	0		194. 04
	07955 RETAIL PHARMACY	2, 432		194. 05
200.00		635		200.00
201.00		0		201.00
202.00	TOTAL (sum lines 118 through 201)	2, 125, 912		202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: Worksheet B-1
From 01/01/2019
To 12/31/2019 Date/Time Prepared: Provi der CCN: 15-3028

					o 12/31/2019	Date/Time Pre 6/30/2020 7:2	
		CAPI TAL REI	LATED COSTS			673072020 7:2	3 alli
	Octob Octob December 1	DI DO A FLYT	MANUE FOLLIE	EMDL OVEE	D	A DAMI AU CEDATI V	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	n	ADMINISTRATIV E AND GENERAL	
		(SQS/IKE TEET)	(SQS/IKE TEET)	DEPARTMENT		(ACCUM. COST)	
				(GROSS			
		1. 00	2.00	SALARI ES) 4. 00	5A. 01	5. 01	
GENE	RAL SERVICE COST CENTERS	1.00	2.00	1.00	071. 01	0.01	
	CAP REL COSTS-BLDG & FIXT	92, 060					1.00
	CAP REL COSTS-MVBLE EQUIP DEMPLOYEE BENEFITS DEPARTMENT	1, 558	92, 060 1, 558				2. 00 4. 00
	1 ADMINISTRATIVE AND GENERAL	2, 923				40, 052, 967	5. 01
	O OTHER A&G - NON FOUNDATION	1, 933	1			1, 368, 108	1
	OPERATION OF PLANT	1, 193			1	1, 803, 679	1
	D LAUNDRY & LI NEN SERVI CE D HOUSEKEEPI NG	0 778	_			112, 586 565, 158	1
	D DI ETARY	3, 226				803, 793	1
	CAFETERI A	1, 532				219, 811	1
	NURSING ADMINISTRATION	634				2, 359, 950	1
	CENTRAL SERVICES & SUPPLY DIPHARMACY	793 392				520, 889 881, 742	1
	MEDICAL RECORDS & LIBRARY	1, 046				607, 238	1
	SOCIAL SERVICE	278				467, 111	1
	O I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	C	0	208, 091	22. 00
	TIENT ROUTINE SERVICE COST CENTERS  ADJULTS & PEDIATRICS	40, 069	40, 069	7, 959, 286	0	12, 041, 709	30.00
	LLARY SERVICE COST CENTERS	40,007	40,007	1,737,200	,	12,041,707	30.00
	OPERATING ROOM	0	_				
	D RADI OLOGY-DI AGNOSTI C D LABORATORY	525 301	525 301	131, 965			1
	RESPI RATORY THERAPY	1, 194		1	_	306, 520 666, 204	1
	PHYSI CAL THERAPY	14, 385				3, 482, 550	1
	1 PHYSICAL THERAPY - CARMEL	0	0			320, 269	1
	O OCCUPATI ONAL THERAPY	12, 335	1			3, 166, 351	1
	O SPEECH PATHOLOGY 1 VI SI ON	1, 800			1	1, 539, 799 295, 196	1
	2 FAC RESOURCE	558	_			1, 971, 141	1
	D ELECTROCARDI OLOGY	0	0	1	1	0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS DIMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	252, 857 0	71. 00 72. 00
	D DRUGS CHARGED TO PATIENTS		0		_		1
74. 00 0740	RENAL DIALYSIS	0	Ö				1
	ATIENT SERVICE COST CENTERS	2.040	2.040	044.074		2/0 400	00.00
	D CLINIC 1 SLEEP CENTER	3, 048	3, 048 0				1
	EMERGENCY	O	Ö				1
	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
99. 00 0990	R REIMBURSABLE COST CENTERS	Ιο	0	l c	0	Ο	99. 00
99. 10 0991		0				1	99. 10
	AL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) EIMBURSABLE COST CENTERS	90, 501	90, 501	23, 128, 959	-8, 680, 952	36, 319, 973	118. 00
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190. 00
192. 00 1920	PHYSICIANS' PRIVATE OFFICES	1, 399				l .	1
	FOUNDATION	160					
	1 PUBLIC RELATIONS 2 ST. VINCENT - ARU	0	0	113, 124	0	425, 682	194. 01 194. 02
	3 MUNCIE - ARU		0	83, 732	. 0	l	1
1	4 RI LEY - ARU	0	Ō	C	0		194. 04
	RETAI L_PHARMACY	0	0	172, 348	0	660, 414	
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B,	819, 554	1, 306, 358	5, 892, 796		8, 680, 952	1
	Part I)	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3,312,113		2, 222, 122	
203. 00	Unit cost multiplier (Wkst. B, Part I)	8. 902390	14. 190289			0. 216737	1
204. 00	Cost to be allocated (per Wkst. B, Part II)			35, 978	3	72, 148	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 001451		0. 001801	205. 00
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

In Lieu of Form CMS-2552-10 Health Financial Systems REHABILITATION HOSPITAL OF INDIANA COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3028 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 6/30/2020 7:23 am Cost Center Description Reconciliatio OTHER A&G -OPERATION OF LAUNDRY & HOUSEKEEPI NG LINEN SERVICE (SQUARE FEET) NON **PLANT** n FOUNDATI ON (SQUARE FEET) (POUNDS OF (ACCUM. COST) LAUNDRY) 7. 00 9. 00 5A. 02 5.02 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00591 ADMINISTRATIVE AND GENERAL 5.01 5.01 5.02 00590 OTHER A&G - NON FOUNDATION -1, 664, 628 47, 069, 291 5.02 00700 OPERATION OF PLANT 2, 194, 603 7 00 84, 453 7 00 00800 LAUNDRY & LINEN SERVICE 136, 988 217, 852 8.00 8.00 9 00 00900 HOUSEKEEPI NG 0 687, 649 778 0 83,675 9 00 01000 DI ETARY 00000 978,005 3, 226 10.00 10.00 3, 226 0 01100 CAFETERI A 11.00 267, 452 1.532 0 1,532 11.00 13.00 01300 NURSING ADMINISTRATION 2, 871, 438 634 0 634 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 633, 785 793 0 793 14.00 ol 01500 PHARMACY 15.00 1,072,848 392 392 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 738, 849 1,046 0 1,046 16.00 01700 SOCIAL SERVICE 568, 351 17.00 17.00 278 278 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 22.00 253, 192 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 14, 651, 587 40, 069 215, 014 40, 069 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 237, 628 525 0 525 54.00 60.00 06000 LABORATORY 0 372, 954 301 0 301 60.00 06500 RESPIRATORY THERAPY 65.00 0000000000 810, 595 1, 194 0 1, 194 65.00 66 00 06600 PHYSI CAL THERAPY 4, 237, 347 14, 385 217 14, 385 66 00 06601 PHYSI CAL THERAPY - CARMEL 66.01 389, 683 2,062 0 66.01 0 06700 OCCUPATIONAL THERAPY 3, 852, 616 12, 335 401 12, 335 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 1,873,530 1.800 158 1.800 68.00 06801 VI SI ON 68.01 359, 176  $\cap$ 0 Ω 68.01 68. 02 06802 FAC RESOURCE 2, 398, 360 558 0 558 68.02 06900 ELECTROCARDI OLOGY 69.00 0 0 0 69.00 307, 660 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS Ω 0 71 00 0 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 2, 183, 706 0 0 0 73.00 73.00 07400 RENAL DIALYSIS 74.00 0 0 0 74.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 449, 218 09000 CLI NI C 0 3,048 0 3,048 90.00 09001 SLEEP CENTER 0 0 90.01 90.01 91.00 09100 EMERGENCY 0 0 0 ol 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 99.00 09910 CORF 99.10 99.10 0 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) -1, 664, 628 42, 527, 220 82, 894 217, 852 82, 116 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 2, 299, 697 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 1, 399 1, 399 192. 00 0 194. 00 07950 FOUNDATI ON 0 775, 131 160 0 160 194.00 0 194. 01 07951 PUBLIC RELATIONS 0 0 517, 943 0 0 194.01 194. 02 07952 ST. VINCENT - ARU 0 0 194, 02 0 194. 03 07953 MUNCI E - ARU 145, 750 0 0 0 194.03 194. 04 07954 RILEY - ARU 0 0 0 0 194.04 194. 05 07955 RETAIL PHARMACY 803, 550 0 194, 05 0 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 2, 272, 215 141, 833 732, 900 202. 00 1,664,628 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.035365 26. 905083 0.651052 8. 758889 203. 00

48, 356

0.001027

33, 107

0.392017

344

0.001579

20, 430 204. 00

206. 00

207.00

0. 244159 205. 00

Part II)

(per Wkst. B-2)

Parts III and IV)

II)

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

NAHE adjustment amount to be allocated

204.00

205.00

206.00

207.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3028 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 6/30/2020 7:23 am Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI O SERVICES & (MEALS (HOURS PAID) (COSTED SERVED) **SUPPLY** REQUIS.) Ν (DIRECT NURS (COSTED HRS. ) REQUIS. ) 10.00 11.00 13.00 14.00 15.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00591 ADMINISTRATIVE AND GENERAL 5.01 5.01 00590 OTHER A&G - NON FOUNDATION 5.02 5.02 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 63, 183 10.00 10.00 11.00 01100 CAFETERI A 622, 881 11.00 13.00 01300 NURSING ADMINISTRATION 0 62, 418 284, 388 13.00 01400 CENTRAL SERVICES & SUPPLY 0 4, 067 14.00 14.00 526, 614 19, 068 01500 PHARMACY 0 100 15.00 19,068 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 12, 526 12, 526 0 0 16.00 01700 SOCIAL SERVICE 17.00 0 9,058 0 0 0 17.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 22.00  $\cap$ 0 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 63, 183 30.00 03000 ADULTS & PEDIATRICS 234, 844 234, 844 132, 489 0 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 0 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 4, 399 4, 399 2, 903 0 54.00 0 60.00 06000 LABORATORY 7, 781 159 0 60.00 13, 551 65 00 06500 RESPIRATORY THERAPY 0 0 13, 551 65 00 77 152 0 06600 PHYSI CAL THERAPY 66.00 61, 292 638 0 66.00 C 06601 PHYSI CAL THERAPY - CARMEL 3, 562 0 1, 496 0 66.01 66.01 06700 OCCUPATI ONAL THERAPY 67.00 00000 59, 348 0 1,673 0 67.00 68 00 06800 SPEECH PATHOLOGY 29, 297 0 1, 909 68 00 0 0 68.01 06801 VI SI ON 5, 296 125 0 68.01 06802 FAC RESOURCE 42, 695 0 0 68.02 68.02 13, 264 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 252, 857 71.00 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 0 100 73.00 07400 RENAL DIALYSIS
OUTPATIENT SERVICE COST CENTERS 74.00 0 0 0 0 74.00 0 90.00 09000 CLI NI C 0 7, 995 0 10, 268 0 90.00 90.01 09001 SLEEP CENTER 0 0 0 0 90.01 09100 EMERGENCY 0 0 91.00 91.00 C 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99.00 99.00 09900 CMHC 0 0 99. 10 99. 10 09910 CORF O ol SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 63, 183 577, 197 284, 388 494, 933 100 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 31, 298 0 192.00 27, 415 0 0 0 194.00 194. 00 07950 FOUNDATI ON 10, 715 0 0 194. 01 07951 PUBLIC RELATIONS 0 0 194, 01 3, 671 0 194. 02 07952 ST. VINCENT - ARU C 0 0 0 194.02 194. 03 07953 MUNCIE - ARU 0 C 0 0 0 194.03 0 194. 04 07954 RILEY - ARU 0 0 194.04 C 0 194. 05 07955 RETAIL PHARMACY 0 194 05 0 C 0 4, 266 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 1, 337, 999 202. 00 3, 028, 821 202.00 Cost to be allocated (per Wkst. B, 1, 127, 644 331, 548 686, 646 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 17.847269 0.532281 10.650312 1. 303889 13, 379. 990000 203. 00 20, 745 15, 886 204. 00 204.00 Cost to be allocated (per Wkst. B, 79,065 37,054 28, 416 Part II) 158. 860000 205. 00 205.00 0.059488 0.099920 0.039393 Unit cost multiplier (Wkst. B, Part 1. 251365 11) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 6/30/2020 7: 23 am

				6/30/2020 7: 2	3 am
Cost Center Description	MEDI CAL RECORDS & LI BRARY (TOTAL PATI ENT DAYS) 16. 00	SOCI AL SERVI CE (TOTAL PATI ENT DAYS)	INTERNS & RESI DENTS SERVI CES-OTHE R PRGM COSTS (ASSI GNED TI ME)		
GENERAL SERVICE COST CENTERS	10.00	17.00	22.00		
1. 00	_				1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00
15. 00   01500   PHARMACY	24.04	.			15.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY 17. 00   01700   SOCI AL SERVI CE 22. 00   02200   I&R SERVI CES-OTHER PRGM CO	• • • • • • • • • • • • • • • • • • •	21, 061	100		16. 00 17. 00 22. 00
INPATIENT ROUTINE SERVICE COST	CENTERS				
30. 00 03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	21, 06	1 21, 061	100		30.00
50. 00 05000 OPERATING ROOM		ol lo	0		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	· · · · · · · · · · · · · · · · · · ·	ol ol	0		54.00
60. 00 06000 LABORATORY			0		60.00
65. 00 06500 RESPIRATORY THERAPY			0		65. 00
66. 00   06600   PHYSI CAL THERAPY		0	0		66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL			0		66. 01
67. 00   06700   OCCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY			0		67. 00 68. 00
68. 01   06800   SPEECH PATHOLOGY			0		68. 01
68. 02   06802 FAC RESOURCE			0		68. 02
69. 00 06900 ELECTROCARDI OLOGY			0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED	TO PATIENTS	0 0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATI	• • • • • • • • • • • • • • • • • • •	0	0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	• • • • • • • • • • • • • • • • • • •		0		73.00
74.00 O7400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS		이	0		74. 00
90. 00   09000   CLINIC		ol lo	0		90.00
90. 01   09001   SLEEP CENTER	· ·		0		90.00
91. 00   09100   EMERGENCY	· · · · · · · · · · · · · · · · · · ·		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DIST	TINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS					
99. 00   09900   CMHC	•		0		99.00
99. 10 09910 CORF SPECI AL PURPOSE COST CENTERS		0	0		99. 10
118. 00 SUBTOTALS (SUM OF LINES 1	through 117) 21,06	1 21, 061	100		118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP		이	0		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CE			0		192.00
194. 00 07950  FOUNDATI ON 194. 01 07951  PUBLI C RELATI ONS	•		0		194. 00 194. 01
194. 01 07951 PUBLIC RELATIONS 194. 02 07952 ST. VINCENT - ARU			0		194. 01
194. 03 07953 MUNCI E - ARU			0		194. 03
194. 04 07954 RI LEY - ARU			0		194. 04
194. 05 07955 RETAIL PHARMACY		0 0	0		194. 05
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	Wko+ D 042.25	( (02 107	2/2 1//		201.00
202.00 Cost to be allocated (per Part I)	Wkst. B, 942, 350	603, 187	262, 146		202. 00
203.00 Unit cost multiplier (Wks	t. B, Part I) 44.74412	28. 639998	2, 621. 460000		203. 00
204.00 Cost to be allocated (per		1 1	635		204.00
Part II)		, , , , ,			
205.00 Unit cost multiplier (Wkst	t. B, Part 1.38459	0. 427330	6. 350000		205. 00
NAME adjustment amount to	be allegated				204 00
206.00 NAHE adjustment amount to (per Wkst. B-2)	be allocated				206. 00
207.00 NAHE unit cost multiplier	(Wkst. D,				207. 00
Parts III and IV)					

Health Financial Syst	ems RE	HABILITATION HOS	SPITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO	OF COSTS TO CHARGES		Provi der Co		Period: From 01/01/2019 To 12/31/2019		pared: 3 am
			Title	XVIII	Hospi tal	PPS	
					Costs		
Cost Cent	er Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1 00	2.00	2 00	4 00	E 00	

		11110	AVIII		113	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col. 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	22, 210, 869		22, 210, 869	0	22, 210, 869	30.00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0		0	0	0	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	317, 733		317, 733	0	317, 733	54.00
60. 00   06000   LABORATORY	401, 227		401, 227	0	401, 227	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 133, 978	0	1, 133, 978	0	1, 133, 978	65.00
66. 00   06600 PHYSI CAL THERAPY	4, 933, 826	0	4, 933, 826	0	4, 933, 826	66.00
66.01 06601 PHYSI CAL THERAPY - CARMEL	408, 653	0	408, 653	0	408, 653	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	4, 462, 811	0	4, 462, 811	0	4, 462, 811	67.00
68.00 06800 SPEECH PATHOLOGY	2, 022, 168	0	2, 022, 168	0	2, 022, 168	68.00
68. 01   06801   VI SI ON	374, 860	0	374, 860	0	374, 860	68. 01
68. 02   06802   FAC   RESOURCE	2, 543, 099	0	2, 543, 099	0	2, 543, 099	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0		0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	648, 238		648, 238	0	648, 238	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 598, 932		3, 598, 932	0	3, 598, 932	73.00
74.00 07400 RENAL DIALYSIS	0		0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						]
90. 00 09000 CLI NI C	591, 453		591, 453	0	591, 453	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						1
99. 00 09900 CMHC	0		0		0	99. 00
99. 10 09910 CORF	0		0		0	99. 10
200.00 Subtotal (see instructions)	43, 647, 847	0	43, 647, 847	o	43, 647, 847	200.00
201.00 Less Observation Beds	0		0			201.00
202.00 Total (see instructions)	43, 647, 847	0	43, 647, 847	0	43, 647, 847	202.00
		•	•		•	

Health Financial Systems	REHABILITATION HOSI	PITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	-	Period: From 01/01/2019 Fo 12/31/2019	6/30/2020 7: 2	pared: 3 am
			XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	6, 00	7. 00	8. 00	9, 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS				1		
30. 00 03000 ADULTS & PEDIATRICS	42, 308, 992		42, 308, 992	2		30.00
ANCILLARY SERVICE COST CENTERS	, , , , , , , ,					
50. 00 05000 OPERATING ROOM	0	0	(	0.000000	0.000000	50.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	1, 100, 206	0	1, 100, 200	0. 288794	0. 000000	54.00
60. 00   06000   LABORATORY	1, 672, 108	0	1, 672, 108	0. 239953	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	3, 246, 223	0	3, 246, 223	0. 349322	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	12, 095, 064	6, 683, 625	18, 778, 689	0. 262735	0.000000	66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	1, 259, 575	1, 259, 57	0. 324437	0.000000	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	12, 312, 889	4, 005, 071			0.000000	
68.00 06800 SPEECH PATHOLOGY	9, 372, 343	1, 780, 980		0. 181306	0.000000	68.00
68. 01   06801   VI SI ON	703, 043	644, 870	1, 347, 913		0. 000000	1
68. 02   06802   FAC RESOURCE	0	612, 159	612, 159		0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0	(	0. 000000	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	ΓS 2, 072, 932	78, 942	2, 151, 87		0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0	(	0. 000000	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 228, 705	4, 368, 964	10, 597, 669		0. 000000	
74. 00 07400 RENAL DI ALYSI S	0	0	(	0. 000000	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	471	2, 656, 117	2, 656, 588		0. 000000	
90. 01   09001   SLEEP CENTER	0	0	(	0.000000	0. 000000	
91. 00   09100   EMERGENCY	0	0	(	0. 000000	0. 000000	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	Γ)   0	0	(	0.000000	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS			1	_1		
99. 00   09900 CMHC	0	0				99.00
99. 10 09910 CORF	01 110 071	00 000 000	440 000 07			99. 10
200.00 Subtotal (see instructions)	91, 112, 976	22, 090, 303	113, 203, 279	7		200.00
201.00 Less Observation Beds 202.00 Total (see instructions)	01 112 074	22 000 202	112 202 27			201. 00 202. 00
202.00   Total (See Histiactions)	91, 112, 976	22, 090, 303	113, 203, 279	7	ı	J2U2. UU

Health Financial Systems	REHABILITATION HOSPITAL OF INDIANA	In Lieu	ı of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-3028	Peri od: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 6/30/2020 7:23 am

PPS Inpatient Ratio				To 12/31/2019	Date/Time Prepared: 6/30/2020 7:23 am
Ratio   11.00			Title XVIII	Hospi tal	
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   3000  ADULTS & PEDIATRICS   30.00	Cost Center Description				
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00					
30.00		11. 00			
ANCILLARY SERVICE COST CENTERS					
50.00     05000   OPERATING ROOM   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   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000					30.00
54. 00   05400   RADI 0LOGY-DI AGNOSTI C   0. 288794   0. 06000   06000   LABORATORY   0. 239953   06500   06500   RESPI RATORY THERAPY   0. 239953   06500   06500   RESPI RATORY THERAPY   0. 262735   06600   06600   PHYSI CAL THERAPY   0. 262735   06500   06600   PHYSI CAL THERAPY   0. 224337   06600   06700   0CUENATI ONAL THERAPY   0. 273491   06700   0CUENATI ONAL THERAPY   0. 273491   06700   0CUENATI ONAL THERAPY   0. 273491   06800   SPEECH PATHOLOGY   0. 181306   08800   SPEECH PATHOLOGY   0. 181306   08800   SPEECH PATHOLOGY   0. 278104   08800   06800   SPEECH PATHOLOGY   0. 278104   08800   SPEECH PATHOLOGY   0. 000000   06900   ELECTROCARDI OLOGY   0. 000000   06900   ELECTROCARDI OLOGY   0. 000000   071. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 301243   07200   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 301243   07300   DRUGS CHARGED TO PATI ENTS   0. 339597   07200   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 339597   07400   RENAL DI ALYSI S   0. 000000   000000   00000   00000   00000   000000					
60. 00   06000   LABORATORY   0. 239953   60. 00   65. 00   66500   RESPI RATORY THERAPY   0. 349322   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 324437   66. 01   66. 01   66. 01   66. 01   67. 00   66. 01   67. 00   68. 00   68. 01   68. 00   68. 00   68. 01   68. 00   68. 01   68. 00   68. 01   68. 00   68. 01   68. 00   68. 01   68. 00   68. 01   68. 01   68. 01   68. 02   68. 02   FAC RESOURCE   4. 154311   68. 02   69. 00   6900   ELECTROCARDI OLOGY   0. 000000   69. 00					
65. 00					
66. 00 06600 PHYSI CAL THERAPY					
66. 01 06601 PHYSI CAL THERAPY - CARMEL 0. 324437 67.00 06700 0CCUPATI ONAL THERAPY 0. 273491 67.00 68.00 06800 SPEECH PATHOLOGY 0. 181306 68.00 68.00 10.00 06800 SPEECH PATHOLOGY 0. 181306 68.00 68.01 06801 VI SI ON 0. 278104 68.00 68.01 06801 VI SI ON 0. 278104 68.02 69.00 06900 ELECTROCARDI OLOGY 0. 000000 69.00 ELECTROCARDI OLOGY 0. 000000 69.00 ELECTROCARDI OLOGY 0. 000000 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 301243 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 301243 71.00 72.00 07300 DRUGS CHARGED TO PATI ENTS 0. 339597 73.00 07300 DRUGS CHARGED TO PATI ENTS 0. 339597 73.00 07400 RENAL DI ALYSI S 0. 000000 74.00 RENAL DI ALYSI S 0. 000000 74.00 RENAL DI ALYSI S 0. 000000 74.00 RENAL DI BALYSI S 0. 000000 99.00 DUTPATI ENT SERVI CE COST CENTERS 99.00 09000 CLI NI C 0. 222636 90.01 09001 SLEEP CENTER 0. 000000 99.01 EMERGENCY 0. 000000 99.00 DESERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 99.00 DESERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 99.00 DESERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 99.00 DESERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 99.10 09000 CMHC 99.10 09000 CMHC 99.10 CORF 99.10 09000 CMF 99.10 09000 CMF 99.10 09000 CMF 99.10 CORF 99.10 000000 00000 00000000 00000000000					
67. 00 06700 OCCUPATIONAL THERAPY 0. 273491 67. 00 06800 SPECH PATHOLOGY 0. 181306 68. 00 68. 01 06801 VI SI ON 0. 278104 68. 01 06801 VI SI ON 0. 278104 68. 02 06802 FAC RESOURCE 4. 154311 68. 02 06900 ELECTROCARDI OLOGY 0. 000000 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 301243 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 039597 72. 00 07400 RENAL DIALYSI S 0. 000000 74. 00 000000 00000 00000 00000 00000 00000					
68. 00					
68. 01					
68. 02					
69. 00		1 1			
71. 00					
72. 00		1 1			
73. 00					
74. 00   07400   RENAL DI ALYSI S   0.000000   74. 00   0   0   0   0   0   0   0   0   0		1 1			
OUTPATIENT SERVICE COST CENTERS   90.00   09000   CLINIC   0.222636   90.00   90.01   09001   SLEEP CENTER   0.000000   91.00   91.00   91.00   09100   EMERGENCY   0.000000   91.00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0.000000   92.00   07HER REIMBURSABLE COST CENTERS   99.00   09900   CMHC   99.10   09910   CORF   99.10   00910   00		1 1			
90. 00   09000   CLINIC   0. 222636   90. 00   90. 01   9001   SLEEP CENTER   0. 000000   91. 00   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0. 000000   92. 00   OP900   CORF   99. 10   09910   CORF   99. 10   00910   CORF   99. 10   CORF   99. 10		0. 000000			74.00
90. 01					
91. 00   09100   EMERGENCY   0.000000   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0.0000000   92. 00   OTHER REIMBURSABLE COST CENTERS   99. 00   09910   CORF   99. 10   200. 00   Subtotal (see instructions)   Less Observation Beds   201. 00   201. 00   CORF   200. 00   CORF   200		1			
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0.0000000   92.00   OTHER REIMBURSABLE COST CENTERS   99.00   09910   CORF   99.10   200.00   Subtotal (see instructions)   Less Observation Beds   201.00   201.00   CORF   200.00		1			
OTHER REIMBURSABLE COST CENTERS   99.00   09900   CMHC   99.10   09910   CORF   99.10   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00		1			
99. 00 99. 10 99. 10 99. 10 200. 00 201. 00 99. 00 99. 10 99. 10 99. 10 200. 00 201. 00 201. 00	· · · · · · · · · · · · · · · · · · ·	0. 000000			92. 00
99. 10   09910   CORF   99. 10   200. 00   201. 00   Less Observation Beds   99. 10   200. 00   201. 00					
200.00         Subtotal (see instructions)         200.00           201.00         Less Observation Beds         201.00					
201.00 Less Observation Beds 201.00					
202. 00   Total (see instructions)					
	202.00   Total (see instructions)				202.00

Health Financial Systems REHA	ABILITATION HOS	SPITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 01/01/2019 To 12/31/2019		pared: 3 am
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2.00	3. 00	4. 00	5. 00	

			- 11 (1	CAIA	1103pi tai	113	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	22, 210, 869		22, 210, 869	0	22, 210, 869	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0		0	0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	317, 733		317, 733	0	317, 733	54.00
60.00	06000 LABORATORY	401, 227		401, 227	0	401, 227	60.00
65.00	06500 RESPI RATORY THERAPY	1, 133, 978	0	1, 133, 978	0	1, 133, 978	65.00
66.00	06600 PHYSI CAL THERAPY	4, 933, 826	0	4, 933, 826	0	4, 933, 826	66.00
66. 01	06601 PHYSI CAL THERAPY - CARMEL	408, 653	0	408, 653	0	408, 653	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	4, 462, 811	0	4, 462, 811	0	4, 462, 811	67.00
68.00	06800 SPEECH PATHOLOGY	2, 022, 168	0	2, 022, 168	0	2, 022, 168	68.00
68. 01	06801 VI SI ON	374, 860	0	374, 860	0	374, 860	68. 01
68. 02	06802 FAC RESOURCE	2, 543, 099	0	2, 543, 099	0	2, 543, 099	68. 02
69.00	06900 ELECTROCARDI OLOGY	0		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	648, 238		648, 238	0	648, 238	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 598, 932		3, 598, 932	0	3, 598, 932	73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	591, 453		591, 453	0	591, 453	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	,					
99. 00	09900 CMHC	0		0		0	99.00
99. 10	09910 CORF	0		0		0	99. 10
200.00		43, 647, 847	0	43, 647, 847	0	43, 647, 847	
201.00	, ,	0		0			201.00
202.00		43, 647, 847	0	43, 647, 847	0		

Heal th	Financial Systems REHA	ABILITATION HOSE	PITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre	enared:
					10 12/31/2017	6/30/2020 7: 2	
			Ti tl	e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	40.000.000					
	03000 ADULTS & PEDI ATRI CS	42, 308, 992		42, 308, 99	2		30.00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM			Ι	0 000000	0.000000	
	05000 OPERATTING ROUM 05400 RADI OLOGY-DI AGNOSTI C	1 100 204	0	1 100 20	0. 000000 6 0. 288794	0. 000000 0. 000000	
	06000 LABORATORY	1, 100, 206	0	1, 100, 20		0. 000000	
	06500 RESPI RATORY THERAPY	1, 672, 108 3, 246, 223	0	1, 672, 10 3, 246, 22		0. 000000	
	06600 PHYSI CAL THERAPY	12, 095, 064	6, 683, 625			0. 000000	
	06601 PHYSI CAL THERAPY - CARMEL	12, 093, 004	1, 259, 575			0. 000000	
	06700 OCCUPATI ONAL THERAPY	12, 312, 889	4, 005, 071			0.000000	
	06800 SPEECH PATHOLOGY	9, 372, 343	1, 780, 980			0.000000	
	06801 VI SI 0N	703, 043	644, 870			0. 000000	
	06802 FAC RESOURCE	700,010	612, 159			0. 000000	
	06900 ELECTROCARDI OLOGY	0	012, 107	· ·	0. 000000	0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 072, 932	78, 942	2, 151, 87		0. 000000	•
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	_,,	0. 000000	0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	6, 228, 705	4, 368, 964	10, 597, 66		0.000000	
74. 00	07400 RENAL DIALYSIS	0	0		0. 000000	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS	,					1
90.00	09000 CLI NI C	471	2, 656, 117	2, 656, 58	0. 222636	0. 000000	90.00
90. 01	09001 SLEEP CENTER	0	0		0. 000000	0.000000	90. 01
91.00	09100 EMERGENCY	0	0		0. 000000	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0. 000000	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09900 CMHC	0	0		0		99.00
	09910 CORF	0	0		0		99. 10
200.00		91, 112, 976	22, 090, 303	113, 203, 27	9		200.00
201.00					_		201.00
202. 00	Total (see instructions)	91, 112, 976	22, 090, 303	113, 203, 27	9		202. 00

Health Financial Systems	REHABILITATION HOSPITAL OF INDIANA	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-3028	Peri od: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 6/30/2020 7:23 am
	T1.11 V1.V		550

			10 12/31/2019	6/30/2020 7: 2	23 am
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCILLARY SERVICE COST CENTERS					_
50.00   05000   OPERATING ROOM	0. 000000				50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 288794				54.00
60. 00   06000   LABORATORY	0. 239953				60.00
65. 00  06500 RESPI RATORY THERAPY	0. 349322				65. 00
66. 00  06600 PHYSI CAL THERAPY	0. 262735				66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0. 324437				66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0. 273491				67.00
68. 00   06800   SPEECH PATHOLOGY	0. 181306				68. 00
68. 01  06801  VI SI ON	0. 278104				68. 01
68. 02   06802   FAC   RESOURCE	4. 154311				68. 02
69. 00   06900   ELECTROCARDI OLOGY	0. 000000				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 301243				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 339597				73.00
74. 00 07400 RENAL DIALYSIS	0. 000000				74. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00   09000   CLI NI C	0. 222636				90.00
90. 01   09001   SLEEP CENTER	0. 000000				90. 01
91. 00   09100   EMERGENCY	0. 000000				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
99. 00   09900   CMHC					99.00
99. 10   09910   CORF					99. 10
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00   Total (see instructions)					202. 00

Health Financial Systems REHABILITATION FOALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2019 | Part I I | To | 12/31/2019 | Date/Time | Prepared: Provi der CCN: 15-3028

					10 12/31/2019	6/30/2020 7:2	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost		Capi tal	Operati ng	
		(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
		Part I, col.	Part II col.	Capital Cost		Reduction	
		26)	26)	(col. 1 -		Amount	
				col. 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	NCILLARY SERVICE COST CENTERS	T		T	-1		
	5000 OPERATING ROOM	0	0		0 0	0	00.00
	5400 RADI OLOGY-DI AGNOSTI C	317, 733	14, 061			0	0 00
	6000 LABORATORY	401, 227	8, 546			0	60.00
	6500 RESPI RATORY THERAPY	1, 133, 978	36, 238			0	65. 00
	6600 PHYSI CAL THERAPY	4, 933, 826	358, 762			0	66. 00
	6601 PHYSI CAL THERAPY - CARMEL	408, 653	1, 500			0	
	6700 OCCUPATI ONAL THERAPY	4, 462, 811	308, 857			0	07.00
	6800 SPEECH PATHOLOGY	2, 022, 168	50, 788			0	68. 00
	6801 VI SI ON	374, 860	1, 549			0	68. 01
	6802 FAC RESOURCE	2, 543, 099	24, 163	2, 518, 93	6 0	0	68. 02
	6900 ELECTROCARDI OLOGY	0	0		0	0	69.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	648, 238	10, 733	637, 50	5 0	0	1
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
	7300 DRUGS CHARGED TO PATIENTS	3, 598, 932	21, 361	3, 577, 57	1 0	0	73.00
	7400 RENAL DIALYSIS	0	0		0 0	0	74.00
	UTPATIENT SERVICE COST CENTERS						
	9000 CLI NI C	591, 453	74, 637	516, 81	6 0	ĭ	
	9001 SLEEP CENTER	0	0		0	0	
	9100 EMERGENCY	0	0		0	0	1 / 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	92.00
	THER REIMBURSABLE COST CENTERS	,					
	9900 CMHC	0	0		0 0	Ŭ	
4	9910 CORF	0	0		0 0	0	1 , , ,
200.00	Subtotal (sum of lines 50 thru 199)	21, 436, 978	911, 195	20, 525, 78	3 0		200.00
201.00	Less Observation Beds	0	0		0		201.00
202.00	Total (line 200 minus line 201)	21, 436, 978	911, 195	20, 525, 78	3  0	0	202. 00

Health Financial Systems REHABILITATION H
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICALD ONLY Provi der CCN: 15-3028

						6/30/2020 7:2	23 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to			
		Operati ng	Part I,	Charge Ratio			
		Cost	column 8)	(col. 6 /			
		Reducti on		col. 7)			
		6. 00	7. 00	8. 00			
	LLARY SERVICE COST CENTERS						
50.00 0500	OO OPERATING ROOM	0	0	0. 00000	00		50.00
54.00 0540	00 RADI OLOGY-DI AGNOSTI C	317, 733	1, 100, 206	0. 28879	94		54.00
60.00 0600	00 LABORATORY	401, 227	1, 672, 108	0. 23995	53		60.00
65.00 0650	00 RESPI RATORY THERAPY	1, 133, 978	3, 246, 223	0. 34932	22		65.00
66.00 0660	00 PHYSI CAL THERAPY	4, 933, 826	18, 778, 689	0. 26273	35		66.00
66. 01 0660	01 PHYSICAL THERAPY - CARMEL	408, 653	1, 259, 575	0. 32443	37		66. 01
67.00 0670	OO OCCUPATI ONAL THERAPY	4, 462, 811	16, 317, 960	0. 27349	91		67.00
68.00 0680	OO SPEECH PATHOLOGY	2, 022, 168	11, 153, 323	0. 18130	)6		68. 00
68. 01 0680	D1 VISION	374, 860	1, 347, 913	0. 27810	)4		68. 01
68. 02 0680	D2 FAC RESOURCE	2, 543, 099	612, 159	4. 15431	1		68. 02
69.00 0690	00 ELECTROCARDI OLOGY	0	0	0. 00000	00		69.00
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS	648, 238	2, 151, 874	0. 30124	13		71.00
72.00 0720	OO IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000	00		72.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	3, 598, 932	10, 597, 669	0. 33959	97		73.00
	DO RENAL DIALYSIS	0	0	0. 00000	00		74.00
OUTP	PATIENT SERVICE COST CENTERS	•					1
90.00 0900	DO CLINIC	591, 453	2, 656, 588	0. 22263	36		90.00
90. 01 0900	01 SLEEP CENTER	0	0	0. 00000	00		90. 01
91.00 0910	DO EMERGENCY	0	0	0. 00000	00		91.00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0. 00000	00		92.00
OTHE	R REIMBURSABLE COST CENTERS						1
99.00 0990	DO CMHC	0	0	0.00000	00		99. 00
99. 10 0991	O CORF	0	0	0. 00000	00		99. 10
200.00	Subtotal (sum of lines 50 thru 199)	21, 436, 978	70, 894, 287				200.00
201.00	Less Observation Beds	0	0				201.00
202.00	Total (line 200 minus line 201)	21, 436, 978	70, 894, 287				202.00
			•	-			-

Health Financial Systems REHA	ABILITATION HOS	PITAL OF INDIA	NA	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider Co	Provider CCN: 15-3028		Worksheet D Part I Date/Time Pre 6/30/2020 7:2		
		Title	: XVIII	Hospi tal	PPS		
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
	1. 00	2.00	3.00	4.00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	1, 159, 327	0	1, 159, 32	7 21, 061	55. 05	30.00	
200.00 Total (lines 30 through 199)	1, 159, 327		1, 159, 32 <sup>-</sup>	7 21, 061		200.00	
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6) 7.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	7, 119		1			30.00	
200.00 Total (lines 30 through 199)	7, 119	391, 901				200. 00	

lealth Financial Systems	REHABILITATION HOSPITAI	AL OF INDIANA	In Lieu	of Form CMS-2552-10

Health Financial Systems REH	ABILITATION HOS	SPITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2019 To 12/31/2019	6/30/2020 7:2	pared: 3 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col . 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		1	T	-1		
50. 00   05000   OPERATI NG ROOM	0	0	0.00000		0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	14, 061				•	
60. 00   06000   LABORATORY	8, 546			· ·	3, 284	
65. 00 06500 RESPI RATORY THERAPY	36, 238		1		16, 247	
66. 00 06600 PHYSI CAL THERAPY	358, 762				78, 830	
66. 01 06601 PHYSI CAL THERAPY - CARMEL	1, 500				0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	308, 857		1		•	
68. 00 06800 SPEECH PATHOLOGY	50, 788				14, 216	
68. 01   06801   VI SI ON	1, 549	,	l .		0	68. 01
68. 02   06802   FAC   RESOURCE	24, 163	612, 159			0	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000		0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 733	2, 151, 874		· ·	3, 932	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	21, 361	10, 597, 669			4, 729	
74. 00 07400 RENAL DIALYSIS	0	0	0.00000	0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	74, 637	2, 656, 588	1		0	90.00
90. 01  09001   SLEEP CENTER	0	0	0.00000		0	90. 01
91. 00   09100   EMERGENCY	0	0	0.00000		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0. 00000		0	
200.00   Total (lines 50 through 199)	911, 195	70, 894, 287	1	17, 360, 881	211, 214	200.00

Health Financial Systems REHABILITATION HOSPITAL OF INDIANA In Lieu of Form CMS-2552-							
APPORTI ONME	NT OF INPATIENT ROUTINE SERVICE OTHER P.	ASS THROUGH COS	STS Provider C		Peri od:	Worksheet D	
					From 01/01/2019 To 12/31/2019		epared:
						6/30/2020 7: 2	
	·			XVIII	Hospi tal	PPS	
	Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
		School	School	Post-Stepdown	Cost	Medi cal	
		Post-Stepdown		Adjustments		Educati on	
		Adjustments				Cost	
		1A	1. 00	2A	2. 00	3. 00	
	TENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	(	0	0	1 00.00
200.00	Total (lines 30 through 199)	0	0	(	0	0	200.00
	Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
		Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
		Amount (see	1 through 3,		col . 6)		
		instructions)	minus col. 4)				
		4. 00	5. 00	6. 00	7. 00	8. 00	
I NPAT	TIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	21, 06	0.00	7, 119	30.00
200.00	Total (lines 30 through 199)		0	21, 06°		7, 119	200.00
	Cost Center Description	Inpati ent					
	·	Program					
		Pass-Through					
		Cost (col. 7					
		x col. 8)					
		9. 00					
I NPAT	TIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0					30.00
200.00	Total (lines 30 through 199)	0					200.00
'		•	•				•

| Peri od: | Worksheet D | From 01/01/2019 | Part IV | To 12/31/2019 | Date/Time Prepared: THROUGH COSTS

				10 12/01/2017	6/30/2020 7: 2	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician		Nursi ng	Allied Health	Allied Health	
	Anestheti st	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	0	0		0	0	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60. 00   06000   LABORATORY	0	0		0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	65.00
66. 00   06600   PHYSI CAL THERAPY	0	0		0	0	66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	0		0	0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0		0	0	68. 00
68. 01  06801  VI SI ON	0	0		0	0	68. 01
68. 02   06802   FAC   RESOURCE	0	0		0	0	68. 02
69. 00   06900   ELECTROCARDI OLOGY	0	0		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72.00 07200 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 DIALYSIS	0	0		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0	0	90.00
90. 01   09001   SLEEP CENTER	0	0		0	0	90. 01
91. 00   09100   EMERGENCY	0	0		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00   Total (lines 50 through 199)	0	0		0 0	0	200. 00

| Peri od: | Worksheet D | From 01/01/2019 | Part IV | To 12/31/2019 | Date/Time Prepared: 
 Heal th Financial
 Systems
 REHABILITATION HOSPITAL OF INDIANA

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

				10 12/31/2019	6/30/2020 7:2	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	_	_	1	_		
50. 00   05000   OPERATI NG ROOM	0	0	9	0	0. 000000	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	9	1, 100, 206		1
60. 00   06000   LABORATORY	0	0	9	1, 672, 108		
65. 00 06500 RESPI RATORY THERAPY	0	0	9	3, 246, 223		1
66. 00 06600 PHYSI CAL THERAPY	0	0		18, 778, 689		
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	0		1, 259, 575		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1	16, 317, 960		
68. 00 06800 SPEECH PATHOLOGY	0	0	1	11, 153, 323		
68. 01   06801   VI SI ON	0	0	1	1, 347, 913		68. 01
68. 02   06802   FAC   RESOURCE	0	0		612, 159		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 151 074	0.000000	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		2, 151, 874	0.000000	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		10 507 740	0.000000	
73. 00   07300   DRUGS CHARGED TO PATIENTS 74. 00   07400   RENAL DIALYSIS	0	0		10, 597, 669		
OUTPATIENT SERVICE COST CENTERS	0	0	1	) 0	0. 000000	74.00
90. 00   09000   CLINIC			1	2, 656, 588	0. 000000	90.00
90. 00   09000   CETNIC 90. 01   09001   SLEEP CENTER			]	2, 000, 588	0.000000	
91. 00   09100  EMERGENCY	0		]		0.000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			]		0.000000	
200.00 Total (lines 50 through 199)			]	70, 894, 287		200.00
200.00   10tal (111163 30 till ough 177)	1	1	1	70,074,207	l	1200.00

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

From 01/01/2019 Part IV To 12/31/2019 Date/Time Prepared: THROUGH COSTS 6/30/2020 7:23 am Title XVIII Hospi tal PPS Cost Center Description Outpati ent I npati ent I npati ent Outpati ent Outpati ent Program Ratio of Cost Program Program Program to Charges Pass-Through Pass-Through Charges Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col . 12) x col. 10) 11.00 9. 00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0.000000 50.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 391, 893 0 0 54.00 06000 LABORATORY 0.000000 642, 464 0 o 0 60.00 60.00 06500 RESPIRATORY THERAPY 0.000000 1, 455, 421 0 65.00 65.00 0 0 06600 PHYSI CAL THERAPY 0.000000 66.00 4, 126, 131 2, 318 0 66.00 66.01 06601 PHYSI CAL THERAPY - CARMEL 0.000000 0 0 0 66.01 67.00 06700 OCCUPATI ONAL THERAPY 0. 000000 4, 489, 259 0 67.00 06800 SPEECH PATHOLOGY 3, 121, 593 0.000000 0 68.00 0 0 68.00 06801 VI SI ON 68.01 0.000000 0 0 68.01 68.02 06802 FAC RESOURCE 0.000000 68.02 06900 ELECTROCARDI OLOGY 0 69.00 0.000000 0 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0.000000 788, 201 17, 239 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 73.00 73.00 2, 345, 919 1, 854, 079 07400 RENAL DI ALYSI S 0 74.00 0.000000 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 000000 730, 090 0 90.00 0 0 0 0 90. 01 09001 SLEEP CENTER 0.000000 0 0 90.01 0 91. 00 09100 EMERGENCY 91.00 0.000000 0 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 92.00 Total (lines 50 through 199) 0 200.00 200.00 17, 360, 881 2, 603, 726

Health Financial Systems REHA	ABILITATION HOS	SPITAL OF INDIA	.NA	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provi der C		Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 6/30/2020 7:2	
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Reimbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Servi ces Not		
	Worksheet C,	inst.)	Subject To	Subj ect To		
	Part I, col.		Ded. & Coins.			
	9		(see inst.)	(see inst.)		
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000			0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 288794			0	0	
60. 00   06000   LABORATORY	0. 239953			0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 349322			0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 262735			0	609	
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0. 324437	0		0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 273491	0		0	0	1 07.00
68. 00  06800 SPEECH PATHOLOGY	0. 181306			0	0	1 00.00
68. 01   06801   VI SI ON	0. 278104	0		0	0	68. 01
68. 02   06802   FAC RESOURCE	4. 154311	0		0	0	68. 02
69. 00  06900 ELECTROCARDI OLOGY	0. 000000			0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 301243			0	5, 193	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	1 /2:00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 339597	1, 854, 079		0	629, 640	73.00
74. 00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	0. 222636			0	162, 544	
90. 01   09001   SLEEP CENTER	0. 000000			0	0	,
91. 00  09100 EMERGENCY	0. 000000	0		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	0	1
200.00 Subtotal (see instructions)		2, 603, 726		0	797, 986	200.00
201.00 Less PBP Clinic Lab. Services-Program				0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		2, 603, 726		0	797, 986	202.00

| Period: | Worksheet D | From 01/01/2019 | Part V | To | 12/31/2019 | Date/Time Prepared: 
 Heal th Financial
 Systems
 REHABILITATION HOS

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Provider CCN: 15-3028

				To 12/31/2019	Date/Time Prepa   6/30/2020 7:23	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOLILIADIV OFRIU OF COOT OFFITERS	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS	1					F0 00
50. 00 05000 OPERATING ROOM	0	0	<u> </u>		ı	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	2			54.00
60. 00 06000 LABORATORY	0	0	<u>'</u>			60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	<u>'</u>			65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	<u>'</u>			66.00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0	0	<u>'</u>			66. 01 67. 00
67. 00   06700   OCCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	0	0			I	67.00 68.00
68. 00   06800  SPEECH PATHOLOGY 68. 01   06801  VI SI ON	0	0			I	68. 00 68. 01
68. 02   06802   FAC   RESOURCE	0	0			I	68. 01 68. 02
69. 00   06900  ELECTROCARDI OLOGY		0			I	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS						71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0					73.00
74. 00   07400   RENAL DI ALYSI S	0	0				74.00
OUTPATIENT SERVICE COST CENTERS			′1			74.00
90. 00 09000 CLI NI C	0	0				90. 00
90. 01   09001   SLEEP CENTER	0	l o				90. 01
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0			20	00.00
201.00 Less PBP Clinic Lab. Services-Program	0				20	01.00
Only Charges						
202.00   Net Charges (line 200 - line 201)	0	0	)		20	02.00

Health Financial Systems REHA	REHABILITATION HOSPITAL OF INDIANA In Lieu of Form C				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od: From 01/01/2019	Worksheet D Part I	
				To 12/31/2019	Date/Time Pre 6/30/2020 7:2	pared: 3 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col . 2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 159, 327	0	1, 159, 32	7 21, 061	55. 05	30.00
200.00 Total (lines 30 through 199)	1, 159, 327		1, 159, 32	7 21, 061		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	850	46, 793				30.00
200.00 Total (lines 30 through 199)	850	46, 793				200. 00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Dravi dan CC				
		Provider CC		Period: From 01/01/2019	Worksheet D Part II	
				To 12/31/2019	Date/Time Pre 6/30/2020 7:2	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description Capital	T	otal Charges	Ratio of Cost	Inpati ent	Capital Costs	
Related C		(from Wkst.	to Charges	Program	(column 3 x	
(from Wks		C, Part I,	(col. 1 ÷	Charges	column 4)	
B, Part I		col. 8)	col. 2)			
<u>col. 26</u>	)					
1.00		2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	0	0	0. 00000		0	50.00
	, 061	1, 100, 206	0. 01278		144	54.00
	, 546	1, 672, 108	0. 00511	•	145	60.00
	, 238	3, 246, 223	0. 01116		785	65.00
	, 762	18, 778, 689	0. 01910	•	4, 341	66. 00
	, 500	1, 259, 575	0. 00119		0	66. 01
	, 857	16, 317, 960	0. 01892		4, 005	67.00
	, 788	11, 153, 323	0. 00455		747	68. 00
	, 549	1, 347, 913			14	68. 01
	, 163	612, 159	0. 03947	2 0	0	68. 02
69. 00   06900   ELECTROCARDI OLOGY	0	0	0.00000		0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 10	, 733	2, 151, 874	0. 00498	36, 303	181	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000		0	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 21,	, 361	10, 597, 669	0.00201	6 107, 241	216	73.00
74.00 07400 RENAL DIALYSIS	0	0	0.00000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C 74	, 637	2, 656, 588	0. 02809	5 0	0	90.00
90. 01   09001   SLEEP CENTER	0	0	0.00000	0	0	90. 01
91. 00   09100   EMERGENCY	0	0	0.00000	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.00000	0 0	0	92.00
200.00 Total (lines 50 through 199) 911	, 195	70, 894, 287		868, 675	10, 578	200. 00

Health Finar	icial Systems REF	HABILITATION HOS	PITAL OF INDIA	INA	In Lie	u of Form CMS-	2552-10
APPORTI ONMEI	NT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COS	TS Provider C		Period: From 01/01/2019 To 12/31/2019		epared: 23 am
				e XIX	Hospi tal	PPS	
	Cost Center Description	Nursi ng School Post-Stepdown	Nursi ng School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education	
		Adjustments				Cost	
		1A	1. 00	2A	2. 00	3. 00	
	IENT ROUTINE SERVICE COST CENTERS				_		
30. 00 03000 200. 00	ADULTS & PEDIATRICS Total (lines 30 through 199)	0	0		0 0 0	0	30. 00 200. 00
	Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
		4. 00	5. 00	6.00	7. 00	8. 00	
I NPAT	IENT ROUTINE SERVICE COST CENTERS			•	•		
30. 00 03000 200. 00	ADULTS & PEDIATRICS Total (lines 30 through 199)	0	0	21, 06 21, 06		850 850	30. 00 200. 00
	Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
	ADULTS & PEDIATRICS Total (lines 30 through 199)	0 0	ŀ				30. 00 200. 00

| Peri od: | Worksheet D | From 01/01/2019 | Part IV | To 12/31/2019 | Date/Time Prepared: THROUGH COSTS

				10 12/31/2017	6/30/2020 7: 2	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	0	0		0	0	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60. 00   06000   LABORATORY	0	0		0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66. 00   06600   PHYSI CAL THERAPY	0	0		0	0	66.00
66. 01   06601 PHYSI CAL THERAPY - CARMEL	0	0		0	0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68.00
68. 01   06801   VI SI ON	0	0		0	0	68. 01
68. 02   06802   FAC   RESOURCE	0	0		0	0	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS			T			
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

| Peri od: | Worksheet D | From 01/01/2019 | Part IV | To 12/31/2019 | Date/Time Prepared: 
 Heal th Financial
 Systems
 REHABILITATION HOSPITAL OF INDIANA

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

			'	0 12/31/2017	6/30/2020 7: 2	
			e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and		C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
				7.00	instructions)	
ANOLILIADIA OFFICIA OF COOT OFFITEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS			1	1	0.000000	F0 00
50. 00   05000   OPERATING ROOM	0	0		1 100 000	0. 000000	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		1, 100, 206	0. 000000	
60. 00   06000   LABORATORY	0	0		1, 672, 108		
65. 00 06500 RESPIRATORY THERAPY	0	0		3, 246, 223		
66. 00 06600 PHYSI CAL THERAPY	0	0		18, 778, 689		66.00
66. 01   06601 PHYSI CAL THERAPY - CARMEL	0	0		1, 259, 575		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		16, 317, 960		
68. 00 06800 SPEECH PATHOLOGY	0	0		11, 153, 323		
68. 01   06801   VI SI ON	0	0		1, 347, 913		
68. 02   06802   FAC   RESOURCE	0	0		612, 159		68. 02
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 151 074	0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		2, 151, 874		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		10 507 ((0	0. 000000	
73. 00   07300   DRUGS CHARGED TO PATIENTS 74. 00   07400   RENAL DIALYSIS	0	0		10, 597, 669	0.000000	
74. 00 O7400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	U	0		U	0. 000000	74.00
90. 00   09000   CLINIC	0			2, 656, 588	0.000000	90.00
90. 01   09001   SLEEP CENTER	0	0		2, 000, 000	0.000000	
91. 00   09100  EMERGENCY	0			0	0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0.000000	
200.00 Total (lines 50 through 199)	0			70, 894, 287		200.00
200.00   10tal (111163 30 till ough 177)	0	1	1	10,094,201		200.00

Health Financial Systems REHABILITATION HOSPITAL OF INDIANA
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-3028 | Peri od: | Worksheet D | From 01/01/2019 | Part IV | To | 12/31/2019 | Date/Time | Prepared: | THROUGH COSTS

					6/30/2020 7:2	3 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000 OPERATING ROOM	0. 000000	0		0	0	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	11, 300		0	0	54.00
60. 00  06000   LABORATORY	0. 000000	28, 390		0	0	60.00
65. 00  06500   RESPI RATORY THERAPY	0. 000000	70, 322		0	0	65.00
66. 00  06600 PHYSI CAL THERAPY	0. 000000	227, 242		0	0	66. 00
66. 01 06601 PHYSI CAL THERAPY - CARMEL	0. 000000	0		0	0	66. 01
67. 00  06700 OCCUPATI ONAL THERAPY	0. 000000	211, 622		0	0	67.00
68. 00   06800   SPEECH PATHOLOGY	0. 000000	164, 083		0	0	68. 00
68. 01  06801  VI SI ON	0. 000000	12, 172		0	0	68. 01
68. 02   06802   FAC   RESOURCE	0. 000000	0		0	0	68. 02
69. 00  06900   ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	36, 303		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	107, 241		0	0	73.00
74. 00 07400 RENAL DIALYSIS	0. 000000	0		0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	0. 000000	0		0	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)		868, 675		0	0	200. 00

Health Financial Systems REHA	ABILITATION HOS	SPITAL OF INDIA	NA	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provi der C		Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 6/30/2020 7:2	epared: 23 am
		Ti tl	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Reimbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subj ect To		
	Part I, col.		Ded. & Coins.			
	9		(see inst.)	(see inst.)		
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	0. 000000	<b>I</b>		0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 288794			0	0	
60. 00   06000   LABORATORY	0. 239953	0		0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 349322	. 0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 262735	0	188, 21	1 0	0	66.00
66.01 06601 PHYSI CAL THERAPY - CARMEL	0. 324437		73		0	66. 01
67. 00  06700 OCCUPATI ONAL THERAPY	0. 273491	0	129, 95	7 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 181306	0	54, 29	0 0	0	68. 00
68. 01   06801   VI SI ON	0. 278104	. 0	36, 38	4 0	0	68. 01
68. 02   06802   FAC   RESOURCE	4. 154311	0		0 0	0	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 301243	0	3, 69	1 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 339597	0	385, 48	6 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 222636	0	126, 50	2 0	0	90.00
90. 01   09001   SLEEP CENTER	0. 000000	0		0	0	90. 01
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Subtotal (see instructions)		0	925, 25	2 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0		201.00
Only Charges 202.00 Net Charges (line 200 - line 201)		0	925, 25	2 0	0	202. 00

Health Financial Systems REHABILITATION HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-3028 Peri od: Worksheet D From 01/01/2019 To 12/31/2019 Part V Date/Time Prepared: 6/30/2020 7:23 am Titl<u>e XIX</u> 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.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 54.00 06000 LABORATORY 0 0 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 49, 450 66.00 06601 PHYSI CAL THERAPY - CARMEL 0 66.01 237 66.01 06700 OCCUPATI ONAL THERAPY 0 67.00 35, 542 67.00 68.00 06800 SPEECH PATHOLOGY 9, 843 68.00 0 68.01 06801 VI SI ON 10, 119 68.01 06802 FAC RESOURCE 0 68.02 68.02 0 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 1, 112 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 72 00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 130, 910 0 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 0 90.00 09000 CLI NI C 28, 164 09001 SLEEP CENTER 90.01 0 90.01

0

0

265, 377

265, 377

0

0

0

0

91.00

92.00

200.00

201.00

202.00

91.00

200.00

201.00

202.00

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)

Health Financial Systems	REHABILITATION HOSPITAL OF INDIANA	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-3028	Peri od: From 01/01/2019	Worksheet D-1	
		To 12/31/2019	Date/Time Pre 6/30/2020 7:2	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				

		Title XVIII	Hospi tal	PPS	
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			21, 061	1.00
2. 00 3. 00	Private room days (excluding swing-bed and observation bed da		rivate room days	21, 061 0	2.00
3.00	do not complete this line.	ys). If you have only pr	Tvate room days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation b			21, 061	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December	21 of the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	oni days) arter becember	31 Of the cost	U	0.00
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7.00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December 3	of the cost	0	8.00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	7, 119	9.00
	newborn days) (see instructions)	3 (4 4 4 5	,	•	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		nom dave) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, e		dom days) arter	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.00
14. 00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	davs)	0	14.00
15. 00	Total nursery days (title V or XIX only)	, 3	,	0	15.00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 c	of the cost	0.00	   17. 00
17.00	reporting period	es till odgir beceilber 31 c	i the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18.00
10.00	reporting period	- thursuph December 21 -f		0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through becember 31 of	the cost	0.00	19. 00
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20.00
04 00	reporting period	`		00 040 040	
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing period (line	22, 210, 869 0	21.00
22.00	5 x line 17)	cr 31 or the cost report	ing period (ind	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23. 00
24.00	x line 18)	- 21 -£ +b++!	(1:	0	24.00
24. 00	Swing-bed cost applicable to NF type services through Decembe $7 \times 1$ ine 19)	1 31 01 the cost reporti	ng period (iine	0	24.00
25. 00	/	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(Line 21 minus line 24)		0 22, 210, 869	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TITIE 21 IIIITIUS TITIE 20)		22, 210, 609	27.00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28.00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)	1: 20)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ 11ne 28)		0. 000000 0. 00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0. 00	
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35)	and private room cost di	fforontial (lim	22 210 960	36.00 37.00
37.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost dr	rielential (IIIIe	22, 210, 869	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				]
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38.00	Adjusted general inpatient routine service cost per diem (see			1, 054. 60	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			7, 507, 697 0	1
	Total Program general inpatient routine service cost (line 39			7, 507, 697	
		•	1	•	

	Financial Systems REH. ATION OF INPATIENT OPERATING COST	ABILITATION HOS		CN: 15-3028	Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	nare
						6/30/2020 7: 2	
	Cost Center Description	Total	Ti tlo	Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription	Inpatient	Inpatient	Di em (col		(col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	2					42
. 00	INTENSIVE CARE UNIT	,					43
. 00	CORONARY CARE UNIT					I	44
. 00	BURN INTENSIVE CARE UNIT					I	45
	SURGICAL INTENSIVE CARE UNIT					1	46
. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47
	·					1. 00	
. 00	Program inpatient ancillary service cost (WI			222)		4, 687, 670	
. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)	(see Instructi	ons)		12, 195, 367	49
. 00	Pass through costs applicable to Program in	patient routine	services (fro	m Wkst. D, su	m of Parts I and	391, 901	50
00	Dage through costs applicable to Dragger in	notiont!!!	m	From Wisc+ D	oum of Dects !!	211 211	
. 00	Pass through costs applicable to Program inpland IV)	vatient ancillai	y services (f	ιυπ WKST. D,	Sum or Parts II	211, 214	51
. 00	Total Program excludable cost (sum of lines	50 and 51)				603, 115	52
. 00	Total Program inpatient operating cost exclu	uding capital re	elated, non-ph	ysician anest	hetist, and	11, 592, 252	
	medical education costs (line 49 minus line	52)					-
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					n	54
. 00						0.00	
. 00	Target amount (line 54 x line 55)					0	
. 00	Difference between adjusted inpatient opera	ting cost and ta	arget amount (	line 56 minus	line 53)	0	
. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	operting period	onding 1006	undated and c	compounded by the	0.00	
. 00	market basket	eportring perrou	enuring 1990,	upuateu anu c	onpounded by the	0.00	1 3
. 00	Lesser of lines 53/54 or 55 from prior year					0. 00	60
. 00	If line 53/54 is less than the lower of line					0	6
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		ts (lines 54 x	(60), or 1% c	of the target	l	
2. 00		riisti deti olis)				0	62
. 00	Allowable Inpatient cost plus incentive payr	ment (see instru	uctions)			0	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ets through Dec	amber 31 of th	e cost report	ing pariod (See	0	64
. 00	instructions)(title XVIII only)	sts through beck	siliber 31 of th	le cost report	ing perrou (see	l	1
. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	oer 31 of the	cost reportir	g period (See	0	65
00	instructions) (title XVIII only)	ina aasta (lina	(4 plus lins	(E) (+; +1 o V)/I	II only) For		
. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	The Costs (Title	64 prus rine	os)(ti ti e xvi	ii oniy). For	l	66
. 00	Title V or XIX swing-bed NF inpatient routing	ne costs through	n December 31	of the cost r	eporting period	0	67
	(line 12 x line 19)						
. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	ne costs after l	December 31 of	the cost rep	porting period	0	68
. 00	Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 + lir	e 68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER N	NURSING FACILITY	, AND ICF/IID	ONLY			
00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service				)	I	70
. 00	Program routine service cost (line 9 x line	,	THE /U ÷ IIN6	: <i>∠)</i>		I	71
. 00	Medically necessary private room cost applic		m (line 14 x l	ine 35)		I	73
. 00	Total Program general inpatient routine serv					I	74
. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	Worksheet B,	Part II, column	I	75
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)				1	76
. 00	Program capital-related costs (line 9 x line					I	77
. 00	Inpatient routine service cost (line 74 minu			1.3		I	78
00	Aggregate charges to beneficiaries for excess Total Program routine service costs for comp				nus lina 70)	I	80
00	Inpatient routine service costs for comp		Jose millitatio	(11116 70 IIII	1103 11110 /7)	1	8
	Inpatient routine service cost limitation (		1)			I	82
00	Reasonable inpatient routine service costs	•	ns)			I	83
00	Program inpatient ancillary services (see in		>			I	84
. 00	Utilization review - physician compensation Total Program inpatient operating costs (sur					I	88
. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS		n ough 65)				1 00
						0	87
. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per					0. 00	

Health Financial Systems REH	ABILITATION HOS	PITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od: From 01/01/2019	Worksheet D-1	
				To 12/31/2019		pared: 3 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 159, 327	22, 210, 869	0. 05219	6 0	0	90.00
91.00 Nursing School cost	0	22, 210, 869	0.00000	0 0	0	91.00
92.00 Allied health cost	0	22, 210, 869	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	22, 210, 869	0. 00000	0 0	0	93.00

Health Financial Systems	REHABILITATION HOSPITAL OF INDIANA	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-3028	Peri od: From 01/01/2019	Worksheet D-1	
		To 12/31/2019	Date/Time Pre 6/30/2020 7:2	
	Ti tle XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
I NPATI ENT DAYS				
1.00 Inpatient days (including private room	days and swing-bed days, excluding newborn)		21, 061	1.00

PART 1 - ALL PROVIDER COMPONENTS		Title XIX Hospital	PPS	
RPART IT - ALL PROVIDER COMPONENTS		Cost Center Description	1. 00	
1.00 Inpatient days (Including private room days and Swing-bed days. excluding newborn) 21,061 22,00   Inpatient days (Including private room days. excluding swing-bed and exeborn days) 21,061 22,00   21,061 23,00   21,061 23,00   21,061 23,00   21,061 23,00   21,061 24,00		PART I - ALL PROVIDER COMPONENTS		
Inipatient days (including private room days, excluding saling-bed and newborn days)   21,061   2.0   3.0   4.0   5.5				
A 200 private room days (excluding swing-bed and observation bed days). If you have only private room days. do not complete this line.  4.00 Semi-private room days (excluding swing-bed and observation bed days). Through December 31 of the cost room days (excluding swing-bed SW type inpattent days (including private room days) after December 31 of the cost reporting period (if cale dard year, enter 0 on this line).  7.00 Total swing-bed SW type inpattent days (including private room days) after December 31 of the cost reporting period (if cale dard year, enter 0 on this line).  7.01 Total swing-bed NF type inpattent days (including private room days) after December 31 of the cost reporting period (if cale dard year, enter 0 on this line).  8.00 Total swing-bed NF type inpattent days (including private room days) after December 31 of the cost reporting period (if cale dard year, enter 0 on this line).  8.01 Total swing-bed NF type inpattent days (including private room days) after December 31 of the cost reporting period (including private room days).  8.01 Swing-bed SWF type inpattent days applicable to title XWII only (including private room days) after December 31 of the cost reporting period (including private room days).  8.02 Swing-bed SWF type inpattent days applicable to title XWII only (including private room days) after December 31 of the cost reporting period (including private room days).  8.02 Swing-bed SWF type inpattent days applicable to title XWII only (including private room days).  8.03 Swing-bed SWF type inpattent days applicable to title XWII only (including private room days).  8.04 Swing-bed SWF type inpattent days applicable to title XWII only (including private room days).  8.05 Swing-bed SWF type inpattent days applicable to services after December 31 of the cost reporting period (including private room days).  8.06 Swing-bed NWF type inpattent days applicable to services after December 31 of the cost reporting period (including type type type type type type type type			· ·	1.00
2.00   Somi-perivate room days (excluding swing-bed and observation bed days)   1.00		Private room days (excluding swing-bed and observation bed days). If you have only private room days,		3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost or sporting 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 or sporting period (including private room days) after December 31 of the cost or sporting period (including private room days) after December 31 of the cost or sporting period (including private room days) after December 31 of the cost or sporting period (including private room days) after December 31 of the cost reporting period (see instructions) (see in		Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost		4. 00 5. 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of Poporting period of Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost of Poporting period (if calendar year, enter 0 on this line) on the Impatient days including private room days applicable to the Program (excluding swing-bed and Poporting P	6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  8. Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  8. Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  8. Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after sylve inpatient days applicable to title XVIII only (including private room days)  8. Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)  8. Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  8. Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  8. Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  8. Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  8. Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  8. Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  8. Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  8. Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  8. Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  8. Swing-bed NF type inpatient days applicable to services after December 31 of the cost reporting period (including private room days applicable to services after December 31 of the cost reporting period (including private room days applicable to Swing-bed cost applicable to Swing-bed Swing-bed Swing-bed Swing-bed Swing-bed Award Swing-bed Swing-b	7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
1.00   Swing-bed NF type inpatient days applicable to the Program (excluding private room days)   0   0   0   0   0   0   0   0   0	8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
through December' 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.10 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.11 ON Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.12 ON Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  1.12 ON Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  1.13 ON Swing-y days (title V or XIX only)  1.14 ON Swing-y days (title V or XIX only)  1.15 ON Swing-y days (title V or XIX only)  1.16 ON Indicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  1.17 ON Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  1.18 ON Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  1.19 ON Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  2.10 ON Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line of the cost reporting period (line of the cost reporting period (line of the cost applicable to SNF type services through December 31 of the cost reporting period (line of the cost applicable to SNF type services through December 31 of the cost reporting period (line of the cost applicable to SNF type services through December 31 of the cost reporting period (line of the cost applicable to SNF type services after December 31 of the cost reporting period (line of the cost applicable to SNF type services after December 31 of the cost reportin	9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	850	9.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medical ly necessary private room days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line of the		through December 31 of the cost reporting period (see instructions)	-	
through December 31 of the cost reporting period  13.00 SW ing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.0 15.00 Total nursery days (title V or XIX only) 0 15.00 Total nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 16.00 Nursery days (title V or XIX only) 0 17.00 Nursery days (title V or XIX only) 0 18.00 Nursery days (title V or XIX only) 0 18.00 Nursery days (title V or XIX only) 0 19.00 Nursery days (title Vor XIX only) 0 19.00 Nursery		December 31 of the cost reporting period (if calendar year, enter 0 on this line)	-	
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  1.10 Total nursery days (it lie V or XIX only)  1.10 Total nursery days (it lie V or XIX only)  1.10 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  1.11 Collect dare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  1.12 Collect dare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  1.13 Collect dare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  1.14 Collect dare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line service)  1.15 Collect dare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line service)  1.16 Collect dare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line service)  1.16 Collect dare rate for swing-bed NF services through December 31 of the cost reporting period (line service)  1.17 Collect dare rate for swing-bed NF type services after December 31 of the cost reporting period (line service)  1.18 Collect dare rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line service)  1.19 Collect dare rate for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line service)  1.10 Collect dare rate for swing-bed cost (see instructions)  1.10 Collect dare rate for swing-bed cost (see instructions)  1.10 Collect dare rate for swing-bed cost (see instructions)  1.10 Collect dare rate for swing-bed cost (see instructions)  1.10 Collect dare rate for swing-bed cost (see instructions)  1.10 Collect dare rate for swing-bed charges)  1.10 Collect		through December 31 of the cost reporting period	_	
15.00   Total nursery days (title V or XIX only)		after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
SWING BED ADJUSTMENT			_	
reporting period  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  December 31 of the cost reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  Total general inpatient routine service cost (see instructions)  Total general inpatient routine service safter December 31 of the cost reporting period (line 5 x line 17)  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 18)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 18)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 30)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 30)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting beriod (line 20 x line 30)  Swi	16. 00	3 3 \ 27	0	16. 00
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22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)   23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 0 x line 18)   24.00   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 x line 19)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   26.00   Total swing-bed cost (see instructions)   0 26.0   27.00   General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   22, 210, 869   27.00   PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   28.00   28.00   Osemi-private room charges (excluding swing-bed charges)   0 28.0   29.00   Semi-private room charges (excluding swing-bed charges)   0 29.0   31.00   General inpatient routine service cost/charge ratio (line 27 ÷ line 28)   0 0.000001   32.00   Average private room per diem charge (line 29 ÷ line 3)   0 0.000001   33.00   Average per diem private room cost differential (line 30 * line 4)   0 0.00   34.00   Average per diem private room cost differential (line 32 minus line 33) (see instructions)   0 0.00   35.00   Average per diem private room cost differential (line 3 x line 35)   0 36.00   37.00   Private room cost differential adjustment (line 3 x line 35)   0 36.00   37.00   Private room cost differential adjustment (line 3 x line 35)   0 36.00   38.00   Adjusted general inpatient routine service cost net of swing-bed cost and private room cost differential (line 22, 210, 869   38.00   Adjusted general inpatient routine service cost per diem (see instructions)   1,054,60   38.00   Adjusted general inpatient routine service cost per diem (see instructions)   1,054,60   38.00   Program general inpatient routine service cost per diem (see instructions)   1,054,60   38.00   Program general inpatient routine service cost per diem (see instructions)   1,054,60   38.00   Program general inpatient rout		reporting period		
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x line 20)  26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 28) Ceneral inpatient routine service cost/charge (line 30 ÷ line 4) Ceneral inpatient routine service cost (line 30 ÷ line 4) Ceneral inpatient routine service cost (line 30 ÷ line 31) Ceneral inpatient routine service cost (line 34 x line 31) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 22, 210, 869) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 22, 210, 869) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 22, 210, 869) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine serv	24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
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34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 22, 210, 869)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 22, 210, 869)  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 instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 35.00 0 35.00 0 35.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 22, 210, 869 27 minus line 36)  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 instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00 36.00 36.00 36.00 36.00 36.00 36.00 37.00				
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 22, 210, 869 27 minus line 36)  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 instructions)  Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37. 0  22, 210, 869 37. 0  37. 0  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 054. 60 38. 0  896, 410 39. 0  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			0.00	
27 minus line 36) 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 instructions)  1,054.60 39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			22, 210, 869	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,054.60 39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		27 minus line 36)	,	
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,054.60 38.0  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1,054.60 38.0  896,410 39.0  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				-
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 896, 410 39.00 40.00 40.00	38 00		1 054 60	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				1
		, , ,		40.00

	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	850	9. 00
	newborn days) (see instructions)		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
44.00	through December 31 of the cost reporting period (see instructions)		44 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12.00	through December 31 of the cost reporting period	٥	12.00
13. 00	1 31	0	13.00
10.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	Ĭ	10.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17.00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
	reporting period		
19. 00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19.00
20.00	reporting period	0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	22, 210, 869	21 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22.00
22.00	5 x Line 17)	١	22.00
23. 00		0	23. 00
	x line 18)	-	
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0	
27. 00	y ,	22, 210, 869	27.00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		00.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)	0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00			32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		33.00
34. 00			34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)		35.00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	22, 210, 869	
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	1, 054. 60	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	896, 410	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	896, 410	41.00

Health Financial Systems REHABILITATION HO COMPUTATION OF INPATIENT OPERATING COST			PITAL OF INDIANA Provi der CCN: 15-3028		worksheet D-1  Date/Time Prepare		
			Ti +	le XIX	Hospi tal	6/30/2020 7: 2 PPS	:3 am
Cost Cer	ter Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	e V & XIX only)						42.
. 00 INTENSIVE CAR	e Type Inpatient Hospital Units FINIT						43.
. 00 CORONARY CARE						I	44.
.00 BURN INTENSIV						1	45.
N	NSIVE CARE UNIT					l	46.
. 00 OTHER SPECIAL	ter Description						47.
0031 061	iter bescription					1. 00	
	ient ancillary service cost (Wk					232, 710	48.
	inpatient costs (sum of lines	41 through 48)	(see instructi	ons)		1, 129, 120	49.
	COST ADJUSTMENTS costs applicable to Program inp	ationt routino	convices (fr	om Wkst D si	ım of Dorte I one	46, 793	50.
III)	costs applicable to Program The	atrent routine	Services (III	JIII WKSt. D, St	IIII OI PALLS I AIIC	40, 793	30.
	costs applicable to Program inp	atient ancilla	ry services (1	from Wkst. D,	sum of Parts II	10, 578	51.
and IV)			·			_	
	excludable cost (sum of lines					57, 371	1
	inpatient operating cost exclution costs (line 49 minus line		erateu, non-pr	iysi ci an anesi	netist, and	1, 071, 749	53.
	AND LIMIT COMPUTATION	02)					1
.00 Program disch						0	
	per di scharge					0.00	
	(line 54 x line 55) tween adjusted inpatient operat	ing cost and t	arget amount	(line 56 minus	: line 53)	0	
		ring cost and t	arget amount	(TTTIC 50 IIITTIGS	3 11110 33)	Ö	1
market basket							
	es 53/54 or 55 from prior year is less than the lower of line					0.00	1
	ng costs (line 53) are less tha					l	01.
amount (line	56), otherwise enter zero (see		`	, ,	3	l	
	atient cost plus incentive paym ENT ROUTINE SWING BED COST	ent (see instr	uctions)			0	63.
	g-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	ne cost report	ing period (See	0	64.
	(title XVIII only)	-		·		I	
	g-bed SNF inpatient routine cos	ts after Decem	ber 31 of the	cost reportir	ng period (See	0	65.
. 00 Total Medicar	(title XVIII only) e swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only) For	0	66.
CAH (see inst			0. p. do	00) (1. 1. 0 /1.			
	X swing-bed NF inpatient routin	e costs throug	h December 31	of the cost r	reporting period	0	67.
(line 12 x li 1.00 Title V or XI	ne 19) X swing-bed NF inpatient routin	o costs after	Docombor 21 of	f the cost rer	porting ported	0	68.
(line 13 x li		le costs arter	becember 31 of	the cost rep	of tring perrou	l	00.
	or XIX swing-bed NF inpatient					0	69.
	LLED NURSING FACILITY, OTHER N				7)		
	ng facility/other nursing facil ral inpatient routine service o				')	I	70.
, ,	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71)					I	72.
.00 Medically nec	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.
	general inpatient routine serv	•		*	Don't II	1	74.
.00 Capital-relat 26, line 45)	ed cost allocated to inpatient	ioutine servic	e costs (from	worksneet B,	Part II, Column	I	75.
1	tal-related costs (line 75 ÷ li	ne 2)				1	76.
.00 Program capit	al-related costs (line 9 x line	76)				1	77.
	tine service cost (line 74 minu		provi dos	cdc)		1	78
00 0	rges to beneficiaries for exces routine service costs for comp	•	•	*.	nus line 79)	I	79   80
,	tine service costs for comp		SSSC TIME CALL	S (11110 70 IIII		I	81
.00 Inpatient rou	tine service cost limitation (I		1)			I	82
	patient routine service costs (		ns)			1	83
	ient ancillary services (see in eview - physician compensation		ons)			I	84
	inpatient operating costs (sum					I	86.
	PUTATION OF OBSERVATION BED PAS						
.00 Total observa	tion bed days (see instructions	5)				0	
.00 Adjusted gene	ral inpatient routine cost per	diem (line 27	∸ line 2)			0.00	1 88

Health Financial Systems REH	ABILITATION HOSPITAL OF INDIANA			In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1		
				From 01/01/2019 To 12/31/2019			
		Ti tl	Title XIX		PPS	S	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation		
		(from line	column 2	Observati on	Bed Pass		
		21)		Bed Cost	Through Cost		
				(from line	(col. 3 x		
				89)	col. 4) (see		
					instructions)		
	1. 00	2. 00	3.00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital -related cost	1, 159, 327	22, 210, 869	0. 05219	0	0	90.00	
91.00 Nursing School cost	0	22, 210, 869	0.00000	0 0	0	91.00	
92.00 Allied health cost	0	22, 210, 869	0.00000	0 0	0	92.00	
93.00 All other Medical Education	0	22, 210, 869	0. 00000	00	0	93. 00	

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Health Financial Systems REHABILITATION HOSPI	TAL OF INDIA	·ΝΔ	In lie	u of Form CMS-2	2552-10
Title XVIII   Hospital   PPS   Activation   Program			CN: 15-3028	Peri od:		
INPATI ENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00						
INPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00		Title			PPS	
INPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3	Cost Center Description			10.00		
INPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3			To Charges			
INPATIENT ROUTINE SERVICE COST CENTERS   14, 353, 751   30.00   3000   ADULTS & PEDIATRICS   30.00   3000   ADULTS & PEDIATRICS   30.00   3000				Charges		
INPATI ENT ROUTINE SERVICE COST CENTERS   14, 353, 751   30.00   3000   ADULTS & PEDI ATRI CS   14, 353, 751   30.00   ADULTS & PEDI ATRI CS   50.00   ADULTS & PEDI ATRI CS   50.00			1 00	2 00		
30. 00   3000   ADULTS & PEDIATRICS   14, 353, 751   30. 00   ANCILLARY SERVICE COST CENTERS   50. 00   50000   PERATING ROOM   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.00000000	INDATIENT POUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS				14 353 751		30 00
50. 00   05000   OPERATI NG ROOM   0.000000   0.005400   0.005400   0.005400   RADI OLOGY-DI AGNOSTI C   0.288794   391, 893   113, 176   54. 00   0.00000   0.005400   RADI OLOGY-DI AGNOSTI C   0.239953   642, 464   154, 161   60. 00   0.005400   RESPI RATORY THERAPY   0.349322   1, 455, 421   508, 411   65. 00   0.005400   PHYSI CAL THERAPY   0.262735   4, 126, 131   1, 084, 079   66. 00   0.005400   PHYSI CAL THERAPY   0.262735   4, 126, 131   1, 084, 079   66. 00   0.005400   PHYSI CAL THERAPY   0.0000000   0.0000000   0.0000000   0.0000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000				14, 333, 731		30.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0.288794   391, 893   113, 176   54. 00   60. 00   06000   LABORATORY   0.239953   642, 464   154, 161   60. 00   60. 00   60. 00   RESPI RATORY   THERAPY   0.349322   1, 455, 421   508, 411   65. 00   66. 00   0600   PHYSI CAL THERAPY   0.262735   4, 126, 131   1, 084, 079   66. 00   0601   PHYSI CAL THERAPY - CARMEL   0.324437   0   0   66. 01   0601   PHYSI CAL THERAPY - CARMEL   0.273491   4, 489, 259   1, 227, 772   67. 00   0600   SPEECH PATHOLOGY   0.181306   3, 121, 593   565, 964   68. 00   06800   SPEECH PATHOLOGY   0.181306   3, 121, 593   565, 964   68. 00   06800   SPEECH PATHOLOGY   0.278104   0   0   68. 01   06801   VI SI ON   0.278104   0   0   068. 01   06802   FAC RESOURCE   4.154311   0   0   68. 02   06802   FAC RESOURCE   4.154311   0   0   68. 02   06900   ELECTROCARDI OLOGY   0.000000   0   0   69, 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.301243   788, 201   237, 440   71. 00   72. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.301243   788, 201   237, 440   71. 00   72. 00   07400   RENAL DI ALYSI S   0.000000   0   0   0   0   0   0   0			0.00000	0 0	0	50.00
60. 00 06000 LABORATORY 60. 00 06500 RESPI RATORY THERAPY 60. 00 06500 RESPI RATORY RESPI RATORY 70. 00 06500 RESPI RATORY RESP					113, 176	
66. 00   06600   PHYSI CAL THERAPY   CARMEL   0. 262735   4, 126, 131   1, 084, 079   66. 00   66. 01   06601   PHYSI CAL THERAPY - CARMEL   0. 324437   0   0   66. 01   67. 00   06700   0CCUPATI ONAL THERAPY   0. 273491   4, 489, 259   1, 227, 772   67. 00   68. 00   08800   SPEECH PATHOLOGY   0. 181306   3, 121, 593   565, 964   68. 00   68. 01   06801   VISION   0. 278104   0   0   68. 01   68. 02   06802   FAC RESOURCE   4. 154311   0   0   0   68. 02   69. 00   06900   ELECTROCARDI OLOGY   0. 000000   0   0   0   69. 02   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 301243   788, 201   237, 440   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 339597   2, 345, 919   796, 667   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 339597   2, 345, 919   796, 667   73. 00   07400   RENAL DI ALYSI S   0. 000000   0   0   0   0   0   0   0	60. 00   06000   LABORATORY		0. 23995	3 642, 464	154, 161	60.00
66. 01 06601 PHYSICAL THERAPY - CARMEL 0.324437 0 0 66. 01 67. 00 06700 OCCUPATI ONAL THERAPY 0.273491 4, 489, 259 1, 227, 772 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.181306 3, 121, 593 565, 964 68. 00 68. 01 06801 VISION 0.278104 0 0 0 68. 01 68. 01 06801 VISION 0.278104 0 0 0 68. 01 68. 02 06802 FAC RESOURCE 4.154311 0 0 0 68. 01 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 69. 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65. 00 06500 RESPIRATORY THERAPY		0. 34932	2 1, 455, 421	508, 411	65.00
67. 00	66. 00 06600 PHYSI CAL THERAPY		0. 26273	5 4, 126, 131	1, 084, 079	66.00
68. 00					0	66. 01
68. 01				.,		
68. 02			1	· · · · · · · · · · · · · · · · · · ·		
69. 00   06900   ELECTROCARDI OLOGY   0.000000   0   0   69. 00   71. 00   77. 00					_	
71. 00					_	
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.000000   0   0   72. 00   0.000000   0   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   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000					-	
73. 00   07300   DRUGS CHARGED TO PATIENTS   0.339597   2,345,919   796,667   73. 00   74. 00   07400   RENAL DIALYSIS   0.000000   0   0   0   0   0   0   0						1
74. 00   07400   RENAL DI ALYSIS   0.000000   0   0   0   74. 00			1			
OUTPATIENT SERVICE COST CENTERS   O. 222636   O O. 22263					•	
90. 00   09000   CLINIC   0. 222636   0   0   90. 00   90. 00   90. 01   90			0.00000	0	U	74.00
90. 01   09001   SLEEP CENTER   0.000000   0   90. 01   91. 00   92. 00   92. 00   08SERVATION BEDS (NON-DISTINCT PART)   0.0000000   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   0.000000   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   0.0000000   0.0000000   0.0000000   0.00000000			0.22263	6 0	0	90 00
91. 00					_	
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0.000000   0   92. 00   200. 00   201. 00   Less PBP Clinic Laboratory Services-Program only charges (line 61)   0   0   201. 00   201. 00   201. 00   0   0   0   0   0   0   0   0   0					_	
200.00       Total (sum of lines 50 through 94 and 96 through 98)       17,360,881       4,687,670 200.00         201.00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       201.00					0	
					4, 687, 670	
202.00   Net charges (line 200 minus line 201)   17,360,881   202.00	201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.00
	202.00 Net charges (line 200 minus line 201)			17, 360, 881		202. 00

Health Financial Systems REHABILITATION HOSPITAL OF INDIA	۸۸۱۸	In Lie	u of Form CMS-:	2552 10
	CCN: 15-3028	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Pre	pared:
	le XIX	Hospi tal	6/30/2020 7: 2 PPS	23 am
Cost Center Description	Ratio of Cos		Inpati ent	
Control Document	To Charges	Program	Program Costs	
		Charges	(col. 1 x	
		3.1	col . 2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS		739, 216		30.00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0.00000		0	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 28879		3, 263	54.00
60. 00   06000   LABORATORY	0. 2399			60.00
65. 00  06500  RESPI RATORY THERAPY	0. 3493		24, 565	65.00
66. 00   06600 PHYSI CAL THERAPY	0. 2627	· ·	59, 704	
66.01   06601   PHYSI CAL THERAPY - CARMEL	0. 32443		0	
67. 00   06700   OCCUPATI ONAL THERAPY	0. 2734		57, 877	67.00
68.00   06800   SPEECH PATHOLOGY	0. 18130			
68. 01   06801   VI SI ON	0. 27810	· ·	3, 385	
68. 02   06802   FAC RESOURCE	4. 1543		0	
69. 00   06900  ELECTROCARDI OLOGY	0. 00000		0	
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 3012	· ·		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 00000		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 33959		36, 419	
74. 00 07400 RENAL DI ALYSI S	0. 00000	00 0	0	74. 00
OUTPATIENT SERVICE COST CENTERS		- 1		
90. 00 09000 CLINIC	0. 2226		0	
90. 01   09001   SLEEP CENTER	0. 00000		0	
91. 00   09100   EMERGENCY	0. 00000		0	
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	0. 00000		0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		868, 675	232, 710	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00   Net charges (line 200 minus line 201)	1	868, 675	l	202. 00

Health Financial Systems REHABILITATION HOSPITAL OF INDIANA In Lieu of Form CMS-2552-10 LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-3028 Peri od: Worksheet E Part A Exhibit 4 From 01/01/2019 Date/Time Prepared: 6/30/2020 7:23 am 12/31/2019 Title XVIII Hospi tal W/S E, Part A Amounts (from Period Prior Total (Col 2 Pre/Post Peri od Entitlement to 10/01 On/After through 4) line E. Part A) 10/01 5.00 0 1.00 2.00 3.00 4.00 1.00 DRG amounts other than outlier 1. 00 1.00 payments 1.01 DRG amounts other than outlier 1.01 0 1.01 0 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 1.03 DRG for Federal specific 1.03 1.03 operating payment for Model 4 BPCI occurring prior to October 1 DRG for Federal specific 1 04 1 04 0 1.04 operating payment for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for 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) Outlier payments for 2.03 2.04 2.03 discharges occurring on or after October 1 (see instructions) Operating outlier 3.00 2.01 3.00 reconciliation 4.00 Managed care simulated 3.00 3, 503, 504 1, 106, 926 4, 610, 430 4.00 payments Indirect Medical Education Adjustment 21. 00 0.000000 0.000000 0.000000 0.000000 5 00 Amount from Worksheet E. Part 5 00 A, line 21 (see instructions) 6.00 IME payment adjustment (see 22.00 0 0 0 6.00 instructions) 6.01 IME payment adjustment for 22.01 0 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 0 8.00 instructions) IME payment adjustment add on 8.01 28.01 0 8.01 for managed care (see instructions) 9.00 Total IME payment (sum of 29.00 9.00 lines 6 and 8) 9 01 Total IME payment for managed 29 01 0 9.01 care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 0.0000 0.0000 10.00 10.00 Allowable disproportionate 33.00 0.0000 0.0000 share percentage (see instructions)

0

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11.00

11.01

12.00

13 00

14.00

15.00

11.00

11.01

12.00

13 00

14.00

15.00

Di sproporti onate share

(see instructions)

(see instructions)

operating costs (see instructions)

adjustment (see instructions) Uncompensated care payments

Total ESRD additional payment

Subtotal (see instructions)

Hospital specific payments

(completed by SCH and MDH, small rural hospitals only.)

Total payment for inpatient

34.00

36,00

46. 00

47.00

48.00

49.00

Additional payment for high percentage of ESRD beneficiary discharges

Heal th	Financial Systems	REHA	BILLIAILON HOS	PLIAL OF INDIA	NA	In Lie	u of Form CMS-	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provi der C	CN: 15-3028	Period: From 01/01/2019 To 12/31/2019		epared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After	through 4)	
			, i			10/01	,	
		0	1. 00	2. 00	3.00	4. 00	5. 00	
16. 00	Payment for inpatient program	50, 00	0	0		0 0	0	16.00
	capital (from Wkst. L, Pt. I, if applicable)			_				
17. 00	Special add-on payments for new technologies	54. 00	0	0		0 0	0	
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from	68. 00	0	0		0	0	17. 02
	manufacturers for replaced devices for applicable MS-DRGs			_			_	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0		0 0	0	18.00
19. 00				0		0	,	19.00
19.00	SUBTUTAL	W/S L, line	(Amounts from L)	0		0 0		19.00
		0	1. 00	2.00	3. 00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	0	0	0.00	0 0	0.00	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	Ö	1
21.00	Capital DRG outlier payments	2. 00	0	0		0 0	0	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	O	21.01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0.000	0. 0000		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0		0 0	0	25.00
26. 00	Total prospective capital payments (see instructions)	12. 00	0	0		0 0	0	26.00
		W/S E, Part A	(Amounts to					
		line	E, Part A)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 00000	0. 000000		27.00
28. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96				0	O	28.00
29. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	O	29.00
100. 00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

Provider CCN: 15-3028

Peri od:

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Part A Exhibit 5

From 01/01/2019 Date/Time Prepared: 6/30/2020 7:23 am 12/31/2019 Hospi tal Title XVIII Period to Total (cols. Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 after 10/01 A. line 2 and 3) A) 0 1.00 2.00 3.00 4.00 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 0 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1 02 0 0 1.02 discharges occurring on or after October 1 DRG for Federal specific operating payment 1.03 1.03 0 1.03 for Model 4 BPCI occurring prior to October 1 04 DRG for Federal specific operating payment 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 0 2.01 **BPCI** 2.02 2.02 Outlier payments for discharges occurring 2.03 0 0 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 3, 503, 504 1, 106, 926 4, 610, 430 4.00 3.00 4.00 Indirect Medical Education Adjustment 0.000000 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 5.00 (see instructions) 6.00 IME payment adjustment (see instructions) 22.00 0 0 6.00 0 6.01 IME payment adjustment for managed care (see 22.01 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 0 8.00 0 0 IME payment adjustment add on for managed 0 28 01 C 0 8 01 8.01 0 care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 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 Di sproporti onate share adjustment (see 34.00 0 0 0 11.00 instructions) 11.01 36 00 0 0 11.01 Uncompensated care payments 0 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 12.00 0 0 0 12.00 instructions) 47.00 13.00 Subtotal (see instructions) 0 13.00 0 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 15 00 49 00 O 0 0 15 00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 0 0 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 0 17.00 Net organ acquisition cost 17.01 17.01 17.02 Credits received from manufacturers for 68.00 0 0 17.02 replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment 93.00 0 0 18.00 amount (see instructions) 19.00 SUBTOTAL 0 19.00

Health Financial Systems	REHABILITATION HOSP	ITAL OF INDIA	NA	In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC)	REDUCTION CALCULATION EXHIBIT 5	Provi der C	CN: 15-3028	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part A Exhibi Date/Time Pre 6/30/2020 7:2	pared:
		Title	e XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				

				T		Date/Time Pre 6/30/2020 7:2	pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2. 00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1. 00	0	0	0	0	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	21. 01
22. 00	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	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0. 0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	0	0	0	0	26. 00
	,	Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. 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		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	0	0	0	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	0	0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	0	0	0	0	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	0	0	0	31. 01
						(Amt. to Wkst. E, Pt. A)	
		0	1. 00	2.00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see	70. 99	1.00	0		0	32.00
100.00	instructions) Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	REHABILITATION HOSPITAL OF INDIANA	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-3028	Peri od: From 01/01/2019   Worksheet E Part B To 12/31/2019   Date/Time Prepared: 6/30/2020 7:23 am

	Title XVII	1	Hospi tal	6/30/2020 7: 2: PPS	23 am
			110001 (41)		
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1.00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)			0	1.00
2. 00	Medical and other services (see Firstractions)  Medical and other services reimbursed under OPPS (see instructions)			797, 986	
3. 00	OPPS payments			702, 371	
4.00	Outlier payment (see instructions)			0	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	
5. 00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	
6. 00	Line 2 times line 5			0	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line	a 200		0	
	Organ acquisitions	E 200			
	Total cost (sum of lines 1 and 10) (see instructions)			o o	1
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
	Ancillary service charges			0	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15. 00	Customary charges Aggregate amount actually collected from patients liable for payment for servi	ices on	a charge hasis	0	15.00
	Amounts that would have been realized from patients liable for payment for set			o o	
	had such payment been made in accordance with 42 CFR §413.13(e)			-	
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
18. 00	Total customary charges (see instructions)			0	18.00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 ex	ceeds li	ne 11) (see	0	19.00
20.00	instructions)		10) (		20.00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exclinstructions)	ceeas 11	ne 18) (See	0	20.00
21. 00	Lesser of cost or charges (see instructions)			o	21.00
	Interns and residents (see instructions)			0	1
	Cost of physicians' services in a teaching hospital (see instructions)			0	1
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			702, 371	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance amounts (for CAH, see instructions)			0	
	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, so			144, 658	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of linstructions)	lines 22	and 23] (see	557, 713	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)			ol	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			o o	
	Subtotal (sum of lines 27 through 29)			557, 713	
31.00	Primary payer payments			125	31.00
32.00	Subtotal (line 30 minus line 31)			557, 588	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			92, 033	1
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)			59, 821 92, 033	1
	Subtotal (see instructions)			617, 409	1
	MSP-LCC reconciliation amount from PS&R			017, 407	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			l ol	
	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	1
	Partial or full credits received from manufacturers for replaced devices (see	instruc	ctions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	
	Subtotal (see instructions)			617, 409	1
	Sequestration adjustment (see instructions)			12, 348	
	Demonstration payment adjustment amount after sequestration			0	
	Sequestration adjustment-PARHM pass-throughs Interim payments			546, 439	40.03
	Interim payments Interim payments-PARHM			340, 439	41.00
	Tentative settlement (for contractors use only)			0	
	Tentative settlement-PARHM (for contractor use only)			ا	42. 01
	Balance due provider/program (see instructions)			58, 622	1
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub.	. 15-2,	chapter 1,	6, 600	44.00
	\$115. 2				-
1	TO BE COMPLETED BY CONTRACTOR				00.00
00 00	Original authior amount (coo instructions)			0	
	Original outlier amount (see instructions)		l	ا ۱	
91. 00	Outlier reconciliation adjustment amount (see instructions)			0 00	
91. 00 92. 00				0 0.00 0	92.00

 
 Heal th
 Financial
 Systems
 REHABILIT

 ANALYSIS
 OF
 PAYMENTS
 TO
 PROVIDERS
 FOR
 SERVICES
 RENDERED
 In Lieu of Form CMS-2552-10 | Peri od: | Worksheet E-1 | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared: Provi der CCN: 15-3028

				10 12/31/2019	6/30/2020 7: 2:	
		Title	e XVIII	Hospi tal	PPS	
		I npati er	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	
1. 00	Total interim payments paid to provider	1.00	10, 815, 31		546, 439	1.00
2. 00	Interim payments payable on individual bills, either		10,010,01	0	0 10, 107	2. 00
2.00	submitted or to be submitted to the contractor for					2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)		L			
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER		1	0	1 0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER			0		3. 01
3. 02				0		3. 02
3. 04				0	0	3. 04
3. 05				o		3. 05
	Provi der to Program		•	-1		
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3. 53				0	0	3. 53
3. 54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		10, 815, 31	5	546, 439	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		10, 013, 31	3	340, 437	4.00
	appropriate)					
	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)					
F 01	Program to Provider TENTATIVE TO PROVIDER					F 01
5. 01 5. 02	TENTATIVE TO PROVIDER			0	0	5. 01 5. 02
5. 02				0		5. 02
5. 05	Provider to Program		1	0		5.05
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5.52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER			0	58, 622	6. 01
6. 01	SETTLEMENT TO PROVIDER		25. 52	-	38, 622	6. 01
7. 00	Total Medicare program liability (see instructions)		10, 789, 78		605, 061	7. 00
7.00	Total mod. od. o program readerity (300 mot. dottons)		10,707,70	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
			0	1. 00	2. 00	
8.00	Name of Contractor					8.00

Health Financial Systems	REHABILITATION HOSPITAL OF INDIANA	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-302	From 01/01/2019	Worksheet E-3 Part III Date/Time Prepared: 6/30/2020 7:23 am
	T1.11 \0.011		222

				6/30/2020 /: 2	<u>3 am </u>
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			10, 097, 096	1.00
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0357	2.00
3. 00	Inpatient Rehabilitation LIP Payments (see instructions)			714, 874	3. 00
4. 00	Outlier Payments			551, 280	4.00
5. 00	Unweighted intern and resident FTE count in the most recent c to November 15, 2004 (see instructions)	ost reporting period er	nding on or prior	0. 34	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE coun program or hospital closure, that would not be counted withou CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0. 00	5. 01
6.00	New Teaching program adjustment. (see instructions)			0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	period of a "new	2. 59	7. 00
	teaching program" (see instructions)			ļ	
8. 00	Current year's unweighted I&R FTE count for residents within teaching program" (see instructions)	the new program growth p	period of a "new	0. 00	8. 00
9.00	Intern and resident count for IRF PPS medical education adjus	tment (see instructions)	)	0. 34	9.00
10.00	Average Daily Census (see instructions)			57. 701370	
11. 00	Teaching Adjustment Factor (see instructions)			0. 005988	
12. 00	Teaching Adjustment (see instructions)			60, 461	
13. 00	Total PPS Payment (see instructions)			11, 423, 711	
14. 00	Nursing and Allied Health Managed Care payments (see instruct	i on)		0	14.00
15. 00	Organ acquisition (DO NOT USE THIS LINE)	. 5,		١	15. 00
16. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	16.00
17. 00	Subtotal (see instructions)	1 40 11 0113)		11, 423, 711	
18. 00	Primary payer payments			5, 000	
19. 00	Subtotal (line 17 less line 18).			11, 418, 711	
20. 00	Deductibles			32, 712	20.00
21. 00	Subtotal (line 19 minus line 20)			11, 385, 999	
22. 00	Coi nsurance			425, 262	
23. 00	Subtotal (line 21 minus line 22)			10, 960, 737	23.00
24. 00	Allowable bad debts (exclude bad debts for professional servi	cos) (cos instructions)		75, 767	
25. 00	Adjusted reimbursable bad debts (see instructions)	ces) (see Histructions)		49, 249	
	, , , , , , , , , , , , , , , , , , , ,	rusti ons)		75, 767	
26. 00 27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructrons)		11, 009, 986	
	Subtotal (sum of lines 23 and 25)	ina 10)		11, 009, 960	28.00
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, I	THE 49)		0	28.00
30.00	Other pass through costs (see instructions)			0	
30.00	Outlier payments reconciliation			0	30. 00 31. 00
31. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0)		0	31.00
31. 50	Prioneer ACO demonstration payment adjustment (see instruction	5)		0	31.50
	Demonstration payment adjustment amount before sequestration			0	
32.00	Total amount payable to the provider (see instructions)			11, 009, 986	
32. 01	Sequestration adjustment (see instructions)			220, 200	
32. 02	Demonstration payment adjustment amount after sequestration			0	32. 02
33.00	Interim payments			10, 815, 315	
34.00	Tentative settlement (for contractor use only)	0. 00		0	34.00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.0			-25, 529	35.00
36. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	237, 155	36. 00
	§115. 2				
F0 05	TO BE COMPLETED BY CONTRACTOR			551 055	F0 00
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			551, 280	
51.00	Outlier reconciliation adjustment amount (see instructions)			0	51.00
52.00	The rate used to calculate the Time Value of Money			0. 00	52.00
53.00	Time Value of Money (see instructions)			0	53.00

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CO		Period: From 01/01/2019	Worksheet E-4	
				To 12/31/2019	Date/Time Pre 6/30/2020 7: 2:	
		Title	XVIII	Hospi tal	PPS	
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.		•		0. 00	1.00
. 00 . 00	Unweighted FTE resident cap add-on for new programs per 42 CF Amount of reduction to Direct GME cap under section 422 of MM	` ,	(1) (see insti	ructions)	0. 00 0. 00	2.00 3.00
. 01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)		R §413.79 (m).	(see	0. 00	3.0
. 00	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	0. 00	4.00
. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst straddling 7/1/2011)		r cost reporti	ng peri ods	0. 00	4. 0 <sup>-</sup>
. 02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (see inst	tructions for	cost reporting	0. 00	4. 02
. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	line 4 plus l	ines 4.01 and	0. 00	5.00
. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	r the current	year from your	2. 59	6. 00
. 00	Enter the lesser of line 5 or line 6				0. 00	7.00
			Primary Care		Total	
. 00	Weighted FTE count for physicians in an allopathic and osteop	athi c	1. 00 0. 0	2. 00 0 2. 23	3. 00 2. 23	8. 00
. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw	ıi se	0.0	0 0.00	0. 00	9. 00
	multiply line 8 times the result of line 5 divided by the amo	ount on line				
0.00	Weighted dental and podiatric resident FTE count for the curr			0. 00 0. 00		10. 00 10. 0
0. 01 1. 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count	irrent year	0. 0			11.00
2. 00	Total weighted resident FTE count for the prior cost reportir instructions)	ng year (see	0.0	1		12.00
3. 00	Total weighted resident FTE count for the penultimate cost reyear (see instructions)	eporti ng	0.0	0.00		13.00
4. 00	Rolling average FTE count (sum of lines 11 through 13 divided	l by 3).	0.0			14.00
	Adjustment for residents in initial years of new programs	rograms	0.0			15. 00 15. 0
5. 01 6. 00	Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital clo		0. 0 0. 0			16.0
6. 01	Unweighted adjustment for residents displaced by program or holosopted colors of the c		0.0			16. 0°
7. 00			0. 0	0.00		17.00
8.00	Per resident amount Approved amount for resident costs		0. 0	0.00	0	18. 00 19. 00
7. 00	Approved amount for resident costs			0	0	17.00
	T				1. 00	
0. 00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots red	ceived under 42	0. 00	20.00
1.00	, , , , , , , , , , , , , , , , , , , ,	,				21.0
2.00	Allowable additional direct GME FTE Resident Count (see instr Enter the locality adjustment national average per resident a		netructions)		0.00	22. 00 23. 00
4. 00	Multiply line 22 time line 23	illourit (see i	nistractions)		0.00	24.00
	Total direct GME amount (sum of lines 19 and 24)				0	25. 00
			Inpatient Part A	Managed Care	Total	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2. 00	3. 00	
6. 00	Inpatient Days (see instructions)		7, 11	9 3, 466		26.00
7. 00	Total Inpatient Days (see instructions)		21, 06	1 21, 061		27.00
8. 00	Ratio of inpatient days to total inpatient days		0. 33801			28.00
9.00	Program direct GME amount			0 0	0	
9. 01 0. 00	Percent reduction for MA DGME Reduction for direct GME payments for Medicare Advantage			o	0	29. 01 30. 00
	induction for direct one paymonts for modificate havailtage			١	U <sub>1</sub>	1 55.00

	Financial Systems REHABILITATION HOSPI	TAL OF INDIANA	In Lie	u of Form CMS-2	2552-10	
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-3028	Peri od:	Worksheet E-4		
MEDI CA	MEDICAL EDUCATION COSTS From 01/01/2019 To 12/31/2019 Date/Time Pr 6/30/2020 7:					
		Title XVIII	Hospi tal	PPS		
				1. 00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLEDUCATION COSTS)	LE XVIII ONLY (NURSING S	CHOOL AND PARAMED	I CAL		
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 a	nd 23, lines 74	0	32.00	
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	0	33.00	
34.00	Ratio of direct medical education costs to total charges (lir	ne 32 ÷ line 33)		0.000000	34.00	
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00	
36.00	00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35)					
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				
	Part A Reasonable Cost					
	Reasonable cost (see instructions)			12, 195, 367		
	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0		
	Cost of physicians' services in a teaching hospital (see inst	tructi ons)		0	39. 00	
40.00	Primary payer payments (see instructions)			·	40.00	
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minu	us line 40)		12, 190, 367	41. 00	
	Part B Reasonable Cost					
	Reasonable cost (see instructions)			797, 986		
43.00	Primary payer payments (see instructions)				43.00	
	Total Part B reasonable cost (line 42 minus line 43)			797, 861		
	Total reasonable cost (sum of lines 41 and 44)			12, 988, 228		
	Ratio of Part A reasonable cost to total reasonable cost (lir			0. 938570		
47. 00	Ratio of Part B reasonable cost to total reasonable cost (lir			0. 061430	47.00	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA	ART B				
	Total program GME payment (line 31)			0		
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)			0		
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	) (see instructions)		0	50.00	

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

Provi der CCN: 15-3028

Peri od: Worksheet G
From 01/01/2019
To 12/31/2019 Date/Time Prepared: 6/30/2020 7: 23 am

——————————————————————————————————————					6/30/2020 7: 2	3 am
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	12, 992, 612	0	0	0	1.00
2.00	Temporary investments	280	0	0		2.00
3.00	Notes receivable	0	0	0		3.00
4. 00	Accounts recei vable	20, 709, 538	0	0	0	4.00
5. 00	Other receivable	780, 007	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable		0	0	0	6.00
7. 00 8. 00	Inventory Prepai d expenses	192, 089 539, 778		0	0	7. 00 8. 00
9. 00	Other current assets	539, 778		0	0	9.00
10.00	Due from other funds			0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	19, 841, 903		0	l	11.00
	FIXED ASSETS			-		
12.00	Land	1, 904, 164	0	0	0	12.00
13.00	Land improvements	370, 910	0	0	0	13.00
14.00	Accumulated depreciation	-296, 418	0	0	0	14.00
15. 00	Bui I di ngs	18, 987, 309	1	0		15. 00
16. 00	Accumulated depreciation	-13, 582, 468		0	0	16.00
17.00	Leasehold improvements	205, 018	1	0	0	17.00
18.00	Accumulated depreciation	-152, 444	1	0	0	18.00
19. 00 20. 00	Fixed equipment	2, 615, 290	1	0	0	19.00 20.00
20.00	Accumulated depreciation Automobiles and trucks	-1, 968, 980	0	0		20.00
21.00	Accumulated depreciation			0		22.00
23. 00	Major movable equipment	14, 582, 511		0	0	23.00
24. 00	Accumulated depreciation	-11, 587, 128		0	o o	24.00
25. 00	Minor equipment depreciable	105, 832		0	Ö	25. 00
26. 00	Accumulated depreciation	-105, 832		0	Ō	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	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)	11, 077, 764	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	1	31.00
32.00	Deposits on Leases	057 000	0	0	0	32.00
33.00	Due from owners/officers	856, 808	1	0	0	33. 00 34. 00
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	602, 474 1, 459, 282	1	0		35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	32, 378, 949		0	1	36.00
00.00	CURRENT LIABILITIES	02,070,717	<u> </u>			00.00
37.00	Accounts payable	2, 533, 659	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2, 232, 310	1	0	0	38. 00
39.00	Payrol I taxes payable	0	0	0	0	39.00
40.00	Notes and Loans payable (short term)	840, 000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1, 102, 146		0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	6, 708, 115	0	0	0	45.00
44 00	LONG TERM LIABILITIES	1 0		0	0	44 00
46. 00 47. 00	Mortgage payable Notes payable	10, 635, 000	0	0	1	46. 00 47. 00
48. 00	Unsecured Loans	10, 033, 000		0	l	48.00
49.00	Other long term liabilities	50, 695		0	l	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10, 685, 695		0	1	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17, 393, 810	1	0	l	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	14, 985, 139				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement,				0	58. 00
F0	replacement, and expansion	4. 05=		-	_	FC 5-
59.00	Total fund balances (sum of lines 52 thru 58)	14, 985, 139		0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	32, 378, 949	0	0	0	60.00
	[59]	I	1		I	I

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 01/01/2019 12/31/2019 Date/Time Prepared: 6/30/2020 7:23 am General Fund Special Purpose Fund Endowment Fund 5.00 1. 00 2.00 3. 00 4.00 1.00 Fund balances at beginning of period 13, 835, 856 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 1, 149, 283 2.00 2.00 3 00 Total (sum of line 1 and line 2) 14, 985, 139 ol 3.00 4.00 Additions (credit adjustments) (specify) 4.00 0 5.00 0000 0 5.00 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 Subtotal (line 3 plus line 10) 14, 985, 139 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 00000 13.00 13.00 14.00 0 0 14.00 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 14, 985, 139 19.00 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 2.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 0 3.00 3.00 Total (sum of line 1 and line 2) 0 4.00 Additions (credit adjustments) (specify) 4.00 5.00 5.00 6.00 0 6.00 0 7.00 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 0 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 Deductions (debit adjustments) (specify) 12.00 12.00 13.00 0 13.00 14.00 0 14.00

0

0

0

0

15.00

16.00

17.00

18.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

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

			0 12/31/2019	Date/IIme Pre   6/30/2020 7:2	
	Cost Center Description	I npati ent	Outpati ent	Total	O dill
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>	•		
	General Inpatient Routine Services				
1.00	Hospi tal	42, 308, 992	2	42, 308, 992	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF			0	5.00
6.00	Swing bed - NF			0	6.00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	42, 308, 992		42, 308, 992	10.00
	Intensive Care Type Inpatient Hospital Services		•		
11.00	INTENSIVE CARE UNIT				11. 00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines			0	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	42, 308, 992		42, 308, 992	17.00
18.00	Ancillary services	48, 803, 513	19, 434, 186	68, 237, 699	18.00
19.00	Outpati ent servi ces	165, 966	3, 716, 630	3, 882, 596	19.00
20.00	RURAL HEALTH CLINIC		o	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		o	0	21.00
22. 00	HOME HEALTH AGENCY				22.00
	AMBULANCE SERVICES				23.00
24. 00	CMHC		o	0	
24. 10	CORF			0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P. )			_	25. 00
26. 00	HOSPI CE				26.00
27. 00	OTHER (SPECIFY)		ol	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	st. 91, 278, 47	23, 150, 816	114, 429, 287	28.00
	G-3, line 1)			,,	
	PART II - OPERATING EXPENSES	<u>'</u>	'		
29.00	Operating expenses (per Wkst. A, column 3, line 200)		46, 153, 875		29. 00
30.00	ADD (SPECIFY)				30.00
31.00					31.00
32.00					32.00
33.00					33.00
34.00					34.00
35. 00					35.00
36. 00	Total additions (sum of lines 30-35)		o		36.00
37. 00	DEDUCT (SPECIFY)				37.00
38. 00					38. 00
39. 00			1		39.00
40. 00					40.00
41. 00					41.00
42. 00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tran	nsfer	46, 153, 875		43.00
	to Wkst. G-3, line 4)				
		•			

		REHABILITATION HOSPITAL OF INDIANA		In Lieu of Form CMS-2552-10		
STATEM	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-3028	Peri od:	Worksheet G-3		
			From 01/01/2019 To 12/31/2019		nared:	
			10 12/01/201/	6/30/2020 7: 2		
				1. 00		
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			114, 429, 287	1.00	
2.00	Less contractual allowances and discounts on patients' accounts			69, 417, 224	1	
3.00				45, 012, 063	•	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			46, 153, 875		
5.00	Net income from service to patients (line 3 minus line 4)			-1, 141, 812	5.00	
	OTHER I NCOME					
6. 00				0	6. 00	
7. 00				0	7. 00	
8. 00				0	0.00	
9. 00	Revenue from television and radio service			0	,	
10.00	Purchase di scounts			0	10.00	
11. 00	Rebates and refunds of expenses			0	11. 00	
12.00	Parking lot receipts			0		
				0	1 .0.00	
14. 00	3 · · · · · · · · · · · · · · · · · · ·			0	1 1.00	
	3 11 11 11			0	1 .0.00	
	Revenue from sale of medical and surgical supplies to other than patients			0		
	Revenue from sale of drugs to other than patients			0	1	
18. 00				0	1 .0.00	
	O Tuition (fees, sale of textbooks, uniforms, etc.)			0		
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00	
	Rental of vending machines			0		
22.00	Rental of hospital space			0	22. 00	
23.00	Governmental appropriations			0	23. 00	
24.00	MI SCELLANEOUS I NCOME			2, 291, 095		
25 00	Total other income (cum of lines 4 24)			2 201 005	25 00	

2, 291, 095 1, 149, 283

0 27.00

1, 149, 283 29. 00

25.00 26.00

28.00

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

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)

27. 00 OTHER EXPENSES (SPECIFY)