This report is	required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to rep	oort can result in all interim FORM AF	PPROVED
payments made	since the beginning of the cost reporting period being deemed over	erpayments (42 USC 1395g). OMB NO.	0938-0050
HOSPITAL AND H AND SETTLEMENT		CCN: 153030   Peri od:   Workshe   From 10/01/2013   Parts   To   09/30/2014   Date/Ti   2/24/20	-111
PART I - COST	REPORT STATUS		
Provi der use only	1. [ X ]Electronically filed cost report 2. [ ]Manually submitted cost report	Date: 2/24/2015 T	ime: 3:50 pm
	3. [ 0 ] If this is an amended report enter the number of times the 4. [ F ] Medicare Utilization. Enter "F" for full or "L" for low.	ne provider resubmitted this cost rep	ort
Contractor use only	5. [ 1 ]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [ N ] Initial Report for this Provided (3) Settled with Audit 9. [ N ] Final Report for this Provided (5) Amended	10. NPR Date: 11. Contractor's Vendor Code: vider CCN 12. [ 0 ]If line 5, column 1 der CCN number of times reop	is 4: Enter

PART II - CERTIFICATION

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

## CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REHABILITATION HOSPITAL OF FT WAYNE (153030) for the cost reporting period beginning 10/01/2013 and ending 09/30/2014 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)	
	Officer or Administrator of Provider(s)
Title	9
Date	

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	60, 496	0	0	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - IRF	0	0	0		0	3.00
4.00	SUBPROVI DER 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
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	60, 496	0	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.

	used in the prior cost reporting period? In column	2, enter "Y	" for yes	or "N" for	no.			
		In-State	In-State	Out-of	Out-of	Medi cai d	Other	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		pai d days	eligible	Medi cai d	Medi cai d		days	
			unpai d	pai d days	el i gi bl e			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00	If this provider is an IPPS hospital, enter the	0	0	0	0	(	0	24.00
	in-state Medicaid paid days in col. 1, in-state							
	Medicaid eligible unpaid days in col. 2,							
	out-of-state Medicaid paid days in col. 3,							
	out-of-state Medicaid eligible unpaid days in col.							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
25. 00	If this provider is an IRF, enter the in-state	724	0	0	0	(	)	25. 00
	Medicaid paid days in col. 1, the in-state Medicaid							
	eligible unpaid days in col. 2, out-of-state							
	Medicaid days in col. 3, out-of-state Medicaid							
	eligible unpaid days in col. 4, Medicaid HMO paid							
	and eligible but unpaid days in col. 5, and other							
	Medicaid days in col. 6.							

	Financial Systems REHABILITATION DATE: TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATE:		PITAL OF FT WAY Provider	CCN: 153030 P	eriod: rom 10/01/	/2013	wof For Workshe	eet S-2	)
				T			2/24/20	015 3:4	7 pm
					Urban/Rui 1.00		Date of 2.0		-
26. 00	Enter your standard geographic classification (not wa			ginning of the		1	2. (	<i>.</i>	26.00
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban of	age) st r "2" f	atus at the en or rural. If a			1			27. 00
35. 00	enter the effective date of the geographic reclassifilf this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35.00
					Begi nni 1. 00		Endi 2. (		
36. 00	Enter applicable beginning and ending dates of SCH sof periods in excess of one and enter subsequent date		Subscript line	36 for number					36.00
37. 00	If this is a Medicare dependent hospital (MDH), enter in effect in the cost reporting period.		number of perio	ds MDH status		0			37.00
38. 00	Enter applicable beginning and ending dates of MDH sof periods in excess of one and enter subsequent date		Subscript line	38 for number					38.00
					Y/N 1.00	١	Y/ 2. (		-
39. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage rec	i)? Ént quireme	er in column 1 ents in accorda	"Y" for yes nce with 42			2. (	<u> </u>	39.00
	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	or "N"	for no. (see	instructions)		V	XVIII	XIX	
	D (DD2) 0 1 1					1.00		3.00	
45. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	nt for	di sproporti ona	te share in ac	cordance	N	N	N	45. 00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete World					N	N	N	46. 00
	III.						N N	N N	47. 00 48. 00
56. 00							56.00		
57. 00	or "N" for no.  If line 56 is yes, is this the first cost reporting programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "	r yes o th of t	or "N" for no i his cost repor	n column 1. If ting period?	column 1 Enter "Y"				57.00
58. 00	"N", complete Worksheet D, Part III & IV and D-2, Pailf line 56 is yes, did this facility elect cost reiml	rt II, burseme	if applicable. ent for physici			N			58.00
	defined in CMS Pub. 15-1, section 2148? If yes, compl Are costs claimed on line 100 of Worksheet A? If yes	s, comp	lete Worksheet			N			59.00
60.00	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"					N			60.00
		Y/N	IME	Direct GME	IME		Di rect	t GME	
		1.00	2. 00	3. 00	4. 00		5. (		
61. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0. 00		0. 00	61.00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0. 00	0.00					61.01
61. 02	instructions) 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		0.00	0.00					61.02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.00					61.03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00					61.04
61. 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00					61.05
61. 06	Enter the amount of ACA \$5503 award that is being		0.00	0.00					61.06

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)

Health Financial Systems RE	EHABILITATION HOSPITAL OF FT	WAYNE	In Lieu	ı of Form CMS-25	552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	FICATION DATA Provide	_	rom 10/01/2013 o 09/30/2014	Worksheet S-2 Part I Date/Time Prep 2/24/2015 3:47	
	Program Name	Program Code	Unweighted	Unwei ghted	

	n Financiai Systems	REHABILITATI					U OT FORM CMS-2	
HOSPI	TAL AND HOSPITAL HEALTH CARE COMP	PLEX IDENTIFICATION DA	ATA	Provi der		eriod: rom 10/01/2013 o 09/30/2014	Worksheet S-2 Part I Date/Time Pre 2/24/2015 3:4	pared:
			Program		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	I		1. 0	00	2. 00	3. 00	4. 00	
	Of the FTEs in line 61.05, speci specialty, if any, and the number for each new program. (see instruction of the program code, enter in column 3 unweighted count and enter in context of the FTEs in line 61.05, speci program specialty, if any, and the residents for each expanded program structions) Enter in column 1 enter in column 2 the program column 2 the IME FTE unweighted count and inect GME FTE unweighted count.	er of FTE residents ructions) Enter in rin column 2 the the IME FTE olumn 4 direct GME fy each expanded the number of FTE gram. (see the program name, ode, enter in column 4				0.00		61. 10
	arrest sme the armer gritted essure.		1		1			
	ACA Provisions Affecting the Hea	al th Docourage and Ca	rvi cos Admi	ni etrati a	n (UDSA)		1.00	
62. 00	Enter the number of FTE resident	ts that your hospital	trained in	this cost	п (пком) t reporting per	iod for which	0.00	62.00
	your hospital received HRSA PCRE Enter the number of FTE resident	E funding (see instru	ctions)				0.00	62. 01
02.01	during in this cost reporting pe	eriod of HRSA THC pro	gram. (see i	nstructio	• •	your nospital	0.00	02.01
63 00	Teaching Hospitals that Claim Re Has your facility trained reside				cost reporting	neriod? Enter	N	63.00
	"Y" for yes or "N" for no in col	•	J	9	<u>e instructions)</u>			
					Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
					Nonprovi der	Hospi tal	col . 2))	
					Si te 1.00	2.00	3. 00	
	Section 5504 of the ACA Base Yea	ar FTE Residents in N	lonprovi der :	setti ngs-	1	L .		
64. 00	period that begins on or after. Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to resident FTEs that trained in your of (column 1 divided by (column).	s yes, or your facili nber of unweighted no otations occurring in e number of unweighte our hospital. Enter i	ty trained ments of the second	residents are ovider ry care the ratio	0.00	0.00	0. 000000	64.00
		Program Name	Program		Unwei ghted	Unwei ghted	Ratio (col.	
					FTEs Nonprovider Site	FTEs in Hospital	3/ (col. 3 + col. 4))	
		1. 00	2. C	00	3. 00	4. 00	5. 00	
55. 50	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.00	0.00	0.00000	55.00

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMP		ON HOSPITAL OF FT WA		In Lie	u of Form CMS-2 Worksheet S-2	
1100111	THE THIS HOST FINE HEALTH STATE SOME	LEX I BENTITION OF	in a straight		rom 10/01/2013	Part I Date/Time Pre	pared:
				Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospital	2/24/2015 3:4   Ratio (col.   1/ (col. 1 +   col. 2))	/ pm
	C+:	V	. Name and date and the	Si te 1.00	2. 00	3.00	
44.00	Section 5504 of the ACA Current beginning on or after July 1, 20 Enter in column 1 the number of	)10		0. 00			44.00
66. 00	FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all non-p unweighted non-priman al. Enter in column 3	orovider settings. ry care resident 3 the ratio of	0.00	0.00	0.00000	00.00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
67. 00	Enter in column 1 the program	1. 00	2. 00	3.00	4. 00	5. 00 0. 000000	67.00
67.00	Enter in column i the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.00000	67.00
					1.00	2.00 3.00	
70. 00	Inpatient Psychiatric Facility F Is this facility an Inpatient Ps		IDE) or does it com	stain an IDE sub	<u>'</u>	2.00 0.00	70.00
71. 00	Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b Column 2: Did this facility trai §412.424 (d)(1)(iii)(D)? Enter "	n. De facility have an ap Defore November 15, 20 In residents in a new Y" for yes or "N" for	oproved GME teaching 204? Enter "Y" for teaching program in r no. Column 3: If c	program in the yes or "N" for accordance wit column 2 is Y, e	most no. h 42 CFR nter 1, 2	0	71.00
	or 3 respectively in column 3. (beginning of the fourth year, enthe new teaching program in exis	ter 4 in column 3, or tence, enter 5. (see	rif the 5th or subs	period covers equent academic	the years of		
75. 00	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re	habilitation Facility	y (IRF), or does it	contain an IRF	Υ		75. 00
76. 00	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR §412.424 (d)(1)(iii)(D)? Ent 1, 2 or 3 respectively in column beginning of the fourth year, enthe new teaching program in exis	ne facility have an apiling on or before Nove train residents in a re "N" for yes or "N" a. (see instructions ter 4 in column 3, on	ember 15, 2004? Ente new teaching progra ' for no. Column 3: s) If this cost repo r if the 5th or subs	er "Y" for yes o mm in accordance If column 2 is orting period co	r "N" for with 42 Y, enter vers the	N O	76.00
	the new reaching program in exis	rtence, enter 3. (see	That detrona)			1.00	
80.00	Long Term Care Hospital PPS Is this a long term care hospita	I (ITCH)? Entar "\/"	for was and "N" for	· no		N N	80.00
	TEFRA Providers				on "N" &		80.00
85. 00 86. 00	Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" for	w Other subprovider	(excluded unit) unde		n	N	85. 00 86. 00
					V 1. 00	XI X 2. 00	
90. 00	Title V and XIX Services  Does this facility have title V		hospital services?	Enter "Y" for	N	Y	90.00
91. 00	yes or "N" for no in the applical is this hospital reimbursed for	title V and/or XIX th			N	Y	91.00
92. 00	full or in part? Enter "Y" for y Are title XIX NF patients occupy	ring title XVIII SNF b	beds (dual certifica			N	92.00
93. 00	<pre>instructions) Enter "Y" for yes Does this facility operate an IC "Y" for yes or "N" for no in the</pre>	F\MR facility for pur		d XIX? Enter	N	N	93. 00
94. 00	Does title V or XIX reduce capit applicable column.		or yes, and "N" for	no in the	N	N	94. 00
95. 00	If line 94 is "Y", enter the red	luction percentage in	the applicable colu	ımn.	0.00	0.00	95. 00

Health Financial Systems REHABILITATION HOSE	PITAL OF FT WAY	/NF	In Lie	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 153030 P	eriod: rom 10/01/201;	Worksheet S-	
			0 09/30/2014		
			V	XIX	47 pill
96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye	es or "N" for n	o in the	1. 00 N	2. 00 N	96.00
applicable column.  97.00 If line 96 is "Y", enter the reduction percentage in the appropriate Rural Providers			0.0	0. 0	97.00
105.00 Does this hospital qualify as a Critical Access Hospital (C 106.00 of this facility qualifies as a CAH, has it elected the all		hod of payment	N N		105. 00 106. 00
for outpatient services? (see instructions)  107.00 Column 1: If this facility qualifies as a CAH, is it eligi for I &R training programs? Enter "Y" for yes or "N" for n instructions) If yes, the GME elimination would not be on W 25 and the program would be cost reimbursed. If yes complet Column 2: If this facility is a CAH, do I&Rs in an approve train in the CAH's excluded IPF and/or IRF unit? Enter "Y column 2. (see instructions)	no in column 1. Worksheet B, Pa te Worksheet D- ed medical educ 7" for yes or "	(see art I, column 2, Part II. aation program N" for no in	N		107.00
108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108. 00
	Physi cal 1.00	Occupational 2.00	Speech 3. 00	Respiratory 4.00	
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.		N	N	N	109.00
			1. (	00 2.00 3.00	)
Miscellaneous Cost Reporting Information					
115.00 s this an all-inclusive rate provider? Enter "Y" for yes center the method used (A, B, or E only) in column 2. If col either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospital provider 15-1, §2208.1.	umn 2 is "E", t for long term	enter in colum care (include	n 3 s	0	115. 00
116.00 s this facility classified as a referral center? Enter "Y" $117.00$ s this facility legally-required to carry malpractice insu			"N" for N		116. 00 117. 00
no.  118.00 Is the malpractice insurance a claims-made or occurrence po	olicy? Enter 1	if the policy	is 1		118. 00
Grafill liliade. Effect 2 11 the portey 13 occurrence.		Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00	2. 00 18, 32	3.00	0118.01
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	2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2 "Y" for yes or "N" for no.	n column 1 "Y" qualifies for t	for yes or the Outpatient	N	N	119.00 120.00
121.00 Did this facility incur and report costs for high cost imples patients? Enter "Y" for yes or "N" for no.	antable device	es charged to	N		121. 00
Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" f	for 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		fication date			126. 00
in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, er	nter the certif	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		ication date			128. 00
in column 1 and termination date, if applicable, in column 129.00 of this is a Medicare certified lung transplant center, ent	2.				129. 00
column 1 and termination date, if applicable, in column 2.			1	1	
130.00 If this is a Medicare certified pancreas transplant center,	enter the cer	ti fi cati on			130.00
130.00 olf this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 131.00 olf this is a Medicare certified intestinal transplant center.	olumn 2. er, enter the c				130. 00 131. 00
130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 131.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in column 132.00 If this is a Medicare certified islet transplant center, en	olumn 2. er, enter the c olumn 2. nter the certif	erti fi cati on			
130.00 of this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 1 an	olumn 2. er, enter the column 2. nter the certif 2. nter the certif	ertification			131.00
130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column	olumn 2. er, enter the c olumn 2. nter the certif 2. nter the certif 2.	ertification fication date			131. 00 132. 00

Health Financial Systems	REHABILITATION HO	SPITAL OF FT WAYN	ΙE	In Lie	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	ENTIFICATION DATA	Provi der C	CCN: 153030	Peri od: From 10/01/2013 To 09/30/2014		epared:
				1.00	2.00	_
All Providers  140.00 Are there any related organization or chapter 10? Enter "Y" for yes or "N" fare claimed, enter in column 2 the hom	for no in column 1.	If yes, and home	office cost	Y	449008	140. 00
1.00	2	. 00		3.00		
If this facility is part of a chain or office and enter the home office contr			ugh 143 the	name and address	of the home	
141.00 Name: CHS/COMMUNITY HEALTH SYSTEMS, I NC.	Contractor's Name:		AN Contract	or's Number: 1030	)1	141.00
142.00 Street: 4000 MERIDIAN BLVD 143.00 City: FRANKLIN	PO Box: State:	TN	Zip Code	: 3706	57	142. 00 143. 00
143. OODI TY. TRANKLIN	State.	TIN	Zip code	. 3700	37	143.00
144 00 Are provider based physicians! costs i	noluded in Westerhee	+ 42			1.00	144.00
144.00 Are provider based physicians' costs i 145.00 If costs for renal services are claims services only? Enter "Y" for yes or "N	ed on Worksheet A, I		costs for i	npati ent	Y N	144. 00 145. 00
				1.00	2. 00	
146.00 Has the cost allocation methodology ch Enter "Y" for yes or "N" for no in col enter the approval date (mm/dd/yyyy) i	umn 1. (See CMS Pub			, N		146. 00
147.00 Was there a change in the statistical				N		147.00
148.00Was there a change in the order of all 149.00Was there a change to the simplified cono.				r N		148. 00 149. 00
		Part A	Part B	Title V	Title XIX	
Does this facility contain a provider or charges? Enter "Y" for yes or "N" f						
155. 00 Hospi tal	or no ror caerr comp	N N	N	N	N N	155. 00
156. 00 Subprovi der – IPF		N	N	N	N	156.00
157. 00 Subprovi der -   IRF 158. 00 SUBPROVI DER		N	N	N	N	157. 00 158. 00
159. 00 SNF		N	N	N	N	159.00
160.00HOME HEALTH AGENCY 161.00CMHC		N	N N	N N	N N	160. 00 161. 00
161. 10 CORF			N	N	N	161. 10
					1.00	
Multicampus  165.00 Is this hospital part of a Multicampus Enter "Y" for yes or "N" for no.	s hospital that has	one or more campu	ses in diff	erent CBSAs?	N	165. 00
	Name	County		p Code CBSA	FTE/Campus	
166.00 If line 165 is yes, for each campus enter the name in column	0	1. 00	2.00	3.00 4.00	5. 00	0166.00
O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						
					1.00	
Health Information Technology (HIT) ir 167.00 s this provider a meaningful user und	ncentive in the Amer	ican Recovery and	Reinvestme	ent Act	N	167. 00
168.00 If this provider is a CAH (line 105 is reasonable cost incurred for the HIT a	s "Y") and is a mean assets (see instruct	ingful user (line ions)	167 is "Y"	), enter the		0168.00
169.00 If this provider is a meaningful user transition factor. (see instructions)	(line 167 is "Y") a	nd is not a CAH (	line 105 is	"N"), enter the	0.0	0169.00
				Begi nni ng 1. 00	Endi ng 2. 00	
				1.00	2.00	

		BILITATION HOSPITAL OF FT WA			u of Form CMS-	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE Provi der		Period: From 10/01/2013 To 09/30/2014	Date/Time Pr	epared:
				Y/N	2/24/2015 3: Date	47 pm
	General Instruction: Enter Y for all YES res	nonces Enter N for all NO m	oonences Ente	1.00	2.00	
	mm/dd/yyyy format.	ponses. Enter N for all No f	esponses. Ente	er all dates in	the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
1. 00	Has the provider changed ownership immediate	ly prior to the beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of	the change in column 2. (see	instructions)	Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in yes, enter in column 2 the date of terminativoluntary or "I" for involuntary.		N			2.00
3. 00	Is the provider involved in business transac contracts, with individuals or entities (e.g or medical supply companies) that are relate officers, medical staff, management personne of directors through ownership, control, or relationships? (see instructions)	., chain home offices, drug d to the provider or its I, or members of the board	N			3.00
			Y/N 1.00	Type 2. 00	Date 3.00	
1. 00	Financial Data and Reports Column 1: Were the financial statements pre Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Compiled, enter date available in	N			4.00
. 00	column 3. (see instructions) If no, see inst Are the cost report total expenses and total those on the filed financial statements? If	revenues different from	N			5.00
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities				2.00	
5. 00	Column 1: Are costs claimed for nursing sch the legal operator of the program?	ool? Column 2: If yes, is t	he provider is	N N		6. 00
7. 00 3. 00	Are costs claimed for Allied Health Programs Were nursing school and/or allied health pro cost reporting period? If yes, see instructi	grams approved and/or renewe	d during the	N N		7. 00 8. 00
9. 00	Are costs claimed for Intern-Resident progra yes, see instructions.		st report? If	N		9. 00
10. 00	Was an Intern-Resident program been initiate period? If yes, see instructions.	d or renewed in the current	cost reporting	g N		10.00
11. 00	Are GME cost directly assigned to cost cente Teaching Program on Worksheet A? If yes, see		proved	N		11.00
	Bad Debts				Y/N 1.00	
	Is the provider seeking reimbursement for ba				Y	12.00
13.00	If line 12 is yes, did the provider's bad de period? If yes, submit copy.	bt collection policy change	during this co	ost reporting	N	13.00
14. 00	If line 12 is yes, were patient deductibles Bed Complement	and/or co-payments waived? I	f yes, see ins	structi ons.	N N	14.00
15. 00	Did total beds available change from the pri	or cost reporting period? If			N	15.00
		Description	Y/N	rt A Date	Part B Y/N	
		0	1.00	2. 00	3. 00	
16. 00	PS&R Data Was the cost report prepared using the PS&R		Y	01/23/2015	N	16.00
0.00	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		·	017 237 2010		10.00
7. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns		N		N	17. 00
8. 00	2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file		N		N	18. 00
19. 00	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 other PS&R Report information? If yes, see instructions.		N		N	19. 00
20 00	16 11 - 17 - 17 1		1	1	l N	1 20 00

Ν

20.00

20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:

Health Financial Systems	REHABILITATION HOSPITAL	OF FT WAYNE	In Lie	u of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE	RELMBURSEMENT OUESTLONNALRE	Provider CCN: 153030	Peri od:	Worksheet S-2

From 10/01/2013 Part II 09/30/2014 Date/Time Prepared: 2/24/2015 3:47 pm Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν 21 00 Ν provider's records? If yes, see instructions. 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered into during this cost reporting period? 24.00 If ves. see instructions 25 00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see 25 00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see 26.00 i nstructi ons. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit 27.00 copy Interest Expense 28.00 Were new Loans, mortgage agreements or Letters of credit entered into during the cost reporting 28.00 period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 30.00 30.00 instructions. Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 31.00 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual 32.00 arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? It 33.00 no, see instructions. Provi der-Based Physicians 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? 34.00 If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based 35.00 physicians during the cost reporting period? If yes, see instructions Y/N Date 1.00 2.00 Home Office Costs Were home office costs claimed on the cost report? 36.00 36, 00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 N 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of Υ 12/31/2013 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, N 39.00 see instructions. If line 36 is yes, did the provider render services to the home office? If yes, see 40 00 40.00 N instructions. 1.00 2.00 Cost Report Preparer Contact Information KING 41.00 Enter the first name, last name and the title/position BRI TTNI 41.00 held by the cost report preparer in columns 1, 2, and 3, respectively. 42 00 COMMUNITY HEALTH SYSTEMS 42 00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 615-465-2769 BRI TTNI \_KI NG@CHS. NET 43.00 report preparer in columns 1 and 2, respectively.

report preparer in columns 1 and 2, respectively.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 153030 Peri od: Worksheet S-2 From 10/01/2013 To 09/30/2014 Part II Date/Time Prepared: 2/24/2015 3:47 pm Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 16.00 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) 17.00 Was the cost report prepared using the PS&R 17.00 Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 19.00 | If line 16 or 17 is yes, were adjustments 19.00 made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions. 20.00 | If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: 21.00 Was the cost report prepared only using the provider's records? If yes, see 21.00 instructions. 3.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position REVENUE MANAGER 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. 42.00 Enter the employer/company name of the cost report 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 43.00

32.00

32.01

33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 153030 Peri od: Worksheet S-3 From 10/01/2013 Part I 09/30/2014 Date/Time Prepared: 2/24/2015 3:47 pm I/P Days / 0/P Visits / Trips CAH Hours Component Worksheet A No. of Beds Bed Days Title V Line Number Avai I abl e 1.00 2.00 3.00 4.00 5.00 13, 140 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 0.00 36 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider 4.00 Hospital Adults & Peds. Swing Bed SNF 5.00 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 Total Adults and Peds. (exclude observation 7.00 13, 140 0.00 0 7.00 36 beds) (see instructions) INTENSIVE CARE UNIT 8.00 31 00 C 0 0.00 0 8 00 9.00 CORONARY CARE UNIT 32.00 0 0 0.00 0 9.00 10.00 BURN INTENSIVE CARE UNIT 33.00 0 0 0.00 10.00 SURGICAL INTENSIVE CARE UNIT 34.00 0.00 11.00 0 0 0 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 43.00 13.00 14.00 Total (see instructions) 36 13, 140 0.00 0 14.00 CAH visits 15.00 0 15.00 SUBPROVIDER - IPF 16.00 16.00 17.00 SUBPROVIDER - IRF 41.00 0 0 0 17.00 SUBPROVI DER 18.00 42.00 0 18.00 19.00 SKILLED NURSING FACILITY 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 24.00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 30.00 24.10 25.00 CMHC - CMHC 25.00 CMHC - CORF 25. 10 99.10 0 25.10 RURAL HEALTH CLINIC 88.00 26.00 0 26.00 FEDERALLY QUALIFIED HEALTH CENTER 89.00 26 25 0 26 25 Total (sum of lines 14-26) 27.00 36 27.00 28.00 Observation Bed Days 0 28.00 29.00 Ambulance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00

0

0

32.01

Labor & delivery days (see instructions)

Total ancillary labor & delivery room outpatient days (see instructions)

33.00 LTCH non-covered days

33 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 153030 F

Peri od: Worksheet S-3 From 10/01/2013 Part I To 09/30/2014 Date/Time Prepared:

2/24/2015 3:47 pm I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Title XIX Total All Component Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 Hospital Adults & Peds. (columns 5, 6, 7 and 5, 384 1.00 2, 265 724 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 864 2.00 3.00 HMO IPF Subprovider 0 3.00 4.00 HMO IRF Subprovider 4.00 0 0 5.00 Hospital Adults & Peds. Swing Bed SNF 0 C 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 2, 265 724 5, 384 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 0 C 0 8 00 9.00 CORONARY CARE UNIT 0 0 0 9.00 10.00 BURN INTENSIVE CARE UNIT 0 0 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 0 0 0 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 2, 265 724 5, 384 0.00 84.41 14.00 CAH visits 15.00 0 15.00 SUBPROVIDER - IPF 16.00 16.00 17.00 SUBPROVIDER - IRF 0 0 0 0.00 0.00 17.00 18.00 SUBPROVI DER 0 0 0.00 0.00 18.00 19.00 SKILLED NURSING FACILITY 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 24.00 24.00 24. 10 HOSPICE (non-distinct part) 0 0 24.10 25.00 CMHC - CMHC 25.00 CMHC - CORF 25. 10 C 0 0.00 0.00 25.10 0 RURAL HEALTH CLINIC 0 0.00 0.00 26.00 0 26.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0.00 26 25 Ω 0 00 26 25 84.41 27.00 Total (sum of lines 14-26) 0.00 27.00 28.00 Observation Bed Days 0 0 28.00 29.00 Ambulance Trips 0 29.00 Employee discount days (see instruction) 0 30 00 30.00 0 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) 0 32.00 Total ancillary labor & delivery room outpatient days (see instructions) 0 32.01 32.01

33.00 LTCH non-covered days

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

Provi der CCN: 153030

Peri od: Worksheet S-3
From 10/01/2013 Part I
To 09/30/2014 Date/Time Prepared: 2/24/2015 3:47 pm

Component   Figur Val ents   Nonpal d   Workers   Title V   Title XVIII   Title XIX   Patients								2/24/2015 3:4	7 pm
No.   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 avail able beds)						Di sch	arges		
10.00		Component		Title V		Title XVIII	Title XIX		
1.00									
8 exclude Swing Bed, Observation Bed and Hospice days/(see instructions for col. 2 for the portion of LDP room available beds)   2 col. 2 for the portion of LDP room available beds)   3 col. 3 col. 3 col. 4 col. 3 col. 4 col. 3 col. 4 col. 4 col. 3 col. 4 col. 4 col. 5 col. 4 col. 4 col. 5 col. 4 col. 4 col. 5 col. 4 col. 5 col. 6 col				12. 00					
3.00   HMO   PF Subprovider	1. 00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2			0	196	37	488	1.00
4. 00   HMO IRF Subprovider   5. 00   5. 00   Hospital Adult s& Peds. Swing Bed NF   6. 00   7. 00   Hospital Adults & Peds. (exclude observation beds) (see instructions)   8. 00   INTENSIVE CARE UNIT   8. 00   10. 00	2.00	HMO and other (see instructions)				0	o		2.00
5.00	3.00	HMO IPF Subprovider							3.00
6.00   Hospital Adults & Peds. Swing Bed NF 7.00   Total Adults and Peds. (exclude observation beds) (see instructions) 8.00   INTENSIVE CARE UNIT   8.00 10.00   BURN INTENSIVE CARE UNIT   10.00 11.00   SURGICAL INTENSIVE CARE UNIT   11.00 12.00   OTHER SPECIAL CARE (SPECIFY)   12.00 13.00   NURSERY   13.00 15.00   CAH visits   15.00 16.00   SUBPROVIDER - IPF   15.00 17.00   SUBPROVIDER - IPF   15.00 18.00   SUBPROVIDER BR   0.00   0   0   0   0   0   17.00 19.00   SKILLED NURSING FACILITY   0.00   0   0   0   0   0   0   18.00 19.00   SKILLED NURSING FACILITY   0.00   0   0   0   0   19.00 21.00   OTHER LONG TERM CARE   21.00 22.00   HOME HEALTH AGENCY   22.00 24.00   HOSPICE   0.00   0   0   0   0   0   0   0   0	4.00	HMO IRF Subprovider							4.00
7. 00 Total Adults and Peds. (exclude observation beds) (see instructions) 8. 00 INTENSIVE CARE UNIT 9. 00 CORONARY CARE UNIT 9. 00 CORONARY CARE UNIT 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IPF 19. 00 SUBPROVIDER - IRF 20. 00 HORSING FACILITY 21. 00 TOTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE 24. 10 HOSPICE 25. 10 CMMC - CMMC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 OD SEPRALLY QUALIFIED HEALTH CENTER 28. 00 Observation Bed Days 29. 00 AMBUlarory days (see instruction) 28. 00 Observation Bed Days 29. 00 AMBUlarory days (see instruction) 28. 00 Employee di scount days (see instructions) 32. 01 Total ancililary labor & delivery room 30. 00 Labor & delivery days (see instructions) 32. 01 Total ancililary labor & delivery room 30. 00 Laptal ent and the servacion and the servacion and the servacion and the servacions and the s	5.00	Hospital Adults & Peds. Swing Bed SNF							5.00
beds) (see instructions)   8	6.00	Hospital Adults & Peds. Swing Bed NF							6.00
8. 00   INTENSIVE CARE UNIT	7. 00	,							7. 00
10. 00 BURN INTENSIVE CARE UNIT	8.00				l				8. 00
11. 00 12. 00 10 OTHER SPECIAL CARE (SPECIFY) 13. 00 10 NURSERY 15. 00 14. 00 15 CAH visits 16. 00 15 SUBPROVI DER - I PF 17. 00 18. 00 19. 00	9.00	CORONARY CARE UNIT							9.00
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER - IRF 19. 00 ON	10.00	BURN INTENSIVE CARE UNIT							10.00
13. 00 14. 00 10	11.00	SURGICAL INTENSIVE CARE UNIT							11.00
14.00	12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
15.00 CAH visits	13.00	NURSERY							13.00
16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 20.00 THER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 25.10 CMHC - CORF 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 Servation Bed Days 27.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)	14.00	Total (see instructions)	0.00		0	196	37	488	14.00
17. 00 SUBPROVIDER - IRF	15.00	CAH visits							15.00
18.00   SUBPROVI DER   0.00   0   0   0   18.00   19.00     SKI LLED NURSI NG FACI LI TY   20.00   NURSI NG FACI LI TY   20.00   O   O   O   O   O   O   O   O   O	16.00	SUBPROVI DER - I PF							16.00
19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.00 HOSPICE 25.00 CMHC - CMFC 25.10 CMHC - CORF 25.10 CMHC - CORF 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 26.25 TO Total (sum of lines 14-26) 27.00 Ambulance Trips 28.00 Observation Bed Days 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)	17.00	SUBPROVI DER - I RF	0.00		0	0	o	0	17.00
20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 25.10 CMHC - CORF 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 FEDERALLY QUALIFIED HEALTH CENTER 26.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01	18.00	SUBPROVI DER	0.00		0	0	0	0	18.00
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 25.00 CMHC - CMHC 25.00 CMHC - CORF 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 29.00 Employee discount days (see instructions) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)	19.00	SKILLED NURSING FACILITY							19.00
22. 00 23. 00 24. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 29. 00 29. 00 20	20.00	NURSING FACILITY							20.00
23.00 24.00 HOSPICE HOSPICE (non-distinct part)  25.00 CMHC - CMHC CMHC - CORF CORF CORF CORF CORF CORF CORF CORF	21.00	OTHER LONG TERM CARE							21.00
24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 25.00 CMHC - CORF 25.10 CMHC - CORF 25.10 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CENTER 26.00 Total (sum of lines 14-26) 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01	22.00	HOME HEALTH AGENCY							22. 00
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 FEDERALLY QUALIFIED HEALTH CENTER 26. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)	23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 Total (sum of lines 14-26) 27. 00 Observation Bed Days 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)	24.00	HOSPI CE							24. 00
25. 10 CMHC - CORF	24. 10	HOSPICE (non-distinct part)							24. 10
26. 00 26. 25 27. 00 28. 00 29. 00 20	25.00	CMHC - CMHC							25.00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 27.00 28.00 Observation Bed Days 28.00 Ambul ance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01	25. 10	CMHC - CORF							25. 10
27.00   Total (sum of lines 14-26)   0.00   27.00   28.00   0bservation Bed Days   28.00   29.00   Ambul ance Trips   29.00   29.00   30.00   Employee discount days (see instruction)   31.00   Employee discount days - IRF   31.00   32.00   Total ancillary labor & delivery room outpatient days (see instructions)   32.01   32.01   32.01   33.	26.00	RURAL HEALTH CLINIC	0.00						26.00
28.00 29.00 Ambulance Trips 29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Jabor & delivery days (see instructions) 31.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01									26. 25
29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)	27.00	Total (sum of lines 14-26)	0.00						27. 00
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)	28. 00	Observation Bed Days							28. 00
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)  31.00 32.00	29. 00	Ambulance Trips							29. 00
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)  32.00									30.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)	31.00								31.00
outpatient days (see instructions)	32.00	Labor & delivery days (see instructions)							32.00
	32. 01	Total ancillary labor & delivery room							32. 01
33.00   LTCH non-covered days                     33.00									
	33.00	LTCH non-covered days							33.00

		AL OI II WAI			u OI IOIIII CW3-2	
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provi der		Period: From 10/01/2013 To 09/30/2014		
Cook Cooker Bookinting	C-1	0+6	T-+-1 (1 1	DI: 6:+	2/24/2015 3: 4	/ pm
Cost Center Description	Sal ari es	0ther		Reclassificat	Reclassified	
			+ col. 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT		280, 649			497, 590	1.00
2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP		135, 933	135, 93	71, 531	207, 464	2.00
3. 00   00300 OTHER CAPITAL RELATED COSTS		0		0 0	0	3.00
4.00   00400 EMPLOYEE BENEFITS DEPARTMENT	115, 882	26, 344	142, 22	6 824, 196	966, 422	4.00
5. 01   00570   ADMI TTI NG	287, 761	146, 677	434, 43	-221	434, 217	5. 01
5. 02 00561 OTHER ADMINISTRATIVE AND GENERAL	439, 771	1, 975, 897	2, 415, 66	-1, 567, 063	848, 605	5. 02
7.00 00700 OPERATION OF PLANT	185, 085	394, 166			576, 184	7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	32, 891			32, 891	8.00
9. 00   00900   HOUSEKEEPI NG	79, 539	21, 972			101, 456	9.00
10. 00   01000 DI ETARY	266, 340	189, 309			169, 948	10.00
	200, 340	107, 307				
11. 00   01100   CAFETERI A	1	10 100		285, 577	285, 577	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	224, 210	19, 139			243, 195	13.00
14.00 O1400 CENTRAL SERVICE & SUPPLY	5, 405	111, 811	117, 21		54, 624	14.00
15. 00   01500   PHARMACY	89, 251	234, 436			100, 818	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	146, 449	39, 005	185, 45	4 -2, 667	182, 787	16.00
17. 00   01700   SOCIAL SERVICE	0	0		0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	1, 580, 042	282, 821	1, 862, 86	3 404, 146	2, 267, 009	30.00
31.00 03100 INTENSIVE CARE UNIT	O	0		o	0	31.00
32.00 03200 CORONARY CARE UNIT		0		ol ol	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	أ	0	1		0	33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		0			0	34.00
41. 00   04100   SUBPROVI DER -   RF		0			0	41.00
42. 00   04200   SUBPROVI DER	0	0			0	42.00
		0			-	
43. 00 04300 NURSERY	J U	U		0	0	43.00
ANCILLARY SERVICE COST CENTERS	2 000	20.024	00.40	- 0	20.407	F 4 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	3, 093	30, 034	33, 12		33, 127	54.00
57. 00   05700   CT   SCAN	0	0	'	0	0	57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0	1	이	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	I 0I	0		0	0	59.00
60. 00  06000  LABORATORY	١					
60. 00  06000  LABORATORT	27, 846	31, 740	59, 58	6  0	59, 586	60.00
60. 01   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY	27, 846 0	31, 740 0	59, 58	0 0	59, 586 0	60. 00 60. 01
	27, 846 0 7, 851	31, 740 0 10, 730		o		
60. 01 06001 BLOOD LABORATORY	0	0	18, 58	0 1 -10, 046	0	60. 01
60. 01   06001   BLOOD LABORATORY 65. 00   06500   RESPI RATORY THERAPY 66. 00   06600   PHYSI CAL THERAPY	7, 851 521, 498	0 10, 730 59, 707	18, 58 581, 20	0 1 -10, 046 5 -312	0 8, 535 580, 893	60. 01 65. 00 66. 00
60. 01   06001   BLOOD LABORATORY 65. 00   06500   RESPI RATORY THERAPY 66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	0 7, 851 521, 498 600, 262	0 10, 730 59, 707 60, 689	18, 58 581, 20 660, 95	0 1 -10, 046 5 -312 1 0	0 8, 535 580, 893 660, 951	60. 01 65. 00 66. 00 67. 00
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 7, 851 521, 498 600, 262 200, 358	0 10, 730 59, 707 60, 689 27, 393	18, 58 581, 20 660, 95 227, 75	0 1 -10, 046 5 -312 1 0 1 0	0 8, 535 580, 893 660, 951 227, 751	60. 01 65. 00 66. 00 67. 00 68. 00
60. 01   06001   BLOOD LABORATORY 65. 00   06500   RESPI RATORY THERAPY 66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	0 7, 851 521, 498 600, 262 200, 358 398	0 10, 730 59, 707 60, 689	18, 58 581, 20 660, 95 227, 75	0 0 1 -10,046 5 -312 1 0 1 0	0 8, 535 580, 893 660, 951 227, 751 815	60. 01 65. 00 66. 00 67. 00 68. 00 69. 00
60. 01   06001   BLOOD LABORATORY 65. 00   06500   RESPIRATORY THERAPY 66. 00   06600   PHYSICAL THERAPY 67. 00   06700   OCCUPATIONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDIOLOGY 71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	0 7, 851 521, 498 600, 262 200, 358	0 10, 730 59, 707 60, 689 27, 393	18, 58 581, 20 660, 95 227, 75	0 1 -10, 046 5 -312 1 0 1 0	0 8, 535 580, 893 660, 951 227, 751 815 15, 227	60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00
60. 01   06001   BLOOD LABORATORY   65. 00   06500   RESPIRATORY THERAPY   66. 00   06600   PHYSICAL THERAPY   67. 00   06700   CCUPATIONAL THERAPY   68. 00   06800   SPEECH PATHOLOGY   69. 00   06900   ELECTROCARDIOLOGY   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS	0 7, 851 521, 498 600, 262 200, 358 398	0 10, 730 59, 707 60, 689 27, 393	18, 58 581, 20 660, 95 227, 75 81:	0 0 1 -10, 046 5 -312 1 0 1 0 5 0 15, 227	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0	60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00
60. 01   06001   BLOOD LABORATORY   65. 00   06500   RESPIRATORY THERAPY   66. 00   06600   PHYSICAL THERAPY   67. 00   06700   OCCUPATIONAL THERAPY   68. 00   06800   SEECH PATHOLOGY   69. 00   06900   ELECTROCARDIOLOGY   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   73. 00   07300   DRUGS CHARGED TO PATIENTS	0 7, 851 521, 498 600, 262 200, 358 398 0 0	0 10, 730 59, 707 60, 689 27, 393 417 0 0	18, 58 581, 20 660, 95 227, 75 81:	0 0 1 -10, 046 5 -312 1 0 1 0 5 0 15, 227 0 219, 992	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992	60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00
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   SEECH PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   73. 00   07300   DRUGS CHARGED TO PATI ENTS   76. 00   03020   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0 7, 851 521, 498 600, 262 200, 358 398 0 0 0 54, 309	0 10, 730 59, 707 60, 689 27, 393 417 0 0 0 4, 989	18, 58 581, 20 660, 95 227, 75 81:	0 0 1 -10, 046 5 -312 1 0 5 0 5 0 5 15, 227 0 219, 992 8 -27	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992 59, 271	60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 00
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   SEECH PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   73. 00   07300   DRUGS CHARGED TO PATI ENTS   76. 00   03020   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   76. 01   03021   HEMODI ALYSI S & OTHER ANCI LLARY	0 7, 851 521, 498 600, 262 200, 358 398 0 0	0 10, 730 59, 707 60, 689 27, 393 417 0 0	18, 58 581, 20 660, 95 227, 75 81:	0 0 1 -10, 046 5 -312 1 0 5 0 5 0 5 15, 227 0 219, 992 8 -27	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992	60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 00
60. 01	0 7, 851 521, 498 600, 262 200, 358 398 0 0 0 54, 309	0 10, 730 59, 707 60, 689 27, 393 417 0 0 0 4, 989	18, 58 581, 20 660, 95 227, 75 81: 59, 29: 49, 91:	0 0 1 -10, 046 5 -312 1 0 1 0 5 0 0 15, 227 0 219, 992 8 -27 5 0	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992 59, 271 49, 915	60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 01
60. 01	0 7, 851 521, 498 600, 262 200, 358 398 0 0 0 54, 309	0 10, 730 59, 707 60, 689 27, 393 417 0 0 4, 989 49, 915	18, 58 581, 20 660, 95 227, 75 81: 59, 29: 49, 91	0 0 0 1 -10, 046 5 -312 0 1 0 5 0 15, 227 0 219, 992 0 219, 992 5 0	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992 59, 271 49, 915	60. 01 65. 00 66. 00 67. 00 68. 00 71. 00 72. 00 73. 00 76. 00 76. 01
60. 01 06001 BLOOD LABORATORY 65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSICAL THERAPY 67. 00 06700 CCUPATIONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDIOLOGY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 76. 01 03021 HEMODIALYSIS & OTHER ANCILLARY 00TPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0 7, 851 521, 498 600, 262 200, 358 398 0 0 0 54, 309	0 10, 730 59, 707 60, 689 27, 393 417 0 0 0 4, 989	18, 58 581, 20 660, 95 227, 75 81: 59, 29: 49, 91	0 0 1 -10, 046 5 -312 1 0 1 0 5 0 0 15, 227 0 219, 992 8 -27 5 0	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992 59, 271 49, 915	60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 01
60. 01 06001 BLOOD LABORATORY 65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATIONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDIOLOGY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 76. 01 03021 HEMODIALYSIS & OTHER ANCILLARY 00UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 89. 00 07100 OTHER REIMBURSABLE COST CENTERS	0 7, 851 521, 498 600, 262 200, 358 398 0 0 0 54, 309	0 10, 730 59, 707 60, 689 27, 393 417 0 0 4, 989 49, 915	18, 58 581, 20 660, 95 227, 75 81 59, 29 49, 91	0 0 0 1 -10, 046 5 -312 1 0 5 0 5 0 15, 227 0 219, 992 8 -27 5 0	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992 59, 271 49, 915	60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 00 76. 01 88. 00 89. 00
60. 01	0 7, 851 521, 498 600, 262 200, 358 398 0 0 0 54, 309	0 10, 730 59, 707 60, 689 27, 393 417 0 0 4, 989 49, 915	18, 58 581, 20 660, 95 227, 75 81 59, 29 49, 91	0 0 0 1 -10, 046 5 -312 0 1 0 5 0 15, 227 0 219, 992 0 219, 992 5 0	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992 59, 271 49, 915	60. 01 65. 00 66. 00 67. 00 68. 00 71. 00 72. 00 73. 00 76. 00 76. 01
60. 01	0 7, 851 521, 498 600, 262 200, 358 398 0 0 0 54, 309	0 10, 730 59, 707 60, 689 27, 393 417 0 0 4, 989 49, 915	18, 58 581, 20 660, 95 227, 75 81 59, 29 49, 91	0 0 0 1 -10, 046 5 -312 1 0 5 0 5 0 15, 227 0 219, 992 8 -27 5 0	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992 59, 271 49, 915	60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 01 88. 00 89. 00
60. 01	0 7, 851 521, 498 600, 262 200, 358 398 0 0 0 54, 309	0 10, 730 59, 707 60, 689 27, 393 417 0 0 4, 989 49, 915	18, 58 581, 20 660, 95 227, 75 81 59, 29 49, 91	0 0 0 1 -10, 046 5 -312 1 0 5 0 5 0 15, 227 0 219, 992 8 -27 5 0	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992 59, 271 49, 915	60. 01 65. 00 66. 00 67. 00 68. 00 71. 00 72. 00 73. 00 76. 00 76. 01 88. 00 89. 00 99. 10
60. 01	0 7, 851 521, 498 600, 262 200, 358 398 0 0 0 54, 309	0 10, 730 59, 707 60, 689 27, 393 417 0 0 4, 989 49, 915	18, 58 581, 20 660, 95 227, 75 81 59, 29 49, 91	0 0 0 1 -10, 046 5 -312 1 0 5 0 5 0 15, 227 0 219, 992 8 -27 5 0	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992 59, 271 49, 915 0 0	60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 01 88. 00 89. 00 99. 10
60. 01	0 7, 851 521, 498 600, 262 200, 358 398 0 0 0 54, 309 0	0 10, 730 59, 707 60, 689 27, 393 417 0 0 4, 989 49, 915	18, 58 581, 20 660, 95 227, 75 81 59, 29 49, 91	0 0 0 1 -10, 046 5 -312 1 0 5 0 5 0 15, 227 0 219, 992 8 -27 5 0	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992 59, 271 49, 915 0 0	60. 01 65. 00 66. 00 67. 00 68. 00 71. 00 72. 00 73. 00 76. 00 76. 01 88. 00 89. 00 99. 10
60. 01	0 7, 851 521, 498 600, 262 200, 358 398 0 0 0 54, 309 0	0 10, 730 59, 707 60, 689 27, 393 417 0 0 4, 989 49, 915	18, 58 581, 20 660, 95 227, 75 81 59, 29 49, 91	0 0 0 1 -10, 046 5 -312 1 0 5 0 5 0 15, 227 0 219, 992 8 -27 5 0	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992 59, 271 49, 915 0 0	60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 01 88. 00 89. 00 99. 10
60. 01	0 7, 851 521, 498 600, 262 200, 358 398 0 0 0 54, 309 0	0 10, 730 59, 707 60, 689 27, 393 417 0 0 4, 989 49, 915	18, 58 581, 20 660, 95 227, 75 81 59, 29 49, 91	0 0 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992 59, 271 49, 915 0 0	60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 73. 00 76. 00 76. 01 88. 00 89. 00 99. 10 109. 00 110. 00 111. 00 113. 00
60. 01   06001   BLOOD LABORATORY   65. 00   06500   RESPIRATORY THERAPY   66. 00   06600   PHYSI CAL THERAPY   67. 00   06700   OCCUPATI ONAL THERAPY   68. 00   06800   SPEECH PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   73. 00   07300   DRUGS CHARGED TO PATIENTS   76. 00   03020   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   76. 01   03021   HEMODI ALYSI S & OTHER ANCI LLARY   0UTPATIENT SERVI CE COST CENTERS   88. 00   08800   RURAL HEALTH CLINI C   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0THER REIMBURSABLE COST CENTERS   99. 10   09910   CORF   SPECIAL PURPOSE COST CENTERS   109. 00   10900   PANCREAS ACQUI SI TI ON   111. 00   111000   INTERESTI NAL ACQUI SI TI ON   113. 00   11300   INTEREST EXPENSE   118. 00   SUBTOTALS (SUM OF LINES 1-117)	0 7, 851 521, 498 600, 262 200, 358 398 0 0 0 54, 309 0	0 10, 730 59, 707 60, 689 27, 393 417 0 0 4, 989 49, 915	18, 58 581, 20 660, 95 227, 75 81 59, 29 49, 91	0 0 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992 59, 271 49, 915 0 0	60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 73. 00 76. 00 76. 01 88. 00 89. 00 99. 10 109. 00 110. 00 111. 00 113. 00
60. 01	0 7, 851 521, 498 600, 262 200, 358 398 0 0 0 54, 309 0 0 0 54, 309 0 0	0 10, 730 59, 707 60, 689 27, 393 417 0 0 4, 989 49, 915	18, 58 581, 20 660, 95 227, 75 81 59, 29 49, 91	0 0 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992 59, 271 49, 915 0 0	60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 73. 00 76. 00 76. 01 88. 00 89. 00 99. 10 109. 00 110. 00 111. 00 118. 00
60. 01   06001   BLOOD LABORATORY   65. 00   06500   RESPIRATORY THERAPY   66. 00   06600   PHYSI CAL THERAPY   67. 00   06700   OCCUPATI ONAL THERAPY   68. 00   06800   SPEECH PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   73. 00   07300   DRUGS CHARGED TO PATIENTS   76. 01   03021   HEMODI ALYSI S & OTHER ANCI LLARY   0UTPATIENT SERVICE COST CENTERS   88. 00   08800   RURAL HEALTH CLINIC   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0THER REI MBURSABLE COST CENTERS   99. 10   09910   CORF   SPECIAL PURPOSE COST CENTERS   109. 00   10900   PANCREAS ACQUISITION   111. 00   11000   INTESTINAL ACQUISITION   113. 00   11300   INTEREST EXPENSE   190. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 7, 851 521, 498 600, 262 200, 358 398 0 0 0 54, 309 0 0 0 0 0 4, 835, 350	0 10, 730 59, 707 60, 689 27, 393 417 0 0 4, 989 49, 915 0 0 0 0 0 4, 166, 664	18, 58 581, 20 660, 95 227, 75 81: 59, 29: 49, 91:	0 0 0 0 1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992 59, 271 49, 915 0 0 0	60. 01 65. 00 66. 00 67. 00 68. 00 71. 00 72. 00 73. 00 76. 01 88. 00 89. 00 99. 10 109. 00 111. 00 111. 00 118. 00
60. 01	0 7, 851 521, 498 600, 262 200, 358 398 0 0 0 54, 309 0 0 0 54, 309 0 0	0 10, 730 59, 707 60, 689 27, 393 417 0 0 4, 989 49, 915	18, 58 581, 20 660, 95 227, 75 81: 59, 29: 49, 91:	0 0 0 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992 59, 271 49, 915 0 0 0	60. 01 65. 00 66. 00 67. 00 68. 00 71. 00 72. 00 73. 00 76. 01 88. 00 89. 00 99. 10 109. 00 110. 00 111. 00 113. 00 119. 00 190. 00 192. 00
60. 01	0 7, 851 521, 498 600, 262 200, 358 398 0 0 0 54, 309 0 0 0 0 0 4, 835, 350	0 10, 730 59, 707 60, 689 27, 393 417 0 0 4, 989 49, 915 0 0 0 0 0 4, 166, 664	18, 58 581, 20 660, 95 227, 75 81: 59, 29: 49, 91:	0 0 0 0 1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992 59, 271 49, 915 0 0 0 0 0 8, 884, 850	60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 73. 00 76. 01 88. 00 89. 00 99. 10 109. 00 110. 00 111. 00 113. 00 118. 00 190. 00 192. 00 194. 00
60. 01   06001   BLOOD LABORATORY   65. 00   06500   RESPIRATORY THERAPY   66. 00   06600   PHYSI CAL THERAPY   67. 00   06700   OCCUPATI ONAL THERAPY   68. 00   06800   SPEECH PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   73. 00   07300   DRUGS CHARGED TO PATIENTS   76. 00   03020   PATIENTS   76. 01   03021   HEMODI ALYSIS & OTHER ANCILLARY   0UTPATIENT SERVICE COST CENTERS   88. 00   08800   RURAL HEALTH CLINIC   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0THER REI MBURSABLE COST CENTERS   99. 10   09910   CORF   SPECIAL PURPOSE COST CENTERS   109. 00   10900   PANCREAS ACQUI SITION   111. 00   11100   INTESTINAL ACQUISITION   113. 00   11300   INTEREST EXPENSE   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   192. 00   19200   PHYSICIANS' PRIVATE OFFICES	0 7, 851 521, 498 600, 262 200, 358 398 0 0 0 54, 309 0 0 0 0 0 4, 835, 350	0 10, 730 59, 707 60, 689 27, 393 417 0 0 4, 989 49, 915 0 0 0 0 0 4, 166, 664	18, 58 581, 20 660, 95 227, 75 81 59, 29 49, 91	0	0 8, 535 580, 893 660, 951 227, 751 815 15, 227 0 219, 992 59, 271 49, 915 0 0 0 0 0 8, 884, 850	60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 73. 00 76. 00 89. 00 99. 10 109. 00 110. 00 111. 00 111. 00 118. 00 190. 00 192. 00 194. 00 194. 01

Health Financial Systems REHA	BILITATION HOSE	PITAL OF FT WAY	YNE	In Lieu	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der	CCN: 153030	Peri od:	Worksheet A	
				From 10/01/2013 To 09/30/2014	Date/Time Pre	nared:
				10 09/30/2014	2/24/2015 3:4	
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For				
		Allocation				
	6. 00	7. 00				
GENERAL SERVICE COST CENTERS			1			
1. 00   00100   NEW CAP REL COSTS-BLDG & FIXT	101, 587	l '	1			1.00
2. 00   00200   NEW CAP REL COSTS-MVBLE EQUIP	125, 966	l ·	1			2.00
3. 00   00300   OTHER CAPITAL RELATED COSTS	0	0	1			3.00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT	-3, 181	963, 241				4.00
5.01	-100, 648		1			5. 01 5. 02
7.00   OO700   OPERATION OF PLANT	128, 378 -4, 874	976, 983 571, 310	1			7.00
8.00   00800   LAUNDRY & LINEN SERVICE	8, 374	41, 265				8.00
9. 00   00900   HOUSEKEEPI NG	0, 374	101, 456	1			9.00
10. 00   01000 DI ETARY	0	169, 948	1			10.00
11. 00 01100 CAFETERI A	-69, 881	215, 696	1			11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	07,001	243, 195	1			13.00
14. 00 01400 CENTRAL SERVICE & SUPPLY	-14, 994	39, 630	1			14.00
15. 00 01500 PHARMACY	0	100, 818				15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	-748	1				16.00
17. 00 01700 SOCIAL SERVICE	0					17.00
INPATIENT ROUTINE SERVICE COST CENTERS			'			
30. 00 03000 ADULTS & PEDIATRICS	-269, 717	1, 997, 292				30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	)			31.00
32.00 03200 CORONARY CARE UNIT	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   SUBPROVI DER - I RF	0	0				41.00
42. 00   04200   SUBPROVI DER	0	0	)			42.00
43. 00 04300 NURSERY	0	0				43.00
ANCILLARY SERVICE COST CENTERS	1		1			
54. 00   05400   RADI OLOGY-DI AGNOSTI C	-12	33, 115	1			54.00
57. 00 05700 CT SCAN	0	0	1			57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON 60. 00   06000   LABORATORY	0	59, 586	1			59. 00 60. 00
60. 01   06001   BLOOD LABORATORY	0	39, 380	1			60.00
65. 00   06500   RESPI RATORY   THERAPY	0	8, 535				65.00
66. 00   06600   PHYSI CAL THERAPY	0	1	1			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	660, 951	1			67.00
68. 00 06800 SPEECH PATHOLOGY	0	227, 751	1			68.00
69. 00 06900 ELECTROCARDI OLOGY	0	815	1			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15, 227	1			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	219, 992				73.00
76. 00 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	59, 271				76.00
76.01 03021 HEMODIALYSIS & OTHER ANCILLARY	0	49, 915				76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	)			89. 00
OTHER REIMBURSABLE COST CENTERS						1
99. 10   09910   CORF	0	0				99. 10
SPECIAL PURPOSE COST CENTERS						
109. 00 10900 PANCREAS ACQUISITION	0	0	1			109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	l	1			110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	1			111.00
113. 00 11300 INTEREST EXPENSE	0	0 705 400	1			113.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	-99, 750	8, 785, 100	1			118.00
NONREI MBURSABLE COST CENTERS			ı			100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	l				190. 00 192. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES 194.00 07950 MARKETING/PUBLIC RELATIONS	0	1				194.00
194.01 07950 MARKETING/PUBLIC RELATIONS	0	117, 250				194.00
200. 00 TOTAL (SUM OF LINES 118-199)	-99, 750	1	1			200.00
	,,,,50	1 2,700,000	1			,_00.00

Health Financial Systems RECLASSIFICATIONS REHABILITATION HOSPITAL OF FT WAYNE

Provider CCN: 153030 Peri od: Worksheet A-6
From 10/01/2013
To 09/30/2014 Date/Time Prepared: 2/24/2015 3:47 pm

					2/24	1/2015 3:47 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - EMPLOYEE BENEFITS					
. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	824, 447		1.0
. 00		0. 00	0	0		2.0
. 00		0. 00	0	0		3.0
. 00		0.00	0_	0		4.0
	0		0	824, 447		
	B - RENTAL AND LEASE					
. 00	NEW CAP REL COSTS-MVBLE	2. 00	0	71, 531		1.0
	EQUI P					
. 00		0. 00	0	0		2.0
. 00		0. 00	0	0		3.0
. 00		0. 00	0	0		4.0
. 00		0. 00	0	0		6.0
. 00		0. 00	0	0		7.0
. 00		0.00	0	0		8. 0
. 00		0.00	0	0		9. (
0. 00		0. 00	0	0		10.0
1. 00		0. 00	0	0		11. (
2. 00		0. 00	0	0		12. (
3. 00		0. 00	0	0		13.0
5. 00		0. 00	0	0		15.0
6. 00		0.00	0	0		16.0
	0		0	71, 531		
	C - OTHER CAPITAL COSTS					
. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	15, 187		1.0
00	FIXT NEW CAP REL COSTS-BLDG &	1. 00	0	201 754		2.0
. 00		1.00	U	201, 754		2.0
	FIXT	+		21 <del>6</del> , 941		
	D - MARKETING		U	210, 941		
00	MARKETING MARKETING	194, 00	86, 912	30, 338		1. (
00	O RELATIONS		86, 912	3 <u>0, 336</u> 30, 338		1. (
	E - MEDICAL SUPPLIES		00, 912	30, 330		
00	MEDICAL SUPPLIES CHARGED TO	71, 00	0	14, 009		1. (
00	PATIENTS	71.00	۷	14, 009		1. (
	[FATI LINIS — — — — —	+		<sub>14,009</sub>		
	F - PHYSICIAN DIRECTORS		<u> </u>	14,007		
00	ADULTS & PEDIATRICS	30.00	0	404, 564		1.0
00	ADULIS & PEDIATRICS	— <u>30.</u> 00	— — — }	404, 564		1. (
	G - DRUGS CHARGED TO PATIENTS		U	404, 564		
. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	219, 992		1. (
UU	DRUGS CHARGED TO PATTENTS			21 <u>9, 9</u> 9 <u>2</u> 219, 992		1.0
	H - DIETARY		U	219, 992		
00		11 00	166 020	110 / 40		1 /
00	CAFETERI A		166, 928	118, 649		1. (
	U OVVCEN COSTS		166, 928	118, 649		
00	I - OXYGEN COSTS	74 00		1 010		
00	MEDICAL SUPPLIES CHARGED TO	71. 00	이	1, 218		1.0
	PATIENTS	+	+			
20.00	TOTALS		0	1, 218		
UU. UU	Grand Total: Increases		253, 840	1, 901, 689		500.0

	Financial Systems	REHABI	LITATION HOSP				of Form CMS-255	52-10
RECLAS	SI FI CATI ONS			Provi der		Peri od:	Worksheet A-6	
						From 10/01/2013 To 09/30/2014	Date/Time Prepar	red:
							2/24/2015 3:47 p	pm
	Cook Cooker	Decreases	Callarin	0+1	W+ A 7 D-E	I		
	Cost Center 6.00	Li ne # 7.00	Sal ary 8. 00	0ther W 9.00	Vkst. A-7 Ref. 10.00	-		
	A - EMPLOYEE BENEFITS	7.00	8.00	9.00	10.00			
1. 00	OTHER ADMINISTRATIVE AND	5. 02	0	824, 178	C			1. 00
1.00	GENERAL	0. 02	Ĭ	021, 170	Č			1.00
2.00	OPERATION OF PLANT	7. 00	О	53	C		1 :	2.00
3.00	HOUSEKEEPI NG	9. 00	0	55	C			3.00
4.00	ADULTS & PEDIATRICS	30.00	o	161	C		1	4.00
	0			824, 447				
	B - RENTAL AND LEASE							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	251	9	l .	1	1.00
2.00	ADMI TTI NG	5. 01	0	221	C	l .	1	2.00
3. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 02	0	4, 130	C			3.00
4. 00	OPERATION OF PLANT	7. 00	o	3, 014	C			4. 00
6. 00	DI ETARY	10.00	o	124	C	l .		6. 00
7. 00	NURSING ADMINISTRATION	13. 00	o	154	C	l .		7.00
8. 00	CENTRAL SERVICE & SUPPLY	14. 00	o	48, 583	C	l .		8.00
9. 00	PHARMACY	15. 00	o	2, 877	C	l .		9. 00
10.00	MEDICAL RECORDS & LIBRARY	16. 00	o	2, 667	C	l .		0.00
11. 00	ADULTS & PEDIATRICS	30. 00	o	257	C	l .		1.00
12.00	RESPI RATORY THERAPY	65. 00	o	8, 828	C	l .		2. 00
13. 00	PHYSI CAL THERAPY	66. 00	o	312	C	l .		3. 00
15.00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 00	0	27	C			5.00
	SERVI CES							
16.00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0	86	0		16	6.00
	0		0	71, 531				
	C - OTHER CAPITAL COSTS					.1		
1. 00	OTHER ADMINISTRATIVE AND	5. 02	0	15, 187	12	2		1.00
2 00	GENERAL	F 02		201 754	10	,		2 00
2. 00	OTHER ADMINISTRATIVE AND	5. 02	0	201, 754	13		4	2.00
	GENERAL			216, 941		+		
	D - MARKETING		U <sub>I</sub>	210, 741				
1. 00	OTHER ADMINISTRATIVE AND	5. 02	86, 912	30, 338	C			1.00
00	GENERAL	0.02	33,7.2	00, 000	· ·			
	0		86, 912	30, 338		1		
	E - MEDICAL SUPPLIES							
1.00	CENTRAL SERVICE & SUPPLY	14. 00	0	14, 009	C			1.00
	0		0	14, 009				
	F - PHYSICIAN DIRECTORS							
1.00	OTHER ADMINISTRATIVE AND	5. 02	0	404, 564	C	)		1.00
	GENERAL			+		1		
	0		0	404, 564				
	G - DRUGS CHARGED TO PATIENTS					.1		
1. 00	PHARMACY	1500	0	219, 992	0	0		1.00
	U DI ETARY		0	219, 992				
1 00	H - DIETARY	10.00	144 020	110 (40		\		1 00
1. 00	DI ETARY	1000	16 <u>6, 928</u> 166, 928	11 <u>8, 6</u> 49_ 118, 649	0	1		1.00
	I - OXYGEN COSTS		100, 928	118, 049				
1. 00	RESPIRATORY THERAPY	65. 00	٥	1, 218		N		1. 00
1.00	TOTALS		0			<u>'</u>		1.00
500 00	Grand Total: Decreases		253, 840	1, 901, 689		†	500	0.00
500.00	prana rotar. Decreases	1	255, 040	1, 701, 009		I	1 300	5.00

HIT designated Assets

10.00 Total (line 8 minus line 9)

Reconciling Items

Subtotal (sum of lines 1-7)

7.00

8.00

9.00

7.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 153030 Peri od: Worksheet A-7 From 10/01/2013 Part I Date/Time Prepared: 09/30/2014 2/24/2015 3:47 pm Acqui si ti ons Begi nni ng Purchases Total Disposals and Donati on Bal ances Retirements 2.00 3.00 4.00 5.00 1.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 900, 000 1.00 Land 0 0 0 260, 000 2.00 Land Improvements 16, 744 16, 744 0 2.00 3.00 206, 200 3.00 Buildings and Fixtures 11, 825, 612 206, 200 190, 547 0 4.00 Building Improvements 476, 439 194, 231 194, 231 11, 464 4.00 Fi xed Equi pment 0 5.00 0 0 5.00 0 6.00 Movable Equipment 0 6.00 O Ω 0 0 7.00 HIT designated Assets 8, 135 0 7.00 8.00 Subtotal (sum of lines 1-7) 13, 470, 186 417, 175 0 417, 175 202, 011 8.00 9.00 Reconciling Items 0 9.00 0 Total (line 8 minus line 9) 13, 470, 186 417, 175 202, 011 417 175 10.00 0 10.00 Endi ng Ful I y Bal ance Depreciated Assets 6. 00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 900,000 0 1.00 2.00 276, 744 0 2.00 Land Improvements 11, 841, 265 3.00 Buildings and Fixtures 0 3.00 4.00 Building Improvements 659, 206 0 4.00 5.00 Fixed Equipment 0 5.00 0 Movable Equipment 0 6.00 6.00 0

8, 135

13, 685, 350

13, 685, 350

0

0

0

0

Не	alth Financial Systems	EHABILITATION HOS	BILITATION HOSPITAL OF FT WAYNE			In Lieu of Form CMS-2552-10			
	CONCILIATION OF CAPITAL COSTS CENTERS		Provi der CCN: 153030		Period:   Worksheet F   From 10/01/2013   Part II   To 09/30/2014   Date/Time F		pared:		
SUMMARY OF CAPITAL					2/24/2015 3: 4	7 pm			
	Cost Center Description	Depreci ati on	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)			
		9. 00	10. 00	11.00	12.00	13.00			
	PART II - RECONCILIATION OF AMOUNTS FROM	WORKSHEET A, COLUI	MN 2, LINES 1 a	and 2					
1.	OO NEW CAP REL COSTS-BLDG & FIXT	280, 649	0		0 0	0	1.00		
2.	OO NEW CAP REL COSTS-MVBLE EQUIP	135, 933	0		0 0	0	2.00		
3.	00 Total (sum of lines 1-2)	416, 582	0		0 0	0	3.00		
		SUMMARY O	F CAPITAL						
	Cost Center Description	Other	Total (1)						
		Capi tal -Rel at	•						
		ed Costs (see	9 through 14)						

Heal th	Financial Systems REHA	BILITATION HOSI	PITAL OF FT WAY	YNE	In Lie	u of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	F	Period: From 10/01/2013 To 09/30/2014	Worksheet A-7 Part III Date/Time Pre 2/24/2015 3:4	pared:
		COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	DADT III DECONOLILATION OF CARLEY COOTS	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C NEW CAP REL COSTS-BLDG & FIXT	ENTERS			1, 000000		1 00
2.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		0.000000		1. 00 2. 00
3. 00	Total (sum of lines 1-2)	0	0		1. 000000		3.00
3.00	Total (Suil Of Titles 1-2)	ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL		F CAPITAL	3.00
	Cost Center Description	Taxes	Other Capi tal -Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		•			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	C	278, 781	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	C	333, 430	0	2.00
3. 00	Total (sum of lines 1-2)	0		C	612, 211	0	3.00
			Sl	JMMARY OF CAPI	ΓAL		
	Cost Center Description	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11. 00	12. 00	13. 00	14.00	15. 00	
	DADT III DECONCLILATION OF CADITAL COSTS C	ENTERC					1

103, 455

103, 455

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

15, 187

15, 187

201, 754

201, 754

0 0 0

599, 177 1. 00 333, 430 2. 00 932, 607 3. 00

1.00

2. 00

3.00 Total (sum of lines 1-2)

	Financial Systems MENTS TO EXPENSES	REHAE	BILITATION HOSPITAL	OF FT WAYNE Provider CCN: 153030	In Lie	u of Form CMS-2 Worksheet A-8	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					From 10/01/2013	Date/Time Pre	pared:
				xpense Classification of rom Which the Amount is		2/24/2015 3: 4	/ pili
			107 F	Tolli will cit the Allouit 1:	s to be Aujusteu		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		(2) 1. 00	2. 00	3. 00	4.00	5. 00	
1. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter		ONEW FIXT	CAP REL COSTS-BLDG &	1.00	0	1. 00
2. 00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		O NEW EQUI	CAP REL COSTS-MVBLE P	2. 00	0	2. 00
3. 00	2) Investment income - other		o		0. 00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		o		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		o		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service (chapter 21)		О		0. 00	0	8. 00
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -269, 717		0. 00	0 0	
11. 00	Sale of scrap, waste, etc. (chapter 23)	В	-12 RADI	OLOGY-DI AGNOSTI C	54.00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	279, 370			0	12. 00
13. 00 14. 00	Laundry and linen service	D	0 -69, 881 CAFE	TEDLA	0. 00 11. 00	0	
15. 00	Rental of quarters to employee and others	B B	-10, 433 NEW	CAP REL COSTS-BLDG &	1.00	9	
16. 00	Sale of medical and surgical supplies to other than		O FI XT		0.00	0	16. 00
17. 00	Sale of drugs to other than		О		0.00	0	17. 00
18. 00	patients Sale of medical records and	В	-748 MEDI	CAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		О		0.00	0	19. 00
20. 00	books, etc.) Vendi ng machi nes	В		R ADMINISTRATIVE AND	5. 02	0	20. 00
21. 00	· ·		GENE O	RAL	0.00	0	21. 00
22. 00	interest, finance or penalty charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0 RESP	RATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	O PHYS	I CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14)		0 ***	Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL	А	4, 647 NEW	CAP REL COSTS-BLDG &	1.00	9	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL	А	FI XT 99, 853 NEW	CAP REL COSTS-MVBLE	2. 00	9	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		EQUI O***	P Cost Center Deleted ***	19.00		28. 00
29. 00 30. 00	Physicians' assistant	A-8-3	0	PATIONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		OADUL	TS & PEDIATRICS	30.00		30. 99

In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provi der CCN: 153030 Peri od: Worksheet A-8 From 10/01/2013 09/30/2014 Date/Time Prepared: 2/24/2015 3:47 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1. 00 2.00 3.00 4.00 5.00 31.00 Adjustment for speech A-8-3 O SPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 32.00 0 0.00 Depreciation and Interest 33.00 0.00 33.00 33. 01 MISCELANEOUS INCOME -340 OTHER ADMINISTRATIVE AND 33.01 В 5.02 GENERAL BAD DEBT EXPENSE 33.02 Α -97, 258 ADMI TTI NG 5.01 33.02 33.03 PATIENT TELEPHONE EXPENSE -16, 969 OTHER ADMINISTRATIVE AND 5.02 33.03 GENERAL PATIENT TELEPHONE EXPENSE -3, 181 EMPLOYEE BENEFITS DEPARTMENT 33.04 4.00 33.04 Α PATIENT PHONE AND TV -3, 464 NEW CAP REL COSTS-MVBLE 33.05 Α 2.00 33.05 DEPRECIATION EX EQUI P 33.06 PATIENT TV CABLE EXPENSE Α -4,874 OPERATION OF PLANT 7.00 33.06 CHARITABLE CONTRIBUTIONS -6, 000 OTHER ADMINISTRATIVE AND 33.07 5.02 33.07 GENERAL 33.08 0.00 33.08 0 0 33.09 LOBBYING EXPENSE IN Α -728 OTHER ADMINISTRATIVE AND 5. 02 33.09 ASSOCIATION DUES GENERAL

-99, 750

50.00

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

50.00

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

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

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provi der CCN: 153030

Worksheet A-8-1

144, 896

424, 266

5.00

From 10/01/2013 09/30/2014 Date/Time Prepared: 2/24/2015 3:47 pm Li ne No. Cost Center Expense Items Amount of Amount Allowable Cost Included in Wks. A, column 5. 00 1.00 2.00 3.00 4 00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS 1.00|NEW CAP REL COSTS-BLDG & FIX|DIRECT ALLOCATION - INTEREST 1.00|NEW CAP REL COSTS-BLDG & FIX|PASI CAPITAL COSTS - BLDG & 1.00 103, 455 1.00 2.00 0 241 2.00 1.00 NEW CAP REL COSTS-BLDG & FIX BUILDING AND FIXTURES 0 3.00 3,677 3.00 4.00 2.00 NEW CAP REL COSTS-MVBLE EQUI MOVABLE EQUI PMENT 0 29, 456 4.00 5. 02 OTHER ADMINISTRATIVE AND GEN HOME OFFICE 4.01 223, 856 0 4.01 5. 02 OTHER ADMINISTRATIVE AND GEN MALPRACTICE ALLOCATIONS 4.02 18, 320 89, 746 4.02 4.03 8.00 LAUNDRY & LINEN SERVICE HOSPITAL LAUNDRY SERVICE 40, 788 32.414 4.03 4.04 2. 00 NEW CAP REL COSTS-MVBLE EQUI PASI CAPITAL COSTS - MOVEABL 121 0 4.04 PASI OPERATING COSTS 4.05 5. 01 ADMITTING 4 05 4, 352 Ω 4.06 5. 01 ADMI TTI NG PASI COLLECTION FEES 5, 292 4.06 4.07 5. 01 ADMITTING EBOS FEES 77 4.07 4.08 5. 01 ADMITTING PASI LIEN UNIT COLLECTION FE 4.08 C 2.373 14.00 CENTRAL SERVICE & SUPPLY HOSPITAL LAUNDRY SERVICE 14.994 4.09 4.09

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 RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6. 00	В		O. OO COMMUNITY HEALT	100.00	6.00
7.00	В		O. OO LUTHERAN	0.00	7. 00
8.00	G	HOSPI TAL LAUNDR	O. OO 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 organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.

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

5.00

Health Financial Systems	REHABILITATION HOSPITAL	OF FT WAYNE	In Lieu of Form CMS-2552-1			
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 153030 Period: Worksheet A-8-1 From 10/01/2013						
OFFICE COSTS				Date/Time Prepared:		
				2/24/2015 3:47 pm		
Net Wkst. A-7 Ref.						
Adiustments						

-					
			Wkst. A-7 Ref.		
		Adjustments			
		(col. 4 minus			
		col. 5)*			
		6. 00	7. 00		
		A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME	
		OFFICE COSTS:			
	1. 00	103, 455	11		1.00
	2. 00	241	9		2. 00
	3. 00	3, 677	9		3.00
	4. 00	29, 456	9		4.00
	4. 01	223, 856	0		4. 01
	4. 02	-71, 426			4. 02
	4. 03	8, 374			4. 03
	4. 04	121			4.04
	4. 05	4, 352			4. 05
	4. 06	-5, 292	0		4.06
	4. 07	-77	0		4. 07
	4. 08	-2, 373	0		4. 08
	4. 09	-14, 994			4. 09
	5. 00	279, 370	1		5.00
-		•		·	•

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

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

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

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

6. 00	HEALTHCARE	6.00
7. 00	HOSPI TAL	7.00
8.00	CONSOL LAUNDRY	8.00
	DEBT COLLECTION	9.00
10. 00 100. 00		10.00
100.00		100.00

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

					'	09/30/2012	2/24/2015 3:4	
	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	
				·	·		Hours	
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	30. 00	ADULTS & PEDIATRICS	278, 589	253, 646	24, 943	136, 700	135	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4. 00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9. 00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			278, 589		24, 943			200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &	Component	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	8, 872	444		0	0	
2. 00	0.00		0	Ĭ	_	0	0	
3. 00	0.00		0	0	0	0	0	
4. 00	0.00		0	0	0	0	0	
5. 00	0.00		0	0	0	0	0	
6. 00	0.00		0	0	0	0	0	
7. 00	0.00		0	0	0	0	0	
8. 00	0.00		0	0	0	0	0	8.00
9. 00	0.00		0	0	0	0	0	
10.00	0. 00		0	0	0	0	0	10.00
200.00	MI+ A I : //	C+ C+ (Db	8, 872		RCE	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE		Adjustment		
		l denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1.00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	13.00			269, 717		1.00
2. 00	0.00	ABOLIO A TEBININI OS	0	0,0,2	1	207,717		2.00
3. 00	0.00		0	١	_	0		3.00
4. 00	0.00		0	0	o o	0		4. 00
5. 00	0.00		0	0	o o	0		5. 00
6. 00	0.00		1 0	l	n	l n		6. 00
7. 00	0.00		0	0	0	0		7. 00
8. 00	0.00		0	l	Ö	Ö		8. 00
9. 00	0.00		0	l	Ö	Ö		9. 00
10.00	0.00		O	Ö	0	Ö		10.00
200.00			Ö		16, 071	269, 717		200.00
			•			•	1	1

0 201.00

413, 528 202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 153030 Peri od: Worksheet B From 10/01/2013 Part I Date/Time Prepared: 09/30/2014 2/24/2015 3:47 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses NEW BLDG & NEW MVBLE **EMPLOYEE** ADMITTI NG for Cost FIXT **FOULP BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 0 1.00 2.00 4. 00 5. 01 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 599, 177 599, 177 1 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 333, 430 2.00 333, 430 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 963, 241 967, 314 4.00 4.00 2.417 1.656 58, 978 00570 ADMITTING 8, 531 5.01 333, 569 12, 450 413, 528 5.01 5.02 00561 OTHER ADMINISTRATIVE AND GENERAL 976, 983 47, 157 32, 314 72, 320 0 5.02 7.00 00700 OPERATION OF PLANT 571, 310 109, 763 75, 215 37, 934 0 7.00 00800 LAUNDRY & LINEN SERVICE 41, 265 8 00 0 0 8 00 00900 HOUSEKEEPI NG 9.00 101, 456 11,858 8, 126 16, 302 0 9.00 10.00 01000 DI ETARY 169, 948 20, 375 0 10.00 11.00 01100 CAFETERI A 215, 696 45, 815 31, 395 34, 213 0 11.00 01300 NURSING ADMINISTRATION 45, 953 243 195 1, 283 879 13 00 13 00 0 14.00 01400 CENTRAL SERVICE & SUPPLY 39,630 9,056 6, 206 1, 108 0 14.00 01500 PHARMACY 100, 818 3, 838 2,630 18, 292 0 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 4, 400 3,015 30, 015 16.00 16,00 182, 039 0 01700 SOCIAL SERVICE 1, 954 17.00 2,851 Ω 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 997, 292 76, 289 52, 277 323, 836 145, 103 30.00 03100 INTENSIVE CARE UNIT 31 00 0 0 31 00 03200 CORONARY CARE UNIT 32.00 0 C 0 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 ol 0 34.00 04100 SUBPROVIDER - LRE 0 0 0 41 00 41 00 0 0 04200 SUBPROVI DER 42.00 0 C 0 0 0 42.00 04300 NURSERY 43.00 0 0 43.00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 2.907 54.00 33, 115 4.242 634 10, 621 57.00 05700 CT SCAN 57.00 0 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 0 0 0 0 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 0 0 0 0 06000 LABORATORY 60 00 59.586 r 0 5.707 14.334 60 00 06001 BLOOD LABORATORY 60.01 60.01 06500 RESPIRATORY THERAPY 65.00 8, 535 987 676 1,609 2,622 65.00 06600 PHYSI CAL THERAPY 106, 883 580, 893 99. 552 66.00 68.218 70, 183 66,00 06700 OCCUPATI ONAL THERAPY 46, 999 67.00 660, 951 32, 206 123, 026 73, 577 67.00 227, 751 41, 064 26, 948 68.00 06800 SPEECH PATHOLOGY 3, 561 2,440 68.00 69.00 06900 ELECTROCARDI OLOGY 815 69.00 0 82 653 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 10, 019 71.00 71 00 15, 227 C 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 219, 992 48, 826 73.00 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 11, 131 7,005 76.00 59.271 4.065 2.785 76.00 03021 HEMODIALYSIS & OTHER ANCILLARY 76.01 49, 915 C 0 0 3, 637 76.01 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 n 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 Ω 0 0 89.00 OTHER REIMBURSABLE COST CENTERS 09910 CORF 0 0 0 0 0 99.10 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 Ω 0 0 0 109, 00 110.00 11000 INTESTINAL ACQUISITION 0 C 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1-117) 949, 462 118.00 8, 785, 100 486, 583 333, 430 413, 528 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 0 0 0 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192, 00 4 488 0 39 0 194. 00 07950 MARKETI NG/PUBLI C RELATIONS 0 117, 250 17, 813 0 194.00 194. 01 07951 TENANT LEASED SPACE 112, 594 0 0 194. 01 200.00 Cross Foot Adjustments 200.00

8, 906, 838

599, 177

333, 430

967, 314

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118-201)

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

| Peri od: | Worksheet B | From 10/01/2013 | Part | To 09/30/2014 | Date/Time Prepared:

COST Center Description					1	0 09/30/2014	2/24/2015 3:4	
SENDRAL SERVICE COST CONTERS   SA. Ol   5.02   7.00   8.00   9.00		Cost Center Description	Subtotal	OTHER	OPERATION OF	LAUNDRY &		, p
GENERAL SERVICE COST CENTERS					PLANT	LINEN SERVICE		
ERRERAL SERVICE COST CENTERS 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.0			54.04		7.00	0.00	0.00	
0.00   0.00		CENEDAL CEDVICE COCT CENTEDO	5A. 01	5.02	7.00	8.00	9.00	
2.00	1 00				1			1 00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT								ł
5.01   ODS/O JADMITTING   1.728, 774   1,128, 774   1,128, 774   7,00   0.00								ł
5. 02 00661 [OTHER ADM IN STRATIVE AND GENERAL 7.128, 774 1.228, 774 1.70. 00700 [OPERATION DEPLANT] 7.94, 222 115, 260 999, 482 8.00 0800 [LAUNRIN & LI NEN SERVICE 41.265 5.989 0.0 47, 254 0.0 180, 00 0000 [OPERATION DEPLANT] 7.94, 222 1.99. 900 25, 234 0.0 182, 966 9.0 0.0 0000 [OPERATION DEPLANT] 7.90. 900 25, 234 0.0 180, 00 00 00 00 00 00 00 00 00 00 00 00 0		l l						ł
7.00 00700 (DPERATION OF PLANT 794, 222 1115, 260 909, 482 7, 580 90 0 47, 254 182, 966 9.00 9000 (LAURORY & LINEW SERVICE 41, 265 5, 969 0 47, 254 0 182, 966 9.00 9000 (HOUSEKEEPING 137, 742 19, 990 25, 234 0 182, 966 9.00 10.00 10.00 1000 (DETARRY ) 100, 232 27, 620 0 0 0 0, 01.00 10.00 11.00 (DETARRY ) 100, 232 27, 620 0 0 0 0, 01.00 10.00 11.00 (DETARRY ) 100, 232 27, 620 0 0 0 0, 01.00 10.00 11.00 (DETARRY ) 100, 232 27, 620 0 0 0 0, 01.00 10.00 11.00 (DETARRY ) 100, 232 27, 620 0 0 0 0, 01.00 10.00 11.00 (DETARRY SERVICE & SUPPLY ) 50, 600 0 42, 27 2, 29 2 0 0 27, 671 11.00 11.00 11.00 (DETARRY & SUPPLY ) 50, 600 0 12.00 11.00 11.00 11.00 (DETARRY & SUPPLY ) 50, 600 0 12.00 11.00 11.00 11.00 11.00 11.00 (DETARRA SERVICE & SUPPLY ) 50, 600 0 150.00 (PARRAGEY ) 125, 578 18, 224 8, 164 0 2, 318 15, 00 17.00 11.00 11.00 (DETARRA SERVICE COST CENTERS ) 1.00 11.00		l l	1, 128, 774	1, 128, 774				ł
9.00 00000 HOUSEKEEPING 137, 742 19, 900 25, 234 0 182, 966 9.00 10.00 10.00 10.00 DITARY 190, 323 27, 620 0 0 0 0 10.00 10.00 11.00 01100 CAFETERI A 327, 119 47, 472 97, 494 0 27, 671 11.00 11.00 01100 CAFETERI A 327, 119 47, 472 97, 494 0 27, 671 11.00 11.00 01100 CAFETERI A 327, 119 47, 472 97, 494 0 27, 671 11.00 11.00 01100 CAFETERI A 120, 119, 119, 119, 119, 119, 119, 119, 11	7.00							7.00
10.00   01000   DIETARY   190, 323   277, 620   0   0   0   10.00	8.00	00800 LAUNDRY & LINEN SERVICE	41, 265	5, 989	0	47, 254		8.00
11.00   01100   CAFETERI A   327, 119   47, 472   97, 494   0   27, 671   11, 00   13.00   13.00   01300   NURSI NG ADMIN INTERATION   291, 310   42, 276   2, 729   0   775   13.00   14.00   14.00   CENTRAL SERVI CE & SUPPLY   56, 000   8, 127   19, 272   0   5, 470   14.00   16.00   1000   PHARMACY   219, 578   18, 224   8, 166   0   2, 318   15.00   16.00   1000   PHARMACY   219, 469   31, 850   9, 36.3   0   2, 657   16.00   16.00   MEDI CAL RECORDS & LIBRARY   219, 469   31, 850   69, 70   6, 607   0   1, 722   17.00   17.	9.00	00900 HOUSEKEEPI NG	137, 742	19, 990	25, 234	0	182, 966	9. 00
13.00   01300 NURSING ADMINISTRATION   291, 310   42, 276   2, 779   0   7.75   13.00						0	0	ł
14 00   01400  CENTRAL SERVICE & SUPPLY   56,000   8,127   19,272   0   5,470   14,000   16.00   01500  MEDICAL RECORDS & LIBRARY   219,469   31,850   9,363   0   2,687   16.00   17.72   17.00   17.00   17.00   01700  SOCI AL SERVICE COST CENTERS   18,244   8,66   0   0   1,722   17.00   17.00   17.00   01700  ADULTS & PEDIA PRICE COST CENTERS   18,244   8,66   0   0   1,722   17.00   17.00   01700  ADULTS & PEDIA PRICE COST CENTERS   18,245   18,260   0   0   0   0   0   0   0   0   0							l .	ı
15. 00   01500   PHARMACY   129, 469   31, 8204   8, 166   0   2, 318   15. 00   17. 00   01700   SOCI AL SERVICE   COST CENTERS							1	ı
16. 00   01400   MEDICAL RECORDS & LIBRARY   219, 469   31, 850   9, 363   0   2, 657   10, 00   1700   1700   1700   0300   0							l .	ı
17. 00   01700  SOCIAL SERVICE COST CENTERS								•
INPATIENT ROUTINE SERVICE COST CENTERS								1
30.00   0300	17.00		4, 603	097	0,007	0	1,722	17.00
131.00	30 00		2 594 797	376 560	162 343	25 932	46 077	30 00
32.00   03200   03200   03700   03700   0   0   0   0   0   0   33.00     33.00   03400   03400   03400   00   0   0   0   0   0   0   0   0			1	0,000		0		•
33.00   03300   03300   03300   0340				Ō	o	0	l	•
41.00   04100   SUBPROVIDER - IRF   0 0 0 0 0 0 0 0 0 0 24.00   42.00   04200   04200   04200   043.00   043.00   043.00   43.00   04300   NURSERY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33.00		C	0	0	0	0	33.00
42.00   04200   SUBPROVIDER	34.00	03400 SURGICAL INTENSIVE CARE UNIT	C	0	0	0	0	34.00
43. 00   04300   NURSERY   0   0   0   0   0   0   0   3. 00	41.00		C	0	0	0	0	41.00
ANCILLARY SERVICE COST CENTERS			C	0	0	0		
S4.00	43.00		C	0	0	0	0	43.00
57.00   05700   CT SCAN   0   0   0   0   0   0   0   57.00			T			_		
58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0   0   0   0   0   0   59.00   69. 00   05900   CARDIAC CATHETERIZATION   0   0   0   0   0   0   0   60. 01   06000   LABORATORY   79, 627   11, 556   0   0   0   0   0   60. 01   06001   BLOOD LABORATORY   79, 627   11, 556   0   0   0   0   0   60. 01   06000   LABORATORY   14, 429   2, 094   2, 099   0   596   65.00   66. 00   066500   RESPI RATORY THERAPY   14, 429   2, 094   2, 099   0   596   65.00   66. 00   06600   PHYSI CAL THERAPY   926, 759   134, 345   211, 846   10, 112   60, 126   66, 00   67. 00   06700   OCCUPATIONAL THERAPY   936, 759   135, 945   100, 013   11, 210   28, 386   67.00   68. 00   06800   SPEECH PATHOLOGY   301, 764   43, 793   7, 579   0   2, 151   68.00   69. 00   06900   ELECTROCARDIOLOGY   1, 550   225   0   0   0   0   0   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   25, 246   3, 664   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   268, 818   39, 012   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   268, 818   39, 012   0   0   0   0   0   76. 00   03020   PSYCHIATRIC/PSYCHOLOGICAL SERVICES   84, 257   12, 228   8, 649   0   2, 455   76.00   76. 01   03021   HEMODIALYSIS & OTHER ANCILLARY   53, 552   7, 772   0   0   0   0   76. 01   07910   MEDICALLY OUALIFIED HEALTH CENTER   0   0   0   0   0   89. 00   08900   FEDERALLY OUALIFIED HEALTH CENTER   0   0   0   0   0   99. 10   09910   09900   PANCREAS ACQUISITION   0   0   0   0   0   0   111. 00   11100   INTERST INAL ACQUISITION   0   0   0   0   0   0   111. 00   11100   INTEREST INAL ACQUISITION   0   0   0   0   0   0   111. 00   1100   1100   1100   1100   1000   1000   0		· ·	i i		1		i .	1
59, 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0   0   0   0		· ·	•	0		0	<b>l</b>	1
60. 00   06000   LABORATORY   79, 627   11, 556   0   0   0   0   00, 00   60. 01   06000   BLOOD LABORATORY   0   0   0   0   0   0   0   0   65. 00   06500   RESPIRATORY THERAPY   14, 429   2, 094   2, 099   0   596   65. 00   66. 00   06600   PHYSI CAL THERAPY   925, 729   134, 345   211, 846   10, 112   60, 126   66. 00   67. 00   06700   0CCUPATIONAL THERAPY   936, 759   134, 345   211, 846   10, 112   60, 126   66. 00   68. 00   06800   SPEECH PATHOLOGY   301, 764   43, 793   7, 579   0   2, 151   68. 00   69. 00   06900   ELECTROCARDI OLOGY   1, 550   225   0   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   25, 246   3, 664   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   268, 818   39, 012   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   268, 818   39, 012   0   0   0   0   0   0   76. 00   03020   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   84, 257   12, 228   8, 649   0   2, 455   76, 00   76. 01   03021   HEMODI ALYSI S.& OTHER ANCI LLARY   53, 552   7, 772   0   0   0   0   0   0   76. 00   03020   RESPIRATORY THERAPY   53, 552   7, 772   0   0   0   0   0   0   76. 00   00   00   00   0   0   0   0   77. 00   07900   PARCREAD TO PATI ENTS   0   0   0   0   0   0   78. 00   08900   FEDERALLY QUALLI FILE D HEALTH CENTER   0   0   0   0   0   0   0   0   78. 00   07900   PARCREAD SCOULI SITI ON   0   0   0   0   0   0   0   79. 10   09901   CORFE   100   0   0   0   0   0   0   0   79. 10   09901   PARCREAS ACQUI SITI ON   0   0   0   0   0   0   0   79. 00   10000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   0   79. 00   10000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   0   79. 00   10000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   0   79. 00   19000   0   0   0   0   0   0   0   0   0						0		1
60.01   06.001   BLOOD LABORATORY   0 0 0 0 0 0 0 0 0 0 0 60.01   65.00   06500   RESPI RATORY THERAPY   14, 429   2, 094   2, 099   0 0 596   65.00   06600   PHYSI CAL THERAPY   925, 729   134, 345   211, 846   10, 112   60, 126   66.00   06600   PHYSI CAL THERAPY   925, 729   134, 345   211, 846   10, 112   60, 126   66.00   06600   PHYSI CAL THERAPY   936, 759   135, 945   100, 013   11, 210   28, 386   67, 00   67.00   06700   0CCUPATI ONAL THERAPY   936, 759   135, 945   100, 013   11, 210   28, 386   67, 00   68.00   06800   SPEECH PATHOLOGY   301, 764   43, 793   7, 579   0   2, 151   68, 00   69.00   06900   ELECTROCARDI OLOGY   1, 550   225   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   25, 246   3, 664   0   0   0   0   0   0   72.00   07200   IMPL DEV. CHARGED TO PATI ENTS   25, 246   3, 664   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   268, 818   39, 012   0   0   0   0   0   0   74.00   03020   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   84, 257   12, 228   8, 649   0   2, 455   76, 00   76.01   03021   HEMODI ALYSI S & OTHER ANCI LLARY   53, 552   7, 772   0   0   0   0   0   76.01   03021   HEMODI ALYSI S & OTHER ANCI LLARY   53, 552   7, 772   0   0   0   0   89.00   08900   FEDERALLY OUALI FI ED HEALTH CENTER   0   0   0   0   0   0   0   89.00   08900   FEDERALLY OUALI FI ED HEALTH CENTER   0   0   0   0   0   0   0   99.10   09900   PANCREAS ACQUIS IT 10N   0   0   0   0   0   0   0   110.00   11000   INTESTINAL ACQUISITION   0   0   0   0   0   0   0   111.00   11100   SLET ACQUISITION   0   0   0   0   0   0   0   111.00   11100   SLET ACQUISITION   0   0   0   0   0   0   0   111.00   11000   SUBTOTALS (SUM OF LINES 1-117)   8,654,654   1,092,176   669,881   47,254   182,966   118.00   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   0   0   191.00   192.00   19400   00   0   0   0   0   0   0   0   0			70 627	11 556		0		1
65.00   06500   RESPIRATORY THERAPY   14, 429   2, 094   2, 099   0   596   65, 00   66.00   06600   O6600   PHYSI CAL THERAPY   925, 729   134, 345   211, 846   10, 112   60, 126   66, 00   67.00   06700   OCCUPATI ONAL THERAPY   936, 759   135, 945   100, 013   11, 210   28, 386   67, 00   68.00   06800   SPECH PATHOLOGY   301, 764   43, 793   7, 579   0   2, 151   68, 00   69.00   06900   ELECTROCARDI OLOGY   1, 550   225   0   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   25, 246   3, 664   0   0   0   0   0   72.00   07200   IMPL DEV. CHARGED TO PATI ENTS   26, 818   39, 012   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   268, 818   39, 012   0   0   0   0   0   0   76.01   03020   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   84, 257   12, 228   8, 649   0   2, 455   76, 00   76.01   03021   HEMODI ALYSI S & OTHER ANCI LLARY   53, 552   7, 772   0   0   0   0   0   76.01   03020   DRUGS CEST CENTERS    88.00   08800   RURAL HEALTH CLINIC   0   0   0   0   0   0   0   89.00   08800   RURAL HEALTH CLINIC   0   0   0   0   0   0   89.00   09910   CORF    99.10   09910   CORF    109.00   10900   PANCREAS ACQUI SI TI ON   0   0   0   0   0   0   111.00   11100   INTESTI NAL ACQUI SI TI ON   0   0   0   0   0   111.00   11100   INTESTI NAL ACQUI SI TI ON   0   0   0   0   0   111.00   11100   INTESTI NAL ACQUI SI TI ON   0   0   0   0   0   110.00   11000   INTESTI NAL ACQUI SI TI ON   0   0   0   0   0   111.00   11100   SUET ACQUI SI TI ON   0   0   0   0   0   110.00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   110.00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   110.00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   0   110.00   19000   OFFI CENTERS   0   0   0   0   0   0   0   0   110.00   19000   OFFI CENTERS   0   0   0   0   0   0   0   0   110.00   19000   OFFI CENTERS   0   0   0   0   0   0   0   0   0   110.00   19000   OFFI CENTERS   0   0   0   0   0   0   0   0   0   110.00			77,027	11, 550		0		1
66. 00   06600   PHYSI CAL THERAPY   925, 729   134, 345   211, 846   10, 112   60, 126   66, 00   67. 00   06700   0CCUPATI ONAL THERAPY   936, 759   335, 945   100, 013   11, 210   28, 386   67. 00   68. 00   06800   SPEECH PATHOLOGY   301, 764   43, 793   7, 579   0   2, 151   68. 00   69. 00   06900   ELECTROCARDI OLOGY   1, 550   225   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   25, 246   3, 664   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   268, 818   39, 012   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   268, 818   39, 012   0   0   0   0   0   0   76. 00   3020   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   84, 257   12, 228   8, 649   0   2, 455   76. 00   76. 01   03021   HEMODI ALYSIS & OTHER ANCI LLARY   53, 552   7, 772   0   0   0   0   0   0   76. 01   08800   RURAL HEALTH CLINIC   0   0   0   0   0   0   89. 00   89. 00   08800   RURAL HEALTH CLINIC   0   0   0   0   0   0   0   89. 00   99. 10   OTHER REI MBURSABLE COST CENTERS   9910   CORF   SPECIAL PURPOSE COST CENTERS   9910   CORF   SPECIAL PURPOSE COST CENTERS   9910   CORF   SPECIAL PURPOSE COST CENTERS   9910   O   0   0   0   0   0   0   0   0   110. 00   110.00   INTESTI NAL ACQUI SI TI ON   0   0   0   0   0   0   0   0   0			14. 429	2.094	2.099	0		1
67. 00   06700   OCCUPATIONAL THERAPY   936, 759   135, 945   100, 013   11, 210   28, 386   67. 00   68. 00   06800   SPEECH PATHOLOGY   301, 764   43, 793   7, 579   0   0, 151   68. 00   69. 00   06900   ELECTROCARDI OLOGY   1, 550   225   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   25, 246   3, 664   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   25, 246   3, 664   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   268, 818   39, 012   0   0   0   0   0   76. 00   03020   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   84, 257   12, 228   8, 649   0   2, 455   76. 00   76. 01   03021   HEMODI ALYSIS & OTHER ANCI LLARY   53, 552   7, 772   0   0   0   0   89. 00   08800   RURAL HEALTH CLINIC   0   0   0   0   0   0   89. 00   08900   RURAL HEALTH CLINIC   0   0   0   0   0   0   89. 00   09900   FEDERALLY OUALI FIED HEALTH CENTER   0   0   0   0   0   0   89. 00   09910   CORF   0   0   0   0   0   0   0   89. 00   09910   CORF   0   0   0   0   0   0   0   8110. 00   10900   PANCREAS ACQUI SI TI ON   0   0   0   0   0   0   8111. 00   11000   INTESTI NAL ACQUI SI TI ON   0   0   0   0   0   8113. 00   SUBTOTALS (SUM OF LINES 1-117)   8, 654, 654   1, 092, 176   669, 881   47, 254   182, 966   818. 00   1800   OFFICE SHOPE SHOPE & CANTEEN   0   0   0   0   0   819. 00   OPPHYSI CLANS PRICE SHOPE & CANTEEN   0   0   0   0   0   810. 00   09900   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   810. 00   09900   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   810. 00   09900   OPPHYSI CLANS PRICE SHOPE & CANTEEN   0   0   0   0   0   810. 00   09900   OFFICE SHOPE & CANTEEN   0   0   0   0   0   810. 00   09900   OFFICE SHOPE & CANTEEN   0   0   0   0   0   810. 00   09900   OFFICE SHOPE & CANTEEN   0   0   0   0   0   810. 00   09900   OFFICE SHOPE & CANTEEN   0   0   0   0   0   810. 00   09900   OFFICE SHOPE & CANTEEN   0   0   0   0   0   0   810. 00   09900   OFFICE SHOPE & CANTEEN   0   0   0   0   0   0   810. 00   09900   OFF			1				l	1
69, 00   06900   ELECTROCARDI OLOGY	67.00	06700 OCCUPATI ONAL THERAPY	936, 759				l .	67.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 25, 246 3, 664 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 268, 818 39, 012 0 0 0 0 73. 00 76. 00 03020 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 84, 257 12, 228 8, 649 0 2, 455 76. 00 76. 01 03021 HEMODIALYSI S & OTHER ANCI LLARY 53, 552 7, 772 0 0 0 0 76. 01  000 03020 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 84, 257 7, 772 0 0 0 0 76. 01  0010 TPATIENT SERVI CE COST CENTERS  88. 00 08900   RURAL HEALTH CLINI C 0 0 0 0 0 0 889. 00  08900   FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 899. 00  0710 CORF 0 0 0 0 0 0 0 0 0 0 999. 10  99. 10 09900   PANCREAS ACQUI SITI ON 0 0 0 0 0 0 0 110. 00  110. 00 11000   INTERSTI NAL ACQUI SITI ON 0 0 0 0 0 0 0 110. 00  111. 00 11100   INTERSTI NAL ACQUI SITI ON 0 0 0 0 0 0 0 0 110. 00  111. 00 1130   INTERSTE EXPENSE 1130 0 0 0 0 0 0 0 0 0 0 110. 00  113. 00 11300   INTERSTE EXPENSE 1130 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	68.00	06800 SPEECH PATHOLOGY	301, 764	43, 793	7, 579	0	2, 151	68.00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   72. 00   73. 00   7300   DRUGS CHARGED TO PATIENTS   268, 818   39, 012   0   0   0   0   73. 00   73. 00   76. 00   03020   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   84, 257   12, 228   8, 649   0   2, 455   76. 00   03021   HEMODI ALYSI S & OTHER ANCI LLARY   53, 552   7, 772   0   0   0   76. 01   0000   000   0   0   0   0   0   0	69. 00		1, 550	225	0	0	0	69. 00
73. 00					. 0	0		1
76. 00			-	_	0	0		ł
76. 01 03021   HEMODI ALYSIS & OTHER ANCI LLARY   53, 552   7, 772   0   0   0   76. 01						0		
Second   S								1
88. 00	76.01		53, 552	1,112	.[	0	0	76.01
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   89. 00	88 NN					0	0	88 00
OTHER REIMBURSABLE COST CENTERS   O   O   O   O   O   O   O   O   O		· ·			•			1
99. 10	07.00				,			07.00
109. 00   10900   PANCREAS ACQUISITION   0   0   0   0   109. 00   110. 00   110. 00   110. 00   110. 00   110. 00   111. 00	99. 10		C	0	0	0	0	99. 10
109. 00   10900   PANCREAS ACQUISITION   0   0   0   0   109. 00   110. 00   110. 00   110. 00   110. 00   110. 00   111. 00		SPECIAL PURPOSE COST CENTERS			•			
111. 00   11100   1SLET ACQUISITION   0   0   0   0   111. 00   113. 00   11300   INTEREST EXPENSE   113. 00   11300   INTEREST EXPENSE   113. 00	109.00		C	0	0	0	0	109. 00
113. 00   11300   1 NTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1-117)   8,654,654   1,092,176   669,881   47,254   182,966   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19900   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   192. 00   192.	110.00	11000 INTESTINAL ACQUISITION	C	0	0	0	0	110.00
118. 00   SUBTOTALS (SUM OF LINES 1-117)   8,654,654   1,092,176   669,881   47,254   182,966   118.00			C	0	0	0	0	
NONRE   MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   190.00     192.00   19200   PHYSI CI ANS' PRI VATE OFFICES   4,527   657   0   0   0   192.00     194.00   07950   MARKETI NG/PUBLI C RELATI ONS   135,063   19,601   0   0   0   194.00     194.01   07951   TENANT LEASED SPACE   112,594   16,340   239,601   0   0   194.01     200.00   Cross Foot Adjustments   0   0   0   0   0     201.00   Negati ve Cost Centers   0   0   0   0   0   0     201.00   0   0   0   0   0   0     190.00   0   0   0   0   0   0     190.00   0   0   0   0   0     190.00   0   0   0   0   0     190.00   0   0   0   0   0   0     190.00   0   0   0   0   0     190.00   0   0   0   0   0   0     190.00   0   0   0   0   0   0     190.00   0   0   0   0   0     190.00   0   0   0   0   0     190.00   0   0   0   0   0   0     190.00   0   0   0   0   0     190.00   0   0   0   0   0     190.00   0   0   0   0   0     190.00   0   0   0   0   0   0     190.00   0   0   0   0   0     190.00   0   0   0   0   0     190.00   0   0   0   0     190.00   0   0   0   0     190.00   0   0   0   0   0     190.00   0   0   0   0     190.00   0   0   0   0     190.00   0   0   0   0     190.00   0   0   0   0     190.00   0   0   0   0     190.00   0   0   0   0     190.00   0   0   0   0     190.00   0   0   0   0     190.00   0   0   0   0     190.00   0   0   0     190.00   0   0   0   0     190.00   0   0   0   0     190.00   0   0   0     190.00   0   0   0								
190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   190. 00   192. 00   192.0	118.00		8, 654, 654	1, 092, 176	669, 881	47, 254	182, 966	118. 00
192. 00   19200   19200   19200   19200   19200   19200   19200   194. 00   194. 00   194. 00   194. 01	400.0				J			1.00.00
194. 00     07950     MARKETI NG/PUBLI C RELATI ONS     135, 063     19, 601     0     0     0 194. 00       194. 01     07951     TENANT LEASED SPACE     112, 594     16, 340     239, 601     0     0 194. 01       200. 00     Cross Foot Adjustments     0     0     0     0     0     201. 00       201. 00     Negati ve Cost Centers     0     0     0     0     0     0     201. 00			•			0		
194. 01 07951 TENANT LEASED SPACE 112, 594 16, 340 239, 601 0 0 194. 01 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00				l .				
200.00     Cross Foot Adjustments     0       201.00     Negative Cost Centers     0       0     0       0     0       0     0								
201.00   Negative Cost Centers   0   0   0   0   201.00			112, 394	10, 340	237,001			
				0	)	n	n	
			8, 906, 838	1, 128, 774	909, 482	47, 254		
			•				•	

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 153030 Peri

Peri od: Worksheet B From 10/01/2013 Part I To 09/30/2014 Date/Time Prepared:

2/24/2015 3:47 pm Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI O SERVICE & SUPPLY Ν 10. 00 15.00 11 00 13 00 14 00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.01 00570 ADMITTING 5.01 00561 OTHER ADMINISTRATIVE AND GENERAL 5.02 5.02 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 217, 943 10.00 01100 CAFETERI A 499, 756 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 0 26, 303 363.393 13.00 14.00 01400 CENTRAL SERVICE & SUPPLY 0 88, 869 14.00 15.00 01500 PHARMACY 0 8,768 0 163, 054 15.00 01600 MEDICAL RECORDS & LIBRARY 0 0 16.00 17, 535 1.552 0 16.00 17.00 01700 SOCIAL SERVICE 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 62, 141 30.00 03000 ADULTS & PEDIATRICS 213, 215 263, 028 0 30.00 363, 393 03100 INTENSIVE CARE UNIT 31 00 0 0 0 31.00 03200 CORONARY CARE UNIT 0 0 0 32.00 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 34.00 0 0 34.00 41.00 04100 SUBPROVI DER - I RF 0 0 0 0 41.00 42.00 04200 SUBPROVI DER 0 0 0 0 0 42.00 04300 NURSERY 0 0 0 43.00 43.00 0 0 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 54.00 05700 CT SCAN 57.00 0 0 0 0 57.00 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 ol 0 58.00 0 05900 CARDI AC CATHETERI ZATI ON 0 59.00 59.00 0 0 60.00 06000 LABORATORY 8,768 0 153 0 60.00 06001 BLOOD LABORATORY 60.01 00000000 0 0 0 60.01 65 00 06500 RESPIRATORY THERAPY 0 0 0 65 00 06600 PHYSI CAL THERAPY 0 66.00 61, 374 4, 373 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 70, 141 0 0 67.00 4.160 68.00 06800 SPEECH PATHOLOGY 26, 303 0 1, 332 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 69 00 0 C 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 12,008 71.00 C 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 163, 054 73.00 r 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 76.00 8,768 215 0 76.00 03021 HEMODIALYSIS & OTHER ANCILLARY 0 0 76.01 76.01 OUTPATIENT SERVICE COST CENTERS 88 00 0 88 00 08800 RURAL HEALTH CLINIC 0 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 89.00 OTHER REIMBURSABLE COST CENTERS 09910 CORF 0 0 0 0 99. 10 0 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 0 0 0 111.00 11100 I SLET ACQUISITION 0 0 C 0 0 1111.00 113. 00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1-117) 213, 215 490, 988 363, 393 85, 934 163, 054 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 4.728 0 166 0 192, 00 194.00 07950 MARKETING/PUBLIC RELATIONS 0 2,769 0 194.00 194. 01 07951 TENANT LEASED SPACE 0 194.01 0 8,768 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 201.00 202.00 TOTAL (sum lines 118-201) 217, 943 499, 756 363. 393 88.869 163, 054 202. 00

REHABILITATION HOSPITAL OF FT WAYNE

Provider CCN: 153030 Period: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

COST ALI	LOCATION - GENERAL SERVICE COSTS			F		Worksheet B Part I Date/Time Pro 2/24/2015 3:4	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	ENERAL CERVICE COCT CENTERS	16. 00	17. 00	24. 00	25. 00	26. 00	
	SENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT		1				1.00
	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00570 ADMITTING						5. 01
	00561 OTHER ADMINISTRATIVE AND GENERAL						5. 02
	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
	1000 DI ETARY						10.00
	01100 CAFETERI A						11.00
	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVICE & SUPPLY						14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	202 424					15. 00 16. 00
	01700 SOCIAL SERVICE	282, 426	13, 291				17.00
	NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	13, 271				17.00
	03000 ADULTS & PEDIATRICS	99, 105	13, 291	4, 219, 882	0	4, 219, 882	30.00
	03100 INTENSIVE CARE UNIT	0	0	0	0	C	
	03200 CORONARY CARE UNIT	0	0	0	0	C	
	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	C	
	04100 SUBPROVI DER – I RF		0	0	0		1
	04200 SUBPROVI DER	l ol	Ö	0	O	Č	1
	04300 NURSERY	0	0	0	0	C	43.00
	NCILLARY SERVICE COST CENTERS	7 252	ol	77 020	O	77 020	F4 00
	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	7, 253	0	77, 838 0		77, 838 0	1
	05800 MAGNETIC RESONANCE IMAGING (MRI)	l ol	Ö	0	Ö	Č	1
	05900 CARDI AC CATHETERI ZATI ON	0	o	0	O	C	
	06000 LABORATORY	9, 790	0	109, 894	0	109, 894	1
	06001 BL00D LABORATORY 06500 RESPI RATORY THERAPY	1, 790	0	21, 008	0	21, 008	60. 01 65. 00
	06600 PHYSI CAL THERAPY	47, 932	ő	1, 455, 837	ő	1, 455, 837	1
	06700 OCCUPATI ONAL THERAPY	50, 250	o	1, 336, 864	0	1, 336, 864	1
	06800 SPEECH PATHOLOGY	18, 404	0	401, 326	0	401, 326	1
	06900 ELECTROCARDI OLOGY	446	0	2, 221	0	2, 221	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 842	0	47, 760 0	0	47, 760 0	1
	07300 DRUGS CHARGED TO PATIENTS	33, 346	Ö	504, 230	=	504, 230	1
	03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	4, 784	0	121, 356	0	121, 356	1
	03021 HEMODI ALYSI S & OTHER ANCI LLARY	2, 484	0	63, 808	0	63, 808	76. 01
_	NUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	0	o	0	0	C	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	l o	ő	0		C	
0	THER REIMBURSABLE COST CENTERS						
	09910 CORF	0	0	0	0	C	99. 10
	PECI AL PURPOSE COST CENTERS 0900 PANCREAS ACQUI SI TI ON		ol	0	ol		109. 00
	1000 INTESTINAL ACQUISITION		0	0			110.00
	1100   SLET ACQUISITION	o	o	0	o		111.00
4	1300 INTEREST EXPENSE				_		113.00
118. 00	SUBTOTALS (SUM OF LINES 1-117) ONREIMBURSABLE COST CENTERS	282, 426	13, 291	8, 362, 024	0	8, 362, 024	]118.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	l ol	ol	0	ol	(	190. 00
192.001	9200 PHYSICIANS' PRIVATE OFFICES	j o	Ö	10, 078			192.00
	07950 MARKETI NG/PUBLI C RELATI ONS	0	o	157, 433		157, 433	
	07951 TENANT LEASED SPACE	0	0	377, 303		377, 303	
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers	0	Ω	0	0		200. 00 201. 00
202. 00	TOTAL (sum lines 118-201)	282, 426	13, 291				
·		·	·		·		

Peri od:

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 153030 Worksheet B From 10/01/2013 Part II Date/Time Prepared: 09/30/2014 2/24/2015 3:47 pm CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Di rectly NEW BLDG & NEW MVBLE Subtotal Assigned New FIXT **FOULP BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4, 073 4.00 2, 417 1,656 4.073 4.00 0 00570 ADMITTING 20, 981 12.450 8.531 248 5.01 5.01 00561 OTHER ADMINISTRATIVE AND GENERAL 5.02 47, 157 32, 314 79, 471 305 5.02 7.00 00700 OPERATION OF PLANT 0 0 0 109, 763 75, 215 184, 978 160 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 0 00900 HOUSEKEEPI NG 11, 858 19.984 69 9 00 9 00 8.126 10.00 01000 DI ETARY 86 10.00 11.00 01100 CAFETERI A 0 0 0 45, 815 31, 395 77, 210 144 11.00 01300 NURSING ADMINISTRATION 879 193 13.00 13.00 1, 283 2.162 01400 CENTRAL SERVICE & SUPPLY 9,056 14.00 14.00 6, 206 15, 262 5 15.00 01500 PHARMACY 3,838 2,630 6, 468 77 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 4, 400 3,015 7, 415 126 16.00 0 01700 SOCIAL SERVICE 17 00 2,851 1,954 4,805 0 17 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 76, 289 52, 277 128, 566 1, 363 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 0 31.00 0 C 0 03200 CORONARY CARE UNIT 0 o 32 00 32 00 Ω 0 03300 BURN INTENSIVE CARE UNIT 33.00 C 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 34.00 0 34.00 0 41.00 04100 SUBPROVI DER - I RF 0 0 ol 0 41.00 04200 SUBPROVI DER 0 0 42 00 42 00 0 0 04300 NURSERY 43.00 0 0 43.00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 0 2, 907 54.00 4. 242 7. 149 3 54.00 0 57 00 05700 CT SCAN 0 57.00 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 0 0 0 0 0 0 59.00 06000 LABORATORY O 24 60 00 0 60 00 0 60.01 06001 BLOOD LABORATORY 0 0 0 60.01 06500 RESPIRATORY THERAPY 65.00 987 676 1, 663 65.00 66.00 06600 PHYSI CAL THERAPY 00000 99, 552 68, 218 167, 770 450 66,00 06700 OCCUPATIONAL THERAPY 46, 999 79, 205 518 67.00 32, 206 67.00 68.00 06800 SPEECH PATHOLOGY 3, 561 2, 440 6,001 173 68.00 69 00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 0 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 r 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 76.00 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 4,065 2, 785 6, 850 47 76.00 03021 HEMODIALYSIS & OTHER ANCILLARY 76.01 0 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 0 0 0 0 0 99. 10 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 109, 00 0 0 0 110.00 11000 INTESTINAL ACQUISITION 0 C 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 C 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 3, 998 118.00 118 00 SUBTOTALS (SUM OF LINES 1-117) 0 486, 583 333, 430 820.013 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 ol 0 192, 00 C 194. 00 07950 MARKETING/PUBLIC RELATIONS 75 194.00 0 0 0 194. 01 07951 TENANT LEASED SPACE 0 112, 594 0 112, 594 0 194. 01 200.00 Cross Foot Adjustments 200.00 0 201 00 Negative Cost Centers 0 201 00

0

599, 177

333, 430

932, 607

4, 073 202. 00

TOTAL (sum lines 118-201)

202.00

Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 153030 Peri od: Worksheet B From 10/01/2013 Part II 09/30/2014 Date/Time Prepared: 2/24/2015 3:47 pm Cost Center Description ADMI TTI NG OTHER OPERATION OF LAUNDRY & HOUSEKEEPI NG ADMI NI STRATI V LINEN SERVICE **PLANT** E AND GENERAL 5. 01 7.00 8. 00 9.00 5 02 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.01 00570 ADMITTING 21, 229 5.01 00561 OTHER ADMINISTRATIVE AND GENERAL 79, 776 5.02 5.02 7.00 00700 OPERATION OF PLANT 0 8, 146 193, 284 7.00 00800 LAUNDRY & LINEN SERVICE 0 8 00 423 423 8 00 9.00 00900 HOUSEKEEPI NG 0 1, 413 5, 363 26, 829 9.00 10.00 01000 DI ETARY 0 1, 952 0 0 10.00 0 01100 CAFETERI A 4, 057 3.355 11.00 20,720 11.00 2, 988 01300 NURSING ADMINISTRATION 13.00 580 0 114 13.00 14.00 01400 CENTRAL SERVICE & SUPPLY 0 574 4,096 0 802 14.00 15.00 01500 PHARMACY 0 1, 288 1,736 o 340 15.00 01600 MEDICAL RECORDS & LIBRARY 0 1, 990 16.00 2, 251 0 390 16.00 17.00 01700 SOCIAL SERVICE 49 1, 289 0 253 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 7, 449 30.00 26, 615 34, 501 6, 756 30.00 232 03100 INTENSIVE CARE UNIT 31 00 0 0 0 0 31.00 03200 CORONARY CARE UNIT 0 0 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 0 0 0 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 34.00 0 0 34.00 41.00 04100 SUBPROVI DER - I RF 0 0 0 41.00 42.00 04200 SUBPROVI DER 0 C 0 0 0 42.00 04300 NURSERY 0 43.00 0 0 43.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 545 528 1, 918 0 376 54.00 05700 CT SCAN 57.00 0 0 0 0 57.00 o 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.00 0 05900 CARDI AC CATHETERI ZATI ON 0 59.00 59.00 0 C 0 60.00 06000 LABORATORY 736 817 0 0 0 60.00 06001 BLOOD LABORATORY 0 60.01 0 0 0 60.01 65 00 06500 RESPIRATORY THERAPY 135 148 446 0 87 65 00 06600 PHYSI CAL THERAPY 91 8,817 66.00 3,603 9, 495 45,022 66.00 67.00 06700 OCCUPATI ONAL THERAPY 3,777 9, 608 21, 255 100 4, 162 67.00 68.00 06800 SPEECH PATHOLOGY 1, 383 3, 095 1,611 0 315 68.00 ol 06900 ELECTROCARDI OLOGY 69 00 69 00 34 16 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 514 259 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 72.00 0 73 00 07300 DRUGS CHARGED TO PATIENTS 2 506 2 757 O 0 Ω 73.00 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.00 360 864 1,838 0 360 76.00 03021 HEMODIALYSIS & OTHER ANCILLARY 76.01 76.01 187 549 0 OUTPATIENT SERVICE COST CENTERS 88 00 0 88 00 08800 RURAL HEALTH CLINIC 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 OTHER REIMBURSABLE COST CENTERS 09910 CORF 0 0 0 0 0 99. 10 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 109, 00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 0 0 0 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 0 0 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1-117) 21, 229 77, 190 142, 365 26, 829 118. 00 423

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0

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0

0

21, 229

46

1, 385

1, 155

79, 776

0

0

0

50, 919

193, 284

0

0

0

0

423

0 190. 00

0 192.00

0 194.00

0 194.01

0 201.00

26, 829 202. 00

200.00

NONREIMBURSABLE COST CENTERS

190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118-201)

194. 00 07950 MARKETING/PUBLIC RELATIONS

194. 01 07951 TENANT LEASED SPACE

200.00

201.00

202.00

Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 153030 Peri od: Worksheet B From 10/01/2013 Part II 09/30/2014 Date/Time Prepared: 2/24/2015 3:47 pm Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI O SERVICE & SUPPLY Ν 10. 00 11. 00 15.00 13 00 14 00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.01 00570 ADMITTING 5.01 00561 OTHER ADMINISTRATIVE AND GENERAL 5.02 5.02 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 2,038 10.00 01100 CAFETERI A 105, 486 11.00 11.00 01300 NURSING ADMINISTRATION 11, 589 13.00 0 5, 552 13.00 14.00 01400 CENTRAL SERVICE & SUPPLY 0 20, 739 14.00 15.00 01500 PHARMACY 0 1, 851 0 11, 760 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 0 3, 701 362 0 16.00 17.00 01700 SOCIAL SERVICE 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 1, 994 30.00 03000 ADULTS & PEDIATRICS 55, 518 0 30.00 11,589 14,502 03100 INTENSIVE CARE UNIT 31 00 0 0 0 31.00 03200 CORONARY CARE UNIT 0 0 0 0 32.00 32.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 34.00 0 0 34.00 41.00 04100 SUBPROVI DER - I RF 0 0 0 0 41.00 42.00 04200 SUBPROVI DER 0 0 0 0 0 42.00 04300 NURSERY 0 0 0 43.00 43.00 0 0 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 54.00 05700 CT SCAN 0 57.00 0 0 0 57.00 0 ol 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 58.00 0 05900 CARDI AC CATHETERI ZATI ON 0 0 59.00 59.00 0 0 60.00 06000 LABORATORY 1,851 36 0 60.00 06001 BLOOD LABORATORY 0 60.01 00000000 0 0 60.01 65 00 06500 RESPIRATORY THERAPY 0 0 0 65 00 0 06600 PHYSI CAL THERAPY 66.00 12, 954 1,020 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 14, 805 0 971 0 67.00 68.00 06800 SPEECH PATHOLOGY 5, 552 0 311 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 69 00 0 C 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 C 2,802 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 11, 760 73.00 C 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 76.00 1,851 50 0 76.00 03021 HEMODIALYSIS & OTHER ANCILLARY 0 0 76.01 76.01 OUTPATIENT SERVICE COST CENTERS 88 00 0 O 88 00 08800 RURAL HEALTH CLINIC 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 89.00 OTHER REIMBURSABLE COST CENTERS

109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 0 0 0 111.00 11100 I SLET ACQUISITION 0 0 111.00 0 C 0 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1-117) 1, 994 103, 635 11, 589 20, 054 11, 760 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 44 0 30 0 192.00 194.00 07950 MARKETING/PUBLIC RELATIONS 0 0 194.00 0 646 194. 01 07951 TENANT LEASED SPACE 0 194.01 0 1, 851 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 201.00 202.00 TOTAL (sum lines 118-201) 2.038 105, 486 11, 589 20.739 11, 760 202. 00

0

0

0

0

0 99.10

09910 CORF

SPECIAL PURPOSE COST CENTERS

Heal th	Financial Systems REHA	BILITATION HOSPI	TAL OF FT WAY	NE	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der		eriod: rom 10/01/2013	Worksheet B Part II	
				To		Date/Time Pre	
	Cost Center Description	MEDI CAL	SOCI AL	Subtotal	Intern &	<u>  2/24/2015 3: 4</u> Total	- / pili
	·	RECORDS &	SERVI CE		Residents		
		LI BRARY			Cost & Post Stepdown		
					Adjustments		
	OFNEDAL CEDIL OF COCT OFNEDO	16. 00	17. 00	24. 00	25. 00	26. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00570 ADMITTING						5. 01
5. 02 7. 00	OO561 OTHER ADMINISTRATIVE AND GENERAL   OO700 OPERATION OF PLANT						5. 02 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON						11. 00 13. 00
14. 00	01400 CENTRAL SERVICE & SUPPLY						14. 00
15.00	01500 PHARMACY						15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	16, 235					16.00
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	6, 396				17. 00
30. 00	03000 ADULTS & PEDIATRICS	5, 698	6, 396	301, 179	0	301, 179	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00 41. 00	03400  SURGICAL INTENSIVE CARE UNIT   04100  SUBPROVIDER - IRF	0	0	0	0	0	34. 00 41. 00
42. 00	04200 SUBPROVI DER	o	o	0	Ö	0	42.00
43.00	04300 NURSERY	0	0	0	0	0	43.00
E4 00	ANCILLARY SERVICE COST CENTERS	417	ol	10.03/	٥	10.024	F4 00
54. 00 57. 00	05400   RADI OLOGY-DI AGNOSTI C   05700   CT   SCAN	417 0	0	10, 936 0	0	10, 936 0	54.00 57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	o	0	Ö	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	563	0	4, 027	0	4, 027	1
60. 01 65. 00	06001   BLOOD LABORATORY   06500   RESPI RATORY THERAPY	103	0	0 2, 589	0	0 2, 589	60. 01 65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 755	o	251, 977	Ö	251, 977	1
67. 00	06700 OCCUPATI ONAL THERAPY	2, 888	0	137, 289	0	137, 289	1
68.00	06800 SPEECH PATHOLOGY	1, 058	0	19, 499	0	19, 499	
69. 00 71. 00	06900  ELECTROCARDI OLOGY   07100  MEDI CAL SUPPLI ES CHARGED TO PATIENTS	26 393	0	76 3, 968	0	76 3, 968	1
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	3, 700	0	0, 700	72.00
	07300 DRUGS CHARGED TO PATIENTS	1, 916	0	18, 939	0	18, 939	73.00
	03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	275	0	12, 495	0		76.00
76. 01	03021   HEMODI ALYSIS & OTHER ANCILLARY   OUTPATIENT SERVICE COST CENTERS	143	0	879	0	879	76. 01
88. 00	08800 RURAL HEALTH CLINIC	O	o	0	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	1
	OTHER REIMBURSABLE COST CENTERS	1	_1	_			
99. 10	O9910   CORF   SPECI AL PURPOSE COST CENTERS	0	0	0	0	0	99. 10
109.00	10900 PANCREAS ACQUISITION	O	ol	0	0	0	109. 00
	11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
	11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
	11300 I NTEREST EXPENSE	1/ 225	/ 20/	7/2 052		7/2 052	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)   NONREIMBURSABLE COST CENTERS	16, 235	6, 396	763, 853	0	763, 853	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	129	O		192.00
	07950 MARKETI NG/PUBLI C RELATIONS	0	0	2, 106	0		194.00
200.00	O7951 TENANT LEASED SPACE   Cross Foot Adjustments		o <sub>l</sub>	166, 519 0	O N	166, 519 0	200.00
201.00		0	О	0	o	0	201.00
202.00	TOTAL (sum lines 118-201)	16, 235	6, 396	932, 607	О	932, 607	202.00

					To 09/30/2014		
		CAPI TAL REL	ATED COSTS			2/24/2015 3.4	/ pili
	Cost Center Description	NEW BLDG & FLXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	ADMI TTI NG (GROSS CHARGES)	Reconciliatio n	
				SALARI ES)			
GENE	RAL SERVICE COST CENTERS	1.00	2. 00	4. 00	5. 01	5A. 02	
	O NEW CAP REL COSTS-BLDG & FIXT	728, 820					1.00
	NEW CAP REL COSTS-MVBLE EQUIP		591, 864				2. 00
	O EMPLOYEE BENEFITS DEPARTMENT	2, 940	2, 940				4.00
-	O ADMITTING 1 OTHER ADMINISTRATIVE AND GENERAL	15, 144 57, 360	15, 144 57, 360				5. 01 5. 02
	O OPERATION OF PLANT	133, 512	133, 512				7.00
	O LAUNDRY & LINEN SERVICE	0	0	(		0	8. 00
	O HOUSEKEEPI NG O DI ETARY	14, 424	14, 424 0			0	9. 00 10. 00
	O CAFETERI A	55, 728	55, 728			•	11.00
	O NURSING ADMINISTRATION	1, 560	1, 560			0	13.00
	O CENTRAL SERVICE & SUPPLY	11, 016	11, 016			1	14.00
	O PHARMACY O MEDICAL RECORDS & LIBRARY	4, 668 5, 352	4, 668 5, 352			1	15. 00 16. 00
	O SOCIAL SERVICE	3, 468	3, 468	· ·			17. 00
	TIENT ROUTINE SERVICE COST CENTERS	00.70/	00.70/	4 500 044	7 750 001		00.00
	O ADULTS & PEDIATRICS O INTENSIVE CARE UNIT	92, 796 0	92, 796 0	1, 580, 042	7, 759, 021	0	30. 00 31. 00
32. 00 0320	O CORONARY CARE UNIT	0	0		0	0	32.00
	O BURN INTENSIVE CARE UNIT	0	0	(	0	0	33.00
	O SURGICAL INTENSIVE CARE UNIT O SUBPROVIDER - IRF		0			0	34. 00 41. 00
	O SUBPROVI DER	0	0		o o		42.00
	O NURSERY	0	0	(	0	0	43.00
	LLARY SERVICE COST CENTERS  O RADIOLOGY-DIAGNOSTIC	5, 160	5, 160	3, 093	567, 922	0	54.00
1	O CT SCAN	0	0				57.00
	O MAGNETIC RESONANCE IMAGING (MRI)	0	0	(	0	0	58.00
	O CARDI AC CATHETERI ZATI ON O LABORATORY		0	27, 840	766, 507	0	59. 00 60. 00
	1 BLOOD LABORATORY	O	0		0	0	60. 01
	O RESPIRATORY THERAPY	1, 200	1, 200				65.00
	O PHYSI CAL THERAPY O OCCUPATI ONAL THERAPY	121, 092 57, 168	121, 092 57, 168			0	66. 00 67. 00
68. 00 0680	O SPEECH PATHOLOGY	4, 332	4, 332				68. 00
	O ELECTROCARDI OLOGY	0	0				69.00
	O MEDICAL SUPPLIES CHARGED TO PATIENTS O IMPL. DEV. CHARGED TO PATIENTS		0		,		71. 00 72. 00
73. 00 0730	O DRUGS CHARGED TO PATIENTS	o	0				73. 00
	O PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	4, 944	4, 944				76.00
	1 HEMODIALYSIS & OTHER ANCILLARY ATIENT SERVICE COST CENTERS	0	0	(	194, 483		76. 01
88. 00 0880	O RURAL HEALTH CLINIC	0	0				88. 00
	O FEDERALLY QUALIFIED HEALTH CENTER R REIMBURSABLE COST CENTERS	0	0	(	0	0	89. 00
99. 10 0991		0	0		0	0	99. 10
	IAL PURPOSE COST CENTERS			1		1 -	
	O PANCREAS ACQUISITION O INTESTINAL ACQUISITION	0	0				109. 00 110. 00
-	O I SLET ACQUISITION	0	0		o o		111.00
1	O INTEREST EXPENSE	504.044		4 (00 55	00 440 570		113.00
118. 00 NONR	SUBTOTALS (SUM OF LINES 1-117) EIMBURSABLE COST CENTERS	591, 864	591, 864	4, 632, 550	22, 112, 572	-1, 128, 774	118.00
190. 00 1900	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
	O PHYSICIANS' PRIVATE OFFICES O MARKETING/PUBLIC RELATIONS	0	0				192. 00 194. 00
	1 TENANT LEASED SPACE	136, 956	0	86, 912	.		194. 00
200. 00	Cross Foot Adjustments		_				200. 00
201. 00	Negative Cost Centers	500 477	222 422	0/7 04	440 500		201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	599, 177	333, 430	967, 314	413, 528		202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 822119	0. 563356	•			203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			4, 073	21, 229		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000863	0. 000960		205. 00
	11)						

COST ALLOCATION - STATISTICAL BASIS			Provi der		eriod: rom 10/01/2013	Worksheet B-1	
					o 09/30/2014		
	Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	2/24/2015 3: 4 DI ETARY	7 pm
	Cost Center Description	ADMI NI STRATI V	PLANT	LINEN SERVICE	(SQUARE	(MEALS	
		E AND GENERAL	(SQUARE	(POUNDS	FEET)	SERVED)	
		(ACCUM.	FEET)	OF LAUNDRY)			
		COST)	7.00	0.00	0.00	10.00	
	GENERAL SERVICE COST CENTERS	5. 02	7.00	8. 00	9. 00	10. 00	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					I	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					I	4.00
5. 01 5. 02	00570   ADMITTING   00561   OTHER ADMINISTRATIVE AND GENERAL	7, 778, 064				I	5. 01 5. 02
7. 00	00700 OPERATION OF PLANT	7,778,004				I	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	41, 265		62, 923		I	8.00
9. 00	00900 HOUSEKEEPI NG	137, 742		C	368, 484	I	9. 00
10.00	01000 DI ETARY	190, 323		C		37, 105	•
11. 00 13. 00	01100  CAFETERI A   01300  NURSI NG   ADMI NI STRATI ON	327, 119 291, 310			55, 728 1, 560	0	11.00
14. 00	01400 CENTRAL SERVICE & SUPPLY	56, 000			1	0	14.00
	01500 PHARMACY	125, 578	·		4, 668	Ö	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	219, 469	5, 352	[ c	5, 352	0	16.00
17. 00	01700 SOCI AL SERVI CE	4, 805	3, 468	C	3, 468	0	17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	2, 594, 797	02.704	24 521	92, 796	36, 300	30.00
31. 00	03100 INTENSIVE CARE UNIT	2, 594, 797	92, 796	34, 531 C		30, 300	1
32. 00	03200 CORONARY CARE UNIT	0	Ö	l c	Ö	ő	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	C	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	C	0	0	34.00
41. 00	04100 SUBPROVI DER - I RF	0	0	C	0	0	
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	0	0	C	1	0	
43.00	ANCI LLARY SERVICE COST CENTERS				1 0	U	43.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	51, 519	5, 160	C	5, 160	0	54.00
57. 00	05700 CT SCAN	0	0	C	0	0	57.00
58. 00 59. 00	05800   MAGNETI C RESONANCE I MAGING (MRI)   05900   CARDIAC CATHETERIZATION	0	0		0	0 0	58. 00 59. 00
60.00	06000 LABORATORY	79, 627	0		0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	Ö	Ċ	Ö	0	60.01
65.00	06500 RESPI RATORY THERAPY	14, 429			1, 200	0	65. 00
66.00	06600 PHYSI CAL THERAPY	925, 729				0	66.00
67. 00 68. 00	06700  OCCUPATI ONAL THERAPY   06800  SPEECH PATHOLOGY	936, 759 301, 764	57, 168 4, 332		57, 168 4, 332	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 550			0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 246		C	0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	268, 818		C	0	0	73.00
76. 00 76. 01	03020   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   03021   HEMODI ALYSI S & OTHER ANCI LLARY	84, 257 53, 552	4, 944	C	.,	0	76. 00 76. 01
70.01	OUTPATIENT SERVICE COST CENTERS	33,332				0	70.01
88. 00		0					
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0	0	89. 00
00 10	OTHER REIMBURSABLE COST CENTERS  09910 CORF	0	0		0	0	99. 10
99. 10	SPECIAL PURPOSE COST CENTERS	0			ıl Ol	0	99.10
109.00	10900 PANCREAS ACQUISITION	0	0	C	0	0	109. 00
	11000 INTESTINAL ACQUISITION	0	0	C	1		110.00
	11100 I SLET ACQUI SI TI ON	0	0	C	0	0	111.00
113.00	11300 INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1-117)	7, 525, 880	382, 908	62, 923	368, 484	36 300	113. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	1, 323, 000	302, 700	02, 723	300, 404	30, 300	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	4, 527		C	0		192. 00
	07950 MARKETING/PUBLIC RELATIONS  07951 TENANT LEASED SPACE	135, 063		C	0		194.00
200.00		112, 594	136, 956		, o	l	194. 01 200. 00
201.00	, ,					I	201.00
202.00		1, 128, 774	909, 482	47, 254	182, 966	217, 943	202. 00
202 62	Part I)	0.445400	1 740///	0.75000	0.404503	F 070/00	202 22
203. 00 204. 00		0. 145123 79, 776			1	5. 873683 2. 038	203.00
204.00	Part II)	17,770	173, 204	423	20, 029	2,030	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 010257	0. 371797	0. 006723	0. 072809	0. 054925	205. 00
			l	l		ı	I

Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 153030 Peri od: Worksheet B-1 From 10/01/2013 09/30/2014 Date/Time Prepared: 2/24/2015 3:47 pm Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL ADMI NI STRATI O SERVICE & (COSTED RECORDS & (FTES) **SUPPLY** REQUIS.) LI BRARY Ν (FTES-NURS (COSTED (GROSS REQUIS.) CHARGES) AREAS) 11.00 13.00 14.00 15.00 16.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 1.00 1.00 2 00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00570 ADMITTING 5.01 5.01 00561 OTHER ADMINISTRATIVE AND GENERAL 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10.00 11.00 01100 CAFETERI A 57 11.00 13.00 01300 NURSING ADMINISTRATION 30 13.00 3 01400 CENTRAL SERVICE & SUPPLY 0 14.00 14.00 C 111, 675 01500 PHARMACY 219, 992 15.00 1 C 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 2 C 1,950 22, 112, 572 16.00 01700 SOCIAL SERVICE 0 17.00 0 0 0 17.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30 30 78,088 7, 759, 021 30.00 03100 INTENSIVE CARE UNIT 0 31.00 0 C 0 0 31.00 0 o 03200 CORONARY CARE UNIT 32.00 32.00 0 0 0 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 0 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 34.00 04100 SUBPROVI DER - I RF 0 0 41.00 0 0 0 41.00 0 42 00 04200 SUBPROVI DER C 0 ol 42 00 0 04300 NURSERY 43.00 0 0 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 567, 922 54.00 0 57 00 05700 CT SCAN Ω 0 0 57 00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 0 0 0 59.00 59.00 0 0 1 0 60.00 06000 LABORATORY 0 192 766, 507 60.00 0 06001 BLOOD LABORATORY 0 0 7 Ω 60.01 0 60 01 65.00 06500 RESPIRATORY THERAPY C 0 140, 185 65.00 3, 752, 901 06600 PHYSI CAL THERAPY 5, 495 0 66.00 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 8 3 0 0 5, 228 3, 934, 415 67.00 06800 SPEECH PATHOLOGY 1, 441, 002 68.00 C 1,674 68.00 69.00 06900 ELECTROCARDI OLOGY 0 34, 925 69.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 15,090 0 535, 734 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 C 72.00 0 0 0 2, 610, 888 07300 DRUGS CHARGED TO PATIENTS 0 219, 992 73.00 C 0 73 00 76.00 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES C 270 374, 589 76.00 03021 HEMODIALYSIS & OTHER ANCILLARY 194, 483 76.01 76.01 0 0 0 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 Ω 89.00 OTHER REIMBURSABLE COST CENTERS 0 0 99.10 99.10 09910 CORF 0 0 0 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 n 0 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 110,00 0 C 0 0 111.00 11100 I SLET ACQUISITION 0 C 0 0 0 111.00 113. 00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 56 30 107, 987 219, 992 22, 112, 572 118.00 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 208 0

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8, 767. 649123 12, 113. 100000

499, 756

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363.393

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0 194.00

0 194, 01

282, 426 202.00

0. 012772 203. 00

0.000734 205.00

16, 235 204. 00

200.00

201.00

200.00

201.00

202.00

203.00

204.00

205.00

194. 00 07950 MARKETING/PUBLIC RELATIONS

Cross Foot Adjustments

Negative Cost Centers

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

Unit cost multiplier (Wkst. B, Part I)

194. 01 07951 TENANT LEASED SPACE

Part I)

Part II)

II)

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 153030 Peri od: Worksheet B-1 From 10/01/2013 To 09/30/2014 Date/Time Prepared: 2/24/2015 3:47 pm Cost Center Description SOCI AL SERVI CE (PATI ENT DAYS %) 17.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00570 ADMITTING 5.01 5.01 5.02 00561 OTHER ADMINISTRATIVE AND GENERAL 5.02 7.00 00700 OPERATION OF PLANT 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9 00 00900 HOUSEKEEPI NG 9 00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICE & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 100 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 100 30.00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 03200 CORONARY CARE UNIT 32.00 0 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 34.00 41.00 04100 SUBPROVI DER - I RF 0 41.00 04200 SUBPROVI DER 0 42.00 42.00 43 00 04300 NURSERY 0 43 00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 57.00 05700 CT SCAN 00000000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 59.00 06000 LABORATORY 60.00 60.00 60 01 06001 BLOOD LABORATORY 60 01 06500 RESPIRATORY THERAPY 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 06800 SPEECH PATHOLOGY 68 00 68 00 06900 ELECTROCARDI OLOGY 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 73 00 0 76.00 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.00 76.01 03021 HEMODIALYSIS & OTHER ANCILLARY 0 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88 00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 99.10 0 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 111.00 11100 I SLET ACQUISITION 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 100 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 194. 00 07950 MARKETING/PUBLIC RELATIONS 0 194.00 194. 01 07951 TENANT LEASED SPACE 0 194. 01 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 13, 291 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 132. 910000 203.00 204.00 Cost to be allocated (per Wkst. B, 204.00 6, 396 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 63. 960000 205.00

11)

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153030 Period: From 10/01/2013 To 09/30/2014 Date/Time Prepared: 2/24/2015 3: 47 pm

Title XVIII Hospital PPS

Cost Center Description

Total Cost (from Wkst. B, Part I, col. 26)

Total Cost Oct Center Description Total Cost (from Wkst. B, Part I, col. 26)

			Ti tl	e XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst.	Adj.		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2.00	3.00	4. 00	5. 00	
11	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03	3000 ADULTS & PEDIATRICS	4, 219, 882		4, 219, 882	16, 071	4, 235, 953	30.00
31.00 0	3100 INTENSIVE CARE UNIT	0		0	o	0	31.00
32.00 0	3200 CORONARY CARE UNIT	0		0	o	0	32.00
33.00 0	3300 BURN INTENSIVE CARE UNIT	0		0	o	0	33.00
34.00 03	3400 SURGICAL INTENSIVE CARE UNIT	0			ol	0	34.00
	4100 SUBPROVI DER - I RF	0			ol	0	41.00
	4200 SUBPROVI DER	0		l	ol	0	42.00
	4300 NURSERY	0		0	ol	0	43.00
	NCILLARY SERVICE COST CENTERS	-	L	·	-1		
	5400 RADI OLOGY-DI AGNOSTI C	77, 838		77, 838	ol	77, 838	54.00
	5700 CT SCAN	0		0	ol	0	57.00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	ol	0	58.00
	5900 CARDI AC CATHETERI ZATI ON	0		i o	ol	0	59.00
	6000 LABORATORY	109, 894		109, 894		109, 894	
	6001 BLOOD LABORATORY	0		107,071	ا	0	60. 01
	6500 RESPI RATORY THERAPY	21, 008	0	21, 008	l ol	21, 008	
	6600 PHYSI CAL THERAPY	1, 455, 837	0	i .		1, 455, 837	66.00
	6700 OCCUPATI ONAL THERAPY	1, 336, 864	1	1, 336, 864		1, 336, 864	
	6800 SPEECH PATHOLOGY	401, 326		401, 326		401, 326	
	6900 ELECTROCARDI OLOGY	2, 221	Ĭ	2, 221		2, 221	69.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	47, 760		47, 760		47, 760	
	7200 IMPL. DEV. CHARGED TO PATIENTS	47,700		47, 700		47, 700	72.00
	7300 DRUGS CHARGED TO PATIENTS	504, 230		504, 230		504, 230	
	3020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	121, 356		121, 356		121, 356	
	3021 HEMODI ALYSI S & OTHER ANCI LLARY	63, 808		63, 808		63, 808	76.00
	UTPATIENT SERVICE COST CENTERS	03,000		03,800	u U	03,000	70.01
	8800 RURAL HEALTH CLINIC	0		С	ol	0	88. 00
	8900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	89.00
	THER REIMBURSABLE COST CENTERS	0			<u> </u>	0	07.00
	9910 CORF	0		0	1	0	99. 10
	PECIAL PURPOSE COST CENTERS		L	· · · · · ·	1		77.10
	0900 PANCREAS ACQUISITION	0		0		0	109. 00
	1000 INTESTINAL ACQUISITION			l o			110.00
	1100 I SLET ACQUISITION	0					111.00
	1300   NTEREST EXPENSE			۲		O	113.00
200. 00	Subtotal (see instructions)	8, 362, 024	0	8, 362, 024	16, 071	8, 378, 095	
200.00	Less Observation Beds	0, 302, 024		0, 302, 024	10,071		200.00
202.00	Total (see instructions)	8, 362, 024	О	8, 362, 024	16, 071		
202.00	Total (See Histiactions)	0, 302, 024	ı	0, 302, 024	10,071	0, 370, 093	1202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Peri od:

Provi der CCN: 153030 Worksheet C From 10/01/2013 Part I 09/30/2014 Date/Time Prepared: 2/24/2015 3:47 pm Title XVIII Hospi tal PPS Charges Total (col. 6 Cost or Other TEFRA Cost Center Description Inpati ent Outpati ent I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 7, 759, 021 7, 759, 021 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 03200 CORONARY CARE UNIT 0 0 32.00 32.00 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34 00 34 00 0 41.00 04100 SUBPROVI DER - I RF 0 41.00 42.00 04200 SUBPROVI DER 0 0 42.00 04300 NURSERY 0 0 43.00 43.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 567, 922 567, 922 0. 137058 0.000000 54.00 57.00 05700 CT SCAN 0.000000 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0.000000 0.000000 0 0 58 00 0 59.00 05900 CARDIAC CATHETERIZATION 0 C 0 0.000000 0.000000 59.00 06000 LABORATORY 0.143370 0.000000 60.00 766, 469 38 766, 507 60.00 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 0 60.01 06500 RESPIRATORY THERAPY 0.000000 65.00 140, 185 r 140, 185 0.149859 65 00 06600 PHYSI CAL THERAPY 3, 750, 833 2,068 3, 752, 901 0.387923 0.000000 66.00 66.00 06700 OCCUPATI ONAL THERAPY 3, 934, 415 0. 339787 67.00 3, 934, 415 C 0.000000 67.00 06800 SPEECH PATHOLOGY 1, 441, 002 1, 441, 002 0.278505 0.000000 68.00 C 68.00 69.00 06900 ELECTROCARDI OLOGY 34, 925 34, 925 0.063593 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 529, 548 6, 186 535, 734 0.089149 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 2, 606, 812 4,076 2, 610, 888 0.193126 0.000000 73.00 76.00 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 374, 589 374, 589 0.323971 0.000000 76.00 03021 HEMODIALYSIS & OTHER ANCILLARY 194, 483 0.328090 76.01 194, 483 0.000000 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 OTHER REIMBURSABLE COST CENTERS 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 0 110.00 111.00 11100 I SLET ACQUISITION 0 O 111.00 Ω 113. 00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 22, 100, 204 22, 112, 572 200.00 12, 368 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 22, 100, 204 12, 368 22, 112, 572 202.00 Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153030 Period: Worksheet C From 10/01/2013 TO 09/30/2014 Date/Time Prepared: 2/24/2015 3: 47 pm

	015 3:47 pm
Title XVIII Hospital	PPS
Cost Center Description   PPS Inpatient	
Rati o Rati o	
11.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
30.00   03000   ADULTS & PEDIATRICS	30.00
31.00 O3100 INTENSIVE CARE UNIT	31.00
32.00 O3200 CORONARY CARE UNIT	32.00
33.00   03300   BURN INTENSIVE CARE UNIT	33.00
34.00   03400   SURGI CAL I NTENSI VE CARE UNI T	34.00
41. 00   04100   SUBPROVI DER -   I RF	41.00
42. 00   04200   SUBPROVI DER	42.00
43. 00   04300   NURSERY	43.00
ANCILLARY SERVICE COST CENTERS	
54. 00	54.00
57. 00   05700   CT SCAN 0. 000000	57.00
58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0. 000000	58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON   0. 000000	59.00
60. 00 06000 LABORATORY 0. 143370	60.00
60. 01 06001 BLOOD LABORATORY 0. 000000	60. 01
65. 00 06500 RESPI RATORY THERAPY 0. 149859	65. 00
66. 00 06600 PHYSI CAL THERAPY 0. 387923	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 339787	67.00
68. 00 06800 SPEECH PATHOLOGY 0. 278505	68. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 063593	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.089149	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000	72. 00
73. 00   07300   DRUGS   CHARGED TO PATIENTS   0. 193126	73.00
76. 00   03020   PSYCHI ATRI C/PSYCHOLOGI CAL   SERVI CES   0. 323971	76.00
76. 01   03021   HEMODI ALYSI S & OTHER ANCI LLARY   0. 328090	76. 01
OUTPATIENT SERVICE COST CENTERS	
88. 00 08800 RURAL HEALTH CLINIC	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	89. 00
OTHER REIMBURSABLE COST CENTERS	
99. 10	99. 10
SPECIAL PURPOSE COST CENTERS	
109. 00 10900 PANCREAS ACQUISITION	109. 00
110. 00 11000 INTESTINAL ACQUISITION	110.00
111. 00 11100   SLET ACQUISITION	111.00
113. 00 11300 I NTEREST EXPENSE	113.00
200.00 Subtotal (see instructions)	200.00
201.00 Less Observation Beds	201.00
202.00 Total (see instructions)	202.00

Provi der CCN: 153030 | Peri od: From 10/01/2013 | To 09/30/2014

Worksheet C Part I

Date/Time Prepared: 2/24/2015 3:47 pm Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 2.00 4. 00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4, 219, 882 4, 219, 882 16, 071 4, 235, 953 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 0 0 32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 34.00 41.00 04100 SUBPROVI DER - I RF 0 0 0 0 41.00 04200 SUBPROVI DER 0 0 42.00 42.00 0 0 04300 NURSERY O 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 77, 838 77, 838 77, 838 54.00 05700 CT SCAN 0 57.00 57.00 0 0 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 59.00 0 06000 LABORATORY 60.00 109, 894 109, 894 0 0 109, 894 60.00 06001 BLOOD LABORATORY 60.01 Ω 60.01 65.00 06500 RESPIRATORY THERAPY 21,008 21,008 21,008 65.00 06600 PHYSI CAL THERAPY 1, 455, 837 1, 455, 837 1, 455, 837 66.00 0 0 0 66.00 06700 OCCUPATI ONAL THERAPY 1, 336, 864 67.00 1, 336, 864 1, 336, 864 67.00 06800 SPEECH PATHOLOGY 401, 326 68.00 401, 326 401, 326 68.00 69.00 06900 ELECTROCARDI OLOGY 2, 221 2, 221 2, 221 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 47, 760 47,760 0 0 47, 760 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS Ω 72 00 0 0 07300 DRUGS CHARGED TO PATIENTS 73.00 504, 230 504, 230 504, 230 73.00 76.00 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 121, 356 121, 356 0 121, 356 76.00 03021 HEMODIALYSIS & OTHER ANCILLARY 63, 808 76.01 63,808 63,808 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 0 0 89.00 OTHER REIMBURSABLE COST CENTERS 99.10 99. 10 09910 CORF 0 0 0 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 0 111.00 111.00 11100 I SLET ACQUISITION 0 0 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 8.362.024 0 8, 362, 024 16,071 8, 378, 095 200. 00 201 00 0 201 00 Less Observation Beds 202.00 Total (see instructions) 8, 362, 024 0 8, 362, 024 16, 071 8, 378, 095 202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 153030 Peri od: Worksheet C From 10/01/2013 Part I 09/30/2014 Date/Time Prepared: 2/24/2015 3:47 pm Title XIX Hospi tal PPS Charges Total (col. 6 Cost or Other TEFRA Cost Center Description Inpati ent Outpati ent I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 7, 759, 021 7, 759, 021 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 03200 CORONARY CARE UNIT 0 0 32.00 32.00 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34 00 34 00 0 41.00 04100 SUBPROVI DER - I RF 0 41.00 42.00 04200 SUBPROVI DER 0 0 42.00 04300 NURSERY 0 0 43.00 43.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 567, 922 567, 922 0. 137058 0.000000 54.00 57.00 05700 CT SCAN 0.000000 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0.000000 0.000000 0 0 58 00 0 59.00 05900 CARDIAC CATHETERIZATION 0 C 0 0.000000 0.000000 59.00 06000 LABORATORY 0.143370 0.000000 60.00 766, 469 38 766, 507 60.00 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 0 60.01 06500 RESPIRATORY THERAPY 0.000000 65.00 140, 185 r 140, 185 0.149859 65 00 06600 PHYSI CAL THERAPY 3, 750, 833 2,068 3, 752, 901 0.387923 0.000000 66.00 66.00 06700 OCCUPATI ONAL THERAPY 3, 934, 415 0. 339787 67.00 3, 934, 415 C 0.000000 67.00 06800 SPEECH PATHOLOGY 1, 441, 002 1, 441, 002 0.278505 0.000000 68.00 C 68.00 69.00 06900 ELECTROCARDI OLOGY 34, 925 34, 925 0.063593 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 529, 548 6, 186 535, 734 0.089149 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 2, 606, 812 4,076 2, 610, 888 0.193126 0.000000 73.00 76.00 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 374, 589 374, 589 0.323971 0.000000 76.00 03021 HEMODIALYSIS & OTHER ANCILLARY 194, 483 194, 483 0.328090 0.000000 76.01 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0.000000 88.00 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 0.000000 89.00 OTHER REIMBURSABLE COST CENTERS 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 0 110.00 111.00 11100 I SLET ACQUISITION 0 O 111.00 Ω 113.00 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 22, 100, 204 22, 112, 572 200.00 12, 368 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 22, 100, 204 12, 368 22, 112, 572 202.00 Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153030 | Period: From 10/01/2013 | Part I To 09/30/2014 | Date/Time Prepared: 2/24/2015 3: 47 pm

				2/24/2015 3: 4	17 pm
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
32.00 03200 CORONARY CARE UNIT					32.00
33.00 03300 BURN INTENSIVE CARE UNIT					33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT					34.00
41. 00   04100   SUBPROVI DER -   RF					41.00
42. 00   04200   SUBPROVI DER					42.00
43. 00   04300   NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 137058				54.00
57. 00 05700 CT SCAN	0. 000000				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
60. 00 06000 LABORATORY	0. 143370				60.00
60. 01 06001 BLOOD LABORATORY	0. 000000				60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 149859				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 387923				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 339787				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 278505				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 063593				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 089149				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 193126				73.00
76. 00 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 323971				76.00
76. 01 03021 HEMODIALYSIS & OTHER ANCILLARY	0. 328090				76. 01
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>				
99. 10 09910 CORF					99. 10
SPECIAL PURPOSE COST CENTERS	<u> </u>				
109. 00 10900 PANCREAS ACQUISITION					109.00
110.00 11000 INTESTINAL ACQUISITION					110.00
111.00 11100 I SLET ACQUI SI TI ON					111.00
113. 00 11300   NTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	REHABILITATION HOSPITAL	OF FT WAYNE	In Lieu	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE (	COST TO CHARGE RATIOS NET OF	Provider CCN: 153030	Peri od:	Worksheet C

Part II From 10/01/2013 REDUCTIONS FOR MEDICAID ONLY 09/30/2014 Date/Time Prepared: 2/24/2015 3:47 pm Title XIX Hospi tal PPS Capital Cost Operating Operati ng Cost Center Description Total Cost Capi tal (Wkst. B, Cost Net of (Wkst. B, Reducti on Cost Reducti on Part I, col Part II col Capital Cost 26) 26) (col. 1 -Amount col. 2) 1. 00 2.00 3.00 4. 00 5. 00 ANCILLARY SERVICE COST CENTERS 10, 936 66, 902 54 00 54 00 05400 RADI OLOGY-DI AGNOSTI C 77.838 0 57.00 05700 CT SCAN 0 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 58.00 0 0 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 59.00 0 0 0 06000 LABORATORY 60.00 109, 894 4,027 105, 867 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 60.01 65.00 06500 RESPIRATORY THERAPY 21,008 2, 589 18, 419 65.00 06600 PHYSI CAL THERAPY 1, 455, 837 251, 977 1, 203, 860 66.00 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 1, 336, 864 137, 289 1, 199, 575 0 67.00 68.00 06800 SPEECH PATHOLOGY 401, 326 19, 499 381, 827 0 68.00 69.00 06900 ELECTROCARDI OLOGY 2, 221 2, 145 0 69.00 76 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 47, 760 3, 968 43, 792 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 504, 230 18, 939 485, 291 0 73.00 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 12, 495 108.861 0 76.00 121, 356 0 76.00 76.01 03021 HEMODIALYSIS & OTHER ANCILLARY 63,808 879 62, 929 0 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 0 0 89.00 OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS 0 109.00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION ol 0 111.00 0 0 0 113.00 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (sum of lines 50 thru 199) 4, 142, 142 462, 674 3, 679, 468 0 0 200.00

4, 142, 142

462, 674

3, 679, 468

0

0 201.00

0 202.00

201.00

202.00

Less Observation Beds

Total (line 200 minus line 201)

					2/24/2015 3:	47 pm
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	Capital and	(Worksheet C,	Cost to			
	Operati ng	Part I,	Charge Ratio			
	Cost	column 8)	(col. 6 /			
	Reduction		col. 7)			
	6. 00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
54. 00   05400   RADI OLOGY-DI AGNOSTI C	77, 838	567, 922	0. 137058			54.00
57. 00  05700   CT   SCAN	0	0	0.000000			57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0	0.000000			58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0	0	0.000000			59.00
60. 00   06000   LABORATORY	109, 894	766, 507	0. 143370			60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.000000			60. 01
65. 00 06500 RESPIRATORY THERAPY	21, 008	140, 185	0. 149859			65.00
66. 00 06600 PHYSI CAL THERAPY	1, 455, 837	3, 752, 901	0. 387923			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 336, 864	3, 934, 415	0. 339787			67.00
68. 00 06800 SPEECH PATHOLOGY	401, 326	1, 441, 002	0. 278505			68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 221	34, 925	0.063593			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	47, 760	535, 734	0. 089149			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	504, 230	2, 610, 888	0. 193126			73.00
76. 00 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	121, 356					76.00
76.01 03021 HEMODIALYSIS & OTHER ANCILLARY	63, 808		1			76. 01
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.000000			88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0. 000000			89. 00
OTHER REIMBURSABLE COST CENTERS	<u>'</u>	<u> </u>				
99. 10 09910 CORF	0	0	0.000000			99. 10
SPECIAL PURPOSE COST CENTERS	<u>'</u>	<u> </u>				
109. 00 10900 PANCREAS ACQUISITION	0	0	0.000000			109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0.000000			110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0.000000			111.00
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (sum of lines 50 thru 199)	4, 142, 142	14, 353, 551				200.00
201.00 Less Observation Beds	0	0				201.00
202.00 Total (line 200 minus line 201)	4, 142, 142	14, 353, 551				202.00

Health Financial Systems	REHABILITATION HOSPITAL	OF FT WAYNE	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT RO	OUTINE SERVICE CAPITAL COSTS	Provi der CCN: 153030	Peri od:	Worksheet D

near the Financial Systems Ren	ADILITATION HUSI	PITAL OF FI WA	TINE	III LI E	u oi foilli civis-2	2332-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	. COSTS	Provi der		Period: From 10/01/2013 To 09/30/2014	Worksheet D Part I Date/Time Pre 2/24/2015 3:4	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
oost conten beschiption	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.	/ raj as tillorit	Related Cost		col . 4)	
	B, Part II,		(col. 1 -		001. 4)	
	col . 26)		col . 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 ADULTS & PEDIATRICS	301, 179	0	301, 17	9 5, 384	55. 94	30.00
31. 00 INTENSIVE CARE UNIT	301, 177		301, 17	0, 304	0.00	
32. 00   CORONARY CARE UNIT			1		0.00	
33. 00 BURN INTENSIVE CARE UNIT	0				0.00	
	0					
34. 00 SURGI CAL I NTENSI VE CARE UNI T	0				0.00	
41. 00 SUBPROVI DER - I RF	0	0	1	0	0.00	
42. 00 SUBPROVI DER	0	1	1	0		42.00
43. 00 NURSERY	0			0		43.00
200.00 Total (lines 30-199)	301, 179		301, 17	9 5, 384		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00 ADULTS & PEDIATRICS	2, 265	126, 704				30.00
31.00   INTENSIVE CARE UNIT	0	0	1			31.00
32.00 CORONARY CARE UNIT	0	0				32.00
33.00 BURN INTENSIVE CARE UNIT	0	0				33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
41. 00   SUBPROVI DER - I RF	0	0	)			41.00
42. 00 SUBPROVI DER	0	0	)			42.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30-199)	2, 265	126, 704				200.00
	,	1	1			

Provider CCN: 153030	Health Financial Systems REHA	BILITATION HOSE	PITAL OF FT WAY	/NE	In Lie	u of Form CMS-2	2552-10
Title XVIII   Hospital   PPS   Capital   Related Cost (from Wkst. Related Cost (from Wkst. B. Part II, col. 26)   Total Charges   Ratio of Cost (col umn 3 x col umn 4)   PS   Cost Center Description   Related Cost (from Wkst. B. Part II, col. 26)   Total Charges   Ratio of Cost (col umn 3 x col umn 4)   PS   Cost Center Description   Related Cost (from Wkst. B. Part II, col. 26)   Total Charges   Ratio of Cost (col umn 3 x col umn 4)   PS   Cost Center Description   Total Charges   Ratio of Cost (col umn 3 x col umn 4)   PS   Cost Center Description   Total Charges   Total Charges	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der				
Capital Related Cost (from Wist. (From Wist. (From Wist. (B. Part II, col. 26))   1.00   2.00   3.00   4.00   5.00   57.00   57.00   59.00   59.00   59.00   59.00   59.00   60.00							nared:
Capital Related Cost (from Wkst. (From Frogram (From Wkst. (From Wkst. (From Wkst. (From Wkst. (From Frogram (From Wkst. (From Kkst. (From Wkst. (From Kkst. (From Wkst. (From Kkit. (From Wkst. (From					10 07/30/2014		
Rel ated Cost (from Wkst. B, Part II, col. 26)   1.00   2.00   3.00   4.00   5.00			Ti tl	e XVIII	Hospi tal	PPS	
Cross   Cros	Cost Center Description						
B, Part II, col. 26)			,	9		•	
ANCILLARY SERVICE COST CENTERS					Charges	column 4)	
1.00   2.00   3.00   4.00   5.00   5.00			col. 8)	col. 2)			
ANCI LLARY SERVI CE COST CENTERS   54.00   05400  RADI OLOGY-DI AGNOSTI C   10,936   567,922   0.019256   213,835   4,118   54.00   57.00   05700   CT SCAN   0 0 0 0 0.000000   0 0 57.00   58.00   05800  MAGNETI C RESONANCE I MAGI NG (MRI )   0 0 0 0.000000   0 0 0 58.00   59.00   05900  CARDI AC CATHETERI ZATI ON   0 0 0 0.000000   0 0 0 0.000000   0 0 0 0							
54. 00         05400 RADI OLOGY-DI AGNOSTI C         10,936         567,922         0.019256         213,835         4,118         54. 00           57. 00         05700 CT SCAN         0         0         0.000000         0         0         57. 00           58. 00         05800 MAGNETI C RESONANCE I MAGI NG (MRI)         0         0         0.000000         0         0         58. 00           59. 00         05900 CARDI AC CATHETERI ZATI ON         0         0         0.000000         0         0         59. 00           60. 01         06000 LABORATORY         4,027         766,507         0.005254         321,147         1,687         60. 00           60. 01         06001 BLOOD LABORATORY         0         0         0.000000         0         0         0.000000           65. 00         06500 RESPI RATORY THERAPY         2,589         140,185         0.018468         44,020         813         65.00           66. 00         06500 PHYSI CAL THERAPY         251,977         3,752,901         0.067142         1,556,160         104,484         66.00           67. 00         06700 OCCUPATI ONAL THERAPY         137,289         3,934,415         0.034894         1,647,603         57,491         67.00 <td< td=""><td></td><td>1. 00</td><td>2. 00</td><td>3. 00</td><td>4. 00</td><td>5. 00</td><td></td></td<>		1. 00	2. 00	3. 00	4. 00	5. 00	
57. 00         05700         CT SCAN         0         0         0.000000         0         57. 00           58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI )         0         0         0.000000         0         0         58. 00           59. 00         05900         CARDI AC CATHETERI ZATI ON         0         0         0.000000         0         0         59. 00           60. 00         06000         LABORATORY         4,027         766,507         0.002524         321,147         1,687         60. 00           65. 00         06500         RESPI RATORY THERAPY         2,589         140,185         0.018468         44,020         813         65. 00           66. 00         06600         PHYSI CAL THERAPY         251,977         3,752,901         0.067142         1,556,160         104,484         66. 00           67. 00         06700         OCCUPATI ONAL THERAPY         137,289         3,934,415         0.034894         1,647,603         57,491         67. 00           68. 00         06800         SPEECH PATHOLOGY         19,499         1,441,002         0.013532         478,740         6,478         68. 00           69. 00         06900         ELECTROCARDI OLOGY         76							
58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         0         0         0.000000         0         0         58. 00           59. 00         05900         CARDI AC CATHETERI ZATI ON         0         0         0.000000         0         0         59. 00           60. 00         06000         LABORATORY         4, 027         766, 507         0.005254         321, 147         1, 687         60. 00           65. 00         06500         RESPI RATORY THERAPY         2, 589         140, 185         0.018468         44, 020         813         65. 00           66. 00         06600         PHYSI CAL THERAPY         251, 977         3, 752, 901         0.067142         1, 556, 160         104, 484         66. 00           67. 00         06700         OCCUPATI ONAL THERAPY         251, 977         3, 752, 901         0.067142         1, 556, 160         104, 484         66. 00           68. 00         06800         SPEECH PATHOLOGY         19, 499         1, 441, 002         0.013532         478, 740         6, 478         68. 00           69. 00         06900         ELECTROCARDI OLOGY         76         34, 925         0.002176         18, 765         41         69. 00           71. 00         O7		10, 936	567, 922			· ·	
59.00         05900         CARDI AC CATHETERI ZATI ON         0         0.000000         0.000000         0         59.00           60.00         06000         LABORATORY         4,027         766,507         0.005254         321,147         1,687         60.00           60.01         06001         BLOOD LABORATORY         0         0         0.000000         0         0         60.01           65.00         06500         RESPI RATORY THERAPY         2,589         140,185         0.018468         44,020         813         65.00           66.00         06600         PHYSI CAL THERAPY         251,977         3,752,901         0.067142         1,556,160         104,484         66.00           67.00         06700         OCCUPATI ONAL THERAPY         137,289         3,934,415         0.034894         1,647,603         57,491         67.00           68.00         08800         SPECH PATHOLOGY         19,499         1,441,002         0.013532         478,740         6,478         68.00           69.00         06900         ELECTROCARDI OLOGY         76         34,925         0.002176         18,765         41         69.00           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS <t< td=""><td></td><td>0</td><td>0</td><td></td><td></td><td>-</td><td></td></t<>		0	0			-	
60. 00		0	0			ū	
60. 01		0	0			•	
65. 00		4, 027					
66. 00   06600   PHYSI CAL THERAPY   251, 977   3, 752, 901   0. 067142   1, 556, 160   104, 484   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   137, 289   3, 934, 415   0. 034894   1, 647, 603   57, 491   67. 00   68. 00   06800   SPECH PATHOLOGY   19, 499   1, 441, 002   0. 013532   478, 740   6, 478   68. 00   69. 00   06900   ELECTROCARDI OLOGY   76   34, 925   0. 002176   18, 765   41   69. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   3, 968   535, 734   0. 007407   181, 635   1, 345   71. 00   72. 00   07200   MPL. DEV. CHARGED TO PATI ENTS   0   0   0. 000000   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   18, 939   2, 610, 888   0. 007254   1, 053, 750   7, 644   73. 00   76. 01   03021   HEMODI ALYSI S & 0THER ANCI LLARY   879   194, 483   0. 004520   141, 634   640   76. 01   00TPATI ENT SERVI CE COST CENTERS   88. 00   08900   FEDERALLY QUALI FIED HEALTH CENTER   0   0   0. 000000   0   0   89. 00   89. 00   08900   FEDERALLY QUALI FIED HEALTH CENTER   0   0   0. 000000   0   0   89. 00   0000000   0   0   0   0   0. 0000000   0		0	Ĭ				
67. 00			· ·		· ·		
68. 00		1				· ·	
69. 00							
71. 00		1			· ·		
72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   18, 939   2, 610, 888   0   007254   1, 053, 750   7, 644   73. 00   76. 00   03020   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   12, 495   374, 589   0   033357   139, 802   4, 663   76. 00   76. 01   03021   HEMODI ALYSI S & OTHER ANCI LLARY   879   194, 483   0   004520   141, 634   640   76. 01   000   000000   000000   000000   000000   000000					· ·		
73. 00   07300   DRUGS CHARGED TO PATIENTS   18, 939   2, 610, 888   0.007254   1, 053, 750   7, 644   73. 00   76. 00   03020   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   12, 495   374, 589   0.033357   139, 802   4, 663   76. 00   03021   HEMODI ALYSI S & OTHER ANCI LLARY   879   194, 483   0.004520   141, 634   640   76. 01   0000000   00000000000000000000000							
76. 00		_	Ĭ			-	
76. 01 03021   HEMODI ALYSI S & OTHER ANCI LLARY   879   194, 483   0.004520   141, 634   640   76. 01   0UTPATI ENT   SERVI CE   COST   CENTERS		1				· ·	
OUTPATIENT SERVICE COST CENTERS         O 08800 RURAL HEALTH CLINIC         O 0 0 0.000000         O 0 88.00           89.00         08900 FEDERALLY QUALIFIED HEALTH CENTER         O 0 0.000000         O 0.000000         O 0 89.00						· ·	
88. 00   08800   RURAL HEALTH CLINIC   0   0.000000   0   0   88. 00   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0.000000   0   89. 00		879	194, 483	0. 00452	0 141, 634	640	76. 01
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0.000000   0   89. 00							
		0	0			-	
200.00   Total (Lines 50-199)   462.674  14.353.551    5.797.091  189.404 200.00		0	0			-	
	200.00   Total (lines 50-199)	462, 674	14, 353, 551		5, 797, 091	189, 404	200. 00

al Systems REHA	ILITATION HOSPITAL OF FT WAYNE	In Lieu of For
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS   Provider CCN: 153030   Period: From 10/01/2013   To 09/30/2014   Date/Time Prepared: 2/24/2015 3: 47 pm.	Health Financial Systems REF	ABILITATION HOS	PITAL OF FT WAY	YNE	In Lie	eu of Form CMS-2	2552-10
Nursing School   Sc	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS			From 10/01/2013 To 09/30/2014	Part III Date/Time Pre 2/24/2015 3:4	
NPATIENT ROUTINE SERVICE COST CENTERS							
NPATIENT ROUTINE SERVICE COST CENTERS	Cost Center Description						
NPATI ENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00		School	Cost				
INPATI ENT ROUTINE SERVICE COST CENTERS							
INPATI ENT ROUTINE SERVICE COST CENTERS							
30.00		1. 00	2.00	3. 00	4. 00	5.00	
1.00							
32. 00   03200   CORONARY CARE UNIT   0   0   0   0   0   32.00   33. 00   03300   BURN INTENSIVE CARE UNIT   0   0   0   0   0   33.00   34. 00   03400   SUBRICIAL INTENSIVE CARE UNIT   0   0   0   0   0   0   41. 00   04100   SUBPROVIDER   1   1   1   1   1   42. 00   04200   SUBPROVIDER   0   0   0   0   0   0   43. 00   04300   NURSERY   0   0   0   0   0   44. 00   04200   SUBPROVIDER   0   0   0   0   0   45. 00   04300   NURSERY   0   0   0   0   46. 00   7. 00   8. 00   9. 00      Inpatient Program Days Pass-Through Cost (col. 7 x col. 8)   9. 00   0   0   0   0   9. 00   0   0   0   9. 00   0   9. 00   0   0   9. 00   0		C	0		0 0	1	
1		C	0		0	0	
1		C	0		0	0	
41.00		C	0		0	1	
42. 00		C	0		0	0	
A3.00		C	) 0	1	0 0	0	
Total (lines 30-199)		C	0	1	0 0	0	
Cost Center Description		C	0	1	0	_	
Days   Col. 5 ÷ Col. 6   Program Days   Program Pass-Through Cost (col. 7 x col. 8)		C	0		0	0	200.00
NPATIENT ROUTINE SERVICE COST CENTERS   6.00   7.00   8.00   9.00	Cost Center Description						
NPATIENT ROUTINE SERVICE COST CENTERS   6.00   7.00   8.00   9.00		Days	1 '	Program Days			
NPATIENT ROUTINE SERVICE COST CENTERS   5,384   0.00   2,265   0   30.00   31.00   31.00   32.00   03100   INTENSI VE CARE UNI T   0   0.00   0   0   32.00   330.0			col. 6)				
NPATIENT ROUTINE SERVICE COST CENTERS					,		
INPATI ENT ROUTI NE SERVI CE COST CENTERS   30.00   03000   ADULTS & PEDI ATRI CS   5,384   0.00   2,265   0   30.00   31.00   31.00   31.00   03100   INTENSI VE CARE UNI T   0   0.00   0   0   0   31.00   32.00   03200   CORONARY CARE UNI T   0   0.00   0   0   0   32.00   33.00   03300   BURN I INTENSI VE CARE UNI T   0   0.00   0   0   0   33.00   34.00   03400   SURGI CAL I INTENSI VE CARE UNI T   0   0.00   0   0   0   34.00   04100   SUBPROVI DER - I RF   0   0.00   0   0   0   0   0   0   0						1	
30. 00		6. 00	7.00	8.00	9. 00		
31. 00   03100   INTENSI VE CARE UNI T   0   0.00   0   0   31. 00   32. 00   33. 00   03200   CORONARY CARE UNI T   0   0.00   0   0   32. 00   33. 00   33. 00   BURN I NTENSI VE CARE UNI T   0   0.00   0   0   0   33. 00   34. 00   03400   SURGI CAL I NTENSI VE CARE UNI T   0   0.00   0   0   0   34. 00   04100   SUBPROVI DER - I RF   0   0.00   0   0   0   0   0   0   0				1	=1		
32. 00   03200   CORONARY CARE UNI T   0   0.00   0   0   32. 00   03300   BURN I NTENSI VE CARE UNI T   0   0.00   0   0   0   33. 00   03400   SURGI CAL I NTENSI VE CARE UNI T   0   0.00   0   0   0   0   0   0   0		5, 384			.5	1	
33. 00   03300   BURN I NTENSI VE CARE UNI T   0   0.00   0   0   33. 00   34. 00   03400   SURGI CAL I NTENSI VE CARE UNI T   0   0.00   0   0   0   34. 00   04100   SUBPROVI DER - I RF   0   0.00   0   0   0   0   0   0   0					0	1	
34. 00     03400     SURGI CAL INTENSI VE CARE UNI T     0     0.00     0     0     34.00       41. 00     04100     SUBPROVI DER - I RF     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		C			0	1	
41. 00     04100     SUBPROVI DER - I RF     0     0.00     0     0     41. 00       42. 00     04200     SUBPROVI DER     0     0.00     0     0     0     42. 00       43. 00     04300     NURSERY     0     0.00     0     0     0     43. 00		0			0	1	
42. 00   04200   SUBPROVI DER					0	1	
43. 00   04300   NURSERY   0   0. 00   0   43. 00		C	l .		0	1	
	· · · · · · · · · · · · · · · · · · ·				0	1	
200.00   Total (lines 30-199)   5,384    2,265  0   200.00	· · · · · · · · · · · · · · · · · · ·	C			0	1	
	200.00    lotal (lines 30-199)	5, 384	+	2, 26	.5  C	1	200. 00

Health Financial Systems	REHABILITATION HOSPITAL	OF FT WAYNE	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 153030		Worksheet D
THROUGH COSTS			From 10/01/2013	Part IV

				T	o 09/30/2014	Date/Time Pre 2/24/2015 3:4	pared: 7 nm
			Ti tl	e XVIII	Hospi tal	PPS	7 piii
	Cost Center Description	Non Physician	Nursi ng	Allied Health		Total Cost	
	·	Anesthetist	School		Medi cal	(sum of col 1	
		Cost			Educati on	through col.	
					Cost	4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
_	NCILLARY SERVICE COST CENTERS						
1	5400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
	5700 CT SCAN	0	0	0	0	0	57.00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
4	5900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
	6000 LABORATORY	0	0	0	0	0	60.00
	6001 BLOOD LABORATORY	0	0	0	0	0	60. 01
	6500 RESPI RATORY THERAPY	0	0	0	0	0	65.00
4	6600 PHYSI CAL THERAPY	0	0	0	0	0	66.00
4	6700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
	6800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
	6900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
	77100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
4	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
4	3020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	76.00
-	3021 HEMODIALYSIS & OTHER ANCILLARY	] 0	0	) 0	0	0	76. 01
_	UTPATIENT SERVICE COST CENTERS	1 _1		_	T	_	
	18800 RURAL HEALTH CLINIC	0	0		0	0	88.00
	8900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89.00
200.00	Total (lines 50-199)	0	U	y O	0	0	200. 00

Health Financial Systems	REHABILITATION HOSPITAL	OF FT WAYNE	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 153030	Peri od:	Worksheet D

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS			Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Pre 2/24/2015 3:4	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges			I npati ent	
	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col. 2, 3 and	col. 8)	col. 7)	(col. 6 ÷		
	4)			col. 7)		
	6. 00	7. 00	8. 00	9. 00	10. 00	
ANCILLARY SERVICE COST CENTERS	1		,			
54. 00   05400 RADI OLOGY-DI AGNOSTI C	0	567, 922			213, 835	
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	766, 507	0. 00000		321, 147	60.00
60. 01   06001   BLOOD LABORATORY	0	0	0. 00000		0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	140, 185			44, 020	65. 00
66. 00  06600 PHYSI CAL THERAPY	0	3, 752, 901			1, 556, 160	
67. 00  06700 OCCUPATI ONAL THERAPY	0	3, 934, 415			1, 647, 603	
68. 00   06800   SPEECH PATHOLOGY	0	1, 441, 002			478, 740	
69. 00  06900   ELECTROCARDI OLOGY	0	34, 925			18, 765	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	535, 734			181, 635	
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0	0.00000	0. 000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 610, 888	0.00000	0. 000000	1, 053, 750	73.00
76. 00 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	374, 589	0.00000	0. 000000	139, 802	76.00
76. 01 03021 HEMODIALYSIS & OTHER ANCILLARY	0	194, 483	0.00000	0. 000000	141, 634	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. 000000	0	89. 00
200.00 Total (lines 50-199)	0	14, 353, 551			5, 797, 091	200. 00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153030 Period: From 10/01/2013 Form 10/01/2013 To 09/30/2014 Date/Time Prepared:

					2/24/2015 3:47	7 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11. 00	12. 00	13. 00			
ANCILLARY SERVICE COST CENTERS			.1	_1		
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	(	)			54.00
57. 00   05700   CT   SCAN	0	(				57.00
58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)	0	(				58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	(				59.00
60. 00   06000   LABORATORY	0	(				60.00
60. 01   06001   BLOOD LABORATORY	0	(				60. 01
65. 00 06500 RESPIRATORY THERAPY	0	(				65.00
66. 00   06600   PHYSI CAL THERAPY	0	(				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	(				67.00
68. 00 06800 SPEECH PATHOLOGY	0	(				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	(				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	(				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	(				73.00
76. 00 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	(				76.00
76. 01 03021 HEMODI ALYSI S & OTHER ANCI LLARY	0	(	)  (	)		76. 01
OUTPATIENT SERVICE COST CENTERS						
88. 00   08800   RURAL HEALTH CLINIC	0	(				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(	(		Į,	89.00
200.00   Total (lines 50-199)	0	(	η (	וע	2	200. 00

Health Financial Systems	REHABILITATION HOSPITAL	OF FT WAYNE	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ROUTINE	SERVICE CAPITAL COSTS	Provi der CCN: 153030	Peri od:	Worksheet D

Health Financial Systems REHA	ABILITATION HOSPITAL OF FT WAYNE			In Lieu of Form CMS-2552-			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Period: From 10/01/2013 To 09/30/2014	Date/Time Pre		
					2/24/2015 3:4	7 pm	
			le XIX	Hospi tal	PPS		
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem		
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /		
	(from Wkst.		Related Cost		col. 4)		
	B, Part II,		(col. 1 -				
	col. 26)		col. 2)				
	1. 00	2.00	3.00	4. 00	5. 00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	301, 179	0	301, 17	9 5, 384	55. 94	30.00	
31.00 INTENSIVE CARE UNIT	0			0 0	0.00	31.00	
32.00 CORONARY CARE UNIT	0			0 0	0.00	32.00	
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33.00	
34.00 SURGICAL INTENSIVE CARE UNIT	0			o o	0.00	34.00	
41. 00 SUBPROVI DER - I RF	0	0		ol ol	0.00	41.00	
42. 00 SUBPROVI DER	0	0		ol ol	0.00	42.00	
43. 00 NURSERY	0			ol ol	0.00	43.00	
200.00 Total (lines 30-199)	301, 179		301, 17	9 5, 384		200.00	
Cost Center Description	I npati ent	I npati ent					
	Program days	Program					
		Capital Cost					
		(col. 5 x					
		col. 6)					
	6. 00	7. 00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	724	40, 501				30.00	
31.00 INTENSIVE CARE UNIT	0	0				31.00	
32. 00   CORONARY CARE UNIT	0	0				32.00	
33.00 BURN INTENSIVE CARE UNIT	0	0				33.00	
34.00 SURGICAL INTENSIVE CARE UNIT	0	0				34.00	
41. 00   SUBPROVI DER - I RF	0	0				41.00	
42. 00 SUBPROVI DER	0	0				42.00	
43. 00 NURSERY	0	0				43.00	
200.00 Total (lines 30-199)	724	40, 501				200.00	
	'		'			•	

In Lieu of Form CMS-2552-10 Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provi der CCN: 153030 Peri od: Worksheet D From 10/01/2013 To 09/30/2014 Part II Date/Time Prepared: 2/24/2015 3:47 pm Title XIX Hospi tal PPS Cost Center Description Total Charges Ratio of Cost Capital Costs Capi tal Inpati ent to Charges Related Cost (from Wkst. Program (column 3 x C, Part I, column 4) (from Wkst. (col. 1 ÷ Charges B, Part II, col. 8) col. 2) col. 26) 1. 00 2.00 3.00 4. 00 5. 00 ANCILLARY SERVICE COST CENTERS 54 00 05400 RADI OLOGY-DI AGNOSTI C 10, 936 567, 922 0.019256 34, 421 54 00 663 57.00 05700 CT SCAN 0.000000 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0.000000 o 58.00 0 0 58.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 59.00 0 0 06000 LABORATORY 766, 507 60.00 4,027 0.00525446, 010 242 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 60.01 65.00 06500 RESPIRATORY THERAPY 2, 589 140, 185 0.018468 22, 573 417 65.00 06600 PHYSI CAL THERAPY 251, 977 3, 752, 901 66.00 0.067142 279, 561 18, 770 66.00 67.00 06700 OCCUPATI ONAL THERAPY 137, 289 3, 934, 415 0.034894 295, 059 10, 296 67.00 06800 SPEECH PATHOLOGY 19, 499 1, 441, 002 0.013532 123, 259 1,668 68.00 69.00 06900 ELECTROCARDI OLOGY 34, 925 0.002176 69.00 76 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 968 0.007407 77, 219 572 71.00 71.00 535, 734 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.007254 73.00 18, 939 2, 610, 888 240, 775 1,747 73.00 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 12, 495 374, 589 0.033357 76.00 76.00 58, 775 1, 961 76.01 03021 HEMODIALYSIS & OTHER ANCILLARY 879 194, 483 0.004520 0 76.01 OUTPATIENT SERVICE COST CENTERS

0

14, 353, 551

462, 674

0.000000

0.000000

1, 177, 652

0 88.00

89.00

0

36, 336 200. 00

88. 00 08800 RURAL HEALTH CLINIC

200.00

89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER

Total (lines 50-199)

Health Financial Systems REHAI	BILITATION HOS	PITAL OF FT WAY	/NE	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	STS Provi der		Peri od:	Worksheet D	
				From 10/01/2013 To 09/30/2014		narad:
				10 09/30/2014	2/24/2015 3: 4	
			le XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Allied Health	All Other	Swi ng-Bed	Total Costs	
	School	Cost	Medi cal	Adjustment	(sum of cols.	
			Educati on	Amount (see	1 through 3,	
			Cost	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	1	30.00
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	33.00
34.00 03400 SURGI CAL INTENSI VE CARE UNIT	0	0		0	0	34.00
41. 00   04100   SUBPROVI DER - I RF	0	0		0	0	41.00
42. 00   04200   SUBPROVI DER	0	0		0	0	42.00
43. 00   04300   NURSERY	0	0		0	0	43.00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient		I npati ent	I npati ent		
	Days	(col. 5 ÷	Program Days			
		col. 6)		Pass-Through		
				Cost (col. 7		
				x col. 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS				.1	T	
30. 00   03000   ADULTS & PEDI ATRI CS	5, 384			4 0		30.00
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		33.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0	0.00		0		34.00
41. 00   04100   SUBPROVI DER -   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
200.00   Total (lines 30-199)	5, 384		72	4  0		200. 00

Health Financial Systems	REHABILITATION HOSPITAL	. OF FT WAYNE	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 153030	Peri od: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/24/2015 3:47 pm
		T: +1 - VIV	11! +-1	חחר

					2/24/2015 3:4	7 pm
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Allied Health	All Other	Total Cost	
	Anesthetist	School		Medi cal	(sum of col 1	
	Cost			Educati on	through col.	
				Cost	4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
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 I MAGING (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 BL00D 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 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	76. 00
76.01 03021 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	REHABILITATION HOSPITAL	OF FT WAYNE		In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 153030	Peri od:	Worksheet D

From 10/01/2013 | Part IV To 09/30/2014 | Date/Time Prepared: THROUGH COSTS 2/24/2015 3:47 pm Title XIX Hospi tal PPS Cost Center Description Total Charges Ratio of Cost I npati ent Total Outpati ent to Charges Program (from Wkst. Outpati ent Ratio of Cost Cost (sum of C, Part I, to Charges (col. 5 ÷ Charges (col. 6 ÷ col. 7) col. 2, 3 and col. 8) col. 7) 4) 6. 00 7.00 8.00 9. 00 10.00 ANCILLARY SERVICE COST CENTERS 54 00 05400 RADI OLOGY-DI AGNOSTI C 567, 922 0.000000 0.000000 54 00 34, 421 57.00 05700 CT SCAN 0.000000 0.000000 0 57.00 000000000000000 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0.000000 58.00 0 0 58.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 59.00 0 06000 LABORATORY 766, 507 0.000000 60.00 0.000000 46, 010 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 65.00 06500 RESPIRATORY THERAPY 140, 185 0.000000 0.000000 22, 573 65.00 0.000000 3, 752, 901 279, 561 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 0.000000 67.00 06700 OCCUPATI ONAL THERAPY 3, 934, 415 0.000000 295, 059 67.00 06800 SPEECH PATHOLOGY 1, 441, 002 0.000000 0.000000 123, 259 68.00 69.00 06900 ELECTROCARDI OLOGY 34, 925 0.000000 0.000000 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0.000000 77, 219 71.00 535, 734 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0.000000 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 2, 610, 888 0.000000 0.000000 240, 775 73.00 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 374, 589 0.000000 0.000000 76.00 58, 775 76.00 76.01 03021 HEMODIALYSIS & OTHER ANCILLARY 194, 483 0.000000 0.000000 0 76.01 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0.000000 0.000000 88.00 ol 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0.000000 0.000000 O 200.00 Total (lines 50-199) 14, 353, 551 1, 177, 652 200. 00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

THOUGH COSTS

REHABILITATION HOSPITAL OF FT WAYNE

In Lieu of Form CMS-2552-10

Period: Worksheet D

From 10/01/2013 | Part IV |
To 09/30/2014 | Date/Time Prepared: 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/2015 | 0.004/

					10 077 007 201	2/24/2015 3:	
			Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	0ut <sub>l</sub>	pati ent	Outpati ent			
	Program		ogram	Program			
	Pass-Through	Ch	narges	Pass-Through			
	Costs (col. 8			Costs (col. 9	9		
	x col . 10)			x col. 12)			
	11. 00	1	2. 00	13. 00			
ANCILLARY SERVICE COST CENTERS				T	_1		4
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0		0		0		54.00
57. 00   05700   CT   SCAN	0		0		0		57.00
58. 00   05800   MAGNETIC RESONANCE   MAGING (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   66. 00   06600   PHYSI CAL   THERAPY	0		0		0		65. 00 66. 00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	0		0		0		67.00
68. 00 06800 SPEECH PATHOLOGY	0		0		0		68.00
69. 00   06900  SPEECH PATHOLOGY	0		0		0		69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		0		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0		0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS			0		0		73.00
76. 00 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		0		0		76.00
76. 00   03020   PSTCHTATRIC/PSTCHOLOGICAL SERVICES  76. 01   03021   HEMODIALYSIS & OTHER ANCILLARY	0		0		0		76.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>				o <sub>l</sub>		70.01
88. 00 08800 RURAL HEALTH CLINIC			0		0		88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER			0		0		89.00
200.00 Total (lines 50-199)			0		0		200.00
	1 9		Ü	ı	~		1

Health Financial Systems	REHABILITATION HOSPITAL	. OF FT WAYNE	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 153030	Peri od: From 10/01/2013	Worksheet D-1	
			To 09/30/2014	Date/Time Pre 2/24/2015 3:4	pared: 7 pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					

	Title XVIII Hospital	PPS	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5, 384	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5, 384	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	5, 366	3.00
4. 00	do not complete this line.    Semi-private room days (excluding swing-bed and observation bed days)	18	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost		•
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
7 00	reporting period (if calendar year, enter 0 on this line)	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	2, 265	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	U	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12. 00		0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	O	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only)	0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
17.00	reporting period	0.00	17.00
18.00		0. 00	18. 00
40.00	reporting period	0.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	4, 235, 953	1
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
23. 00	5 x line 17)  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
23.00	Swilling teld cost appricable to swill type services after became of or the cost reporting period (The C		25.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
05 00	7 x line 19)		05.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 $\times$ line 20)	0	25. 00
26. 00		0	26.00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4, 235, 953	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	7, 759, 021	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	7, 491, 809	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	267, 212 0. 545939	
32.00		1, 396. 16	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	14, 845. 11	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	ı
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	0 4, 235, 953	36. 00 37. 00
37.00	27 minus line 36)	7, 200, 700	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00		786. 77	38.00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35)	1, 782, 034 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 + line 40)	1, 782, 034	

30.00	Semi-private room charges (excluding swing-bed charges)	267, 212	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 545939	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	1, 396. 16	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	14, 845. 11	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	4, 235, 953	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)	786. 77	38. 00
	Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)	786. 77 1, 782, 034	
39. 00			
39. 00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35)		39. 00 40. 00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35)	1, 782, 034 0	39. 00 40. 00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35)	1, 782, 034 0	39. 00 40. 00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35)	1, 782, 034 0	39. 00 40. 00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35)	1, 782, 034 0	39. 00 40. 00

OMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 153030	Peri od: From 10/01/2013 To 09/30/2014	Date/Time Pre	pared:
			T: ±1	- 20/111	11	2/24/2015 3: 4	7 pm
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
		I npati ent	Inpatient	Diem (col.		(col. 3 x	
		Cost	Days	÷ col . 2)	4.00	col . 4)	
2 00	NURSERY (title V & XIX only)	1. 00	2.00	3.00	4.00	5. 00	42.00
2.00	Intensive Care Type Inpatient Hospital Units	<u> </u>		,	50, 0	J	12.00
3. 00	INTENSIVE CARE UNIT	0	(	•		0	
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	(	1		0	
6. 00	SURGI CAL I NTENSI VE CARE UNI T	ő	(	•		Ö	
7. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
8. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3. line 200)			1, 691, 437	48.00
	Total Program inpatient costs (sum of lines			ons)		3, 473, 471	
0 00	PASS THROUGH COST ADJUSTMENTS			WI+ D		10/ 704	
0. 00	Pass through costs applicable to Program inp III)	atient routine	services (Tro	m WKST. D, SU	ım or Parts I and	126, 704	50.00
1. 00	Pass through costs applicable to Program inp	atient ancilla	y services (f	rom Wkst. D,	sum of Parts II	189, 404	51.00
	and IV)	50 1 54)				04/ 400	
2. 00 3. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated non-nh	vsician anest	hetist and	316, 108 3, 157, 363	
3. 00	medical education costs (line 49 minus line		oratea, non pi	iyar er arr arreat	metrat, and	3, 137, 303	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge					0 0. 00	
	Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operat	ing cost and ta	arget amount (	line 56 minus	s line 53)	0	
	Bonus payment (see instructions)	norting noried	anding 1004	undoted and a	sampaundad by the	0	
9. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996,	updated and d	compounded by the	0.00	59.00
	Lesser of lines 53/54 or 55 from prior year					0. 00	
1. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha					0	61.00
	amount (line 56), otherwise enter zero (see		ts (Titles 54 X	. 60), OI 1% C	or the target		
	Relief payment (see instructions)					0	
	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	63.00
	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64.00
	instructions)(title XVIII only)	o o		•			
5. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 of the	cost reportin	ng period (See	0	65.00
5. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
	CAH (see instructions)						
7. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 31	of the cost r	reporting period	0	67.00
3. 00	Title V or XIX swing-bed NF inpatient routin	e costs after [	December 31 of	the cost rep	orting period	0	68.00
	(line 13 x line 20)		<i>(</i> 1.1	(0)			,, ,,
9. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N		•			0	69.00
0. 00	Skilled nursing facility/other nursing facil						70.00
1.00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71.00
2. 00 3. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		m (line 14 x l	ine 35)			72.00
4. 00	Total Program general inpatient routine serv						74.00
5. 00	Capital -related cost allocated to inpatient	routine service	e costs (from	Worksheet B,	Part II, column		75.00
5. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
7. 00	Program capital related costs (line 9 x line						77.00
3. 00	Inpatient routine service cost (line 74 minu	,		1.3			78.0
0.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	, ,		*.	nus line 70)		79. 0 80. 0
. 00	Inpatient routine service costs for comp		Jose Trill Call C	(IIIIC /O IIII	nus iine /7)		81.0
2. 00	Inpatient routine service cost limitation (I	ine 9 x line 8	* .				82.0
	Reasonable inpatient routine services costs (		ns)				83.0
4. 00	Program inpatient ancillary services (see in	structions) (see instructio					84.0

85. 00 86. 00

00 88.00 0 89.00

0 87.00

0.00

85.00 Utilization review - physician compensation (see instructions)

86.00 Total Program inpatient operating costs (sum of lines 83 through 85)

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

Total observation bed days (see instructions)

88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)

89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems REHA	BILITATION HOS	PITAL OF FT WAY	/NE	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od: From 10/01/2013	Worksheet D-1	
				To 09/30/2014		pared: 7 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		27)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	301, 179	4, 235, 953	0. 07110	1 0	0	90.00
91.00 Nursing School cost	0	4, 235, 953	0. 00000	0	0	91.00
92.00 Allied health cost	0	4, 235, 953	0. 00000	0	0	92.00
93.00 All other Medical Education	0	4, 235, 953	0. 00000	0 0	0	93.00

	Financial Systems REHABILITATION HOSPITAL			u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST	Provi der CCN: 153030	Peri od: From 10/01/2013	Worksheet D-1	
			To 09/30/2014		
		Title XIX	Hospi tal	PPS	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		5, 384	1.00
2.00	Inpatient days (including private room days, excluding swing-be			5, 384	2.00
3.00	Private room days (excluding swing-bed and observation bed days	s). If you have only p	rivate room days,	0	3.00
	do not complete this line.				
4. 00	Semi-private room days (excluding swing-bed and observation bed			5, 384	4.00
5. 00	Total swing-bed SNF type inpatient days (including private roor	m days) through Decembe	er 31 of the cost	0	5.00
/ 00	reporting period		21 -6 -1	0	/ 00
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceiibei	31 Of the Cost	U	6.00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7.00
7.00	reporting period	aaye, : eag.: becombe.	0. 0. 1 0001	, and the second	,,,,,
8.00					
	reporting period (if calendar year, enter 0 on this line)				
9. 00					9. 00
10.00	newborn days)				10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instructions)		room days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		room days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, en		days) arter	Ü	11.00
12.00			te room days)	0	12.00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
44.00	after December 31 of the cost reporting period (if calendar year				
	Medically necessary private room days applicable to the Program	m (excluding swing-bed	days)	0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
10.00	SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 o	of the cost	0.00	17.00
	reporting period	3			
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	f the cost	0. 00	19. 00
20. 00	reporting period	ofter December 21 of	the cost	0.00	20.00
20.00	Medicaid rate for swing-bed NF services applicable to services reporting period	arter becember 31 01	the cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	)		4, 235, 953	21.00
22. 00	Swing-bed cost applicable to SNF type services through December		tina period (line		22.00
	5 x line 17)		3   1		
23. 00	Swing-bed cost applicable to SNF type services after December 3	31 of the cost reportio	ng period (line d	0	23. 00
	x line 18)			_	
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)				l

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 153030	Period: From 10/01/2013	Worksheet D-1	
					To 09/30/2014	Date/Time Pre 2/24/2015 3:4	
				tle XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col.		Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)	'	col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	0	(	0.	00 0	0	42.00
42.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	ol	(	0.	00 0	0	43.00
43. 00 44. 00	CORONARY CARE UNIT	0	(	•		0	44.00
45. 00	BURN INTENSIVE CARE UNIT	Ö	(			0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	o	(	1		0	46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1 00	
48. 00	Program inpatient ancillary service cost (Wks	st D_3 col 3	R line 200)			1. 00 330, 155	48. 00
49. 00	Total Program inpatient costs (sum of lines			ons)		899, 776	
	PASS THROUGH COST ADJUSTMENTS	<u> </u>		,			
50.00	Pass through costs applicable to Program inpa	atient routine	services (fro	om Wkst. D, su	um of Parts I and	40, 501	50.00
E1 00		ationt oncillor		From What D	oum of Donto II	24 224	F1 00
51. 00	Pass through costs applicable to Program inpa and IV)	atrent ancillar	y services (T	I UIII WKST. D,	Suil OF Parts II	36, 336	51.00
52.00	Total Program excludable cost (sum of lines!	50 and 51)				76, 837	52.00
53. 00	Total Program inpatient operating cost exclu	ding capital re	elated, non-ph	ysician anest	thetist, and	822, 939	
	medical education costs (line 49 minus line !	52)					
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION					0	54.00
54. 00 55. 00	Program discharges Target amount per discharge					0 0. 00	
56. 00	Target amount (line 54 x line 55)					0.00	
57.00	Difference between adjusted inpatient operati	ng cost and ta	arget amount (	line 56 minus	s line 53)	0	57.00
58.00	Bonus payment (see instructions)					0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and o	compounded by the	0. 00	59.00
60.00	market basket Lesser of lines 53/54 or 55 from prior year (	rost renort ur	ndated by the	market hasket	+	0. 00	60.00
61.00	If line 53/54 is less than the lower of line					0.00	
	which operating costs (line 53) are less than						
	amount (line 56), otherwise enter zero (see	nstructions)					,,,,,,
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (coo instru	ictions)			0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mistro	icti ons)			0	03.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost report	ting period (See	0	64.00
	instructions)(title XVIII only)					_	
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reportir	ng period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
	CAH (see instructions)	•	•		,	_	
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost r	reporting period	0	67.00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	o costs often [	Nocombor 21 of	the cost re	porting ported	0	68.00
06.00	(line 13 x line 20)	e costs arter t	becelliber 31 01	the cost rep	on tring perrou	U	00.00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (	(line 67 + lir	ie 68)		0	69.00
76	PART III - SKILLED NURSING FACILITY, OTHER NU						
70.00	Skilled nursing facility/other nursing facili	•		• • • • •	)		70.00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line		THE 70 ÷ TIME	: ∠)			71.00
73. 00	Medically necessary private room cost applications		n (line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine servi	ce costs (line	e 72 + line 73	3)			74.00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B,	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77. 00	Program capital-related costs (line 9 x line						77.00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79.00	Aggregate charges to beneficiaries for excess				70		79.00
80. 00 81. 00	Total Program routine service costs for companient routine service cost per diem limi		cost iimitatio	on (IIne 78 mi	nus iine /9)		80. 00 81. 00
82.00	Inpatient routine service cost per drem rim Inpatient routine service cost limitation (li		1)				82.00
83.00	Reasonable inpatient routine service costs (		* .				83.00
84.00	Program inpatient ancillary services (see in	structions)	ŕ				84.00
85.00	Utilization review - physician compensation						85.00
86. 00	Total Program inpatient operating costs (sum		nrough 85)				86.00
97 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	87.00
	instant specification bod days (see instructions)	,				U	1 57.00
87. 00 88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0. 00	88. 00

Health Financial Systems REHA	BILITATION HOS	PITAL OF FT WAY	/NE	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od: From 10/01/2013	Worksheet D-1	
				To 09/30/2014		pared: 7 pm
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		27)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	301, 179	4, 235, 953	0. 07110	1 0	0	90.00
91.00 Nursing School cost	0	4, 235, 953	0. 00000	0	0	91.00
92.00 Allied health cost	0	4, 235, 953	0. 00000	0	0	92.00
93.00 All other Medical Education	0	4, 235, 953	0. 00000	0 0	0	93. 00

Heelth Finer	DELIABLE TATION HOSDITAL OF F	T WAY	/NE	In Lie	u of Form CMC (	DEED 10
	ncial Systems REHABILITATION HOSPITAL OF F		CCN: 153030	Peri od:	u of Form CMS-2 Worksheet D-3	
THE ATTENT AT	NOTEENING SOST ALTONITONIMENT	ruci	CON. 133030	From 10/01/2013 To 09/30/2014	Date/Time Pre 2/24/2015 3:4	pared:
		Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2) 3.00	
I NPAT	IENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 31. 00 03100 32. 00 03200 33. 00 03300 34. 00 03400 41. 00 04100 42. 00 04200	ADULTS & PEDIATRICS INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IRF SUBPROVIDER NURSERY			3, 342, 258 0 0 0 0 0 0		30. 00 31. 00 32. 00 33. 00 34. 00 41. 00 42. 00 43. 00
ANCI L	LARY SERVICE COST CENTERS					
57. 00 05700 58. 00 05800 59. 00 05900 60. 01 06001 65. 00 06600 67. 00 06700 68. 00 06800 69. 00 06900 71. 00 07200 72. 00 07300 76. 00 03020 76. 01 03021	RADI OLOGY-DI AGNOSTI C CT SCAN  MAGNETI C RESONANCE I MAGI NG (MRI) CARDI AC CATHETERI ZATI ON LABORATORY BLOOD LABORATORY RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY ELECTROCARDI OLOGY MEDI CAL SUPPLI ES CHARGED TO PATI ENTS I MPL. DEV. CHARGED TO PATI ENTS DRUGS CHARGED TO PATI ENTS PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES HEMODI ALYSI S & OTHER ANCI LLARY TI ENT SERVI CE COST CENTERS		0. 1370: 0. 0000( 0. 0000( 0. 0000( 0. 1433' 0. 0000( 0. 1498) 0. 3879: 0. 2785( 0. 0635' 0. 0891- 0. 0000( 0. 1931; 0. 3239' 0. 3280'	00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29, 308 0 0 46, 043 0 6, 597 603, 670 559, 834 133, 331 1, 193 16, 193 0 203, 507 45, 292 46, 469	57. 00 58. 00 59. 00 60. 01 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 00
88. 00 08800	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 50-94 and 96-98) Less PBP Clinic Laboratory Services-Program only charges (line Net Charges (line 200 minus line 201)	61)	0. 00000 0. 00000		0 0 1, 691, 437	89. 00

Heal th Financial Systems REHABILITATION HOSPITAL				u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 153030	Peri od: From 10/01/2013	Worksheet D-3	
			To 09/30/2014	Date/Time Pre 2/24/2015 3:4	
	Ti t	le XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00	2.00	col . 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			643, 777		30.00
31. 00   03100   NTENSI VE CARE UNI T			043,777		31.00
32. 00   03200   CORONARY CARE UNIT			0		32.00
33. 00   03300 BURN INTENSIVE CARE UNIT			0		33.00
34. 00   03400 SURGI CAL I NTENSI VE CARE UNI T			0		34.00
41. 00   04100   SUBPROVI DER - I RF			0		41.00
42. 00   04200   SUBPROVI DER			0		42.00
43. 00 04300 NURSERY			0		43.00
ANCILLARY SERVICE COST CENTERS					
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 1370	· ·	4, 718	1
57. 00   05700   CT   SCAN		0.0000		0	57.00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)		0.0000		0	58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON		0.0000		0	59.00
60. 00   06000   LABORATORY		0. 1433		6, 596	60.00
60. 01   06001   BLOOD LABORATORY 65. 00   06500   RESPI RATORY THERAPY		0. 0000 0. 1498		0 3, 383	60. 01 65. 00
66. 00   06600   PHYSI CAL THERAPY		0. 1498		108, 448	66.00
67. 00   06700   0CCUPATI ONAL THERAPY		0. 3397		100, 446	
68. 00   06800  SPEECH PATHOLOGY		0. 2785		34, 328	
69. 00   06900   ELECTROCARDI OLOGY		0. 0635		0 1, 020	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 0891		6, 884	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1931:	26 240, 775	46, 500	73.00
76. 00 03020 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 3239	71 58, 775	19, 041	76.00
76.01 03021 HEMODIALYSIS & OTHER ANCILLARY		0. 3280	90 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.0000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	89. 00
200.00 Total (sum of lines 50-94 and 96-98)			1, 177, 652	330, 155	
201.00 Less PBP Clinic Laboratory Services-Program only charges (	line 61)		1 177 (52		201.00
202.00   Net Charges (line 200 minus line 201)		I	1, 177, 652		202.00

Health Financial Systems REHABILITA
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 Provider CCN: 153030 | Period: | Worksheet E-1 | Part I | Date/Time Prepared: | 2/24/2015 3: 47 pm

					2/24/2015 3:4	7 pm
	<u> </u>		le XVIII	Hospi tal	PPS	
		Inpatie	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		3, 112, 588		0	
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
0.00	write "NONE" or enter a zero					0.00
3. 00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		1		1	
3. 01	ADJUSTMENTS TO PROVIDER		1 0		0	3.01
3. 02	THE SECTION OF THE TREET				0	
3. 03			0		0	
3.04			0		0	3.04
3. 05			0		0	3. 05
	Provider to Program		•			1
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	
3. 52			0		0	
3. 53			0		0	
3. 54			0		0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
4 00	3. 50-3. 98)		0 440 500			4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 112, 588		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider		•			1
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	
5.03			0		0	5. 03
	Provi der to Program			ı	1	
5. 50	TENTATI VE TO PROGRAM		0		0	
5. 51			0		0	0.0.
5. 52 5. 99	Subtatal (sum of lines E O1 E 40 minus sum of lines		0		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				0	5.99
6. 00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)				1	
6. 01	SETTLEMENT TO PROVIDER		60, 496		0	
6. 02	SETTLEMENT TO PROGRAM		0		0	0.02
7. 00	Total Medicare program liability (see instructions)		3, 173, 084		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1. 00	2. 00	
8. 00	Name of Contractor					8.00

Health Financial Systems	REHABILITATION HOSPITAL	OF FT WAYNE	In Lieu	ı of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 1	From 10/01/2013 To 09/30/2014	Worksheet E-3 Part III Date/Time Prepared: 2/24/2015 3:47 pm
		T: ±1 = \(\lambda \tau \tau \tau \tau \tau \tau \tau \ta	Hanni Ani	DDC

		Title XVIII	Hospi tal	PPS	7 рііі
			1.0001 tu		
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			3, 111, 210	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0294	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			153, 694	3.00
4.00	Outlier Payments			57, 360	4.00
5. 00	Unweighted intern and resident FTE count in the most recent costs to November 15, 2004 (see instructions)	st reporting period en	nding on or prior	0. 00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count	for residents that wer	ra displaced by	0. 00	5. 01
5.01	program or hospital closure, that would not be counted without			0.00	3.01
	\$412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	a temperary cap aajas	illione dilaci		
6.00	New Teaching program adjustment. (see instructions)			0.00	6.00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the	ne new program growth m	period of a "new	0.00	7. 00
7.00	teaching program". (see inst.)	io non program grontin p	,0,,,04,0,,4,,,,0,,,	0.00	/
8.00	Current year's unweighted I&R FTE count for residents within the	ne new program growth p	period of a "new	0.00	8. 00
	teaching program". (see inst.)				
9.00	Intern and resident count for IRF PPS medical education adjust	ment (see instructions)		0. 00	1
10.00	Average Daily Census (see instructions)			14. 750685	1
11. 00	Teaching Adjustment Factor (see instructions)			0. 000000	11. 00
12.00	9 3			0	12.00
13. 00	Total PPS Payment (see instructions)			3, 322, 264	
14. 00	Nursing and Allied Health Managed Care payments (see instruction	on)		0	
	Organ acquisition (DO NOT USE THIS LINE)				15. 00
	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	
17. 00	Subtotal (see instructions)			3, 322, 264	1
	Primary payer payments			31, 915	•
	Subtotal (line 17 less line 18).			3, 290, 349	1
	Deducti bl es			19, 264	1
21. 00	Subtotal (line 19 minus line 20)			3, 271, 085	1
22. 00	Coinsurance			45, 056 3, 226, 029	
	Subtotal (line 21 minus line 22) Allowable bad debts (exclude bad debts for professional service	os) (soo instructions)		3, 226, 029 18, 512	•
	Adjusted reimbursable bad debts (see instructions)	es) (see Histructions)		12, 033	1
	Allowable bad debts for dual eligible beneficiaries (see instru	ictions)		18, 512	1
	Subtotal (sum of lines 23 and 25)	de trons)		3, 238, 062	1
	Direct graduate medical education payments (from Worksheet E-4,	line 49)		0, 250, 002	•
	Other pass through costs (see instructions)	11116 17)		0	
30.00	Outlier payments reconciliation			0	
	OTHER ADJUSTMENTS			-221	1
	Recovery of Accelerated Depreciation			0	•
	Total amount payable to the provider (see instructions)			3, 237, 841	32.00
32. 01	Sequestration adjustment (see instructions)			64, 757	32. 01
33.00	Interim payments			3, 112, 588	33.00
34.00	Tentative settlement (for contractor use only)			0	34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and	34		60, 496	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2,	chapter 1,	17, 734	36.00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
50 OO	Original outlier amount from Worksheet E-3, Part III, line 4		T	57, 360	50.00
	Outlier reconciliation adjustment amount (see instructions)			57, 360	ı
	The rate used to calculate the Time Value of Money			0. 00	
	Time Value of Money (see instructions)			0.00	
55. 55	1		l	O	, 55.00

Health Financial Systems	REHABILITATION HOSPITAL	OF FT WAYNE	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 153030	Peri od: From 10/01/2013	Worksheet E-3 Part VII

Title XIX

		I npati ent	Outpati ent		
		1. 00	2. 00		
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX	SERVI CES			
	COMPUTATION OF NET COST OF COVERED SERVICES				
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)	o	0	4.00	
5.00	Inpatient primary payer payments	o		5.00	
6.00	Outpatient primary payer payments		0	6.00	
7.00	Subtotal (line 4 less sum of lines 5 and 6)	o	0	7.00	
	COMPUTATION OF LESSER OF COST OR CHARGES			1	
	Reasonabl e Charges			]	
8.00	Routine service charges	643, 777		8.00	
9.00	Ancillary service charges	1, 177, 652	0	9.00	
10.00	Organ acquisition charges, net of revenue	o		10.00	
11.00	Incentive from target amount computation	o		11.00	
12.00		1, 821, 429	0	12.00	
	CUSTOMARY CHARGES			1	
13.00	Amount actually collected from patients liable for payment for services on a charge	0	0	13.00	
	basis				
14.00	Amounts that would have been realized from patients liable for payment for services on	o	0	14.00	
	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0.000000	15.00	
16.00	Total customary charges (see instructions)	1, 821, 429	0	16.00	
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	1, 821, 429	0	17.00	
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	o	0	18. 00	
	16) (see instructions)				
19.00	Interns and Residents (see instructions)	0	0	19.00	
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00	
21.00	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 completed for PPS provide	rs.			
22.00	Other than outlier payments	0	0	22.00	
23.00	Outlier payments	0	0	23.00	
24.00	Program capital payments	o		24.00	
25.00	Capital exception payments (see instructions)	o		25.00	
26.00	Routine and Ancillary service other pass through costs	o	0	26.00	
27.00	Subtotal (sum of lines 22 through 26)	o	0	27.00	
28.00	Customary charges (title V or XIX PPS covered services only)	o	0	28. 00	
29.00	Titles V or XIX (sum of lines 21 and 27)	o	0	29. 00	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	o	0	31.00	
32.00	Deducti bl es	o	0	32.00	
33.00	Coinsurance	o	0	33.00	
34.00	Allowable bad debts (see instructions)	o	0	34.00	
35.00	Utilization review	o		35.00	
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	ol	0	36.00	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ol	0	37.00	
	, , , , , ,	o	0	1	
	Direct graduate medical education payments (from Wkst. E-4)	o		39.00	
	Total amount payable to the provider (sum of lines 38 and 39)	o	0	40.00	
	Interim payments	ō	0		
42.00		o	0		
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	o	0	1	
	chapter 1, §115.2				
	• •	'		•	

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

Provi der CCN: 153030

Peri od: From 10/01/2013 To 09/30/2014 Worksheet G Date/Time Prepared: 2/24/2015 3:47 pm

In Lieu of Form CMS-2552-10

				077 007 2011	2/24/2015 3: 4	7 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
			Purpose Fund	Fund		
	[	1.00	2.00	3. 00	4. 00	
1 00	CURRENT ASSETS	1 004		0		1 00
1.00	Cash on hand in banks	-1, 034		0	0	1.00
2.00	Temporary investments	0	0	0		2.00
3.00	Notes recei vabl e	1 24/ 200	0	0	0	3.00
4. 00	Accounts receivable	1, 346, 882	0	0	0	4.00
5. 00	Other receivable	140 225		0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable			0	0	6.00
7.00	Inventory	15, 667	1	0		7.00
8. 00	Prepai d expenses	27, 342	1	0	0	8.00
9. 00 10. 00	Other current assets Due from other funds	-4, 172	1	0		9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	1, 244, 350		0		11.00
11.00	FIXED ASSETS	1, 244, 330	n o	U	0	11.00
12. 00	Land	900, 000	0	0	0	12.00
13. 00	Land improvements	276, 453		0	-	13.00
14. 00	Accumulated depreciation	-94, 048	1	0		14.00
15. 00	Buildings	11, 624, 396		0	0	15.00
16. 00	Accumulated depreciation	-1, 777, 228		0	0	16.00
17. 00	Leasehold improvements	170, 664		0	0	17. 00
18. 00	Accumulated depreciation	-51, 187		0	0	18.00
19. 00	Fixed equipment	137, 448		0	Ö	19.00
20. 00	Accumulated depreciation	-35, 422		0	Ö	20.00
21. 00	Automobiles and trucks	113, 428		0	Ö	21.00
22. 00	Accumulated depreciation	-64, 010		0	Ö	22.00
23. 00	Major movable equipment	186, 816		0	Ö	23. 00
24. 00	Accumulated depreciation	-106, 090		0	Ö	24.00
25. 00	Mi nor equi pment depreci abl e	276, 145		0	0	25.00
26. 00	Accumulated depreciation	-211, 664		0	0	26.00
27. 00	HIT desi gnated Assets	-211,004		0	0	27.00
28. 00	Accumulated depreciation			0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e			0	0	29.00
30. 00	Total fixed assets (sum of lines 12-29)	11, 345, 701	-	0	l	30.00
30.00	OTHER ASSETS	11, 343, 701	<u> </u>	<u> </u>	0	30.00
31. 00	Investments		0	0	0	31.00
32. 00	Deposits on Leases			0	o o	32.00
33. 00	Due from owners/officers			0	Ö	33.00
34. 00	Other assets	696, 699	-	0	Ö	34.00
35. 00	Total other assets (sum of lines 31-34)	696, 699		0	1	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	13, 286, 750	1	0	l .	36.00
	CURRENT LIABILITIES	,	·	-		
37.00	Accounts payable	117, 393	0	0	0	37.00
38.00	Salaries, wages, and fees payable	495, 236		0	0	38.00
39.00	Payroll taxes payable		o	0	0	39.00
40.00	Notes and Loans payable (short term)	l 0	o	0	0	40.00
41.00	Deferred income	l 0	o	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	14, 524, 818	0	0	0	43.00
44.00	Other current liabilities	258, 106	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15, 395, 553	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured Loans	0	0	0	0	48. 00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	15, 395, 553	0	0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	-2, 108, 803	В			52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0	l	55.00
56.00	Governing body created - endowment fund balance			0	l	56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	-2, 108, 803	1	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	13, 286, 750	0	0	0	60.00
	[59]	I	1		I	l

18.00

19.00

STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 153030 Peri od: Worksheet G-1 From 10/01/2013 09/30/2014 Date/Time Prepared: 2/24/2015 3:47 pm General Fund Special Purpose Fund Endowment Fund 5.00 1. 00 2.00 3. 00 4.00 1.00 Fund balances at beginning of period 19, 967, 239 0 1.00 Net income (loss) (from Wkst. G-3, line 29) -1, 254, 336 2.00 2.00 3.00 Total (sum of line 1 and line 2) 18, 712, 903 ol 3.00 4.00 Additions (credit adjustments) (specify) 4.00 0 5.00 0000 0 5.00 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 Subtotal (line 3 plus line 10) 18, 712, 903 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 00000 13.00 13.00 14.00 0 0 14.00 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 18, 712, 903 19.00 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 0 3.00 3.00 Total (sum of line 1 and line 2) 0 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 6.00 0 6.00 0 7.00 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 0 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 Deductions (debit adjustments) (specify) 12.00 12.00 13.00 0 13.00 14.00 0 14.00 15.00 15.00 16.00 0 16.00 17.00 17.00

0

0

0

18.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

| Peri od: | Worksheet G-2 | From 10/01/2013 | Parts | & II | To 09/30/2014 | Date/Time Prepared: 
 Heal th Financial
 Systems
 REHABIL

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 Provi der CCN: 153030

			To 09/30/2014	Date/Time Pre 2/24/2015 3:4	pared:
	Cost Center Description	I npati ent	Outpati ent	Total	Pill
	oost contor bescription	1.00	2.00	3. 00	
	PART I - PATIENT REVENUES	11.00	2.00	0.00	
	General Inpatient Routine Services				1
1.00	Hospi tal	7, 759, 02	21	7, 759, 021	1.00
2. 00	SUBPROVIDER - I PF			, , , , ,	2.00
3. 00	SUBPROVI DER - I RF		0	0	3.00
4. 00	SUBPROVI DER		0	0	4.00
5. 00	Swing bed - SNF		0	0	
6. 00	Swing bed - NF		0	0	6.00
7. 00	SKILLED NURSING FACILITY				7. 00
8. 00	NURSING FACILITY				8.00
9. 00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7, 759, 02	21	7, 759, 021	
	Intensive Care Type Inpatient Hospital Services	1,707,0	- •	1,707,021	1
11. 00	INTENSIVE CARE UNIT		0	0	11.00
12. 00	CORONARY CARE UNIT		o	0	
13. 00	BURN INTENSIVE CARE UNIT		0	0	
14. 00	SURGI CAL INTENSI VE CARE UNIT		0	0	14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines		0	0	1
	11-15)				10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	7, 759, 02	21	7, 759, 021	17.00
18. 00	Ancillary services	14, 341, 18			1
19. 00	Outpati ent servi ces	1 .,, 5 ,	0 13, 26		1
20. 00	RURAL HEALTH CLINIC			0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	ol o	21.00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24.00
24. 10	CORF		0	o lo	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P. )			1	25. 00
26. 00	HOSPI CE				26.00
27. 00	OTHER (SPECIFY)		0	o lo	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	22, 100, 20	13, 26		1
20.00	G-3, line 1)	22/100/2	10, 200	22, 110, 100	20.00
	PART II - OPERATING EXPENSES			<u>'</u>	1
29.00	Operating expenses (per Wkst. A, column 3, line 200)		9, 006, 588	3	29. 00
30.00	ADD (SPECIFY)		0		30.00
31. 00	()		0		31.00
32. 00			0		32.00
33. 00			0		33.00
34. 00			0		34.00
35. 00			0		35. 00
36. 00	Total additions (sum of lines 30-35)				36.00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38. 00			o		38. 00
39. 00			o		39.00
40.00			o		40.00
41. 00			o		41.00
42.00	Total deductions (sum of lines 37-41)			ol	42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	r	9, 006, 588	3	43.00
	to Wkst. G-3, line 4)				

Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of					of Form CMS-2552-10	
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 153030	Peri od:	Worksheet G-3		
			From 10/01/2013	D-+- /T: D		
			To 09/30/2014	Date/Time Pre 2/24/2015 3:4		
				2/24/2013 3.4	/ piii	
				1. 00		
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	e 28)		22, 113, 466	1.00	
2.00	Less contractual allowances and discounts on patients' accounts			14, 443, 196	•	
3.00	Net patient revenues (line 1 minus line 2)			7, 670, 270	1	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		9, 006, 588	•	
5.00	Net income from service to patients (line 3 minus line 4)			-1, 336, 318	1	
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc			0	6.00	
7.00					7.00	
8.00	.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			0	14.00	
15.00	Revenue from rental of living quarters			0	15.00	
16.00	Revenue from sale of medical and surgical supplies to other t	han patients		0	16.00	
17.00	Revenue from sale of drugs to other than patients			0	17. 00	
18.00	Revenue from sale of medical records and abstracts			0	18.00	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00	
21.00	Rental of vending machines			0	21.00	
22. 00	Rental of hospital space			0	22. 00	
23.00	Governmental appropriations			0	23. 00	
	OTHER INCOME			81, 982		
25 00	Total ather income (our of lines ( 24)			01 002	1 25 00	

0 27.00

-1, 254, 336 29. 00

25.00 26.00

28.00

81, 982 -1, 254, 336

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

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