modi en i i namor	a. eyeteme	71E 01 1 1 11/11/1E		u 01 1 01 111 01110 E00E 10
This report is	required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai	Ture to report can res	sult in all interim	FORM APPROVED
payments made	OMB NO. 0938-0050			
				EXPIRES 05-31-2019
HOSPITAL AND H AND SETTLEMENT	IOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY	Provider CCN: 15-3030	From 10/01/2016	Worksheet S Parts I-III Date/Time Prepared: 2/28/2018 4:24 pm
PART I - COST	REPORT STATUS			
Provi der	1. [X] Electronically filed cost report		Date: 2/28/20	18 Time: 4:24 pm
use only	2. [] Manually submitted cost report			
	3.[0] If this is an amended report enter the number 4.[F] Medicare Utilization. Enter "F" for full or "I		resubmitted this co	ost report
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 (3) Settled with Audit 9. [N] Final Report for (4) Reopened (5) Amended	or this Provider CCN 12		
DADT II CEDT	TIELCATION			

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REHABILITATION HOSPITAL OF FT WAYNE (15-3030) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 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.

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

(Si gned)	
	Officer or Administrator of Provider(s)
Ti t	l e
Dat	e

			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	54, 212	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
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	54, 212	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. HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3030 Peri od: Worksheet S-2 From 10/01/2016 To 09/30/2017 Part I Date/Time Prepared: 2/28/2018 4:23 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 7970 WEST JEFFERSON BOULEVARD PO Box: 1.00 State: IN 2.00 City: FORT WAYNE Zip Code: 46804-County: ALLEN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 REHABILITATION HOSPITAL 153030 23060 5 11/01/1993 Ν 3.00 OF FT WAYNE Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2016 09/30/2017 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 N N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N N 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 Ν 23 00 3 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for yes or In-State Out-of Medi cai d Other In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d 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 24. 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 237 0 0 0 819 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

	60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)						60. 00
any programs that meet	the criteria under §413.85? (
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2. 00	3. 00	4.00	5. 00	
61.00 Did your hospital recei	ve FTE slots under ACA	N			0.00	0.00	61. 00
	' for yes or "N" for no in						
column 1. (see instruct							
	er of unweighted primary care		0. 00	0.00			61. 01
ě .	s 3 most recent cost reports						
	efore March 23, 2010. (see						
i nstructi ons)	2101 C March 23, 2010. (366						
	total unweighted primary care		0.00	0.00			61. 02
	9 .		0.00	0.00			01.02
	B/GYN, general surgery FTEs,						
, ,	added under section 5503 of						
ACA). (see instructions							
	E count for primary care		0. 00	0.00			61. 03
and/or general surgery	residents, which is used for						
determining compliance	with the 75% test. (see						
i nstructi ons)							
•				,		,	

Health Financial Systems REHABILITATION DAY HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAY	PITAL OF FT WAY Provider CC	CN: 15-3030 P	In Lie Period: Prom 10/01/2016 O 09/30/2017	w of Form CMS-2 Worksheet S-2 Part I Date/Time Pre 2/28/2018 4:2	pared:	
	Y/N	IME	Direct GME	IME	Direct GME	
	1. 00	2. 00	3. 00	4.00	5. 00	-
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary		0.00	0.0	O	3,33	61. 04
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00				61. 06
	Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 00	2. 00	3. 00	4. 00	
 61.10 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 				0. 00		61. 20
					1.00	-
ACA Provisions Affecting the Health Resources and Ser						
 62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruction). 62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC programment. 	tions) Teachi Jram. (s	ng Health Cent see instruction	ter (THC) into			62. 00
Teaching Hospitals that Claim Residents in Nonprovide 63.00 Has your facility trained residents in nonprovider se			et reporting	noriod2 Entor	l N	63. 00
"Y" for yes or "N" for no in column 1. If yes, comple			57. (see instr	uctions)		63.00
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor			This base year	is your cost r	reporting	
64.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted	y trair n-priman all nor	ned residents ry care nprovider	0.00	0.00	0. 000000	64. 00

Unwei ghted FTEs Nonprovi der

Si te

3. 00

2.00

Unweighted FTEs in

Hospi tal

4.00

Ratio (col. 3/ (col. 3 + col. 4))

5.00

settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

Program Name Program Code

1.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3030 Peri od: Worksheet S-2 From 10/01/2016 Part I 09/30/2017 Date/Time Prepared: 2/28/2018 4:23 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Health Financial Systems REHABILITATION HOSPITAL			u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-3030	Peri od:	Worksheet S	-2
		From 10/01/2016 To 09/30/2017	Date/Time Pi	cenared:
		10 077 007 2017	2/28/2018 4:	
			1.00	
Long Term Care Hospital PPS				
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and			N	80.0
81.00 Is this a LTCH co-located within another hospital for part or al "Y" for yes and "N" for no.	I of the cost reportin	g period? Enter	N	81. 0
TEFRA Provi ders				_
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEF	FRA? Enter "V" for yes	or "N" for no	N	85.0
86.00 Did this facility establish a new Other subprovider (excluded un			"	86. 0
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	ii t) didei 12 ei k eeeti	011		00.00
87.00 Is this hospital a "subclause (II)" LTCH classified under section	on 1886(d)(1)(B)(iv)(II)? Enter "Y"	N	87. 0
for yes or "N" for no.				
		V	XIX	4
Title Ward VIV Comitee		1. 00	2. 00	
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital se	prvi cos2 Entor "V" for	N	Υ	90.0
yes or "N" for no in the applicable column.	ervices: Litter i ioi	IN IN	ı ı	70.00
91.00 Is this hospital reimbursed for title V and/or XIX through the c	cost report either in	l N	Y	91. 0
full or in part? Enter "Y" for yes or "N" for no in the applicab				
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual c			N	92. 0
instructions) Enter "Y" for yes or "N" for no in the applicable				
93.00 Does this facility operate an ICF/IID facility for purposes of t	title V and XIX? Enter	N	N	93. 00
"Y" for yes or "N" for no in the applicable column.				
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and	"N" for no in the	N	N	94.00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applica	able column	0.00	0.00	95. 0
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or		0.00 N	0.00 N	96. 0
applicable column.	N TOT HO THE CHE	14		70.0
97.00 If line 96 is "Y", enter the reduction percentage in the applica	able column.	0.00	0.00	97. 0
98.00 Does title V or XIX follow Medicare (title XVIII) for the intern		Y	Υ	98. 0
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for y	yes or "N" for no in			
column 1 for title V, and in column 2 for title XIX.				
98.01 Does title V or XIX follow Medicare (title XVIII) for the report			Y	98. 0
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title	V, and in column 2 for			
title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calcul	ation of observation	Υ	Y	98. 0
bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N		· ·	ı ı	70.0
for title V, and in column 2 for title XIX.	V TOT TIO THE COLUMN T			
98.03 Does title V or XIX follow Medicare (title XVIII) for a critical	access hospital (CAH)	N	N	98. 0
reimbursed 101% of inpatient services cost? Enter "Y" for yes or	"N" for no in column	1		
for title V, and in column 2 for title XIX.				
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reim		N	N	98. 04
outpatient services cost? Enter "Y" for yes or "N" for no in col	umn 1 for title V, and			
in column 2 for title XIX.	DCE	Y	Y	98. 0!
98.05 Does title V or XIX follow Medicare (title XVIII) and add back t Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colum			Y	98.0
column 2 for title XIX.	mirior title v, and r	"		
98.06 Does title V or XIX follow Medicare (title XVIII) when cost reim	nbursed for Wkst D	Υ	Y	98. 00
Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 f	for title V, and in	·	•	/5.00
column 2 for title XIX.				
Rural Providers				

Rural Providers					
105.00 Does this hospital qualify as a CAH?			N		105. 00
106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	-inclusive meth	nod of payment	N		106. 00
107.00 If this facility qualifies as a CAH, is it eligible for costraining programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, column reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107. 00		
108.00 is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	dul e? See 42	N		108. 00	
	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3. 00	4. 00	
109.00 of 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	N	109. 00

	1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A	N	110. 00
Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,		
complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as		
applicable.		1

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	rovi der CCN: 15-3030	Peri od:		Worksheet S-	2
		From 10/01 To 09/30			epared
		1. 00)	2.00	-
11.00 If this facility qualifies as a CAH, did it participate in the Fr Health Integration Project (FCHIP) demonstration for this cost re "Y" for yes or "N" for no in column 1. If the response to column integration prong of the FCHIP demo in which this CAH is particip Enter all that apply: "A" for Ambulance services; "B" for addition for tele-health services.	eporting period? Ente 1 is Y, enter the pating in column 2.	N	,	2.00	111. (
			1. 00	2.00 3.00)
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" is yes, enter the method used (A, B, or E only) in column 2. If c 3 either "93" percent for short term hospital or "98" percent for psychiatric, rehabilitation and long term hospitals providers) ba Pub. 15-1, chapter 22, §2208.1.	column 2 is "E", enter long term care (incased on the definition	r in column Iudes	N	0	115. (
16.00 s this facility classified as a referral center? Enter "Y" for y 17.00 s this facility legally-required to carry malpractice insurance? no.	? Enter "Y" for yes o		N N		116. (
18.00 s the malpractice insurance a claims-made or occurrence policy? claim-made. Enter 2 if the policy is occurrence.	Enter 1 if the polic	y is	1		118. (
	Premi ums	Losse	es	Insurance	
	1.00	2.00)	3.00	-
18.01 List amounts of malpractice premiums and paid losses:		0 4	14, 568	3	0 118.
		1. 00)	2.00	+
18.02 Are malpractice premiums and paid losses reported in a cost center Administrative and General? If yes, submit supporting schedule I and amounts contained therein.		N			118.
19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harm §3121 and applicable amendments? (see instructions) Enter in colu "N" for no. Is this a rural hospital with < 100 beds that qualifi Hold Harmless provision in ACA §3121 and applicable amendments? (Enter in column 2, "Y" for yes or "N" for no.	umn 1, "Y" for yes or es for the Outpatien			N	119. 120.
21.00 Did this facility incur and report costs for high cost implantabl	e devices charged to	N			121.
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is " the Worksheet A line number where these taxes are included.					122.
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes	s and "N" for no If	l N			125.
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enter t					126.
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the	ne certification date				127.
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter th	ne certification date				128.
in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the	e certification date	in			129.
column 1 and termination date, if applicable, in column 2. 30.00 oll f this is a Medicare certified pancreas transplant center, enter					130.
date in column 1 and termination date, if applicable, in column 2 11.00 If this is a Medicare certified intestinal transplant center, ent date in column 1 and termination date, if applicable, in column 2	ter the certification				131.
uate in column 1 and termination date, it applicable, in column 2. 12.00 If this is a Medicare certified islet transplant center, enter the in column 1 and termination date, if applicable, in column 2.					132.
33.00 T this is a Medicare certified other transplant center, enter the in column 1 and termination date, if applicable, in column 2.	ne certification date				133.
34.00 If this is an organ procurement organization (OPO), enter the OPO and termination date, if applicable, in column 2.	number in column 1				134.
All Providers	ad in CMC Dub. 1E 1	Y		449008	140
40.00 Are there any related organization or home office costs as define		ı V		449008	140.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE			PITAL OF FT WAY Provider CO					w of Form CMS Worksheet S- Part I Date/Time Pr 2/28/2018 4:	-2 repared:
1.00		2. 0	0				3. 00	2/20/2010 4.	23 piii
If this facility is part of a cha					the nam	ne and	d address	of the	
home office and enter the home office and enter the home office and enter the home office. 141.00 Name: CHS/COMMUNITY HEALTH SYSTEM INC.		ame: WI			tractor	's Nu	mber: 1030	1	141. 00
142.00 Street: 4000 MERIDIAN BLVD	PO Box:	JL	IKVI CES						142. 00
143.00 City: FRANKLIN	State:	TN		Zi p	Code:		3706	7	143. 00
								1.00	
144.00 Are provider based physicians' cos	sts included in Works	sheet A	4 ?					Y	144. 00
							1. 00	2. 00	
145.00 of costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility inceperiod? Enter "Y" for yes or "N" of the cost allocation methodology. 146.00 Has the cost allocation methodology. Enter "Y" for yes or "N" for no in	for yes or "N" for clude Medicare utiliz for no in column 2. gy changed from the p n column 1. (See CMS	no in zation previou Pub.	column 1. If of for this cost usly filed cost	column 1 reporti t report	ng ?		N		145. 00
yes, enter the approval date (mm/d	dd/yyyy) in column 2.								
								1. 00	
147.00 Was there a change in the statisti								N	147. 00
148.00 Was there a change in the order of 149.00 Was there a change to the simplifi					" for n			N N	148. 00 149. 00
144. 00 was there a change to the simpiff	ed cost irriding meth	iou: Li	Part A		t B		itle V	Title XIX	149.00
			1. 00	2.			3. 00	4. 00	
Does this facility contain a provi									
or charges? Enter "Y" for yes or '	N TOT NO TOT EACH C	compone	N N		<u>гв. (з</u> 1	see 42	N 9413	. 13) N	155. 00
156. 00 Subprovi der - IPF			N	1	J		N	N	156. 00
157. 00 Subprovi der – IRF			N	1	1		N	N	157. 00
158. 00 SUBPROVI DER 159. 00 SNF			N	,	J		N	N	158. 00 159. 00
160.00HOME HEALTH AGENCY			N N	1	J		N	N	160. 00
161. 00 CMHC				1	I		N	N	161. 00
								1. 00	
Multicampus 165.00 Is this hospital part of a Multica	ampus hospital that h	nas one	e or more campu	uses in	di ffere	ent CB	SAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Name		County	State	e Zin	Code	CBSA	FTE/Campus	
	0		1. 00	2. 00		00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0. (00 166. 00
								1. 00	
Health Information Technology (HI	Γ) incentive in the A	Americ	an Recovery and	d Reinve	stment	Act			
167.00 s this provider a meaningful user 168.00 If this provider is a CAH (line 10	05 is "Y") and is a m	neani ng	gful user (line			enter	the	N	167. 00 0168. 00
reasonable cost incurred for the H 168.01 If this provider is a CAH and is r				oqualif	y for a	hard	shi p		168. 01
exception under §413.70(a)(6)(ii)							о р		
169.00 If this provider is a meaningful u) and	is not a CAH ((line 10	5 is "N	l"), e	nter the	0. (00 169. 00
transition factor. (see instruction	JIIS)					Beg	gi nni ng	Endi ng	
170 00 5-1			1-1- 6				1. 00	2. 00	170.00
170.00 Enter in columns 1 and 2 the EHR begins period respectively (mm/dd/yyyy)	beginning date and en	nding (date for the re	eporting					170. 00
							1. 00	2. 00	
171.00 If line 167 is "Y", does this proving section 1876 Medicare cost plans in "Y" for yes and "N" for no in column 1876 Medicare days in column 2. (s	reported on Wkst. S-3 umn 1. If column 1 is	3, Pt.	I, line 2, col	. 6? En			00	2.00	0171.00

Heal th	Financial Systems REHABILITATION HOSPITA				u of Form CMS-	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co	CN: 15-3030	Peri od: From 10/01/2016 To 09/30/2017	Worksheet S-: Part II Date/Time Pro 2/28/2018 4::	epared:
				Y/N	Date	
	0			1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N fomm/dd/yyyy format.	or all NO re	sponses. Ente	er all dates in t	the	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the be reporting period? If yes, enter the date of the change in colu			N		1.0
	reporting period? IT yes, enter the date of the change in cort	ıllırı 2. (See	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare Progres, enter in column 2 the date of termination and in column 3 voluntary or "I" for involuntary.		N			2. 00
3. 00	Is the provider involved in business transactions, including m contracts, with individuals or entities (e.g., chain home offi or medical supply companies) that are related to the provider officers, medical staff, management personnel, or members of t of directors through ownership, control, or family and other s relationships? (see instructions)	ces, drug or its the board	N			3.00
			Y/N	Туре	Date	
			1.00	2. 00	3. 00	_
4. 00 5. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certifi Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date availa column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reconditions.	Compiled, able in nt from	N N			4.00
	those on the fired imancial statements: If yes, submit recond	ZITI ati Oli.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities					4
5. 00	Column 1: Are costs claimed for nursing school? Column 2: If the legal operator of the program?	yes, is th	ie provider i	s N		6. 00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see instr	ructions.		N		7.00
3. 00	Were nursing school and/or allied health programs approved and	d/or renewed	l during the	N		8. 00
9. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved gra	aduate medic	al education	N		9.00
,, 00	program in the current cost report? If yes, see instructions.					// 0.
10. 00	Was an approved Intern and Resident GME program initiated or r	renewed in t	he current	N		10.00
11. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I &	R in an App	roved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.	а л.рр	0 1 0 4			
					Y/N	
	Bad Debts				1. 00	
	Is the provider seeking reimbursement for bad debts? If yes, s If line 12 is yes, did the provider's bad debt collection poli			ost reporting	Y N	12. 00 13. 00
	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments Ped Complement	s waived? If	yes, see in:	structi ons.	N	14.00
	Bed Complement Did total beds available change from the prior cost reporting	period? If	ves. see ins	tructions	N	15. 00
3. 30	2. a total bods available shangs from the piror cost reporting		t A		t B	15.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4.00	

	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	Υ	02/22/2018	Υ	02/22/2018	16. 00
	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 Report for	N		N		17. 00
	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 made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					

Heal th	Financial Systems REHABILITATION HOS	PITAL OF FT WA	YNE	In Lie	eu of Form CMS-	2552-10		
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der 0	CCN: 15-3030	Peri od: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II	epared:		
	<u> </u>		iption	Y/N	Y/N			
20.00	16 1: 1/ 17 :		0	1.00	3. 00	20.00		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
		Y/N	Date	Y/N	Date			
04.00	lui di	1.00	2. 00	3. 00	4. 00	01.00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS I	HOSPI TALS)					
22.00	Capi tal Related Cost				I	22.00		
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		sals made duri	ing the cost		22. 00		
23.00	reporting period? If yes, see instructions.	due to apprais	sars made dari	riig the cost		25.00		
24. 00	Were new leases and/or amendments to existing leases entere	ed into during	this cost rep	porting period?		24. 00		
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost reno	rting period?	If was saa		25. 00		
23.00	instructions.	the cost repo	tring perrous	11 yes, see		25.00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the	ne cost report	ing period? It	f yes, see		26. 00		
27. 00	instructions. Has the provider's capitalization policy changed during the	e cost renortii	na neriod? If	ves submit		27. 00		
27.00	copy.	- cost roportri	ng perrou. Tr	yes, subin t				
20.00	Interest Expense	atawad i mta du	ning the cost	nonesti na		28. 00		
28. 00	00 Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.							
29. 00								
30. 00	treated as a funded depreciation account? If yes, see instructions							
30.00	00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.							
31. 00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see		31. 00		
	instructions. Purchased Services							
32. 00	Have changes or new agreements occurred in patient care ser	rvices furnish	ed through cor	ntractual		32. 00		
	arrangements with suppliers of services? If yes, see instru							
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 applino, see instructions.	olled pertainii	ng to competi	tive blading? IT		33. 00		
	Provi der-Based Physi ci ans							
34. 00	Are services furnished at the provider facility under an a	rrangement witl	h provi der-bas	sed physi ci ans?		34. 00		
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	istina aareeme	nts with the m	nrovi der-based		35. 00		
	physicians during the cost reporting period? If yes, see in					00.00		
				Y/N	Date			
	Home Office Costs			1. 00	2. 00			
36. 00	Were home office costs claimed on the cost report?			Y		36. 00		
37. 00	If line 36 is yes, has a home office cost statement been p	repared by the	home office?	N		37. 00		
38. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of	Υ	12/31/2015	38. 00		
	the provider? If yes, enter in column 2 the fiscal year end	d of the home	offi ce.					
39. 00	If line 36 is yes, did the provider render services to other see instructions.	er chain compo	nents? If yes,	, N		39. 00		
40. 00	If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40. 00		
	i nstructi ons.							
		1.	. 00	2.	00	-		
	Cost Report Preparer Contact Information							
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	KUZI WA		TSI GA		41. 00		
	respectively.							
42. 00	Enter the employer/company name of the cost report	COMMUNITY HEAL	_TH SYSTEMS			42. 00		
43. 00	preparer. Enter the telephone number and email address of the cost	615-465-3416		KUZIWA TSIGA@C	HS. NFT	43.00		
	report preparer in columns 1 and 2, respectively.				- · · · ·			

Heal th	Financial Systems	REHABILITATION HOS	SPI TA	L OF FT WAYNE		In Lie	u of Form CMS	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMEN	IT QUESTI ONNAI RE		Provider CCN:		Peri od:	Worksheet S-	2
						From 10/01/2016 To 09/30/2017	Part II Date/Time Pr	onarod:
						10 09/30/2017	2/28/2018 4:	
					·			
				3. 00				
	Cost Report Preparer Contact Information	n						
41.00	Enter the first name, last name and the		REVI	ENUE MANAGER				41. 00
	held by the cost report preparer in col	umns 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 ad							43. 00
	report preparer in columns 1 and 2, res	pecti vel y.						

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3	
From 10/01/2016	Part	
To 09/30/2017	Date/Time Prepared:	2/28/2018 4:23 pm

						2/28/2018 4: 2:	3 pm
	·					I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	36	13, 140	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7. 00	Total Adults and Peds. (exclude observation		36	13, 140	0. 00	0	7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)		36	13, 140	0. 00		14. 00
15. 00	CAH visits					0	15. 00
16. 00	SUBPROVIDER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		36				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)		0	0			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01

33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3030

Peri od: Worksheet S-3 From 10/01/2016 Part I To 09/30/2017 Date/Time Prepared:

2/28/2018 4:23 pm Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 10.00 6.00 7.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 2, 601 237 6, 461 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 823 819 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 C 0 6.00 7.00 Total Adults and Peds. (exclude observation 2,601 237 6, 461 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 2,601 237 6, 461 0.00 95.44 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24.00 24 00 24. 10 HOSPICE (non-distinct part) 0 0 0 24. 10 CMHC - CMHC 25.00 25.00 26, 00 RURAL HEALTH CLINIC 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0 0.00 26. 25 0 Ω 26.25 27.00 Total (sum of lines 14-26) 0.00 95.44 27.00 28.00 Observation Bed Days 0 28.00 29.00 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room 0 32.00 32.00 0 0 0 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00

33.01 LTCH site neutral days and discharges

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3030

Peri od: Worksheet S-3 From 10/01/2016 Part I To 09/30/2017 Date/Time Prepared:

2/28/2018 4:23 pm Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 12.00 13.00 14.00 11.00 15.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 232 82 563 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 66 HMO IPF Subprovider 3.00 0 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 7.00 Total Adults and Peds. (exclude observation 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 0.00 0 232 82 563 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 24.00 24 00 HOSPICE (non-distinct part) 24. 10 24. 10 25. 00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26, 25 0 00 27.00 Total (sum of lines 14-26) 0.00 27.00 28.00 Observation Bed Days 28.00 29.00 29.00 Ambul ance Trips 30 00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room 32.00 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 33.01

		BILITATION HOSPI	TAL OF FT WAY	/NE	In Lie	eu of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
					From 10/01/2016 Fo 09/30/2017	Date/Time Pre	narod:
					10 09/30/2017	2/28/2018 4: 2	pareu. 3 nm
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		, p
	F			+ col . 2)	ons (See A-6)	Trial Balance	
				<u> </u>	, ,	(col. 3 +-	
						col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		282, 710	282, 710	161, 693	444, 403	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		117, 709	117, 709	9 102, 497	220, 206	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	132, 682	28, 977		9 837, 487	999, 146	4. 00
5.01	00570 ADMI TTI NG	63, 346	86, 949	150, 29	-173	150, 122	5. 01
5.02	00590 OTHER ADMINISTRATIVE AND GENERAL	235, 360	1, 867, 999	2, 103, 359	9 -1, 373, 875	729, 484	
7.00	00700 OPERATION OF PLANT	213, 415	488, 738	702, 153	3 0	702, 153	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	36, 941	36, 94°	1 0	36, 941	8. 00
9.00	00900 HOUSEKEEPI NG	106, 190	28, 157	134, 34	7 -52	134, 295	9. 00
10.00	01000 DI ETARY	348, 860	209, 387	558, 24	7 -99, 417	458, 830	10.00
11.00	01100 CAFETERI A	o	0		98, 136	98, 136	11. 00
13.00	01300 NURSING ADMINISTRATION	618, 700	78, 867	697, 56 ⁻	7 -194	697, 373	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	13, 556	115, 107	128, 663	-81, 188	47, 475	14. 00
15.00	01500 PHARMACY	88, 528	276, 764	365, 292	2 -258, 276	107, 016	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	166, 884	63, 059	229, 943	-2, 701	227, 242	16. 00
17. 00	01700 SOCIAL SERVICE	0	0		0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>		1
30.00	03000 ADULTS & PEDIATRICS	2, 190, 665	372, 856	2, 563, 52	1 342, 662	2, 906, 183	30. 00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	7, 478	7, 478	3 0	7, 478	54.00
60.00	06000 LABORATORY	21, 040	25, 049	46, 089	9 0	46, 089	60.00
65.00	06500 RESPI RATORY THERAPY	10, 004	12, 963	22, 96	7 -8, 377	14, 590	65. 00
66.00	06600 PHYSI CAL THERAPY	552, 731	65, 615	618, 346	5 -72	618, 274	66. 00
67.00	06700 OCCUPATIONAL THERAPY	768, 196	70, 180	838, 376	-150	838, 226	67.00
68.00	06800 SPEECH PATHOLOGY	319, 380	37, 472	356, 852	2 0	356, 852	68. 00
69.00	06900 ELECTROCARDI OLOGY	82	254	330	5 0	336	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	0		16, 761	16, 761	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	O	0		236, 084	236, 084	73. 00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	40, 236	3, 988	44, 22		44, 200	76. 00
76. 01	03950 HEMODIALYSIS & OTHER ANCILLARY	O	84, 550	84, 550	0	84, 550	76. 01
	SPECIAL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	5, 889, 855	4, 361, 769	10, 251, 62	4 -29, 179	10, 222, 445	118. 00
	NONREI MBURSABLE COST CENTERS						1
192.00	19200 PHYSICIANS' PRIVATE OFFICES	174	5, 711	5, 88!	-97	5, 788	192. 00
194.00	07950 NON-REIMBURSABLE COST	0	0		0		194. 00
194. 01	07951 MARKETING/PUBLIC RELATIONS	o	0		29, 276	29, 276	194. 01
194. 02	07952 TENANT LEASED SPACE	o	0		0		194. 02
200.00	TOTAL (SUM OF LINES 118 through 199)	5, 890, 029	4, 367, 480	10, 257, 50	9 0	10, 257, 509	200.00
		•			*	-	

 Heal th Financial
 Systems
 REHABILITATION HOSPITAL OF FT WAYNE

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN: 15-3030
 | Peri od: | From 10/01/2016 | To 09/30/2017 | Date/Time Prepared:

Cost Center Description					2/28/2018 4	
GENERAL SERVICE COST CENTERS		Cost Center Description	Adjustments	Net Expenses		
GENERAL SERVICE COST CENTERS 1,000		·	(See A-8)	For Allocation		
1.00			6.00	7. 00		
2. 00 02.00 CAP REL COSTS-MVBLE EQUIP						
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 999, 146 5. 01	1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 205	445, 608		1. 00
5. 01 00570 ADMITTING	2.00	00200 CAP REL COSTS-MVBLE EQUIP	-64, 037	156, 169		2. 00
5. 02	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	999, 146		4. 00
7. 00 00700 OPERATION OF PLANT 5-, 918 696, 235 8. 00 00800 LAUNDRY & LI NEN SERVICE 44, 264 81, 205 8. 00 9. 00 00900 HOUSEKEEPI NG 0 134, 295 9. 00 10. 00 01000 DIETARY 0 458, 830 10. 00 11. 00 01100 CAFETERI A -81, 359 16, 777 11. 00 13. 00 01300 NURSI NG ADMINI STRATI ON 0 697, 373 13. 00 14. 00 01400 CENTRAL SERVI CES & SUPPLY -27, 086 20, 389 14. 00 15. 00 01500 PHARMACY 0 107, 016 15. 00 16. 00 01600 MEDICAL RECORDS & LI BRARY 0 227, 242 16. 00 17. 00 01700 SOCI AL SERVI CE 0 0 0 17. 00 01700 SOCI AL SERVI CE 0 0 0 10. 00 1000 ADDITION SERVI CE COST CENTERS 17. 00 10. 00 04000 LABBORATORY 0 46, 089 60. 00 60. 00 06000 LABORATORY 0 46, 089 65. 00 60. 00 06600 PHYSI CAL THERAPY 0 41, 590 65. 00 60. 00 06600 PHYSI CAL THERAPY 0 838, 226 66. 00 60. 00 06600 PHYSI CAL THERAPY 0 838, 226 66. 00 60. 00 06600 PHYSI CAL THERAPY 0 838, 226 66. 00 60. 00 06600 PHYSI CAL THERAPY 0 336, 852 68. 00 60. 00 06600 SPECEN PATHOLOGY 0 336 69. 00 60. 00 06600 SPECH PATHOLOGY 0 336 69. 00 60. 00 06600 SPECH PATHOLOGY 0 336 69. 00 60. 00 06500 CALURUS SUPPLIES CHARGED TO PATIENT 0 16, 761 71. 00 07300 DRUGS CHARGED TO PATIENT 0 16, 761 73. 00 07300 DRUGS CHARGED TO PATIENT 0 16, 761 74. 01 07590 HAMDIA LYSI & OTHER ANCILLARY 0 84, 550 76. 01 80 00 08900 ELECTROCARDIOLOGY 0 336 69. 00 60 00 08900 ELECTROCARDIOLOGY 0 346, 550 60 00 08900 DRUGS CHARGED TO PATIENTS 0 236, 084 73. 00 76. 01 03550 PSYCHI ATRI C-PSYCHOLOGIC IAL SERVI CES 0 44, 200 76. 01 80 00 08900 DRUGS CHARGED TO PATIENTS 0 236, 084 73. 00 76. 01 03950 HAMDIA LYSI & OTHER ANCILLARY 0 84, 550 76. 01 80 00 08900 DRUGS CHARGED TO PATIENTS 0 5, 788 192. 00 194. 00 07950 NON-REI MBURSABLE COST CENTERS 194. 01 194. 01 07951 MARKETI NG-PUBLI C RELATI	5.01	00570 ADMITTING	-31, 313	118, 809		5. 01
8. 00 00800 LAUNDRY & LINEN SERVICE	5.02	00590 OTHER ADMINISTRATIVE AND GENERAL	321, 433	1, 050, 917		5. 02
9. 00 00900 HOUSEKEEPING 0 13.4 295 10.00 10100 DIETARY 0 458, 830 10.00 10.00 10100 DIETARY 11.00 11.00 10.	7.00	00700 OPERATION OF PLANT	-5, 918	696, 235		7. 00
10. 00 01000 01 ETARY 0 458, 830 10. 00 11. 00 11. 00 01100 CAFETERI A -81, 359 16, 777 11. 00	8.00	00800 LAUNDRY & LINEN SERVICE	44, 264	81, 205		8. 00
11. 00 01100 CAFETERI A -81,359 16,777 11. 00 13. 00 01300 NURSI NG ADMIN I STRATION 0 697,373 13. 00 14. 00 01400 CENTRAL SERVI CES & SUPPLY -27,086 20,389 14. 00 01500 PHARMACY 0 107,016 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 16. 00 17.	9.00	00900 HOUSEKEEPI NG	0	134, 295		9. 00
13. 00 0 1300 NURSI NG ADMINI STRATI ON 14. 00 0 11400 CENTRAL SERVI CES & SUPPLY -27, 086 20, 389 14. 00 16. 00 0 10500 PHARMACY 0 107, 0016 15. 00 16. 00 16. 00 16. 00 16. 00 16. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 18 SERVI CE COST CENTERS 30. 00 0 3000 ADULTS & PEDI ATRI CS -342, 739 2, 563, 444 30. 00 40. 00	10.00	01000 DI ETARY	0	458, 830		10. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY -27,086 20,389 14. 00 15. 00 01500 PHARMACY 0 107,016 15. 00 16. 00 01600 MEDICAL RECORDS & LI BRARY 0 227,242 16. 00 17. 00 01700 SOCI AL SERVICE 0 0 0 0 17. 00 1700 SOCI AL SERVICE COST CENTERS 30. 00 3000 ADULTS & PEDIATRICS -342,739 2,563,444 30. 00 40. 00 05400 RADI OLOGY-DI AGNOSTI C 0 7,478 50. 00 60. 00 06000 LABORATORY 0 0 46,089 65. 00 65. 00 06500 RESPIRATORY THERAPY 0 14,590 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 618,274 66. 00 67. 00 06500 PHYSI CAL THERAPY 0 0 618,274 66. 00 68. 00 06800 SPEECH PATHOLOGY 0 336,852 67. 00 69. 00 06900 ELECTROCARDI OLOGY 0 336, 852 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 336, 852 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 336, 852 68. 00 69. 00 07100 MCDIAL SUPPLIES CHARGED TO PATI ENT 0 16,761 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENT 0 16,761 71. 00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 44, 200 76. 01 5PECI AL PURPOSE COST CENTERS 118. 00 SPECI AL PURPOSE COST CENTERS 119. 00 07951 MARKETI NG/PUBLIC RELATI ONS 0 29, 276 194. 01 194. 00 07951 MARKETI NG/PUBLIC RELATI ONS 0 29, 276 194. 01 194. 01 07951 MARKETI NG/PUBLIC RELATI ONS 0 29, 276 194. 02 194. 02 07952 TENANT LEASED SPACE 0 0 194. 02	11. 00	01100 CAFETERI A	-81, 359	16, 777		11. 00
15. 00 01500 PHARMACY 0 107, 016 15. 00 16. 00 01600 MEDI CAL RECORDS & LI BRARY 0 227, 242 16. 00 17. 00 1700 SOCIAL SERVI CE 0 0 0 17. 00 18. 00 03000 ADULTS & PEDI ATRI CS -342, 739 2, 563, 444 3. 00 03000 ADULTS & PEDI ATRI CS -342, 739 2, 563, 444 3. 00 04. 00 05000 RADI DLOGY - DI AGNOSTI C 0 7, 478 6. 00 05400 RADI DLOGY - DI AGNOSTI C 0 7, 478 6. 00 06. 00 06000 LABORATORY 0 46, 089 6. 00 06. 00 06500 RESPI RATORY THERAPY 0 14, 590 6. 00 06. 00 06500 RESPI RATORY THERAPY 0 618, 274 66. 00 06. 00 06600 PHYSI CAL THERAPY 0 618, 274 66. 00 06. 00 06600 PHYSI CAL THERAPY 0 356, 852 68. 00 06. 00 06900 ELECTROCARDI DLOGY 0 336, 852 68. 00 06. 00 06900 ELECTROCARDI DLOGY 0 336 69. 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 16, 761 71. 00 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0 236, 084 73. 00 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 44, 200 76. 00 0750 0 07500 DRUGS CHARGED TO PATI ENTS 0 236, 084 73. 00 0750 0 07500 PHYSI CS S OTHER ANCILLARY 0 84, 550 76. 01 0 07950 HEMODI ALYSIS & OTHER ANCILLARY 0 84, 550 76. 01 0 192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES 0 5, 788 192. 00 194. 00 197951 MARKETI NG/PUBLI C RELATIONS 0 29, 276 194. 00 194. 01 07951 MARKETI NG/PUBLI C RELATIONS 0 29, 276 194. 00 194. 01 07951 MARKETI NG/PUBLI C RELATIONS 0 29, 276 194. 00	13.00	01300 NURSING ADMINISTRATION	o	697, 373		13. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 0 227, 242 17. 00 1700 SOCI AL SERVI CE 0 0 0 0 17. 00 1700 SOCI AL SERVI CE COST CENTERS	14.00	01400 CENTRAL SERVICES & SUPPLY	-27, 086	20, 389		14. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 0 227, 242 17. 00 1700 SOCI AL SERVI CE 0 0 0 0 17. 00 1700 SOCI AL SERVI CE COST CENTERS	15.00	01500 PHARMACY	0			15. 00
17. 00			o	227, 242		16. 00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00	17. 00	01700 SOCI AL SERVI CE	o			17. 00
ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 7,478 54.00 60.00 60.00 60.00 LABORATORY 0 46,089 60.00 65.00 65.00 65.00 RESPI RATORY THERAPY 0 14,590 65.00 66.00			'			
54. 00	30.00	03000 ADULTS & PEDIATRICS	-342, 739	2, 563, 444		30. 00
60. 00		ANCILLARY SERVICE COST CENTERS	,			
65. 00	54.00	05400 RADI OLOGY-DI AGNOSTI C	0	7, 478		54. 00
66. 00	60.00	06000 LABORATORY	0	46, 089		60.00
67. 00	65.00	06500 RESPIRATORY THERAPY	O	14, 590		65. 00
68. 00	66.00	06600 PHYSI CAL THERAPY	0	618, 274		66. 00
69. 00	67.00	06700 OCCUPATIONAL THERAPY	0	838, 226		67. 00
71. 00	68.00	06800 SPEECH PATHOLOGY	0	356, 852		68. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 236, 084 73. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 01 76. 00	69.00	06900 ELECTROCARDI OLOGY	0	336		69. 00
76. 00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 01 03950 HEMODI ALYSI S & OTHER ANCI LLARY 0 84, 550 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -185, 550 10, 036, 895 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194. 00 07950 NON-REI MBURSABLE COST 194. 01 07951 MARKETI NG/PUBLI C RELATI ONS 194. 02 07952 TENANT LEASED SPACE 0 44, 200 4	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	16, 761		71. 00
76. 01 03950 HEMODI ALYSI S & OTHER ANCI LLARY 0 84,550 76. 01	73.00	07300 DRUGS CHARGED TO PATIENTS	0	236, 084		73. 00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) -185,550 10,036,895 118.00 NONREI MBURSABLE COST CENTERS 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 5,788 192.00 194.00 07950 NON-REI MBURSABLE COST 0 0 194.00 194.01 07951 MARKETI NG/PUBLI C RELATI ONS 0 29,276 194.01 194.02 07952 TENANT LEASED SPACE 0 0 194.02 19	76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	44, 200		76. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -185,550 10,036,895 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 5,788 192. 00 194. 00 07950 NON-REI MBURSABLE COST 0 0 0 194. 00 194. 01 194. 02 07951 MARKETI NG/PUBLI C RELATI ONS 0 29,276 194. 01 194. 02 07952 TENANT LEASED SPACE 0 0 0 194. 02	76. 01	03950 HEMODIALYSIS & OTHER ANCILLARY	0	84, 550		76. 01
NONRE MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 5,788 192. 00 194. 00 07950 NON-REI MBURSABLE COST 0 0 194. 00 194. 01 07951 MARKETI NG/PUBLI C RELATI ONS 0 29,276 194. 01 194. 02 07952 TENANT LEASED SPACE 0 0 194. 02		SPECIAL PURPOSE COST CENTERS				
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 5, 788 192. 00 194. 00 07950 NON-REI MBURSABLE COST 0 0 194. 00 194. 01 07951 MARKETI NG/PUBLI C RELATI ONS 0 29, 276 194. 01 194. 02 07952 TENANT LEASED SPACE 0 0 0 194. 02	118.0	SUBTOTALS (SUM OF LINES 1 through 117)	-185, 550	10, 036, 895		118. 00
194. 00 07950 NON-REI MBURSABLE COST 0 0 0 194. 00 194. 01 07951 MARKETI NG/PUBLI C RELATI ONS 0 29, 276 194. 01 194. 02 07952 TENANT LEASED SPACE 0 0 194. 02		NONREI MBURSABLE COST CENTERS				
194. 01 07951 MARKETI NG/PUBLI C RELATI ONS 0 29, 276 194. 01 194. 02 07952 TENANT LEASED SPACE 0 0 194. 02	192.0	19200 PHYSICIANS' PRIVATE OFFICES	0	5, 788		192. 00
194. 02 07952 TENANT LEASED SPACE 0 0 194. 02	194.0	0 07950 NON-REIMBURSABLE COST	0	ol		194. 00
194. 02 07952 TENANT LEASED SPACE 0 0 194. 02			0	29, 276		194. 01
	194. 0	2 07952 TENANT LEASED SPACE	O			194. 02
	200.0	TOTAL (SUM OF LINES 118 through 199)	-185, 550	10, 071, 959		200. 00

Health Financial Systems RECLASSIFICATIONS REHABILITATION HOSPITAL OF FT WAYNE

Provider CCN: 15-3030

Heal th	Financial Systems	REHA	BILITATION HOSP	ITAL OF FT WAYNE	In Lieu	of Form CMS-2552-10
RECLAS	SIFICATIONS			Provider CCN: 15-303		Worksheet A-6
					From 10/01/2016	Data /Time Dranamad
					To 09/30/2017	Date/Time Prepared: 2/28/2018 4: 23 pm
		Increases				2,20,2010 1.20 pm
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3.00	4.00	5. 00		
	A - EMPLOYEE BENEFITS		<u> </u>			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	837, 646		1. 00
2.00		0.00	O	О		2. 00
3.00		0.00	O	О		3. 00
4.00		0.00	O	О		4. 00
5.00		0.00	0	О		5. 00
6.00		0.00	0	О		6. 00
7.00		0.00	0	0		7. 00
	TOTALS		0	837, 646		
	B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	405		1.00
	PATI ENT					
	TOTALS		0	405		
	C - RENTAL AND LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	102, 497		1.00
2.00		0. 00	0	0		2. 00
3.00		0. 00	0	0		3. 00
4.00		0.00	0	O		4. 00
5.00		0.00	0	O		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12. 00 13. 00		0. 00 0. 00	0	0		12. 00 13. 00
13.00	TOTALS — — — —	<u> </u>		00 102, 497		13.00
	D - OTHER CAPITAL COSTS		<u> </u>	102, 497		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	10, 114		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	o	151, 579		2. 00
2.00	TOTALS		— — — — —	161, 693		2.00
	E - MARKETI NG		<u> </u>	101, 073		
1.00	MARKETING/PUBLIC RELATIONS	194. 01	16, 396	12, 880		1. 00
00	TOTALS		16, 396	12, 880		1 55
	F - MEDICAL SUPPLIES		107070	.2, 666		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	16, 356		1. 00
00	PATI ENT	,	٦	. 5, 555		
	TOTALS	+		16, 356		İ
	G - DRUGS CHARGED TO PATIENTS			· · · · · · · · · · · · · · · · · · ·		
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	236, 084		1. 00
	TOTALS			236, 084		
	H - PHYSICIAN DIRECOTRS			·		
1.00	ADULTS & PEDIATRICS	30.00	0	342, 739		1.00
	TOTALS	= = = +		342, 739		
	I - DIETARY					
1.00	CAFETERI A	11. 00	59, 224	38, 912		1. 00
	TOTALS		59, 224	38, 912		
500.00	Grand Total: Increases		75, 620	1, 749, 212		500.00

Health Financial Systems RECLASSIFICATIONS

Peri od: From 10/01/2016 To 09/30/2017

Date/Time Prepared: 2/28/2018 4:23 pm

					l .	2/28/2018 4: 2	23 DIII
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - EMPLOYEE BENEFITS						
1. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 02	0	837, 351	0		1.00
2.00	HOUSEKEEPI NG	9, 00	o	52	o		2.00
3.00	DI ETARY	10.00	o	57			3.00
4. 00	NURSING ADMINISTRATION	13. 00	0	9			4. 00
5. 00	MEDICAL RECORDS & LIBRARY	16.00	ő	24	- 1		5. 00
6.00	OCCUPATI ONAL THERAPY	67.00	0	150			6. 00
7. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0	130	0		7. 00
7.00	TOTALS	192.00	— — — 0				7.00
	B - OXYGEN COSTS		U _I	837, 646			-
1 00		\r 00	ما	405			1 00
1. 00	RESPIRATORY THERAPY	65.00	0				1. 00
	TOTALS		UU	405			-
	C - RENTAL AND LEASE			450	10		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	159			1.00
2.00	ADMITTING	5. 01	0	173			2. 00
3. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 02	0	2, 816	0		3. 00
4.00	DI ETARY	10.00	0	1, 224	0		4. 00
5.00	NURSING ADMINISTRATION	13.00	0	185	0		5. 00
6.00	CENTRAL SERVICES & SUPPLY	14.00	O	64, 832	0		6.00
7.00	PHARMACY	15. 00	0	22, 192			7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	2, 677	o		8.00
9.00	ADULTS & PEDIATRICS	30.00	o	77			9. 00
10.00	RESPIRATORY THERAPY	65.00	0	7, 972	0		10.00
11. 00	PHYSI CAL THERAPY	66.00	ō	72			11. 00
12. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	76.00	0	24			12. 00
.2.00	SERVI CES	, 5. 55	٦				12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	o	94	o		13.00
	TOTALS		— — - -	102, 497			
	D - OTHER CAPITAL COSTS		-,		L		1
1.00	OTHER ADMINISTRATIVE AND	5. 02	0	161, 693	12		1.00
	GENERAL						
2.00		0.00	o	0	13		2.00
	TOTALS			161, 693			
	E - MARKETING		<u> </u>		'		
1.00	OTHER ADMINISTRATIVE AND	5. 02	16, 396	12, 880	0		1.00
	GENERAL						
	TOTALS		16, 396	12, 880			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	16, 356	0		1.00
	TOTALS		0	16, 356			
	G - DRUGS CHARGED TO PATIENTS	S					
1.00	PHARMACY	15. 00	0	236, 084	0		1.00
	TOTALS		0	236, 084			
	H - PHYSICIAN DIRECOTRS						
1.00	OTHER ADMINISTRATIVE AND	5. 02	0	342, 739	0		1.00
	GENERAL						
	TOTALS	_		342, 739			
	I - DIETARY						
1.00	DI ETARY	10.00	59, 224	38, 912	0		1.00
	TOTALS — — — —		59, 224	38, 912			
500.00	Grand Total: Decreases		75, 620	1, 749, 212			500.00
	•	'		•	, ,		

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

				'	0 07/30/2017	2/28/2018 4: 2:	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	900, 000	0	0	0	0	1. 00
2.00	Land Improvements	276, 453	0	0	0	0	2. 00
3.00	Buildings and Fixtures	11, 859, 432	0	0	0	0	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	745, 332	224, 406	0	224, 406	0	6. 00
7.00	HIT designated Assets	7, 715	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	13, 788, 932	224, 406	0	224, 406	0	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	13, 788, 932	224, 406	0	224, 406	0	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	900, 000	0				1. 00
2.00	Land Improvements	276, 453	0				2. 00
3.00	Buildings and Fixtures	11, 859, 432	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	969, 738	0				6. 00
7.00	HIT designated Assets	7, 715	0				7. 00
8.00	Subtotal (sum of lines 1-7)	14, 013, 338	0				8. 00
9.00	Reconciling Items	o	0				9. 00
10.00	Total (line 8 minus line 9)	14, 013, 338	0				10. 00
				•		•	

			Т	o 09/30/2017	Date/Time Pre 2/28/2018 4:2	
		SU	JMMARY OF CAPIT	AL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
	9. 00	10. 00	11. 00	instructions) 12.00	instructions) 13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	282, 710	0	C	0	0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	117, 709	0	C	0	0	2. 00
3.00 Total (sum of lines 1-2)	400, 419	0	C	0	0	3. 00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1) (sum				
·	Capi tal -Relate	` ' `				
	d Costs (see	through 14)				
	instructions)					
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	0	282, 710				1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	117, 709				2. 00
3.00 Total (sum of lines 1-2)	0	400, 419				3. 00

	CMS-2552-10			
	e Prepared: 8 4:23 pm			
COMPUTATION OF RATIOS ALLOCATION OF OTHER CAI	PI TAL			
Cost Center Description Gross Assets Leases Gross Assets Leases Gross Assets Fatio (see instructions) (col. 1 - col. 2)	nce			
1.00 2.00 3.00 4.00 5.00				
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS				
1. 00 CAP REL COSTS-BLDG & FLXT 12, 135, 885 0 12, 135, 885 0. 941574	0 1.00			
2.00 CAP REL COSTS-MVBLE EQUIP 753,047 0 753,047 0.058426	0 2.00			
3.00 Total (sum of lines 1-2) 12,888,932 0 12,888,932 1.000000	0 3.00			
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				
Cost Center Description Taxes Other Total (sum of Depreciation Lease	9			
Capi tal -Rel ate col s. 5				
d Costs through 7)				
6.00 7.00 8.00 9.00 10.00)			
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS				
1. 00 CAP REL COSTS-BLDG & FIXT 0 0 0 233, 220	0 1.00			
	2, 497 2. 00			
	2, 497 3. 00			
SUMMARY OF CAPITAL				
Cost Center Description Interest Insurance (see Taxes (see Other Total (2)				
instructions instructions Capital -Relate of cols				
d Costs (see through	14)			
instructions)				
11.00 12.00 13.00 14.00 15.00)			

50, 695

0 50, 695

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

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

10, 114

10, 114

151, 579

0 151, 579

445, 608 1. 00 156, 169 2. 00 601, 777 3. 00

0 0 0

1.00

2.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES

Provider CCN: 15-3030

Peri od: Worksheet A-8 From 10/01/2016

09/30/2017 Date/Time Prepared: 2/28/2018 4:23 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 4 00 0 00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay -2, 886 CAP REL COSTS-MVBLE EQUIP 7.00 2.00 7.00 Α stations excluded) (chapter 8.00 Tel evi si on and radio servi ce -2, 620 CAP REL COSTS-MVBLE EQUIP 2.00 8.00 Α (chapter 21) Parking lot (chapter 21) 9.00 9.00 0.00 Provider-based physician -342, 739 10.00 10.00 A-8-2 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 466, 255 12.00 transactions (chapter 10) 13 00 13 00 Laundry and linen service 0 00 14.00 Cafeteria-employees and guests В -81, 359 CAFETERI A 11.00 14.00 Rental of quarters to employee -6, 309 CAP REL COSTS-BLDG & FIXT 15.00 15.00 1.00 and others 16.00 Sale of medical and surgical 0.00 16.00 0 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 0 17.00 pati ents 18.00 Sale of medical records and В 0.00 18.00 abstracts Nursing and allied health 19 00 19 00 0 00 education (tuition, fees, books, etc.) 20.00 -1,559 OTHER ADMINISTRATIVE AND 20.00 Vending machines 5.02 GENERAL Income from imposition of 0.00 21.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 22.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory 23.00 A - 8 - 3ORESPIRATORY THERAPY 65.00 23.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24.00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review -0 *** Cost Center Deleted *** 114.00 25.00 physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL -48, 751 CAP REL COSTS-BLDG & FIXT 1.00 26.00 Α COSTS-BLDG & FLXT Depreciation - CAP REL -91,558 CAP REL COSTS-MVBLE EQUIP 2.00 27.00 27.00 COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00 Physicians' assistant 29.00 0.00 29 00 Adjustment for occupational OCCUPATIONAL THERAPY 30.00 A-8-3 67.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 OADULTS & PEDIATRICS 30.00 30. 99 instructions) OSPEECH PATHOLOGY 31.00 Adjustment for speech A-8-3 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0 0.00 32.00 Depreciation and Interest

From 10/01/2016
To 09/30/2017 Date/Time Prepared:

					10 09/30/201/	2/28/2018 4:2	
				Expense Classification of	n Worksheet A		
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
	1	1. 00	2. 00	3. 00	4. 00	5. 00	
33. 00	MI SCELANEOUS I NCOME	В		OTHER ADMINISTRATIVE AND	5. 02	0	33. 00
				GENERAL			
33. 01	LEGAL FEES	A	·	OTHER ADMINISTRATIVE AND	5. 02	0	33. 01
00.00	MARKETING			GENERAL	F 00		00.00
33. 02	MARKETI NG	A		OTHER ADMINISTRATIVE AND	5. 02	0	33. 02
22.02	DATI ENT TELEPHONE EVDENCE			GENERAL	F 00		22.02
33. 03	PATIENT TELEPHONE EXPENSE	A	·	OTHER ADMINISTRATIVE AND GENERAL	5. 02	0	33. 03
33. 06	PATIENT TV CABLE EXPENSE	A		OPERATION OF PLANT	7. 00	0	33. 06
33. 07	CHARI TABLE CONTRIBUTIONS		·	OTHER ADMINISTRATIVE AND	5. 02		33. 07
33.07	CHARTTABLE CONTRIBUTIONS	A		GENERAL	5.02	0	33.07
33. 09	LOBBYING EXPENSE IN	A		OTHER ADMINISTRATIVE AND	5. 02	_	33. 09
33.09	ASSOCIATION DUES	_ ^		GENERAL	5.02	0	33.09
50. 00	TOTAL (sum of lines 1 thru 49)		-185, 550	1			50.00
50.00	(Transfer to Worksheet A,		- 160, 000				30.00
	column 6, line 200.)						
	[COT UIIII O, TTTIE 200.]						

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-3030 Peri od: Worksheet A-8-1 From 10/01/2016
To 09/30/2017 Date/Time Prepared: OFFICE COSTS

					2/28/2018 4: 2	3 pm
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:		I	1	_	
1.00	1		DIRECT ALLOCATION - INTEREST	50, 695		1. 00
2.00		CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	285		2. 00
3.00		CAP REL COSTS-BLDG & FIXT	BUILDING AND FIXTURES	5, 285		3. 00
4.00		CAP REL COSTS-MVBLE EQUIP	MOVABLE EQUIPMENT	32, 948		4. 00
4. 01		OTHER ADMINISTRATIVE AND GEN		156, 169		4. 01
4. 02	1	OTHER ADMINISTRATIVE AND GEN	•	44, 568	· ·	4. 02
4. 03	II	LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICE	44, 264		4. 03
4.04	1	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	79	-	4. 04
4.05		ADMITTING	PASI OPERATING COSTS	4, 191		4. 05
4.06		ADMI TTI NG	PASI COLLECTION FEES	0	902	4. 06
4.07	5. 01	ADMI TTI NG	HIIM ALLOCATION	0	25, 973	4. 07
4.08		ADMI TTI NG	PASI LIEN UNIT COLLECTION FE	0	8, 629	4. 08
4.09		CENTRAL SERVICES & SUPPLY	HOSPITAL LAUNDRY SERVICE	0	27, 086	4. 09
4. 10		OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL ALLOCATIONS	305, 519	0	4. 10
5.00	TOTALS (sum of lines 1-4).			644, 003	177, 748	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

				Related Organization(s) and/	or Home Office		
	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		0.00	COMMUNITY HEALT	100.00	6. 00
7.00	В		0.00	LUTHERAN	100.00	7. 00
8.00	G	HOSPITAL LAUNDR	100.00	LAUNDRY	100.00	8. 00
9.00	В		0.00	PASI	100.00	9. 00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider. B. Corporation, partnership, or other organization has financial interest in provider.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- 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

								2/28/2018 4:2	23 pm
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
			MENTS REQUIRED AS A RESULT	OF TRANS	SACTIONS WITH	RELATED 0	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE CO								
1.00	50, 695								1. 00
2.00	285								2. 00
3.00	5, 285								3.00
4.00	32, 948								4.00
4.01	131, 011								4. 01
4.02	-45, 432								4. 02
4.03	44, 264								4. 03
4.04	79	9							4. 04
4.05	4, 191	0							4. 05
4.06	-902	0							4. 06
4.07	-25, 973	0							4. 07
4.08	-8, 629	0							4. 08
4.09	-27, 086	0							4. 09
4. 10	305, 519	0							4. 10
5.00	466, 255								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.

1100 110 0	The state of the s	cordinate transfer 2, the amount arrowable should be that cated the cordinate transfer to	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	31		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HOME OFFICE:	
	DI THILLINGERITIONOMIT TO MEEN	ALE STOCKET EXTENSIVE OF THE FOR THEME STATES	

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
9.00	DEBT COLLECTION	9.00
10.00		10.00
100.00		100.00

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

Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CMS-2552-10 PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-3030 Worksheet A-8-2 Peri od: From 10/01/2016 09/30/2017 Date/Time Prepared: 2/28/2018 4:23 pm Cost Center/Physician Wkst. A Line # Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er Remuneration Component Component ider Component Hours 7.00 1. 00 2.00 3.00 4.00 5. 00 6. 00 1.00 30.00 ADULTS & PEDIATRICS 342, 739 342, 739 1.00 0 0 0 0 0 0 2.00 0.00 0 2.00 3.00 0.00 0 0 3.00 0 0 4.00 0.00 0 0 4.00 0 0.00 0 5.00 0 5.00 6.00 0.00 0 6.00 0 0.00 0 0 7.00 0 0 7.00 0.00 8.00 0 8.00 9.00 0.00 9.00 10.00 0.00 10.00 342, 739 200.00 342, 739 200.00 Cost Center/Physician Physician Cost Wkst. A Line # Unadjusted RCE 5 Percent of Provi der Cost of I denti fi er Limit Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col. Insurance Education 12.00 1.00 2.00 8.00 9.00 13.00 14. 00 30. 00 ADULTS & PEDIATRICS 1.00 0 0 0 1.00 2.00 0.00 0 0 0 0 2.00 3.00 0.00 0 0 0 0 0 3.00 0 0 0 0 4.00 0.00 000000 4.00 0.00 5.00 5.00 0 0 6.00 0.00 6.00

	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	
		ldentifier	Component	Li mi t	Di sal I owance		
			Share of col.				
			14				
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00	
1.00	30. 00	ADULTS & PEDIATRICS	0	0	0	342, 739	1. 00
2.00	0. 00		0	0	0	0	2. 00
3.00	0. 00		0	0	0	0	3.00
4.00	0. 00		0	0	0	0	4. 00
5.00	0. 00		0	0	0	0	5. 00
6.00	0.00		0	0	0	0	6. 00
7.00	0. 00		0	0	0	0	7. 00
8.00	0. 00		0	0	0	0	8. 00
9.00	0. 00		0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	10.00
200.00			0	0	0	342, 739	200. 00

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Provider CCN: 15-3030

				To	o 09/30/2017	Date/Time Pre 2/28/2018 4:2	pared: 3 pm
			CAPI TAL REL	CAPITAL RELATED COSTS		2,20,2010 112	, p
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMI TTI NG	
		col . 7)		0.00	4.00		
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	4. 00	5. 01	
1. 00	00100 CAP REL COSTS-BLDG & FIXT	445, 608	445, 608				1.00
2. 00	00200 CAP REL COSTS-BLDG & FIXT	156, 169	443, 606				2.00
4. 00	1	1	1 700	156, 169	1 001 700		
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT	999, 146	1, 798		1, 001, 720	142 004	4. 00 5. 01
		118, 809	9, 259	3, 996	11, 022	143, 086	
5. 02	00590 OTHER ADMINISTRATIVE AND GENERAL	1, 050, 917	35, 070		38, 098	0	5. 02
7.00	00700 OPERATION OF PLANT	696, 235	81, 631	35, 227	37, 132	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	81, 205	0	0	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	134, 295	8, 819	3, 806	18, 476	0	9.00
10.00	01000 DI ETARY	458, 830	0	0	50, 394	0	10.00
11.00	01100 CAFETERI A	16, 777	34, 073	14, 704	10, 304	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	697, 373	954	412	107, 648	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	20, 389	6, 735		2, 359	0	14. 00
15. 00	01500 PHARMACY	107, 016	2, 854	1, 232	15, 403	0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	227, 242	3, 272		29, 036	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	2, 120	915	0	0	17. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	2.5(2.444	F/ 70/	24 405	201 151	FO 20/	20.00
30. 00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	2, 563, 444	56, 736	24, 485	381, 151	50, 206	30. 00
E4 00	05400 RADI OLOGY-DI AGNOSTI C	7 470	2 155	1 2/2	0	1 105	 E4 00
54. 00 60. 00	06000 LABORATORY	7, 478	3, 155 0		~ i	1, 105	1
	06500 RESPI RATORY THERAPY	46, 089		_	3, 661	4, 448	1
65. 00	06600 PHYSI CAL THERAPY	14, 590	734	317	1, 741 96, 170	136	1
66. 00 67. 00	06700 OCCUPATI ONAL THERAPY	618, 274	74, 037	31, 951		21, 720	•
68.00	06800 SPEECH PATHOLOGY	838, 226	34, 953	·	133, 658	22, 945	•
	l l	356, 852	2, 649	1, 143	55, 569	12, 261	68.00
69. 00 71. 00	06900 ELECTROCARDI OLOGY	336 16, 761	0	0	14 0	177 4, 626	69. 00 71. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1	_	ŭ	-	•	1
73.00	07300 DRUGS CHARGED TO PATIENTS	236, 084	0	1 205	7 001	21, 508	•
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	44, 200	3, 023	1, 305	7, 001 0	1, 746	1
76. 01	03950 HEMODIALYSIS & OTHER ANCILLARY SPECIAL PURPOSE COST CENTERS	84, 550	0	0	U	2, 208	76. 01
110 00		10, 036, 895	361, 872	156, 169	998, 837	143, 086	110 00
118.00	NONREIMBURSABLE COST CENTERS	10, 030, 895	301, 872	150, 109	998, 837	143, 086	1118.00
100.00	19200 PHYSI CLANS' PRI VATE OFFI CES	F 700	0	0	30	0	192. 00
	07950 NON-REIMBURSABLE COST	5, 788	0		30		194. 00
	07951 MARKETING/PUBLIC RELATIONS	29, 276	0		2, 853		194. 00
	207951 MARKETTING/PUBLIC RELATIONS	27, 270	83, 736		∠, 853		194. 01
200.00		١	03, /30	ا	۷	Ü	200. 00
200.00	1 1	1	0	_	0	0	200.00
201.00	1 9	10, 071, 959	445, 608	156, 169	1, 001, 720	143, 086	
202. UL	TIOTAL (Sum TITIES TTO LINGUIST 201)	10,0/1,959	440, 008	130, 109	1,001,720	143, 080	1202. UU

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3030

Peri od: Worksheet B From 10/01/2016 Part I To 09/30/2017 Date/Time Prepared:

2/28/2018 4:23 pm Cost Center Description Subtotal OTHER OPERATION OF LAUNDRY & HOUSEKEEPI NG ADMI NI STRATI VE LINEN SERVICE **PLANT** AND GENERAL 5A. 01 7.00 8. 00 9. 00 5.02 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00570 ADMITTING 5.01 00590 OTHER ADMINISTRATIVE AND GENERAL 1, 139, 220 1, 139, 220 5.02 5.02 7.00 00700 OPERATION OF PLANT 850, 225 108, 432 958, 657 7.00 00800 LAUNDRY & LINEN SERVICE 10, 356 91, 561 8.00 81, 205 8.00 26, 599 9.00 00900 HOUSEKEEPI NG 165, 396 21,093 213, 088 9.00 10.00 01000 DI ETARY 509, 224 64, 943 0 0 10.00 01100 CAFETERI A 75, 858 32, 227 9, 674 102, 765 11.00 0 11.00 01300 NURSING ADMINISTRATION 806, 387 102, 841 0 13.00 2.877 902 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 32, 390 4, 131 20, 314 0 6, 370 14.00 15.00 01500 PHARMACY 126, 505 16, 134 8,608 0 2,699 15.00 260, 962 01600 MEDICAL RECORDS & LIBRARY 0 3, 095 16.00 33, 281 9,869 16.00 01700 SOCIAL SERVICE 17.00 3,035 387 6, 395 2,005 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 076, 022 392, 295 171, 121 51, 358 53, 662 30.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 13, 100 1, 671 9, 515 0 2, 984 54.00 06000 LABORATORY 54, 198 6, 912 0 60.00 C 0 60.00 06500 RESPIRATORY THERAPY 17, 518 2, 234 2, 213 65.00 65.00 0 694 06600 PHYSI CAL THERAPY 107, 402 223, 300 66.00 842, 152 19, 066 70, 027 66.00 67.00 06700 OCCUPATIONAL THERAPY 1,044,866 133, 255 105, 421 21, 137 33, 059 67.00 06800 SPEECH PATHOLOGY 54, 645 68.00 428, 474 7, 988 0 2,505 68.00 69 00 06900 ELECTROCARDI OLOGY 527 67 0 0 69 00 0 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 2, 728 71.00 21, 387 0 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 257, 592 32, 851 0 0 0 73.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 57, 275 7, 304 9, 117 ol 2,859 76.00 03950 HEMODIALYSIS & OTHER ANCILLARY 76.01 86, 758 11, 065 0 76.01 SPECIAL PURPOSE COST CENTERS 91, 561 213, 088 118. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 9, 950, 276 1, 123, 701 706, 102 NONREI MBURSABLE COST CENTERS 0 192. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 5,818 742 0 0 194. 00 07950 NON-REI MBURSABLE COST 0 0 0 0 194.00 0 194. 01 194. 01 07951 MARKETING/PUBLIC RELATIONS 32, 129 4,098 0 0 194. 02 07952 TENANT LEASED SPACE 252, 555 o 0 194, 02 83.736 10, 679 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201. 00

10, 071, 959

1, 139, 220

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202.00

TOTAL (sum lines 118 through 201)

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3030

Peri od: Worksheet B From 10/01/2016 Part I To 09/30/2017 Date/Time Prepared:

2/28/2018 4:23 pm Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI ON SERVICES & SUPPLY 10.00 11.00 13.00 15.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00570 ADMITTING 5.01 00590 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 574, 167 10.00 01100 CAFETERI A 220, 524 11.00 11.00 01300 NURSING ADMINISTRATION 939, 922 13.00 0 26, 915 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 1, 136 64, 341 14.00 15.00 01500 PHARMACY 0 2,808 36, 016 192, 770 15.00 01600 MEDICAL RECORDS & LIBRARY 7, 951 16.00 0 16.00 C 621 0 01700 SOCIAL SERVICE 17.00 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 574, 167 115, 233 891, 243 52, 650 0 30.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 06000 LABORATORY 8, 560 330 60.00 60.00 00000000 2, 146 0 06500 RESPIRATORY THERAPY 473 4,070 792 65.00 65.00 0 06600 PHYSI CAL THERAPY 23, 759 3, 585 66.00 0 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 27, 798 0 4, 253 0 67.00 06800 SPEECH PATHOLOGY 68.00 10, 160 0 745 0 68.00 69 00 06900 ELECTROCARDI OLOGY 33 0 69.00 C 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 C 0 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 192, 770 73.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 1, 325 0 76.00 87 0 76.00 03950 HEMODIALYSIS & OTHER ANCILLARY 76.01 0 0 76.01 SPECIAL PURPOSE COST CENTERS 939, 922 SUBTOTALS (SUM OF LINES 1 through 117) 192, 770 118. 00 118.00 574, 167 219, 704 63, 063 NONREI MBURSABLE COST CENTERS 0 192. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 24 194. 00 07950 NON-REI MBURSABLE COST 0 C 0 0 194.00 194. 01 07951 MARKETING/PUBLIC RELATIONS 0 194. 01 0 820 0 1, 254 194. 02 07952 TENANT LEASED SPACE 0 0 0 194, 02 C 0 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201. 00 202.00 TOTAL (sum lines 118 through 201) 574, 167 220, 524 939, 922 64, 341 192, 770 202. 00

Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-3030 Peri od: Worksheet B From 10/01/2016 Part I 09/30/2017 Date/Time Prepared: 2/28/2018 4:23 pm Cost Center Description MEDI CAL SOCIAL SERVICE Subtotal Intern & Total RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 16.00 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00570 ADMITTING 5. 01 5.01 00590 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 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 315, 779 16.00 01700 SOCIAL SERVICE 17.00 11,822 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 110, 815 11, 822 5, 500, 388 0 5, 500, 388 30.00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 2, 438 29, 708 29, 708 54.00 06000 LABORATORY 0 60 00 9,816 0 81, 962 60 00 81, 962 06500 RESPIRATORY THERAPY 0 65.00 300 0 28, 294 28, 294 65.00 06600 PHYSI CAL THERAPY 47, 932 1, 337, 223 0 1, 337, 223 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 50, 634 0 1, 420, 423 0 1, 420, 423 67.00 531, 574 06800 SPEECH PATHOLOGY 27,057 0 531, 574 68 00 68 00 06900 ELECTROCARDI OLOGY 69.00 390 0 1, 017 1,017 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 10, 208 0 34, 323 34, 323 71.00 0 71.00 07300 DRUGS CHARGED TO PATIENTS 47, 463 0 530, 676 530, 676 73.00 73.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 81, 820 81, 820 3.853 76.00 C 76.00

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202.00

03950 HEMODIALYSIS & OTHER ANCILLARY

Cross Foot Adjustments

Negative Cost Centers

SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS

TOTAL (sum lines 118 through 201)

SPECIAL PURPOSE COST CENTERS

192. 00 19200 PHYSICIANS' PRIVATE OFFICES

194. 01 07951 MARKETING/PUBLIC RELATIONS

194. 00 07950 NON-REI MBURSABLE COST

194. 02 07952 TENANT LEASED SPACE

Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3030 Peri od: Worksheet B From 10/01/2016 Part II Date/Time Prepared: 09/30/2017 2/28/2018 4:23 pm CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Directly BLDG & FIXT MVBLE EQUIP Subtotal **BENEFITS** Assigned New Capi tal DEPARTMENT Related Costs 0 1.00 2.00 2A 4.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 798 776 2,574 2, 574 4.00 5.01 00570 ADMITTING 0000000000 9, 259 3, 996 13, 255 28 5.01 00590 OTHER ADMINISTRATIVE AND GENERAL 35, 070 15, 135 50, 205 98 5 02 5 02 00700 OPERATION OF PLANT 7.00 81,631 35, 227 116, 858 95 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 0 8.00 9.00 00900 HOUSEKEEPI NG 8.819 12, 625 47 9.00 3 806 01000 DI ETARY 10.00 10.00 129 11.00 01100 CAFETERI A 34, 073 14, 704 48, 777 26 11.00 01300 NURSING ADMINISTRATION 13.00 954 412 1, 366 277 13.00 01400 CENTRAL SERVICES & SUPPLY 2, 907 6, 735 9,642 14 00 14 00 6 15.00 01500 PHARMACY 2,854 1, 232 4, 086 40 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 3, 272 1, 412 4, 684 75 16.00 01700 SOCIAL SERVICE 17.00 0 915 3,035 0 17.00 2, 120 INPATIENT ROUTINE SERVICE COST CENTERS 30.00

30.00 03000 ADULTS & PEDIATRICS 0 56, 736 24, 485 81, 221 982 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 155 0 54.00 00000000000 1, 362 4. 517 06000 LABORATORY 60.00 60.00 C 9 65.00 06500 RESPIRATORY THERAPY 734 317 1,051 65.00 06600 PHYSI CAL THERAPY 74, 037 31, 951 105, 988 247 66.00 66.00 06700 OCCUPATIONAL THERAPY 15, 084 67.00 34.953 50.037 343 67.00 06800 SPEECH PATHOLOGY 3, 792 143 68.00 2,649 1, 143 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 C 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.00 3,023 1, 305 4, 328 18 76.00 03950 HEMODIALYSIS & OTHER ANCILLARY 76.01 76.01 0 SPECIAL PURPOSE COST CENTERS 118.00 361, 872 156, 169 518, 041 2, 567 118. 00

SUBTOTALS (SUM OF LINES 1 through 117) 0 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194. 00 07950 NON-REI MBURSABLE COST 0 192. 00 0 0 0 0 194. 00 0 0 0 C 194. 01 07951 MARKETI NG/PUBLIC RELATIONS 0 7 194. 01 0 0 194. 02 07952 TENANT LEASED SPACE 0 83, 736 0 83, 736 0 194. 02 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 0 445, 608 156, 169 601, 777 2, 574 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| Peri od: | Worksheet B | From 10/01/2016 | Part II | To 09/30/2017 | Date/Time Prepared:

				'	0 09/30/201/	2/28/2018 4: 2	
	Cost Center Description	ADMITTING	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	<u> </u>
	, , , , , , , , , , , , , , , , , , ,		ADMI NI STRATI VE	PLANT	LINEN SERVICE		
			AND GENERAL				
		5. 01	5. 02	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00570 ADMI TTI NG	13, 283					5. 01
5.02	00590 OTHER ADMINISTRATIVE AND GENERAL	0	50, 303				5. 02
7.00	00700 OPERATION OF PLANT	0	4, 788	121, 741			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	457	0	457		8.00
9.00	00900 HOUSEKEEPI NG	0	931	3, 378	0	16, 981	9. 00
10.00	01000 DI ETARY	0	2, 867		0	0	•
11. 00	01100 CAFETERI A	0	427	13, 050	0	2, 568	
13. 00	01300 NURSING ADMINISTRATION	0	4, 541	365		72	•
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	182			508	1
15. 00	01500 PHARMACY	0	712	,		215	
16. 00	01600 MEDICAL RECORDS & LI BRARY	0	1, 469			247	16.00
17. 00	01700 SOCIAL SERVICE	0	1, 407			160	•
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		17	012	U	100	17.00
30. 00	03000 ADULTS & PEDIATRICS	4, 669	17, 323	21, 731	256	4, 276	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	4,007	17, 323	21,731	230	4,270	30.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	102	74	1, 208	0	238	54.00
60.00	06000 LABORATORY	413				0	60.00
65. 00	06500 RESPIRATORY THERAPY	13	l e		0	55	
66. 00	06600 PHYSI CAL THERAPY	2, 014				5, 580	ł
67. 00	06700 OCCUPATI ONAL THERAPY	2, 128				2, 634	
68. 00	06800 SPEECH PATHOLOGY	1, 137	2, 413		0	200	ł
69. 00	06900 ELECTROCARDI OLOGY	1, 137			0	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	429	-		0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 995			0	0	
76. 00	03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES	1, 443			0	228	
76. 00	03950 HEMODIALYSIS & OTHER ANCILLARY	205				0	76. 00
76.01	SPECIAL PURPOSE COST CENTERS		409		U	0	76.01
118. 00		13, 283	49, 617	89, 668	457	16, 981	110 00
110.00	NONREI MBURSABLE COST CENTERS	13, 203	49,017	09,000	437	10, 901	1110.00
102.00	19200 PHYSI CI ANS' PRI VATE OFFI CES		33	0	0	0	192. 00
	07950 NON-REIMBURSABLE COST	0	0		_		194. 00
	07951 MARKETI NG/PUBLI C RELATIONS	0			0		194. 00
	07951 MARKETING/PUBLIC RELATIONS 07952 TENANT LEASED SPACE		181		0		194. 01
			472	32, 073	U	0	200. 00
200.00		_		_		,	
201.00		12 202	0	ľ	457	16, 981	201. 00
202.00	TOTAL (sum lines 118 through 201)	13, 283	50, 303	121, 741	457	10, 981	2U2. UU

ALLOCATION OF CAPITAL RELATED COSTS

TOTAL (sum lines 118 through 201)

Provider CCN: 15-3030

Peri od: Worksheet B From 10/01/2016 Part II 09/30/2017 Date/Time Prepared:

2/28/2018 4:23 pm Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI ON SERVICES & SUPPLY 10.00 11.00 13.00 15.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00570 ADMITTING 5.01 5.02 00590 OTHER ADMINISTRATIVE AND GENERAL 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 2,996 10.00 01100 CAFETERI A 11.00 64,848 11.00 0 01300 NURSING ADMINISTRATION 7, 915 14, 536 13.00 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 334 13, 252 14.00 15.00 01500 PHARMACY 0 826 557 7, 529 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 2, 338 128 16.00 0 0 01700 SOCIAL SERVICE 17.00 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 996 33, 885 13, 783 10, 844 0 30.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 54.00 06000 LABORATORY 631 132 60.00 60.00 00000000 68 0 06500 RESPIRATORY THERAPY 65.00 65.00 139 63 163 0 06600 PHYSI CAL THERAPY 6, 987 66.00 0 738 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 8, 174 0 876 0 67.00 06800 SPEECH PATHOLOGY 68.00 2, 988 0 154 0 68.00 69 00 06900 ELECTROCARDI OLOGY C 0 Ω 69.00 1 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 C 0 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 7, 529 73.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 76.00 390 18 0 76.00 03950 HEMODIALYSIS & OTHER ANCILLARY 76.01 0 0 76.01 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 2, 996 14, 536 12, 989 7, 529 118. 00 118.00 64, 607 NONREI MBURSABLE COST CENTERS 0 192. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 194. 00 07950 NON-REI MBURSABLE COST 0 С 0 0 0 194.00 194. 01 07951 MARKETING/PUBLIC RELATIONS 0 194. 01 0 241 0 258 0 194. 02 194. 02 07952 TENANT LEASED SPACE 0 0 C 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 2, 996

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Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-3030 Peri od: Worksheet B From 10/01/2016 Part II 09/30/2017 Date/Time Prepared: 2/28/2018 4:23 pm Cost Center Description MEDI CAL SOCIAL SERVICE Subtotal Intern & Total RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 16.00 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.01 00570 ADMITTING 5. 01 00590 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 01100 CAFETERI A 11.00 11.00 13.00 | 01300 | NURSI NG ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 01600 MEDICAL RECORDS & LIBRARY 16.00 10, 194 16.00 01700 SOCIAL SERVICE 17.00 4,024 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 574 4, 024 199, 564 0 199, 564 30.00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 6, 218 6, 218 54.00 06000 LABORATORY 1, 875 0 1, 875 60 00 317 60 00 Ω 06500 RESPIRATORY THERAPY 0 65.00 10 0 1,878 1,878 65.00 06600 PHYSI CAL THERAPY 1,548 156, 296 156, 296 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 1,635 0 85, 205 85, 205 67.00 68 00

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194. 00 07950 NON-REI MBURSABLE COST

194. 02 07952 TENANT LEASED SPACE

200.00

201.00

202.00

194. 01 07951 MARKETING/PUBLIC RELATIONS

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3030 Peri od: Worksheet B-1 From 10/01/2016 09/30/2017 Date/Time Prepared: 2/28/2018 4:23 pm CAPITAL RELATED COSTS ADMI TTI NG Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation (SOUARE FEET) (SOUARE FEET) BENEFITS (GROSS CHARGES) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 01 5A. 02 GENERAL SERVICE COST CENTERS 1 00 1 00 00100 CAP REL COSTS-BLDG & FLXT 728 820 2.00 00200 CAP REL COSTS-MVBLE EQUIP 591, 864 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2,940 2, 940 5, 757, 347 4.00 00570 ADMITTING 63, 346 5 01 15, 144 15, 144 31, 372, 779 5 01 00590 OTHER ADMINISTRATIVE AND GENERAL 5.02 57, 360 57, 360 218, 964 -1, 139, 220 5.02 7.00 00700 OPERATION OF PLANT 133, 512 133, 512 213, 415 0 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 0 8.00 0 00900 HOUSEKEEPING 14, 424 106, 190 9 00 9 00 14.424 0 10.00 01000 DI ETARY 289, 636 0 10.00 01100 CAFETERI A 55, 728 55, 728 59, 224 0 11.00 0 11.00 0 01300 NURSING ADMINISTRATION 1,560 618, 700 13.00 13.00 1.560 0 01400 CENTRAL SERVICES & SUPPLY 11, 016 14.00 14.00 11,016 13, 556 0 15.00 01500 PHARMACY 4,668 4, 668 88, 528 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 5, 352 5, 352 166, 884 0 16.00 01700 SOCIAL SERVICE 17.00 0 17.00 3,468 3, 468 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 92, 796 92, 796 2, 190, 665 11, 008, 701 0 30.00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 242, 230 0 54.00 5, 160 5, 160 06000 LABORATORY 60.00 21.040 975, 230 0 60.00 06500 RESPIRATORY THERAPY 1, 200 10,004 29, 798 65.00 65.00 1, 200 0 66.00 06600 PHYSI CAL THERAPY 121, 092 121, 092 552, 731 4, 762, 213 66.00 67.00 06700 OCCUPATIONAL THERAPY 57, 168 57, 168 768, 196 5, 030, 708 67.00 0 68.00 06800 SPEECH PATHOLOGY 4, 332 4, 332 319, 380 2, 688, 266 0 68.00 06900 ELECTROCARDI OLOGY 69.00 82 38, 724 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 C 0 1, 014, 251 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 4, 715, 649 0 73.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 382, 852 76.00 76.00 4,944 4,944 40, 236 0 76.01 03950 HEMODIALYSIS & OTHER ANCILLARY 484, 157 0 76.01 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 591, 864 591, 864 5, 740, 777 31, 372, 779 -1, 139, 220 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 174 194. 00 07950 NON-REI MBURSABLE COST 0 0 194, 00 0 194. 01 07951 MARKETING/PUBLIC RELATIONS 0 16, 396 0 0 194. 01 194. 02 07952 TENANT LEASED SPACE 136, 956 0 0 194. 02 200.00 200. 00 Cross Foot Adjustments 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 445, 608 156, 169 1,001,720 143, 086 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.173990 0.004561 203. 00 0.611410 0.263860 Cost to be allocated (per Wkst. B, 204.00 2,574 13, 283 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000447 0.000423 205.00 11)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

| Peri od: | From 10/01/2016 | To 09/30/2017 | Date/Time Prepared:

				1	0 09/30/201/	2/28/2018 4:2	
	Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5 piii
	000 t 00.1101 B0001 t pt. 0.1	ADMI NI STRATI VE		LI NEN SERVI CE		(MEALS SERVED)	
		AND GENERAL	(SQUARE FEET)	(POUNDS OF	(====,	(==)	
		(ACCUM. COST)	,	LAUN)			
		5. 02	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00570 ADMI TTI NG						5. 01
5.02	00590 OTHER ADMINISTRATIVE AND GENERAL	8, 932, 739					5. 02
7.00	00700 OPERATION OF PLANT	850, 225					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	81, 205	l e	67, 239			8. 00
9.00	00900 HOUSEKEEPI NG	165, 396	14, 424	1 0	368, 484		9. 00
10. 00		509, 224	[C	0		39, 106	10. 00
11. 00		75, 858	55, 728	0	55, 728	0	11. 00
13. 00		806, 387	1, 560	1	., 000	0	13. 00
14. 00		32, 390		l .	11, 016	0	14. 00
15. 00		126, 505		1	4, 668	0	15. 00
16. 00		260, 962			-,	0	16. 00
17. 00		3, 035	3, 468	3 0	3, 468	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00		3, 076, 022	92, 796	37, 716	92, 796	39, 106	30. 00
	ANCILLARY SERVICE COST CENTERS	10.100					
54.00		13, 100				0	54.00
60.00		54, 198		ή		0	60.00
65. 00		17, 518			., 200	0	65. 00
66. 00		842, 152	121, 092	1		0	66.00
67. 00		1, 044, 866		1	· ·	0	67. 00
68. 00		428, 474	4, 332	1	4, 332	0	68. 00
69. 00		527	C	1	0	0	69.00
71. 00 73. 00	1 1	21, 387	· ·		0	0	71.00
76. 00		257, 592	l	ή	4, 944	0	73. 00 76. 00
76. 00 76. 01		57, 275 86, 758	l		4, 944	0	76.00
76.01	SPECIAL PURPOSE COST CENTERS	00, 730		<u> </u>	U	0	76.01
118. 0		8, 811, 056	382, 908	67, 239	368, 484	39, 106	118 00
110.0	NONREI MBURSABLE COST CENTERS	0,011,030	302, 700	07,237	300, 404	37, 100	1110.00
192 0	0 19200 PHYSI CLANS' PRI VATE OFFI CES	5, 818	C	0	0	0	192.00
	007950 NON-REI MBURSABLE COST	0,010	Ĭ	1	0	_	194. 00
	1 07951 MARKETING/PUBLIC RELATIONS	32, 129	Ĭ	ol o	0		194. 01
	207952 TENANT LEASED SPACE	83, 736	ł		0		194. 02
200. 0			,				200.00
201. 0							201. 00
202. 0	1 3	1, 139, 220	958, 657	91, 561	213, 088	574, 167	
	Part I)		·		·		
203.0	Unit cost multiplier (Wkst. B, Part I)	0. 127533	1. 844053	1. 361725	0. 578283	14. 682325	203. 00
204.0	Cost to be allocated (per Wkst. B,	50, 303	121, 741	457	16, 981	2, 996	204. 00
	Part II)						
205.0		0. 005631	0. 234179	0. 006797	0. 046083	0. 076612	205. 00
	11)						

Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3030 Peri od: Worksheet B-1 From 10/01/2016 09/30/2017 Date/Time Prepared: 2/28/2018 4:23 pm Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL ADMI NI STRATI ON SERVICES & (COSTED RECORDS & (FTES) **SUPPLY** REQUIS.) LI BRARY (FTES-NURS (COSTED (GROSS REQUIS.) CHARGES) AREAS) 15.00 11.00 13.00 14.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00570 ADMITTING 5. 01 5.01 00590 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 01100 CAFETERI A 11.00 6,989 11.00 13.00 01300 NURSING ADMINISTRATION 853 2, 310, 319 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 36 116, 542 14.00 01500 PHARMACY 88, 528 236, 084 15 00 15 00 89 16.00 01600 MEDICAL RECORDS & LIBRARY 252 1, 125 31, 372, 779 16.00 01700 SOCIAL SERVICE 17.00 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 652 2, 190, 665 95, 364 0 11, 008, 701 30.00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 242, 230 54.00 06000 LABORATORY 21, 040 0 68 598 975, 230 60 00 60 00 06500 RESPIRATORY THERAPY 65.00 15 10,004 1, 434 0 29, 798 65.00 06600 PHYSI CAL THERAPY 753 6, 494 4, 762, 213 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 67.00 881 0 7,704 5, 030, 708 67.00 06800 SPEECH PATHOLOGY 2, 688, 266 68 00 68 00 322 C 1, 350 06900 ELECTROCARDI OLOGY 69.00 0 82 0 0 38, 724 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 1, 014, 251 71.00 71.00 07300 DRUGS CHARGED TO PATIENTS 236, 084 73.00 0 0 0 4, 715, 649 73.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 382, 852 76.00 42 C 158 76.00 03950 HEMODIALYSIS & OTHER ANCILLARY 484, 157 76.01 76.01 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 236, 084 118.00 6, 963 2, 310, 319 114, 227 31, 372, 779 118. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 44 194. 00 07950 NON-REI MBURSABLE COST 0 o 0 194.00 0 0 194. 01 07951 MARKETING/PUBLIC RELATIONS 0 194, 01 0 26 0 2, 271 194. 02 07952 TENANT LEASED SPACE 0 194. 02 0 200.00 Cross Foot Adjustments 200.00

220, 524

64,848

31. 553012

9. 278581

939, 922

0.406836

0.006292

14, 536

201. 00 315, 779 202. 00

0. 010065 203. 00

0.000325 205.00

10, 194 204. 00

192, 770

0.816531

0.031891

7,529

64, 341

13, 252

0.552084

0.113710

201.00

202.00

203.00

204.00

205.00

Negative Cost Centers

Part I)

Part II)

II)

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)

In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3030 Peri od: Worksheet B-1 From 10/01/2016 To 09/30/2017 Date/Time Prepared: 2/28/2018 4:23 pm Cost Center Description SOCIAL SERVICE (PATIENT DAYS %) 17.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.01 00570 ADMITTING 5.01 00590 OTHER ADMINISTRATIVE AND GENERAL 5.02 5.02 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11. 00 |01100 | CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 6, 461 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 30.00 6, 461 ANCILLARY SERVICE COST CENTERS 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 60. 00 06000 LABORATORY 000000 60.00 65. 00 06500 RESPIRATORY THERAPY 65 00 66. 00 06600 PHYSI CAL THERAPY 66.00 67. 00 06700 OCCUPATIONAL THERAPY 67.00 68. 00 06800 SPEECH PATHOLOGY 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76 00 76 00 03950 HEMODIALYSIS & OTHER ANCILLARY 76.01 76.01 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 461 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192.00 194. 00 07950 NON-REI MBURSABLE COST 0 194. 00 194. 01 07951 MARKETING/PUBLIC RELATIONS 0 194. 01 194. 02 07952 TENANT LEASED SPACE 194. 02 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 202. 00 202.00 Cost to be allocated (per Wkst. B, 11,822 Part I) 1. 829748 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, 4,024 204. 00 Part II) Unit cost multiplier (Wkst. B, Part 0. 622814 205. 00

205.00

111)

Health Financial Systems	REHABILITATION HOSPIT	AL OF FT WAYNE	In Lie	u of Form CMS-2552-10
COMPUTATION OF DATIO OF COSTS TO CHARCES		Dravi dan CCN, 1E 2020	Doni od:	Waskahaat C

Health Financial Systems		IABILITATION HOSPITAL OF FI WAYNE			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CO		Period: From 10/01/2016 To 09/30/2017		
			Title	XVIII	Hospi tal	PPS	
			<u> </u>		Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
I NPATI	ENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	5, 500, 388		5, 500, 38	8 0	5, 500, 388	30. 00
ANCI LL	_ARY SERVICE COST CENTERS						
54.00 05400	RADI OLOGY-DI AGNOSTI C	29, 708		29, 70	8 0	29, 708	54.00
60.00 06000	LABORATORY	81, 962		81, 96	2 0	81, 962	60.00
65. 00 06500	RESPI RATORY THERAPY	28, 294	0	28, 29	4 0	28, 294	65. 00
66. 00 06600	PHYSI CAL THERAPY	1, 337, 223	0	1, 337, 22	3 0	1, 337, 223	66. 00
67. 00 06700	OCCUPATI ONAL THERAPY	1, 420, 423	0	1, 420, 42	3 0	1, 420, 423	67. 00
68. 00 06800	SPEECH PATHOLOGY	531, 574	0	531, 57	4 0	531, 574	68. 00
69. 00 06900	ELECTROCARDI OLOGY	1, 017		1, 01	7 0	1, 017	69. 00
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34, 323		34, 32	3 0	34, 323	71. 00
73. 00 07300	DRUGS CHARGED TO PATIENTS	530, 676		530, 67	6 0	530, 676	73. 00
76. 00 03550	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	81, 820		81, 82	0 0	81, 820	76. 00
76. 01 03950	HEMODIALYSIS & OTHER ANCILLARY	102, 696		102, 69	6 0	102, 696	76. 01
200.00	Subtotal (see instructions)	9, 680, 104	0	9, 680, 10	4 0	9, 680, 104	200. 00
201.00	Less Observation Beds	0			0	ol	201. 00
202.00	Total (see instructions)	9, 680, 104	0	9, 680, 10	4 0	9, 680, 104	202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3030 Peri od: Worksheet C From 10/01/2016 To 09/30/2017 Part I Date/Time Prepared: 2/28/2018 4:23 pm Titl<u>e X</u>VIII Hospi tal PPS Charges TEFRA Cost or Other Cost Center Description Inpati ent Outpati ent Total (col. 6 I npati ent + col . 7) Ratio Ratio 8.00 9. 00 6.00 7.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 11, 008, 701 11, 008, 701 30.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 242, 230 242, 230 0. 122644 0.000000 54.00 60.00 06000 LABORATORY 975, 230 0 975, 230 0.084044 0.000000 60.00 06500 RESPIRATORY THERAPY 29, 798 0.949527 29, 798 0.000000 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 4, 762, 213 4, 762, 213 0. 280799 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 5, 009, 162 21, 546 5, 030, 708 0. 282351 0.000000 67.00 06800 SPEECH PATHOLOGY 2, 688, 266 2, 688, 266 0. 197739 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 38, 724 0. 026263 0.000000 69.00 Ω 38, 724 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1,014,251 0 1, 014, 251 0.033841 0.000000 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 4, 715, 649 0 4, 715, 649 0. 112535 0.000000 73.00 0.000000 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 213712 76.00 382, 852 382, 852 0 76.00 03950 HEMODIALYSIS & OTHER ANCILLARY 76. 01 484, 157 r 484, 157 0. 212113 0.000000 76.01 200.00 Subtotal (see instructions) 31, 351, 233 31, 372, 779 200.00 21, 546 201.00 Less Observation Beds 201. 00

31, 351, 233

21, 546

31, 372, 779

202.00

Total (see instructions)

Health Financial Systems	REHABILITATION HOSPITAL OF FT WAYNE	In Lieu of Form CMS-2552		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-3030		Worksheet C Part I Date/Time Prepared: 2/28/2018 4:23 pm	

		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Rati o				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCILLARY SERVICE COST CENTERS					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 122644				54.00
60. 00 06000 LABORATORY	0. 084044				60.00
65. 00 06500 RESPIRATORY THERAPY	0. 949527				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 280799				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 282351				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 197739				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 026263				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 033841				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 112535				73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 213712				76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	0. 212113				76. 01
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 HOSPIT.	AL OF FT WAYNE	In Lie	u of Form CMS-2552-
COMPUTATION OF DATIO OF COCTS TO CHARGES		D 1 1 00N 4E 0000	D	W 1 1 1 0

Health Financial Systems		ABILITATION HOSPITAL OF FT WAYNE			In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CO	CN: 15-3030	Period: From 10/01/2016 To 09/30/2017		
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 500, 388		5, 500, 38	88 0	5, 500, 388	30. 00
	ANCILLARY SERVICE COST CENTERS					1	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	29, 708		29, 70		29, 708	
60.00	06000 LABORATORY	81, 962		81, 96		81, 962	1
65. 00	06500 RESPI RATORY THERAPY	28, 294		28, 29		28, 294	•
66. 00	06600 PHYSI CAL THERAPY	1, 337, 223		1, 337, 22		1, 337, 223	1
67. 00	06700 OCCUPATI ONAL THERAPY	1, 420, 423	0	1, 420, 42		1, 420, 423	
	06800 SPEECH PATHOLOGY	531, 574	0	531, 57		531, 574	
69. 00	06900 ELECTROCARDI OLOGY	1, 017		1, 01		1, 017	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	34, 323		34, 32		34, 323	1
	07300 DRUGS CHARGED TO PATIENTS	530, 676		530, 67		530, 676	1
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	81, 820		81, 82		81, 820	l .
	03950 HEMODIALYSIS & OTHER ANCILLARY	102, 696		102, 69		102, 696	
200.00		9, 680, 104	0	9, 680, 10	04	9, 680, 104	
201.00		0			0	l	201. 00
202. 00	Total (see instructions)	9, 680, 104	0	9, 680, 10	04 0	9, 680, 104	202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3030 Peri od: Worksheet C From 10/01/2016 To 09/30/2017 Part I Date/Time Prepared: 2/28/2018 4:23 pm Title XIX Hospi tal PPS Charges TEFRA Cost or Other Cost Center Description Inpati ent Outpati ent Total (col. 6 I npati ent + col . 7) Ratio Ratio 7. 00 8. 00 9. 00 6.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 11, 008, 701 11, 008, 701 30.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 242, 230 242, 230 0. 122644 0.000000 54.00 60.00 06000 LABORATORY 975, 230 0 975, 230 0.084044 0.000000 60.00 06500 RESPIRATORY THERAPY 29, 798 0.949527 29, 798 0.000000 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 4, 762, 213 4, 762, 213 0. 280799 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 5, 009, 162 21, 546 5, 030, 708 0. 282351 0.000000 67.00 06800 SPEECH PATHOLOGY 2, 688, 266 2, 688, 266 0. 197739 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 38, 724 0. 026263 0.000000 69.00 Ω 38, 724 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1,014,251 0 1, 014, 251 0.033841 0.000000 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 4, 715, 649 0 4, 715, 649 0. 112535 0.000000 73.00 0.000000 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 213712 76.00 382, 852 382, 852 0 76.00 03950 HEMODIALYSIS & OTHER ANCILLARY 76. 01 484, 157 r 484, 157 0. 212113 0.000000 76.01 200.00 Subtotal (see instructions) 31, 351, 233 31, 372, 779 200.00 21, 546 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 31, 351, 233 21, 546 31, 372, 779 202. 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:	From 10/01/2016 To 09/30/2017	Worksheet C Part I Date/Time Prepared: 2/28/2018 4:23 pm

			Title XIX	Hospi tal	PPS	
Cost Center D	escription	PPS Inpatient				
		Ratio				
		11.00				
INPATIENT ROUTINE S	ERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI	ATRI CS					30. 00
ANCILLARY SERVICE C	OST CENTERS					
54. 00 05400 RADI OLOGY-DI A	GNOSTI C	0. 122644				54.00
60. 00 06000 LABORATORY		0. 084044				60.00
65. 00 06500 RESPI RATORY T	HERAPY	0. 949527				65. 00
66. 00 06600 PHYSI CAL THER	APY	0. 280799				66. 00
67. 00 06700 0CCUPATI ONAL	THERAPY	0. 282351				67. 00
68. 00 06800 SPEECH PATHOL	OGY	0. 197739				68. 00
69. 00 06900 ELECTROCARDI 0	LOGY	0. 026263				69. 00
71.00 07100 MEDICAL SUPPL	IES CHARGED TO PATIENT	0. 033841				71. 00
73. 00 07300 DRUGS CHARGED	TO PATIENTS	0. 112535				73. 00
76. 00 03550 PSYCHI ATRI C/P	SYCHOLOGICAL SERVICES	0. 213712				76. 00
76. 01 03950 HEMODI ALYSI S	& OTHER ANCILLARY	0. 212113				76. 01
200.00 Subtotal (see	instructions)					200. 00
201.00 Less Observat	ion Beds					201. 00
202.00 Total (see in	structions)					202. 00

Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICALD ONLY Provider CCN: 15-3030

						2/28/2018 4:2	3 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -	-	Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
1A	NCILLARY SERVICE COST CENTERS						
54.00 0	5400 RADI OLOGY-DI AGNOSTI C	29, 708	6, 218	23, 490	0	0	54. 00
60.00	6000 LABORATORY	81, 962	1, 875	80, 087	7 0	0	60.00
65.00 0	6500 RESPI RATORY THERAPY	28, 294	1, 878	26, 416	6 0	0	65. 00
66.00 0	6600 PHYSI CAL THERAPY	1, 337, 223	156, 296	1, 180, 927	7 0	0	66. 00
67. 00 0	6700 OCCUPATI ONAL THERAPY	1, 420, 423	85, 205	1, 335, 218	3 0	0	67. 00
68. 00 0	6800 SPEECH PATHOLOGY	531, 574	12, 715	518, 859	9 0	0	68. 00
69. 00 0	6900 ELECTROCARDI OLOGY	1, 017	33	984	1 0	0	69. 00
71. 00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	34, 323	879	33, 444	1 0	0	71. 00
73. 00 0	7300 DRUGS CHARGED TO PATIENTS	530, 676	12, 508	518, 168	3 0	0	73.00
76. 00 0	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	81, 820	6, 749	75, 07	0	0	76. 00
76. 01 0	3950 HEMODIALYSIS & OTHER ANCILLARY	102, 696	851	101, 845	5 0	0	76. 01
200.00	Subtotal (sum of lines 50 thru 199)	4, 179, 716	285, 207	3, 894, 509	9 0	0	200. 00
201.00	Less Observation Beds	0	0) (0	0	201. 00
202.00	Total (line 200 minus line 201)	4, 179, 716	285, 207	3, 894, 509	9 0	0	202. 00

					2/28/2018 4:23 pm	i
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	Capital and	(Worksheet C,	Cost to Charge			
	Operating Cost	Part I, column	Ratio (col. 6			
	Reduction	8)	/ col . 7)			
	6. 00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	29, 708	242, 230	0. 122644		54.	00
60. 00 06000 LABORATORY	81, 962	975, 230	0. 084044		60.	00
65. 00 06500 RESPIRATORY THERAPY	28, 294	29, 798	0. 949527		65.	00
66. 00 06600 PHYSI CAL THERAPY	1, 337, 223	4, 762, 213	0. 280799		66.	00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 420, 423	5, 030, 708	0. 282351		67.	00
68.00 06800 SPEECH PATHOLOGY	531, 574	2, 688, 266	0. 197739		68.	00
69. 00 06900 ELECTROCARDI OLOGY	1, 017	38, 724	0. 026263		69.	00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	34, 323	1, 014, 251	0. 033841		71.	00
73.00 07300 DRUGS CHARGED TO PATIENTS	530, 676	4, 715, 649	0. 112535		73.	00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	81, 820	382, 852	0. 213712		76.	00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	102, 696	484, 157	0. 212113		76.	01
200.00 Subtotal (sum of lines 50 thru 199)	4, 179, 716	20, 364, 078			200.	00
201.00 Less Observation Beds	0	0			201.	00
202.00 Total (line 200 minus line 201)	4, 179, 716	20, 364, 078			202.	00

Health Financial Systems REHA	ABILITATION HOSE	PITAL OF FT WAY	/NE	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 10/01/2016 To 09/30/2017		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)	2.00	2)	4.00	F 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1. 00	2.00	3.00	4. 00	5. 00	
30. 00 ADULTS & PEDIATRICS	199, 564	0	199, 56	4 6, 461	30. 89	30. 00
200.00 Total (lines 30 through 199)	199, 564		199, 56	4 6, 461		200. 00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	2, 601		•			30. 00
200.00 Total (lines 30 through 199)	2, 601	80, 345				200. 00

Health Financial Systems	REHABILITATION HOSPITA	AL OF FT WAYNE	In Lie	u of Form CMS-2552-10
ADDODEL ONMENT OF LADATICAL	ANGLI LADV CEDVICE CADITAL COCTO	D	D!!	Wasslands D

Health Financial Systems REHABILITATION HOSPITAL OF FI WAYNE In Lieu of For					eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der C		Peri od: From 10/01/2016		
				To 09/30/2017	Date/Time Pre 2/28/2018 4:2	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 218	242, 230	0. 02567	0 173, 566	4, 455	54.00
60. 00 06000 LABORATORY	1, 875	975, 230	0. 00192	3 411, 733	792	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 878	29, 798	0. 06302	4 2, 113	133	65.00
66. 00 06600 PHYSI CAL THERAPY	156, 296	4, 762, 213	0. 03282	0 1, 932, 434	63, 422	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	85, 205	5, 030, 708	0. 01693	7 2, 020, 520	34, 222	67. 00
68.00 06800 SPEECH PATHOLOGY	12, 715	2, 688, 266	0.00473	0 968, 047	4, 579	68. 00
69. 00 06900 ELECTROCARDI OLOGY	33	38, 724	0. 00085	2 22, 180	19	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	879	1, 014, 251	0.00086	7 289, 337	251	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	12, 508			2 1, 863, 190	4, 941	73. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	6, 749				l	76. 00
76. 01 03950 HEMODIALYSIS & OTHER ANCILLARY	851	· ·	1	•		1
200.00 Total (lines 50 through 199)	285, 207	· ·		8, 088, 224	l	

Health Financial Systems REHA	ABILITATION HOS	PITAL OF FT WAY	/NE	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS		<u> </u>	Period: From 10/01/2016 Fo 09/30/2017	Date/Time Pre 2/28/2018 4:2	
			XVIII	Hospi tal	PPS	
Cost Center Description				Allied Health		
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	C	0	(0	0	30.00
200.00 Total (lines 30 through 199)	C	0	(0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	-			
	instructions)	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	C	0	6, 46	0.00	2, 601	30. 00
200.00 Total (lines 30 through 199)		0	6, 46°	1	2, 601	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	C)	<u> </u>			30. 00
200.00 Total (lines 30 through 199)	C					200. 00

Heal th Financ	ial Systems	REHABI LI TAT	ION HOSPITA	In Lieu of Form CMS-2552-10		
APPORTI ONMEN THROUGH COST	T OF INPATIENT/OUTPATIENT S	ANCILLARY SERVICE OT	THER PASS	Provider CCN: 15-3030	Peri od: From 10/01/2016 To 09/30/2017	Worksheet D Part IV Date/Time Prepared:

							2/28/2018 4: 2	3 pm
				Ti tl e	: XVIII	Hospi tal	PPS	
		Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
			Anesthetist	Post-Stepdown	-	Post-Stepdown		
			Cost	Adjustments		Adjustments		
			1.00	2A	2.00	3A	3.00	
	ANCI LL	LARY SERVICE COST CENTERS						
54.00	05400	RADI OLOGY-DI AGNOSTI C	0	C	(0	0	54.00
60.00	06000	LABORATORY	0	C	(0	0	60.00
65.00	06500	RESPI RATORY THERAPY	0	C	(0	0	65.00
66.00	06600	PHYSI CAL THERAPY	0	C	(0	0	66. 00
67.00	06700	OCCUPATIONAL THERAPY	0	C	(0	0	67. 00
68. 00	06800	SPEECH PATHOLOGY	0	l c	(o	0	68. 00
69.00	06900	ELECTROCARDI OLOGY	0	l c	(o	0	69. 00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	l c	(o	0	71. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	l c	(o	0	73. 00
76.00	03550	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C	(o	0	76. 00
76. 01	03950	HEMODIALYSIS & OTHER ANCILLARY	0		·	ol	0	76. 01
200.00		Total (lines 50 through 199)	1 0		1	ol	0	200.00

Health Financial Systems	REHABILITATION HOSPITAL OF FT WAYNE In Lie					u of Form CMS-2	2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERV	ICE OTHER PASS	5	Provider CC	N: 15-3030	Peri od: From 10/01/2016	Worksheet D	
Timoodii costs							Date/Time Prep 2/28/2018 4:23	
				Title	XVIII	Hospi tal	PPS	
Cost Center Description		All Other	To	otal Cost	Total	Total Charges	Ratio of Cost	

			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col. 2, 3 and	8)	7)	
				4)			
		4.00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	242, 230	0.000000	54.00
60.00	06000 LABORATORY	0	0	C	975, 230	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	C	29, 798	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	C	4, 762, 213	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C	5, 030, 708	0.000000	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	C	2, 688, 266	0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	C	38, 724	0. 000000	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	1, 014, 251	0. 000000	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	4, 715, 649	0. 000000	73. 00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		382, 852	0.000000	76. 00
76. 01	03950 HEMODIALYSIS & OTHER ANCILLARY	0	0		484, 157	0.000000	76. 01
200.00	Total (lines 50 through 199)	0	0	C	20, 364, 078		200. 00
	, ,	1	1	•		. '	

Health Financial Systems REI	HABILITATION HOSPI	TAL OF FT WAY	/NE	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY STATEMENT COSTS		Provider Co	CN: 15-3030	Period: From 10/01/2016 To 09/30/2017	Worksheet D	pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Pass-Through	Outpatient Program Charges	Outpatient Program Pass-Through	
	(col . 6 ÷ col .	onal ges	Costs (col.		Costs (col. 9	
	7)		x col. 10)		x col . 12)	
	9. 00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	173, 566		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	411, 733		0 0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	2, 113		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 932, 434		0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	2, 020, 520		0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000	968, 047		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	22, 180		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	289, 337		0	0	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 863, 190		0	0	
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	119, 936		0	0	
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	0. 000000	285, 168		0	0	
200.00 Total (lines 50 through 199)		8, 088, 224		0 0) 0	200. 00

Health Financial Systems REHA	REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CM:						2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	F	rovider C		Period: From 10/01/2016 To 09/30/2017		
			Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal		ing Bed	Reduced		Per Diem (col.	
	Related Cost		ustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,			Related Cost			
	Part II, col.			(col . 1 - col			
	26)			2)			
	1. 00		2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDI ATRI CS	199, 564	1	0	199, 56	6, 461	30. 89	30.00
200.00 Total (lines 30 through 199)	199, 564	ļ		199, 56	6, 461		200. 00
Cost Center Description	I npati ent	In	pati ent				
	Program days	P	rogram				
		Capi	tal Cost				
		(col.	5 x col.				
			6)				
	6.00		7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	237	7	7, 321				30.00
200.00 Total (lines 30 through 199)	237	/	7, 321				200. 00

Health Financial Systems	REHABILITATION HOSP	In Lieu of Form CMS-2552		
APPORTIONMENT OF INPATIENT ANCILL	ARY SERVICE CAPITAL COSTS	Provi der CCN: 15-3030	Peri od: From 10/01/2016	Worksheet D Part II

					From 10/01/2016 To 09/30/2017	Part II Date/Time Pre 2/28/2018 4:2	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges		I npati ent	Capital Costs	
			(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col.	Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 218		0. 025670			54.00
60.00	06000 LABORATORY	1, 875	975, 230	0. 00192	31, 501	61	60.00
65.00	06500 RESPI RATORY THERAPY	1, 878	29, 798	0. 06302	4 11, 267	710	65. 00
66.00	06600 PHYSI CAL THERAPY	156, 296	4, 762, 213	0. 032820	166, 507	5, 465	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	85, 205	5, 030, 708	0. 01693	7 189, 620	3, 212	67. 00
68.00	06800 SPEECH PATHOLOGY	12, 715	2, 688, 266	0. 004730	115, 458	546	68. 00
69. 00	06900 ELECTROCARDI OLOGY	33	38, 724	0. 00085	2 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	879	1, 014, 251	0. 00086	7 82, 583	72	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	12, 508	4, 715, 649	0. 00265	206, 168	547	73. 00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	6, 749	382, 852	0. 01762	3 23, 340	411	76. 00
76. 01	03950 HEMODIALYSIS & OTHER ANCILLARY	851	484, 157	0. 00175	3 0	0	76. 01
200.00	Total (lines 50 through 199)	285, 207	20, 364, 078		863, 274	11, 969	200. 00

Health Financial Systems	REHABILITATION HOSE	PITAL OF FT WAY	/NE	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	HER PASS THROUGH COST	TS Provider CO	F	Period: From 10/01/2016 To 09/30/2017	Date/Time Pre 2/28/2018 4:2	
			e XIX	Hospi tal	PPS	
Cost Center Description		Nursing School		Allied Health	All Other	
	Post-Stepdown		Post-Stepdown		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	(0	0	00.00
200.00 Total (lines 30 through 199)	0	0	C	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	6, 461		237	30. 00
200.00 Total (lines 30 through 199)		0	6, 461		237	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30. 00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	REHABILITATION HOSPIT	In Lieu of Form CMS-2552		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-3030		Worksheet D Part IV Date/Time Prepared: 2/28/2018 4:23 pm

							2/20/2010 4.2	J PIII
				Titl	e XIX	Hospi tal	PPS	
		Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
			Anesthetist	Post-Stepdown		Post-Stepdown		
			Cost	Adjustments		Adjustments		
			1.00	2A	2.00	3A	3. 00	
	ANCI L	LARY SERVICE COST CENTERS						
54.00	05400	RADI OLOGY-DI AGNOSTI C	0	C	(0	0	54. 00
60.00	06000	LABORATORY	0	0	(0	0	60.00
65.00	06500	RESPI RATORY THERAPY	0	0	(0	0	65. 00
66. 00	06600	PHYSI CAL THERAPY	0	0	(0	0	66. 00
67.00	06700	OCCUPATI ONAL THERAPY	0	0	(0	0	67. 00
68. 00	06800	SPEECH PATHOLOGY	0	0	(0	0	68. 00
69. 00	06900	ELECTROCARDI OLOGY	0	l c		0	0	69. 00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	l c		0	0	71. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	l c		0	0	73. 00
76. 00	03550	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0	76. 00
76. 01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0		0	0	76. 01
200.0	1	Total (lines 50 through 199)	0	d		0	0	200.00

Health Financial Systems	REHABILITATION HOSPIT	AL OF FT WAYNE	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-3030	Peri od: From 10/01/2016 To 09/30/2017	Worksheet D Part IV Date/Time Prepared: 2/28/2018 4:23 pm
		Title XIX	Hospi tal	PPS

						2/28/2018 4:2	s piii
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col. 2, 3 and	8)	7)	
				4)			
		4.00	5.00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0) (242, 230	0.000000	54. 00
60.00	06000 LABORATORY	0	0) (975, 230	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	0	0) (29, 798	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0) (4, 762, 213	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0) (5, 030, 708	0.000000	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0) (2, 688, 266	0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		38, 724	0.000000	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		1, 014, 251	0.000000	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0) (4, 715, 649	0.000000	73. 00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		382, 852	0.000000	76. 00
76. 01	03950 HEMODIALYSIS & OTHER ANCILLARY	0	0		484, 157	0.000000	76. 01
200.00	Total (lines 50 through 199)	0	0) (20, 364, 078		200. 00

APPORTI ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-3030 Peri od: From 10/01/2016 To 09/30/2017 To 09/30/2017 Part IV	Health Financial Systems REHA	ABILITATION HOSPI	TAL OF FT WAY	'NE	In Lie	eu of Form CMS-2	2552-10
Cost Center Description		RVICE OTHER PASS			From 10/01/2016 To 09/30/2017	Part IV Date/Time Pre 2/28/2018 4:2	
Ratio of Cost to Charges (col . 6 ÷ col . 7) Program Charges (col . 6 ÷ col . 7) Program Charges (col . 8 ± x col . 10) Program Charges (col . 8 ± x col . 10) Program Charges (col . 6 ÷ col . 7) Program Charges (col . 8 ± x col . 10) Program Charges (col . 9 ± x col . 12)			Titl	e XIX	Hospi tal	PPS	
ANCI LLARY SERVI CE COST CENTERS 9,00 10,00 11,00 12,00 13,00	Cost Center Description	Ratio of Cost to Charges	Program	Program Pass-Through	Program Charges	Program Pass-Through	
ANCI LLARY SERVI CE COST CENTERS		(col. 6 ÷ col.			3	· ·	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 36,830 0 0 0 54.00 60. 00 06000 LABORATORY 0.000000 31,501 0 0 0 60.00 65. 00 06500 RESPI RATORY THERAPY 0.000000 11,267 0 0 0 65.00 66. 00 06600 PHYSI CAL THERAPY 0.000000 166,507 0 0 0 0 66.00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 189,620 0 0 0 67.00 68. 00 06800 SPEECH PATHOLOGY 0.000000 115,458 0 0 0 68.00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 0 68.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 82,583 0 0 0 73.00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 206,168 0 0 0 76.00 76. 01 03950 HEMODI ALYSI S		9.00	10.00		12.00		
60. 00 06000 LABORATORY 0.000000 31, 501 0 0 0 60. 00 65. 00 65. 00 660. 00 65. 00 660. 00	ANCILLARY SERVICE COST CENTERS	<u>'</u>					
65. 00	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	36, 830		0 0	0	54.00
66. 00	60. 00 06000 LABORATORY	0. 000000	31, 501		0 0	0	60.00
67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 189, 620 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 000000 0 115, 458 0 0 0 0 68. 00 69. 00 69. 00 0 0 0 0 0 0 69. 00 0 0 0 0 0 0 0 0 0	65. 00 06500 RESPIRATORY THERAPY	0. 000000	11, 267		0 0	0	65. 00
68. 00 06800 SPEECH PATHOLOGY 0.000000 115, 458 0 0 0 68. 00 69. 00 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 206, 168 0 0 0 0 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 206, 168 0 0 0 0 73. 00 76. 01 03950 HEMODI ALYSI S & OTHER ANCI LLARY 0.000000 0 0 0 0 76. 01 03950 0 0 0 0 0 0 0 0 0	66. 00 06600 PHYSI CAL THERAPY	0. 000000	166, 507		0 0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 69. 00 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 82, 583 0 0 0 0 71. 00 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 206, 168 0 0 0 0 73. 00 076. 01 03950 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 23, 340 0 0 0 0 76. 01 03950 HEMODI ALYSI S & OTHER ANCI LLARY 0.000000 0 0 0 0 76. 01 03950 0 0 0 0 0 0 0 0 0	67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	189, 620		0 0	0	67. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 000000 82, 583 0 0 0 71. 00 73. 00 73. 00 73. 00 74. 00 75	68.00 06800 SPEECH PATHOLOGY	0. 000000	115, 458		0 0	0	68. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 206, 168 0 0 73. 00 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 23, 340 0 0 76. 00 76. 00 76. 01 03950 HEMODI ALYSI S & OTHER ANCI LLARY 0.000000 0 0 0 76. 01	69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0. 000000 23, 340 0 0 76. 00 76. 00 76. 01 03950 HEMODI ALYSI S & OTHER ANCI LLARY 0. 000000 0 0 76. 01	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	82, 583		0	0	71. 00
76. 01 03950 HEMODI ALYSI S & OTHER ANCI LLARY 0. 000000 0 0 0 76. 01					0	0	
	76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	23, 340		0	0	76. 00
200.00 Total (lines 50 through 199) 863,274 0 0 0 200.00	76.01 03950 HEMODIALYSIS & OTHER ANCILLARY 200.00 Total (lines 50 through 199)	0. 000000	0 863, 274		0 0	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: 15-3030	Peri od: From 10/01/2016	Worksheet D-1	
		To 09/30/2017	Date/Time Prep 2/28/2018 4:23	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				

		Title XVIII	Hospi tal	2/28/2018 4: 2 PPS	s piii
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	e eveluding newborn)		6, 461	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed days)			6, 461	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		vate room days,	0	3. 00
	do not complete this line.	, , , , , , , , , , , , , , , , , , , ,	3 .		
4.00	Semi-private room days (excluding swing-bed and observation be			6, 461	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	om days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December 2	1 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	on days) at tel becember 3	i oi the cost	U	0.00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December 3	31 of the cost	0	7. 00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Drogram (evaluding o	swing had and	2 401	9. 00
9.00	newborn days)	the Program (excluding s	swifig-bed and	2, 601	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private roo	om days)	0	10. 00
	through December 31 of the cost reporting period (see instruct	tions)	3 ,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		om days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (frict during private	1 ddiii days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed da	ays)	0	14. 00
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 service	es through December 31 of	the cost	0.00	17. 00
	reporting period	-			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of th	ne cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombor 21 of	the cost	0.00	19. 00
19.00	reporting period	s through becember 31 of	the cost	0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of the	e cost	0.00	20. 00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe	•	ag poriod (line	5, 500, 388 0	21. 00 22. 00
22.00	5 x line 17)	er 31 of the cost reporting	ig period (Title	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	າ 31 of the cost reportino	g period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting (neriod (line 8	0	25. 00
20.00	x line 20)	or the cost reporting p	derrod (Trite o	· ·	20.00
26.00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		5, 500, 388	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	l and abacquetion had abou	\	0	20.00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed char	(ges)	0	28. 00 29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	11116 20)		0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instructi	ions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin		- /	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	•		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	5, 500, 388	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ISTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			851. 32	38. 00
39.00	Program general inpatient routine service cost per drem (see	*		2, 214, 283	
40.00	Medically necessary private room cost applicable to the Progra	•		0	
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		2, 214, 283	41. 00

		BILITATION HOSE				u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-3030	Peri od: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Pre 2/28/2018 4:2	pared:
			Title	e XVIII	Hospi tal	PPS	o piii
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.	
		1.00	2.00	col. 2)	4.00	4)	
42. 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT						43. 00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wks	r+ D 2 col 2	Line 200)			1. 00 1, 668, 608	48. 00
49. 00	Total Program inpatient costs (sum of lines 4			nns)		3, 882, 891	
17.00	PASS THROUGH COST ADJUSTMENTS	ii tiii ougii io) (See Thisti detre	51137		0,002,071	17.00
50.00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sur	n of Parts I and	80, 345	50. 00
51. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	115, 429	51.00
52. 00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				195, 774	52. 00
53. 00	Total Program inpatient operating cost exclude		lated non-phy	usician anesth	netist and	3, 687, 117	1
00.00	medical education costs (line 49 minus line 5		ratea, non prij	yor or arr arrostr	icti st, una	0,007,117	00.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	55. 00
56. 00	Target amount (line 54 x line 55)					0	
57. 00	Difference between adjusted inpatient operati	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)					0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost repmarket basket	porting period	enaing 1996, t	updated and co	ompounded by the	0. 00	59. 00
60. 00	Lesser of lines 53/54 or 55 from prior year of	cost report. up	dated by the m	narket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of lines				the amount by	0	
	which operating costs (line 53) are less than	n expected cost	s (lines 54 x	60), or 1% of	the target		
	amount (line 56), otherwise enter zero (see i	nstructions)			-		
62.00	Relief payment (see instructions)					0	1
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	mher 31 of the	cost reporti	ng pariod (See	0	64. 00
04.00	instructions)(title XVIII only)	ts through bece	illiber 31 of the	cost reporti	ng perrou (see	0	04.00
65.00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the d	cost reporting	g period (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	55)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	o costs through	Docombon 21 o	of the cost re	porting ported	0	67. 00
07.00	(line 12 x line 19)	e costs till ough	pecelliper 31 (or the cost re	sporting perrou	0	07.00
68.00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
	(line 13 x line 20)			•	0 .		
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU						70.00
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	,		, ,	1		70. 00 71. 00
71.00	Program routine service cost (line 9 x line 3		70 - IIIIE	<i>L)</i>			71.00
73. 00	Medically necessary private room cost applica		(line 14 x li	ne 35)			73.00
74. 00	Total Program general inpatient routine servi						74. 00
75. 00	Capital -related cost allocated to inpatient	•	,		Part II, column		75. 00
	26, line 45)		•				
76. 00	Per diem capital-related costs (line 75 ÷ lin						76. 00
77. 00	Program capital-related costs (line 9 x line	/6)					77. 00

MCRI F32 - 13. 1. 164. 3

Health Financial Systems REHA	BILITATION HOS	PITAL OF FT WAY	ΝE	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2016 To 09/30/2017	Date/Time Pre 2/28/2018 4:2	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	199, 564	5, 500, 388	0. 03628	2 0	0	90. 00
91.00 Nursing School cost	0	5, 500, 388	0.00000	0 0	0	91. 00
92.00 Allied health cost	0	5, 500, 388	0.00000	0	0	92. 00
93.00 All other Medical Education	0	5, 500, 388	0. 00000	0 0	0	93. 00

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: 15-3030	Peri od: From 10/01/2016		
			Date/Time Pre 2/28/2018 4:2	
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	

-		Title XIX	Hospi tal	2/28/2018 4: 2 PPS	3 pm
	Cost Center Description	II tie xix	поѕрі таі	PPS	
				1. 00	
-	PART I - ALL PROVIDER COMPONENTS				
4 00	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			6, 461	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day		vato room days	6, 461 0	2. 00 3. 00
3.00	do not complete this line.	(s). If you have only pri	vate room days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		6, 461	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December :	31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		21 -6	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	i days) through becember	31 Of the Cost	U	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roor	n davs) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	237	9. 00
	newborn days)			_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		nom dave) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en		Joil days) arter	U	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
	through December 31 of the cost reporting period	3 (3 /		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
44.00	after December 31 of the cost reporting period (if calendar ye				44.00
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	14. 00 15. 00
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 service	es through December 31 o	f the cost	0.00	17. 00
	reporting period	3			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
40.00	reporting period				40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	tne cost	0.00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			5, 500, 388	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	5 x line 17)	21 of the cost reporting	a poriod (line 4	0	23. 00
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (iine o	0	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportion	na period (line	0	24. 00
	7 x line 19)	от	.g p (
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)			_	
26. 00	Total swing-bed cost (see instructions)	(line 21 minus line 24)		0	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Title 21 illinus Title 26)		5, 500, 388	27.00
28 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		g/	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	- line 28)		0.000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 22) (:+	h!)	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin		LI UNS)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	ie 31 <i>)</i>		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	5, 500, 388	
200	27 minus line 36)			2, 333, 300	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see	•		851. 32	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line	•		201, 763	
	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			0 201, 763	40.00
11.00	1.000 ogram gonorar impatront routine ou vice cost (Tine or			201,703	

	Financial Systems REHATION OF INPATIENT OPERATING COST	ABILITATION HOSI	Provider CO	CN: 15-3030 P	eri od:	u of Form CMS-2 Worksheet D-1	2552-10
					rom 10/01/2016 o 09/30/2017	Date/Time Prep 2/28/2018 4:23	
			Ti tl	e XIX	Hospi tal	PPS	<u>o piii </u>
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days		Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)		2.00	0.00	1. 00	0.00	42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.00
45. 00 46. 00	SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description	'					
						1. 00	
48. 00	Program inpatient ancillary service cost (Wk			>		171, 971	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)((see instructio	ns)		373, 734	49. 00
50. 00	Pass through costs applicable to Program inc	atient routine	services (from	Wkst. D. sum	of Parts I and	7, 321	50. 00
	III)			,		, -	
51. 00							51. 00
52.00	Total Program excludable cost (sum of lines					19, 290	52. 00
53. 00	Total Program inpatient operating cost exclu		elated, non-phy	sician anesthe	tist, and	354, 444	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55. 00
56.00	Target amount (line 54 x line 55)					0	56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (I	ine 56 minus I	ine 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting poriod	anding 1004 u	ndatad and com	nounded by the	0 0. 00	58. 00 59. 00
39.00	market basket	sporting period	ending 1996, u	puateu anu com	pounded by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	odated by the m	arket basket		0.00	60. 00
61. 00	If line 53/54 is less than the lower of line					0	61. 00
	which operating costs (line 53) are less that		ts (lines 54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	Instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	nent (see instru	uctions)			0	63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST	(5.555				-	
64. 00	Medicare swing-bed SNF inpatient routine cos	sts through Dece	ember 31 of the	cost reportin	g period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	sts after Decemb	per 31 of the c	ost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only)	no costs (line	44 plus lino 4	E) (+; + o V\/	only) For	0	66. 00
00.00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	THE COSTS (TITLE	64 prus rine 6	5)(title XVIII	oniy). Foi	U	00.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	ne costs through	n December 31 o	f the cost rep	orting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after [December 31 of	the cost repor	ting period	0	68. 00
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs ((line 67 ± line	68)		0	69. 00
69 00	Total title V of XIX SWING bed W Impatrent					Ü	07.00
69. 00	PART III - SKILLED NURSING FACILITY, OTHER N	IONSTING THEFT					1
69. 00 70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	utine service c	` ,			70. 00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	ity/ICF/IID rou cost per diem (I	utine service c	` ,			71. 00
70. 00 71. 00 72. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of Program routine service cost (line 9 x line	ity/ICF/IID rou cost per diem (I 71)	utine service c ine 70 ÷ line	2)			71. 00 72. 00
70. 00 71. 00 72. 00 73. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of Program routine service cost (line 9 x line Medically necessary private room cost applic	ity/ICF/IID rou cost per diem (I 71) cable to Program	utine service c ine 70 ÷ line n (line 14 x li	2)			71. 00 72. 00 73. 00
70. 00 71. 00 72. 00 73. 00 74. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of Program routine service cost (line 9 x line Medically necessary private room cost application of the cost o	ity/ICF/IID rou cost per diem (I 71) cable to Program vice costs (Iine	utine service c ine 70 ÷ line n (line 14 x li e 72 + line 73)	2) ne 35)	rt II. column		71. 00 72. 00 73. 00 74. 00
70. 00 71. 00 72. 00 73. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of Program routine service cost (line 9 x line Medically necessary private room cost applic	ity/ICF/IID rou cost per diem (I 71) cable to Program vice costs (Iine	utine service c ine 70 ÷ line n (line 14 x li e 72 + line 73)	2) ne 35)	rt II, column		71. 00 72. 00 73. 00
70. 00 71. 00 72. 00 73. 00 74. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of Program routine service cost (line 9 x line Medically necessary private room cost application of the program general inpatient routine services capital—related cost allocated to inpatient	ity/ICF/IID roucost per diem (I 71) cable to Program vice costs (Iine routine service ne 2)	utine service c ine 70 ÷ line n (line 14 x li e 72 + line 73)	2) ne 35)	rt II, column		71. 00 72. 00 73. 00 74. 00

Interest via Care Purple Inpatient Hospital Units 43,00 INTERSITY CARE UNIT 44,00 14,00 CORDINARY CARE UNIT 44,00 46,0				Titl	e XIX	Hospi tal	PPS	
1.00 2.00 3.00 4.00 5.00		Cost Center Description			Diem (col. 1 ÷	Program Days	(col. 3 x col.	
Internsive Curr Type Inpatient Hospital Units			1.00	2.00		4. 00		
	42.00	NURSERY (title V & XIX only)						42. 00
44.00 CROPAMAY CARE UNIT			,					
45.00 BURNE INTENSIVE CARE UNIT								43. 00
SURGICAL INTERSIVE CARE UNIT 7.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description 1.00 Cost Center Description 1.00 1.00 Total Program inputient costs (sum of lines 41 through 48) (see instructions) 5.00 Pass through costs applicable to Program inpatient routine services (From West. D. sum of Parts I and 7, 321 50.00 Pass through costs applicable to Program inpatient and III ary services (From West. D. sum of Parts I and 7, 321 50.00 Pass through costs applicable to Program inpatient and III ary services (From West. D. sum of Parts II 11, 969 51.00 10.00 Pass through costs applicable to Program inpatient and III ary services (From West. D. sum of Parts II 11, 969 51.00 10.01 10.01 10.01 10.01 10.02 10.01 10.01 10.02 10.01 10.01 10.02 10.01 10.02 10.03 10.04 10.04 10.04 10.04 10.05 10.05 10.05 10.07								44. 00
								•
200 Program inpatient costs (sum of lines 41 through 48) (see instructions) 1.00								•
1.00	47.00							47.00
48.00 Program Inpatient ancillary Service cost (West In-3, col. 3, line 200) 171, 971 48.00 All Program Inpatient costs (sur of lines 41 Prhrough 48) (see instructions) 373, 734 49.00 All Program Inpatient costs (sur of lines 41 Prhrough 48) (see instructions) 373, 734 49.00 All Program Inpatient costs (sur of lines 50 and 51) 50.00 Pass through costs applicable to Program Inpatient routline services (from West. D., sum of Parts II and II) 11, 660 51.00 All Program excludable cost (sum of lines 50 and 51) 19, 200 52.00 51.00 Total Program excludable cost (sum of lines 50 and 51) 19, 200 52.00 53.00 Total Program excludable cost (sum of lines 50 and 51) 19, 200 52.00 53.00 Total Program excludable cost (sum of lines 50 and 51) 19, 200 52.00 53.00 Total Program excludable costs (sum of lines 50 and 51) 19, 200 52.00 53.00 10, 200 54.00 55.00 55.00 56.0		Cost Center Description					1.00	
49 00 Iotal Program Inpattent costs (sum of lines 41 through 49)(see Instructions) 373,374 49,00 Pass through costs applicable to Program Inpatient routine services (from Wkst. D., sum of Parts I and I 11) 50,00 111 11 11 12 12 12 13 13	49.00	Drogram i proti ent ancil Lary corvi co cost (Wk	ct D 2 col 1	2 Line 200)				49.00
PASS THROUGH COST ADJUSTMENTS 50.00 Pass through costs applicable to Program inpatient routine services (from West. D, sum of Parts I and 7, 321 50.00 Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II 11, 969 51.00 Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II 11, 969 51.00 Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II 11, 969 51.00 Page 11, 960 Pa		3	·	. ,	ne)			
50.00 Pass through costs applicable to Program inpatient reutine services (from West. D., sum of Parts I and III)	47.00		41 through 40)	(See Thistruction	113)		373, 734	47.00
1110 Sess through costs applicable to Program Inpatient ancillary services (From West. D. sum of Parts II and II) 11,999 51.00 Total Program excludable cost (sum of lines 50 and 51) 19,290 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 354,444 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 354,444 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 354,444 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 354,444 53.00 Total Program discharges 0.54,00 0.54,00 0.55,00 Total Program discharges 0.54,00 0.55,00 0.56,00 Total Program discharges 0.55,00 0.56,0	50 00		atient routine	services (from	Wkst D sum	of Parts L and	7 321	50 00
51.00 Pass through costs applicable to Program Inpatient ancillary services (from Wkst. D. sum of Parts II 19.969 51.00 and IV) 10.10 Total Program excludable cost (sum of lines 50 and 51) 10.10 Total Program excludable cost (sum of lines 50 and 51) 10.10 Total Program excludable cost (sum of lines 50 and 51) 10.10 Total Program excludable cost (sum of lines 50 and 51) 10.10 Total Program excludable cost (sum of lines 50 and 51) 10.10 Total Program excludable costs (sum of lines 50 medical education costs (line 40 minus line 52) 10.10 Total Excluding Program inpatient (sum of lines 50) 10.10 Total Excluding Program excludation costs (line 40 minus line 52) 10.10 Total Excluding Program excludable costs (sum of lines 50 minus line 53) 10.10 Total Excluding Program excludable costs (sum of lines 50 minus line 53) 10.10 Total Excluding Program excludable costs (sum of lines 50 minus line 53) 10.10 Excluding Program excludable costs (sum of lines 50 minus line 53) 10.10 Excluding Program excludable costs (sum of lines 50 minus line 53) 10.10 Excluding Program excludable costs (sum of lines 50 minus line 53) 10.10 Excluding Program excludable costs (sum of lines 50 minus line 53) 10.10 Excluding Program excludable costs (sum of lines 50 minus line 53) 10.10 Excluding Program excludable costs (sum of lines 50 minus line 53) 10.10 Excluding Program excluding excl	00.00		att one toutino	00. 1. 000 (1. 0	moer by bam	or ranto r and	,, 02.	00.00
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Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	52.00	1	50 and 51)				19, 290	52. 00
medical education costs (tine 49 minus line 52) TARKET AMOUNT AND LIMIT COMPUTATION Frogram discharges 0.0 54.00				elated, non-phy	sician anesthe	tist, and		
54.00 Program discharges 0.0 54.00 55.00 Target amount per discharge 0.0 55.00 56.00 Target amount per discharge 0.0 55.00 56.00 Target amount (line 54 x line 55) 0.5 50.00 56.00 56.00 57.00 56.00								
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99.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 lines from the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0.62.00 Relief payment (see instructions) 0.63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0.63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0.63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0.64.00 Instructions)(title XVIII only) 0.65.00 Mica cre swing-bed SNF inpatient routine costs after becember 31 of the cost reporting period (See instructions) (title XVIII only) 0.66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 0.67.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 0.68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 20) 0.69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0.69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0.69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37) 70.00 Skilled nursing facility/often nursing facility/often pursing facility/often nursing facility/often pursing facility/		1	ing cost and ta	arget amount (I	ine 56 minus I	ine 53)		
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71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiarles for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Part IV - Computation of 085ErVATION BED PASS THROUGH COST	70.00							70.00
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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 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 88.00		,		,				
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				ons)				85. 00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00								86. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00								
89.00 Ubservation bed cost (line 87 x line 88) (see instructions)								
	89. 00	jubservation bed cost (line 87 x line 88) (see	e instructions))			0	89.00

Health Financial Systems REHA	ABILITATION HOSPITAL OF FT WAYNE			In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2016 To 09/30/2017	Date/Time Pre 2/28/2018 4:2	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	199, 564	5, 500, 388	0. 03628	2 0	0	90. 00
91.00 Nursing School cost	0	5, 500, 388	0.00000	0	0	91. 00
92.00 Allied health cost	0	5, 500, 388	0.00000	0	0	92. 00
93.00 All other Medical Education	0	5, 500, 388	0. 00000	0 0	0	93. 00

Health Financial Systems REH.	ABILITATION HOSPITAL OF FT WAY	YNE	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CO			Peri od: From 10/01/2016	Worksheet D-3	
			To 09/30/2017	Date/Time Pre 2/28/2018 4:2	pared: 3 pm
	Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00 03000 ADULTS & PEDI ATRI CS			4, 461, 237		30. 00
ANCI LLARY SERVI CE COST CENTERS		0.400/4	470.5//	04 007	F 4 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 12264			54. 00
60. 00 06000 LABORATORY		0. 08404			60.00
65. 00 06500 RESPIRATORY THERAPY		0. 94952	, ,		
66. 00 06600 PHYSI CAL THERAPY		0. 28079			
67. 00 06700 OCCUPATIONAL THERAPY		0. 28235			67.00
68. 00 06800 SPEECH PATHOLOGY		0. 19773			68. 00
69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 02626			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 03384 0. 11253			
73. 00 07300 DRUGS CHARGED TO PATTENTS 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 11253			
76. 00 03550 PSTCHTATRIC/PSTCHOLOGICAL SERVICES 76. 01 03950 HEMODIALYSIS & OTHER ANCILLARY		0. 21371			
200.00 Total (sum of lines 50 through 94 and	04 through 00)	0.21211	8, 088, 224		
201.00 Less PBP Clinic Laboratory Services-Pr			0, 000, 224		200.00
202.00 Net charges (line 200 minus line 201)	ogram only charges (Title 61)		8, 088, 224		201.00
202.00 Net Charges (Title 200 IIII hus Title 201)		I	0,000,224	I	J202. 00

Heal th F	Financial Systems REHABILITATION HOSPITA	L OF FT WAY	/NE	In Lie	eu of Form CMS-2	2552-10
		Provi der Co		Peri od: From 10/01/2016 To 09/30/2017	Worksheet D-3	
				10 09/30/2017	2/28/2018 4: 2	pareu. 3 pm
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS		1	450.000		
_	3000 ADULTS & PEDI ATRI CS			458, 832		30. 00
_	NCI LLARY SERVI CE COST CENTERS		0.4007	1.4	4 547	F 4 00
	15400 RADI OLOGY-DI AGNOSTI C		0. 12264	· ·		
	16000 LABORATORY		0. 08404			60.00
	16500 RESPI RATORY THERAPY		0. 94952			
	16600 PHYSI CAL THERAPY		0. 28079	· ·		
4	16700 OCCUPATIONAL THERAPY		0. 28235			67. 00
	16800 SPEECH PATHOLOGY		0. 19773			
	16900 ELECTROCARDIOLOGY 17100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 02626		0 2, 795	
	17100 MEDICAL SUPPLIES CHARGED TO PATTENT 17300 DRUGS CHARGED TO PATTENTS		0. 03384 0. 11253	· ·		
	13550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 11253			76.00
	13950 HEMODIALYSIS & OTHER ANCILLARY		0. 2137		4, 988	76. 00 76. 01
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0.2121	863, 274	1	
200.00	Less PBP Clinic Laboratory Services-Program only charges	(Lino 61)		003, 274		200.00
201.00	Net charges (line 200 minus line 201)	(TITIE OI)		863, 274	l	201.00
202.00	INGL Changes (Title 200 IIII has Title 201)		I	003, 274	I	1202.00

			'	0 09/30/2017	2/28/2018 4: 2	
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2, 00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		4, 384, 330		0	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		0		ō	
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment 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)					3. 00
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	
3. 02			0		0	
3.03			0		0	
3.04			0		0	
3. 05			0		0	3. 05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM		0		0	
3. 51			0		0	
3. 52			0		0	
3. 53			0		0	0.00
3. 54			0		0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		4, 384, 330		0	4. 00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			T	ı	
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider				l	1
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TENTITIVE TO TROVIDEN		ĺ		o o	
5. 03			0		0	
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		54, 212		0	6, 01
6. 02	SETTLEMENT TO PROGRAM		01,212		o o	
7. 00	Total Medicare program liability (see instructions)		4, 438, 542		0	
	,		.,, 012	Contractor	NPR Date	
			`	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	()	1. 00	2. 00	8. 00
6.00	INAILE OF COTTLEACTOR			l	I	J 0.00

Health Financial Systems	REHABILITATION HOSPITAL OF FT WAYNE	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-3030	Peri od: From 10/01/2016 To 09/30/2017

		Title XVIII	Hospi tal	2/28/2018 4: 2: PPS	3 pm
		I tre xviii	1103pi tai	113	
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			4, 147, 444	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0. 0262	2. 00	
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			235, 160	3. 00
4.00	Outlier Payments			195, 338	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent of to November 15, 2004 (see instructions)	ost reporting period en	ding on or prior	0.00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE country program or hospital closure, that would not be counted without CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0. 00	5. 01
6. 00	New Teaching program adjustment. (see instructions)			0.00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	7. 00
	teaching program" (see instructions)	pg g p		1	
8.00	Current year's unweighted I&R FTE count for residents within teaching program" (see instructions)	the new program growth p	eriod of a "new	0. 00	8. 00
9.00	Intern and resident count for IRF PPS medical education adjust	tment (see instructions)		0.00	9. 00
10.00	Average Daily Census (see instructions)			17. 701370	10.00
11. 00	Teaching Adjustment Factor (see instructions)			0.000000	11. 00
12. 00	Teaching Adjustment (see instructions)			0	12. 00
13. 00	Total PPS Payment (see instructions)			4, 577, 942	13. 00
14. 00	Nursing and Allied Health Managed Care payments (see instructi	on)		0	14. 00
15. 00	Organ acquisition (DO NOT USE THIS LINE)			1	15. 00
16. 00	Cost of physicians' services in a teaching hospital (see insti	ructions)		0	16. 00
17. 00	Subtotal (see instructions)	,		4, 577, 942	17. 00
18. 00	Primary payer payments			0	18. 00
19. 00	Subtotal (line 17 less line 18).			4, 577, 942	
20. 00	Deducti bl es			19, 600	20.00
21. 00	Subtotal (line 19 minus line 20)			4, 558, 342	21. 00
22. 00	Coinsurance			29, 218	
23. 00	Subtotal (line 21 minus line 22)			4, 529, 124	
24. 00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		0	24. 00
25. 00	Adjusted reimbursable bad debts (see instructions)	, (, , , , , , , , , , , , , , , , , ,		0	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		Ö	26. 00
27. 00	Subtotal (sum of lines 23 and 25)	,		4, 529, 124	
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ne 49)		0	28. 00
29. 00	Other pass through costs (see instructions)	,		0	29. 00
30. 00	Outlier payments reconciliation			0	30. 00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31. 00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	31. 50
31. 99	Demonstration payment adjustment amount before sequestration	,		0	31. 99
32.00	Total amount payable to the provider (see instructions)			4, 529, 124	32. 00
32. 01	Sequestration adjustment (see instructions)			90, 582	32. 01
32. 02	Demonstration payment adjustment amount after sequestration			0	32. 02
33.00	Interim payments			4, 384, 330	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, 32.02	2. 33. and 34)		54, 212	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordan	· · · · · · · · · · · · · · · · · · ·	chapter 1.	23, 643	36. 00
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			195, 338	50. 00
51. 00	Outlier reconciliation adjustment amount (see instructions)			0	51. 00
52.00	The rate used to calculate the Time Value of Money			0.00	52.00
	Time Value of Money (see instructions)			0	53.00
			'		•

Health Financial Systems	REHABILITATION HOSPITAL OF FT WAYNE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-3030	Peri od:	Worksheet E-3

From 10/01/2016 To 09/30/2017 Part VII
Date/Time Prepared: 2/28/2018 4:23 pm Title XIX Hospi tal PPS Inpati ent Outpati ent 1.00 2.00 PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient hospital/SNF/NF services 1.00 2.00 Medical and other services Λ 2.00 3.00 Organ acquisition (certified transplant centers only) 0 3.00 Subtotal (sum of lines 1, 2 and 3) 0 4.00 4.00 Inpatient primary payer payments 5.00 5.00 Outpatient primary payer payments 6.00 Ω 6.00 7.00 Subtotal (line 4 less sum of lines 5 and 6) 0 7.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 8.00 9.00 Ancillary service charges 863, 274 0 9.00 10.00 Organ acquisition charges, net of revenue 10.00 Incentive from target amount computation 11 00 11 00 12.00 Total reasonable charges (sum of lines 8 through 11) 863, 274 0 12.00 CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge 0 0 13.00 basi s Amounts that would have been realized from patients liable for payment for services on 14.00 0 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) 863, 274 16.00 863. 274 17.00 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 0 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0 18.00 0 (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 providers 22.00 0 0 22.00 Other than outlier payments 0 23.00 Outlier payments 23.00 Λ 24.00 Program capital payments 24.00 25.00 Capital exception payments (see instructions) 0 25.00 Routine and Ancillary service other pass through costs 26.00 26 00 0 Subtotal (sum of lines 22 through 26) 27.00 0 27.00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 0 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 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) 0 0 0 0 0 0 0 0 0 0 0 0 31.00 32.00 Deducti bl es 32.00 0 33 00 Coi nsurance 33 00 0 34.00 Allowable bad debts (see instructions) Λ 34.00 Utilization review 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36, 00 0 36, 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 37.00 0 37.00 38.00 Subtotal (line 36 ± line 37) 0 38.00 Direct graduate medical education payments (from Wkst. E-4) 39.00 39.00 40.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 0 41.00 Interim payments 0 41.00 Balance due provider/program (line 40 minus line 41) 42.00 0 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00 43.00 chapter 1, §115.2

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

Provider CCN: 15-3030

oni y)					2/28/2018 4: 2	3 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-35, 914		0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable			-	0	2. 00 3. 00
4. 00	Accounts receivable	2, 139, 761	1	1	0	
5.00	Other recei vabl e	0		0	Ō	
6.00	Allowances for uncollectible notes and accounts receivable	-443, 923	s c	0	0	6. 00
7.00	Inventory	24, 908		0	0	7. 00
8.00	Prepai d expenses	33, 965		0	0	
9. 00 10. 00	Other current assets Due from other funds	48		1	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	1, 718, 845		-	1	11.00
	FI XED ASSETS	.,,				
12.00	Land	900, 000	1			1
13. 00	Land improvements	276, 453	1	_	1	
14.00	Accumulated depreciation	-136, 315	1	-	0	14.00
15. 00 16. 00	Buildings Accumulated depreciation	11, 624, 396 -2, 534, 021	1	_	0	15. 00 16. 00
17. 00	Leasehold improvements	369, 719	1	_	Ö	17. 00
18. 00	Accumulated depreciation	-95, 240	1	0	0	18. 00
19. 00	Fi xed equi pment	156, 727	' c	0	0	19. 00
20. 00	Accumulated depreciation	-60, 749	1	0	0	20. 00
21. 00	Automobiles and trucks	113, 428	1	_	0	21.00
22. 00 23. 00	Accumulated depreciation Major movable equipment	-110, 827 418, 564	1	_	0	22. 00
24. 00	Accumulated depreciation	-154, 165	1	_	0	24. 00
25. 00	Mi nor equipment depreciable	301, 775		0	Ō	25. 00
26.00	Accumulated depreciation	-256, 177	' C	0	0	26. 00
27. 00	HIT designated Assets	0		0	0	27. 00
28. 00	Accumulated depreciation	0		_	0	28. 00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	10, 813, 568	3	_	0	29. 00 30. 00
30.00	OTHER ASSETS	10, 013, 300	y C	,	<u> </u>	30.00
31.00	Investments	C) (0	0	31. 00
32. 00	Deposits on Leases	0	0	_	1	32. 00
33. 00	Due from owners/officers	0		_	0	33. 00
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	550, 164 550, 164		_	0 0	34. 00 35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	13, 082, 577		1	l	36.00
00.00	CURRENT LI ABILITIES	10/002/07/		,		00.00
37.00	Accounts payable	224, 817	(0	0	37. 00
38. 00	Salaries, wages, and fees payable	529, 503	1	_	1	38. 00
39. 00	Payroll taxes payable	64, 168		0	0	39. 00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income			0	0	40. 00 41. 00
42. 00	Accel erated payments			0	0	42.00
43. 00	Due to other funds	16, 278, 871		0	0	1
44.00	Other current liabilities	194, 851		1	1	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	17, 292, 210) (0	0	45. 00
44 00	LONG TERM LIABILITIES	1 0			0	44 00
46. 00 47. 00	Mortgage payable Notes payable			1		
48. 00	Unsecured Loans			-	l	48. 00
49.00	Other long term liabilities	C		0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	C) (0		
51. 00	Total liabilities (sum of lines 45 and 50)	17, 292, 210) (0	0	51.00
E2 00	CAPITAL ACCOUNTS General fund balance	-4, 209, 633				E2 00
52. 00 53. 00	Specific purpose fund	-4, 209, 633))		52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	-4, 209, 633			0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	13, 082, 577		Ö	ő	60.00
	59)		1			

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

| Peri od: | From 10/01/2016 | To 09/30/2017 | Date/Time Prepared:

						2/28/2018 4: 2	3 pm
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		-3, 916, 848	1	C		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-472, 335				2.00
3.00	Total (sum of line 1 and line 2)		-4, 389, 183		C		3.00
4.00	Additions (credit adjustments) (specify)	0			0	0	4. 00
5.00		0			0	0	5.00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8.00
9.00		0			0	0	9. 00
10. 00	Total additions (sum of line 4-9)		0)	C		10.00
11. 00	Subtotal (line 3 plus line 10)		-4, 389, 183		C		11. 00
12.00	ADJUSTMENTS	-179, 550			0	0	12.00
13.00		0			0	0	13.00
14.00		0			0	0	14.00
15. 00		0			0	0	15.00
16.00		0			0	0	16.00
17. 00		0			0	0	17.00
18. 00	Total deductions (sum of lines 12-17)		-179, 550	1	C		18.00
19. 00	Fund balance at end of period per balance		-4, 209, 633		C		19.00
	sheet (line 11 minus line 18)						
		Endowment Fund	PI ant	Fund			
		Endowment Fund 6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period				0		1. 00
1. 00 2. 00	Net income (loss) (from Wkst. G-3, line 29)	6.00			0		1. 00 2. 00
		6.00			0		
2.00	Net income (loss) (from Wkst. G-3, line 29)	6.00					2.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00					2. 00 3. 00
2. 00 3. 00 4. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00					2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00					2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	6.00					2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	6.00					2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9)	6.00					2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	6.00			0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9)	6.00			0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6.00			0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6.00			0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6.00			0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	6.00			0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ADJUSTMENTS	6.00 0 0			0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ADJUSTMENTS Total deductions (sum of lines 12-17)	6. 00 0 0			0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ADJUSTMENTS Total deductions (sum of lines 12-17) Fund balance at end of period per balance	6.00 0 0			0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ADJUSTMENTS Total deductions (sum of lines 12-17)	6. 00 0 0			0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00

	2/28/2018 4: 23 pm
Cost Center Description Inpatient Outpat	
1.00 2.0	
PART I - PATIENT REVENUES	
General Inpatient Routine Services	
1.00 Hospi tal 11,008,701	11, 008, 701 1. 00
2. 00 SUBPROVIDER - I PF	2.00
3.00 SUBPROVIDER - I RF	3.00
4. 00 SUBPROVI DER	4.00
5.00 Swing bed - SNF 0	0 5.00
6.00 Swing bed - NF	0 6.00
7.00 SKILLED NURSING FACILITY	7.00
8.00 NURSING FACILITY	8.00
9. 00 OTHER LONG TERM CARE	9.00
10.00 Total general inpatient care services (sum of lines 1-9) 11,008,701	11, 008, 701 10. 00
Intensive Care Type Inpatient Hospital Services	11,7559,151
11. 00 INTENSIVE CARE UNIT	11.00
12.00 CORONARY CARE UNIT	12.00
13.00 BURN INTENSIVE CARE UNIT	13. 00
14. 00 SURGICAL INTENSIVE CARE UNIT	14. 00
15. 00 OTHER SPECIAL CARE (SPECIFY)	15. 00
16.00 Total intensive care type inpatient hospital services (sum of lines 0	0 16.00
11-15)	
17.00 Total inpatient routine care services (sum of lines 10 and 16) 11,008,701	11, 008, 701 17. 00
	21, 546 20, 364, 078 18. 00
19.00 Outpatient services	0 0 19.00
20. 00 RURAL HEALTH CLINIC 0	0 0 20.00
21.00 FEDERALLY QUALIFIED HEALTH CENTER 0	0 0 21.00
22. 00 HOME HEALTH AGENCY	22.00
23. 00 AMBULANCE SERVICES	23.00
24. 00 CMHC	24.00
25.00 AMBULATORY SURGI CAL CENTER (D. P.)	25. 00
26. 00 HOSPI CE	26. 00
27. 00 OTHER (SPECIFY)	0 0 27.00
· · ·	21, 546 31, 372, 779 28. 00
G-3, line 1)	,
PART II - OPERATING EXPENSES	
	29.00
30. 00 ROUNDI NG 3	30.00
31.00	31.00
32.00	32.00
33.00	33.00
34.00	34.00
35. 00	35.00
36.00 Total additions (sum of lines 30-35)	36.00
37. 00 DEDUCT (SPECIFY) 0	37.00
38.00	38.00
39.00	39.00
40.00	40.00
41.00	41.00
42.00 Total deductions (sum of lines 37-41)	0 42.00
·	257, 512 43. 00
to Wkst. G-3, line 4)	

Heal th	Financial Systems	REHABILITATION HOSPITAL OF FT WAYNE	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-3030	Peri od:	Worksheet G-3	
			From 10/01/2016 To 09/30/2017	Date/Time Pre 2/28/2018 4:2	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, F	Part I, column 3, line 28)		31, 372, 779	1. 00
2.00	Less contractual allowances and discounts	s on patients' accounts		21, 497, 827	2. 00
3.00	Net patient revenues (line 1 minus line 2	2)		9, 874, 952	3. 00
4.00	Less total operating expenses (from Wkst.	G-2, Part II, line 43)		10, 257, 512	4. 00
5.00	5.00 Net income from service to patients (line 3 minus line 4)				5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscell	aneous communication services		0	8. 00
9.00	Revenue from television and radio service	9		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 than patients		0	16. 00
	l				1

18.00

21.00

24.00

25.00

26.00

28.00

0 19.00

0 20.00

0 22.00

0 23.00

0 27.00

-472, 335 29. 00

-89, 775

-89, 775

-472, 335

17.00 Revenue from sale of drugs to other than patients

18.00 Revenue from sale of medical records and abstracts

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)

Revenue from gifts, flowers, coffee shops, and canteen

19.00 Tuition (fees, sale of textbooks, uniforms, etc.)

21.00 Rental of vending machines

23.00 Governmental appropriations

24. 00 OTHER OPERATING REVENUE

27. 00 OTHER EXPENSES (SPECIFY)

Rental of hospital space

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

20.00

22. 00