Health Financial Systems	REHABILITATION HOSPITA	AL OF FT WAYNE	In Lieu	J of Form CMS-2552-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Fail	ure to report can resu	lt in all interim	FORM APPROVED
payments made since the beginnir	g of the cost reporting period being	deemed overpayments (42	2 USC 1395g).	OMB NO. 0938-0050
	E COMPLEX COST REPORT CERTIFICATION	Provider CCN: 153030	Peri od:	Worksheet S
AND SETTLEMENT SUMMARY				Parts I-III Date/Time Prepared:
			10 077 307 2013	2/25/2016 12: 52 pm
PART I - COST REPORT STATUS				
Provider 1. [X] Electroni	cally filed cost report		Date: 2/25/20	16 Time: 12:52 pm
	submitted cost report			
3.[0] fthisi: 4.[F]Medicare	s an amended report enter the number o Jtilization. Enter "F" for full or "L	of times the provider r " for low.	esubmitted this co	ost report
use only (1) As Submitte	hout Audit 8. [N] Initial Report fo	r this Provider CCN 12.		
PART II - CERTIFICATION				
ADMINISTRATIVE ACTION, FINE AND	ON OF ANY INFORMATION CONTAINED IN TH OR IMPRISONMENT UNDER FEDERAL LAW. F PAYMENT DIRECTLY OR INDIRECTLY OF A VOR IMPRISONMENT MAY RESULT.	FURTHERMORE, IF SERVICE	S IDENTIFIED IN TH	IS REPORT WERE
CERTIFICATION E	Y OFFICER OR ADMINISTRATOR OF PROVIDE	R(S)		
	have read the above certification sta			

electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REHABILITATION HOSPITAL OF FT WAYNE (153030) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 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.

(Si gned)_

Title

Officer or Administrator of Provider(s)

			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	5, 023	0	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
	RURAL HEALTH CLINIC I	0		0		0	10.00
	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	
200.00	Total	0	5, 023		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.

00	1.00						From 10/0		Part I		
00	1.00						To 09/30	0/2015	Date/Ti 2/23/20		
00		2.0	00	3. (00			4.00			
	Hospital and Hospital Health Care Cor Street: 7970 WEST JEFFERSON BOULEVARD	PO Box:									1 1.0
	City: FORT WAYNE	State: IN		p Code: 4			ty: ALLEN				2.0
		Component Nam			CBSA umber	Provi de Type	- Date Certifie		ent Syste , 0, or		
						.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		V	XVIII	XIX	
	Hospital and Hospital-Based Component	1.00	2	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
+		REHABILI TATI ON HOS	SPI TAL 15	53030 2	3060	5	11/01/199	3 N	Р	Р	3.0
00	Subprovider - IPF	OF FT WAYNE									4.
	Subprovider - IRF										5.0
	Subprovider - (Other)										6.
	Swing Beds – SNF Swing Beds – NF										7.0 8.0
	Hospi tal -Based SNF										9. (
	Hospital-Based NF										10.
	Hospi tal -Based OLTC Hospi tal -Based HHA										11. 12.
. 00	Separately Certified ASC										13.
	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14. 15.
	Hospital-Based Health Clinic - FQHC										16.
	Hospital-Based (CMHC) I										17.
	Hospital-Based (CORF) I Renal Dialysis										17. 18.
	0ther										19.
							Froi 1. 0				-
. 00	Cost Reporting Period (mm/dd/yyyy)						10/01/		09/30/		20.
	Type of Control (see instructions)							4			21.
	Inpatient PPS Information Does this facility qualify and is it	currently receivi	ng paymen	ts for di	spropo	ortionate	e N		N		22.
	share hospital adjustment, in accorda										
	for yes or "N" for no. Is this facili amendment hospital?) In column 2, en1)6(C)(2	?) (PI CKI 6	2				
. 01	Did this hospital receive interim und	compensated care p	ayments f	or this c			N		Ν		22.
	period? Enter in column 1, "Y" for ye reporting period occurring prior to (
	for no for the portion of the cost re										
	(see instructions) Is this a newly merged hospital that	roquiroc final un	component	od caro r	oumont	c to bo	N		N		22.
	determined at cost report settlement?				2				IN		22.
	or "N" for no, for the portion of the										
	in column 2, "Y" for yes or "N" for r or after October 1.	no, for the portio	on of the	cost repo	orting	period d	n				
. 03	Did this hospital receive a geographi							-	Ν		22.
	of the OMB standards for delineating in column 1, "Y" for yes or "N" for r										
	prior to October 1. Enter in column 2						ie				
	cost reporting period occurring on or						h				
	hospital contain at least 100 but not 42 CFR 412.105)? Enter in column 3, '				accord		.11				
. 00	Which method is used to determine Med	licaid days on lin	nes 24 and				1	3	Ν		23.
	1, enter 1 if date of admission, 2 if method of identifying the days in thi						1				
	used in the prior cost reporting peri							Ma all a a		h h	
			In-State Medicaid	In-Stat Medicai		ut-of tate	Out-of State	Medica HMO da		ther i cai d	
			oaid days	eligibl	e Med	di cai d	Medi cai d		~	ays	
				unpai d days	pai	d days	el i gi bl e unpai d				
			1.00	2.00		3. 00	4.00	5.00		. 00	
	If this provider is an IPPS hospital,		0		0	0	0		0	0	24.
	in-state Medicaid paid days in columm Medicaid eligible unpaid days in colu										
	out-of-state Medicaid paid days in co	olumn 3,									
	out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible but										
	column 5, and other Medicaid days in										
. 00	If this provider is an IRF, enter the	e in-state	610		0	О	о		0		25.
	Medicaid paid days in column 1, the i Medicaid eligible unpaid days in colu										
	out-of-state Medicaid days in column	3, out-of-state									
	Medicaid eligible unpaid days in colu	ump 4 Medicaid		1	1				1		1
	HMO paid and eligible but unpaid days										

	0/2015 0 1 1 0 1 1 0 1	2/23/20 Date of 2.0	me Pre 016 2:5 Geogr	epared: 53 pm
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 1.0 27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2. 1.0 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period. Begint 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 1.0	0 1 1 0 i ng:	Date of 2.0	Geogr	26.00
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period. Beginn 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number	1 1 C i ng:			
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period. Beginn 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number				27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period. Beginn 1.0 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number				
Beginn 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number				35.00
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number	-	2. (ng: 00	-
lot periods in excess of one and enter subsequent dates.				36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	C)		37.00
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.				38.00
Y/ 1.(Y/ 2.0		-
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42		N		39.00
 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) 		N	I	40.00
	V	XVIII 0 2.00	XI X 3.00	-
Prospective Payment System (PPS)-Capital 45.00 Does this facility gualify and receive Capital payment for disproportionate share in accordance	N	N	N	45.00
 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 	N	N	N	46.00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no. 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N N	N N	47.00 48.00
Teaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes	N			56.00
or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column is "Y" did residents start training in the first month of this cost reporting period? Enter "Y"				57.00
for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as	N			58.00
defined in CMS Pub. 15–1, chapter 21, §2148? If yes, complete Wkst. D–5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D–2, Pt. I.	N			59.00
60.00 Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00
Y/N IME Direct GME IME	Ξ	Direc	t GME	
1.00 2.00 3.00 4.0		5.0		
61.00 Did your hospital receive FTE slots under ACA N section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	0.00		0.0	0 61.00
61.01Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see0.000.00				61.01
i nstructions) 61.02 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				61.02
ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 0.00 0.00 and/or general surgery residents, which is used for				61.03
determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the				61.04
current cost reporting period. (see instructions).61.05Enter the difference between the baseline primary and/or general surgery FTEs and the current year's0.00				61.05
primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

ISPI TAL AND HOSPI TAL HEALTH CARE COMPL	EX IDENTIFICATION DA	TA Provi o	F	Period: From 10/01/2014 Fo 09/30/2015	Worksheet S-2 Part I Date/Time Pre 2/23/2016 2:5	pared
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
 .10 Of the FTEs in line 61.05, special ty, if any, and the number for each new program. (see instrucolumn 1, the program name, enter program code, enter in column 3, unweighted count and enter in col FTE unweighted count. .20 Of the FTEs in line 61.05, specif program special ty, if any, and th residents for each expanded progrinstructions) Enter in column 1, enter in column 2, the program could be added and the set of the FTE unweighted count and the set of the	of FTE residents actions) Enter in in column 2, the the IME FTE umn 4, direct GME [™] y each expanded the number of FTE am. (see the program name, ode, enter in column and enter in column			0.00		61.
					1.00	
ACA Provisions Affecting the Heal 0.00 Enter the number of FTE residents				i od for which	0.00	62.
your hospital received HRSA PCRE			ost reporting per		0.00	02.
.01 Enter the number of FTE residents during in this cost reporting per Teaching Hospitals that Claim Res	iod of HRSA THC prog	jram. (see instruc		your hospital	0.00	62.
.00 Has your facility trained resider "Y" for yes or "N" for no in colu	nts in nonprovider se	ettings during thi	<u>see instructions)</u>		N	63.
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year period that begins on or after Ju			jsThis base year	ris your cost r	reporting	
.00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	yes, or your facilit per of unweighted nor cations occurring in number of unweighted ur hospital. Enter ir + column 2)). (see	y trained residen n-primary care all nonprovider non-primary care n column 3 the rat	io			
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
5.00 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			0.00	0 0.00	0. 000000	00.0

	nancial Systems	REHABI LI TATI (n Lie	u of For		2552-10
HOSPI TAL	AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	ТА	Provi der	F	eriod: rom 10/01/ o 09/30/		Workshe Part I Date/Ti 2/23/20	me Pre	
					Unweighted FTEs Nonprovider Site	Unwei gh FTEs i Hospi ta	n al	Ratio (c (col. 1 2)	+ col.)	
Se	ection 5504 of the ACA Current	Year FTE Residents ir	n Nonprovide	r Setting	1.00 sEffective f	2.00 or cost re		<u>3.0</u> ng perio		
be	ginning on or after July 1, 20	10	•							
FT En FT	ter in column 1 the number of Es attributable to rotations o ter in column 2 the number of Es that trained in your hospit olumn 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	ovider setti y care resid the ratio d	ngs. Jent	0.00)	0. 00	0.	000000	66.00
		Program Name	Program	Code	Unweighted FTEs Nonprovider Site	Unweigh FTEs i Hospita	n	Ratio (c (col. 3 4)	+ col.	
	-	1.00	2.00	C	3.00	4.00		5. C	00	
na yo wh En co nu ca to no co un re yo 5, di	ter in column 1, the program me associated with each of ur primary care programs in ich you trained residents. ter in column 2, the program de. Enter in column 3, the mber of unweighted primary re FTE residents attributable o rotations occurring in all on-provider settings. Enter in olumn 4, the number of weighted primary care sident FTEs that trained in our hospital. Enter in column the ratio of (column 3 vided by (column 3 + column). (see instructions)				0.00		0.00		000000	67.00
							1.00) 2.00	2 00	
l n	patient Psychiatric Facility P	PS					1.00	5 2.00	3.00	
71.00 If re 42 pr Co (s	this facility an Inpatient Ps ter "Y" for yes or "N" for no line 70 yes: Column 1: Did th cent cost report filed on or b CFR 412.424(d)(1)(iii)(c)) Co ogram in accordance with 42 CF olumn 3: If column 2 is Y, indi- tee instructions)	e facility have an ap efore November 15, 20 Lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	proved GME 1 004? Enter " lity train r (D)? Enter "	teaching 'Y" for yo residents 'Y" for yo	, program in the es or "N" for r in a new teach es or "N" for r	most no. (see ning no.	N		0	70. 00 71. 00
	patient Rehabilitation Facilit this facility an Inpatient Re		(IRE) or (loes it c	ontain an IRE		Y			75.00
76.00 If re no CF	bprovider? Enter "Y" for yes 'line 75 yes: Column 1: Did th cent cost reporting period end Column 2: Did this facility R 412.424 (d)(1)(iii)(D)? Ente dicate which program year bega	and "N" for no. e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	proved GME 1 mber 15, 200 new teaching for no. Colu	teaching)4? Enter g program umn 3: If	program in the "Y" for yes on in accordance column 2 is Y,	r "N" for with 42	N	N	0	76.00
								1. 0	0	
80.00 Is 81.00 Is "Y	ng Term Care Hospital PPS this a long term care hospita this a LTCH co-located within "for yes and "N" for no.					period? Er	nter	N		80. 00 81. 00
85.00 Is 86.00 Di	FRA Providers this a new hospital under 42 d this facility establish a ne 13.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider (excl uded uni				no.	N		85. 00 86. 00
87.00 Is	this hospital a "subclause (l or yes or "N" for no.			n 1886(d)	(1)(B)(iv)(II)	? Enter "Y		N		87.00
10						V		XI		
Ti	tle V and XIX Services					1.00		2.0	00	
90.00 Do	es this facility have title V s or "N" for no in the applica		hospital ser	vi ces? E	nter "Y" for	N		Y		90.00
91.00 Ís	this hospital reimbursed for	title V and/or XIX th				N		Y		91.00
	ll or in part? Enter "Y" for y e title XIX NF patients occupy							N		92.00
i n	es this facility operate an IC	or"N" for no in the	applicable of	column.		N		N		93.00
"Y 94.00 Do	" for yes or "N" for no in the wes title V or XIX reduce capit	applicable column.				N		N		93.00 94.00
lap	plicable column.					I		I		

Health Financial Systems REHABILITATION HOSE	PITAL OF FT WAY	/NE	١r	n Lieu	ı of For	m CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	F	Period: From 10/01/ Fo 09/30/	2014 2015	Workshe Part I Date/Ti	me Pre	pared:
			V		2/23/20 XI		3 pm
			1.00		2.0	0	_
 95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column. 			N	0.00	Ν		95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the ap	plicable colum	n		0.00		0.00	97.00
Rural Providers 105.00 Does this hospital qualify as a critical access hospital (C. 106.00 on this facility qualifies as a CAH, has it elected the all		hod of payment	N N				105. 00 106. 00
<pre>for outpatient services? (see instructions) 107.00 f this facility qualifies as a CAH, is it eligible for cos training programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col reimbursed. If yes complete Wkst. D-2, Pt. II.</pre>	n 1. (see insti	ructions) lf	N				107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	1		N		-		108.00
	Physi cal 1.00	Occupational	Speech		Respir		-
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.		2.00 N	3.00 N		4.0 N		109.00
				-	1.0	00	-
110.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N"		on project (41	OA Demo)for	-	N		110.00
				1.00	2.00	3.00	_
Miscellaneous Cost Reporting Information 115.00(Is this an all-inclusive rate provider? Enter "Y" for yes o	r "N" for no iu	n column 1 lf	colump 1	N	1	0	115.00
is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide Pub.15-1, chapter 22, §2208.1.	. If column 2 i nt for long te rs) based on tl	is "E", enter rm care (inclu he definition	in column des			0	
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insu no.	2		"N" for	N N			116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1 i	if the policy	is	1			118.00
jerann-made. Enter zint the porrey is decurrence.		Premi ums	Losses	5	Insur	ance	
		1.00	2.00		3. 0	0	-
118.01 List amounts of malpractice premiums and paid losses:				3, 936	3.0		118.01
			1.00		2.0	0	-
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche- and amounts contained therein.			1.00 N		2.0	10	118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hole \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendment	n column 1, "Y ualifies for th	" for yes or he Outpatient	N		Ν		119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impli- patients? Enter "Y" for yes or "N" for no. Transclupt Contor Laformation	antable devices	s charged to	N				121.00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" for	or yes and "N"	for no. If	N				125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column		fication date					126. 00
127.00 If this is a Medicare certified heart transplant center, en	ter the certifi	ication date					127.00
in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column	ter the certifi	ication date					128.00
129.00 If this is a Medicare certified lung transplant center, ent		cation date in					129. 00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in co		ti fi cati on					130. 00
131.00 If this is a Medicare certified intestinal transplant cente	r, enter the c	erti fi cati on					131.00
date in column 1 and termination date, if applicable, in co 132.00 If this is a Medicare certified islet transplant center, en in column 1 and termination date, if applicable, in column	ter the certifi	ication date					132.00
133.00 If this is a Medicare certified other transplant center, en in column 1 and termination date, if applicable, in column	ter the certifi 2.						133.00
134.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.	he OPO number i	in column 1					134.00

Health Financial Systems	REHABILI TATION F	HOSPI TAL	OF FT WAYNE			In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	K IDENTIFICATION DATA		Provider CCM	N: 153030		: 0/01/2014 9/30/2015	Worksheet S-2 Part I Date/Time Pre 2/23/2016 2:5	pared:
						1.00	2.00	
All Providers 140.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1.	lf yes,	and home of	fice cost	s	Y	449008	140. 00
1.00		2.00				3.00		
If this facility is part of a chai				143 the	name an	d address	of the	
home office and enter the home off 141.00 Name: CHS/COMMUNITY HEALTH SYSTEM I NC.	<u>ice contractor name an</u> IS, Contractor's Name		SIN PHYSICIAN	I Contrac	tor's Nu	umber: 1030	1	141.00
142.00 Street: 4000 MERIDIAN BLVD	PO Box:	SERVI SE						142.00
143.00 City: FRANKLIN	State:	TN		Zip Cod	e:	3706	7	143.00
							1.00	-
144.00 Are provider based physicians' cos	ts included in Worksho	ot 12					1.00 Y	144.00
144. OUALE PLOVI del Dased physicialis Cos	ts meruded m worksne	et A?					T	144.00
						1.00	2.00	1
145.00 If costs for renal services are cl inpatient services only? Enter "Y" no, does the dialysis facility inc	for yes or "N" for no lude Medicare utilizat	in colu	mn 1. lf col	umn 1 is		N		145.00
period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	y changed from the pre column 1. (See CMS Pul				f	Ν		146. 00
							1.00	
147.00 Was there a change in the statisti							N	147.00
148.00 Was there a change in the order of 149.00 Was there a change to the simplifi					r no		N N	148.00 149.00
			Part A	Part B		Fitle V	Title XIX	149.00
			1.00	2.00		3.00	4.00	1
Does this facility contain a provi								
or charges? Enter "Y" for yes or "	N" for no for each com	ponent f			(See 4		· · ·	-
155.00Hospi tal			N	N		N	N	155.00
156.00 Subprovider - IPF 157.00 Subprovider - IRF			N N	N N		N N	N N	156.00 157.00
158. 00 SUBPROVI DER				IN IN		IN IN	, IN	158.00
159. 00 SNF			N	Ν		Ν	N	159.00
160.00 HOME HEALTH AGENCY			N	Ν		N	N	160. 00
161.00 CMHC				Ν		N	N	161.00
161. 10 CORF				N		N	N	161.10
							1.00	
Multicampus				- 1 11-00		204-2		1/5 00
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	inpus nospital that has	one or	more campuse	s in diff	erent Cl	SSAS?	N	165.00
	Name	Со	unty	State Z	ip Code	CBSA	FTE/Campus	
	0		. 00	2.00	3.00	4.00	5.00	
166.00 If line 165 is yes, for each							0.00	166.00
campus enter the name in column 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)								
							1.00	-
Health Information Technology (HIT) incentive in the Ame	eri can Re	covery and R	einvestme	ent Act		1.00	
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10	under §1886(n)? Enter 5 is "Y") and is a mean	r "Y" fo ningful	r yes or "N"	for no.		r the	N	167. 00 168. 00
reasonable cost incurred for the H 168.01 If this provider is a CAH and is n	ot a meaningful user, o	does thi				dshi p		168. 01
exception under §413.70(a)(6)(ii)? 169.00 If this provider is a meaningful u transition factor. (see instructio	ser (line 167 is "Y") a					enter the	0.00	169. 00
	,				Be	egi nni ng	Endi ng	
						1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)	eginning date and endi	ng date	for the repo	rting				170. 00

Health Financial Systems	REHABILITATION HOSPITAL	OF FT WAYNE	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMF	PLEX IDENTIFICATION DATA	Provider CCN: 153030	From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Pre 2/23/2016 2:5	epared:
				1,00	-
171.00 If line 167 is "Y", does this pu Medicare cost plans reported on (see instructions)				1.00	171.00

	Financial Systems REHAE AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	BILITATION HOSPITAL OF F STIONNAIRE Provi		CCN: 153030 F F	Period: From 10/01/2014 To 09/30/2015		2 epared:
				· · ·	Y/N	Date	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for all N	10 res	sponses. Enter	1.00 all dates in t	2.00 the	_
Ì	Provider Organization and Operation Has the provider changed ownership immediatel				N		1.0
	reporting period? If yes, enter the date of t	ine change in corumn z. (Y/N	Date	V/I	
				1.00	2.00	3.00	
	Has the provider terminated participation in yes, enter in column 2 the date of terminatic voluntary or "I" for involuntary.			Ν			2.0
	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or f	, chain home offices, dr d to the provider or its , or members of the boar	rug	Ν			3. 0
	relationships? (see instructions)				_	-	
			-	Y/N 1.00	Туре 2.00	Date 3.00	
	Financial Data and Reports			1.00	2.00	5.00	
00	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr	Audited, "C" for Compile enter date available in		N			4.0
00	Are the cost report total expenses and total those on the filed financial statements? If y	revenues different from	on.	Ν			5. 0
					Y/N	Legal Oper.	
	Approved Educational Activities				1.00	2.00	
00	Column 1: Are costs claimed for nursing scho the legal operator of the program?			e provider is	N		6. C
	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health prog cost reporting period? If yes, see instruction	grams approved and/or rer		during the	N N		7. C 8. C
	Are costs claimed for Interns and Residents i program in the current cost report? If yes, s	see instructions.			N		9.0
	Was an approved Intern and Resident GME progr cost reporting period? If yes, see instructic Are GME cost directly assigned to cost center	ons. rs other than I & R in ar			N		10.0
	Teaching Program on Worksheet A? If yes, see	instructions.				Y/N	-
						1.00	-
	Bad Debts						
00	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad deb period? If yes, submit copy.				st reporting	Y N	12. 0 13. 0
00	If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments waived	1? If	yes, see inst	ructions.	N	14. C
. 00	Did total beds available change from the pric	or cost reporting period?	?lfy			N	15.0
		Description	-	Par Y/N	-t A Date	Part B Y/N	
		0		1.00	2.00	3.00	-
	PS&R Data				I	1	
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see			Y	01/29/2016	Y	16.0
00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is			Ν		Ν	17.0
	yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional			Ν		Ν	18.0
00	claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of			Ν		N	19. C
	other PS&R Report information? If yes, see instructions. If line 16 or 17 is yes, were adjustments			N		N	20. 0

Heal th	Financial Systems REHAI	BILITATION HOS	PITAL OF FT WAY	/NE	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		Period:	Worksheet S-2	2
					rom 10/01/2014 o 09/30/2015		nared
						2/23/2016 2:5	
		5			rt A	Part B	
			iption 0	Y/N 1.00	Date 2.00	Y/N 3.00	
21.00	Was the cost report prepared only using the		0	N 1.00	2.00	3.00	21.00
21.00	provider's records? If yes, see						21.00
	instructions.						
						1 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT		DT CULLDENS U			1.00	
	Capital Related Cost	ALS UNET (LAG		03111723)			1
22.00	Have assets been relifed for Medicare purpose	es? If yes, se	e instructions				22.00
23.00	Have changes occurred in the Medicare depreci	ation expense	due to apprais	als made durir	ng the cost		23.00
24.00	reporting period? If yes, see instructions.	- Langage anton	ad into during	this post mone	sting pariod2		24.00
24.00	Were new leases and/or amendments to existing If yes, see instructions	g reases enter	eu mito during	this cost repu	n tring period?		24.00
25.00	Have there been new capitalized leases entere instructions.	ed into during	the cost repor	ting period? I	fyes, see		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acqu	uired during tl	he cost reporti	ng period? If	yes, see		26.00
	instructions.	0		0 1			
27.00	Has the provider's capitalization policy char	nged during the	e cost reportin	g period? If y	ves, submit		27.00
	copy. Interest Expense					<u> </u>	-
28.00	Were new Loans, mortgage agreements or letter	rs of credit e	ntered into dur	ing the cost r	eporting		28.00
	period? If yes, see instructions.			-			
29.00	Did the provider have a funded depreciation a			bt Service Res	erve Fund)		29.00
30, 00	treated as a funded depreciation account? If Has existing debt been replaced prior to its			deht? If ves	SAA		30.00
50.00	instructions.	Schedul ed matt	arrey wren new	debt: 11 yes,	300		30.00
31.00	Has debt been recalled before scheduled matur	rity without is	ssuance of new	debt? If yes,	see		31.00
	instructions.						-
32.00	Purchased Services Have changes or new agreements occurred in pa	ationt care se	rvices furnishe	d through cont	ractual		32.00
52.00	arrangements with suppliers of services? If y			a through cont	i ac tuai		52.00
33.00	If line 32 is yes, were the requirements of S			g to competiti	ve bidding? If		33.00
	no, see instructions.						-
34 00	Provider-Based Physicians Are services furnished at the provider facili	ty under an a	rrangement with	nrovi der-base	d như si ci ans?		34.00
54.00	If yes, see instructions.			provider-base			54.00
35.00	If line 34 is yes, were there new agreements	or amended exi	isting agreemen	ts with the pr	ovi der-based		35.00
	physicians during the cost reporting period?	lfyes, see in	nstructions.				
					Y/N 1.00	Date 2.00	
	Home Office Costs				1.00	2.00	
	Were home office costs claimed on the cost re	eport?			Y		36.00
37.00	If line 36 is yes, has a home office cost sta	atement been p	repared by the	home office?	Ν		37.00
20.00	If yes, see instructions.	af the home of	fi oo di fforont	from that of	V	10/01/0014	20.00
38.00	If line 36 is yes, was the fiscal year end of the provider? If yes, enter in column 2 the f				Y	12/31/2014	38.00
39.00	If line 36 is yes, did the provider render se				Ν		39.00
	see instructions.						
40.00	If line 36 is yes, did the provider render se	ervices to the	home office?	lfyes, see	Ν		40.00
	instructions.						
			1.	00	2.	00	
	Cost Report Preparer Contact Information						_
41.00	Enter the first name, last name and the title	•	BRI TTNI		KI NG		41.00
	held by the cost report preparer in columns 1 respectively.	1, 2, and 3,					
42.00	Enter the employer/company name of the cost r	report	COMMUNITY HEAL	TH SYSTEMS			42.00
	preparer.						
43.00	Enter the telephone number and email address		615-465-2769		BRI TTNI _KI NG@C	HS. NET	43.00
	report preparer in columns 1 and 2, respectiv	/егу.	1		1		

		BILITATION HOS			150000		u of Form CMS-	
HOSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE		Prov	vider CCN:		Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part II Date/Time Pre 2/23/2016 2:5	epared:
		Part B						
		Date						
		4.00						
	PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	01/29/2016						16.00
17.00								17.00
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.							18.00
19. 00								19.0
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:							20. 0
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.							21.0
				3.00		_		
	Cost Report Preparer Contact Information			5.00				
41.00			SENI OR RE	VENUE MAN	AGER			41. C
42.00	Enter the employer/company name of the cost r preparer.	report						42.0
43.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv							43.0

OSPI T	Financial Systems REHA AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Pr	ovi der	CCN: 153030		eri od:	Worksheet S		2552-1
						Fr To	rom 10/01/2014 09/30/2015	Part I Date/Time P 2/23/2016 2		
								I/P Days / O Visits / Tri		
	Component	Worksheet A	No. of	Beds	Bed Days		CAH Hours	Title V	<u>ps</u>	
		Line Number			Avai I abl e					
		1.00	2. (3.00		4.00	5.00		
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		36	13, 1	40	0.00		0	1. (
	8 exclude Swing Bed, Observation Bed and									
	Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)									
. 00	HMO and other (see instructions)									2.
. 00	HMO I PF Subprovi der									2. 3.
. 00	HMO I RF Subprovi der									4.
. 00	Hospital Adults & Peds. Swing Bed SNF								0	5.
. 00	Hospital Adults & Peds. Swing Bed NF								0	6.
. 00	Total Adults and Peds. (exclude observation			36	13, 1	40	0.00		0	7.
00	beds) (see instructions)			50	10, 1	-0	0.00		0	7.
00	INTENSIVE CARE UNIT	31.00		0		0	0.00		0	8.
00	CORONARY CARE UNIT	32.00		0		0	0.00		0	9.
). 00	BURN INTENSIVE CARE UNIT	33.00		0		0	0.00		0	10.
. 00	SURGI CAL I NTENSI VE CARE UNI T	34.00		0		0	0.00		0	11.
2.00	OTHER SPECIAL CARE (SPECIFY)	0 11 00				Ŭ	01.00		Ŭ	12.
3.00	NURSERY	43.00							0	13.
. 00	Total (see instructions)	101 00		36	13, 1	40	0.00		0	14.
. 00	CAH visits								0	15.
. 00	SUBPROVIDER - IPF								-	16.
. 00	SUBPROVIDER - IRF	41.00		0		0			0	17.
. 00	SUBPROVI DER	42.00		0		0			0	18.
. 00	SKILLED NURSING FACILITY								-	19
. 00	NURSING FACILITY									20
. 00	OTHER LONG TERM CARE									21
. 00	HOME HEALTH AGENCY									22
. 00	AMBULATORY SURGICAL CENTER (D. P.)									23
00	HOSPI CE									24
10	HOSPICE (non-distinct part)	30.00								24
00	CMHC – CMHC									25
. 10	CMHC - CORF	99.10							0	25
. 00	RURAL HEALTH CLINIC	88.00							0	26.
. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00							0	26
. 00	Total (sum of lines 14-26)			36						27
. 00	Observation Bed Days								0	28.
. 00	Ambul ance Trips									29
. 00	Employee discount days (see instruction)									30.
. 00	Employee discount days - IRF									31.
. 00	Labor & delivery days (see instructions)			0		0				32.
. 01	Total ancillary labor & delivery room									32.
	outpatient days (see instructions)									
3.00	LTCH non-covered days									33.

	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider	F	Period: From 10/01/2014 Fo 09/30/2015	Worksheet S-3 Part I Date/Time Pre 2/23/2016 2:5	parec
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	·	6.00	7.00	8.00	9.00	10.00	
00	Hospital Adults & Peds. (columns 5, 6, 7 and	2, 353	610			10100	1.
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
00	HMO and other (see instructions)	773	0				2.
00	HMO IPF Subprovider	0	0				3.
00	HMO IRF Subprovider	0	0				4
00	Hospital Adults & Peds. Swing Bed SNF	0	0				5.
00	Hospital Adults & Peds. Swing Bed NF	0	0		2		6
00	Total Adults and Peds. (exclude observation	2, 353	610				7
00	beds) (see instructions)	2, 555	010	5, 55,			'
00	INTENSIVE CARE UNIT	0	0	(8
00	CORONARY CARE UNIT	0	0				9
		0	0				
. 00	BURN INTENSIVE CARE UNIT	0	•				10
. 00	SURGI CAL I NTENSI VE CARE UNI T	0	0	, ()		11
. 00	OTHER SPECIAL CARE (SPECIFY)						12
. 00	NURSERY		0				13
. 00	Total (see instructions)	2, 353	610		0.00	82.64	
. 00	CAH visits	0	0	()		15
. 00	SUBPROVIDER - IPF						16
. 00	SUBPROVIDER - IRF	0	0			0.00	
. 00	SUBPROVI DER	0	0	(0.00	0.00	
. 00	SKILLED NURSING FACILITY						19
. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
. 00	HOME HEALTH AGENCY						22
. 00	AMBULATORY SURGICAL CENTER (D. P.)						23
. 00	HOSPICE						24
. 10	HOSPICE (non-distinct part)	0	0	()		24
. 00	CMHC - CMHC						25
. 10	CMHC - CORF	0	0	(0.00	0.00	25
. 00	RURAL HEALTH CLINIC	0	0	(0.00	0,00	26
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0.00	26
. 00	Total (sum of lines 14-26)				0.00	82.64	
. 00	Observation Bed Days		0	(28
. 00	Ambulance Trips	0	0				29
. 00	Employee discount days (see instruction)	0		0			30
. 00	Employee discount days (see fistraction)						31
. 00	Labor & delivery days (see instructions)	0	0				31
		0	0				
2. 01	Total ancillary labor & delivery room						32
	outpatient days (see instructions)				1		33

OSPI ⁻	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 153030	Period: From 10/01/2014 To 09/30/2015	Worksheet S-3 Part I Date/Time Pre 2/23/2016 2:55	
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Patients	
		11.00	12.00	13.00	14.00	15.00	
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT		0		12 46 56 0 0 0	492	1. 2. 3. 4. 5. 6. 7. 8. 9.
0.00 1.00 2.00 3.00 4.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions)	0. 00	0	2	12 46	492	
5. 00 5. 00	CAH visits SUBPROVIDER - IPF						15. 16.
7.00 3.00 9.000 9.000 9.000 9.000 9.000 9.0000 9.000 9.000 9.000 9.	SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	0. 00 0. 00	0000		0 0 0 0	000	17. 18. 19. 20. 21. 22. 23. 24. 24. 25.
5. 10 5. 00 5. 25 7. 00 8. 00 9. 00 9. 00 9. 00 9. 00 9. 00 2. 00 2. 01	CMHC - CORF RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0.00 0.00 0.00 0.00					25. 25. 26. 27. 28. 29. 30. 31. 32. 32. 33.

RECLAS	Financial Systems REHA SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	BILITATION HOSPI F EXPENSES		CCN: 153030 P	eri od:	u of Form CMS- Worksheet A	2002
					rom 10/01/2014 o 09/30/2015	Date/Time Pre 2/23/2016 2:5	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)		
		1.00	2.00	3.00	4.00	5.00	
1 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	1	277.020	077.000	205, 077	482, 915	1 1 00
1.00 2.00	00200 NEW CAP REL COSTS-BLDG & FIXT		277, 838 177, 428			482, 915 251, 982	
2.00 3.00	00300 OTHER CAPITAL RELATED COSTS		177, 428			231, 982	1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	123, 470	27, 071	-	-	935, 257	
5.01	00570 ADMI TTI NG	269,047	390, 858			659, 699	
5.02	00590 OTHER ADMINISTRATIVE AND GENERAL	375, 574	2,037,666			887, 795	
7.00	00700 OPERATION OF PLANT	194, 284	417, 872			608, 604	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	31, 522	31, 522	0	31, 522	8.00
9.00	00900 HOUSEKEEPI NG	81, 642	21, 576	103, 218	-43	103, 175	9.00
10. 00	01000 DI ETARY	275, 759	192, 836	468, 595	-312, 081	156, 514	10.00
11.00	01100 CAFETERI A	0	0	C	311, 016	311, 016	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	252, 846	22, 139			274, 867	
14.00	01400 CENTRAL SERVICE & SUPPLY	7, 450	78, 351			32, 461	
15.00	01500 PHARMACY	92, 864	201, 786			103, 199	
16.00	01600 MEDICAL RECORDS & LIBRARY	154, 115	58, 448			209, 915	
17.00	01700 SOCIAL SERVICE	0	0	C	0 0	0	17.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 (10 457	01/ 417	1 000 074	407 401	2 257 255	1 20 00
30.00	03000 ADULTS & PEDIATRICS	1, 613, 457	216, 417			2, 257, 355	
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0	0		0	0	
32.00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		0	0	
41.00	04100 SUBPROVIDER - IRF	0	0		0	0	
42.00	04200 SUBPROVI DER	0	0	-	-	0	
43.00	04300 NURSERY	0	0	-	-	0	
	ANCI LLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	14, 095	14, 095	0	14, 095	54.00
57.00	05700 CT SCAN	0	0	C	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59.00
60. 00	06000 LABORATORY	28, 560	35, 119	63, 679	0	63, 679	
60. 01	06001 BLOOD LABORATORY	0	0	-	0	0	
65.00	06500 RESPI RATORY THERAPY	3, 771	11, 228			4, 582	
66.00	06600 PHYSI CAL THERAPY	479, 185	54, 090			531, 637	
67.00	06700 OCCUPATIONAL THERAPY	630, 685	60, 065			690, 750	
68.00		220, 914	25, 723			246, 633	
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	406	3, 035			3, 441	
72.00	07200 IMPL. DEV. CHARGED TO PATTENTS	0	0			11, 250 0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	-	-	183, 791	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	41, 579	6, 034	-			76.00
76.01	03950 HEMODI ALYSI S & OTHER ANCI LLARY	0	35, 030				
	OUTPATIENT SERVICE COST CENTERS		00,000	00,000		00,000	
88.00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
89.00		0	0			0	
	OTHER REIMBURSABLE COST CENTERS						
99. 10		0	0	C	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION	0	0				109.00
	11000 INTESTINAL ACQUISITION	0	0		-		110. 00
	11100 I SLET ACQUI SI TI ON	0	0	C	0		111.00
	11300 INTEREST EXPENSE		0	C	0		113.00
118.00		4, 845, 608	4, 396, 227	9, 241, 835	-103, 084	9, 138, 751	1118.00
100 -	NONREI MBURSABLE COST CENTERS						100 -
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	141	3, 353				192.00
194.00	07950 MARKETI NG/PUBLI C RELATI ONS	0	0		103, 170 0		194.00
10/ 01							
194.01 200.00	IO7951 TENANT LEASED SPACE TOTAL (SUM OF LINES 118-199)	4, 845, 749	4, 399, 580	9, 245, 329			200 0

Heal th	Fi nanci al	Systems	

 REHABILITATION HOSPITAL OF FT WAYNE
 In Lieu of Form CMS-2552-10

RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provi der	CCN: 153030	Period: From 10/01/2014 To 09/30/2015	Worksheet A Date/Time Prep	ared [.]
						2/23/2016 2:53	
	Cost Center Description	Adjustments	Net Expenses				
		(See A-8) 6.00	For Allocation 7.00	-			
	GENERAL SERVICE COST CENTERS	0.00	1.00				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	137, 996	620, 911				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-74,030		•			2.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0		1			3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	935, 257				4.00
5.01	00570 ADMI TTI NG	-303, 471					5.01
5.02	00590 OTHER ADMINISTRATIVE AND GENERAL	126, 445	1, 014, 240				5.02
7.00	00700 OPERATION OF PLANT	-4,852	603, 752				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	5, 679	37, 201				8.00
9.00	00900 HOUSEKEEPI NG	0	103, 175				9.00
10.00	01000 DI ETARY	0	156, 514				10.00
11.00	01100 CAFETERI A	-67,683	243, 333				11.00
13.00	01300 NURSING ADMINISTRATION	0	274, 867				13.00
14.00	01400 CENTRAL SERVICE & SUPPLY	-21, 335					14.00
15.00		0					15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	- 30		1			16.00
17.00	01700 SOCIAL SERVICE	0	0				17.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS	1/0 47/	0.007.470	1			~~ ~
30.00	03000 ADULTS & PEDIATRICS	-160, 176					30.00
31.00		0	-				31.00
32.00	03200 CORONARY CARE UNIT	0	0				32.00
33.00		0	0				33.00
34.00 41.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	0	0				34.00 41.00
41.00	04200 SUBPROVIDER - TRF	0	0				41.00
42.00	04300 NURSERY	0					43.00
43.00	ANCI LLARY SERVICE COST CENTERS	0	0	1			45.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	14, 095				54.00
57.00	05700 CT SCAN	0					57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0					58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60.00	06000 LABORATORY	0	63, 679				60.00
60. 01	06001 BLOOD LABORATORY	0	0				60. O ²
65.00	06500 RESPI RATORY THERAPY	0	4, 582				65.00
66.00	06600 PHYSI CAL THERAPY	0	531, 637				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	690, 750				67.00
68.00	06800 SPEECH PATHOLOGY	0	246, 633				68.00
69.00	06900 ELECTROCARDI OLOGY	0	3, 441				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11, 250				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		1			73.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0					76.00
76. 01		0	35, 030				76. 0 ⁻
~~ ~~	OUTPATIENT SERVICE COST CENTERS			1			~~ ~
	08800 RURAL HEALTH CLINIC	0					88.00
07. UU	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1			89.00
00 10	OTHER REIMBURSABLE COST CENTERS	0	0				99.10
77.10	SPECIAL PURPOSE COST CENTERS	0	0	1			77.10
109 00	DI0900 PANCREAS ACQUISITION	0	0			1	109.00
	11000 INTESTINAL ACQUISITION	0					110.00
	11100 I SLET ACQUI SI TI ON	0					111.00
	11300 INTEREST EXPENSE	0	0				113.00
118.00		-361, 457	8, 777, 294				118.00
. 5. 50	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			1	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0		1			192.00
	07950 MARKETI NG/PUBLIC RELATIONS	0		1			194.00
		-					
194.01	07951 TENANT LEASED SPACE	0	0	1		[1	194. Oʻ

Health Financial Systems RECLASSIFICATIONS

REHABILITATION HOSPITAL OF FT WAYNE

Provider CCN: 153030

ASS	IFICATIONS			Provi der	CCN: 153030	Peri od:	Worksheet A-6	
						From 10/01/2014 To 09/30/2015	Date/Time Prep 2/23/2016 2:53	
		Increases						
	Cost Center	Line #	Salary	Other				
		3.00	4.00	5.00				
	A - EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT	4.00	0	784, 973				1
	EMPLOTEE BENEFITS DEPARTMENT	0.00	0	/04, 9/3				2
		0.00	0	0				3
		0.00	0	0				4
	<u> </u>			784, 973				
	B - RENTAL AND LEASE	•		· · ·				
	NEW CAP REL COSTS-MVBLE	2.00	0	74, 554				1
	EQUI P							
		0.00	0	0				2
)		0.00	0	0				3
		0.00	0	0				4
		0.00	0	0				6
)		0.00 0.00	0	0				7 8
		0.00	0	0				ç
0		0.00	0	0				10
00		0.00	0	0				11
00		0.00	0	0				12
00		0.00	0	0				13
00		0.00	0	0				14
00		0.00	0	0				15
00		0.00	0	0	_			16
	0		0	74, 554				
- H	C - OTHER CAPITAL COSTS		_		T			
	NEW CAP REL COSTS-BLDG &	1.00	0	18, 095				1
	FIXT NEW CAP REL COSTS-BLDG &	1.00	o	186, 982				2
	FIXT	1.00	0	100, 902				2
		+			-			
	D - MARKETING		-1					
) [MARKETING/PUBLIC RELATIONS	194.00	86, 048	17, 122				1
[0		86, 048	17, 122				
	E - MEDICAL SUPPLIES							
	MEDICAL SUPPLIES CHARGED TO	71.00	0	10, 739				1
-	PATI ENTS	+						
ł			0	10, 739				
	F - PHYSICIAN DIRECTORS ADULTS & PEDIATRICS	30.00	0	427, 709				1
ŕ		<u>30.00</u>	0	427,709				
	G - DRUGS CHARGED TO PATIENTS	I	0	427,707	I			
	DRUGS CHARGED TO PATIENTS	73.00	0	183, 791				1
	<u> </u>			183, 791	1			-
İ	H - DIETARY							
	CAFETERI A	11.00	183, 444	127, 572				1
	0		183, 444	127, 572	<u> </u>			
[I – OXYGEN COSTS							
	MEDICAL SUPPLIES CHARGED TO	71.00	0	511				1
ļ	PATI ENTS	+						
	U		0	511	1			

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	S

REHABILITATION HOSPITAL OF FT WAYNE

Provi c

In Lieu of Form CMS-2552-10 Worksheet A-6

der	CCN:	153030	Peri od:
			E 10

Peri od:Worksheet A-6From 10/01/2014Date/Time Prepared:To09/30/2015

						To 09/30/2015	Date/Time Prepared: 2/23/2016 2:53 pm
		Decreases					
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS				1	-	
1.00	OTHER ADMINISTRATIVE AND	5.02	0	784, 711	(2	1.00
	GENERAL						
2.00	PHYSICAL THERAPY	66.00	0	45			2.00
3.00	HOUSEKEEPING	9.00	0	43			3.00
4.00	ADULTS & PEDIATRICS		0	174		2	4.00
	0		0	784, 973			
	B - RENTAL AND LEASE		-		-	-1	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	257			1.00
2.00	ADMI TTI NG	5.01	0	206			2.00
3.00	OTHER ADMINISTRATIVE AND	5.02	0	4, 778	(ן	3.00
	GENERAL		_				
4.00	OPERATION OF PLANT	7.00	0	3, 552			4.00
6.00	DI ETARY	10.00	0	1, 065			6.00
7.00	NURSING ADMINISTRATION	13.00	0	118			7.00
8.00	CENTRAL SERVICE & SUPPLY	14.00	0	42, 601	(8.00
9.00	PHARMACY	15.00	0	7,660			9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	2, 648			10.00
11.00	ADULTS & PEDIATRICS	30.00	0	54			11.00
12.00	RESPI RATORY THERAPY	65.00	0	9, 906			12.00
13.00	PHYSICAL THERAPY	66.00	0	1, 593			13.00
14.00	SPEECH PATHOLOGY	68.00	0	4	(14.00
15.00	PSYCHI ATRI C/PSYCHOLOGI CAL	76.00	0	26	(ס	15.00
	SERVICES						
16.00	PHYSICIANS' PRIVATE OFFICES	<u> </u>	0	86		2	16.00
	0		0	74, 554			
	C - OTHER CAPITAL COSTS				1	1	
1.00	OTHER ADMINISTRATIVE AND	5.02	0	18, 095	12	2	1.00
	GENERAL		_				
2.00	OTHER ADMINISTRATIVE AND	5.02	0	186, 982	13	3	2.00
	<u>GENERAL</u>					4	
	0		0	205, 077			
4 00	D - MARKETING	5 00	04.040	17 100			
1.00	OTHER ADMINISTRATIVE AND	5.02	86, 048	17, 122	(1.00
	<u>GENERAL</u>	+			<u> </u>	-	
			86, 048	17, 122			
1.00	E - MEDICAL SUPPLIES	14.00	0	10, 739	(1.00
1.00	CENTRAL SERVICE & SUPPLY	<u>14.</u> 00	0	10, 739 10, 739		4	1.00
	F - PHYSICIAN DIRECTORS		U	10, 739			
1 00		E 02	0	407 700			1.00
1.00	OTHER ADMINISTRATIVE AND	5.02	0	427, 709	(1.00
	GENERAL	+				-	
	5	ļ I.	0	427, 709			
1 00	G - DRUGS CHARGED TO PATIENTS		0	102 701			1.00
1.00	PHARMACY	<u>15.</u> 00	0			-	1.00
			U	183, 791		I	
1 00	H - DIETARY	10.00	102 444	107 570			1.00
1.00	DI ETARY		183, 444	127,572		2	1.00
			183, 444	127, 572			
1 00	I - OXYGEN COSTS	(E. 00		F 1 4	1		
1.00	RESPIRATORY_THERAPY	<u>65.</u> 00	0	511		2	1.00
	U Grand Total: Decreases		269, 492	511 1, 832, 048		4	500.00

Heal th	Financial Systems REHA	BILITATION HOSF	NITAL OF FT WAY	'NE	In Lie	eu of Form CMS-2	2552-10
	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 153030	Period: From 10/01/2014 To 09/30/2015		pared:
				Acqui si ti on	S	272072010 210	
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	900, 000	0		0 0	0	1.00
2.00	Land Improvements	276, 744	0		0 0	0	2.00
3.00	Buildings and Fixtures	11, 841, 265	158, 949		0 158, 949	104, 910	3.00
4.00	Building Improvements	659, 206	52, 138		0 52, 138	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	0	0		0 0	0	6.00
7.00	HIT designated Assets	8, 135	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	13, 685, 350	211, 087		0 211, 087	104, 910	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	13, 685, 350	211, 087		0 211, 087	104, 910	10.00
		Ending Balance	Fully				
		Ŭ	Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	900, 000	0				1.00
2.00	Land Improvements	276, 744	0				2.00
3.00	Buildings and Fixtures	11, 895, 304	0				3.00
4.00	Building Improvements	711, 344	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	8, 135	0				7.00
8.00	Subtotal (sum of lines 1-7)	13, 791, 527	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	13, 791, 527	0				10.00

Health Financial Systems RE	HABILITATION HOS	PITAL OF FT WAY	/NE	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 153030	Peri od:	Worksheet A-7	
				From 10/01/2014 To 09/30/2015		pared [.]
				10 07/00/2010	2/23/2016 2:5	<u>3 pm</u>
	SUMMARY OF CAPITAL					
Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
				instructions)	· · · · · · · · · · · · · · · · · · ·	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WO			nd 2			
1.00 NEW CAP REL COSTS-BLDG & FLXT	277, 838	0		0 0	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	177, 428	0		0 0	0	2.00
3.00 Total (sum of lines 1-2)	455, 266	0		0 0	0	3.00
	SUMMARY C	OF CAPITAL				
Cost Center Description	0ther	Total (1) (sum				
	Capi tal -Rel ate					
	d Costs (see	through 14)				
	instructions)					
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUN	<u>/N 2, LINES 1 a</u>	nd 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	C	277, 838				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	C	177, 428				2.00
3.00 Total (sum of lines 1-2)	C	455, 266				3.00

Health Financial Systems REH.	ABILITATION HOS	PITAL OF FT WAY	/NE	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 10/01/2014 Fo 09/30/2015		pared:
	COM	PUTATION OF RAT	ri os	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 NEW CAP REL COSTS-BLDG & FIXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0 0 0 11 ON OF OTHER (0 1.000000 0 0.000000 0 1.000000 SUMMARY 0	0 0	1.00 2.00 3.00
Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 NEW CAP REL COSTS-BLDG & FIXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	, s		0 315, 810 0 177, 952 0 493, 762	0	1.00 2.00 3.00
		SL	JMMARY OF CAPI			0100
Cost Center Description	Interest	Insurance (see instructions)			Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C			-			_
1.00 NEW CAP REL COSTS-BLDG & FIXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	100, 024 0 100, 024	0		0 0	177, 952	1.00 2.00 3.00

ci al	Systems	REHABILI TATI ON	HOSPI TAL	0F	FT

In Lieu of Form CMS-2552-10

DJUST	MENTS TO EXPENSES			Provi der CCN: 153030	Period: From 10/01/2014	Worksheet A-8	
					To 09/30/2015	Date/Time Pre 2/23/2016 2:5	
				Expense Classification of To/From Which the Amount is		2/23/2010 2.3	
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	1.00		NEW CAP REL COSTS-BLDG & FLXT	1.00	0	1.
00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		C	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2
00	2) Investment income - other		C		0.00	0	3
00	(chapter 2) Trade, quantity, and time		C		0.00	0	4
00	discounts (chapter 8) Refunds and rebates of		C		0.00	0	5
00	expenses (chapter 8) Rental of provider space by		C		0.00	0	6
	suppliers (chapter 8)		-				
00	Telephone services (pay stations excluded) (chapter		C		0.00	0	
00	21) Television and radio service (chapter 21)		C		0.00	0	8
00	Parking lot (chapter 21)		C		0.00	0	
. 00	Provider-based physician adjustment	A-8-2	-160, 176			0	
00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11
00	Related organization transactions (chapter 10)	A-8-1	241, 197			0	12
00	Laundry and linen service	P	C		0.00	0	
00 00	Cafeteria-employees and guests Rental of quarters to employee	B B		CAFETERIA NEW CAP REL COSTS-BLDG &	11.00 1.00	9	
00	and others Sale of medical and surgical supplies to other than		C	FIXT	0.00	0	16
00	patients Sale of drugs to other than		C		0.00	0	17
00	patients Sale of medical records and	в	-30	MEDICAL RECORDS & LIBRARY	16.00	0	18
	abstracts	D					
00	Nursing school (tuition, fees, books, etc.)		C		0.00	0	19
00	Vending machines	В	-892	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	20
. 00	Income from imposition of interest, finance or penalty		C		0.00	0	21
. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22
. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23
. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24
. 00	limitation (chapter 14) Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	* 114.00		25
00	(chapter 21) Depreciation - NEW CAP REL	A	47, 806	NEW CAP REL COSTS-BLDG &	1.00	9	26
00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL	А	-89, 877	FIXT NEW CAP REL COSTS-MVBLE	2.00	9	27
00	COSTS-MVBLE EQUIP Non-physician Anesthetist		C	EQUIP *** Cost Center Deleted ***	* 19.00		28
00	Physicians' assistant Adjustment for occupational	A-8-3	C	OCCUPATI ONAL THERAPY	0.00 67.00	0	29 30
00	therapy costs in excess of	¥-0-2	Ĺ	COULTIONAL INLKAPT	67.00		
. 99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30
. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31

Heal th	Financial Systems	REHAI	BILITATION HOSI	PITAL OF FT WAYNE	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 153030	Peri od:	Worksheet A-8	
					From 10/01/2014 To 09/30/2015		
				Expense Classification of	on Worksheet A		
				To/From Which the Amount i	s to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						
33.00	MI SCELANEOUS I NCOME	В		OTHER ADMINISTRATIVE AND	5.02	0	33.00
				GENERAL			
33.02	BAD DEBT EXPENSE	A		ADMI TTI NG	5.01		33. 02
33.03	PATIENT TELEPHONE EXPENSE	А		OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33. 03
33.06	PATIENT TV CABLE EXPENSE	А		OPERATION OF PLANT	7.00	0	33.06
33.07	CHARI TABLE CONTRI BUTI ONS	A		OTHER ADMINI STRATI VE AND	5.02		33.07
				GENERAL		_	
33.09	LOBBYING EXPENSE IN	A		OTHER ADMINISTRATIVE AND	5.02	0	33.09
	ASSOCIATION DUES			GENERAL			
50.00	TOTAL (sum of lines 1 thru 49)		-361, 457				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.

 (2) Basis for adjustment (see instructions).

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

 B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	REHABILITATION HOS	SPITAL OF FT WAYNE	In Lie	eu of Form CMS-	2552-10
STATEME	NT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 10/01/2014 To 09/30/2015		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00		NEW CAP REL COSTS-BLDG & FIX			0	1.00
2.00		NEW CAP REL COSTS-BLDG & FIX		782	0	2.00
3.00		NEW CAP REL COSTS-BLDG & FIX		1, 922	0	3.00
4.00		NEW CAP REL COSTS-MVBLE EQUI		12, 797	0	4.00
4.01		OTHER ADMINISTRATIVE AND GEN		184, 080		4.01
4.02		OTHER ADMINISTRATIVE AND GEN		8, 936		4.02
4.03			HOSPITAL LAUNDRY SERVICE	37, 201	31, 522	4.03
4.04	2.00	NEW CAP REL COSTS-MVBLE EQUI	PASI CAPITAL COSTS - MOVEABL	3, 050	0	4.04
4.05	5. 01	ADMI TTI NG	PASI OPERATING COSTS	4, 148	0	4.05
4.06	5. 01	ADMI TTI NG	PASI COLLECTION FEES	0	484	4.06
4.07	5. 01	ADMI TTI NG	EBOS FEES	0	79	4.07
4.08	5. 01	ADMI TTI NG	PASI LIEN UNIT COLLECTION FE	0	13	4.08
4.09	14.00	CENTRAL SERVICE & SUPPLY	HOSPITAL LAUNDRY SERVICE	0	21, 335	4.09
4.10	5. 02	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL ALLOCATIONS	31, 690	0	4.10
5.00	0		0	384, 630	143, 433	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	
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	FD ORGANIZATION(S) AND/OR HO	ME_OFFLCE:			

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

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

i oi iiiodii					
6.00	В		0.00 COMMUNI TY HEALT	100.00	6.00
7.00	В		0. 00 LUTHERAN	0.00	7.00
8.00	G	HOSPI TAL LAUNDR	0. 00 LAUNDRY	0.00	8.00
9.00	В		0. 00 PASI	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or	NON-FI NANCI AL			100.00
	non-financial) specify:				

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

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

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

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

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

E. Individual is director, officer, administrator, or key person of provider and related organization.

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

Health Financial Systems	REHABILITATION HOSPITAL OF	F FT WAYNE	In Lieu	ı of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATION	FED ORGANIZATIONS AND HOME Pr	rovider CCN: 153030	Period:	Worksheet A-8-1
OFFICE COSTS			From 10/01/2014	
			To 09/30/2015	Date/Time Prepared:

					2/23/2016 2:	53 pm
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
			ENTS REQUIRED AS A RESULT OF TRANS	ACTIONS WITH RELATED O	ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO					_
1.00	100, 024					1.00
2.00	782	9				2.00
3.00	1, 922	9				3.00
4.00	12, 797	9				4.00
4.01	184, 080					4.01
4.02	-81, 064					4.02
4.03	5, 679					4.03
4.04	3, 050	9				4.04
4.05	4, 148	0				4.05
4.06	-484	0				4.06
4.07	-79	0				4.07
4.08	-13	0				4.08
4.09	-21, 335	0				4.09
4.10	31, 690	0				4.10
5.00	241, 197					5.00

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

Related Organization(s) and/or Home Office		
Type of Business		
 6.00		
 B. INTERRELATIONSHIP TO RELAT	ED 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 XULL

1 01 110 01			
6.00	HEALTHCARE		6.00
7.00	HOSPI TAL		7.00
8.00	CONSOL LAUNDRY		8.00
9.00	DEBT COLLECTION		9.00
10.00			10.00
100.00			00.00
· · · · · ·			

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

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

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

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

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

E. Individual is director, officer, administrator, or key person of provider and related organization.

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

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

	ER BASED PHYSICI					Peri od:	Worksheet A-8	
1100101				11001 der		From 10/01/2014	Ļ į	. 2
						To 09/30/2015		
							2/23/2016 2:5	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component	
	1.00	2.00	0.00	4.00	F 00	(00	Hours	
1.00	1.00	2.00	3.00	4.00	5.00	6.00	7.00	1.00
1.00		ADULTS & PEDIATRICS	160, 176	160, 176	0			
2.00		INTENSIVE CARE UNIT	0	0	0	-	-	
3.00	0.00		0	-		-	0	3.00
4.00	0.00		0	0	C	0	0	4.00
5.00	0.00		0	0	(0	0	5.00
6.00	0.00		0	0	C	0	0	
7.00	0.00		0	0	(0	0	7.00
8.00	0.00		0	0	(0	0	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00		0	0	C	0	0	10.00
200.00			160, 176			1	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0	0	C		-	
2.00		INTENSIVE CARE UNIT	0	-			0	2.00
3.00	0.00		0	0	C		0	3.00
4.00	0.00		0	-	C	0	0	
5.00	0.00		0	0	C	0	0	5.00
6.00	0.00		0	0	C	0	0	
7.00	0.00		0	0	C	0	0	7.00
8.00	0.00		0	°	0	0	0	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00		0	0	C	0	0	10.00
200.00			0	0		-	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00		14	14.00	17.00	10.00	-	
1	1.00	2.00	15.00	16.00	17.00	18.00		1.05
1.00		ADULTS & PEDIATRICS	0	0	0			1.00
2.00		INTENSIVE CARE UNIT	0	0	-	-		2.00
3.00	0.00		0	0	C	-		3.00
4.00	0.00		0	0	C	-		4.00
5.00	0.00		0	0	C			5.00
6.00	0.00		0	-				6.00
7.00	0.00		0	Ŭ	C			7.00
8.00	0.00		0			-		8.00
9.00	0.00		0			-		9.00
10.00	0.00		0		C			10.00
200.00			0	0	C	160, 176		200.00

OST ALLO	CATION - GENERAL SERVICE COSTS				Period: From 10/01/2014 To 09/30/2015	Worksheet B Part I Date/Time Pre 2/23/2016 2:5	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL REL NEW BLDG & FI XT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	ADMI TTI NG	
		0	1.00	2.00	4.00	5. 01	
	ERAL SERVICE COST CENTERS	(00.011	(20, 011				1 1 0
. 00 002 . 00 004 . 01 005 . 02 005	00 NEW CAP REL COSTS-BLDG & FIXT 00 NEW CAP REL COSTS-MVBLE EQUIP 00 EMPLOYEE BENEFITS DEPARTMENT 70 ADMITTING 90 OTHER ADMINISTRATIVE AND GENERAL	620, 911 177, 952 935, 257 356, 228 1, 014, 240	620, 911 2, 505 12, 902 48, 867	177, 95 88 4, 55 17, 24	4 938, 646 3 53, 478 6 57, 549	427, 161 0	5.0
. 00 008 . 00 009 0. 00 010	00 OPERATION OF PLANT 00 LAUNDRY & LINEN SERVICE 00 HOUSEKEEPING 00 DIETARY 00 CAFETERIA	603, 752 37, 201 103, 175 156, 514 243, 333	113, 744 0 12, 288 0 47, 477	40, 14 4, 33 16, 75	0 0 7 16, 228 0 18, 349		8. 0 9. 0 10. 0
3.00 013 4.00 014 5.00 015	00 CAFETERTA 00 NURSI NG ADMI NI STRATI ON 00 CENTRAL SERVI CE & SUPPLY 00 PHARMACY 00 MEDI CAL RECORDS & LI BRARY	243, 333 274, 867 11, 126 103, 199 209, 885	47, 477 1, 329 9, 385 3, 977 4, 560	46 3, 31 1, 40 1, 60	9 50, 258 2 1, 481 3 18, 459	0 0 0 0 0) 13.0 14.0 15.0
7.00 017	00 SOCIAL SERVICE	0	2, 955	1, 04		0	
	ATLENT ROUTINE SERVICE COST CENTERS						
1.00 031 2.00 032	00 ADULTS & PEDIATRICS 00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT 00 BURN INTENSIVE CARE UNIT	2, 097, 179 0 0 0	79, 057 0 0 0		0 320, 705 0 0 0 0 0 0	150, 419 0 0 0) 31. C 32. C
1.00 041 2.00 042	00 SURGI CAL I NTENSI VE CARE UNI T 00 SUBPROVI DER – I RF 00 SUBPROVI DER 00 NURSERY	0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0	0 0 0 0	41. C
	I LLARY SERVI CE COST CENTERS						
	00 RADI OLOGY-DI AGNOSTI C	14, 095	4, 396	1, 55		8, 204	
	00 CT SCAN 00 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	
	OO CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
	00 LABORATORY	63, 679	0		0 5, 677	16, 534	60.
	01 BLOOD LABORATORY	0	0		0 0	0	
		4, 582	1,022	36		1,604	
	00 PHYSI CAL THERAPY 00 OCCUPATI ONAL THERAPY	531, 637 690, 750	103, 163 48, 704	36, 40 17, 18		68, 817 72, 986	
	00 SPEECH PATHOLOGY	246, 633	3, 691	1, 30		32, 085	
	OO ELECTROCARDI OLOGY	3, 441	0		0 81	656	
	00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	11, 250	0		0 0	10, 995	
	00 I MPL. DEV. CHARGED TO PATIENTS 00 DRUGS CHARGED TO PATIENTS	183, 791	0		0 0	0 55, 345	
	50 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	47, 587	4, 212	1, 48		5, 621	
	50 HEMODIALYSIS & OTHER ANCILLARY	35, 030	0		0 0	3, 895	
8.00 088 9.00 089	PATIENT SERVICE COST CENTERS 00 RURAL HEALTH CLINIC 00 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0 0 0	0	
01H 9.10 099	ER REIMBURSABLE COST CENTERS	0	0		0 0	0	99.1
	CIAL PURPOSE COST CENTERS						
	00 PANCREAS ACQUISITION	0	0		0 0		109. 0
	00 INTESTINAL ACQUISITION	0	0		0 0		110. 0
	00 I SLET ACQUI SI TI ON 00 I NTEREST EXPENSE	0	0		0 0	0	1111. 0 113. 0
13.00113 18.00	SUBTOTALS (SUM OF LINES 1-117)	8, 777, 294	504, 234	177, 95	921, 514	427, 161	
	REIMBURSABLE COST CENTERS						
90.00190	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.
	00 PHYSI CI ANS' PRI VATE OFFI CES	3, 408	0		0 28		192.
	50 MARKETI NG/PUBLI C RELATI ONS	103, 170	11/ / 77		0 17, 104		194.
94.01079 00.00	51 TENANT LEASED SPACE Cross Foot Adjustments	0	116, 677		0	0) 194. (200. (
		1					1200.1
01.00	Negative Cost Centers		0		0 0	0	201. (

	J	BILITATION HOS	PITAL OF FT WAY			u of Form CMS-	2552-10
COST	ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	eriod: rom 10/01/2014 o 09/30/2015	Worksheet B Part I Date/Time Pre 2/23/2016 2:5	epared: 3 pm
	Cost Center Description	Subtotal	OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5A. 01	5.02	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	1		1			
1.00 2.00 4.00 5.01 5.02 7.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	1, 137, 902 796, 259					1.00 2.00 4.00 5.01 5.02 7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY	37, 201 136, 028	3 19, 983	25, 338	42, 666 0 0	181, 349	
10. 00 11. 00	01100 CAFETERIA	174, 863 344, 028			-	27, 426	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	326, 923			0	768	
14.00		25, 304			-	5, 422	
15.00	01500 PHARMACY	127, 038				2, 297	
16.00	01600 MEDICAL RECORDS & LIBRARY	246, 687	7 36, 239	9, 402	0	2, 634	16.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	3, 998	1	· ·	0	1, 707	
30.00	03000 ADULTS & PEDIATRICS	2, 675, 260			23, 933	45, 669	
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T			0	0	0	31.00 32.00
33.00	03300 BURN I NTENSI VE CARE UNI T			0	0	0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T			0	0	0	
41.00	04100 SUBPROVIDER - IRF			0	0	0	
42.00	04200 SUBPROVI DER	0	o o	0	0	0	42.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	C	0	0	0	0	43.00
54.00		28, 246	6 4, 149	9, 064	0	2, 539	54.00
57.00	05700 CT SCAN	20, 240				2, 337	
58.00				0	0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	o o	0	0	0	59.00
60.00	06000 LABORATORY	85, 890	12, 617	0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	C	0 0	0	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	8, 319	1, 222	2, 108	0	591	65.00
66.00	06600 PHYSI CAL THERAPY	835, 273				59, 596	
67.00	06700 OCCUPATI ONAL THERAPY	954, 989				28, 135	
68.00	06800 SPEECH PATHOLOGY	327, 622			0	2, 132	
69.00		4, 178			0	0	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	22, 245			0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	239, 136	-	-	0	0	
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	67, 171			-	2, 433	
76.01	03950 HEMODIALYSIS & OTHER ANCILLARY	38, 925				0	
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	C	0 0			0	88.00
89.00		C	0 0	0	0	0	89.00
	OTHER REIMBURSABLE COST CENTERS	-	-1 -	-	_	-	
99. 10			0 0	0	0	0	99.10
100 0	SPECIAL PURPOSE COST CENTERS	C	0 0	0	0	0	109.00
	D11000 INTESTINAL ACQUISITION		-				1109.00
	D11100 I SLET ACQUI SI TI ON			0	0		111.00
	D11300 INTEREST EXPENSE			l	0	0	113.00
118.0	SUBTOTALS (SUM OF LINES 1-117)	8, 643, 485	5 1, 102, 589	672, 643	42, 666	181, 349	
	NONREI MBURSABLE COST CENTERS	1					1.00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0		190.00
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	3,436			0		192.00
	DO7950 MARKETING/PUBLIC RELATIONS 107951 TENANT LEASED SPACE	120, 274 116, 677			0		194. 00 194. 01
200.0		110,077		240, 388	0	0	200.00
200.0) n	0	0	n	200.00
202.0		8, 883, 872	1, 137, 902	913, 231	42, 666		

	Financial Systems REHA ALLOCATION - GENERAL SERVICE COSTS	<u>BILITATION HOSP</u>		CCN: 153030	Period: From 10/01/2014 To 09/30/2015	u of Form CMS- Worksheet B Part I Date/Time Pre 2/23/2016 2:5	epared:
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI C	CENTRAL ON SERVICE & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
4	GENERAL SERVICE COST CENTERS	1		1			1 1 25
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICE & SUPPLY 01500 PHARMACY	200, 551 0 0 0	519, 888 28, 883 0 9, 628	407, 34	.0 0 53, 795 0 0	165, 825	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	19, 255		0 989	005,025	
17.00	01700 SOCIAL SERVICE	0	0		0 0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS			·			1
30.00	03000 ADULTS & PEDIATRICS	200, 551	279, 198	407, 34		0	
31.00	03100 I NTENSI VE CARE UNI T	0	0		0 0	0	
32.00	03200 CORONARY CARE UNIT	0	0		0 0	0	
33.00 34.00	03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	
41.00	03400 SURGICAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	0	0		0 0	0	
42.00	04200 SUBPROVI DER	0	0		0 0	0	
43.00	04300 NURSERY	0	0		0 0	0	
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
57.00	05700 CT SCAN	0	0		0 0	0	
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
60.00	06000 LABORATORY	0	9, 628		0 114	0	
60.01	06001 BLOOD LABORATORY	0	0		0 0	0	
65.00	06500 RESPI RATORY THERAPY	0	0		0 134	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	67, 393		0 1, 653	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	77, 020		0 1, 627	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	28, 883		0 99	0	
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 0 0 6,681	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0,031	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	165, 825	
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 1, 178	0	76.00
76.01	03950 HEMODIALYSIS & OTHER ANCILLARY	0	0)	0 0	0	76.01
~~ ~~	OUTPATIENT SERVICE COST CENTERS			I			
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER OTHER REIMBURSABLE COST CENTERS	0	0	/	0 0	0	89.00
99, 10		0	0)	0 0	0	99.10
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	SPECIAL PURPOSE COST CENTERS				0 0		
109.00	10900 PANCREAS ACQUI SI TI ON	0	0)	0 0	0	109.00
	11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
	11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
	11300 INTEREST EXPENSE	200 551	F10 000	407.24	D E1 000	145 005	113.00
118.00	SUBTOTALS SUBTOTALS SUB OF LI NES 1-117 NONREI MBURSABLE COST CENTERS CENTERS	200, 551	519, 888	407, 34	0 51,088	165, 825	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 33		192.00
	07950 MARKETI NG/PUBLI C RELATI ONS	o o	0		0 2,674	0	194.00
194. O´	07951 TENANT LEASED SPACE	0	0		0 0		194.01
200.00							200.00
201.00			0 510,000	407.04	0 50 705		201.00
202.00) TOTAL (sum lines 118-201)	200, 551	519, 888	407, 34	53, 795	165, 825	JZUZ. 00

	Financial Systems REHA	BILITATION HOSE		CN: 153030	Peri od:	u of Form CMS-2 Worksheet B	2332-10
					From 10/01/2014 To 09/30/2015	Part I Date/Time Pre 2/23/2016 2:5	pared: 3 pm
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
1 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1 1 00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$	00100 NEW CAP REL COSTS-BLOG & FTXT 00200 NEW CAP REL COSTS-MUBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTI NG 00590 OTHER ADMINI STRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LINEN SERVI CE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CE & SUPPLY						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						15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	315, 206 0	12, 384				16.00 17.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	12, 304				17.00
30.00	03000 ADULTS & PEDIATRICS	110, 995	12, 384	4, 349, 96		4, 349, 960	30.00
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0	0		0 0 0 0	0	31.00
32.00	03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	33.00
34.00	03400 SURGI CAL INTENSI VE CARE UNI T	0	0		0 0	0	34.00
41.00	04100 SUBPROVIDER - IRF	0	0		0 0	0	41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0	0		0 0 0 0	0	42.00
	ANCI LLARY SERVI CE COST CENTERS				-		
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 054	0	50, 05		50, 052	1
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0 0 0	0	57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	12, 201	0	120, 45	0 0	120, 450 0	60.00 60.01
65.00	06500 RESPI RATORY THERAPY	1, 183	0	13, 55	о О	13, 557	1
66.00	06600 PHYSI CAL THERAPY	50, 781	0	1, 359, 00		1, 359, 002	
67.00	06700 OCCUPATIONAL THERAPY	53, 857	0	1, 366, 19		1, 366, 192	1
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	23, 676	0	438, 15 5, 27		438, 150 5, 276	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 113	0	40, 30		40, 307	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
73.00 76.00	07300 DRUGS CHARGED TO PATI ENTS 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	40, 840 4, 148	0	480, 93 93, 48		480, 931 93, 483	
	03950 HEMODIALYSIS & OTHER ANCILLARY						1 /0 00
	03730 HENODIAETSI'S & OTHER ANOTEEART	2, 874	0	47, 51		47, 517	
	OUTPATIENT SERVICE COST CENTERS	2, 874		47, 51	7 0	47, 517	76.01
88.00	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	2,874	0	47, 51	7 <u>0</u>	47, 517	76.01 88.00
88.00	OUTPATIENT SERVICE COST CENTERS	2, 874		47, 51	7 0	47, 517	76.01 88.00
88. 00 89. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER OTHER REIMBURSABLE COST CENTERS 09910 CORF	2,874	0	47, 51	7 <u>0</u>	47, 517 0 0	76.01 88.00
88. 00 89. 00 99. 10	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER OTHER REIMBURSABLE COST CENTERS 09910 CORF SPECIAL PURPOSE COST CENTERS	2,874	0	47, 51	7 0 0 0 0 0	47, 517 0 0	76. 01 88. 00 89. 00 99. 10
88.00 89.00 99.10 109.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER OTHER REIMBURSABLE COST CENTERS 09910 CORF	2,874	0	47, 51	7 0 0 0 0 0	47, 517 0 0 0	76.01 88.00 89.00
88.00 89.00 99.10 109.00 110.00 111.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER OTHER REIMBURSABLE COST CENTERS 09910 CORF SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	2,874	0	47, 51	7 0 0 0 0 0	47, 517 0 0 0 0 0 0 0 0	76.01 88.00 89.00 99.10 109.00 110.00 111.00
 88. 00 89. 00 99. 10 109. 00 110. 00 111. 00 113. 00 	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER OTHER REIMBURSABLE COST CENTERS 09910 CORF SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION 11100 INTESTINAL ACQUISITION 11100 INTEST EXPENSE	2,874	0 0 0	47, 51	7 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	47, 517 0 0 0 0 0 0 0 0 0	76.01 88.00 89.00 99.10 109.00 110.00 111.00 113.00
88.00 89.00 99.10 109.00 110.00 111.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER OTHER REIMBURSABLE COST CENTERS 09910 CORF SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11300 INTEREST EXPENSE	2,874	0	47, 51	7 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	47, 517 0 0 0 0 0 0 0 0	76.01 88.00 89.00 99.10 109.00 110.00 111.00 113.00
88.00 89.00 99.10 109.00 110.00 111.00 113.00 118.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER OTHER REIMBURSABLE COST CENTERS 09910 CORF SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11300 INTERST EXPENSE SUBTOTALS (SUM OF LINES 1-117) NORREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,874	0 0 0	47, 51		47, 517 0 0 0 0 0 0 0 0 8, 364, 877 0	76. 01 88. 00 89. 00 99. 10 109. 00 111. 00 113. 00 118. 00
88.00 89.00 99.10 109.00 110.00 113.00 113.00 118.00 190.00 192.00	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER OTHER REI MBURSABLE COST CENTERS 09910 CORF SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11100 ISLET ACQUISITION 11100 GUTTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	2,874	0 0 0	47, 51 8, 364, 87 3, 97	7 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 7 0 0 0 4 0	47, 517 0 0 0 0 0 0 0 0 0 0 0 8, 364, 877 0 3, 974	76. 01 88. 00 89. 00 99. 10 109. 00 110. 00 111. 00 113. 00 118. 00 190. 00 192. 00
88.00 89.00 99.10 109.00 111.00 113.00 118.00 190.00 192.00 194.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER OTHER REIMBURSABLE COST CENTERS 09910 CORF SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11300 INTERST EXPENSE SUBTOTALS (SUM OF LINES 1-117) NORREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,874	0 0 0	47, 51	7 0 0 0 0 0 0 0 0 0 0 0 0 0 7 0 0 0 4 0 6 0	47, 517 0 0 0 0 0 0 0 0 8, 364, 877 0	76. 01 88. 00 89. 00 99. 10 109. 00 110. 00 111. 00 113. 00 118. 00 190. 00 192. 00 194. 00
88.00 89.00 99.10 109.00 110.00 111.00 113.00 118.00 190.00 194.01 200.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER OTHER REIMBURSABLE COST CENTERS 09910 CORF SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11100 ISLET ACQUISITION 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 MARKETING/PUBLIC RELATIONS 07951 TENANT LEASED SPACE Cross Foot Adjustments	2,874	0 0 0	47, 51 8, 364, 87 3, 97 140, 61	7 0 0 0	47, 517 0 0 0 0 0 0 8, 364, 877 0 3, 974 140, 616 374, 405 0 0	76.01 88.00 89.00 99.10 109.00 111.00 113.00 113.00 190.00 194.01 194.01 200.00
88. 00 89. 00 99. 10 109. 00 111. 00 113. 00 118. 00 190. 00 192. 00 194. 01	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER OTHER REI MBURSABLE COST CENTERS 09910 CORF SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 INTERST EXPENSE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 MARKETING/PUBLIC RELATIONS 07950 TENANT LEASED SPACE Cross Foot Adjustments Negative Cost Centers	2,874		47, 51 8, 364, 87 3, 97 140, 61	7 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 7 0 0 0 4 0 5 0 0 0 0 0	47, 517 0 0 0 0 0 0 8, 364, 877 0 3, 974 140, 616 374, 405 0 0	76.01 88.00 89.00 99.10 109.00 111.00 113.00 190.00 192.00 194.01 200.00 201.00

LOCATION OF CAPITAL RELATED COSTS				Period: From 10/01/2014 To 09/30/2015	Worksheet B Part II Date/Time Pre 2/23/2016 2:5	
Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL REL NEW BLDG & FI XT	ATED COSTS NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						
00 00100 NEW CAP REL COSTS-BLDG & FIXT 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 505	88		3, 389	
01 00570 ADMI TTI NG 02 00590 OTHER ADMI NI STRATI VE AND GENERAL	0	12, 902 48, 867	4, 55 17, 24	6 66, 113	193 208	5.
00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE	0	113, 744	40, 14	5 153, 889 0 0	139 0	
00 00900 HOUSEKEEPI NG	0	12, 288	4, 33		59	
0. 00 01000 DI ETARY	0	0		0 0	66	
1.00 01100 CAFETERIA	0	47, 477	16, 75		132 182	
3. 00 01300 NURSING ADMINISTRATION 1. 00 01400 CENTRAL SERVICE & SUPPLY	0	1, 329 9, 385	46 3, 31		5	
5. 00 01500 PHARMACY	0	3, 977	1, 40		67	
5. 00 01600 MEDICAL RECORDS & LIBRARY	0	4, 560	1,60		111	
7.00 01700 SOCIAL SERVICE	0	2, 955	1, 04	3 3, 998	0	17.
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	79, 057	27, 90	106, 957	1, 155	30.
I. 00 03100 I NTENSI VE CARE UNI T	0	0	27,70	0 0	0	
2. 00 03200 CORONARY CARE UNI T	0	0		0 0	0	
3. 00 03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	
I. 00 03400 SURGI CAL INTENSI VE CARE UNI T	0	0		0 0	0	
1. 00 04100 SUBPROVI DER – I RF 2. 00 04200 SUBPROVI DER	0	0		0 0	0	
3. 00 04300 NURSERY	0	0		0 0	0	
ANCILLARY SERVICE COST CENTERS						
I. 00 05400 RADI OLOGY-DI AGNOSTI C	0	4, 396	1, 55		0	
7.00 05700 CT SCAN	0	0		0 0	0	
3. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 2. 00 05900 CARDIAC CATHETERIZATION	0	0		0 0	0	
0. 00 06000 LABORATORY	0	0		0 0	21	
0. 01 06001 BLOOD LABORATORY	0	0		0 0	0	
5. 00 06500 RESPI RATORY THERAPY	0	1, 022	36		3	
6. 00 06600 PHYSI CAL THERAPY	0	103, 163	36, 40		344	
7. 00 06700 OCCUPATI ONAL THERAPY 3. 00 06800 SPEECH PATHOLOGY	0	48, 704 3, 691	17, 18 1, 30		453 159	
2. 00 06900 ELECTROCARDI OLOGY	0	3, 091	1, 30	0 4,993	0	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72
8. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
b. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES b. 01 03950 HEMODI ALYSI S & OTHER ANCI LLARY	0	4, 212	1, 48	6 5,698 0 0	30 0	
OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	_ /0
8. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.
P. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.
OTHER REIMBURSABLE COST CENTERS				<u> </u>		
2. 10 09910 CORF SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	99.
09. 00 10900 PANCREAS ACQUISITION	0	0		0 0	0	109.
0.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.
1.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.
3. 00 11300 I NTEREST EXPENSE		504.004	177.05		0.007	113.
8.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	504, 234	177, 95	682, 186	3, 327	1118.
0. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190
22.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192
04.00 07950 MARKETI NG/PUBLI C RELATI ONS	0	0		0 0		194
04.01 07951 TENANT LEASED SPACE	0	116, 677		0 116, 677	0	194
00.00 Cross Foot Adjustments				0		200.
11.00 Negative Cost Centers		0	477 05	0 0		201
02.00 TOTAL (sum lines 118-201)	0	620, 911	177, 95	52 798, 863	3, 389	1202

ALLOCA	TION OF CAPITAL RELATED COSTS			F	eriod: rom 10/01/2014 o 09/30/2015	Worksheet B Part II Date/Time Pre 2/23/2016 2:5	pared: 3 pm
	Cost Center Description	ADMI TTI NG	OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5.01	5.02	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\end{array}$	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA	17, 648 C C C C C C C C C C C C	66, 321	0 4, 463 0	319 0 0	22, 312 0 3, 374	10.00
13.00 14.00 15.00 16.00 17.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CE & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	C C C C C	2, 799 217 1, 088 2, 112 34	3, 408 1, 444 1, 656	0 0 0	94 667 283 324 210	15.00 16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	(00.744			
30.00 31.00 32.00 33.00 34.00 41.00 42.00 43.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	6, 218 C C C C C C C C C C C		28, 711 0 0 0 0 0 0 0 0	179 0 0 0 0 0 0 0 0	5, 619 0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 41. 00 42. 00 43. 00
54.00	ANCI LLARY SERVI CE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C	339	242	1, 597	0	312	54.00
57.00 58.00 59.00 60.00 60.01	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY	C C C C C 683 C	0 0 0 0 735	0 0 0	0 0 0	0 0 0 0 0 0 0	57.00 58.00 59.00 60.00 60.01
65.00 66.00 67.00 68.00 69.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	66 2, 842 3, 015 1, 325 27	7, 152 8, 177 2, 805 36	371 37, 466 17, 688 1, 340 0	74 0 0	73 7, 333 3, 462 262 0	67.00 68.00 69.00
71.00 72.00 73.00 76.00 76.01	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03950 HEMODI ALYSI S & OTHER ANCI LLARY OUTPATI ENT SERVI CE COST CENTERS	454 C 2, 286 232 161	0 2,047 2 575			0 0 0 299 0	72.00 73.00 76.00
88.00	08800 RURAL HEALTH CLINIC	C				0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER OTHER REIMBURSABLE COST CENTERS	C	0	0	0	0	89.00
99. 10	OP910 CORF SPECIAL PURPOSE COST CENTERS	C	0	0	0	0	99. 10
110.00 111.00 113.00	10900 PANCREAS ACQUI SI TI ON 11000 I NTESTI NAL ACQUI SI TI ON 11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE			0	0	0 0	109.00 110.00 111.00 113.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	17, 648	64, 263	118, 472	319	22, 312	118.00
192.00 194.00 194.01 200.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 MARKETING/PUBLIC RELATIONS 07951 TENANT LEASED SPACE Cross Foot Adjustments	C C C C) 0 29 0 1, 030 999	0	0 0	0 0 0	190. 00 192. 00 194. 00 194. 01 200. 00
201.00 202.00		C 17, 648	0 3 66, 321	0 160, 846	0 319		201. 00 202. 00

Health Financial Systems RE	HABILITATION HOSP	NTAL OF FT WAY	'NE	In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der			Worksheet B Part II Date/Time Pre 2/23/2016 2:5	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CE & SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00570 ADMI TTI NG 5.02 00590 OTHER ADMI NI STRATI VE AND GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CE & SUPPLY 15.00 01500 PHARMACY 16.00 000 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE	1, 563 0 0 0 0 0 0 0 0 0	87, 926 4, 885 0 1, 628 3, 257 0	10, 241 0 0 0 0	16, 994 0 313 0	9, 890 0 0	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 16.00 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER 43. 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS	1, 563 0 0 0 0 0 0 0 0	47, 219 0 0 0 0 0 0 0 0	10, 241 0 0 0 0 0 0 0 0	12, 198 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 41. 00 42. 00 43. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 60.01 06001 BLOOD LABORATORY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY		0 0 1,628 0 11,398 13,026 4,885	0 0 0 0 0 0 0 0	0 0 36 0 42 522 514 31	0 0 0 0 0 0 0 0 0 0 0	57.00 58.00 59.00 60.00 60.01 65.00 66.00 67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	4, 885	0	0	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 76. 01 03950 HEMODIALYSIS & OTHER ANCILLARY 0UTPATIENT SERVICE COST CENTERS		0 0 0 0	0 0 0 0	2, 110 0 0 372 0	0 0 9, 890 0 0	71.00 72.00 73.00 76.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	•
0THER REI MBURSABLE COST CENTERS 99. 10 09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUI SI TI ON 110.00 11000 INTESTI NAL ACQUI SI TI ON 111.00 11100 I SLET ACQUI SI TI ON 113.00 11300 I NTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1-117)	0 0 0 1, 563	0 0 0 87, 926	0 0 0 10, 241	0 0 16, 138	0 0	109.00 110.00 111.00 113.00 118.00
NONREI MBURSABLE COST CENTERS	.,				., ., .,	1
190.0019000GIFT, FLOWER, COFFEE SHOP & CANTEEN192.0019200PHYSICIANS' PRIVATE OFFICES194.0007950MARKETING/PUBLIC RELATIONS194.0107951TENANT LEASED SPACE200.00Cross Foot Adjustments201.00Negative Cost Centers202.00TOTAL (sum Lines 118-201)	0 0 0 0 1,563	0 0 0 0 87, 926	0 0 0 0 10, 241	0 11 845 0 0 16, 994	0 0 0 0	190.00 192.00 194.00 194.01 200.00 201.00 202.00
202.00 101AL (SUM 11165 110-201)	1, 303	07, 720	10, 241	10, 794	7,090	1202. UU

	Financial Systems REHA TION OF CAPITAL RELATED COSTS	BILITATION HOSE	PITAL OF FT WAY		In Lie Period:	u of Form CMS- Worksheet B	2552-10
ALLUUA	HON OF CALLARE RELATED COSTS		TTOVIDEL	F	rom 10/01/2014 o 09/30/2015	Part II	pared: 3 pm
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	GENERAL SERVICE COST CENTERS	16.00	17.00	24.00	25.00	26.00	
1.00 2.00 4.00 5.01 5.02 7.00 8.00 9.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						1.00 2.00 4.00 5.01 5.02 7.00 8.00 9.00
11.00 13.00 14.00 15.00 16.00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CE & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE INPATI ENT ROUTI NE SERVI CE COST CENTERS	13, 942 0	5, 315				10.00 11.00 13.00 14.00 15.00 16.00 17.00
30.00	03000 ADULTS & PEDIATRICS	4, 903	5, 315	253, 183	0	253, 183	30.00
32.00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0 0 0	0 0 0	C C C		0 0 0	32.00
	03400 SURGI CAL I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	0	0	C	0	0	
	04200 SUBPROVIDER	0	0	C	0	0	
43.00	04300 NURSERY	0	0	C	0	0	43.00
54.00	ANCI LLARY SERVI CE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C	268	0	8, 705	0	8, 705	54.00
	05700 CT SCAN	0	0	C	0	0	
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0	C	0	0	
		540	0	3, 643		3, 643	
	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0 52	0	C 2, 061	0	0 2, 061	
66.00	06600 PHYSI CAL THERAPY	2, 248	0	208, 942	0	208, 942	66.00
	06700 OCCUPATIONAL THERAPY	2, 384	0	114, 685		114, 685	1
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 048 21	0	16, 848 84		16, 848 84	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	359	0	3, 113		3, 113	1
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 1, 808	0	14 021	0	0	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1,808	0	16, 031 8, 920	0	16, 031 8, 920	76.00
	03950 HEMODIALYSIS & OTHER ANCILLARY	127	0	621			
88.00	OUTPATIENT SERVICE COST CENTERS	0	0	C	0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C			
99. 10	OTHER REIMBURSABLE COST CENTERS 09910 CORF SPECIAL PURPOSE COST CENTERS	0	0	C	0	0	99.10
109.00	10900 PANCREAS ACQUISITION	0	0	C	0	0	109.00
	11000 INTESTINAL ACQUISITION	0	0	C	0		110.00
	11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE	0	0	C	0	0	111.00 113.00
118.00		13, 942	5, 315	636, 836	0	636, 836	
100.00	NONREI MBURSABLE COST CENTERS		a			0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0	C 4C	-		190.00 192.00
194.00	07950 MARKETI NG/PUBLIC RELATI ONS	Ő	0 0	1, 937	0	1, 937	194.00
	07951 TENANT LEASED SPACE	0	0	160, 050	0	160, 050	
200.00 201.00	5	0	0	C.	0		200.00 201.00
	TOTAL (sum lines 118-201)	13, 942	5, 315		-		202.00

T ALLOCATION - STATIST	I CAL BASI S		Provi der		Period:	u of Form CMS- Worksheet B-1	
					From 10/01/2014 To 09/30/2015		
		CAPI TAL REL	ATED COSTS			2/23/2016 2:5	<u>3 p</u> i
Cost Center D	escription	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFITS	ADMI TTI NG (GROSS	Reconciliation	
		(SQUARE FEET)	(SQUARE	DEPARTMENT	CHARGES)		
		(SOUARE ILLI)	FEET)	(GROSS	CHARGES)		
			1221)	SALARI ES)			
		1.00	2.00	4.00	5. 01	5A. 02	
GENERAL SERVICE COS		700,000					
0 00100 NEW CAP REL C		728, 820	504 0/4				1
0 00200 NEW CAP REL C		2.040	591, 864		0		2
0 00400 EMPLOYEE BENE 1 00570 ADMI TTI NG	FITS DEPARTMENT	2, 940 15, 144	2, 940 15, 144				4
	TRATIVE AND GENERAL	57, 360	57, 360				
0 00700 OPERATI ON OF		133, 512	133, 512			-1, 137, 902	
0 00800 LAUNDRY & LIN		133, 312	133, 312		0 0	0	
0 00900 HOUSEKEEPI NG		14, 424	14, 424				
00 01000 DI ETARY		0	0	92, 31		0	
00 01100 CAFETERIA		55, 728	55, 728	183, 44	4 0	0	11
00 01300 NURSING ADMIN	I STRATI ON	1, 560	1, 560	252, 84	6 0	0	13
00 01400 CENTRAL SERVI	CE & SUPPLY	11, 016	11, 016	7, 45	0 0	0	14
00 01500 PHARMACY		4, 668	4, 668			0	
00 01600 MEDI CAL RECOR		5, 352	5, 352				
00 01700 SOCIAL SERVIC		3, 468	3, 468		0 0	0	17
00 03000 ADULTS & PEDI	ERVICE COST CENTERS	92, 796	92, 796	1, 613, 45	7 7, 975, 976	0	30
00 03100 I NTENSI VE CAR		92, 798	92, 790		0 7, 975, 978		
00 03200 CORONARY CARE		0	0		0 0	0	
00 03300 BURN INTENSIV		0	0		0 0	0	
00 03400 SURGI CAL INTE		0	0		0 0	0	
00 04100 SUBPROVIDER -		0	0		0 0	0	41
00 04200 SUBPROVI DER		0	0		0 0	0	42
00 04300 NURSERY		0	0		0 0	0	43
ANCILLARY SERVICE C		,		1			
00 05400 RADI OLOGY-DI A	GNOSTIC	5, 160	5, 160		0 434, 988		
00 05700 CT SCAN		0	0		0 0		
00 05800 MAGNETIC RESO		0	0		0 0	0	
00 05900 CARDI AC CATHE 00 06000 LABORATORY	IERIZATION	0	0	20 54	0 074 474	0	
01 06001 BLOOD LABORAT		0	0	28, 56	0 876, 674	0	
00 06500 RESPI RATORY T		1, 200	1, 200	3, 77	1 85, 034	0	
00 06600 PHYSI CAL THER		121, 092	121, 092			0	
00 06700 OCCUPATI ONAL		57, 168	57, 168				
00 06800 SPEECH PATHOL		4, 332	4, 332				68
00 06900 ELECTROCARDI 0	LOGY	0	0	40	6 34, 762	0	69
00 07100 MEDICAL SUPPL	IES CHARGED TO PATIENTS	0	0		0 582, 963	0	
00 07200 IMPL. DEV. CH		0	0		0 0	-	
00 07300 DRUGS CHARGED		0	0		0 2, 934, 525		
	SYCHOLOGI CAL SERVI CES	4, 944	4, 944				
01 03950 HEMODI ALYSI S		0	0		0 206, 541	0	76
00 08800 RURAL HEALTH		0	0		0 0	0	88
	LIFIED HEALTH CENTER	0	0		0 0		
OTHER REI MBURSABLE			0		-1 0		1 ັ
10 09910 CORF		0	0		0 0	0	99
SPECIAL PURPOSE COS		·					
. 00 10900 PANCREAS ACQU		0	0		0 0		109
. 00 11000 INTESTINAL AC		0	0		0 0		110
. 00 11100 I SLET ACQUI SI		0	0		0 0	0	111
. 00 11300 I NTEREST EXPE		FOL OUT	F01 0			4 407 077	113
	M OF LINES 1-117)	591, 864	591, 864	4, 636, 09	0 22, 649, 476	-1, 137, 902	1118
NONREI MBURSABLE COS		0	0		0 0	0	190
. 00 19000 GFFT, FLOWER, . 00 19200 PHYSI CLANS' P		0	0		-		190
. 00 07950 MARKETI NG/PUB		0	0	86, 04			194
. 01 07951 TENANT LEASED		136, 956	0	55,01	0 0		194
.00 Cross Foot Ad			Ū				200
.00 Negative Cost							201
	located (per Wkst. B,	620, 911	177, 952	938, 64	6 427, 161		202
Part I)							
	tiplier (Wkst. B, Part I)	0. 851940	0. 300664				203
	located (per Wkst. B,			3, 38	9 17, 648		204
.00 Part II) Unit cost mul				0 00077	0 0 000770		005
UNI IUDIT COST MUL	tiplier (Wkst. B, Part	1 1		0.00071	8 0.000779		205

	Financial Systems REH. LLOCATION - STATISTICAL BASIS	ABILITATION HOSE			In Lie Period:	u of Form CMS- Worksheet B-1	
JUST A	LLUCATION - STATISTICAL BASIS		Provi der		From 10/01/2014		
				-	To 09/30/2015	Date/Time Pre 2/23/2016 2:5	
	Cost Center Description	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST)	OPERATI ON OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	
		5.02	7.00	8.00	9.00	10.00	
00	GENERAL SERVICE COST CENTERS	1					1 1 00
1.00 3.00 4.00 5.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICE & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	7, 745, 970 796, 259 37, 201 136, 028 174, 863 344, 028 326, 923 25, 304 127, 038 246, 687	519, 864 0 14, 424 0 55, 728 1, 560 11, 016 4, 668 5, 352	60, 62((((((((((6 0 368, 484 0 55, 728 0 1, 560 0 11, 016 0 4, 668 0 5, 352	33, 896 0 0 0 0 0 0 0	11.00 13.00 14.00 15.00
7.00	01700 SOCIAL SERVICE	3, 998	3, 468	(3, 468	0	17.00
0.00	INPATIENT ROUTINE SERVICE COST CENTERS	0.475.040		04.62		20.001	1 20 00
 31. 00 32. 00 33. 00 34. 00 41. 00 42. 00 	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	2, 675, 260 0 0 0 0 0 0 0 0	92, 796 0 0 0 0 0 0 0 0 0		7 92, 796 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33, 896 0 0 0 0 0 0 0 0 0	31.00 32.00 33.00 34.00 41.00 42.00
64.00	ANCI LLARY SERVI CE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C	28, 246	5, 160		5, 160	0	54.00
57.00 58.00 59.00 50.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 066001 LABORATORY 06001 BLOOD LABORATORY	0 0 85, 890	0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0	0 0 0 0 0 0	57.00 58.00 59.00 60.00
5.00 6.00 7.00 8.00 9.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	8, 319 835, 273 954, 989 327, 622 4, 178	1, 200 121, 092 57, 168 4, 332 0	12, 624 13, 999 (0 0 0 0 0	65.00 66.00 67.00 68.00 69.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	22, 245	0	(0 0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 239, 136	0			0	
6. 00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 03950 HEMODIALYSIS & OTHER ANCILLARY OUTPATIENT SERVICE COST CENTERS	67, 171 38, 925	4, 944 0	(0 4, 944 0 0		76.00
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0 0 0	0	
	OTHER REIMBURSABLE COST CENTERS						
9.10	09910 CORF SPECIAL PURPOSE COST CENTERS	0	0	[(0 0	0	99.10
09.00	10900 PANCREAS ACQUISITION	0	0	(0 0	0	109.00
10.00	11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
	11100 I SLET ACQUI SI TI ON	0	0	(0 0	0	111.00
18.00		7, 505, 583	382, 908	60, 620	6 368, 484	33, 896	
90 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	3, 436	0		0 0		192.00
94.00	07950 MARKETI NG/PUBLI C RELATI ONS	120, 274	0		0 0	0	194.00
	07951 TENANT LEASED SPACE	116, 677	136, 956	(0 0	0	194.0
200.00	5						200.0
01.00		1, 137, 902	913, 231	42, 660	6 181, 349	200, 551	
	Part I)	1, 137, 702	713,231	42,000	101, 349	200, 001	202.0
203.00 204.00	Unit cost multiplier (Wkst. B, Part I)	0. 146902 66, 321	1. 756673 160, 846			5. 916657 1, 563	203. 00 204. 00
		1		1	1		1

	Financial Systems REHA ALLOCATION - STATISTICAL BASIS	DILITATION 1103	PITAL OF FT WAY	CCN: 153030	Period:	u of Form CMS-2 Worksheet B-1	
					From 10/01/2014 To 09/30/2015	Date/Time Pre	pared:
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	2/23/2016 2:5 MEDI CAL	3 pm
	bost benter bescription	(FTES)	ADMI NI STRATI ON	SERVICE &	(COSTED	RECORDS &	
			(FTES-NURS	SUPPLY	REQUIS.)	LIBRARY	
			AREAS)	(COSTED REQUI S.)		(GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS	1	1 1				
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
5. 01	00570 ADMI TTI NG						5.0
5. 02	00590 OTHER ADMINISTRATIVE AND GENERAL						5.0
7.00 3.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.0
7.00 7.00	00900 HOUSEKEEPING						9.0
10.00	01000 DI ETARY						10.0
11.00	01100 CAFETERI A	54					11. C
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICE & SUPPLY	3	29	90, 59	1		13.0 14.0
15.00	01500 PHARMACY	1	0		0 183, 794		15.0
16.00	01600 MEDICAL RECORDS & LI BRARY	2	0	1, 66		22, 649, 476	
17.00	01700 SOCIAL SERVICE	0	0		0 0	0	17.0
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	20	20	(5.02		7.075.07/	1 20 0
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	29	1	65, 02	3 0 0 0	7, 975, 976 0	
32.00	03200 CORONARY CARE UNI T	0	0		0 0	0	
33.00	03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 0	0	
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER				0 0	0	
43.00	04300 NURSERY				0 0	0	
	ANCI LLARY SERVI CE COST CENTERS		1 1		- L - L	-	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0			0 0	434, 988	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			0	
59.00	05900 CARDI AC CATHETERI ZATI ON				0 0	0	
60.00	06000 LABORATORY	1	0	19	-	876, 674	
50. 01	06001 BLOOD LABORATORY	0	0		0 0	0	
65.00		0	0	22		85,034	
56.00 57.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	/	0	2, 78 2, 74		3, 648, 854 3, 869, 898	
58.00	06800 SPEECH PATHOLOGY	3	0	16		1, 701, 229	
59.00	06900 ELECTROCARDI OLOGY	0	0		0 0	34, 762	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	11, 25	0 0	582, 963	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS				0 183, 794	0 2, 934, 525	1
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	1, 98		298, 032	
	03950 HEMODIALYSIS & OTHER ANCILLARY	0	0		0 0	206, 541	
	OUTPATIENT SERVICE COST CENTERS						
38.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER				0 0 0 0	0	
57.00	OTHER REIMBURSABLE COST CENTERS		1 0				07.0
99. 10	09910 CORF	0	0		0 0	0	99. 1
100.00	SPECIAL PURPOSE COST CENTERS						1100 0
	0 10900 PANCREAS ACQUISITION 0 11000 INTESTINAL ACQUISITION	0	0				109. 0 110. 0
	11100 I SLET ACQUI SI TI ON	0	0		0 0		1111.0
	11300 INTEREST EXPENSE						113.0
18.00		54	- 29	86, 03	2 183, 794	22, 649, 476	118.0
00 00	NONREIMBURSABLE COST CENTERS	0				0	190. 0
	19200 PHYSI CLANS' PRI VATE OFFI CES		0	5	6 0		192.0
	07950 MARKETI NG/PUBLIC RELATIONS	0	0	4, 50			194.0
	07951 TENANT LEASED SPACE	0	0		0 0	0	194.0
200.00	5						200.0
201.00 202.00		519, 888	407, 340	53, 79	5 165, 825	315, 206	201.0
	Part I)	317,000	407, 540	55,77	100,020	515,200	202.0
203.00	Unit cost multiplier (Wkst. B, Part I)	9, 627. 555556		0. 59382		0.013917	
204.00		87, 926	10, 241	16, 99	4 9, 890	13, 942	204. 0
	Part II) Unit cost multiplier (Wkst. B, Part	1, 628. 259259	353. 137931	0. 18759	0 0. 053810	0.000616	205 0
205.00							

Heal t	h Financial	Systems
COST	ALL OCATLON	

Health Financia	N - STATISTICAL BASIS	ABILITATION HOSPI	TAL OF FT WAYNE Provider CCN: 153030	In Lieu Period:	u of Form CMS-2552-10 Worksheet B-1
				From 10/01/2014 To 09/30/2015	Date/Time Prepared:
Cos	st Center Description	SOCI AL SERVI CE		<u> </u>	2/23/2016 2:53 pm
		(PATI ENT			
		DAYS %) 17.00			
	SERVICE COST CENTERS				
	W CAP REL COSTS-BLDG & FIXT W CAP REL COSTS-MVBLE EQUIP				1.00
4.00 00400 EMF	PLOYEE BENEFITS DEPARTMENT				4.00
5.01 00570 ADM 5.02 00590 0TH	MITTING HER ADMINISTRATIVE AND GENERAL				5. 01 5. 02
	ERATION OF PLANT				7.00
1 1	UNDRY & LINEN SERVICE				8.00
9.00 00900 HOU 10.00 01000 DIE	USEKEEPI NG FTARY				9.00 10.00
11.00 01100 CAR					11.00
	RSING ADMINISTRATION				13.00
14.00 01400 CEN 15.00 01500 PH	NTRAL SERVICE & SUPPLY				14. 00 15. 00
	DI CAL RECORDS & LI BRARY				16.00
		100			17.00
	T ROUTI NE SERVI CE COST CENTERS	100			30.00
	TENSI VE CARE UNI T	0			31.00
	RONARY CARE UNIT	0			32.00
	RN INTENSIVE CARE UNIT RGICAL INTENSIVE CARE UNIT	0			33.00 34.00
	BPROVIDER - IRF	0			41.00
	BPROVI DER	0			42.00
43.00 04300 NUE	RSERY Y SERVICE COST CENTERS	0			43.00
	DI OLOGY-DI AGNOSTI C	0			54.00
57.00 05700 CT	SCAN	0			57.00
1 1	GNETIC RESONANCE IMAGING (MRI) RDIAC CATHETERIZATION	0			58.00 59.00
60.00 06000 LA		0			60.00
60. 01 06001 BL	OOD LABORATORY	0			60. 01
1 1	SPI RATORY THERAPY YSI CAL THERAPY	0			65. 00 66. 00
	CUPATIONAL THERAPY	0			67.00
68.00 06800 SPI	EECH PATHOLOGY	0			68.00
1 1	ECTROCARDI OLOGY DI CAL SUPPLI ES CHARGED TO PATI ENTS	0			69.00 71.00
	PL. DEV. CHARGED TO PATIENTS	0			71.00
73.00 07300 DRI	UGS CHARGED TO PATIENTS	0			73.00
	YCHIATRIC/PSYCHOLOGICAL SERVICES MODIALYSIS & OTHER ANCILLARY	0			76. 00 76. 01
	NT SERVICE COST CENTERS	0			70.01
88.00 08800 RUF	RAL HEALTH CLINIC	0			88.00
	DERALLY QUALIFIED HEALTH CENTER	0			89.00
99.10 09910 COF		0			99.10
	PURPOSE COST CENTERS	· · ·			
	NCREAS ACQUISITION TESTINAL ACQUISITION	0			109. 00 110. 00
	LET ACQUISITION	0			111.00
113.00 11300 I N					113.00
	BTOTALS (SUM OF LINES 1-117) URSABLE COST CENTERS	100			118.00
	FT, FLOWER, COFFEE SHOP & CANTEEN	0			190. 00
	YSICIANS' PRIVATE OFFICES	0			192.00
	RKETING/PUBLIC RELATIONS NANT LEASED SPACE	0			194. 00 194. 01
1 1	oss Foot Adjustments	0			200. 00
201.00 Neg	gative Cost Centers				201.00
	st to be allocated (per Wkst. B, rt I)	12, 384			202.00
1 1	it cost multiplier (Wkst. B, Part I)	123. 840000			203.00
	st to be allocated (per Wkst. B,	5, 315			204.00
	rt II) it cost multiplier (Wkst. B, Part	53. 150000			205.00

Heal th	Fi nanci	Syst	ems				
COMPLIT				0F	27200	ΤO	CHA

Health Financial Systems REH/	ABILITATION HOST	PITAL OF FI WAY	INE .	In Lie	U OT FORM CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 153030	Peri od: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Pre	pared:
					2/23/2016 2:5	3 pm
			e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1 0 4 0 0 4 0		1 0 4 0 0		4 9 4 9 9 4 9	0.00
30. 00 03000 ADULTS & PEDI ATRI CS	4, 349, 960		4, 349, 96		4, 349, 960	
31. 00 03100 I NTENSI VE CARE UNI T	0			0 0	0	
32.00 03200 CORONARY CARE UNIT	0			0 0	0	
33.00 03300 BURN INTENSIVE CARE UNIT	0			0 0	0	
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0			0 0	0	
41. 00 04100 SUBPROVIDER - IRF	0			0 0	0	
42. 00 04200 SUBPROVI DER	0			0 0	0	
43. 00 04300 NURSERY	0			0 0	0	43.00
ANCILLARY SERVICE COST CENTERS	1		1			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	50, 052		50, 05		50, 052	
57.00 05700 CT SCAN	0			0 0	0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
60. 00 06000 LABORATORY	120, 450		120, 45	50 0	120, 450	60.00
60. 01 06001 BLOOD LABORATORY	0			0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	13, 557	0	13, 55	57 0	13, 557	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 359, 002	0	1, 359, 00	02 0	1, 359, 002	66.00
67.00 06700 OCCUPATIONAL THERAPY	1, 366, 192	0	1, 366, 19	92 0	1, 366, 192	67.00
68.00 06800 SPEECH PATHOLOGY	438, 150	0	438, 15	50 0	438, 150	68.00
69. 00 06900 ELECTROCARDI OLOGY	5, 276		5, 27	76 0	5, 276	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	40, 307		40, 30	07 0	40, 307	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	480, 931		480, 93	31 0	480, 931	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	93, 483		93, 48	33 0	93, 483	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	47, 517		47, 51		47, 517	
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0			0 0	0	1 88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89.00
OTHER REIMBURSABLE COST CENTERS		1	1	- <u> </u>		
99. 10 09910 CORF	0			0	0	99, 10
SPECIAL PURPOSE COST CENTERS		•	•			
109. 00 10900 PANCREAS ACQUISITION	0			0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0			0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	0			0		111.00
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	8, 364, 877	0	8, 364, 87	77 0	8, 364, 877	
201.00 Less Observation Beds	0,000,077	Ĭ	0,001,07	0		201.00
202.00 Total (see instructions)	8, 364, 877	0	8, 364, 87	7 0		
	0,001,077		1 0,004,07	. 0	0,001,077	1202.00

	Financial Systems REHA ATION OF RATIO OF COSTS TO CHARGES	BILITATION HOSP		CCN: 153030	Peri od:	u of Form CMS-2 Worksheet C	2002 10
0000101			riovidei	0011. 100000	From 10/01/2014	Part I	
					To 09/30/2015	Date/Time Pre	pared:
				e XVIII	Hospi tal	2/23/2016 2:5 PPS	<u>3 pm</u>
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
				,		Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	·					
30.00	03000 ADULTS & PEDIATRICS	7, 975, 976		7, 975, 97	76		30.00
31.00	03100 I NTENSI VE CARE UNI T	0			0		31.00
32.00	03200 CORONARY CARE UNI T	0			0		32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0			0		33.00
34.00	03400 SURGI CAL INTENSI VE CARE UNI T	0			0		34.00
41.00	04100 SUBPROVIDER - IRF	0			0		41.00
42.00	04200 SUBPROVI DER	0			0		42.00
43.00		0			0		43.00
54.00	ANCI LLARY SERVI CE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C	434, 468	520	434, 98	0. 115065	0. 000000	54.00
54.00 57.00	05700 CT SCAN	434,400	520	434, 90	0 0. 000000	0.000000	
57.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0.000000	0.000000	•
50.00 59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0.000000	•
60.00	06000 LABORATORY	876, 674	0	876, 67		0.000000	•
60.01	06001 BLOOD LABORATORY	0/0,0/4	0	070,07	0 0.000000	0.000000	•
65.00	06500 RESPI RATORY THERAPY	84, 131	903	85, 03		0.000000	•
66.00	06600 PHYSI CAL THERAPY	3, 648, 854	0	3, 648, 85		0.000000	•
67.00	06700 OCCUPATI ONAL THERAPY	3, 869, 898	0	3, 869, 89		0.000000	•
68.00	06800 SPEECH PATHOLOGY	1, 701, 229	0	1, 701, 22		0.00000	68.00
69.00	06900 ELECTROCARDI OLOGY	34, 762	0	34, 76	0. 151775	0.00000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	579, 814	3, 149	582, 96	0. 069142	0.00000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0.000000	0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 924, 201	10, 324	2, 934, 52	0. 163887	0.00000	73.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	298, 032	0	298, 03	0. 313668	0.00000	76.00
76.01	03950 HEMODIALYSIS & OTHER ANCILLARY	197, 119	9, 422	206, 54	0. 230061	0. 000000	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0		0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	0		0		99.10
100.00	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION	0	0		0		109.00
	11000 INTESTINAL ACQUISITION	0	0		0		1109.00
	11100 I SLET ACQUISITION	0	0		0		111.00
	11300 INTEREST EXPENSE	0	0				113.00
200.00		22, 625, 158	24, 318	22, 649, 47	76		200.00
200.00		22,023,130	24, 310	22,047,47			200.00

Cost Center Description PPS Inpatient Ratio Title XVIII Hospital PPS INPATIENT ROUTINE SERVICE COST CENTERS 30.00 33.00 31.00 33.00 31.00 33.00 31.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 94.00 33.00 94.00 33.00 94.00 33.00 94.00 33.00 94.00 33.00 94.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 94.00 56.00 55.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 50.00	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 153030	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Prepa 2/23/2016 2:53	ared:
INPATIENT RUTINE SERVICE COST CENTERS 30.00 1000 03000 ADULTS & PERVICE COST CENTERS 31.00 31.00 03100 INTENSIVE CARE UNIT 32.00 32.00 03300 CRONNARY CARE UNIT 33.00 34.00 03400 INTENSIVE CARE UNIT 33.00 34.00 04100 SUBEROVIDER - IRF 41.00 42.00 04200 SUBERCIAL INTENSIVE CARE UNIT 43.00 34.00 04100 SUBEROVIDER - IRF 41.00 42.00 04200 SUBERCIAL INTENSIVE COST CENTERS 54.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.115065 54.00 54.00 05500 CASON JAC CATHETER JATION 0.000000 55.00 56.00 05500 LABORATORY 0.137394 60.00 60.00 GEOD LABORATORY 0.372446 66.00 65.00 DESDI ADRATORY THERAPY 0.353330 67.00 66.00 DECOULARDRATORY 0.372446 66.00 67.00 DECOULARDRATORY 0.372446 66.00 68.00 SPSCILLATHERAPY 0.372446 67.00 70.00 <td></td> <td></td> <td>Title XVIII</td> <td>Hospi tal</td> <td>PPS</td> <td></td>			Title XVIII	Hospi tal	PPS	
11.00 11.00 30.00 30001 ADULTS & PEDI ATRICS 30.00 30.00 03000 INTERSI VE CARE UNI T 31.00 33.00 33.00 03300 BURN INTERSIVE CARE UNI T 33.00 34.00 03400 SURGI CAL INTERSIVE CARE UNI T 33.00 32.00 03300 BURN INTERSIVE CARE UNI T 33.00 34.00 SURGI CAL INTERSIVE CARE UNI T 34.00 42.00 04200 SURGI CAL INTERSIVE CARE UNI T 43.00 42.00 04300 SURGI CAL INTERSIVE CARE UNI T 43.00 43.00 SURGI CAL INTERSIVE CARE UNI T 43.00 54.00 05400 RADI OLOCY-DI AGNOSTI C 0.115065 57.00 D5700 CT SCAN 0.000000 58.00 58.00 06000 CARDI AC CARHETER IZATI ON 0.000000 58.00 60.01 16000 LABORATORY 0.000000 66.00 61.00 06500 RESPI RATORY THERAPY 0.353330 66.00 62.00 06500 RESPI RATORY THERAPY 0.353330 67.00 63.00 06500 RESPI RATORY THERAPY 0.353330 67.00 64.00	Cost Center Description	PPS Inpatient				
IMPATI ENT ROUTINE SERVICE COST CENTERS 30.00 00 00000 ADULTS & PEDIATRI CS 31.00 031 00 03100 (INTENSI VE CARE UNI T 32.00 03200 00300 BURCI CAL INTENSI VE CARE UNI T 33.00 034 00 0300 BURCI CAL INTENSI VE CARE UNI T 34.00 04100 SUBPROVI DER - IRF 42.00 41.00 04200 SUBPROVI DER - IRF 42.00 42.00 ALO OCADOR AND USER VE CARE UNI T 43.00 34.00 CASDO RADICI LARY SERVICE COST CENTERS 45.00 54.00 C5400 RADI CLOCY-DI ACMOSTIC 0.115065 54.00 57.00 C5700 CT SCAN 0.0000000 58.00 58.00 D600 MARCHT C RESONANCE I MAGI NG (MRI) 0.0000000 59.00 60.00 G6000 LABORATORY 0.0137394 66.00 60.01 G6001 BLODD LABORATORY 0.372446 65.00 66.00 D600 SPESPI RATORY THERAPY 0.353330 67.00 70.00 OCCUPATIONAL THERAPY 0.353330 67.00 71.00 OCCUPATIONAL THERAPY 0.353330 67.00 72.00 OCCUPATIONAL THERAPY 0.353330 67.00 72		Ratio				
30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSI VE CARE UNIT 31.00 33.00 03200 DORONARY CARE UNIT 33.00 34.00 03400 SURGI CAL INTENSI VE CARE UNIT 34.00 34.00 03400 SURGI CAL INTENSI VE CARE UNIT 34.00 34.00 03400 SURGI CAL INTENSI VE CARE UNIT 34.00 34.00 04300 SURGI CAL INTENSI VE CARE UNIT 41.00 34.00 04300 SURGI CAL INTENSI VE CARE UNIT 41.00 34.00 04300 NURSERY 41.00 ARCILLARY SERVICE COST CENTERS 54.00 55.00 54.00 05400 RADI CLORY-DI AGNOSTIC 0.115065 57.00 05700 OT SCAN 0.000000 58.00 58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0.000000 58.00 60.01 06001 LABORATORY 0.037346 66.00 60.00 06000 PHYSI CLA IHTERAPY 0.372446 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.353030 67.00 68.00 06900 OJELCAD LABORATORY 0.257549 68.00		11.00				
31 00 03100 INTENSIVE CARE UNIT 31.00 32 00 03200 CRONARY CARE UNIT 32.00 33 00 03400 SURGI CAL INTENSIVE CARE UNIT 33.00 41 00 03400 SURGI CAL INTENSIVE CARE UNIT 33.00 33 00 03300 BURN INTENSIVE CARE UNIT 33.00 34 00 03400 SURGI CAL INTENSIVE CARE UNIT 33.00 31 00 0300 BURN INTENSIVE CARE UNIT 33.00 31 00 0300 SURGI CAL INTENSIVE CARE UNIT 33.00 31 00 0300 BURN INTENSIVE CARE UNIT 33.00 31 00 04300 SUBPROVIDER - IRF 41.00 42 00 ANCILLARY SERVICE COST CENTERS 43.00 ANCILLARY SERVICE COST CENTERS 54.00 55.00 50 00 SPOOL CADIAC CATHETER ZATION 0.000000 55.00 50 00 05000 ABADTORY 0.000000 65.00 60.01 60 00 05000 CABATORY 0.000000 60.01 60.00 61 00 05000 RESPI RATORY THERAPY 0.372446 66.00 67.00 63 00 06000 SPECE HATHOLOGY 0.257549 68.00 67.00<		T				
32.00 03200/CORONARY CARE UNIT 32.00 33.00 033000 BURN INTENSIVE CARE UNIT 33.00 34.00 04100/SURGICAL INTENSIVE CARE UNIT 34.00 41.00 04100/SURGICAL INTENSIVE CARE UNIT 41.00 20.00 04200/SUBRENUIDER 42.00 42.00 04300/SURGICAL INTENSIVE CARE UNIT 42.00 43.00 04300/SURGICAL INTENSIVE CARE UNIT 42.00 43.00 04300/SURGICAL INTENSIVE CARE UNIT 42.00 44.00 05400/SURGICAL INTENSIVE CARE UNIT 43.00 64.00 05400/SURGICAL INTENSIVE CARE UNIT 54.00 75.00 57.00 57.00 57.00 57.00 57.00 58.00 05800 (ARGNETIC RESONANCE IMAGING (MRI) 0.000000 60.00 060.01 60.00 60.00 060.01 BLODRATORY 0.137394 60.00 60.00 060.00 RESPIE RATORY 0.35230 65.00 66.00 06600 PHYSICAL THERAPY 0.35230 67.00 67.00 05600 RESPIE RATORY 0.353030 67.00						
33:00 03300 BURN INTENSIVE CARE UNIT 33:00 34:00 03400 SURGICAL INTENSIVE CARE UNIT 31:00 41:00 04100 SUBPROVI DER - IRF 41:00 41:00 042:00 SUBPROVI DER 42:00 41:00 04300 NURSERY 42:00 ANCILLARY SERVICE COST CENTERS 54:00 55:00 50:00 05:00 (RADICLOCY-DIAGNOSTIC 0.115065 54:00 50:00 05:00 (RADICLOCY-DIAGNOSTIC 0.115065 54:00 50:00 05:00 (ARDICLOCY-DIAGNOSTIC 0.115065 56:00 50:00 05:00 (ARDICLOCY-DIAGNOSTIC 0.13734 60:00 60:00 06:00 (ARDICLOCY-DIAGNOSTICY 0.13734 60:00 60:00 06:00 ADRICTIC RESONANCE I MAGING (MRI) 0.000000 60:01 60:01 06:00 BLOOD LABORATORY 0.13734 60:00 60:00 06:00 CARDIC THERAPY 0.327549 66:00 61:00 06:00 SPECH PATHOLOGY 0.257549 68:00 60:00 00 COSOO CARDIC CARDICLOCY 0.13736 76:00 70:00 072:00 IMPL. DEV. CHARGED TO PATIENTS						
34 00 03400 SUBPROVIDER 1 AF 34 000 41 00 41 00 04200 SUBPROVIDER 1 AF 41 00 42 00 42 00 04200 SUBPROVIDER 41 00 42 00 43 00 04300 NURSERY 43 00 ANCILLARY SERVICE COST CENTERS 54 00 05400 RADIOLOCY-DIAGNOSTIC 0.115065 57.00 05700 CT SCAN 0.0000000 58.00 59.00 06500 CARDIA C ATHETERIZATION 0.000000 58.00 60.01 06000 LABORATORY 0.137394 60.00 60.01 06000 RESPI RATORY THERAPY 0.1372446 66.00 60.00 06000 RESPI RATORY THERAPY 0.353030 67.00 67.00 06000 SPECH PATHOLOGY 0.257549 68.00 68.00 06900 SPECH PATHOLOGY 0.257549 68.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.0400000 72.00 73.00 07300 JRAGE ATHE ANCELLARY 0.1333668 73.00 74.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0.333668 76.01 75.00 003500 PURAREGED TO PATIENTS <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
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99.10 09910 CORF 99.10 SPECIAL PURPOSE COST CENTERS 109.00 109.00 10900 PANCREAS ACQUI SI TI ON 109.00 110.00 INTESTI NAL ACQUI SI TI ON 110.00 111.00 111.00 ISLET ACQUI SI TI ON 111.00 111.00 113.00 INTERST EXPENSE 113.00 113.00 200.00 Subtotal (see instructions) 200.00 201.00	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				5	89.00
SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 109.00 110.00 INTESTINAL ACQUISITION 110.00 111.00 ISLET ACQUISITION 110.00 111.00 ISLET ACQUISITION 110.00 113.00 INTERST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	OTHER REIMBURSABLE COST CENTERS					
109.00 10900 PANCREAS ACQUI SI TI ON 109.00 110.00 11000 INTESTI NAL ACQUI SI TI ON 110.00 111.00 1SLET ACQUI SI TI ON 111.00 113.00 1NTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	99. 10 09910 CORF				(99. 10
110.00 11000 INTESTINAL ACQUISITION 110.00 111.00 1SLET ACQUISITION 111.00 113.00 1NTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00						
111.00 1SLET ACQUISITION 111.00 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 Less Observation Beds 201.00	109.00 10900 PANCREAS ACQUI SI TI ON				1(09.00
113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	110.00 11000 INTESTINAL ACQUISITION				1'	10.00
200.00 Subtotal (see instructions) 200.00 200.00 201.00 <td></td> <td></td> <td></td> <td></td> <td>1</td> <td>11.00</td>					1	11.00
201.00 Less Observation Beds 201.00	113.0011300 INTEREST EXPENSE					
	200.00 Subtotal (see instructions)				20	00.00
202.00 Total (see instructions) 202.00	201.00 Less Observation Beds				20	01.00
	202.00 Total (see instructions)				20	02.00

Heal th	alth Financial	I Syst	ems				
COMPLIT		0F	PATIO	OF	27200	ΤO	СНА

In Lieu of Form CMS-2552-10

COMPUTATION OF	RATIO OF COSTS TO CHARGES		Provi der	CCN: 153030	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Pre 2/23/2016 2:5	pared: 3 pm
			Ti t	le XIX	Hospi tal	PPS	
					Costs		
Cc	ost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)	0.00	0.00	4.00	F 00	
	NT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	DULTS & PEDIATRICS	4, 349, 960		4 240 0		4 240 040	30,00
	NTENSIVE CARE UNIT	4, 349, 960		4, 349, 90	50 0 0 0	4, 349, 960	
	DRONARY CARE UNIT	0			0 0	0	31.00 32.00
	JRN INTENSIVE CARE UNIT	0			0 0	0	32.00
	JRGI CAL INTENSIVE CARE UNIT	0			0 0	0	34.00
	JBPROVIDER - IRF	0			0 0	0	41.00
	JBPROVI DER – TRF	0			0 0	0	41.00
43.00 04300 NL		0			0 0	0	42.00
	RY SERVICE COST CENTERS	0		<u> </u>	0 0	0	43.00
	ADI OLOGY-DI AGNOSTI C	50, 052		50, 0	52 0	50, 052	54.00
57.00 05700 CT		0		50, 0.	0 0	50, 052	57.00
	AGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58.00
	ARDI AC CATHETERI ZATI ON	0				0	59.00
	ABORATORY	120, 450		120, 4	50 0	120, 450	•
	LOOD LABORATORY	120, 100		120, 1	0 0	0	60.01
	ESPI RATORY THERAPY	13, 557	0	13, 5	5	13, 557	65.00
	IYSI CAL THERAPY	1, 359, 002	0			1, 359, 002	
	CCUPATIONAL THERAPY	1, 366, 192	0			1, 366, 192	
	PEECH PATHOLOGY	438, 150	0	438, 1		438, 150	
	LECTROCARDI OLOGY	5, 276		5, 2		5, 276	
	EDICAL SUPPLIES CHARGED TO PATIENTS	40, 307		40, 30		40, 307	
	MPL. DEV. CHARGED TO PATIENTS	0			0 0	0	1
	RUGS CHARGED TO PATIENTS	480, 931		480, 93	31 0	480, 931	73.00
	SYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	93, 483		93, 4		93, 483	
	EMODIALYSIS & OTHER ANCILLARY	47, 517		47, 5		47, 517	
	ENT SERVICE COST CENTERS						
	JRAL HEALTH CLINIC	0			0 0	0	88.00
89.00 08900 FE	EDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89.00
OTHER RE	EIMBURSABLE COST CENTERS			•			1
99. 10 09910 CC)RF	0			0	0	99.10
SPECI AL	PURPOSE COST CENTERS						
	ANCREAS ACQUISITION	0			0	0	109.00
	ITESTINAL ACQUISITION	0			0	0	110.00
	SLET ACQUISITION	0			0	0	111.00
	ITEREST EXPENSE						113.00
200. 00 SL	ubtotal (see instructions)	8, 364, 877	C	8, 364, 8	77 0	8, 364, 877	200. 00
201.00 Le	ess Observation Beds	0			0		201.00
202.00 To	otal (see instructions)	8, 364, 877	C	8, 364, 8	77 0	8, 364, 877	202.00

	Financial Systems REHA ATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 153030	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Pre 2/23/2016 2:5	pared:
			Titl	le XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 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						
30.00	03000 ADULTS & PEDIATRICS	7, 975, 976		7, 975, 97	76		30.00
31.00	03100 I NTENSI VE CARE UNI T	0			0		31.00
32.00	03200 CORONARY CARE UNI T	0			0		32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0			0		33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0			0		34.00
41.00	04100 SUBPROVIDER - IRF	0			0		41.00
42.00	04200 SUBPROVI DER	0			0		42.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0			0		43.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	434, 468	520	434, 98	0. 115065	0. 000000	54.00
57.00	05700 CT SCAN	434, 400	0	434, 90	0 0. 000000	0.000000	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0.000000	0.000000	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0.000000	
60,00	06000 LABORATORY	876, 674	o	876, 67		0. 000000	
60.01	06001 BLOOD LABORATORY	0	0	0,0,0,	0 0.000000	0, 000000	
65.00	06500 RESPI RATORY THERAPY	84, 131	903	85, 03		0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	3, 648, 854	0	3, 648, 85	0. 372446	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	3, 869, 898	0	3, 869, 89	0. 353030	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	1, 701, 229	0	1, 701, 22	0. 257549	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	34, 762	0	34, 76	62 0. 151775	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	579, 814	3, 149	582, 96	0. 069142	0.00000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0.000000	0.00000	
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 924, 201	10, 324	2, 934, 52		0.00000	1
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	298, 032	0	298, 03		0.000000	
76. 01	03950 HEMODI ALYSI S & OTHER ANCI LLARY	197, 119	9, 422	206, 54	0. 230061	0. 000000	76.01
~~ ~~	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0.000000	0.000000	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.000000	0. 000000	89.00
99, 10	OTHER REIMBURSABLE COST CENTERS	0	0		0		99, 10
99. IU	SPECIAL PURPOSE COST CENTERS	<u> </u>	U				99.10
109 00	10900 PANCREAS ACQUISITION	0	0		0		109.00
	11000 INTESTINAL ACQUISITION	0	0		0		110,00
	11100 I SLET ACQUI SI TI ON	0	0		õ		111.00
	11300 I NTEREST EXPENSE		Ű		-		113.00
200.00		22, 625, 158	24, 318	22, 649, 47	76		200.00
201.00							201.00

Heal th	Financial Systems REHA	ABILITATION HOSPITAL	∟ OF FT WAYNE	In Lie	eu of Form CMS-2552-10
	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 153030	Peri od:	Worksheet C
				From 10/01/2014	
				To 09/30/2015	Date/Time Prepared:
		,		<u> </u>	2/23/2016 2:53 pm
			Title XIX	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDIATRICS				30.00
	03100 I NTENSI VE CARE UNI T				31.00
	03200 CORONARY CARE UNI T				32.00
	03300 BURN INTENSIVE CARE UNIT				33.00
	03400 SURGICAL INTENSIVE CARE UNIT				34.00
	04100 SUBPROVI DER – I RF				41.00
	04200 SUBPROVI DER				42.00
43.00	04300 NURSERY				43.00
/	ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 115065			54.00
57.00 0	05700 CT SCAN	0. 000000			57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58.00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
	06000 LABORATORY	0. 137394			60.00
	06001 BLOOD LABORATORY	0. 000000			60.01
	06500 RESPI RATORY THERAPY	0. 159430			65.00
	06600 PHYSI CAL THERAPY	0. 372446			66.00
	06700 OCCUPATI ONAL THERAPY	0.353030			67.00
	06800 SPEECH PATHOLOGY	0. 257549			68.00
	06900 ELECTROCARDI OLOGY	0. 257549			69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 151775			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 163887			73.00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 313668			76.00
	03950 HEMODIALYSIS & OTHER ANCILLARY	0. 230061			76. 01
	OUTPATIENT SERVICE COST CENTERS				
	08800 RURAL HEALTH CLINIC	0. 000000			88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
	OTHER REIMBURSABLE COST CENTERS				
	09910 CORF				99.10
	SPECIAL PURPOSE COST CENTERS				
	10900 PANCREAS ACQUISITION				109.00
	11000 INTESTINAL ACQUISITION				110.00
	11100 I SLET ACQUI SI TI ON				111.00
	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00					201.00
202.00					202.00
		1			

Health Financial Systems REHA	BILITATION HOS	PITAL OF FT WAY	YNF	In Lie	eu of Form CMS-:	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA			CCN: 153030	Peri od:	Worksheet C	
REDUCTIONS FOR MEDICALD ONLY				From 10/01/2014	Part II	
				To 09/30/2015		pared:
				11	2/23/2016 2:5	3 pm
Cost Center Description	Total Cost	Capital Cost	le XIX	Hospital st Capital	PPS Operating Cost	
cost center bescription		(Wkst. B, Part			Reduction	
	(WKSL B, Part	II col. 26)			Amount	
	I, COI. 20)	11 COL. 20)	cost (cor. r	-	Amount	
	1.00	2.00	3.00	4, 00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	0.00	4.00	3.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	50, 052	8, 705	i 41, 34	17 0	0	54.00
57. 00 05700 CT SCAN	00,002	0,700		0 0	0	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
60. 00 06000 LABORATORY	120, 450	3, 643	116, 80	07 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0			0 0	0	60.01
65. 00 06500 RESPIRATORY THERAPY	13, 557	2, 061	11, 49	96 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 359, 002				0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 366, 192				0	67.00
68. 00 06800 SPEECH PATHOLOGY	438, 150				0	68.00
69. 00 06900 ELECTROCARDI OLOGY	5, 276				0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	40, 307				0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	480, 931	16, 031	464, 90	0 00	0	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	93, 483				0	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	47, 517				0	1
OUTPATIENT SERVICE COST CENTERS			1		. · · ·	
88.00 08800 RURAL HEALTH CLINIC	0	C)	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	c c		0 0	0	89.00
OTHER REIMBURSABLE COST CENTERS						
99. 10 09910 CORF	0	C)	0 0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUI SI TI ON	0	C		0 0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	C		0 0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	C		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (sum of lines 50 thru 199)	4, 014, 917	383, 653	3, 631, 20	64 0		200.00
201.00 Less Observation Beds	0	C		0 0		201.00
202.00 Total (line 200 minus line 201)	4, 014, 917	383, 653	3, 631, 20	64 0	0	202.00

Health Financial Systems REHA	BILITATION HOS	PITAL OF FT WAY	YNE	In Lie	u of Form CMS-2552-1
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY	TIOS NET OF		CCN: 153030	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part II Date/Time Prepared: 2/23/2016 2:53 pm
			le XIX	Hospi tal	PPS
Cost Center Description	Cost Net of	Total Charges	Outpati ent		
	Capital and	(Worksheet C,	Cost to Char	ge	
	Operating Cost	Part I, column	Ratio (col.	6	
	Reducti on	8)	/ col. 7)		
	6.00	7.00	8.00		
ANCI LLARY SERVI CE COST CENTERS			_		
54.00 05400 RADI OLOGY-DI AGNOSTI C	50, 052	434, 988	0. 1150	65	54.00
57.00 05700 CT SCAN	0	0	0.0000	00	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.0000	00	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	c c	0.0000	00	59.00
60. 00 06000 LABORATORY	120, 450	876, 674	0. 1373	94	60.00
60.01 06001 BLOOD LABORATORY	0	l c	0.0000	00	60.01
65. 00 06500 RESPI RATORY THERAPY	13, 557	85, 034			65.00
66. 00 06600 PHYSI CAL THERAPY	1, 359, 002				66.00
67.00 06700 OCCUPATI ONAL THERAPY	1, 366, 192				67.00
68.00 06800 SPEECH PATHOLOGY	438, 150				68.00
69. 00 06900 ELECTROCARDI OLOGY	5, 276				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	40, 307				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0		1		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	480, 931	-			73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	93, 483				76.00
76. 01 03950 HEMODI ALYSI S & OTHER ANCI LLARY	47, 517				76.01
OUTPATIENT SERVICE COST CENTERS	1,017	200,011	0.2000		70.01
88.00 08800 RURAL HEALTH CLINIC	0	C	0,0000	00	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				89.00
OTHER REIMBURSABLE COST CENTERS		<u> </u>	0.0000		07.00
99. 10 09910 CORF	0	0	0.0000	00	99.10
SPECIAL PURPOSE COST CENTERS			0.0000	50	
109. 00 10900 PANCREAS ACQUISITION	0	0	0.0000	00	109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON			1		110.00
111. 00 11100 SLET ACQUI SI TI ON			0.0000		111.00
113. 00 11300 I NTEREST EXPENSE			0.0000		113.00
200.00 Subtotal (sum of lines 50 thru 199)	4,014,917	14, 673, 500			200.00
201.00 Less Observation Beds	4,014,917				200.00
202.00 Total (line 200 minus line 201)	4, 014, 917	-			201.00

Health Financial Systems	REHABILITATION HOSE	PITAL OF FT WAY	YNE	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	ITAL COSTS			Period: From 10/01/2014 To 09/30/2015	2/23/2016 2:5	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
·	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS				-		
30. 00 ADULTS & PEDIATRICS	253, 183	0	253, 18	3 5, 333	47.47	30.00
31.00 INTENSIVE CARE UNIT	0			0 0	0.00	31.00
32.00 CORONARY CARE UNI T	0			o o	0.00	32.00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0,00	
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0,00	34.00
41. 00 SUBPROVIDER - IRF	0	0		0 0	0.00	
42. 00 SUBPROVI DER	0	0		0 0	0,00	
43.00 NURSERY	0	-		0 0		43.00
200.00 Total (lines 30-199)	253, 183		253, 18	3 5, 333	0100	200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	2, 353	111, 697	7			30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
32.00 CORONARY CARE UNI T	0	C				32.00
33.00 BURN INTENSIVE CARE UNIT	0	C				33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	C				34.00
41.00 SUBPROVIDER - IRF	0	C				41.00
42.00 SUBPROVI DER	0	C				42.00
43.00 NURSERY	0	C				43.00
200.00 Total (lines 30-199)	2, 353	111, 697	/			200.00
	, ,					

Health Financial Systems REH,	ABILITATION HOSI	PITAL OF FT WAY	YNE	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der		Period: From 10/01/2014	Worksheet D Part II	
				To 09/30/2015	Date/Time Pre	
					2/23/2016 2:5	3 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS				-		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 705	434, 988				
57.00 05700 CT SCAN	0	C	0.00000		0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C	0.00000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000		0	59.00
60. 00 06000 LABORATORY	3, 643	876, 674			1, 628	
60. 01 06001 BLOOD LABORATORY	0	0	0.00000		0	60. 01
65. 00 06500 RESPI RATORY THERAPY	2,061	85, 034				65.00
66. 00 06600 PHYSI CAL THERAPY	208, 942	3, 648, 854	0. 05726	2 1, 628, 692	93, 262	66.00
67.00 06700 OCCUPATI ONAL THERAPY	114, 685	3, 869, 898	0. 02963	5 1, 701, 657	50, 429	67.00
68.00 06800 SPEECH PATHOLOGY	16, 848	1, 701, 229	0.00990	3 745, 181	7, 380	68.00
69. 00 06900 ELECTROCARDI OLOGY	84	34, 762	0. 00241	6 19, 678	48	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 113	582, 963	0.00534	0 243, 359	1, 300	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	16, 031	2, 934, 525	0. 00546	3 1, 225, 528	6, 695	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	8, 920	298, 032	0. 02993	0 135, 848	4, 066	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	621	206, 541	0.00300	7 110, 586	333	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C	0.00000	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	0 0	0	89.00
200.00 Total (lines 50-199)	383, 653	14, 673, 500		6, 416, 765	169, 540	200.00

Health Financial Systems REH.	ABILITATION HOS	PITAL OF FT WAY	YNE	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provi der		Period: From 10/01/2014 To 09/30/2015	Worksheet D Part III Date/Time Pre 2/23/2016 2:5	
	_	. Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adj ustment	(sum of cols.	
			Education Cos		1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			_			
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 I NTENSI VE CARE UNI T	0	0		0	0	31.00
32. 00 03200 CORONARY CARE UNI T	0	0		0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0)	0	0	33.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0	0	34.00
41. 00 04100 SUBPROVI DER - I RF	0	0		0 0	0	41.00
42. 00 04200 SUBPROVI DER	0	0 0)	0 0	0	42.00
43. 00 04300 NURSERY	0	0 0		0	0	43.00
200.00 Total (lines 30-199)	0	0 0		0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpatient	Inpati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 333	0.00	2, 35	0		30.00
31.00 03100 I NTENSI VE CARE UNI T	0	0.00		0 0		31.00
32.00 03200 CORONARY CARE UNI T	0	0.00		0 0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0.00		0 0		33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0.00)	0 0		34.00
41.00 04100 SUBPROVIDER - IRF	0	0.00)	0 0		41.00
42. 00 04200 SUBPROVI DER	0	0.00)	0 0		42.00
43.00 04300 NURSERY	0	0.00		0 0		43.00
200.00 Total (lines 30-199)	5, 333		2, 35	03		200.00
· · · · · · · · · · · ·						

Health Financial Systems	REHABILITATION HOS	PITAL OF FT WAY	YNE	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PASS	S Provi der	CCN: 153030	Period: From 10/01/2014	Worksheet D Part IV	
THROUGH COSTS				To 09/30/2015		pared:
					2/23/2016 2:5	
			e XVIII	Hospi tal	PPS	
Cost Center Description		Nursing School	Allied Healt		Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost		
	1.00	2.00	3.00	4, 00	4) 5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
57.00 05700 CT SCAN	0	C		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	0	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
60.01 06001 BLOOD LABORATORY	0	C		0 0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	C)	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	S 0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C)	0 0	0	73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C)	0 0	0	76.00
76. 01 03950 HEMODIALYSIS & OTHER ANCILLARY	0	(C)	0 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS		1				
88. 00 08800 RURAL HEALTH CLINIC	0	C		0 0	-	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89.00
200.00 Total (lines 50-199)	1 0	1 C	4	U U		200. 00

Health Financial Systems REHA	BILITATION HOSI	PITAL OF FT WAY	YNE	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider		Period:	Worksheet D	
THROUGH COSTS				From 10/01/2014 To 09/30/2015	Part IV Date/Time Pre	narad
				10 09/ 30/ 2015	2/23/2016 2:5	
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	1			
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	434, 988				
57.00 05700 CT SCAN	0	0	0.00000		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.00000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000		0	59.00
60. 00 06000 LABORATORY	0	876, 674				60.00
60.01 06001 BLOOD LABORATORY	0	0	0.00000			60. 01
65. 00 06500 RESPI RATORY THERAPY	0	85, 034				65.00
66. 00 06600 PHYSI CAL THERAPY	0	3, 648, 854			1, 628, 692	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	3, 869, 898	0.00000	0 0.000000	1, 701, 657	67.00
68.00 06800 SPEECH PATHOLOGY	0	1, 701, 229	0.00000	0 0.000000	745, 181	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	34, 762	0.00000	0 0.000000	19, 678	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	582, 963			243, 359	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0.00000	0 0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 934, 525	0.00000	0.000000	1, 225, 528	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	298, 032	0.00000	0.000000	135, 848	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	0	206, 541	0.00000	0.000000	110, 586	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0.000000	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0.00000	0	89.00
200.00 Total (lines 50-199)	0	14, 673, 500			6, 416, 765	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 153030 Period: Period: From 10/01/2014 From 10/01/2014 Worksheet 0 Part IV Date/Time Prepared: 2/23/2016 2:53 pm	Health Financial Systems REH/	ABILITATION HOSP	TAL OF FT WAY	/NE	In Lie	u of Form CMS-	2552-10
ANCI LLARY SERVICE COST CENTERS Title XVIII Hospital Program Program Program Program Charges Outpatient Program Pro		RVICE OTHER PASS	Provi der	CCN: 153030			
ANCILLARY SERVICE COST CENTERS Inpati ent Program Pass-Through Costs (col. 8 x col. 10) Outpati ent Program Charges Outpati ent Program Costs (col. 9 x col. 12) St. 00 ANCILLARY SERVICE COST CENTERS 0 520 0 54.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 58.00 60.00 60.00 60.00 60.00 58.00 60.00 60.00 60.00 60.00 60.00 58.00 58.00 58.00 59.00 59.00 59.00 59.00 59.00 50.00 57.00 57.00 58.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 59.00 58.00 59.00 59.00 59.00 59.00 59.00 50.00 57.00 57.00 58.00 59.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00	THROUGH COSTS						nored.
Cost Center Description Inpatient Program Pass-Through Costs (col. 9 x col. 10) Outpatient Program Charges Outpatient Program Pass-Through Costs (col. 9 x col. 12) Hospital PPS ANCILLARY SERVICE COST CENTERS 11.00 12.00 13.00 13.00 54.00 54.00 54.00 55.00 50.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 59.00 60.00 60.00 60.00 60.00 58.00 59.00 60.00 60.00 60.00 60.00 60.00 58.00 59.00 60.00 60.00 60.00 60.01 60.01 60.01 60.01 60.01 60.01 60.01 60.01 60.01 60.01 60.01 60.01 66.00 <t< td=""><td></td><td></td><td></td><td></td><td>10 09/30/2013</td><td></td><td></td></t<>					10 09/30/2013		
Program Pass-Through Costs (col. 9 x col. 10) Program Charges Program Pass-Through Costs (col. 9 x col. 12) ANCI LLARY SERVICE COST CENTERS 11.00 12.00 13.00 54.00 05400 RADI 0L0GY-DI AGNOSTI C 0 520 0 57.00 05700 CT SCAN 0 0 0 54.00 58.00 05900 CARDI AC CATHETERI ZATI 0N 0 0 0 57.00 59.00 05900 CARDI AC CATHETERI ZATI 0N 0 0 0 0 60.01 06001 LABORATORY 0 0 0 0 60.01 65.00 06500 RESPI RATORY THERAPY 0 0 0 60.01 65.00 66.00 066000 PHYSI CAL THERAPY 0 0 0 66.00 66.00 67.00 05900 ELECTROCARDI OLOGY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 71.00 71.00 00 0 0 0 0 72.00 73.00			Ti tl	e XVIII	Hospi tal		
Pass-Trrough Costs (col. 8 x col. 10) Charges x col. 12) Pass-Trrough Costs (col. 9 x col. 12) ANCI LLARY SERVI CE COST CENTERS 11.00 12.00 13.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 57.00 05700 CT SCAN 0 0 57.00 58.00 05900 (CARDI AC CATHETERI ZATI ON 0 0 0 58.00 59.00 05900 (CARDI AC CATHETERI ZATI ON 0 0 0 58.00 60.01 BLODD LABORATORY 0 0 0 0 60.01 65.00 06500 RESPI RATORY THERAPY 0 903 0 60.01 60.00 66.00 67.00 68.00 71.00 72.00 70.0 68.00 71.00 72.00 70.0 68.00	Cost Center Description	Inpatient	Outpati ent	Outpati ent			
ANCI LLARY SERVICE COST CENTERS Costs (col. 8 x col. 10) Costs (col. 9 x col. 12) 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 520 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 520 0 57.00 CSCAN 0 0 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 58.00 59.00 CSSOV CARDI AC CATHETERI ZATI ON 0 0 0 0 59.00 60.00 LABORATORY 0 0 0 0 0 60.00 66.00 D6500 RESPI RATORY THERAPY 0 0 0 0 66.00 67.00 66.00 66.00 67.00 66.00 67.00 69.00 71.00		Program	Program	Program			
x col. 10) x col. 12) 11.00 12.00 13.00 ANCI LLARY SERVICE COST CENTERS 54.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 520 0 57.00 05700 CT SCAN 0 0 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59.00 60.00 LABORATORY 0 0 0 0 60.00 60.01 LOGOD LABORATORY 0 0 0 60.01 65.00 65.00 DESPI RATORY THERAPY 0 0 0 65.00 67.00 06700 OCUPATI ONAL THERAPY 0 0 0 65.00 68.00 OB600 SPECH PATHOLOGY 0 0 0 64.00 69.00 OROD CALECTROCARDI OLOGY 0 0 0 71.00 71.00			Charges				
Incomplexity Incomplexity<		Costs (col. 8			9		
ANCI LLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 520 0 57.00 05700 CT SCAN 0 0 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59.00 60.01 BLOOD LABORATORY 0 0 0 0 60.01 65.00 06500 RESPI RATORY THERAPY 0 903 0 65.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 66.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 67.00 66.00 067.00 0 0 0 66.00 67.00 67.00 06700 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 67.00							
54.00 05400 RADIOLOGY-DIAGNOSTIC 0 520 0 57.00 05700 CT SCAN 0 0 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 59.00 CARDIAC CATHETERIZATION 0 0 0 58.00 60.00 CABORATORY 0 0 0 60.00 60.01 BLOOD LABORATORY 0 0 0 60.01 65.00 06500 RESPI RATORY THERAPY 0 903 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 67.00 67.00 06700 0 0 0 0 67.00 68.00 67.00 06700 0 0 0 0 67.00 67.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 71.00 71.00 71.00 71.00 71.00 72.00 0 0 73.00 73.00 73.00 73		11.00	12.00	13.00			
57.00 05700 CT SCAN 0 0 0 57.00 58.00 05800 MGNETIC RESONANCE I MAGI NG (MRI) 0 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 69.00 60.00 06000 LABORATORY 0 0 0 60.00 60.01 06000 LABORATORY 0 0 0 60.01 65.00 06500 RESPI RATORY THERAPY 0 903 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 67.00 67.00 06700 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 10, 324 0 71.00 72.00 IMPL DEV. CHARGED TO PATI ENTS 0 10, 324 0 73.00 76.00 76.01		1 1		1	- 1		
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59.00 60.00 06000 LABORATORY 0 0 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 60.01 65.00 06500 RESPI RATORY THERAPY 0 0 0 65.00 66.00 06001 DK000 CCUPATI ONAL THERAPY 0 0 0 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 66.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 CALS SUPLIES CHARGED TO PATI ENTS 0 0 0 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 73.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 76.00 </td <td></td> <td>0</td> <td>520</td> <td></td> <td>0</td> <td></td> <td></td>		0	520		0		
59.00 05900 CARDI AC CATHETERI ZATI ON 0		0	0		0		
60.00 06000 LABORATORY 0 0 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0 903 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 67.00 68.00 SPECH PATHOLOGY 0 0 0 68.00 68.00 69.00 ELECTROCARDI OLOGY 0 0 0 69.00 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 3,149 0 71.00 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 10,324 0 73.00 73.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00 76.00<		0	0		0		
60.01 06001 BLOOD LABORATORY 0 0 0 60.01 65.00 06500 RESPI RATORY THERAPY 0 903 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 3,149 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 10,324 0 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 74.00 74.01 03500 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 74.00 76.01 03950 HEMODI ALYSI S & OTHER ANCI LLARY 0 9,422 0 76.00 76.01 03950 RURAL HEALTH CLINIC 0		0	0		0		
65.00 06500 RESPI RATORY THERAPY 0 903 0 65.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 66.00 67.00 66.00 67.00 67.00 68.00 69.00 0 0 0 68.00 69.00 68.00 69.00 71.00 69.00 71.00 71.00 71.00 71.00 71.00 71.00 72.00 72.00 72.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 9.422 0 74.00 75.00 76.00 76.00 78.00		0	0		0		
66.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 3,149 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 10,324 0 73.00 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 9,422 0 0UTPATI ENT SERVICE COST CENTERS 0 9,422 0 76.01 76.01 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 89.00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 89.00		0	0		0		
67.00 06700 OCCUPATIONAL THERAPY 0 0 0 67.00 68.00 69.00 0 0 0 0 68.00 69.00 0 0 0 0 0 68.00 69.00 0 0 0 0 0 0 69.00 69.00 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 3,149 0 71.00 72.00 72.00 72.00 0 0 0 0 72.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 76.01 73.92 0 76.00 76.01 <td></td> <td>0</td> <td>903</td> <td></td> <td>0</td> <td></td> <td></td>		0	903		0		
68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 3,149 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 10,324 0 73.00 76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 0 0 76.01 03950 HEMODIALYSIS & OTHER ANCILLARY 0 9,422 0 76.01 0UTPATIENT SERVICE COST CENTERS 0 0 0 88.00 88.00 88.00 08800 RURAL HEALTH CLINIC 0 0 0 89.00		0	0		0		
69.00 06900 ELECTROCARDIOLOGY 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 3,149 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 10,324 0 73.00 76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 0 0 76.00 70.01 03950 HEMODIALYSIS & OTHER ANCILLARY 0 9,422 0 76.01 001PATIENT SERVICE COST CENTERS 0 0 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00		0	0		0		
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 3, 149 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 10, 324 0 73.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 76.00 76.01 03950 HEMODI ALYSI S & OTHER ANCI LLARY 0 9, 422 0 76.00 76.02 017ATI ENT SERVICE COST CENTERS 0 0 0 88.00 88.00 88.00 08800 RURAL HEALTH CLINIC 0 0 0 89.00		0	0		0		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 10, 324 0 73.00 76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 0 0 76.00 76.01 03950 HEMODIALYSIS & OTHER ANCILLARY 0 9, 422 0 76.01 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 88.00 88.00 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00		0	0		0		
73.00 07300 DRUGS CHARGED TO PATIENTS 0 10,324 0 73.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 76.00 76.01 03950 HEMODI ALYSI S & OTHER ANCI LLARY 0 9,422 0 76.01 0UTPATI ENT SERVICE COST CENTERS 0 0 0 88.00 88.00 89.00 60 88.00 89		0	3, 149		0		
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 76. 00 76. 00 76. 00 76. 01 <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td></td> <td>72.00</td>		0	0		0		72.00
76. 01 03950 HEMODIALYSIS & OTHER ANCILLARY 0 9,422 0 76. 01 OUTPATI ENT SERVICE COST CENTERS 0 0 0 0 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 89.00 69.00 0 0 0 89.00<		0	10, 324		0		
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00	76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0		76.00
88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00	76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	0	9, 422		0		76.01
89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 89. 00							
		0	0		0		
200.00 Total (lines 50-199) 0 24,318 0 200.00		0	0		0		
	200.00 Total (lines 50-199)	0	24, 318		0		200.00

Health Financial Systems REHA	BILITATION HOSI	PITAL OF FT WAY	/NE	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 153030	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Pre	epared:
		T; +1	e XVIII	Hospi tal	2/23/2016 2:5 PPS	is pill
		1111	Charges	HOSPITAL	Costs	
Cost Center Description	Cost to Charge	DDS Doimbursod		Cost	PPS Services	
cost center bescription		Services (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not	(366 1131.)	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins	,		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS				!		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 115065	520	I	0 0	60	54.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 137394	0		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0.000000	0		0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	0. 159430	903		0 0	144	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 372446	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 353030	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 257549	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 151775	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 069142	3, 149		0 0	218	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. 163887	10, 324		0 0	1, 692	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 313668	0		0 0	0	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	0. 230061	9, 422		0 0	2, 168	76.01
OUTPATIENT SERVICE COST CENTERS		•	•	·		
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
200.00 Subtotal (see instructions)		24, 318		0 0	4, 282	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		24, 318	1	0 0	4, 282	202.00

Health Financial Systems REHA	BILITATION HOS	PITAL OF FT WAYNE		In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CCN:		Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Pro 2/23/2016 2:	
			/111	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed Services	Reimbursed Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS	0100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60.01
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	0	0				76. 01
OUTPATIENT SERVICE COST CENTERS	1	1 1				_
88.00 08800 RURAL HEALTH CLINIC	0	0				88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						202.00
202.00 Net Charges (line 200 +/- line 201)	0	0				202.00

Health Financial Systems	REHABILITATION HOSF	NTAL OF FT WAY	/NE	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE (CAPI TAL COSTS		-	Period: From 10/01/2014 To 09/30/2015	2/23/2016 2:5	
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	2	Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTER	S		•			
30. 00 ADULTS & PEDIATRICS	253, 183	0	253, 18	3 5, 333	47.47	30.00
31.00 INTENSIVE CARE UNIT	0			0 0	0.00	31.00
32.00 CORONARY CARE UNI T	0			o o	0.00	32.00
33.00 BURN INTENSIVE CARE UNIT	0			o o	0,00	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0,00	34.00
41.00 SUBPROVIDER - IRF	0	0		0	0.00	
42. 00 SUBPROVI DER	0	0		0 0	0,00	
43. 00 NURSERY	0	0		n 0		43.00
200.00 Total (lines 30-199)	253, 183		253, 18	3 5, 333	0.00	200.00
Cost Center Description	Inpati ent	Inpati ent	200,10	0,000		200.00
obst benter bescription	Program days	Program				
	ri ogi alli days	Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTER	S					
30.00 ADULTS & PEDIATRICS	610	28, 957				30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
32.00 CORONARY CARE UNI T	0	0				32.00
33. 00 BURN INTENSIVE CARE UNIT	0	0				33.00
34. 00 SURGI CAL INTENSI VE CARE UNI T	0	0				34.00
41. 00 SUBPROVIDER - IRF	0	0				41.00
42. 00 SUBPROVI DER	0	0				42.00
43. 00 NURSERY	0	0				42.00
200.00 Total (lines 30-199)	610	28, 957				200.00
200.00/10/01 (11/165 30-177)		20, 907	1			200.00

Health Financial Systems REHA	BILITATION HOS	PITAL OF FT WAY	YNE	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	IL COSTS	Provi der		Period: From 10/01/2014 To 09/30/2015		
	_	Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	-	1		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 705	434, 988			739	
57.00 05700 CT SCAN	0	0	0.00000		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.00000	0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0 0	0	59.00
60. 00 06000 LABORATORY	3, 643	876, 674	0. 00415	5 63, 948	266	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000	0 0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	2,061	85, 034	0. 02423	7 4, 576	111	65.00
66.00 06600 PHYSI CAL THERAPY	208, 942	3, 648, 854	0. 05726	2 208, 619	11, 946	66.00
67.00 06700 OCCUPATI ONAL THERAPY	114, 685	3, 869, 898	0. 02963	5 215, 576	6, 389	67.00
68.00 06800 SPEECH PATHOLOGY	16, 848	1, 701, 229	0. 00990	3 62, 577	620	68.00
69.00 06900 ELECTROCARDI OLOGY	84	34, 762	0. 00241	6 1, 304	3	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 113	582, 963	0. 00534	0 64, 758	346	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0. 00000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	16, 031	2, 934, 525	0. 00546	3 171, 908	939	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	8, 920	298, 032	0. 02993	0 10, 347	310	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	621	206, 541	0.00300		0	76.01
OUTPATIENT SERVICE COST CENTERS	•		·	<u>.</u>	·	1
88.00 08800 RURAL HEALTH CLINIC	0	C	0.00000	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	0 0	0	89.00
200.00 Total (lines 50-199)	383, 653	14, 673, 500		840, 531	21, 669	200. 00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 153030 Period: From 10/07/2014 From 10/07/2014 Worksheet D Date/Time Prepared: 12/23/2016 2:53 pm Cost Center Description Nursing School All Other Cost Mursing School All Other Cost Mursing School All Other Medical Education Cost Swing-Bed Adjustment Instructions Total Costs (sum of cols.) Instructions 0 0 0.00 3.00 4.00 5.00 1 0.00 2.00 3.00 4.00 5.00 1 0 0 0 0 0 30.00 30.00 03000 ADULTS & PEDIATICS 0 0 0 0 30.00 30.00 03000 BURN INTENSIVE CARE UNIT 0 0 0 0 31.00 31.00 03000 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 33.00 32.00 03000 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Health Financial Systems REHA	ABILITATION HOSI	PITAL OF FT WAY	YNE	In Lie	u of Form CMS-	2552-10
Cost Center Description Nursing School Allied Health Cost Allied Health Cost Allied Health Medical Education Cost Swing-Bed Adjustment Adjustment Total Costs (sum of cols. 1 through 3, minus col. 4) 1.00 2.00 3.00 4.00 5.00 5.00 5.00 31.00 03000 ADULTS & PEDIATRICS 03000 (SURORARY CARE UNIT 0 0 0 0 0 31.00 30.00 33.00 30.00 30.00 31.00 31.00 31.00 32.00 30.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 34.00 34.00 0		ASS THROUGH COS	TS Provi der		From 10/01/2014	Part III Date/Time Pre	pared: 3 pm
Image: Normal State Cost Medical Education Cost Adjustment Amount (see instructions) (sum of cols. 1 through 3, minus col. 4) 30.00 3000 ADULTS & PEDIATRICS 0 <td< td=""><td></td><td></td><td>Ti t</td><td>le XIX</td><td>Hospi tal</td><td>PPS</td><td></td></td<>			Ti t	le XIX	Hospi tal	PPS	
INPATI ENT_ROUTI NE_SERVICE_COST_CENTERS 0	Cost Center Description	Nursing School	Allied Health	All Other	Swing-Bed	Total Costs	
Impart entry Impartentry Impartenty Impartentry		-	Cost	Medi cal	Adj ustment	(sum of cols.	
INPATI ENT ROUTI NE SERVICE COST CENTERS 0.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 0 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 0 0 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 0 0 31.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 33.00 34.00 04200 SUBPROVIDER - IRF 0				Education Cos	st Amount (see	1 through 3,	
INPATI ENT ROUTINE SERVICE COST CENTERS 0					instructions)	minus col. 4)	
30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 0 0 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 0 0 0 31.00 32.00 03200 DRONARY CARE UNIT 0 0 0 0 0 31.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 33.00 34.00 04100 SUBROVI DER 1 0		1.00	2.00	3.00	4.00	5.00	
31.00 03100 INTENSIVE CARE UNIT 0 0 0 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 32.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 34.00 41.00 O4100 SUBPROVI DER - IRF 0 0 0 0 0 44.00 42.00 O4200 SUBPROVI DER - IRF 0 </td <td>INPATIENT ROUTINE SERVICE COST CENTERS</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	INPATIENT ROUTINE SERVICE COST CENTERS						
32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 33.00 34.00 04100 SUBPROVI DER 1RF 0 0 0 0 41.00 42.00 04200 SUBPROVI DER 0 0 0 0 0 43.00 200.00 Total (Lines 30-199) 0 0 0 0 0 200.00 0 0 0 0 0 0 200.00 0	30. 00 03000 ADULTS & PEDI ATRI CS	0	0)	0 0	0	30.00
33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 34.00 41.00 04100 SUBPROVIDER - IRF 0 0 0 0 34.00 42.00 04200 SUBPROVIDER 0 0 0 0 0 41.00 43.00 04300 NURSERY 0 0 0 0 0 42.00 200.00 Total (lines 30-199) 0 0 0 0 0 200.00 0 0 0 0 200.00 0 0 0 0 0 0 200.00 0 <td>31. 00 03100 I NTENSI VE CARE UNI T</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>31.00</td>	31. 00 03100 I NTENSI VE CARE UNI T	0	0		0	0	31.00
34.00 03400 SURGI CAL INTENSI VE CARE UNIT 0 0 0 34.00 41.00 O4100 SUBPROVI DER - IRF 0 0 0 0 41.00 42.00 O4200 SUBPROVI DER 0	32.00 03200 CORONARY CARE UNI T	0	0		0	0	32.00
41.00 04100 SUBPROVI DER - 1 RF 0	33.00 03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33.00
42.00 04200 SUBPROVIDER 0 0 0 0 0 42.00 43.00 04300 NURSERY 0 <td>34.00 03400 SURGI CAL I NTENSI VE CARE UNI T</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>34.00</td>	34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0	0	34.00
43.00 04300 Total (lines 30-199) 0 <	41. 00 04100 SUBPROVIDER - IRF	0	c c		0 0	0	41.00
200.00 Total (lines 30-199) 0 0 0 0 200.00 Cost Center Description Total Patient Days Per Diem (col. Days Inpatient Program Days Inpatient Program Days Program Days Pass-Through Cost (col. 7 x col. 8) Cost. 8) 0	42. 00 04200 SUBPROVI DER	0	c c		0 0	0	42.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS Total Pati ent Days Per Di em (col. 5 ÷ col. 6) Inpati ent Program Days Inpati ent Program Pass-Through Cost (col. 7 x col. 8) 30.00 03000 ADULTS & PEDI ATRI CS 6.00 7.00 8.00 9.00 31.00 03100 INTENSI VE CARE UNI T 0 0.00 0 31.00 32.00 03200 CORNARY CARE UNI T 0 0.00 0 32.00 33.00 03300 BURN I INTENSI VE CARE UNI T 0 0.00 0 32.00 34.00 03400 SUBGI CAL INTENSI VE CARE UNI T 0 0.00 0 34.00 41.00 04100 SUBPROVI DER - I RF 0 0.00 0 41.00 42.00 04300 NURSERY 0 0.00 0 43.00	43.00 04300 NURSERY	0	l d		0	0	43.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS Total Pati ent Days Per Di em (col. 5 ÷ col. 6) Inpati ent Program Days Inpati ent Program Pass-Through Cost (col. 7 x col. 8) 30.00 03000 ADULTS & PEDI ATRI CS 6.00 7.00 8.00 9.00 31.00 03100 INTENSI VE CARE UNI T 0 0.00 0 31.00 32.00 03200 CORNARY CARE UNI T 0 0.00 0 32.00 33.00 03300 BURN I INTENSI VE CARE UNI T 0 0.00 0 32.00 34.00 03400 SUBGI CAL INTENSI VE CARE UNI T 0 0.00 0 34.00 41.00 04100 SUBPROVI DER - I RF 0 0.00 0 41.00 42.00 04300 NURSERY 0 0.00 0 43.00	200.00 Total (lines 30-199)	0	l d		0	0	200.00
Days 5 ÷ col. 6) Program Days Program Pass-Through Cost (col. 7 x col. 8) 0.00 03000 ADULTS & PEDI ATRI CS 6.00 7.00 8.00 9.00 1.00 03000 ADULTS & PEDI ATRI CS 5,333 0.00 610 0 30.00 31.00 03100 INTENSI VE CARE UNI T 0 0.00 0 31.00 32.00 03200 CORNARY CARE UNI T 0 0.00 0 32.00 33.00 03000 BURN INTENSI VE CARE UNI T 0 0.00 0 32.00 34.00 03400 SUBGI CAL INTENSI VE CARE UNI T 0 0.00 0 34.00 41.00 04100 SUBPROVI DER - I RF 0 0.00 0 41.00 42.00 04200 SUBPROVI DER 0 0.00 0 43.00		Total Patient	Per Diem (col.	Inpati ent	I npati ent		
INPATIENT ROUTINE SERVICE COST CENTERS 6.00 7.00 8.00 9.00 30.00 03000 ADULTS & PEDIATRICS 5,333 0.00 610 0 30.00 31.00 03100 INTENSI VE CARE UNIT 0 0.00 0 0 31.00 32.00 03200 CORNARY CARE UNIT 0 0.00 0 32.00 33.00 03000 BURN INTENSI VE CARE UNIT 0 0.00 0 32.00 34.00 03400 SURGICAL INTENSI VE CARE UNIT 0 0.00 0 33.00 34.00 04100 SUBPROVIDER - IRF 0 0.00 0 41.00 41.00 O4200 SUBPROVIDER 0 0.00 0 43.00 43.00 04300 NURSERY 0 0.00 0 43.00							
INPATI ENT ROUTI NE SERVI CE COST CENTERS 6.00 7.00 8.00 9.00 30.00 03000 ADULTS & PEDI ATRI CS 5,333 0.00 610 0 30.00 31.00 03100 INTENSI VE CARE UNI T 0 0.00 0 0 31.00 32.00 03200 CORNARY CARE UNI T 0 0.00 0 32.00 33.00 33.00 03300 BURN I NTENSI VE CARE UNI T 0 0.00 0 32.00 33.00 34.00 03400 SUBFROVI DER - I RF 0 0.00 0 34.00 41.00 41.00 42.00 43.00 43.00 43.00 43.00 50.00 50.00 43.00 50.00 <td< td=""><td></td><td></td><td>,</td><td></td><td></td><td></td><td></td></td<>			,				
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 5, 333 0. 00 610 0 30. 00 31. 00 03100 INTENSI VE CARE UNI T 0 0.00 0 0 31. 00 32. 00 03200 CORONARY CARE UNI T 0 0.00 0 0 32. 00 33. 00 03300 BURN I INTENSI VE CARE UNI T 0 0.00 0 32. 00 34. 00 03400 SUBGI CAL INTENSI VE CARE UNI T 0 0.00 0 34. 00 41. 00 04100 SUBPROVI DER - I RF 0 0.00 0 41. 00 42. 00 04200 SUBPROVI DER 0 0.00 0 42. 00 43. 00 04300 NURSERY 0 0.00 0 43. 00							
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 5, 333 0. 00 610 0 30. 00 31. 00 03100 INTENSI VE CARE UNI T 0 0. 00 0 31. 00 32. 00 03200 CORNARY CARE UNI T 0 0. 00 0 32. 00 33. 00 03300 BURN I NTENSI VE CARE UNI T 0 0. 00 0 32. 00 34. 00 03400 SURGI CAL I INTENSI VE CARE UNI T 0 0. 00 0 33. 00 34. 00 04100 SUBPROVI DER - I RF 0 0. 00 0 41. 00 42. 00 04200 SUBPROVI DER 0 0. 00 0 42. 00 43. 00 04300 NURSERY 0 0. 00 0 43. 00					col. 8)		
30. 00 03000 ADULTS & PEDIATRICS 5, 333 0. 00 610 0 30. 00 31. 00 03100 INTENSIVE CARE UNIT 0 0.00 0 0 31. 00 32. 00 03200 CORNARY CARE UNIT 0 0.00 0 0 32. 00 33. 00 03200 CORNARY CARE UNIT 0 0.00 0 32. 00 34. 00 03400 SURGI CAL INTENSI VE CARE UNIT 0 0.00 0 33. 00 34. 00 04100 SUBPROVI DER - I RF 0 0.00 0 34. 00 41. 00 64100 SUBPROVI DER I RF 0 0. 00 0 41. 00 42. 00 04200 SUBPROVI DER 0 0. 00 0 42. 00 43. 00 04300 NURSERY 0 0. 00 0 43. 00		6.00	7.00	8.00	9.00		
31.00 03100 INTENSIVE CARE UNIT 0 0.00 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0.00 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0.00 0 0 33.00 34.00 03400 SURGI CAL INTENSI VE CARE UNIT 0 0.00 0 0 34.00 41.00 VAIDO SUBPROVI DER - IRF 0 0.00 0 0 41.00 42.00 04200 SUBPROVI DER 0 0.00 0 42.00 43.00 04300 NURSERY 0 0.00 0 43.00	INPATIENT ROUTINE SERVICE COST CENTERS			•			
32.00 03200 CORONARY CARE UNIT 0 0.00 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0.00 0 33.00 34.00 03400 SURGI CAL INTENSIVE CARE UNIT 0 0.00 0 34.00 41.00 04100 SUBPROVIDER - IRF 0 0.00 0 41.00 42.00 04200 SUBPROVIDER 0 0.00 0 42.00 43.00 04300 NURSERY 0 0.00 0 43.00	30. 00 03000 ADULTS & PEDI ATRI CS	5, 333	0.00) 61	0 0		30.00
33.00 03300 BURN INTENSIVE CARE UNIT 0 0.00 0 03.00 34.00 03400 SURGI CAL INTENSIVE CARE UNIT 0 0.00 0 0 34.00 41.00 04100 SUBPROVI DER - IRF 0 0.00 0 0 41.00 42.00 04200 SUBPROVI DER 0 0.00 0 0 42.00 43.00 04300 NURSERY 0 0.00 0 0 43.00	31.00 03100 I NTENSI VE CARE UNI T	0	0.00		0 0		31.00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT 0 0.00 0 34. 00 41. 00 04100 SUBPROVI DER - I RF 0 0.00 0 41. 00 42. 00 04200 SUBPROVI DER 0 0.00 0 42. 00 43. 00 04300 NURSERY 0 0.00 0 43. 00	32.00 03200 CORONARY CARE UNIT	0	0.00		0 0		32.00
41.00 04100 SUBPROVI DER - I RF 0 0.00 0 41.00 42.00 04200 SUBPROVI DER 0 0.00 0 42.00 43.00 04300 NURSERY 0 0.00 0 43.00	33.00 03300 BURN INTENSIVE CARE UNIT	0	0.00		0 0		33.00
41.00 04100 SUBPROVI DER - I RF 0 0.00 0 41.00 42.00 04200 SUBPROVI DER 0 0.00 0 42.00 43.00 04300 NURSERY 0 0.00 0 43.00	34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0.00)	0 0		34.00
42. 00 04200 SUBPROVI DER 0 0.00 0 42. 00 43. 00 04300 NURSERY 0 0.00 0 0 43. 00		0			0 0		41.00
43. 00 04300 NURSERY 0 0.00 0 0 43. 00		0			0 0		42.00
		0			0 0		•
		5, 333		61	0 0		200.00

Health Financial Systems RE	HABILITATION HOSI	PITAL OF FT WAY	YNE	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS	ERVICE OTHER PASS	S Provi der	CCN: 153030	Period: From 10/01/2014	Worksheet D Part IV	
THROUGH CUSTS				To 09/30/2015	Date/Time Pre	
					2/23/2016 2:5	3 pm
			le XIX	Hospi tal	PPS	
Cost Center Description	Anesthetist	Nursing School	AILIED HEALT	h All Other Medical	Total Cost	
	Cost			Education Cost	(sum of col 1 through col.	
	COST				4)	
	1.00	2.00	3.00	4,00	5,00	
ANCI LLARY SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
57.00 05700 CT SCAN	0	0)	0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0)	0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0)	0 0	0	59.00
60. 00 06000 LABORATORY	0	0)	0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0)	0 0	0	60.01
65. 00 06500 RESPI RATORY THERAPY	0	0)	0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0)	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0)	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 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
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	0	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
200.00 Total (lines 50-199)	0	0		0 0	0	200. 00

Health Financial Systems REHA	ABILITATION HOSI	PITAL OF FT WAY	/NE	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider		Period:	Worksheet D	
THROUGH COSTS				From 10/01/2014 To 09/30/2015	Part IV Date/Time Pre	narad
				10 09/30/2013	2/23/2016 2:5	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col.		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	1	1		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	434, 988			36, 918	
57.00 05700 CT SCAN	0	0	0.00000		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.00000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000		0	59.00
60. 00 06000 LABORATORY	0	876, 674			63, 948	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0100000		0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	85, 034			4, 576	65.00
66. 00 06600 PHYSI CAL THERAPY	0	3, 648, 854			208, 619	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	3, 869, 898	0.00000	0. 000000	215, 576	67.00
68.00 06800 SPEECH PATHOLOGY	0	1, 701, 229	0.00000		62, 577	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	34, 762	0.00000	0. 000000	1, 304	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	582, 963			64, 758	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000	0. 000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 934, 525	0.00000	0. 000000	171, 908	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	298, 032	0.00000	0. 000000	10, 347	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	0	206, 541	0.00000	0. 000000	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.00000		0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	0. 000000	0	89.00
200.00 Total (lines 50-199)	0	14, 673, 500			840, 531	200.00

Health Financial Systems REH	ABILITATION HOSF	ITAL OF FT WAY	YNE	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	6 Provi der	CCN: 153030	Period:	Worksheet D	
THROUGH COSTS				From 10/01/2014 To 09/30/2015	Part IV Date/Time Pre	narod
				10 07/30/2013	2/23/2016 2:5	53 pm
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)	10.00	x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS 54. 00 05400 RADI OLOGY-DI AGNOSTI C			J	0		F 4 00
57. 00 05700 CT SCAN	0	C C		0		54.00 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0		57.00
59. 00 05900 CARDIAC CATHETERIZATION	0			0		58.00
60. 00 106000 LABORATORY	0			0		60,00
60. 01 06001 BLOOD LABORATORY	0			0		60.00
65. 00 06500 RESPIRATORY THERAPY	0			0		65.00
66. 00 06600 PHYSI CAL THERAPY	0			0		66,00
67. 00 06700 0CCUPATI ONAL THERAPY	0			0		67.00
68. 00 06800 SPEECH PATHOLOGY	0			0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0		69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C		0		76.00
76. 01 03950 HEMODIALYSIS & OTHER ANCI LLARY	0	C		0		76.01
OUTPATI ENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0	C)	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0		89.00
200.00 Total (lines 50-199)	0	C		0		200. 00

COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 153030	Peri od:	Worksheet D-1			
			From 10/01/2014 To 09/30/2015	Date/Time Pre 2/23/2016 2:55			
		Title XVIII	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,			5, 333	1.00		
2.00	Inpatient days (including private room days, excluding swing-be			5, 333	2.00		
3.00	Private room days (excluding swing-bed and observation bed days	s). If you have only pr	rivate room days,	5, 177	3.00		
4 00	do not complete this line.			15/	1 00		
4.00 5.00	Semi-private room days (excluding swing-bed and observation bed		r 21 of the east	156 0	4.00 5.00		
5.00	Total swing-bed SNF type inpatient days (including private room reporting period	i days) thi ough beceilibe	a si ui the cost	0	5.00		
6.00	Total swing-bed SNF type inpatient days (including private room	davs) after December	31 of the cost	0	6.00		
0.00	reporting period (if calendar year, enter 0 on this line)	all days) at ter becember		0	0.00		
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7.00		
	reporting period	adje) in eagn becomen		0			
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8.00		
	reporting period (if calendar year, enter 0 on this line)	5 /					
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 353	9.00		
	newborn days)		-				
10. 00							
	through December 31 of the cost reporting period (see instructions)						
11.00							
	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 privat	e room days)	0	12.00		
12 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	anly (including privat	a ream day(a)	0	13.00		
13.00	after December 31 of the cost reporting period (if calendar yea			0	13.00		
14.00	Medically necessary private room days applicable to the Program			0	14.00		
15.00	Total nursery days (title V or XIX only)	Coxer daring similig bed	uuysy	0	15.00		
16.00	Nursery days (title V or XIX only)			0			
	SWING BED ADJUSTMENT			_			
17.00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 c	of the cost	0.00	17.00		
	reporting period	5					
18.00	Medicare rate for swing-bed SNF services applicable to services	s after December 31 of	the cost	0.00	18.00		
	reporting period						
19.00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19.00		
	reporting period						
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20.00		
04 00	reporting period			1 0 10 0 10	01 00		
21.00	Total general inpatient routine service cost (see instructions)			4, 349, 960			
22.00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	31 of the cost report	ing period (line	0	22.00		
23.00		1 of the cost reportin	a poriod (lipo 6	0	23.00		
23.00	x line 18)	of the cost reportin	ig period (inne o	0	25.00		
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24.00		
21.00	7 x line 19)		ng period (inne	0	21.00		
25.00	Swing-bed cost applicable to NF type services after December 31	l of the cost reporting	period (line 8	0	25.00		
	x line 20)			-			
26.00	Total swing-bed cost (see instructions)			0	26.00		
	General inpatient routine service cost net of swing-bed cost (I	ing 21 minus ling 24)		4, 349, 960			

27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT
28.00	General inpatient routine service charges (excluding swing-bed and observation bed cha
29.00	Private room charges (excluding swing-bed charges)
30.00	Semi-private room charges (excluding swing-bed charges)

	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	7, 975, 976	28.00
29.00	Private room charges (excluding swing-bed charges)	7, 743, 526	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	232, 450	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 545383	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	1, 495. 76	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1, 490. 06	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	5.70	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	3. 11	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	16, 100	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	4, 333, 860	37.00
	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)	815.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1, 919, 272	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 919, 272	41.00

	ATION OF INPATIENT OPERATING COST		11001	uer (eriod: rom 10/01/2014	Worksheet D-1	
					Ť			
				Title	XVIII	Hospi tal	PPS	, <u>,</u>
	Cost Center Description	Total Inpatient Cost	Total Inpatient I	Days	Average Per Nem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00		3.00	4.00	5.00	
00	NURSERY (title V & XIX only)	0		0	0.00	0	0	42
00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		0	0.00	0	0	43
00	CORONARY CARE UNIT	0		0	0.00	-		
00	BURN I NTENSI VE CARE UNI T	Ő		0	0.00			
	SURGICAL INTENSIVE CARE UNIT	0		0	0.00	0	0	
00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description							47
	·						1.00	
00	Program inpatient ancillary service cost (Wks						1, 767, 625	
00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	1 through 48)(see instru	ction	s)		3, 686, 897	49
00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D. sum	of Parts L and	111, 697	50
							,	
00	Pass through costs applicable to Program inpa	atient ancillar	y services	(fro	m Wkst. D, su	n of Parts II	169, 540	51
00	and IV) Total Program excludable cost (sum of lines {	0 and 51)					281, 237	52
00	Total Program inpatient operating cost exclude		lated, non	-phvs	ician anesthe	tist, and	3, 405, 660	
	medical education costs (line 49 minus line s			. , , , , ,				
~~	TARGET AMOUNT AND LIMIT COMPUTATION						-	۱ ₋ .
00 00	Program discharges Target amount per discharge						0.00	
00	Target amount (line 54 x line 55)						0.00	
00	Difference between adjusted inpatient operati	ng cost and ta	rget amoun	t (li	ne 56 minus l	ne 53)	0	
00	Bonus payment (see instructions)						0	
00	Lesser of lines 53/54 or 55 from the cost rep market basket	orting period	ending 199	6, up	dated and com	bounded by the	0.00	59
00	Lesser of lines 53/54 or 55 from prior year of	cost report, up	dated by t	he ma	rket basket		0.00	60
00	If line 53/54 is less than the lower of lines	s 55, 59 or 60	enter the	l esse	r of 50% of t		0	61
	which operating costs (line 53) are less than		s (lines 5	4 x 6	0), or 1% of	the target		
00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)					0	62
00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)				0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						-	
00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s through Dece	mber 31 of	the	cost reporting	g period (See	0	64
00	Medicare swing-bed SNF inpatient routine cost	s after Decemb	er 31 of t	he co	st reporting	period (See	0	65
	instructions)(title XVIII only)							
00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus li	ne 65)(title XVIII	only). For	0	66
00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	December	31 of	the cost rep	orting period	0	67
	(line 12 x line 19)	0				0 1		
00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31	of t	he cost repor	ting period	0	68
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	outine costs (line 67 +	line	68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER NU	RSING FACILITY	, AND ICF/	IID O	NLY			
00	Skilled nursing facility/other nursing facili							70
00 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 5		ine /0 ÷ I	ine 2)			71
00	Medically necessary private room cost applica		(line 14	x lir	e 35)			73
00	Total Program general inpatient routine servi	0	•					74
00	Capital-related cost allocated to inpatient r	routine service	costs (fr	om Wc	rksheet B, Pa	rt II, column		75
00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)						76
00	Program capital-related costs (line 75 ÷ 11) Program capital-related costs (line 9 x line							77
00	Inpatient routine service cost (line 74 minus							78
00	Aggregate charges to beneficiaries for excess	• •			· .			79
00	Total Program routine service costs for compa		ost limita	tion	(line 78 minu	s line 79)		80
00 00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li)					81
00	Reasonable inpatient routine service cost frim tation (in							83
00	Program inpatient ancillary services (see ins	structions)						84
00	Utilization review - physician compensation							85
00	Total Program inpatient operating costs (sum		rough 85)					86
00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)						0	87
	3 .		Line 2)					88
00	Adjusted general inpatient routine cost per o	arem (rine 27 ÷	Time z)				0.00	

Health Financial Systems REHA	BILITATION HOSI	PITAL OF FT WAY	'NE	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 10/01/2014	Worksheet D-1	
				To 09/30/2015	Date/Time Pre 2/23/2016 2:53	
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	253, 183	4, 349, 960	0. 05820	4 0	0	90.00
91.00 Nursing School cost	0	4, 349, 960	0.00000	0 0	0	91.00
92.00 Allied health cost	0	4, 349, 960	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 349, 960	0. 00000	0 0	0	93.00

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In Lieu of Form CMS-2552-10

	ncial Systems REHABILITATION HOSPITA			u of Form CMS-2	
COMPUTATIO	N OF INPATIENT OPERATING COST	Provi der CCN: 153030	Period: From 10/01/2014 To 09/30/2015	2/23/2016 2:5	pared:
	Cost Center Description	Title XIX	Hospi tal	PPS	
	cost center bescription			1.00	
PART	I - ALL PROVIDER COMPONENTS				
	TI ENT DAYS			5.000	
	itient days (including private room days and swing-bed days,			5, 333	
	ntient days (including private room days, excluding swing-be vate room days (excluding swing-bed and observation bed days		sivata room dave	5, 333 0	
	not complete this line.	s). IT you have only pr	I vate I oolii uays,	0	3.0
	-private room days (excluding swing-bed and observation bed	d days)		5, 333	4.0
	I swing-bed SNF type inpatient days (including private room		er 31 of the cost	0	5.0
	orting period				
	I swing-bed SNF type inpatient days (including private room	n days) after December	31 of the cost	0	6.0
	nting period (if calendar year, enter 0 on this line) I swing-bed NF type inpatient days (including private room	dave) through December	21 of the cost	0	7.0
	orting period	days) through becember	ST OF THE COST	0	/.0
	I swing-bed NF type inpatient days (including private room	davs) after December 3	31 of the cost	0	8.0
	orting period (if calendar year, enter 0 on this line)				
	I inpatient days including private room days applicable to	the Program (excluding	g swing-bed and	610	9.0
	porn days)				
	ng-bed SNF type inpatient days applicable to title XVIII onl bugh December 31 of the cost reporting period (see instructi		room days)	0	10. 0
	ng-bed SNF type inpatient days applicable to title XVIII onl		room days) after	0	11.0
	ember 31 of the cost reporting period (if calendar year, ent		oom days) arter	0	
2.00 Swi r	ng-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12.0
	ough December 31 of the cost reporting period				
	ng-bed NF type inpatient days applicable to titles V or XIX			0	13.0
	er December 31 of the cost reporting period (if calendar yea cally necessary private room days applicable to the Program			0	14. C
	I nursery days (title V or XIX only)	I (exer during swring bed	uuys)	0	
	sery days (title V or XIX only)			0	
	G BED ADJUSTMENT]
	care rate for swing-bed SNF services applicable to services	s through December 31 c	of the cost	0.00	17.0
	orting period care rate for swing-bed SNF services applicable to services	after December 21 of	the cost	0.00	18.0
	orting period	salter becenber 51 01	the cost	0.00	10.0
	caid rate for swing-bed NF services applicable to services	through December 31 of	f the cost	0.00	19.0
	orting period				
	caid rate for swing-bed NF services applicable to services	after December 31 of t	the cost	0.00	20.0
	orting period Il general inpatient routine service cost (see instructions)			4, 349, 960	21.0
	ng-bed cost applicable to SNF type services through December		ing period (line	4, 349, 900	
	line 17)			_	
	g-bed cost applicable to SNF type services after December 3	31 of the cost reportir	ng period (line 6	0	23.0
	ne 18)				
	ng-bed cost applicable to NF type services through December line 19)	31 of the cost report	ng period (line	0	24.0
1	ng-bed cost applicable to NF type services after December 3	1 of the cost reporting	period (line 8	0	25.0
	ne 20)				
	I swing-bed cost (see instructions)			0	
	eral inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		4, 349, 960	27.0
	ATE ROOM DIFFERENTIAL ADJUSTMENT eral inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28.0
	vate room charges (excluding swing-bed charges)	and observation bed ci	iai ges)	0	
	-private room charges (excluding swing-bed charges)			0	
1.00 Gene	eral inpatient routine service cost/charge ratio (line 27 \div	line 28)		0.00000	31.0
	age private room per diem charge (line 29 ÷ line 3)			0.00	
	rage semi-private room per diem charge (line 30 ÷ line 4)	ic line 22) (cas instant	stions)	0.00	
	age per diem private room charge differential (line 32 minu age per diem private room cost differential (line 34 x line			0. 00 0. 00	
	vate room cost differential adjustment (line 3 x line 35)	,		0.00	
	eral inpatient routine service cost net of swing-bed cost ar	nd private room cost di	fferential (line	4, 349, 960	
27 m	ii nus liine 36)		•		1
	II - HOSPITAL AND SUBPROVIDERS ONLY				-
	RAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			815.67	38.0
10 00 1 M di 1	isted general inpatient routine service cost per diem (see i	113 LI UG LI UHS/		010.07	
		38)		497 559	39 0
39.00 Prog	pram general inpatient routine service cost (line 9 x line 3 cally necessary private room cost applicable to the Program			497, 559 0	

	ATI ON OF INPATIENT OPERATING COST		Provi	der (eriod: rom 10/01/2014 o 09/30/2015		epare
				Ti t l	e XIX	Hospi tal	PPS	, p
	Cost Center Description	Total Inpatient Cost	Total I npati ent	Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00		3.00	4.00	5.00	
00	NURSERY (title V & XIX only)	0		0	0.00	0	0) 42.
00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		0	0.00	0	C	43.
00	CORONARY CARE UNIT	0		0	0.00			
00	BURN I NTENSI VE CARE UNI T	0		0	0.00			
00	SURGI CAL I NTENSI VE CARE UNI T	0		0	0.00		0	
00	OTHER SPECIAL CARE (SPECIFY)							47.
	Cost Center Description						1.00	
00	Program inpatient ancillary service cost (Wks	$t D_3 col 3$	line 200)			1.00 219,779	9 48.
00	Total Program inpatient costs (sum of lines 4				ns)		717, 338	
	PASS THROUGH COST ADJUSTMENTS			01101	107		111/000	
00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sum (of Parts I and	28, 957	50.
00	Pass through costs applicable to Program inpa	atient ancillar	y services	(fro	om Wkst. D, sur	n of Parts II	21, 669	51
00	and IV) Total Program excludable cost (sum of lines 5	50 and 51)					50, 626	52.
00	Total Program inpatient operating cost exclud	,	lated, non	-phys	sician anesthe	tist, and	666, 712	
	medical education costs (line 49 minus line 5							
	TARGET AMOUNT AND LIMIT COMPUTATION						-	
00	Program di scharges							
00 00	Target amount per discharge Target amount (line 54 x line 55)						0.00	
00	Difference between adjusted inpatient operati	ng cost and ta	rget amoun	t (li	ne 56 minus li	ne 53)		
00	Bonus payment (see instructions)	5	9			/	C	
00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 199	6, up	odated and com	bounded by the	0.00	59
~~	market basket						0.00	
00 00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines					he amount by	0.00	
00	which operating costs (line 53) are less than							101
	amount (line 56), otherwise enter zero (see i					J. J		
00	Relief payment (see instructions)						C	
00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)				0	63
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	s through Dece	mber 31 of	the	cost reportin	n period (See	C	64
00	instructions) (title XVIII only)	.s through beec		the	cost reporting			/
00	Medicare swing-bed SNF inpatient routine cost	s after Decemb	er 31 of t	he co	ost reporting p	period (See	0	65
	instructions)(title XVIII only)							
00	Total Medicare swing-bed SNF inpatient routir CAH (see instructions)	ne costs (line	64 plus li	ne 65	b)(title XVIII	only). For	0	66
00	Title V or XIX swing-bed NF inpatient routine	costs through	December	31 of	^e the cost rep	orting period	l c	67.
	(line 12 x line 19)	, coole thi dagi	December	0. 0.	110 0001 100	si ting poir ou		
00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31	of t	the cost repor	ting period	0	68 (
00	(line 13 x line 20)	/	line (7	1 :	(0)			
00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU	· · · · · · · · · · · · · · · · · · ·			/) 69.
00	Skilled nursing facility/other nursing facili							70
00	Adjusted general inpatient routine service co	ost per diem (I						71
00	Program routine service cost (line 9 x line 7	,	<i>.</i>		>			72
00	Medically necessary private room cost applica	Ű	•		ne 35)			73
00 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r				orksheet R Da	st II column		74
00	26, line 45)	Satine Service	00313 (11	on we	A RONCEL D, Pdl	tir, corunni		'3
00	Per diem capital-related costs (line 75 ÷ lir	ne 2)						76
00	Program capital-related costs (line 9 x line	,						77
00	Inpatient routine service cost (line 74 minus				->			78
00 00	Aggregate charges to beneficiaries for excess	• •			· .	cline 70)		79 80
00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		ost rimita	u un		5 IIIC /7)		80
00	Inpatient routine service cost per drem rimit)					82
00	Reasonable inpatient routine service costs (s		· .					83
00	Program inpatient ancillary services (see ins							84
00	Utilization review - physician compensation (85
00	Total Program inpatient operating costs (sum		rough 85)					86
00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)						C	87.
	Adjusted general inpatient routine cost per c		line 2)				0.00	
00								1

Health Financial Systems REHA	BILITATION HOSI	PITAL OF FT WAY	ΊΝΕ	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 10/01/2014	Worksheet D-1	
				To 09/30/2015	Date/Time Pre 2/23/2016 2:5	
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	253, 183	4, 349, 960	0. 05820	4 0	0	90.00
91.00 Nursing School cost	0	4, 349, 960	0.00000	0 0	0	91.00
92.00 Allied health cost	0	4, 349, 960	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 349, 960	0.00000	0 0	0	93.00

Health Financial Systems	REHABILITATION HOSPITAL OF FT WA	YNE	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMEN	T Provi der	CCN: 153030	Period: From 10/01/2014	Worksheet D-3	
			To 09/30/2015	Date/Time Pre 2/23/2016 2:5	pared:
	Tit	le XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			3, 517, 799		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31.00
32.00 03200 CORONARY CARE UNIT			0		32.00
33. 00 03300 BURN I NTENSI VE CARE UNI T			0		33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT			0		34.00
41. 00 04100 SUBPROVI DER – I RF 42. 00 04200 SUBPROVI DER			0		41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY			0		42.00
ANCI LLARY SERVICE COST CENTERS					43.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1150	65 188, 496	21, 689	54.00
57. 00 05700 CT SCAN		0.0000		21,007	1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	1
60. 00 06000 LABORATORY		0. 1373		53, 839	
60. 01 06001 BLOOD LABORATORY		0.0000		0	
65.00 06500 RESPI RATORY THERAPY		0. 1594		4, 126	
66.00 06600 PHYSI CAL THERAPY		0.3724	46 1, 628, 692	606, 600	
67.00 06700 OCCUPATI ONAL THERAPY		0.3530	30 1, 701, 657	600, 736	67.00
68.00 06800 SPEECH PATHOLOGY		0. 2575	49 745, 181	191, 921	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1517	75 19, 678	2, 987	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	INTS	0.0691	42 243, 359	16, 826	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1638		200, 848	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CE	S	0. 3136			
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY		0. 2300	61 110, 586	25, 442	76.01
OUTPATIENT SERVICE COST CENTERS		1			
88.00 08800 RURAL HEALTH CLINIC		0.0000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
200.00 Total (sum of lines 50-94 and 96-			6, 416, 765	1, 767, 625	
201.00 Less PBP Clinic Laboratory Servic			0		201.00
202.00 Net Charges (line 200 minus line	201)	1	6, 416, 765		202.00

Health Financial Systems	REHABILITATION HOSPITAL OF FT WA	AYNE	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONME	NT Provi der	- CCN: 153030	Peri od:	Worksheet D-3	
			From 10/01/2014 To 09/30/2015	Date/Time Pre	narod
			10 09/30/2015	2/23/2016 2:5	3 pm
	Ti	tle XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
UNDATE ENT. DOUTENE, CEDVILOE, COOT, CENTERO		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			410.210		20.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T			418, 310		30.00
32. 00 03200 CORONARY CARE UNIT			0		32.00
33. 00 03300 BURN INTENSIVE CARE UNIT			0		33.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT			0		34.00
41. 00 04100 SUBPROVIDER - IRF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVICE COST CENTERS					
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 1150	65 36, 918	4, 248	54.00
57.00 05700 CT SCAN		0.0000		0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0000	00 00	0	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON		0.0000	00 00	0	59.00
60. 00 06000 LABORATORY		0. 1373	94 63, 948	8, 786	60.00
60.01 06001 BLOOD LABORATORY		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 1594		730	
66. 00 06600 PHYSI CAL THERAPY		0. 3724		77, 699	
67.00 06700 OCCUPATI ONAL THERAPY		0. 3530			
68.00 06800 SPEECH PATHOLOGY		0. 2575		16, 117	
69. 00 06900 ELECTROCARDI OLOGY		0. 1517		198	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI	ENTS	0. 0691		4, 477	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	50	0. 1638		28, 173	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI C	ES	0. 3136		3, 246	
76. 01 03950 HEMODI ALYSI S & OTHER ANCI LLARY		0.2300	61 0	0	76.01
OUTPATI ENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC		0.0000	00 0	0	00 00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTE	P	0.0000		0	
200.00 Total (sum of lines 50-94 and 96		0.0000	840, 531	219, 779	
	ces-Program only charges (line 61)		840, 331 0	217,119	200.00
202.00 Net Charges (line 200 minus line			840, 531		201.00
	2017	1	040,001	l	1202.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 153030	Period: From 10/01/2014 To 09/30/2015	2/23/2016 2:5	
		Title XVIII	Hospi tal	PPS	
				1.00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			0	1 00
1.00 2.00 3.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct PPS payments	i ons)		0 4, 282 4, 030	1.00 2.00 3.00
4.00	Outlier payment (see instructions)			0	4.00
5.00 6.00	Enter the hospital specific payment to cost ratio (see instruc Line 2 times line 5	tions)		0. 000 0	5.00 6.00
7.00 7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	9.00 10.00
10.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
10.00	Reasonable charges			0	10.00
12.00 13.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ne 69)		0	12.00
	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15 00	Customary charges			0	15 00
15.00 16.00	Aggregate amount actually collected from patients liable for p Amounts that would have been realized from patients liable for	5	0	0	15.00 16.00
	had such payment been made in accordance with 42 CFR §413.13(e	1 5	a ona gobaci c	Ū	
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00 19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete onl	vifline 18 exceeds li	ne 11) (see	0	18.00 19.00
17.00	instructions)			0	17.00
20. 00	Excess of reasonable cost over customary charges (complete onl	0	20.00		
21.00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see	0	21.00		
22.00	Interns and residents (see instructions)	0	22.00		
	Cost of physicians' services in a teaching hospital (see instr	0	23.00		
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT	4, 030	24.00		
25.00	Deductibles and coinsurance (for CAH, see instructions)			806	25.00
	Deductibles and Coinsurance relating to amount on line 24 (for			0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p instructions)	Tus the sum of times 22	and 23] (See	3, 224	27.00
	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
	Subtotal (sum of lines 27 through 29) Primary payer payments			3, 224	30.00 31.00
32.00	Subtotal (line 30 minus line 31)			3, 224	
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)		0	22.00
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	33.00 34.00
	Adjusted reimbursable bad debts (see instructions)			0	35.00
	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		0	36.00
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			3, 224 0	37.00 38.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
	Pioneer ACO demonstration payment adjustment (see instructions			0	39.50
39. 98 39. 99	Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION	ed devices (see instruc	ctions)	0	39.98 39.99
40.00	Subtotal (see instructions)			3, 224	
40. 01	Sequestration adjustment (see instructions)			64	40. 01
	Interim payments Tentative settlement (for contractors use only)			3, 160 0	41.00 42.00
	Balance due provider/program (see instructions)			0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordan §115.2	ce with CMS Pub. 15-2,	chapter 1,	0	
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0.00	91.00 92.00
93.00	Time Value of Money (see instructions)			0	93.00
01 00	Total (sum of lines 91 and 93)			0	94.00

		Fr		Period: From 10/01/2014 To 09/30/2015		pared:
		Ti tl	e XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		3, 562, 47	76 0	3, 160 0	1.00 2.00 3.00
5.00	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3.03
3.04 3.05				0	0	3.04 3.05
5.05	Provider to Program				0	5.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52				0	0	3.52
3.53 3.54				0	0	3.53 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) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3, 562, 47	76	3, 160	4.00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVIDER			0	0	5.01
5.02				0	0	5. 02
5.03				0	0	5.03
	Provider to Program					
5.50 5.51	TENTATIVE TO PROGRAM			0	0	5.50 5.51
5.51				0	0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.9
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		5, 02		0	6.0 [°] 6.0 [°]
6.02 7.00	Total Medicare program liability (see instructions)		3, 567, 49	0	0 3, 160	
,	Total modele program traditity (see fist detroits)		3, 307, 45	Contractor Number	NPR Date (Mo/Day/Yr)	7.00
		()	1.00	2.00	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 153030	Period: From 10/01/2014 To 09/30/2015		pare
	· · · · · · · · · · · · · · · · · · ·	Title XVIII	Hospi tal	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
. 00	Net Federal PPS Payment (see instructions)			3, 408, 780	
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0226	
. 00	Inpatient Rehabilitation LIP Payments (see instructions)			141, 805	3.
. 00	Outlier Payments	t agent responsible married an	ding on or prior	127, 842	4.
. 00	Unweighted intern and resident FTE count in the most recent to November 15, 2004 (see instructions)		0 1	0.00	
. 01	Cap increases for the unweighted intern and resident FTE coprogram or hospital closure, that would not be counted with CFR \$412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	5.
. 00	New Teaching program adjustment. (see instructions)			0.00	6.
. 00	Current year's unweighted FTE count of I&R excluding FTEs i	in the new program growth p	eriod of a "new	0.00	7.
	teaching program" (see instructions)				
. 00	Current year's unweighted I&R FTE count for residents within teaching program" (see instructions)			0.00	
00	Intern and resident count for IRF PPS medical education adj	ustment (see instructions)		0.00	
	Average Daily Census (see instructions)			14.610959	
	Teaching Adjustment Factor (see instructions)			0.00000	
2.00	5, , , , , , , , , , , , , , , , , , ,			0	
8.00				3, 678, 427	
	Nursing and Allied Health Managed Care payments (see instru Organ acquisition (DO NOT USE THIS LINE)	uction)		0	14 15
	Cost of physicians' services in a teaching hospital (see in	astructions)		0	
	Subtotal (see instructions)			3, 678, 427	
	Primary payer payments			217	
	Subtotal (line 17 less line 18).			3, 678, 210	
	Deducti bl es			31, 324	
	Subtotal (line 19 minus line 20)			3, 646, 886	
	Coinsurance			8, 190	
3. 00	Subtotal (line 21 minus line 22)			3, 638, 696	23
. 00	Allowable bad debts (exclude bad debts for professional ser	rvices) (see instructions)		2, 476	24
5.00	Adjusted reimbursable bad debts (see instructions)			1, 609	25
. 00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		2, 476	26
	Subtotal (sum of lines 23 and 25)			3, 640, 305	
	Direct graduate medical education payments (from Wkst. E-4,	line 49)		0	28
	Other pass through costs (see instructions)			0	29
	Outlier payments reconciliation			0	30
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	>		0	31
	Pioneer ACO demonstration payment adjustment (see instructi Recovery of Accelerated Depreciation	ions)		0	31
	Total amount payable to the provider (see instructions)			3, 640, 305	
	Sequestration adjustment (see instructions)			72, 806	
	Interim payments			3, 562, 476	
	Tentative settlement (for contractor use only)			3, 302, 470	
5.00		3. and 34)		5, 023	
5. 00			chapter 1,	81, 811	
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount from Wkst. E-3, Pt. III, line 4			127, 842	
	Outlier reconciliation adjustment amount (see instructions))		0	51
<u> </u>	The rate used to calculate the Time Value of Money			0.00	1 52

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 153030	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part VII Date/Time Pre	pared:
			llaani tal	2/23/2016 2:5	3 pm
		Title XIX	Hospital	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR X		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
0 00	Reasonable Charges		410.210		0.00
8.00 9.00	Routine service charges Ancillary service charges		418, 310 840, 531	0	8.00 9.00
	Organ acquisition charges, net of revenue		840, 531	0	10.00
	Incentive from target amount computation		0		11.00
	Total reasonable charges (sum of lines 8 through 11)		1, 258, 841	0	•
.2.00	CUSTOMARY CHARGES		17 2007 011		1 121 00
13.00	Amount actually collected from patients liable for payment for s	ervices on a charge	0	0	13.00
14.00	basis Amounts that would have been realized from patients liable for p	0	n O	0	14.00
	a charge basis had such payment been made in accordance with 42				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0.00000	15.00	
16.00	Total customary charges (see instructions)	1, 258, 841	0	16.00	
17.00	Excess of customary charges over reasonable cost (complete only	1, 258, 841	0	17.00	
	line 4) (see instructions)		_		
18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds lin	e 0	0	18.00
10.00	16) (see instructions)		0	0	19.00
	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see instruc	tions)	0	0	
	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	•
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	moleted for PPS provid	-	0	21.00
22.00	Other than outlier payments		0	0	22.00
	Outlier payments		0	0	•
	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
	Subtotal (sum of lines 22 through 26)		0	0	27.00
	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	
	Deductibles		0	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	•
	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	3)	0	0	35.00 36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	5)	0	0	37.00
	Subtotal (line 36 ± 1 line 37)		0	0	37.00
	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	•
	Interim payments		0	0	
42.00	Balance due provider/program (line 40 minus line 41)		0	0	1
43.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2,	0	0	
+5.00					

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column onl			Period: From 10/01/2014	Worksheet G	
	,			To 09/30/2015	Date/Time Pre 2/23/2016 2:5	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	513		0 0	0	1.
00	Temporary investments	0		0 0	0	2.
00	Notes receivable	0		0 0	0	
00	Accounts receivable	1, 676, 861		0 0	0	
00 00	Other receivable Allowances for uncollectible notes and accounts receivable	-246, 792		0 0	0	
00	Inventory	-240, 792 32, 738			0	
00	Prepaid expenses	31, 876		0 0	0	
00	Other current assets	784		0 0	0	9
. 00	Due from other funds	0		0 0	0	
. 00	Total current assets (sum of lines 1-10)	1, 495, 980		0 0	0	11
00	FI XED ASSETS Land	900, 000	1	0 0	0	1 1 2
. 00 . 00	Land improvements	276, 453		0 0	0	
. 00	Accumul ated depreciation	-108, 121		0 0	0	
. 00	Bui I di ngs	11, 624, 396		0 0	0	15
. 00	Accumulated depreciation	-2, 029, 493		0 0	0	
. 00	Leasehold improvements	235, 036		0 0	0	
. 00	Accumulated depreciation	-62, 688		0 0	0	
. 00 . 00	Fixed equipment Accumulated depreciation	137, 158 -45, 232		0 0	0	
. 00	Automobiles and trucks	113, 428		0 0	0	
. 00	Accumulated depreciation	-79, 616		0 0	0	
. 00	Major movable equipment	199, 137		0 0	0	
. 00	Accumul ated depreciation	-124, 146		0 0	0	
. 00	Minor equipment depreciable	305, 919		0 0	0	
. 00	Accumulated depreciation	-233, 101		0 0	0	
. 00 . 00	HIT designated Assets Accumulated depreciation	0		0 0	0	
9.00	Mi nor equi pment-nondepreci abl e			0 0	0	
. 00	Total fixed assets (sum of lines 12-29)	11, 109, 130		0 0	0	
	OTHER ASSETS					
. 00	Investments	0		0 0	0	
. 00	Deposits on Leases	0		0 0	0	
8.00	Due from owners/officers	0		0 0	0	
. 00 5. 00	Other assets Total other assets (sum of lines 31-34)	691, 701 691, 701		0 0 0 0	0	
b. 00	Total assets (sum of lines 11, 30, and 35)	13, 296, 811		0 0	0	
. 00	CURRENT LIABILITIES	13, 270, 011		0 0	0	
. 00	Accounts payable	145, 625		0 0	0	37
. 00	Salaries, wages, and fees payable	517, 282		0 0	0	
. 00	Payroll taxes payable	0		0 0	0	
. 00		0		0 0	0	
. 00	Deferred income Accelerated payments			0 0	0	41
. 00 . 00	Due to other funds	15, 889, 854		0 0	0	
. 00	Other current liabilities	252, 271		0 0	0	
6. 00	Total current liabilities (sum of lines 37 thru 44)	16, 805, 032		0 0	0	
	LONG TERM LIABILITIES			-		
. 00	Mortgage payable	0		0 0	0	
. 00	Notes payable	0		0 0	0	
. 00 . 00	Unsecured Loans Other Long term Liabilities				0	
0.00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49			0 0	0	
. 00	Total liabilites (sum of lines 45 and 50)	16, 805, 032		0 0	0	
55	CAPITAL ACCOUNTS				0	1
. 00	General fund balance	-3, 508, 221				52
. 00	Specific purpose fund			0		53
. 00	Donor created - endowment fund balance - restricted			0		54
. 00	Donor created - endowment fund balance - unrestricted			0		55
. 00 . 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56
3. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
. 00	replacement, and expansion				0	
. 00	Total fund balances (sum of lines 52 thru 58)	-3, 508, 221		0 0	0	59
	Total liabilities and fund balances (sum of lines 51 and	13, 296, 811		al a	0	60

Heal th	Financial Systems REHA	BILITATION HOSP	ITAL OF FT WAY	ŃΕ		In Lie	u of Form CMS	5-2!	552-10
STATE	IENT OF CHANGES IN FUND BALANCES		Provi der	CCN: 153030	Period: From 10/01/2014 To 09/30/2015		Date/Time Prep 2/23/2016 2:53		
		General	Fund	Speci al	Pur	pose Fund	Endowment Fur	nd	
1 00	Fund halances at beginning of pariod	1.00	2.00	3.00		4.00	5.00		1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)		18, 712, 903 -1, 399, 417 17, 313, 486 0 17, 313, 486			0		0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 16.00 17.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		17, 313, 486			0			19.00
		Endowment Fund	Pl ant	Fund					
		6.00	7.00	8.00					
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	000000000000000000000000000000000000000		0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0	0 0 0 0 0 0		0 0				10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 153030	Peri Froi To	iod: m 10/01/2014 09/30/2015	Worksheet G-2 Parts I & II Date/Time Pre 2/23/2016 2:55	pared:
	Cost Center Description		Inpatient		Outpatient	Total	
			1.00		2.00	3.00	
	PART I – PATIENT REVENUES						
	General Inpatient Routine Services		1				
1.00	Hospi tal		7, 975, 9	76		7, 975, 976	1.00
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF			0		0	3.00
4.00	SUBPROVIDER			0		0	4.00
5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - NF			0		0	6.00
7.00	SKILLED NURSING FACILITY						7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE		7 075 0				9.00
10.00	Total general inpatient care services (sum of lines 1-9)		7, 975, 9	76		7, 975, 976	10.00
11.00	Intensive Care Type Inpatient Hospital Services INTENSIVE CARE UNIT		1	0		0	11.00
12.00	CORONARY CARE UNIT			0		0	12.00
12.00	BURN INTENSIVE CARE UNIT			0		0	12.00
14.00	SURGI CAL I NTENSI VE CARE UNI T			0		0	•
14.00	OTHER SPECIAL CARE (SPECIFY)			0		0	15.00
16.00	Total intensive care type inpatient hospital services (sum of I	inos		0		0	
10.00	11-15)	i nes		0		0	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		7, 975, 9	76		7, 975, 976	17.00
18.00	Ancillary services		14, 649, 1		0	14, 649, 179	
19.00	Outpati ent servi ces			0	24, 318	24, 318	
20.00	RURAL HEALTH CLINIC			0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULANCE SERVICES						23.00
24.00	СМНС						24.00
24.10	CORF			0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPI CE						26.00
27.00	OTHER (SPECIFY)			0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst.	22, 625, 1	55	24, 318	22, 649, 473	28.00
	G-3, line 1)						
	PART II - OPERATING EXPENSES		1				
29.00	Operating expenses (per Wkst. A, column 3, line 200)			_	9, 245, 329		29.00
30.00	ADD (SPECIFY)			0			30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0	0		35.00
36.00	Total additions (sum of lines 30-35)			0	0		36.00
37.00 38.00	DEDUCT (SPECI FY)			0			37.00
38.00				0			38.00
40. 00				0			40.00
40.00				0			40.00
41.00	Total deductions (sum of lines 37-41)				0		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer			9, 245, 329		42.00
13.00	to Wkst. G-3, line 4)				1, 270, 327		1 10.00

	Financial Systems REHABILITATION HOSPITAL OF FT WAYNE			u of Form CMS-2	
STATEN	IENT OF REVENUES AND EXPENSES Provider CCN:	153030	Peri od:	Worksheet G-3	
			From 10/01/2014 To 09/30/2015	Date/Time Pre	nared
			10 07/30/2013	2/23/2016 2:5	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			22, 649, 473	1.00
2.00	Less contractual allowances and discounts on patients' accounts			14, 885, 279	2.00
3.00	Net patient revenues (line 1 minus line 2)			7, 764, 194	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			9, 245, 329	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-1, 481, 135	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication services			0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			67, 683	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients			0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			30	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			892	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER I NCOME			13, 113	24.00
25.00	Total other income (sum of lines 6-24)			81, 718	25.00
26.00	Total (line 5 plus line 25)			-1, 399, 417	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			-1, 399, 417	29.00