Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CMS-2552-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-3030 Worksheet S Peri od. From 10/01/2017 Parts I-III AND SETTLEMENT SUMMARY 09/30/2018 Date/Time Prepared: То 2/25/2019 11:42 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 2/25/2019 Time: 11:42 am use only Manually submitted cost report 2 []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 0 Ē 4 [

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OF 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 OF 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 10/01/2017 and ending 09/30/2018 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)

Title

Date

	· · · · · · · · · · · · · · · · · · ·		Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	16, 034	0	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	16, 034	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.

PLL	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provi	der cor	N: 15-3030	Period: From 10/			
						To 09/	30/2018	Date/Time 2/25/2019	
	1.00	2.00		3.00			4.00		
	Hospital and Hospital Health Care Con Street: 7970 WEST JEFFERSON BOULEVARD	PO Box:							1.
	City: FORT WAYNE	State: IN	Zip Co	de: 4680	04- Cou	nty: ALLEN			2.
		Component Name	CCN	CBS				ent System	(P,
			Number	Numb	er Type	Certifi		「, O, or N) XVIII XI	x
		1.00	2.00	3.0	0 4.00	5.00	6.00		
	Hospital and Hospital-Based Component		150000		(a) 5	11/01/10			
C		REHABILITATION HOSPITA DF FT WAYNE	L 153030	2306	60 5	11/01/19	93 N	P F) 3.
0	Subprovider - IPF								4.
	Subprovider - IRF								5
	Subprovider - (Other)								6
))	Swing Beds - SNF Swing Beds - NF								7.
	Hospi tal -Based SNF								9
	Hospital-Based NF								10
	Hospi tal -Based OLTC								11.
	Hospital-Based HHA Separately Certified ASC								12
	Hospi tal -Based Hospi ce								14.
	Hospital-Based Health Clinic - RHC								15
	Hospital-Based Health Clinic - FQHC								16
	Hospital-Based (CMHC) I Renal Dialysis								17
	Other								19
							om: 00	To: 2.00	
00	Cost Reporting Period (mm/dd/yyyy)						/2017	09/30/201	8 20
	Type of Control (see instructions)						4		21
				-	1.00		00	2 00	
	Inpatient PPS Information				1.00	Ζ.	00	3.00	-
00	Does this facility qualify and is it				N		N		22.
	disproportionate share hospital adjus §412.106? In column 1, enter "Y" for			R					
	facility subject to 42 CFR Section §4	12.106(c)(2)(Pickle a	mendment						
	hospital?) In column 2, enter "Y" for								
01	Did this hospital receive interim unc				N		N		22.
	cost reporting period? Enter in colum the portion of the cost reporting per								
	Enter in column 2, "Y" for yes or "N"								
	reporting period occurring on or afte								
)2	Is this a newly merged hospital that payments to be determined at cost rep				Ν		N		22
	Enter in column 1, "Y" for yes or "N"								
	cost reporting period prior to Octobe	r 1. Enter in column	2, "Y" for	yes					
	or "N" for no, for the portion of the October 1.	cost reporting perio	d on or af	ter					
03	Did this hospital receive a geographi	c reclassification fr	om urban t	:o	Ν		N	N	22
	rural as a result of the OMB standard								
	adopted by CMS in FY2015? Enter in co								
	for the portion of the cost reporting in column 2, "Y" for yes or "N" for r			er					
	reporting period occurring on or afte								
	Does this hospital contain at least 1								
	counted in accordance with 42 CFR 412 yes or "N" for no.	. 105)? Enter in colum	пз, "Y" f	or					
	Which method is used to determine Mec					3	N		23.
	below? In column 1, enter 1 if date c								
	if date of discharge. Is the method or reporting period different from the m			COST					
	reporting period an referrence from the management of the management of the reporting period? In column 2, enter	"Y" for yes or "N" f	or no.						
		In-S		State	Out-of	Out-of	Medi ca		
		Medi paid		icaid gible	State Medi cai d	State Medi cai d	HMO da	ays Medica days	a
		para		°	pai d days	eligible		days	
				ays	0.05	unpai d			
0	If this provider is an LDDS bosnital	1.	00 2	. 00	3.00	4.00	5.00	0 6.00	0.24
JU	If this provider is an IPPS hospital, in-state Medicaid paid days in columr		U	0	0	L C		U	0 24.
	Medicaid eligible unpaid days in colu	imn 2,							
	out-of-state Medicaid paid days in co								
	aut of state Mediasist structure in								
	out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible but								

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA I	Provider CC	N: 15-3030	Period: From 10/01		Workshe Part I		
					To 09/30	/2018	Date/Ti 2/25/20		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	State Medi cai d el i gi bl e unpai d	Medica HMO da	iys Mea	ther di cai d days	
5.00	If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4.00	<u>5.00</u> 1) é 153	5.00	25.0
	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.				Urban/Ru			Geogr	
					1.00		2. (1
6.00 7.00 5.00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	r rural. age) status r "2" for ru ication in d	at the end ural. If ap column 2.	l of the cos pplicable,	t	1			26. 0 27. 0 35. 0
5.00	effect in the cost reporting period.					-			33.0
					Begi nni 1. 00		Endi 2. (-
6. 00	Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		cript line	36 for numb					36.0
7.00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		r of period	ls MDH statu	s	0			37.0
7. 01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)								37. (
8. 00	If line 37 is 1, enter the beginning and ending date: greater than 1, subscript this line for the number of enter subsequent dates.								38. (
					Y/N 1.00		Y/ 2. (-
9.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent requiremen	er in colum nts in	me N n	<u> </u>	N		39. (
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1.	ber 1. Ente	r "Y" for y				N		40. (
						V 1.00	XVIII 2.00	XIX 3.00	-
E 00	Prospective Payment System (PPS)-Capital	nt for dic-	coport: on-t	o chara in	accordance				45.0
5.00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exco		•			N N	N N	N N	45.
5.00	pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.							14	
7.00 8.00	Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment					N N	N N	N N	47.
6. 00	Teaching Hospitals Is this a hospital involved in training residents in	approved G	ME programs	? Enter "Y	" for yes	N			56.0
7.00	or "N" for no. If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	r yes or "N' th of this o Y", complete	" for no in cost report e Worksheet	n column 1. ing period?	If column 1 Enter "Y"				57.
	If line 56 is yes, did this facility elect cost reim	bursement fo	or physicia	ins' service	s as	N			58.
				D+ I		N			59. (
8. 00	Are costs claimed on line 100 of Worksheet A? If yes		Wkst. D-2,	NAHE 413.8 Y/N	35 Workshe Line	#	Pass-Tl Qualifi Criterio	cation	1
8. 00 9. 00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	s, complete		NAHE 413.8		#	Qualifi	cation on Code	

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT	ΓA	Provider CO	Fi	eriod: rom 10/01/2017		
			T		2/25/2019 11:	
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 	N			0.00		61.
02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.
 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 						61.
04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.
05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.
06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	-
		1.00	2.00	3.00	4.00	1
 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. 20 Of the FTEs in line 61.05, specify each expanded program special ty, 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 name. Enter in column 4, the direct GME FTE unweighted count. 				0.00		61.
					1.00	-
ACA Provisions Affecting the Health Resources and Ser	vi ces A	Administration	(HRSA)			
 OD Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc O1 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide 	tions) Teachi <u>ram. (s</u>	ng Health Cen [.] see instruction	ter (THC) into		0.00	
0 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this co		<u>ictions)</u>	N	63.
			Unweighted FTEs Nonprovider Site	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Continue EEOA of the ACA Deer Very ETE D. 1. 1. 1.		lon Cott!	1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor 00 Enter in column 1, if line 63 is yes, or your facilit	e June	30, 2010.	This base year	-		64.
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 resident FTEs that trained in your hospital. Enter in	-primar all non non-pr	ry care nprovider rimary care				

	Financial Systems L AND HOSPITAL HEALTH CARE COMPLI		ON HOSPITAL OF FT WA	CN: 15-3030 Pe	riod: om 10/01/2017	eu of Form CMS- Worksheet S-2 Part I	
				To		Date/Time Pre	pared:
		Program Name	Program Code	Unweighted	Unwei ghted	2/25/2019 11: Ratio (col. 3/	
				FTËs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	-	1.00	2.00	3.00	4.00	5.00	-
i t yaa Fprrt curr n cur r	Enter in column 1, if line 63 s yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care orogram 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			0.00	0.00	0. 000000) 65. O
d	5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
				Nonprovider Site	Hospi tal	2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Y Deginning on or after July 1, 201		n Nonprovider Setting	gsEffective fo	r cost reporti	ng periods	
F E F	Enter in column 1 the number of u TEs attributable to rotations oc Enter in column 2 the number of u TEs that trained in your hospita (column 1 divided by (column 1 +	curring in all nonp nweighted non-prima I. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00 Unweighted FTEs Nonprovider Site	0.00 Unweighted FTEs in Hospital	0 0.000000 Ratio (col. 3/ (col. 3 + col. 4))	/
	-	1.00	2.00	3.00	4.00	5.00	1
n y w E c n c t n c u r y 5 d	Enter in column 1, the program hame 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 humber of unweighted primary care FTE residents attributable to rotations occurring in all hon-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0.000000	0 67.00
					1.0	0 2.00 3.00	-
	npatient Psychiatric Facility PF						
	s this facility an Inpatient Psy Enter "Y" for yes or "N" for no.	chiatric Facility (IPF), or does it cont	ain an IPF subp	rovider? N		70.0
1.00 r 4 C C	f line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic (see instructions)	fore November 15, 2 umn 2: Did this fac 412.424 (d)(1)(iii ate which program y	004? Enter "Y" for y ility train residents)(D)? Enter "Y" for y	ves or "N" for no s in a new teach ves or "N" for no	o. (see i ng o.	0	71.0
5. 00 T	npatient Rehabilitation Facility s this facility an Inpatient Reh	abilitation Facilit	y (IRF), or does it c	contain an IRF	Y		75.0
6.00 s	subprovider? Enter "Y" for yes a fline 75 is yes: Column 1: Did recent cost reporting period endi	nd "N" for no. the facility have a	n approved GME teachi	ng program in tl		N O	76.00

Health Financial Systems	REHABILITATION HOSPI	TAL OF FT WAY	'NE	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE CO	MPLEX IDENTIFICATION DATA	Provider CC	CN: 15-3030	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I	2
				10 077 307 2010	2/25/2019 11:	
					1.00	-
	ital (LTCH)? Enter "Y" for yes nin another hospital for part or			g period? Enter	N N	80. 00 81. 00
TEFRA Provi ders		TEEDAO E 1				
 85.00 s this a new hospital under 86.00 Did this facility establish a §413.40(f)(1)(ii)? Enter "Y" 					N	85.00 86.00
	neoplastic disease care hospital	classified u	under section		N	87.00
				V 1.00	XI X 2.00	-
Title V and XIX Services						
90.00 Does this facility have title yes or "N" for no in the appl		servi ces? Er	nter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for	or title V and/or XIX through th r yes or "N" for no in the appli			Ν	Y	91.00
92.00 Are title XIX NF patients occ	upying title XVIII SNF beds (dua	al certificati			N	92.00
93.00 Does this facility operate an			d XIX? Enter	N	N	93.00
"Y" for yes or "N" for no in 94.00 Does title V or XIX reduce ca		and "N" for no	o in the	Ν	N	94.00
applicable column. 95.00 If line 94 is "Y", enter the	reduction percentage in the appl	icable column	٦.	0.00	0.00	95.00
96.00 Does title V or XIX reduce op	erating cost? Enter "Y" for yes	or "N" for no	o in the	N	N	96.00
97.00 If line 96 is "Y", enter the 98.00 Does title V or XIX follow Me stepdown adjustments on Wkst.	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					97.00 98.00
98.01 Does title V or XIX follow Me	n 1 for title V, and in column 2 for title XIX. title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. . I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for					98. 01
98.02 Does title V or XIX follow Me bed costs on Wkst. D-1, Pt. I	V, line 89? Enter "Y" for yes or			Y	Y	98. 02
<pre>for title V, and in column 2 98.03 Does title V or XIX follow Me reimbursed 101% of inpatient for title V, and in column 2</pre>	dicare (title XVIII) for a criti services cost? Enter "Y" for yes			N 1	Ν	98.03
98.04 Does title V or XIX follow Me outpatient services cost? Ent				N	Ν	98.04
	dicare (title XVIII) and add bac "Y" for yes or "N" for no in co				Y	98. 05
	dicare (title XVIII) when cost r for yes or "N" for no in column			Y	Y	98.06
column 2 for title XIX. Rural Providers					l	
105.00 Does this hospital qualify as 106.00 If this facility qualifies as		nclusive meth	nod of paymen	N t N		105.00
for outpatient services? (see	instructions)		1 5			
yes, the GME elimination is n	for yes or "N" for no in column ot made on Wkst. B, Pt. I, col.	1. (see instr	ructions) If	t		107.00
reimbursed. If yes complete W 108.00 Is this a rural hospital qual CFR Section §412.113(c). Ente	ifying for an exception to the C	CRNA fee sched	dul e? See 42	N		108.00
CFR Section 9412. ITS(C): Ente	t tot yes of in tot ho.	Physi cal	Occupati ona	I Speech	Respi ratory	
		1.00	2.00	3.00	4.00	
109.00 f this hospital qualifies as therapy services provided by for yes or "N" for no for eac	outside supplier? Enter "Y"	Ν	N	N	N	109.00
					1.00	-
	in the Rural Community Hospital cost reporting period? Enter "Y lines 200 through 218, and Work	(" for yes or	"N" for no.	lf yes,	N	110.00

Health Financial Systems REHABILITATION HOSPI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCI		Period: From 10/01		Workshe		<u>2552-10</u> 2
)/2018		me Pre	epared: 42 am
			1.0	0	2. (0	-
111.00 If this facility qualifies as a CAH, did it participate in th Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	t reporting p umn 1 is Y, e icipating in d	eriod? Enter nter the column 2.	N				111.00
Miscellaneous Cost Reporting Information				1.0	0 2.00	3.00	
 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or is yes and the short term hospital center? 	lf column 2 is for long tern) based on the	s "E", enter m care (incl e definition	in column udes			0	115.00
117.00 Is this facility legally-required to carry malpractice insura no.			"N" for	N			117.00
118.00 Is the malpractice insurance a claims-made or occurrence poli- claim-made. Enter 2 if the policy is occurrence.	cy? Enter 1 i	f the policy	is	1	_		118.00
		Premiums	Loss	es	Insur	ance	
	-						
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.0	0 11, 289	3. (0 118. 01
	I		1.0		2.0		-
118.02 Are malpractice premiums and paid losses reported in a cost c			N	0	2.0	50	118.02
Administrative and General? If yes, submit supporting schedu and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment	Harmless prov column 1, "Y" lifies for th	ision in ACA for yes or e Outpatient			N		119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implan	table devices	charged to	N				121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.							122.00
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N"	for no. If	N				125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ent		ication date					126.00
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, ente in column 1 and termination date, if applicable, in column 2.		cation date					127.00
128.00 If this is a Medicare certified liver transplant center, ente in column 1 and termination date, if applicable, in column 2.		cation date					128.00
129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		ation date i	n				129.00
30.00 If this is a Medicare certified pancreas transplant center, e date in column 1 and termination date, if applicable, in colu		i fi cati on					130.00
31.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colu	enter the ce	rti fi cati on					131.00
32.00 If this is a Medicare certified islet transplant center, ente in column 1 and termination date, if applicable, in column 2.		cation date					132.00
33.00 If this is a Medicare certified other transplant center, ente in column 1 and termination date, if applicable, in column 2.							133.00
I34.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.	UPU number i	n column 1					134.00
All Providers 140.00 Are there any related organization or home office costs as de chapter 10? Enter "Y" for yes or "N" for no in column 1. If y			Y		4490	800	140. 00

Health Financial Systems			TAL OF FT WAY	NE			In Lie	u of Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DA	TA	Provider CC	N: 15-30		riod:)/01/2017	Worksheet S-2 Part I	2
					To		9/30/2018	Date/Time Pre	
1.00		0.00					0.00	2/25/2019 11:	42 am
1.00 If this facility is part of a chai	n organization en	<u>2.00</u> ter on Li	nes 141 throu	iah 143 -	the nam	e and	3.00	of the	
home office and enter the home off					the nam	c ana	1 4441 033	of the	
141.00 Name: CHS/COMMUNITY HEALTH SYSTEM		Name: WIS	CONSIN PHYSICI		ractor'	s Nur	mber: 1030	1	141.00
INC. 142.00 Street: 4000 MERIDIAN BLVD	PO Box:	SER	VICES						142.00
142.00 City: FRANKLIN	State:	TN		Zin	Code:		3706	7	142.00
				[=·]*					
								1.00	
144.00 Are provider based physicians' cos	ts included in Work	ksheet A'	,					Y	144.00
					ł		1.00	2.00	-
145.00 If costs for renal services are cl									145.00
inpatient services only? Enter "Y"									
no, does the dialysis facility inc period? Enter "Y" for yes or "N"			or this cost	reportir	ig				
146.00 Has the cost allocation methodolog			ly filed cost	report?	,		Ν		146.00
Enter "Y" for yes or "N" for no ir			-2, chapter 4	0, §4020)) I f				
yes, enter the approval date (mm/c	ld/yyyy) in column 2	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					6	_		N	148.00
149.00 Was there a change to the simplifi	ed cost finding met		Part A	Part			tle V	N Title XIX	149.00
		-	1.00	2.0			3.00	4.00	-
Does this facility contain a provi									
or charges? Enter "Y" for yes or ' 155.00Hospi tal	N" for no for each	componer	nt for Part A N	and Par	<u> </u>	ee 42	CFR §413 N	. 13) N	155.00
155.00 Subprovi der – TPF			N	N N			N	N	156.00
157.00 Subprovi der – I RF			N	N			N	N	157.00
158. 00 SUBPROVI DER									158.00
159.00 SNF 160.00 HOME HEALTH AGENCY			N N	N N			N N	N N	159.00 160.00
161. 00 CMHC			IN .	N N			N	N	161.00
					•				
Multicampus								1.00	
165.00 Is this hospital part of a Multica	mpus hospital that	has one	or more campu	ises in c	li fferei	nt CB	SAs?	N	165.00
Enter "Y" for yes or "N" for no.	· ·				_				
	Name 0		County 1.00		Zip (3.(CBSA 4.00	FTE/Campus 5.00	-
166.00 If line 165 is yes, for each	0	_	1.00	2.00	3.0	50	4.00		0 166. 00
campus enter the name in column									
0, county in column 1, state in									
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in									
column 5 (see instructions)									
								1 00	-
Health Information Technology (HI) incentive in the	Americar	Recovery and	Reinver	stment	Act		1.00	
167.00 Is this provider a meaningful user								N	167.00
168.00 If this provider is a CAH (line 10				e 167 is	"Y"), e	enter	the		0168.00
reasonable cost incurred for the H 168.01 If this provider is a CAH and is r				aualify	for a	bard	chin		168. 01
exception under §413.70(a) (6) (ii)?						naru	Silip		100.01
169.00 If this provider is a meaningful u	ser (line 167 is "א					'), e	nter the	0.0	0169.00
transition factor. (see instruction	ns)					Dec		Ending	
					-		gi nni ng 1. 00	Endi ng 2. 00	-
170.00 Enter in columns 1 and 2 the EHR k	eginning date and e	ending da	te for the re	porting				2.00	170.00
period respectively (mm/dd/yyyy)		-							
					-		1.00	2.00	-
171.00 If line 167 is "Y", does this prov	ider have anv davs	for indi	viduals enrol	led in			1.00		0171.00
section 1876 Medicare cost plans r	eported on Wkst. S-	-3, Pt. I	, line 2, col	. 6? Ent					
"Y" for yes and "N" for no in column 2 (s		s yes, e	enter the numb	er of se	ection				
1876 Medicare days in column 2. (s	ee instructions)				I			l	1

	Financial Systems REHABILITATION HOS				u of Form CMS-	2552-10
10SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	1	Period: From 10/01/2017 Fo 09/30/2018		epared:
				V /N	2/25/2019 11:	42 am
				Y/N 1.00	Date 2.00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses. Enter			
	mm/dd/yyyy format.					_
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
1.00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in a		instructions)			
			Y/N	Date	V/I	
2.00	Has the provider terminated participation in the Medicare P	Program? If	1.00 N	2.00	3.00	2.0
	yes, enter in column 2 the date of termination and in colum					2.0
	voluntary or "I" for involuntary.					
3.00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of		N			3.00
	or medical supply companies) that are related to the provid					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other	er similar				
	relationships? (see instructions)		Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Cerr Accountant? Column 2: If yes, enter "A" for Audited, "C"		N			4.00
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
5.00	Are the cost report total expenses and total revenues differences on the filed financial statements? If was submit re-		N			5.00
	those on the filed financial statements? If yes, submit rea			Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities		· · · ·			1
5.00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	ne provider is	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		Ν		7.00
3. 00	Were nursing school and/or allied health programs approved	and/or renewed	during the	Ν		8.00
9.00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	araduato modic	al oducation	N		9.00
7.00	program in the current cost report? If yes, see instruction	0		IN		9.00
10.00	Was an approved Intern and Resident GME program initiated of		he current	Ν		10.00
11 00	cost reporting period? If yes, see instructions.	0 Din on Ann	way and	N		11 00
11.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R In an App	proved	N		11.00
					Y/N	
					1.00	
12.00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s see instruct	ions		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection p			st reporting	N	13.00
	period? If yes, submit copy.	5 0	0			
14.00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	⁻ yes, see inst	ructions.	N	14.00
15.00	Bed Complement Did total beds available change from the prior cost reporti	ng period? If	ves, see instr	uctions.	N	15.00
		Par	t A	Par	tВ	
		Y/N	Date	Y/N	Date	
			2.00	3.00	4.00	
	DSID Data	1.00	2.00	0.00		
16.00	PS&R Data Was the cost report prepared using the PS&R Report only?	1.00 Y	12/19/2018	Y	12/19/2018	16.00
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through		-		12/19/2018	16.00
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see		-		12/19/2018	16.00
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	-	Y	12/19/2018	
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If		-		12/19/2018	
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	-	Y	12/19/2018	
17.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	-	Y N	12/19/2018	17.00
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	Y	-	Y	12/19/2018	17.00
17.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	-	Y N	12/19/2018	17.00
17. 00 18. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Y N N	-	Y N N	12/19/2018	16. 00 17. 00 18. 00
17.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Y	-	Y N	12/19/2018	17.00

Health Financial System

REHABI LI TATI ON	HOSPI TAL	0F	FΤ	WAYNE

In lieu of Form CMS-2552-10

IEERPITAL AND NESPITAL HEALTH CARL BETMERISTER IN CORPORATE Provider CCR 15-3030 Provider	Heal th	Financial Systems REHABILITATION HOS	SPITAL OF FT WAY	YNE	In Lie	u of Form CMS	-2552-10
Description V/R 12/25/2019 11:42 are 20.00 IF Line 16 or 17 Is yes, were adjustments and to PSM 0 1.00 3.00 20.00 IF Line 16 or 17 Is yes, were adjustments and to PSM N 0 2.00 3.00 4.00 21.00 Bac the cost report prepared only using the provider's N 0.2.00 3.00 4.00 21.00 21.01 Bac the cost report prepared only using the provider's N 2.00 3.00 4.00 21.00 22.00 Reveal additional additionadditional additional additional additional additio				CN: 15-3030 F	Period: From 10/01/2017	Worksheet S- Part II	2
0 1 0 1 0 1 0 2 0 20 00 If I Ine 16 or 17 Is yes, were adjustments ander to PSR Report data for Other? Describe the other adjustments: 1 0 20 0 V/IL Date Y/IL Date Date Date Date					_	2/25/2019 11	
20.00 If I inc 16 or 17 is yes, were adjustments made to PSAR N N 20.00 21.00 Report data for Other? Describe the other adjustments: V/N Date V/N Date 21.00 Resort data for Other? Severibe the other adjustments: N N 21.00 3.00 4.00 21.00 21.00 Resort data for Other? Describe the other adjustments: N N 21.00 3.00 4.00 21.00 21.00 Resort data for Other? Describe the other adjustments: N N 21.00 N 21.00 22.00 Ikwa essets been call for for Medi care purposes? If yes, see instructions 1.00 1.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00							
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1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 N N 21.00 1.00 N N 21.00 Completing periods? If yes, see instructions. 1.00 N 21.00 Completing period? If yes, see instructions. 1.00 22.00 22.00 20.00 Have dassets been relified rom feel date date date date date and the date of appraisals made during the cost reporting period? If yes, see instructions. 22.00 20.00 Were average lastes advoct amendments to existing leases entered into during the cost reporting period? If yes, see instructions. 22.00 20.00 Were average advoct date of the depreciation account and/or boot funds (Debt Service Reserve Fund) transformed depreciation account and/or boot funds (Debt Service Reserve Fund) transformed depreciation account and/or boot funds (Debt Service Reserve Fund) transformed services? If yes, see instructions. 20.00 20.00 Have changes or new agreements or leaduring the cast reporting period? If yes, see instructions. 30.00 31.00 Have changes or new agreements or second for the service second period advoct of the second period advoct of the debt deft for the second period? If yes, see instructions. 30.00 32.00 If ine 32 is yes, we	20.00					N	20.00
21.00 Was the cost report prepared only using the provider's N N 21.00 20.00 Precords? If yes, see instructions: 1.00 20.00 Digital Related Cost 22.00 21.00 Were new Leases and/or amedments to existing Leases entered into during the cost reporting period? If yes, see Instructions. 22.00 22.00 Have there been new capitalized Leases entered into during the cost reporting period? If yes, see Instructions. 26.00 27.00 Have there been new capitalized Leases entered into during the cost reporting period? If yes, see Instructions. 27.00 28.00 Were new Leans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see Instructions. 28.00 29.00 Did the provider's capitalization policy changed during the cast reporting period? If yes, see Instructions. 29.00 20.01 Did the provider's capitalization account and/or bend finds (Debt Service Reserve Fund) 29.00 20.02 Did the provider account of If yes, see Instructions. 30.00 21.03 Distoretoot account of If yes, see Instructions. 31.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
Incords? If yes, see instructions. 1.00 Commeters by roots real networks of the field are purpose? If yes, see instructions 1.00 20.00 Have assets hear relifed for Weilcare purpose? If yes, see instructions 22.00 20.00 Have assets hear relifed for Weilcare purpose? If yes, see instructions 22.00 20.00 Have assets hear relifed for Weilcare purpose? If yes, see instructions 22.00 20.00 Have meases them relifed for Weilcare purpose? If yes, see instructions 22.00 20.00 Have meases subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 24.00 20.00 Have meases subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 26.00 20.00 Have new leans, mothage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions 28.00 20.00 Have changes our leans, mothage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions 20.00 20.00 Have changes or new agreements or instructions see instructions. 20.00 21.00 Have changes or new agreements or secure services furnished through contractual as funded depreciation account in fyes, see instructions. 30.00 31.00 Have changes or new agreements of secure services furnished through contractual as funded depreciatin account and yes, see instructions. 3				2.00		4.00	
COMPLETED BY COST RETINUEURSD AND TERM HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) 22.00 Capit Lar Related Cost 22.00 1ave assets been relifed for Medicare purposes? If yes, see instructions 23.00 20.00 Have changes occurred in the Medicare purposes? If yes, see instructions 22.00 21.00 Wave changes occurred in the Medicare depreciation expense due to apprialsals made during the cost reporting period? 24.00 25.00 Wave casets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 25.00 26.00 Wave assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, submit copy. Interest Expense 28.00 29.00 Ud the provider have a funded depreciation account and/or bord funds (bebt Service Reserve Fund) 29.00 29.00 Ud the provider have a funded depreciation account and/or bord funds (bebt Service Reserve Fund) 29.00 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 31.00 31.00 Have debt been replaced prior to its scheduled maturity without issuance of new debt? If yes, see 31.00 32.00 Thine 31 is yes, were the requirements of Sec. 2332. 2applied pertaining to competitive bidding? If yes, see instructions. 32.00 33.00 Trine 31 is yes, were there new agreements or amended existing agreements with the provider-based physiciaans? 34.00 <td>21.00</td> <td></td> <td>N</td> <td></td> <td>N</td> <td></td> <td>21.00</td>	21.00		N		N		21.00
COMPLETED BY COST RETINUEURSD AND TERM HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) 22.00 Capit Lar Related Cost 22.00 1ave assets been relifed for Medicare purposes? If yes, see instructions 23.00 20.00 Have changes occurred in the Medicare purposes? If yes, see instructions 22.00 21.00 Wave changes occurred in the Medicare depreciation expense due to apprialsals made during the cost reporting period? 24.00 25.00 Wave casets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 25.00 26.00 Wave assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, submit copy. Interest Expense 28.00 29.00 Ud the provider have a funded depreciation account and/or bord funds (bebt Service Reserve Fund) 29.00 29.00 Ud the provider have a funded depreciation account and/or bord funds (bebt Service Reserve Fund) 29.00 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 31.00 31.00 Have debt been replaced prior to its scheduled maturity without issuance of new debt? If yes, see 31.00 32.00 Thine 31 is yes, were the requirements of Sec. 2332. 2applied pertaining to competitive bidding? If yes, see instructions. 32.00 33.00 Trine 31 is yes, were there new agreements or amended existing agreements with the provider-based physiciaans? 34.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td>1.00</td> <td></td>						1.00	
22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 23.00 23.00 Have changes occurred in the Medicare depreciation expense due to apprecisals made during the cost reporting period? 23.00 23.00 Have changes occurred in the Medicare depreciation expense due to appreciation period? 24.00 23.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions. 24.00 26.00 Mere assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 26.00 27.00 Have here here new capitalized leases entered into during the cost reporting period? If yes, see instructions. 28.00 28.00 Were new lease, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 28.00 30.00 Instructions. 28.00 29.00 31.00 Interest expense 30.00 31.00 Interest expense 30.00 31.00 Have been recalled depreciation account? If yes, see instructions. 30.00 31.00 Have been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 30.00 31.00 Have been recalled bore scheduled maturity under an arrangement with the provider-b			EPT CHILDRENS H	OSPI TALS)			
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Health Financial Systems	REHABILITATION HOSP	PITAL OF FT WAYNE	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provider CCN: 15-3030	Peri od:	Worksheet S-2	
			From 10/01/2017 To 09/30/2018	Part II Date/Time Pre 2/25/2019 11:	pared: 42 am
		3.00			
Cost Report Preparer Contact Information					
41.00 Enter the first name, last name and the	title/position	REVENUE MANAGER			41.00
held by the cost report preparer in colu	mns 1, 2, and 3,				
respecti vel y.					
42.00 Enter the employer/company name of the c	ost report				42.00
preparer.					
43.00 Enter the telephone number and email add	ress of the cost				43.00
report preparer in columns 1 and 2, resp	ecti vel y.				

	Financial Systems REHA AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	BILITATION HOSP AI DATA	Provider C		Period:	u of Form CMS-2 Worksheet S-3	
105111	AL AND HOST THE HEALTH OAKE COMPLEX STATISTIC				From 10/01/2017 To 09/30/2018	Part I	pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	30.00	36			0	1.00
2.00 3.00 4.00	for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider						2.00 3.00 4.00
5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation		36	13, 14	.0 0.00	0	5. 00 6. 00 7. 00
8.00 9.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT			,			8. 00 9. 00
10. 00 11. 00 12. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						10.00 11.00 12.00
13.00 14.00 15.00	NURSERY Total (see instructions) CAH visits		36	13, 14	0 0.00	0	13.00 14.00 15.00
6.00 7.00 8.00	SUBPROVI DER – I PF SUBPROVI DER – I RF SUBPROVI DER						16.0 17.0 18.0
9.00 0.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE						19.0 20.0 21.0
2.00 3.00 4.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						22. 0 23. 0 24. 0
4. 10 5. 00	HOSPICE (non-distinct part) CMHC - CMHC	30. 00					24. 0 24. 1 25. 0 26. 0
5.00 5.25 7.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	89. 00	36			0	26. 27.
3.00 9.00 0.00	Observation Bed Days Ambulance Trips Employee discount days (see instruction)					0	28. 29. 30.
1. 00 2. 00 2. 01	Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)		0		0		31. 32. 32.
3. 00 3. 01	LTCH non-covered days LTCH site neutral days and discharges						33. 33.

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO	CN: 15-3030	Period: From 10/01/201 To 09/30/201		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	3, 305	137 1, 153	8, 2	59		1.0
3.00	HMO I PF Subprovi der	0	0				3.0
4.00	HMO I RF Subprovider	0	0				4.0
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	0	0		0		5.0
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3, 305	137		-		7.0
8.00 9.00 10.00 11.00 12.00 13.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8.0 9.0 10.0 11.0 12.0 13.0
4.00 5.00 6.00 7.00 8.00 9.00 2.00 2.00 2.00 2.00 2.00 2.00 2	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	3, 305 0	137 0	8, 2	0 0.0	0 106.46	14. (15. (16. (17. (18. (20. (21. (22. (23. (24. (24. (24. (24. (24. (24. (25. ())))))))))))))))))))))))))))))))))))
26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	0 0 0	0 0 0		0 0.0 0 0.0 0 0 0 0		
3. 00 3. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges	0 0					33. 33.

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C		Period: From 10/01/2017 To 09/30/2018	Worksheet S-3 Part I Date/Time Pre 2/25/2019 11:	
		Full Time Equivalents		Di s	scharges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 29.\ 00\\ 30.\ 00\\ 31.\ 00\\ \end{array}$	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT BURN INTENSI VE CARE UNIT SURGICAL INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVI DER - IPF SUBPROVI DER - IPF SUBPROVI DER - IRF SUBPROVI DER - IRF - SUBPROVI DER - IRF	0. 00 0. 00 0. 00	0		54 79 85 0 0 0 54 79	635	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 25.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ 00\\ 26.\ $
32.00 32.01 33.00 33.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		32.00 32.01 33.00 33.01

	Financial Systems REHABILITATION HOSPI AL WAGE RELATED COSTS	TAL OF FT WAYNE Provider CCN: 15-3030	Peri od:	u of Form CMS-2			
JSPII	AL WAGE RELATED CUSTS	Provider CCN: 15-3030	From 10/01/2017	Worksheet S-3 Part IV			
			To 09/30/2018	Date/Time Pre	pare		
				2/25/2019 11:	<u>42 a</u>		
				Amount			
				Reported	<u> </u>		
				1.00	<u> </u>		
	PART IV - WAGE RELATED COSTS						
	Part A - Core List RETIREMENT COST						
00	401K Employer Contributions			114 540	1		
00 00	Tax Sheltered Annuity (TSA) Employer Contribution			116, 548 0			
00	Nonqualified Defined Benefit Plan Cost (see instructions)			0			
00							
00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			0	4		
00	401K/TSA Plan Administration fees			0	5		
00	Legal /Accounting/Management Fees-Pension Plan			0	6		
00	Employee Managed Care Program Administration Fees			0			
00	HEALTH AND INSURANCE COST			0	'		
00	Health Insurance (Purchased or Self Funded)			0	8		
00	Health Insurance (Self Funded without a Third Party Administr	rator)		0	ľ		
02	Health Insurance (Self Funded with a Third Party Administrate			626, 415	-		
02	Health Insurance (Purchased)	л)		020, 413			
00	Prescription Drug Plan			0			
. 00	Dental, Hearing and Vision Plan			3, 008			
. 00	Life Insurance (If employee is owner or beneficiary)			5, 416			
. 00	Accident Insurance (If employee is owner or beneficiary)				12		
	Disability Insurance (If employee is owner or beneficiary)			2, 390			
. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	0		2, 390			
. 00	'Workers' Compensation Insurance	()		80, 042			
. 00	Retirement Health Care Cost (Only current year, not the extra	and party accrual require	d by FASP 104	80, 042			
0.00	Non cumulative portion)	autiliary accruai require	U DY FASE 100.	0			
	TAXES						
. 00	FICA-Employers Portion Only			431, 330	17		
	Medicare Taxes - Employers Portion Only			100, 876			
	Unemployment Insurance			100, 070			
	State or Federal Unemployment Taxes			29, 422			
. 00	OTHER			27, 422	20		
. 00	Executive Deferred Compensation (Other Than Retirement Cost F	Reported on lines 1 throu	igh 4 above (see	0	21		
. 00	instructions))			0	1 - '		
. 00	Day Care Cost and Allowances			0	22		
	Tui ti on Rei mbursement			Ő			
	Total Wage Related cost (Sum of lines 1 -23)			1, 395, 512			
	Part B - Other than Core Related Cost			., 576, 612	1 - 1		
	OTHER WAGE RELATED COSTS (SPECIFY)			23, 413	25		

RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider C		Period:	Worksheet A	
					From 10/01/2017 To 09/30/2018	Date/Time Pre 2/25/2019 11:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Trial Balance (col. 3 +-	
						col . 4)	<u> </u>
		1.00	2.00	3.00	4.00	5.00	-
	GENERAL SERVICE COST CENTERS		044 050	011.05	474 500	105 014	1 1 0
1.00	00100 CAP REL COSTS-BLDG & FIXT		311, 259				
2.00	00200 CAP REL COSTS-MVBLE EQUI P	450 (15	126, 417				
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	158, 645	36, 752				
5. 01	00570 ADMI TTI NG	88, 437	104, 586				
5. 02	00590 OTHER ADMINISTRATIVE AND GENERAL	505, 774	1, 921, 410				
7.00	00700 OPERATION OF PLANT	242, 866	534, 195				
3.00	00800 LAUNDRY & LINEN SERVICE	0	41, 578				
9.00	00900 HOUSEKEEPI NG	122, 464	29, 453				
10.00	01000 DI ETARY	376, 473	269, 519	645, 992			10.00
1.00	01100 CAFETERI A	0	0	(218, 257		11.0
13.00	01300 NURSI NG ADMI NI STRATI ON	658, 210	100, 237	758, 44	7 - 387	758, 060	13.0
14.00	01400 CENTRAL SERVICES & SUPPLY	7,439	76, 940	84, 37	-65, 403	18, 976	14.0
15.00	01500 PHARMACY	84, 286	368, 268	452, 55	4 -357,031	95, 523	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	166, 938	79, 579	246, 51	7 -2, 752	243, 765	16.00
17.00	01700 SOCIAL SERVICE	0	0		0 0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS					•	1
30.00	03000 ADULTS & PEDI ATRI CS	2, 990, 288	738, 463	3, 728, 75	1 375, 975	4, 104, 726	30. 0
	ANCI LLARY SERVICE COST CENTERS						1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	6, 513	6, 51	3 0	6, 513	54.0
50.00	06000 LABORATORY	26, 313	34, 010				
55.00	06500 RESPI RATORY THERAPY	11, 194	15, 322				
56.00	06600 PHYSI CAL THERAPY	604, 188	64, 890				
57.00	06700 OCCUPATI ONAL THERAPY	811,049	76, 279				
58.00	06800 SPEECH PATHOLOGY	401, 815	48,058				
59.00	06900 ELECTROCARDI OLOGY	0	731	73			
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		24, 817		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		325, 326		
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	86, 371	7,008				
76.00	03950 HEMODI ALYSI S & OTHER ANCI LLARY	00, 371	124, 038				
0.01	SPECIAL PURPOSE COST CENTERS	U	124, 036	124, 03		124, 030	10.0
118.00		7, 342, 750	5, 115, 505	12, 458, 25	5 577	12, 458, 832	1118 00
	NONREI MBURSABLE COST CENTERS	110121100	0,110,000	12/ 100/ 20		12/100/002	1.101.01
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	230	4, 206	4, 43	-577	3, 859	192.00
	07950 NON-REI MBURSABLE COST	0	1, 200		0 0		194.0
	07951 MARKETI NG/PUBLI C RELATI ONS	0	0		0 0		194.0
	207952 TENANT LEASED SPACE	0	0		0 0		194.0
200.00		7, 342, 980	5, 119, 711		-		

	Financial Systems REHA SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	BILITATION HOSPI	Provider CCN: 15-3030		u of Form CMS-2552 Worksheet A
REULASS	OFFICATION AND ADJUSTMENTS OF TRIAL BALANCE U	F EAPENSES		From 10/01/2017	Date/Time Prepare
				10 09/30/2018	2/25/2019 11:42 a
	Cost Center Description	Adjustments I	Net Expenses		
	·	(See A-8) Fo	or Allocation		
		6.00	7.00		
C	GENERAL SERVICE COST CENTERS				
	DO100 CAP REL COSTS-BLDG & FIXT	31, 210	517, 051		1.
2.00 0	DO200 CAP REL COSTS-MVBLE EQUIP	-93, 287	104, 610		2.
1.00 0	DO400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 048, 673		4.
5.01 0	DO570 ADMI TTI NG	-36, 741	156, 105		5.
. 02 0	00590 OTHER ADMINISTRATIVE AND GENERAL	288, 646	1, 296, 633		5.
.00 0	DO700 OPERATION OF PLANT	-6, 614	818, 812		7.
. 00 0	DO800 LAUNDRY & LINEN SERVICE	0	41, 578		8.
. 00	DO900 HOUSEKEEPI NG	0	150, 459		9.
0.00	D1000 DI ETARY	0	416, 933		10.
	01100 CAFETERI A	-82, 522	135, 735		11.
	01300 NURSI NG ADMI NI STRATI ON	0	758, 060		13.
	01400 CENTRAL SERVICES & SUPPLY	0	18, 976		14.
	D1500 PHARMACY	0	95, 523		15.
	01600 MEDICAL RECORDS & LIBRARY	0	243, 765		16.
	01700 SOCIAL SERVICE	0	245, 705		17.
	NPATIENT ROUTINE SERVICE COST CENTERS	U	0		17.
	D3000 ADULTS & PEDIATRICS	-377, 973	3, 726, 753		30.
	ANCI LLARY SERVICE COST CENTERS	-377, 773	5,720,755		
-	05400 RADI OLOGY-DI AGNOSTI C	0	6, 513		54.
	26000 LABORATORY	0	60, 267		60.
	06500 RESPI RATORY THERAPY	0	16, 969		65.
	26600 PHYSICAL THERAPY	0			66.
		0	664, 149		
1	06700 OCCUPATI ONAL THERAPY	0	885, 850		67.
	06800 SPEECH PATHOLOGY	0	449, 873		68.
	06900 ELECTROCARDI OLOGY	0	731		69.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	24, 817		71.
	07300 DRUGS CHARGED TO PATIENTS	0	325, 326		73.
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	93, 352		76.
	03950 HEMODIALYSIS & OTHER ANCILLARY	0	124, 038		76.
-	SPECIAL PURPOSE COST CENTERS				
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	-277, 281	12, 181, 551		118.
	NONREI MBURSABLE COST CENTERS	1			
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	3, 859		192.
	07950 NON-REI MBURSABLE COST	0	0		194.
	07951 MARKETI NG/PUBLI C RELATI ONS	0	0		194.
	07952 TENANT LEASED SPACE	0	0		194.
200.00	TOTAL (SUM OF LINES 118 through 199)	-277, 281	12, 185, 410		200.

Health Financial Systems RECLASSIFICATIONS

REHABILITATION HOSPITAL OF FT WAYNE Provider CCN: 15-3030

In Lieu of Form CMS-2552-10

Period: Worksheet A-6 From 10/01/2017 To 09/30/2018 Date/Time Prepared:

					To 09/30/2018 Date/Time Pr 2/25/2019 11	
		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1 00	A - EMPLOYEE BENEFITS	1.00		050,400		1 00
1.00 2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00 0.00	0	853, 490 0		1.00 2.00
2.00		0.00		0		3.00
3.00		0.00	0	<u>853, 490</u>		3.00
	B - RENTAL AND LEASE		UU	033, 470		_
1.00	CAP REL COSTS-MVBLE EQUI P	2.00	0	71, 480		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00			<u>0</u>	0		14.00
			0	71, 480		_
1 00	C - OTHER CAPITAL COSTS CAP REL COSTS-BLDG & FIXT	1.00	0	14 124		1 00
1.00 2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	14, 134 160, 448		1.00 2.00
2.00	CAP REL COSTS-BLDG & FIXI		<u>0</u>	174, 582		2.00
	D - REPAIRS & MAINTENANCE COS		U	174, 302		_
1.00	OPERATION OF PLANT	7.00	0	50, 141		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
			0	50, 141		_
1.00	E - MEDICAL SUPPLIES MEDICAL SUPPLIES CHARGED TO	71.00	0	24 017		1.00
1.00	PATIENT	71.00	0	24, 817		1.00
		+	— — — ₀	24,817		
	F - DRUGS CHARGED TO PATIENTS		0	24,017		_
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	325, 326		1.00
1.00			0	325, 326		1.00
	G - PHYSICIAN DIRECOTRS			0207 020		_
1.00	ADULTS & PEDIATRICS	30.00	0	377, 973		1.00
			0	377, 973		
	H – DIETARY					
1.00	CAFETERI A	11.00	121, 770	96, 487		1.00
	0		121, 770	96, 487		
500.00	Grand Total: Increases		121, 770	1, 974, 296		500.00

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	IS

REHABILITATION HOSPITAL OF FT WAYNE Provider CCN: 15-3030

In Lieu of Form CMS-2552-10

Period: Worksheet A-6 From 10/01/2017 To 09/30/2018 Date/Time Prepared:

					lo	09/30/2018 Date/lime 2/25/2019	
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE AND	5.02	0	853, 163	0		1.00
	GENERAL						
2.00	NURSING ADMINISTRATION	13.00	0	324			2.00
3.00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	•	3	<u> </u>		3.00
			0	853, 490			_
1 00	B - RENTAL AND LEASE	4.00			10		1.00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	214			1.00
2.00 3.00	ADMI TTI NG OTHER ADMI NI STRATI VE AND	5.01 5.02	0	177 2, 910			2.00
3.00	GENERAL	5.02	0	2,910	0		3.00
4.00	OPERATION OF PLANT	7.00	0	1, 776	0		4.00
5.00	DI ETARY	10.00	0	1, 312			5.00
6.00	NURSING ADMINISTRATION	13.00	0	23			6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	28, 198			7.00
8.00	PHARMACY	15.00	0	24, 265			8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	2, 752			9.00
10.00	ADULTS & PEDIATRICS	30.00	0	59			10.00
11.00	RESPI RATORY THERAPY	65.00	0	9, 547	0		11.00
12.00	PHYSI CAL THERAPY	66.00	0	121	0		12.00
13.00	PSYCHI ATRI C/PSYCHOLOGI CAL	76.00	0	27	0		13.00
	SERVICES						
14.00	PHYSICIANS' PRIVATE OFFICES	<u> </u>	0	99			14.00
	0		0	71, 480			
	C - OTHER CAPITAL COSTS		-				
1.00	OTHER ADMINI STRATI VE AND	5.02	0	174, 582	12		1.00
2.00	GENERAL	0.00		0	10		2.00
2.00	<u> </u>		0	174, 582	<u>13</u>		2.00
	D - REPAIRS & MAINTENANCE COS	27	U	174, 302	· .		
1.00	OTHER ADMINI STRATI VE AND	5.02	0	10, 569	0		1.00
1.00	GENERAL	5.02	0	10, 307	0		1.00
2.00	HOUSEKEEPING	9.00	0	1, 458	o		2.00
3.00	DI ETARY	10.00	0	9, 490			3.00
4.00	NURSING ADMINISTRATION	13.00	0	40			4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	12, 388	0		5.00
6.00	PHARMACY	15.00	0	7,440	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	1, 939	0		7.00
8.00	LABORATORY	60.00	0	56	0		8.00
9.00	PHYSI CAL THERAPY	66.00	0	4, 808	0		9.00
10.00	OCCUPATI ONAL THERAPY	67.00	0	1, 478	0		10.00
11.00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0	475	0		11.00
	0		0	50, 141			
	E - MEDI CAL SUPPLI ES				1		
1.00	CENTRAL SERVICES & SUPPLY		•	2 <u>4, 8</u> 17			1.00
	0		0	24, 817			
	F - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	<u>15.00</u>		325, 326			1.00
			0	325, 326			_
1 00	G - PHYSICIAN DIRECOTRS	5 02	0	277 072			1 00
1.00	OTHER ADMINISTRATIVE AND	5.02	U	377, 973	0		1.00
	<u>GENERAL</u>	+	— — — 	377, 973	┼── ── ┤		
	H – DIETARY		U	311, 713			_
1.00	DIETARY	10.00	121, 770	96, 487	0		1.00
1.00		<u> </u>	121, 770	9 <u>0, 407</u> 96, 487			1.00
500 00	Grand Total: Decreases		121, 770	1, 974, 296			500.00
000.00		I	.21,770	., // 1, 2/0	1 I		1000.00

REHABILITATION HOSPITAL OF FT WAYNE In Provider CCN: 15-3030 Period: From: 10 /01 /02 From: 10 /01 /02

In Lieu of Form CMS-2552-10 Worksheet A-7

					Fror To	m 10/01/2017 09/30/2018	Part I Date/Time Pre 2/25/2019 11:	
				Acqui si ti on:	s			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	900, 000			0	0	0	1.00
2.00	Land Improvements	276, 453			0	11, 840	0	2.00
3.00	Buildings and Fixtures	11, 859, 432			0	38, 136	0	3.00
4.00	Building Improvements	969, 738	228, 568		0	228, 568	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	0	0		0	0	0	6.00
7.00	HIT designated Assets	7, 715	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14, 013, 338	278, 544		0	278, 544	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	14, 013, 338	278, 544		0	278, 544	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						1.00
2.00	Land Improvements	288, 293	0					2.00
3.00	Buildings and Fixtures	11, 897, 568	0					3.00
4.00	Building Improvements	1, 198, 306	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	0	0					6.00
7.00	HIT designated Assets	7, 715	0					7.00
8.00	Subtotal (sum of lines 1-7)	14, 291, 882	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	14, 291, 882	0					10.00

Heal th	Financial Systems REHA	BILITATION HOSE	PITAL OF FT WAY	/NE	In Lieu of Form CMS-2552-10		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-3030	Peri od:	Worksheet A-7	
					From 10/01/2017		nored.
					To 09/30/2018	Date/Time Pre 2/25/2019 11:	
			SL	JMMARY OF CAP	I TAL	272072017 11.	
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	311, 259	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	126, 417			0 0	0	2.00
3.00	Total (sum of lines 1-2)	437, 676			0 0	0	3.00
		SUMMARY O	F CAPITAL				
							
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	15.00				
	DADT ILL DECONCLULATION OF ANOUNTS FROM WORK	14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	CSHEET A, COLUM					
1.00	CAP REL COSTS-BLDG & FIXT	0	311, 259				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	126, 417				2.00
3.00	Total (sum of lines 1-2)	0	437, 676				3.00

			F	eriod: rom 10/01/2017 o 09/30/2018	Worksheet A-7 Part III Date/Time Prep 2/25/2019 11:4	pared	
	COM	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPIT.					
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COST	<u> </u>	1		1 1			
00 CAP REL COSTS-BLDG & FIXT 00 CAP REL COSTS-MVBLE EQUIP 00 Total (sum of lines 1-2)	13, 085, 861 1, 206, 021 14, 291, 882	0	13, 085, 861 1, 206, 021 14, 291, 882	0. 084385	0 0	1.0 2.0 3.0	
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COST	S CENTERS						
00 CAP REL COSTS-BLDG & FIXT 00 CAP REL COSTS-MVBLE EQUIP 00 Total (sum of lines 1-2)	0	0			0 71, 480 71, 480	1. 2. 3.	
		0	IMMARY OF CAPIT		, 1, 400		
Cost Center Description		Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COST		1					
00 CAP REL COSTS-BLDG & FIXT	46, 645	14, 134	160, 448	0	517,051	1.	

Heal th Financial Systems	REHAE	BILITATION HOSE	PITAL OF FT WAYNE		u of Form CMS-2	
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-3030	Period: From 10/01/2017 To 09/30/2018	Worksheet A-8 Date/Time Pre 2/25/2019 11:	pared:
			Expense Classification o To/From Which the Amount is			
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00 Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00 0	1.00
COSTS-BLDG & FIXT (chapter 2)						
 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2) Investment income - other 		0	CAP REL COSTS-MVBLE EQUIP	2.00 0.00		2.00 3.00
(chapter 2) 4.00 Trade, quantity, and time		0		0.00	0	4.00
di scounts (chapter 8) 5.00 Refunds and rebates of		0		0.00		5.00
expenses (chapter 8)		0				
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		
7.00 Tel ephone services (pay stations excluded) (chapter 21)	A	-2, 886	CAP REL COSTS-MVBLE EQUIP	2.00	9	7.00
8.00 Television and radio service (chapter 21)		0		0.00	9	8.00
9.00 Parking lot (chapter 21) 10.00 Provider-based physician adjustment	A-8-2	0 -377, 973		0.00	0 0	9. 00 10. 00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	412, 127			0	12.00
13.00 Laundry and Linen service 14.00 Cafeteria-employees and guests	s B	0	CAFETERI A	0.00 11.00		
15.00 Rental of quarters to employee			CAP REL COSTS-BLDG & FIXT	1.00		15.00
and others 16.00 Sale of medical and surgical supplies to other than		0		0.00	0	16.00
patients 17.00 Sale of drugs to other than patients		О		0.00	0	17.00
18.00 Sale of medical records and		0		0.00	0	18.00
abstracts 19.00 Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
20.00 Vending machines	В		OTHER ADMI NI STRATI VE AND GENERAL	5.02	0	20. 00
21.00 Income from imposition of interest, finance or penalty		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	0		0.00	0	22. 00
23.00 Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 00
(chapter 21) 26.00 Depreciation - CAP REL	A	-12, 120	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-124, 242	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***			28.00
 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of 	A-8-3	0 0	OCCUPATI ONAL THERAPY	0. 00 67. 00		29.00 30.00
limitation (chapter 14) 30.99 Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
instructions) 31.00 Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

Heal th	Financial Systems	REHA	BILITATION HOSI	PITAL OF FT WAYNE	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 10/01/2017 To 09/30/2018		
				Expense Classification or	n 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.	
		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
				GENERAL			
33.02	PATIENT TELEPHONE EXPENSE	A		OTHER ADMINISTRATIVE AND	5.02	0	33.02
				GENERAL	7.00		
33.03	PATIENT TV CABLE EXPENSE	A		OPERATION OF PLANT	7.00		33.03
33.06	CHARI TABLE CONTRI BUTI ONS	A		OTHER ADMINISTRATIVE AND	5.02	0	33.06
				GENERAL			
50.00	TOTAL (sum of lines 1 thru 49)		-277, 281				50.00
	(Transfer to Worksheet A,						
	column 6 line 200)						

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

 (2) Basis for adjustment (see instructions).

(2) basis for adjustment (see first definis).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CMS-255.									
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Period:	Worksheet A-8	3-1				
OFFICE	COSTS			From 10/01/2017 To 09/30/2018	Date/Time Pre 2/25/2019 11:	epared: 42 am				
	Line No.	Cost Center	Expense Items	Amount of	Amount					
				Allowable Cost						
					Wks. A, column					
					5					
	1.00	2.00	3.00	4.00	5.00					
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:									
1.00		CAP REL COSTS-BLDG & FIXT	CAPITAL - RELATED INTEREST	46, 645	0	1.00				
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAP COSTS - BLDG & FIXT	228	0	2.00				
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAP COSTS - MOVEABLE EQ	40	0	3.00				
4.00	5. 01	ADMI TTI NG	PASI OPERATING COSTS	3, 591	3, 168	4.00				
4.01	5. 02	OTHER ADMINISTRATIVE AND GEN	SHARED SERVICE CENTER ALLOCA	124, 947	25, 821	4.01				
4.02	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	5, 350	0	4.02				
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVEABLE EQUIP	33, 801	0	4.03				
4.04	5. 02	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL HOME OFFICE COST	342, 389	0	4.04				
4.05	5. 02	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE COSTS	11, 289	90, 000	4.05				
4.06	5. 01	ADMI TTI NG	HIIM ALLOCATION	0	37, 150	4.06				
4.07	5. 01	ADMI TTI NG	PASI LIEN UNIT COLLECTION FE	0	14	4.07				
5.00	TOTALS (sum of lines 1-4).			568, 280	156, 153	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	
		Ownership		Ownershi p	
1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

i ci indui i						
6.00	В		0.00	COMMUNITY HEALT	100.00	6.00
7.00	В		0.00	LUTHERAN	100.00	7.00
8.00	G	HOSPI TAL 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	NON-FI NANCI AL				100.00
	non-financial) specify:					

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.B. Corporation, partnership, or other organization has financial interest in provider.

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

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

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

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

Health Financial Systems	REHABILITATION HOSPITA	In Lieu of Form CMS-2552-10			
STATEMENT OF COSTS OF SERVICES FROM R	ELATED ORGANIZATIONS AND HOME	Provider CCN: 15-3030		Worksheet A-8-1	
OFFICE COSTS			From 10/01/2017		
			To 09/30/2018	Date/Time Prepared:	
				0 105 10010 11 10	

					2/25/2019 11:	42 am
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED C	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:				
1.00	46, 645	11				1.00
2.00	228	9				2.00
3.00	40	9				3.00
4.00	423	0				4.00
4.01	99, 126	0				4.01
4.02	5, 350	9				4.02
4.03	33, 801	9				4.03
4.04	342, 389	0				4.04
4.05	-78, 711	0				4.05
4.06	-37, 150	0				4.06
4.07	-14	0				4.07
5.00	412, 127					5.00
				c		

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 not been nosted to Worksheet A columns 1 and/or 2, the amount allowable should be indicated in column 4 of this par

nas no	L DEEL PUSTED TO MOLKSHEET A,	COT UNITS	Ζ, ι	the amount	arrowabre	Shouru	be mulcate	4 01	this part.	
	Related Organization(s)									
	and/or Home Office									
	Type of Business	1								
	6, 00	1								
			(C) AN							

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

rermbur		
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 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

Heal th	Financial Syste	ems RFI	HABILITATION HOS	SPITAL OF FT WA	YNF	Inlie	eu of Form CMS-	2552-10
	R BASED PHYSIC				CCN: 15-3030	Period: From 10/01/2017 To 09/30/2018	Worksheet A-8 Date/Time Pre	3-2 epared:
							2/25/2019 11:	42 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der		Physi ci an/Prov	
		Identifier	Remunerati on	Component	Component		ider Component	
	1.00	0.00			5.00	(Hours	
1.00	1.00	2.00	3.00	4.00	5.00	6.00	7.00	1.00
1.00		ADULTS & PEDIATRICS	377, 973			0 0	0	
2.00	0.00		0	-		0 0		
3.00	0.00		0	-		0 0	0	
4.00	0.00		0	0		0 0	0	
5.00	0.00		0	0		0 0	0	
6.00	0.00		0	0		0 0	0	6.00
7.00	0.00		0	0		0 0	0	
8.00	0.00		0	0		0 0	0	0.00
9.00	0.00		0	0	(0 0	0	1.00
10.00	0.00		0	0	(0 0	0	10.00
200.00			377, 973		(0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		Identifier	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0	, s		0 0	0	
2.00	0.00		0	-		0 0	0	
3.00	0.00		0	0		0 0	0	
4.00	0.00		0	0		0 0	0	
5.00	0.00		0	0		0 0	0	
6.00	0.00		0	0		0 0	0	
7.00	0.00		0	0	(0 0	0	
8.00	0.00		0	0	(0 0	0	8.00
9.00	0.00		0	0		0 0	0	
10.00	0.00		0	0		0 0	0	
200.00			0	0		0 0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	0.00	14	14.00	17.00	10.00		
1.00	1.00	2.00	15.00	16.00	17.00	18.00		1.00
1.00		ADULTS & PEDIATRICS	0			377, 973		1.00
2.00	0.00		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				10.00
200.00			0	0	(377, 973		200. 00

REHABILITATION HOSPITAL OF FT WAYNE Provider CCN: 15-3030

In Lieu of Form CMS-2552-10 Period: Worksheet B From 10/01/2017 Part I

					rom 10/01/2017 o 09/30/2018	Part I	narod:
				1	0 09/30/2018	Date/Time Pre 2/25/2019 11:	
			CAPI TAL REL	ATED COSTS		272072017 11.	
			0/11/1/12 1122	21120 00010			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMI TTI NG	
		for Cost			BENEFITS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)					
		0	1.00	2.00	4.00	5. 01	
	GENERAL SERVICE COST CENTERS			•			
1.00	00100 CAP REL COSTS-BLDG & FIXT	517, 051	517, 051				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	104, 610		104, 610			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1,048,673	2, 086	520	1, 051, 279		4.00
5.01	00570 ADMI TTI NG	156, 105	10, 744	2, 677	12, 941	182, 467	5.01
5.02	00590 OTHER ADMINISTRATIVE AND GENERAL	1, 296, 633	40, 693	10, 138	74,009	0	5.02
7.00	00700 OPERATION OF PLANT	818, 812	94, 718		35, 538	0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	41, 578	0	C		0	8.00
9.00	00900 HOUSEKEEPI NG	150, 459	10, 233	2, 549	17, 920	0	9.00
10.00	01000 DI ETARY	416, 933	0			0	10.00
11.00	01100 CAFETERIA	135, 735	39, 535	9, 850		0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	758,060	1, 107	276		0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	18, 976	7, 815			0	14.00
15.00	01500 PHARMACY	95, 523	3, 312			0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	243, 765	3, 797			0	16.00
17.00	01700 SOCIAL SERVICE	243,703	2,460			0	17.00
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	U0	2,400	013	0	0	17.00
30.00	03000 ADULTS & PEDIATRICS	3, 726, 753	65, 833	16, 401	437, 570	64, 900	30.00
00.00	ANCI LLARY SERVICE COST CENTERS	011201100	00,000	10,101	1077070	01,700	00100
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 513	3, 661	912	0	2, 194	54.00
60.00	06000 LABORATORY	60, 267	0,001			6,048	60.00
65.00	06500 RESPIRATORY THERAPY	16, 969	851	212		149	65.00
66,00	06600 PHYSI CAL THERAPY	664, 149	85, 907	21, 403		26, 176	66.00
67.00	06700 OCCUPATI ONAL THERAPY	885, 850	40, 557	10, 104		27, 410	67.00
68.00	06800 SPEECH PATHOLOGY	449, 873	3, 073			15, 186	68.00
69.00	06900 ELECTROCARDI OLOGY	731	0,0,0	0		142	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	24, 817	0		-	3,006	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	325, 326	0		-	31, 189	73.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	93, 352	3, 507	-	-	3, 174	76.00
76.01	03950 HEMODIALYSIS & OTHER ANCILLARY	124, 038	3, 307			2, 893	76.01
70.01	SPECIAL PURPOSE COST CENTERS	124,030	0		0	2,075	70.01
118.00		12, 181, 551	419, 889	104, 610	1,051,245	182, 467	118 00
110.00	NONREI MBURSABLE COST CENTERS	12, 101, 001	417,007	104,010	1,001,240	102,407	110.00
192 00	19200 PHYSI CLANS' PRI VATE OFFI CES	3, 859	0	C	34	0	192.00
	07950 NON-REI MBURSABLE COST	3,037	0				194.00
	07951 MARKETI NG/PUBLI C RELATI ONS	0	0		0		194.00
	07952 TENANT LEASED SPACE	0	97, 162	-	0		194.02
200.00		0	77, 102		0	0	200.00
200.00	5		0		0	0	200.00
201.00		12, 185, 410	517,051	104, 610	1, 051, 279		
202.00		1 12, 100, 410	517,051	1 104,010	1,001,277	102,407	202.00

Heal th	Financial Systems REHA	BILITATION HOSI	PITAL OF FT WAY	YNE	In Lie	u of Form CMS-:	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 10/01/2017 To 09/30/2018	Worksheet B Part I Date/Time Pre 2/25/2019 11:	pared: 42 am
	Cost Center Description	Subtotal	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPING	42 am
			ADMI NI STRATI VE		LINEN SERVICE	nooceneer mo	
			AND GENERAL				
		5A. 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						5.01
5.02	00590 OTHER ADMINISTRATIVE AND GENERAL	1, 421, 473	1, 421, 473				5.02
7.00	00700 OPERATION OF PLANT	972, 665	128, 449	1, 101, 11	4		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	41, 578	5, 491		0 47,069		8.00
9.00	00900 HOUSEKEEPI NG	181, 161	23, 924	30, 55	1 0	235, 636	9.00
10.00	01000 DI ETARY	454, 203	59, 982		0 0	0	10.00
11.00	01100 CAFETERI A	202, 938	26, 800	118, 03	6 0	35, 637	11.00
13.00	01300 NURSING ADMINISTRATION	855, 758	113, 011	3, 30	4 0	998	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	29, 827	3, 939	23, 33	3 0	7,044	14.00
15.00	01500 PHARMACY	111, 993				2, 985	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	272, 936				3, 422	
17.00	01700 SOCIAL SERVICE	3,073				2, 218	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS		•	• · · ·	-4		
30.00	03000 ADULTS & PEDIATRICS	4, 311, 457	569, 364	196, 54	9 26, 402	59, 341	30.00
	ANCILLARY SERVICE COST CENTERS		•	·			
54.00	05400 RADI OLOGY-DI AGNOSTI C	13, 280	1, 754	10, 92	9 0	3, 300	54.00
60.00	06000 LABORATORY	70, 165	9, 266		0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	19, 819	2, 617	2, 54	2 0	767	65.00
66.00	06600 PHYSI CAL THERAPY	886, 045	117, 010	256, 48	3 9, 801	77, 435	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 082, 601	142, 967	121, 08	6 10, 866	36, 557	67.00
68.00	06800 SPEECH PATHOLOGY	527, 695	69, 687	9, 17	6 0	2, 770	68.00
69.00	06900 ELECTROCARDI OLOGY	873	115		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	27, 823	3, 674		0 0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	356, 515	47, 081		0 0	0	73.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	113, 546	14, 995	10, 47	2 0	3, 162	76.00
76.01	03950 HEMODIALYSIS & OTHER ANCILLARY	126, 931	16, 762		0 0	0	76.01
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	12, 084, 355	1, 408, 128	811, 03	0 47, 069	235, 636	118.00
	NONREI MBURSABLE COST CENTERS		•				1
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	3, 893	514		0 0	0	192.00
	07950 NON-REI MBURSABLE COST	0	0		0 0	0	194.00
194.01	07951 MARKETING/PUBLIC RELATIONS	0	0		0 0	0	194.01
194.02	07952 TENANT LEASED SPACE	97, 162	12, 831	290, 08	4 0	0	194.02
200.00		0					200.00
201.00		0	0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	12, 185, 410	1, 421, 473	1, 101, 11	4 47,069	235, 636	202.00
			•		•		•

Heal th	Financial Systems REHA	BILITATION HOSPI	TAL OF FT WAY	YNE	In Lie	u of Form CMS-25	52-10
	ALLOCATION - GENERAL SERVICE COSTS			CN: 15-3030	Period: From 10/01/2017 To 09/30/2018	2/25/2019 11:42	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI (SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS			1			
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						5.02
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	514, 185					10.00
11.00	01100 CAFETERI A	0	383, 411				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	40, 900				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	998		0 65, 141		14.00
15.00	01500 PHARMACY	0	4, 190				15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	13, 168		0 383		16.00
17.00	01700 SOCIAL SERVICE	0	0)	0 0	0 1	17.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1			
30.00	03000 ADULTS & PEDIATRICS	514, 185	211, 732	974, 21	6 54, 762	0 3	30.00
	ANCI LLARY SERVICE COST CENTERS	-		1			
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0		54.00
60.00	06000 LABORATORY	0	4, 289				60.00
65.00	06500 RESPI RATORY THERAPY	0	848				65.00
66.00	06600 PHYSI CAL THERAPY	0	38, 655		0 1,975		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	45, 189		0 4, 274		67.00
68.00	06800 SPEECH PATHOLOGY	0	19, 103		0 830		68.00
69.00	06900 ELECTROCARDI OLOGY	0	0)	0 0		69.00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0)	0 0		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1 200		0 0		73.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	4, 289		0 124	-	76.00
76.01	03950 HEMODIALYSIS & OTHER ANCILLARY	0	0		0 163	0 7	76. 01
440.00	SPECIAL PURPOSE COST CENTERS	544.405	000.0/4	1 010 00	(0.005	474 005 4/	10.00
118.00		514, 185	383, 361	1, 013, 89	63, 935	171, 305 11	18.00
400.00	NONREI MBURSABLE COST CENTERS			-	10		
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	50		75 12		92.00
	07950 NON-REI MBURSABLE COST	0	0		0 0	-	94.00
	07951 MARKETI NG/PUBLI C RELATI ONS	0	0		0 1, 194		94.01
	207952 TENANT LEASED SPACE	0	U		0		94.02
200.00			~				00.00
201.00			202 /11	1 010 0			01.00
202.00	TOTAL (sum lines 118 through 201)	514, 185	383, 411	1, 013, 97	65, 141	171, 305 20	JZ. UU

IST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 10/01/2017 To 09/30/2018	Date/Time Pre 2/25/2019 11:	
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
00 00100 CAP REL COSTS-BLDG & FIXT						1.0
00 00200 CAP REL COSTS-MVBLE EQUIP						2.0
00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
01 00570 ADMI TTI NG						5.0
02 00590 OTHER ADMINISTRATIVE AND GENERAL						5.0
00 00700 OPERATION OF PLANT						7.0
00 00800 LAUNDRY & LINEN SERVICE						8. (
00 00900 HOUSEKEEPI NG						9.1
0. 00 01000 DI ETARY						10. (
. 00 01100 CAFETERI A						11.
8. 00 01300 NURSING ADMINISTRATION						13.
. 00 01400 CENTRAL SERVICES & SUPPLY						14.
5. 00 01500 PHARMACY						15.
0. 00 01600 MEDICAL RECORDS & LIBRARY	337, 289					16.
7.00 01700 SOCIAL SERVICE	0	13, 043				17.0
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	110 070	12 042	7 051 0		7 051 024	1 20
0. 00 03000 ADULTS & PEDIATRICS	119, 973	13, 043	7,051,02	24 0	7, 051, 024	30.
ANCI LLARY SERVI CE COST CENTERS	4,055	0	22.25	18 0	22.210	54.
00 05400 RADI 0LOGY-DI AGNOSTI C 00 06000 LABORATORY		0	33, 3		33, 318	
5. 00 06500 RESPI RATORY THERAPY	11, 180 275	0	103, 59		103, 598	
0. 00 06600 PHYSI CAL THERAPY	48, 385	0	31, 8		31, 814	
2. 00 06700 OCCUPATIONAL THERAPY	48, 383 50, 666	0	1, 435, 78 1, 494, 20		1, 435, 789 1, 494, 206	
3. 00 06800 SPEECH PATHOLOGY	28, 071	0	657, 3		657, 332	
2. 00 06900 ELECTROCARDI OLOGY	262	0	1, 2		1, 250	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 557	0	37, 0		37,054	
8. 00 07300 DRUGS CHARGED TO PATIENTS	57,651	0	632, 5		632, 552	
0. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	5,866	0	152, 45		152, 454	
b. 01 03950 HEMODI ALYSI S & OTHER ANCI LLARY	5,348	0	149, 20			
SPECIAL PURPOSE COST CENTERS	0,010				117/201	1 / 0.
8.00 SUBTOTALS (SUM OF LINES 1 through 117)	337, 289	13, 043	11, 779, 59	95 0	11, 779, 595	1118.
NONREI MBURSABLE COST CENTERS		,			,,	1
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	4, 54	14 0	4, 544	192.
4. 00 07950 NON-REI MBURSABLE_COST	0	0	.10	0 0		194.
24. 01 07951 MARKETI NG/PUBLI C RELATI ONS	0	Ő	1, 10		1, 194	
04. 02 07952 TENANT LEASED SPACE	0	0	400, 0		400, 077	
00.00 Cross Foot Adjustments		-		0 0		200.
11.00 Negative Cost Centers	0	0		0 0		201.
D2.00 TOTAL (sum lines 118 through 201)	337, 289	13, 043	12, 185, 4 ⁻			

Heal th	Fina	inci a	al S	yste	ems	
		0F	CΔΡΙ	ΤΔΙ	RELATED	C

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

ALLOCATION OF CAPIT			Provider CO	CN: 15-3030 P F T	eriod: rom 10/01/2017 o 09/30/2018		pared:
Cost Ce	enter Description	Directly Assigned New Capital Related Costs	CAPI TAL REI BLDG & FI XT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	CE COST CENTERS	1					
2.00 00200 CAP REL	. COSTS-BLDG & FIXT . COSTS-MVBLE EQUIP E BENEFITS DEPARTMENT	0	2, 086	520	2, 606	2, 606	1.00 2.00 4.00
5.01 00570 ADMI TTI	NG	0	10, 744	2,677	13, 421	32	5.01
	DMINISTRATIVE AND GENERAL	0	40, 693			184	5.02
7.00 00700 OPERATI		0	94, 718			88	7.00
8.00 00800 LAUNDRY	& LINEN SERVICE	0	0			0	8.00
9.00 00900 HOUSEKE		0	10, 233	2, 549	12, 782	44	9.00
10. 00 01000 DI ETARY	,	0	0	0	0	92	10.00
11.00 01100 CAFETER	I A	0	39, 535	9, 850	49, 385	44	11.00
	ADMINI STRATI ON	0	1, 107	276		239	13.00
	SERVICES & SUPPLY	0	7, 815			3	14.00
15.00 01500 PHARMAC	Υ	0	3, 312	825	4, 137	31	15.00
16.00 01600 MEDI CAL	RECORDS & LI BRARY	0	3, 797	946	4, 743	61	16.00
17.00 01700 SOCIAL		0	2, 460	613	3, 073	0	17.00
INPATIENT ROL	JTINE SERVICE COST CENTERS						
30.00 03000 ADULTS		0	65, 833	16, 401	82, 234	1, 084	30.00
ANCI LLARY SER	RVICE COST CENTERS						
	IGY-DI AGNOSTI C	0	3, 661	912		0	
60.00 06000 LABORAT		0	0	-		10	
65. 00 06500 RESPI RA		0	851	212		4	65.00
66. 00 06600 PHYSI CA		0	85, 907			219	1
	IONAL THERAPY	0	40, 557			294	
68.00 06800 SPEECH		0	3, 073			146	
69.00 06900 ELECTRO		0	0	0	0	0	
	SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
	HARGED TO PATIENTS	0	0	0	0	0	
	TRI C/PSYCHOLOGI CAL SERVI CES	0	3, 507			31	76.00
	LYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
	DSE COST CENTERS		410,000	104 (10	F04 400	2 (0)	110 00
	LS (SUM OF LINES 1 through 117)	0	419, 889	104, 610	524, 499	2,606	118.00
	BLE COST CENTERS		0	0		0	102.00
192.00 19200 PHYSICI 194.00 07950 NON-REI	ANS' PRIVATE OFFICES	0	0	0	-		192.00
194.00/07950 NON-RET 194.01/07951 MARKETI		0	0		0		194.00 194.01
194. 01 07951 MARKETT 194. 02 07952 TENANT		0	97, 162		0 97, 162		194.01
	oot Adjustments	0	97, 102		97, 102	0	200.00
	ve Cost Centers		0	_	0	0	200.00
	sum lines 118 through 201)	0	517, 051	104, 610	621, 661		201.00
202.00 TOTAL (Sum Tries fro through 201)	0	1 317,031	1 104,010	021,001	∠,000	202.00

Heal th	Financial Systems REHA	BILITATION HOSE	PITAL OF FT WAY	/NE	In Lie	eu of Form CMS-2	2552-10
	ATION OF CAPITAL RELATED COSTS	,	Provider C	F	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part II	pared:
	Cost Center Description	ADMI TTI NG	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
			ADMI NI STRATI VE	PLANT	LINEN SERVICE		
		F 01	AND GENERAL	7.00	0.00	0.00	
	GENERAL SERVICE COST CENTERS	5.01	5.02	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT			1			1.00
2.00	00200 CAP REL COSTS-BEDG & FIXT						2.00
2.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.00 5.01	00570 ADMITTING	10 450					4.00 5.01
5.01	00590 OTHER ADMINISTRATIVE AND GENERAL	13, 453	51, 015				5.01
5.02 7.00	00590 OTHER ADMINISTRATIVE AND GENERAL	0	4, 609				5.02 7.00
7.00 8.00		0	4, 609				8.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	859			17 009	
		0				17, 098	
10.00		0	2, 152			-	10.00
11.00		0	962			2, 586	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	4,055			72	•
14.00	01400 CENTRAL SERVICES & SUPPLY	0	141	2,60		511	
15.00	01500 PHARMACY	0	531	1, 105		217	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	1, 293			248	
17.00	01700 SOCIAL SERVICE	0	15	82	0	161	17.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4, 785	20 427	21.050	111	4 204	20.00
30.00	03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS	4, 785	20, 437	21, 958	3 111	4, 306	30.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	140	4.2	1 22	0	220	
	06000 LABORATORY	162	63				
60.00		446	333		-	0	
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	11			-		
66.00 67.00	06700 OCCUPATI ONAL THERAPY	1, 930				5, 619	
67.00	06800 SPEECH PATHOLOGY	2, 021 1, 120	5, 130	13, 52 1, 025			
68.00 69.00	06900 ELECTROCARDI OLOGY	1, 120		1, 023		201	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	222	132		-		
73.00	07300 DRUGS CHARGED TO PATTENT	2,299	-		-		
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 299			-	229	
76.00	03950 HEMODI ALYSI S & OTHER ANCI LLARY	213	602				
70.01	SPECIAL PURPOSE COST CENTERS	213	002		0	0	70.01
118.00		13, 453	50, 537	90, 606	197	17, 098	110 00
110.00	NONREI MBURSABLE COST CENTERS	15,455		90, 800	0 197	17,090	110.00
102.00	19200 PHYSICIANS' PRIVATE OFFICES	0	18		0 0	0	192.00
	007950 NON-REIMBURSABLE COST	0			-		192.00
	107950 NON-RETING/PUBLIC RELATIONS				-	-	194.00
	207952 TENANT LEASED SPACE	0	460				194.01
200.00		0	400	32,400		0	200.00
200.00		0	0		0	0	200.00
201.00	5	13, 453	, s		, O		
202.00		1 15,455	1 51,015	1 125,012	- 177	17,070	202.00

Heal th	Financial Systems REHAI	BILITATION HOSPI	TAL OF FT WAY	YNE	In Lie	eu of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C		Peri od: From 10/01/2017 To 09/30/2018	Date/Time Pre 2/25/2019 11:	
	Cost Center Description	DI ETARY		NURSI NG ADMI NI STRATI (SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS			1			
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						5.02
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	2, 244					10.00
11.00	01100 CAFETERI A	0	66, 164				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	7, 058				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	172		0 13, 196		14.00
15.00	01500 PHARMACY	0	723		57 0		
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	2, 272		0 78		
17.00	01700 SOCI AL SERVI CE	0	0		0 0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00	03000 ADULTS & PEDIATRICS	2, 244	36, 538	12, 6	50 11, 094	0	30.00
	ANCI LLARY SERVICE COST CENTERS	-		1		-	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0		
60.00	06000 LABORATORY	0	740		11 25		
65.00	06500 RESPI RATORY THERAPY	0	146		47 263		
66.00	06600 PHYSI CAL THERAPY	0	6, 671		0 400		
67.00	06700 OCCUPATIONAL THERAPY	0	7, 798		0 866		
68.00	06800 SPEECH PATHOLOGY	0	3, 297		0 168		
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	-	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	-	
73.00	07300 DRUGS CHARGED TO PATI ENTS 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	.,	
76.00		0	740		0 25 0 33		
76. 01	03950 HEMODIALYSIS & OTHER ANCILLARY	U	0	1	0 33	0	76. 01
110.00	SPECIAL PURPOSE COST CENTERS	2.244	(/ 155	10.1	10.050	7 101	1110 00
118.00		2, 244	66, 155	13, 1	75 12, 952	7, 101	118.00
100.00	NONREI MBURSABLE COST CENTERS			1	1 0		100.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	9 0		1 2 0 0		192.00 194.00
	07950 NON-REI MBURSABLE COST	0	0		-	-	
	07951 MARKETING/PUBLIC RELATIONS 07952 TENANT LEASED SPACE	0	0		0 242		194. 01 194. 02
194.02 200.00		0	0	1	0	0	200.00
200.00	3	~	0		0		200.00
201.00	5	2, 244	66, 164	13, 1	76 13, 196		201.00
202.00		2, 244	00, 104	1 13, 1	10, 190	1 7,101	1202.00

Heal th	Fi na	nci a	al S	yste	ms		
				TAI	DEL	ATED	COSTS

In Lieu of Form CMS-2552-10

ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-3030	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part II Date/Time Pre 2/25/2019 11:	pared: 42 am
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown	Total	
					Adjustments		
		16.00	17.00	24.00	25.00	26.00	
	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						5.02
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	9, 961					16.00
17.00	01700 SOCI AL SERVI CE	0	4, 070				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
30.00	03000 ADULTS & PEDIATRICS	3, 554	4, 070	205, 07	5 0	205, 075	30.00
	ANCI LLARY SERVI CE COST CENTERS						-
54.00	05400 RADI OLOGY-DI AGNOSTI C	120		6, 37		6, 378	•
60.00	06000 LABORATORY	330		1, 99		1, 995	•
65.00	06500 RESPI RATORY THERAPY	8		1, 97		1, 976	•
66.00	06600 PHYSI CAL THERAPY	1, 426		156, 46		156, 468	•
67.00	06700 OCCUPATI ONAL THERAPY	1, 494		84, 48		84, 489	
68.00	06800 SPEECH PATHOLOGY	827		13, 12		13, 124	•
69.00	06900 ELECTROCARDI OLOGY	8	0		.2 0	22	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	164	0	51		518	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 699		12, 78		12, 789	
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	173		7, 52		7, 521	76.00
76.01	03950 HEMODIALYSIS & OTHER ANCILLARY	158	0	1, 00	06 0	1, 006	76.01
	SPECIAL PURPOSE COST CENTERS				4	101.0/1	
118.00		9, 961	4, 070	491, 36	01 0	491, 361	118.00
102.00	NONREI MBURSABLE COST CENTERS			· · · · · · · · · · · · · · · · · · ·		20	100.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0		3			192.00
	07950 NON-REI MBURSABLE COST	0	-	2	-		194.00
	07951 MARKETI NG/PUBLI C RELATI ONS	0	0	120 02			194.01
	07952 TENANT LEASED SPACE	0	0	130, 02		130, 028	
200.00		0			0 0		200.00
201.00 202.00	5	0 9, 961	4, 070	621, 66	0		
202.00		7, 901	4,070	021,00	U U	021,001	202.00

REHABILITATION HOSPITAL OF FT WAYNE Provider CCN: 15-3030 Period:

In Lieu of Form CMS-2552-10 Worksheet B-1

COST A	LLOCATION - STATISTICAL BASIS		Provider C		Period: From 10/01/2017	Worksheet B-1	
					To 09/30/2018	Date/Time Pre	
						2/25/2019 11:	42 am
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMI TTI NG	Reconciliation	
	bost bontor boschiption	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	(GROSS		
		(000,000 1001)	(040/112 1221)	DEPARTMENT	CHARGES)		
				(GROSS	01// ((020))		
				SALARI ES)			
		1.00	2.00	4.00	5. 01	5A. 02	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	728, 820					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		591, 864				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 940	2, 940	7, 184, 33	5		4.00
5.01	00570 ADMI TTI NG	15, 144	15, 144	88, 43	7 41, 772, 915		5.01
5.02	00590 OTHER ADMINISTRATIVE AND GENERAL	57, 360	57, 360	505, 77	4 C	-1, 421, 473	5.02
7.00	00700 OPERATION OF PLANT	133, 512	133, 512	242, 86	6 C		
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0 0	0	8.00
9.00	00900 HOUSEKEEPI NG	14, 424	14, 424	122, 46	4 C	0	9.00
10.00	01000 DI ETARY	0	0	254, 70			1
11.00	01100 CAFETERIA	55, 728	55, 728				
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 560	1, 560			-	
14.00	01400 CENTRAL SERVICES & SUPPLY	11,016	11, 016			-	
15.00	01500 PHARMACY	4, 668	4, 668				
16.00	01600 MEDI CAL RECORDS & LI BRARY	5, 352	5, 352				1
17.00	01700 SOCIAL SERVICE	3, 468	3, 468				
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	5,400	5,400		0 0	<u> </u>	17.00
30.00	03000 ADULTS & PEDIATRICS	92, 796	92, 796	2, 990, 28	8 14, 857, 339	0	30.00
50.00	ANCI LLARY SERVICE COST CENTERS	72,770	72,170	2,770,20	0 14,007,007	0	30.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 160	5, 160		0 502, 225	0	54.00
60.00	06000 LABORATORY	0,100	0,100				1
65.00	06500 RESPI RATORY THERAPY	1,200	1, 200				1
66.00	06600 PHYSI CAL THERAPY	121,092	121, 092				1
67.00	06700 OCCUPATI ONAL THERAPY	57, 168	57, 168				1
68.00	06800 SPEECH PATHOLOGY	4, 332	4, 332				
69.00	06900 ELECTROCARDI OLOGY	0	1,002	101,01	0 32, 481		1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 688, 246		1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 7, 140, 345		
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	4,944	4, 944	86, 37			
76.01	03950 HEMODI ALYSI S & OTHER ANCI LLARY	4, 744	4, 744		0 662, 344		1
70.01	SPECIAL PURPOSE COST CENTERS	0	0		0 002, 344	0	1 /0.01
118.00		591, 864	591, 864	7, 184, 10	5 41, 772, 915	-1, 421, 473	118 00
110.00	NONREI MBURSABLE COST CENTERS	071,001	071,001	7,101,10	0 11,772,710	1, 121, 170	
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	23	0 0	0	192.00
	07950 NON-REI MBURSABLE COST	0	0		0 0		194.00
	07951 MARKETI NG/PUBLI C RELATI ONS	0	0		0 0		194.01
	07952 TENANT LEASED SPACE	136, 956	0		0 0		194.02
200.00		100, 700	0		0	0	200.00
200.00	5						201.00
201.00	5	517,051	104, 610	1, 051, 27	9 182, 467	,	202.00
202.00	Part I)	517,051	104, 010	1,001,27	102,407		202.00
203.00		0. 709436	0. 176747	0. 14632	9 0.004368		203.00
203.00		0.709430	0. 170747	2,60			203.00
204.00	Part II)			2, 00	13, 453		204.00
205.00				0.00036	3 0.000322		205.00
200.00	II)			0.00030	0.000322		205.00
206.00							206.00
200.00	(per Wkst. B-2)						200.00
207.00							207.00
207.00	Parts III and IV)						
		1 1		I	1	I.	1

COST ALL	inancial Systems REHA _OCATION - STATISTICAL BASIS	BILITATION HOSI		CN: 15-3030	Peri od:	Worksheet B-1	
					From 10/01/2017		
					To 09/30/2018	Date/Time Pre 2/25/2019 11:	pared: 42 am
	Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	<u>+2 am</u>
		ADMI NI STRATI VE		LINEN SERVIC		(MEALS SERVED)	
		AND GENERAL	(SQUARE FEET)	(POUNDS OF			
		(ACCUM. COST)		LAUN)			
		5.02	7.00	8.00	9.00	10.00	
	ENERAL SERVICE COST CENTERS				-		1 1 0
	0100 CAP REL COSTS-BLDG & FIXT 0200 CAP REL COSTS-MVBLE EQUIP						1.0
	0200 CAP REL COSTS-MUBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT						4.0
	0400 EMPLOTEE BENEFITS DEPARTMENT 0570 ADMITTING						5.0
	0590 OTHER ADMINISTRATIVE AND GENERAL	10, 763, 937					5.0
	0700 OPERATION OF PLANT	972, 665					7.0
	0800 LAUNDRY & LINEN SERVICE	41, 578		80, 43	5		8.0
	0900 HOUSEKEEPING	181, 161			0 368, 484		9.0
	1000 DI ETARY	454, 203			0 0	49, 826	
	1100 CAFETERIA	202, 938			0 55, 728	0	
	1300 NURSING ADMINISTRATION	855, 758			0 1,560	0	
	1400 CENTRAL SERVICES & SUPPLY	29, 827			0 11,016	0	
15.00 0'	1500 PHARMACY	111, 993			0 4,668	0	15.0
16.00 0'	1600 MEDI CAL RECORDS & LI BRARY	272, 936	5, 352		0 5, 352	0	16.0
17.00 0'	1700 SOCIAL SERVICE	3, 073	3, 468		0 3, 468	0	17.0
11	NPATIENT ROUTINE SERVICE COST CENTERS						1
	3000 ADULTS & PEDIATRICS	4, 311, 457	92, 796	45, 11	8 92, 796	49, 826	30.0
	NCILLARY SERVICE COST CENTERS						
	5400 RADI OLOGY-DI AGNOSTI C	13, 280			0 5, 160	0	
	6000 LABORATORY	70, 165			0 0	0	
	6500 RESPI RATORY THERAPY	19, 819			0 1, 200	0	
	6600 PHYSI CAL THERAPY	886, 045				0	
	6700 OCCUPATIONAL THERAPY	1,082,601				0	
	6800 SPEECH PATHOLOGY	527, 695			0 4, 332	0	
	6900 ELECTROCARDI OLOGY 7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	873			0 0	0	
	7300 DRUGS CHARGED TO PATIENTS	27, 823 356, 515			0 0	0	
	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	113, 546			0 4,944	0	
	3950 HEMODIALYSIS & OTHER ANCILLARY	126, 931	4, 744		0 0	0	
SE	PECIAL PURPOSE COST CENTERS	120,731		1	0 0	0	1 /0.0
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	10, 662, 882	382, 908	80, 43	368, 484	49, 826	118.0
NC	ONREI MBURSABLE COST CENTERS			· · · · ·		· · · ·	1
92.0019	9200 PHYSI CLANS' PRI VATE OFFI CES	3, 893	0)	0 0	0	192.0
	7950 NON-REI MBURSABLE COST	0	0)	0 0		194.0
	7951 MARKETI NG/PUBLIC RELATIONS	0	0		0 0		194.0
	7952 TENANT LEASED SPACE	97, 162	136, 956		0 0	0	194.0
200. 00	Cross Foot Adjustments						200. 0
201.00	Negative Cost Centers						201.0
202.00	Cost to be allocated (per Wkst. B,	1, 421, 473	1, 101, 114	47,06	9 235, 636	514, 185	202.0
	Part I)	0 400050	0 44000	0 50510		10 040/10	202 0
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 132059				10. 319612	
204.00	Cost to be allocated (per Wkst. B,	51, 015	123, 012	19	17, 098	2,244	204.0
205.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 004739	0. 236623	0. 00244	0. 046401	0. 045037	205 0
200.00	II)	0.004739	0. 230023	0.00244	0.040401	0. 045037	205.0
206, 00	NAHE adjustment amount to be allocated						206.0
	(per Wkst. B-2)						200.0
207.00	NAHE unit cost multiplier (Wkst. D,						207.0
1	Parts III and IV)	1	1	1			1

UST AL	LOCATION - STATISTICAL BASIS		Provider CC		Peri od:	Worksheet B-1	2552-
					From 10/01/2017 To 09/30/2018	Date/Time Pre	naro
					10 09/ 30/ 2018	2/25/2019 11:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(FTES)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
				SUPPLY	REQUIS.)	LI BRARY	
			(FTES-NURS	(COSTED		(GROSS	
			AREAS)	REQUIS.)		CHARGES)	
		11.00	13.00	14.00	15.00	16.00	_
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.
	00200 CAP REL COSTS-MVBLE EQUIP						2.
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
	00570 ADMI TTI NG						5.
	00590 OTHER ADMINISTRATIVE AND GENERAL						5.
	00700 OPERATION OF PLANT						7.
	00800 LAUNDRY & LINEN SERVICE						8.
	00900 HOUSEKEEPI NG						9.
	01000 DI ETARY						10.
	01100 CAFETERIA	7,687	,				111.
		820	1				13.
	01300 NURSI NG ADMI NI STRATI ON			150 50			
	01400 CENTRAL SERVICES & SUPPLY	20		158, 58			14.
	01500 PHARMACY	84			0 325, 326	44 770 045	15.
	01600 MEDI CAL RECORDS & LI BRARY	264	1	93		41, 772, 915	
	01700 SOCIAL SERVICE	C	0		0 0	0	17.
	INPATIENT ROUTINE SERVICE COST CENTERS	4.245	2, 990, 288	100.01	3 0	14 057 000	30.
	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	4, 245	2, 990, 200	133, 31	<u> </u>	14, 857, 339	30
	05400 RADI OLOGY-DI AGNOSTI C	C	ol		0 0	502, 225	54.
	06000 LABORATORY	86	1	30		1, 384, 661	
	06500 RESPI RATORY THERAPY	17		3, 16		34, 025	
	06600 PHYSI CAL THERAPY	775		4, 80		5, 992, 702	
	06700 OCCUPATI ONAL THERAPY	906		10, 40		6, 275, 233	
	06800 SPEECH PATHOLOGY	383		2, 02		3, 476, 731	
	06900 ELECTROCARDI OLOGY	C		2,02	0 0	32, 481	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		-		0 0	688, 246	
	07300 DRUGS CHARGED TO PATIENTS		, s		0 325, 326	7, 140, 345	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	86	-	30		726, 583	
1	03950 HEMODIALYSIS & OTHER ANCILLARY			39		662, 344	
	SPECIAL PURPOSE COST CENTERS		<u>y</u> 0		0 0	002, 344	/0.
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	7,686	3, 112, 081	155, 64	4 325, 326	41, 772, 915	1118
- H	NONREI MBURSABLE COST CENTERS		, ., ., ., ., .,	,			
	19200 PHYSI CLANS' PRI VATE OFFI CES	1	230	3	0 0	0	192
	07950 NON-REI MBURSABLE COST	C			0 0	0	194
94.01	07951 MARKETI NG/PUBLI C RELATI ONS	C	0	2,90	06 0	0	194.
	07952 TENANT LEASED SPACE	C	0		0 0		194.
00.00	Cross Foot Adjustments	1					200.
01.00	Negative Cost Centers	1					201.
02.00	Cost to be allocated (per Wkst. B,	383, 411	1, 013, 971	65, 14	1 171, 305	337, 289	202.
	Part I)						
03.00	Unit cost multiplier (Wkst. B, Part I)	49. 877846	0. 325794	0. 41077	7 0. 526564	0.008074	203.
04.00	Cost to be allocated (per Wkst. B,	66, 164		13, 19		9, 961	
	Part II)					-	
05.00	Unit cost multiplier (Wkst. B, Part	8. 607259	0. 004234	0. 08321	4 0. 021827	0. 000238	205.
	11)						
	NAHE adjustment amount to be allocated						206.
06.00							
206.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.

In Lieu of Form CMS-2552-10

		BILLIATION HOSP	TIAL OF FI WAYNE	In Lieu of Form CM	
COST A	ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-3030	Period: Worksheet B	3–1
				From 10/01/2017)
				To 09/30/2018 Date/Time P 2/25/2019 1	repared:
	Cost Center Description	SOCI AL SERVI CE		272372014 1	1.42 dili
	cost center bescription	SUCIAL SERVICE			
		(PATIENT DAYS			
		(FATTEINT DATS %)			
		17.00			
		17.00			_
1 00	GENERAL SERVICE COST CENTERS	1			1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P				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				5.02
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPI NG				9.00
10.00	01000 DI ETARY				10.00
11.00	01100 CAFETERI A				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY				14.00
15.00	01500 PHARMACY				15.00
	01600 MEDICAL RECORDS & LIBRARY				16.00
	01700 SOCIAL SERVICE	8, 259			17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30, 00	03000 ADULTS & PEDIATRICS	8, 259			30, 00
	ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADI OLOGY-DI AGNOSTI C	0			54.00
60.00	06000 LABORATORY	0			60.00
65.00	06500 RESPI RATORY THERAPY	0			65.00
66.00	06600 PHYSI CAL THERAPY	0			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0			67.00
	06800 SPEECH PATHOLOGY	0			68.00
	06900 ELECTROCARDI OLOGY	0			69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71.00
	07300 DRUGS CHARGED TO PATIENTS	0			73.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			
76.00		0			76.00
76.01	03950 HEMODI ALYSI S & OTHER ANCI LLARY	0			76. 01
110.00	SPECIAL PURPOSE COST CENTERS	0.050			110.00
118.00		8, 259			118.00
400.00	NONREI MBURSABLE COST CENTERS				100.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0			192.00
	07950 NON-REI MBURSABLE COST	0			194.00
	07951 MARKETI NG/PUBLI C RELATI ONS	0			194.01
	07952 TENANT LEASED SPACE	0			194.02
200.00	5				200.00
201.00	5				201.00
202.00		13, 043			202.00
	Part I)				
203.00		1. 579247			203.00
204.00		4,070			204.00
	Part II)				
205.00	Unit cost multiplier (Wkst. B, Part	0. 492796			205.00
	11)				
206.00					206.00
	(per Wkst. B-2)				
207.00					207.00
	Parts III and IV)				I

Health Financial Systems	REH	ABILITATION HOSE	PITAL OF FT WAY	/NE	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COS	TS TO CHARGES		Provider C		Period:	Worksheet C	
					From 10/01/2017 To 09/30/2018		nared
					10 097 307 2010	2/25/2019 11:	42 am
			Title	XVIII	Hospi tal	PPS	
					Costs		
Cost Center Des	cription	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 SER				1	-1	1	-
30. 00 03000 ADULTS & PEDI AT		7, 051, 024		7, 051, 02	4 0	7, 051, 024	30.00
ANCI LLARY SERVICE COS					. 1		-
54.00 05400 RADI OLOGY-DI AGN	OSTIC	33, 318		33, 31		33, 318	•
60. 00 06000 LABORATORY		103, 598		103, 59		103, 598	•
65. 00 06500 RESPI RATORY THE		31, 814		31, 81		31, 814	
66.00 06600 PHYSI CAL THERAP		1, 435, 789		1, 435, 78		1, 435, 789	
67.00 06700 OCCUPATIONAL TH		1, 494, 206		1, 494, 20		1, 494, 206	•
68.00 06800 SPEECH PATHOLOG		657, 332	0	657, 33	2 0	657, 332	•
69.00 06900 ELECTROCARDI OLO		1, 250		1, 25		1, 250	•
71.00 07100 MEDICAL SUPPLIE		37, 054		37, 05		37, 054	
73.00 07300 DRUGS CHARGED T		632, 552		632, 55	2 0	632, 552	
76. 00 03550 PSYCHI ATRI C/PSY	CHOLOGI CAL SERVI CES	152, 454		152, 45	4 0	152, 454	76.00
76.01 03950 HEMODIALYSIS & 0	OTHER ANCILLARY	149, 204		149, 20	4 0	149, 204	76.01
200.00 Subtotal (see i	nstructions)	11, 779, 595	0	11, 779, 59	5 0	11, 779, 595	200.00
201.00 Less Observation		0			0		201.00
202.00 Total (see inst	ructions)	11, 779, 595	0	11, 779, 59	5 0	11, 779, 595	202.00

Health Financial Syste	ems REHA	ABILITATION HOSP	ITAL OF FT WAY	/NE	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO	OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
					From 10/01/2017 To 09/30/2018		nored.
					10 09/30/2018	Date/Time Pre 2/25/2019 11:	42 am
			Title	XVIII	Hospi tal	PPS	12 0111
			Charges				
Cost Cent	er Description	Inpatient	Outpati ent	Total (col. d	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTI	NE SERVICE COST CENTERS						
30.00 03000 ADULTS &	PEDI ATRI CS	14, 857, 339		14, 857, 33	9		30.00
ANCI LLARY SERVI	CE COST CENTERS						
54.00 05400 RADI OLOGY	-DI AGNOSTI C	502, 225	0	502, 22	5 0. 066341	0.000000	54.00
60.00 06000 LABORATOR	Y	1, 384, 661	0	1, 384, 66	1 0. 074818	0.00000	60.00
65. 00 06500 RESPI RATO	RY THERAPY	34, 025	0	34, 02	5 0. 935018	0.000000	65.00
66. 00 06600 PHYSI CAL	THERAPY	5, 992, 702	0	5, 992, 70	2 0. 239590	0.00000	66.00
67.00 06700 0CCUPATI 0	NAL THERAPY	6, 251, 392	23, 841	6, 275, 23	3 0. 238112	0.00000	67.00
68.00 06800 SPEECH PA		3, 476, 731	0	3, 476, 73	1 0. 189066	0.00000	68.00
69.00 06900 ELECTROCA	RDI OLOGY	32, 481	0	32, 48	1 0. 038484	0.00000	69.00
71.00 07100 MEDICAL S	UPPLIES CHARGED TO PATIENT	688, 246	0	688, 24	6 0. 053838	0.00000	
73.00 07300 DRUGS CHA	RGED TO PATIENTS	7, 140, 345	0	7, 140, 34	5 0. 088588	0.00000	73.00
76. 00 03550 PSYCHI ATR	I C/PSYCHOLOGI CAL SERVI CES	726, 583	0	726, 58	3 0. 209823	0.00000	76.00
	SIS & OTHER ANCILLARY	662, 344	0	662, 34		0. 000000	
	(see instructions)	41, 749, 074	23, 841	41, 772, 91	5		200.00
201.00 Less Obse	rvation Beds						201.00
202.00 Total (se	e instructions)	41, 749, 074	23, 841	41, 772, 91	5		202.00

Health Financial Systems RE	HABILITATION HOSPI	TAL OF FT WAYNE	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3030	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Prepared: 2/25/2019 11:42 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient Ratio 11.00		· · · · · ·	
INPATIENT ROUTINE SERVICE COST CENTERS	11100			
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
ANCI LLARY SERVI CE COST CENTERS				
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 066341			54.00
60. 00 06000 LABORATORY	0. 074818			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 935018			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 239590			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 238112			67.00
68.00 06800 SPEECH PATHOLOGY	0. 189066			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 038484			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 053838			71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 088588			73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 209823			76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	0. 225267			76.01
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3030 Period: From 10/01/2017 To 09/30/2018 Worksheet C Part I Date/Time Prep 2/25/2019 11: 4 Cost Center Description Total Cost (from Wkst. B, Part I, col. 26) Therapy Limit Adj. Hospital PPS Costs RCE Di sal I owance Total Costs INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7,051,024 7,051,024 0 7,051,024
Impatience Total Cost (from Wkst. B, Part I, col. 26) Total Costs Adj. Total Costs Total Costs Total Costs RCE Disal I owance Total Costs Disal I owance INPATIENT ROUTINE SERVICE COST CENTERS 7,051,024 7,051,024 0 7,051,024 0 7,051,024
Cost Center Description Total Cost (from Wkst. B, Part I, col. 26) Therapy Limit Adj. Total Costs Total Costs RCE Di sal I owance Total Costs INPATI ENT ROUTI NE SERVI CE COST CENTERS 1.00 2.00 3.00 4.00 5.00 30.00 03000 ADULTS & PEDI ATRI CS 7,051,024 7,051,024 0 7,051,024
Title XIX Hospital PPS Cost Center Description Total Cost (from Wkst. B, Part I, col. 26) Total Costs RCE Disal I owance Total Costs INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 7,051,024 7,051,024 0 7,051,024
Cost Center Description Cost Center Description Total Cost (from Wkst. B, Part I, col. 26) Therapy Limit Adj. Total Costs Disal I owance Total Costs 1.00 2.00 3.00 4.00 5.00 30.00 03000 ADULTS & PEDI ATRI CS 7,051,024 7,051,024 0 7,051,024
Cost Center Description Total Cost (from Wkst. B, Part I, col. 26) Therapy Limit Adj. Total Costs Disal owance RCE Disal owance Total Costs 1.00 2.00 3.00 4.00 5.00 30.00 03000 ADULTS & PEDIATRICS 7,051,024 7,051,024 0 7,051,024
INPATI ENT ROUTI NE SERVI CE COST CENTERS 7,051,024 7,051,024 7,051,024 7,051,024
Part I, col. Part I, col. 26) 1.00 2.00 3.00 4.00 5.00 INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7,051,024 7,051,024 0 7,051,024
26) 26) 1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7,051,024 7,051,024 7,051,024
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 7, 051, 024 7, 051, 024 7, 051, 024
30. 00 03000 ADULTS & PEDI ATRI CS 7, 051, 024 7, 051, 024 0 7, 051, 024
ANCI LLARY SERVICE COST CENTERS
54.00 05400 RADI OLOGY-DI AGNOSTI C 33, 318 33, 318 0 33, 318
60. 00 06000 LABORATORY 103, 598 0 103, 598
65. 00 06500 RESPI RATORY THERAPY 31, 814 0 31, 814 0 31, 814
66. 00 06600 PHYSI CAL THERAPY 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 435, 789 0 1, 4
67. 00 06700 OCCUPATI ONAL THERAPY 1, 494, 206 0 1, 494, 206 0 1, 494, 206
68. 00 06800 SPEECH PATHOLOGY 657, 332 0 657, 332 0 657, 332
69.00 06900 ELECTROCARDI OLOGY 1, 250 1, 250 1, 250
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 37, 054 37, 054 0 37, 054
73. 00 07300 DRUGS CHARGED TO PATI ENTS 632, 552 632, 552 0 632, 552
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 152, 454 152, 454 0 152, 454
76. 01 03950 HEMODI ALYSI S & OTHER ANCI LLARY 149, 204 149, 204 0 149, 204
200.00 Subtotal (see instructions) 11,779,595 0 11,779,595 0 11,779,595
201.00 Less Observation Beds 0 0 0
202.00 Total (see instructions) 11, 779, 595 0 11, 779, 595 0 11, 779, 595

Health Financial Systems	REHA	BILITATION HOSP	ITAL OF FT WAY	'NE	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS	TO CHARGES		Provider C		Period:	Worksheet C	
					From 10/01/2017 To 09/30/2018		nared
					10 07/00/2010	2/25/2019 11:	42 am
			Titl	e XIX	Hospi tal	PPS	
			Charges				
Cost Center Descri	ption	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Rati o	Inpati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVI		· · · · · ·			-		
30. 00 03000 ADULTS & PEDIATRI (14, 857, 339		14, 857, 33	9		30.00
ANCILLARY SERVICE COST		· · · · · ·			-		
54.00 05400 RADI OLOGY-DI AGNOS	TIC .	502, 225	0	502, 22		0.000000	•
60. 00 06000 LABORATORY		1, 384, 661	0	1, 384, 66		0.000000	
65.00 06500 RESPI RATORY THERAF	PΥ	34, 025	0	34, 02			
66.00 06600 PHYSI CAL THERAPY		5, 992, 702	0	5, 992, 70			
67.00 06700 OCCUPATIONAL THER	APY	6, 251, 392	23, 841	6, 275, 23			•
68.00 06800 SPEECH PATHOLOGY		3, 476, 731	0	3, 476, 73		0. 000000	
69.00 06900 ELECTROCARDI OLOGY		32, 481	0	32, 48		0. 000000	•
71.00 07100 MEDICAL SUPPLIES (688, 246	0	688, 24			
73.00 07300 DRUGS CHARGED TO F		7, 140, 345	0	7, 140, 34			
76.00 03550 PSYCHI ATRI C/PSYCH		726, 583	0	726, 58	3 0. 209823	0. 000000	76.00
76.01 03950 HEMODIALYSIS & OTH	IER ANCI LLARY	662, 344	0	662, 34		0. 000000	
200.00 Subtotal (see inst		41, 749, 074	23, 841	41, 772, 91	5		200.00
201.00 Less Observation E	Beds						201.00
202.00 Total (see instruc	ctions)	41, 749, 074	23, 841	41, 772, 91	5		202.00

Health Financial Systems	REHABILITATION HOSPI	TAL OF FT WAYNE	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3030	Peri od:	Worksheet C
			From 10/01/2017	Part I
			To 09/30/2018	
				2/25/2019 11:42 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
ANCI LLARY SERVI CE COST CENTERS				
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 066341			54.00
60.00 06000 LABORATORY	0. 074818			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 935018			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 239590			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 238112			67.00
68.00 06800 SPEECH PATHOLOGY	0. 189066			68,00
69. 00 06900 ELECTROCARDI OLOGY	0. 038484			69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN				71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 088588			73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 209823			75.00
	0. 225267			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 REHA	YNE	In Lie	eu of Form CMS-2	2552-10		
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA	ATIOS NET OF	Provider C	CN: 15-3030	Peri od:	Worksheet C	
REDUCTIONS FOR MEDICALD ONLY				From 10/01/2017	Part II	
				To 09/30/2018	Date/Time Pre 2/25/2019 11:	
			e XIX	Hospi tal	PPS	4 <u>2</u> alli
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
	(Wkst. B, Part				Reduction	
	I, col. 26)		Cost (col. 1		Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	33, 318	6, 378	26, 94	0 0	0	54.00
60. 00 06000 LABORATORY	103, 598	1, 995	101, 60	03 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	31, 814	1, 976	29, 83	8 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 435, 789	156, 468	1, 279, 32	1 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	1, 494, 206	84, 489	1, 409, 71	7 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	657, 332	13, 124	644, 20	0 8	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 250	22	1, 22	.8 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	37,054	518	36, 53	6 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	632, 552	12, 789	619, 76	03 0	0	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	152, 454	7, 521	144, 93	3 0	0	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	149, 204	1, 006	148, 19	0 8	0	76.01
200.00 Subtotal (sum of lines 50 thru 199)	4, 728, 571	286, 286	4, 442, 28	85 0	0	200.00
201.00 Less Observation Beds	0	C		0 0	0	201.00
202.00 Total (line 200 minus line 201)	4, 728, 571	286, 286	4, 442, 28	85 O	0	202.00

Health Financial Systems REHA	ABILITATION HOSE	PITAL OF FT WAY	/NE	In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA	ATIOS NET OF	Provider C	CN: 15-3030	Peri od:	Worksheet C	
REDUCTIONS FOR MEDICAID ONLY				From 10/01/2017 To 09/30/2018	Part II Date/Time Pre	narod
				10 09/30/2018	2/25/2019 11:	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		(Worksheet C,				
	Operating Cost		Ratio (col.	6		
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCI LLARY SERVI CE COST CENTERS			1			
54.00 05400 RADI OLOGY-DI AGNOSTI C	33, 318					54.00
60. 00 06000 LABORATORY	103, 598					60.00
65. 00 06500 RESPI RATORY THERAPY	31, 814					65.00
66. 00 06600 PHYSI CAL THERAPY	1, 435, 789					66.00
67.00 06700 OCCUPATI ONAL THERAPY	1, 494, 206					67.00
68.00 06800 SPEECH PATHOLOGY	657, 332					68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 250					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	37,054					71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	632, 552	7, 140, 345	0. 08858	38		73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	152, 454					76.00
76. 01 03950 HEMODIALYSIS & OTHER ANCILLARY	149, 204	662, 344	0. 22520	57		76.01
200.00 Subtotal (sum of lines 50 thru 199)	4, 728, 571	26, 915, 576				200. 00
201.00 Less Observation Beds	0	0				201.00
202.00 Total (line 200 minus line 201)	4, 728, 571	26, 915, 576				202.00

Health Financial Systems	REHABILITATION HOSI	PITAL OF FT WAY	YNE	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI	TAL COSTS	Provider C		Period: From 10/01/2017 To 09/30/2018		pared: 42 am
		Title	e 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)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		•			•	
30. 00 ADULTS & PEDIATRICS	205, 075	0	205, 07	5 8, 259	24.83	30.00
200.00 Total (lines 30 through 199)	205, 075		205, 07	5 8, 259		200.00
Cost Center Description	Inpatient Program days	Inpatient Program				
		Capital Cost				
		(col. 5 x col.				
		6)	4			
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS		1	1			
30. 00 ADULTS & PEDIATRICS	3, 305					30.00
200.00 Total (lines 30 through 199)	3, 305	82, 063	6			200.00

Health Financial Systems REH/	ealth Financial Systems REHABILITATION HOSPI					In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Period: From 10/01/2017 To 09/30/2018				
		Title	XVIII	Hospi tal	PPS			
Cost Center Description		Total Charges (from Wkst. C, Part I, col	to Charges	Program	Capital Costs (column 3 x column 4)			
	Part II, col. 26)	8)	2)					
	1.00	2.00	3.00	4.00	5.00			
ANCI LLARY SERVICE COST CENTERS								
54.00 05400 RADI OLOGY-DI AGNOSTI C	6, 378	502, 225	0. 01269	9 286, 112	3, 633	54.00		
60. 00 06000 LABORATORY	1, 995	1, 384, 661	0. 00144	1 636, 503	917	60.00		
65. 00 06500 RESPI RATORY THERAPY	1, 976	34, 025	0. 05807	5 21, 371	1, 241	65.00		
66. 00 06600 PHYSI CAL THERAPY	156, 468	5, 992, 702	0. 02611	0 2, 371, 534	61, 921	66.00		
67.00 06700 OCCUPATI ONAL THERAPY	84, 489	6, 275, 233	0. 01346	4 2, 466, 604	33, 210	67.00		
68.00 06800 SPEECH PATHOLOGY	13, 124	3, 476, 731	0. 00377	5 1, 274, 686	4, 812	68.00		
69. 00 06900 ELECTROCARDI OLOGY	22	32, 481	0. 00067	7 16, 982	11	69.00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	518	688, 246	0.00075	3 196, 736	148	71.00		
73.00 07300 DRUGS CHARGED TO PATIENTS	12, 789	7, 140, 345	0. 00179	2, 930, 877	5, 249	73.00		
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	7, 521	726, 583	0. 01035	1 261, 199	2, 704	76.00		
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	1,006	662, 344	0. 00151	9 516, 496	785	76.01		
200.00 Total (lines 50 through 199)	286, 286	26, 915, 576		10, 979, 100	114, 631	200. 00		

Health Financial Systems REH	ABILITATION HOS	PITAL OF FT WAY	YNE	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provider C		Period: From 10/01/2017	Worksheet D Part III	
				To 09/30/2018	Date/Time Pre 2/25/2019 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdowr		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	0	
200.00 Total (lines 30 through 199)	0	0		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 & PEDI ATRI CS	0	0	8, 25	9 0.00		30.00
200.00 Total (lines 30 through 199)		0	8, 25	9	3, 305	200.00
Cost Center Description	Inpati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems REHA	ABILITATION HOSI	PITAL OF FT WAY	YNE	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	S Provider C	CN: 15-3030	Period: From 10/01/2017 To 09/30/2018		pared [.]
					2/25/2019 11:	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician				Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS			_			
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C)	0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0	76.00
76. 01 03950 HEMODIALYSIS & OTHER ANCILLARY	0	0		0 0	0	76.01
200.00 Total (lines 50 through 199)	0	i i i i i i i i i i i i i i i i i i i		0 0	Ũ	200.00
······································	-	-	1	-1 -	-	

Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lie					u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2017		
				To 09/30/2018		
					2/25/2019 11:	42 am
			XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 502, 225	0.00000	54.00
60. 00 06000 LABORATORY	0	0		0 1, 384, 661	0. 000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 34, 025	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 5, 992, 702	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	1	0 6, 275, 233	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	1	0 3, 476, 731	0.00000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 32, 481	0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 688, 246	0. 000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 7, 140, 345	0. 000000	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 726, 583	0. 000000	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	0	0		0 662, 344	0. 000000	76.01
200.00 Total (lines 50 through 199)	0	0		0 26, 915, 576		200.00
	1 -1		1	-1 -1 -1 -1 -1 -1	1	

Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In					u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provider CO	CN: 15-3030	Period: From 10/01/2017	Worksheet D Part IV	
				To 09/30/2018	Date/Time Pre 2/25/2019 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	286, 112		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	636, 503		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	21, 371		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 371, 534		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	2, 466, 604		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	1, 274, 686		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	16, 982		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	196, 736		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 930, 877		0 0	0	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	261, 199		0 0	0	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	0. 000000	516, 496		0 0	0	76.01
200.00 Total (lines 50 through 199)		10, 979, 100		0 0		200. 00

Health Financial Systems	REHABILITATION HOS	PITAL OF FT WAY	YNE	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	TAL COSTS	Provider C		Period: From 10/01/2017 To 09/30/2018		pared: 42 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col 2)	Days	Per Diem (col. 3 / col. 4)	
	1,00	2.00	3.00	4,00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 ADULTS & PEDIATRICS	205, 075	0	205, 07	5 8, 259	24.83	30.00
200.00 Total (lines 30 through 199)	205, 075		205, 07	5 8, 259		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 & PEDIATRICS 200.00 Total (lines 30 through 199)	137 137					30. 00 200. 00

Health Financial Systems REHA	alth Financial Systems REHABILITATION HOSPITAL OF FT WAYNE					2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-3030	Peri od:	Worksheet D	
				From 10/01/2017 To 09/30/2018	Part II Date/Time Pre	oared:
					2/25/2019 11:	
			e XIX	Hospi tal	PPS	
Cost Center Description		Total Charges			Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	r		1	- 1		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 378	502, 225	0. 01269	9,571	122	54.00
60. 00 06000 LABORATORY	1, 995	1, 384, 661	0.00144	13, 048	19	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 976	34, 025	0. 05807	75 786	46	65.00
66. 00 06600 PHYSI CAL THERAPY	156, 468	5, 992, 702	0. 02611	0 117, 820	3, 076	66.00
67.00 06700 OCCUPATI ONAL THERAPY	84, 489	6, 275, 233	0.01346	126, 097	1, 698	67.00
68.00 06800 SPEECH PATHOLOGY	13, 124	3, 476, 731	0.00377	75 57, 431	217	68.00
69.00 06900 ELECTROCARDI OLOGY	22	32, 481	0.00067	7 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	518	688, 246	0. 00075	6, 176	5	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	12, 789	7, 140, 345	0.00179	147, 864	265	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	7, 521	726, 583	0. 01035	51 9, 612	99	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	1,006	662, 344	0.00151	9 0	0	76. 01
200.00 Total (lines 50 through 199)	286, 286			488, 405	5, 547	200. 00

Health Financial Systems REH	ABILITATION HOS	PITAL OF FT WAY	/NE	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS		-	Period: From 10/01/2017 To 09/30/2018	Date/Time Pre 2/25/2019 11:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdowr	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	0	0		0 0	0	30.00
200.00 Total (lines 30 through 199)	0	0 0		o o	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
'	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,		· · · ·	5 5	
		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	8, 25	9 0.00	137	30.00
200.00 Total (lines 30 through 199)		0	8, 25	9	137	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)						200.00
i i i i i i i i i i i i i i i i i i i	1	1				

Health Financial Systems RE	PITAL OF FT WAY	YNE	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI THROUGH COSTS	ERVICE OTHER PASS	6 Provider C	CN: 15-3030	Period: From 10/01/2017 To 09/30/2018		
			e XIX	Hospi tal	PPS	
Cost Center Description				Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	<u>Cost</u> 1.00	Adjustments 2A	2.00	Adjustments 3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	20	2.00	5/4	3.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C)	0 0	0	54.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C)	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0 0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0 0	0	73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0)	0 0	0	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCI LLARY	0	0				76.01
200.00 Total (lines 50 through 199)	0	0	4	U U	0	200. 00

Health Financial Systems REH.	Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In					2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2017		
				To 09/30/2018		
					2/25/2019 11:	42 am
			e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 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	1	0 502, 225	0. 000000	54.00
60. 00 06000 LABORATORY	0	0		0 1, 384, 661	0.00000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 34, 025	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 5, 992, 702		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 6, 275, 233		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 3, 476, 731	0.00000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 32, 481	0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 688, 246		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 7, 140, 345		•
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 726, 583		•
	0	0				•
76. 01 03950 HEMODIALYSIS & OTHER ANCILLARY	0	0		0 662, 344		
200.00 Total (lines 50 through 199)	0	0		0 26, 915, 576		200. 00

Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CMS						2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider CO		Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2017 To 09/30/2018	Part IV	norod.
				To 09/30/2018	Date/Time Pre 2/25/2019 11:	42 am
		Titl	e XIX	Hospi tal	PPS	<u>12 a</u>
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	9, 571		0 0	0	54.00
60. 00 06000 LABORATORY	0.000000	13, 048		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	786		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	117, 820		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	126, 097		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	57, 431		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	6, 176		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	147, 864		0 0	0	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	9, 612		0 0	0	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	0. 000000	0		0 0	0	76.01
200.00 Total (lines 50 through 199)		488, 405		0 0	0	200. 00

REHABILITATION HOSPITAL OF FT WAYNE

In Lieu of Form CMS-2552-10

<u>Heal th</u>	Financial Systems REHABILITATION HOSPI	TAL OF FT WAYNE	In Lie	u of Form CMS-2	<u>2552-10</u>
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-3030	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prep 2/25/2019 11:	pared:
	Cast Castas Description	Title XVIII	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				1
1.00	Inpatient days (including private room days and swing-bed day			8, 259	1.00
2.00	Inpatient days (including private room days, excluding swing-			8, 259	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3.00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed days)		8, 259	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost		5.00
	reporting period			-	
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private roc	om days) through Decembe	r 31 of the cost	0	7.00
0 00	reporting period	m dave) after December (21 of the cost	0	0 00
8.00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) after becember .	si oi the cost		8.00
9.00	Total inpatient days including private room days applicable t	to the Program (excluding	a swing-bed and	3, 305	9.00
	newborn days)		9	-,	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII c	only (including private i	room days)	0	10.00
	through December 31 of the cost reporting period (see instruc				
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		to room dave)	0	12.00
12.00	through December 31 of the cost reporting period		te room days)		12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva-	te room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y	/ear, enter 0 on this li	ne)		
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	
15.00	Total nursery days (title V or XIX only)			0	
16.00	Nursery days (title V or XIX only)			0	16.00
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	res through December 31 (of the cost	0.00	17.00
17.00	reporting period	the ough becember of t		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18.00
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19.00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to service	s ofter December 21 of :	the cost	0.00	20.00
20.00	reporting period	es al tel December 31 01	the cost	0.00	20.00
21.00	Total general inpatient routine service cost (see instruction	าร)		7, 051, 024	21.00
22.00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line		1
	5 x line 17)				
23.00	Swing-bed cost applicable to SNF type services after December	⁻ 31 of the cost reportin	ng period (line 6	0	23.00
24 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 21 of the cost report	ing pariod (line	0	24.00
24.00	7 x line 19)	a si di the cost reporti	ng period (inne		24.00
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25.00
	x line 20)				
	Total swing-bed cost (see instructions)			0	1
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 051, 024	27.00
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	and observation bed cl	parges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)		lai ges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)				32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mi		ctions)		34.00
35.00 36.00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	1
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	7, 051, 024	1
200	27 minus line 36)	and private room cost u		,, 001, 024	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY]
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38.00	Adjusted general inpatient routine service cost per diem (see			853.74	
39.00	Program general inpatient routine service cost (line 9 x line	-		2, 821, 611	
	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39			0 2, 821, 611	
4 1.00	Inter royani yenerar inpatrent routine service cost (ITNE 39	7 + 1110 + 0)		2,021,011	41.00

	ATI ON OF INPATIENT OPERATING COST		Provider C		Period: From 10/01/2017 To 09/30/2018	2/25/2019 11:	eparec
		.		XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	· · ·	col . 2)	÷ 5 5	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	10
2.00	NURSERY (title V & XIX only)					<u>i</u>	42.
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43.
. 00	CORONARY CARE UNIT						44.
. 00	BURN INTENSIVE CARE UNIT						45.
. 00	SURGI CAL I NTENSI VE CARE UNI T					1	46.
. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description						
			1.1 000)			1.00	10
. 00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines		· · ·	nc)		1, 925, 152	
. 00	PASS THROUGH COST ADJUSTMENTS	41 thi ough 46) (JIIS)		4, 746, 763	49.
. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D. sur	m of Parts I and	82,063	50.
	111)						
. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	114, 631	51.
00	and IV)	EQ and E1)				10/ /01	F 2
2.00 3.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non ph	cician anost	botict and	196, 694 4, 550, 069	
. 00	medical education costs (line 49 minus line 1		ιατέα, ποπ-ρηγ	an chain aneSti	netist, dilu	4, 000, 009	33.
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
. 00	Program discharges					0	54.
. 00	Target amount per discharge					0.00	55.
. 00	Target amount (line 54 x line 55)					0	
. 00	Difference between adjusted inpatient operati	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	nonting ported	anding 100/	undeted and a	ampounded by the	0.00	
. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	enaling 1996, t	ipuated and co	unpounded by the	0.00	/ 59.
. 00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	narket basket		0.00	60.
. 00	If line 53/54 is less than the lower of line				the amount by	0	61.
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% or	f the target		
~ ~	amount (line 56), otherwise enter zero (see	instructions)					
. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paymu	ant (and instru	ati ana)			0	
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST					0	03.
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	ina period (See	0	64.
	instructions)(title XVIII only)	5			5 1		
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	cost reporting	g period (See	0	65.
~~	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (IIne	64 prus rine 6	5)(title XVI	II ONLY). FOR	0	66.
00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 c	of the cost re	eporting period	0	67.
	(line 12 x line 19)	o ocoro tin ough			opor tring por roa		
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	orting period	0	68.
	(line 13 x line 20)						
. 00	Total title V or XIX swing-bed NF inpatient			,		0	69.
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil)		70.
. 00	Adjusted general inpatient routine service of)		71.
. 00	Program routine service cost (line 9 x line)			,		1	72.
. 00	Medically necessary private room cost application	able to Program	(line 14 x li	ne 35)		ĺ	73.
. 00	Total Program general inpatient routine serv						74.
. 00	Capital-related cost allocated to inpatient	routine service	costs (from V	lorksheet B, I	Part II, column	1	75.
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)				1	76.
. 00	Program capital-related costs (line 75 - 11)						77.
00	Inpatient routine service cost (line 74 minu:					1	78.
00	Aggregate charges to beneficiaries for excess	,	rovi der record	ls)			79.
00	Total Program routine service costs for compa		ost limitatior	n (line 78 min	nus line 79)		80.
00	Inpatient routine service cost per diem limi		、 、			1	81.
. 00	Inpatient routine service cost limitation (I		•			1	82.
. 00	Reasonable inpatient routine service costs (:		5)				83.
. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ns)			1	84.
	Total Program inpatient operating costs (sum					1	86.
	PART IV - COMPUTATION OF OBSERVATION BED PASS						1
. 00	Total observation bed days (see instructions))				0	
. 00	Adjusted general inpatient routine cost per		line 2)			0.00	
	Observation bed cost (line 87 x line 88) (see						89

Health Financial Systems REHA	BILITATION HOSE	PITAL OF FT WAY	'NE	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 10/01/2017	Worksheet D-1	
				To 09/30/2018	Date/Time Pre 2/25/2019 11:	pared: 42 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	205, 075	7, 051, 024	0. 02908	4 0	0	90.00
91.00 Nursing School cost	0	7, 051, 024	0.00000	0 0	0	91.00
92.00 Allied health cost	0	7,051,024	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	7, 051, 024	0. 00000	0 0	0	93.00

Health Financial System

REHABI LI TATI ON	HOSPI TAL	0F	FΤ	WAYNE	

In Lieu of Form CMS-2552-10

Heal th	Financial Systems REHABILITATION HOSPIT	AL OF FT WAYNE	In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-3030	Peri od:	Worksheet D-1	
				Date/Time Prep 2/25/2019 11:4	
	Cost Center Description	Title XIX	Hospi tal	PPS	
	Cost center beschiption			1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS			0.050	
1.00	Inpatient days (including private room days and swing-bed days			8, 259	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day		ivato room dave	8, 259 0	2.00 3.00
3.00	do not complete this line.	ys). If you have only pr	I vate Toolii uays,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		8, 259	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5.00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.00
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m davic) through December	21 of the cost	0	7.00
7.00	reporting period	in days) thi ough becember	ST OF THE COST	0	7.00
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8,00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	137	9.00
	newborn days)				
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of	5 1 5 1	oom days)	0	10.00
11.00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		nom davs) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, en		oom days) arter	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI.		e room days)	0	12.00
	through December 31 of the cost reporting period		- ·		
13.00	Swing-bed NF type inpatient days applicable to titles V or XI.			0	13.00
14 00	after December 31 of the cost reporting period (if calendar yo			0	14 00
14.00 15.00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	0	14.00 15.00
16.00	Nursery days (title V or XIX only)			0	16.00
.0.00	SWING BED ADJUSTMENT				10100
17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	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	the cost	0.00	18.00
19.00	reporting period Medicaid rate for swing-bed NF services applicable to service:	s through December 31 of	the cost	0.00	19.00
19.00	reporting period	s through becember 51 of	the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20.00
	reporting period				
21.00	Total general inpatient routine service cost (see instruction			7, 051, 024	
22.00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22.00
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	0	23.00
20.00	x line 18)		ig period (inne o	0	20.00
24.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)				
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.00
26.00	x line 20) 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)		7,051,024	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	· · · ·		.,	
28.00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 -	÷ line 28)		0.000000	
32.00 33.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34.00	Average per diem private room charge differential (line 32 mil	nus line 33)(see instruc	tions)	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	and private room cost di	fferential (line	7, 051, 024	37.00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	USTMENTS			
				853.74	38.00
38 00	Adjusted general inpatient routine service cost per diem (see				
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			116, 962	
		38)			39.00

MPUT	ATION OF INPATIENT OPERATING COST		Provio	ler CO	CN: 15-3030	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Pre 2/25/2019 11:	epare
					e XIX	Hospi tal	PPS	-
	Cost Center Description	Total Inpatient Cost			col. 2)	÷	Program Cost (col. 3 x col. 4)	
		1.00	2.00		3.00	4.00	5.00	1.0
00	NURSERY (title V & XIX only)						<u> </u>	42.
00	Intensive Care Type Inpatient Hospital Units							43.
00	CORONARY CARE UNI T							44
00	BURN INTENSIVE CARE UNIT							45
00	SURGICAL INTENSIVE CARE UNIT							46
00	OTHER SPECIAL CARE (SPECIFY)							47
	Cost Center Description							
00				<u></u>			1.00	10
00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines				n c)		86, 906	
00	PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instr	uctio	115)		203, 868	49
00	Pass through costs applicable to Program inp	atient routine	servi ces	(from	Wkst D sur	n of Parts I and	3, 402	50
	111)		00. 11 000	(0,102	
00	Pass through costs applicable to Program inp	atient ancillar	y service	s (fr	om Wkst. D, s	sum of Parts II	5, 547	51
	and IV)							_
00	Total Program excludable cost (sum of lines	,					8, 949	
00	Total Program inpatient operating cost exclu-		el ated, no	n-pny	sician anestr	netist, and	194, 919	53
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					1	
00	Program di scharges						0	54
00	Target amount per discharge						0.00	
00	Target amount (line 54 x line 55)						0	56
00	Difference between adjusted inpatient operat	ing cost and ta	irget amou	nt (I	ine 56 minus	line 53)	0	
00	Bonus payment (see instructions)						0	
00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 19	96, u	pdated and co	ompounded by the	0.00	59
00	market basket Lesser of lines 53/54 or 55 from prior year	cost report ur	dated by	tha m	arkat haskat		0.00	60
. 00	If line 53/54 is less than the lower of line					the amount by	0.00	
00	which operating costs (line 53) are less that							
	amount (line 56), otherwise enter zero (see					5		
00	Relief payment (see instructions)						0	
00	Allowable Inpatient cost plus incentive paym	ent (see instru	ictions)				0	63
~~	PROGRAM INPATIENT ROUTINE SWING BED COST	+- +		£ +				
00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through bece		i the	cost reporti	ng period (see	0	64
00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of	the c	ost reportino	period (See	0	65
	instructions)(title XVIII only)						_	
00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus l	ine 6	5)(title XVII	I only). For	0	66
	CAH (see instructions)							
00	Title V or XIX swing-bed NF inpatient routin	e costs through	December	31 o	f the cost re	eporting period	0	67
00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	o costs after [locombor 2	1 of	the cost ron	orting poriod	0	68
00	(line 13 x line 20)		ecember 3	1 01	the cost rep	bitting period	0	00
00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 +	line	68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF	/IID	ONLY			
00	Skilled nursing facility/other nursing facil	3)		70
00	Adjusted general inpatient routine service c		ine 70 ÷	line	2)			71
00	Program routine service cost (line 9 x line	,	(line 14	v 13	no 2E)			72
00 00	Medically necessary private room cost applic Total Program general inpatient routine serv				118 35)			73
00	Capital -related cost allocated to inpatient				orksheet B	Part II column		75
	26, line 45)			W		corumit		'
00	Per diem capital-related costs (line 75 ÷ li	ne 2)						76
00	Program capital-related costs (line 9 x line							77
00	Inpatient routine service cost (line 74 minu	,		-				78
00	Aggregate charges to beneficiaries for exces					aug Ling 70)		79
00 00	Total Program routine service costs for comp. Inpatient routine service cost per diem limi		JUST IIMIT	auon	(IINe /8 MII	ius i i ne 79)		80
00	Inpatient routine service cost per drem frim)					82
00	Reasonable inpatient routine service cost frim tatron (i							83
00	Program inpatient ancillary services (see in		,					84
00	Utilization review - physician compensation		ons)					85
00	Total Program inpatient operating costs (sum							86
00	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST						
00	Total observation bed days (see instructions Adjusted general inpatient routine cost per)					0.00	87

Health Financial Systems REH.	ABILITATION HOSE	PITAL OF FT WAY	ΊΝΕ	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 10/01/2017	Worksheet D-1	
				To 09/30/2018		pared: 42 am
	_	Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	205, 075	7, 051, 024	0. 02908	4 0	0	90.00
91.00 Nursing School cost	0	7,051,024	0.00000	0 0	0	91.00
92.00 Allied health cost	0	7,051,024	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	7, 051, 024	0. 00000	0 0	0	93.00

Health Financial Systems REHA	BILITATION HOSPITAL OF FT WAY	/NE	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC		Peri od:	Worksheet D-3	
			From 10/01/2017		
			To 09/30/2018	Date/Time Pre 2/25/2019 11:	pared: 42 am
	Title	e XVIII	Hospi tal	PPS	42 am
Cost Center Description		Ratio of Cost		I npati ent	
		To Charges		Program Costs	
		j i i i i i gi i		(col. 1 x col.	
			5	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			5, 940, 795		30.00
ANCI LLARY SERVI CE COST CENTERS					
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.06634	1 286, 112	18, 981	54.00
60. 00 06000 LABORATORY		0. 07481	8 636, 503		
65. 00 06500 RESPI RATORY THERAPY		0. 93501	8 21, 371	19, 982	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 23959	0 2, 371, 534	568, 196	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 23811			1
68.00 06800 SPEECH PATHOLOGY		0. 18906			1
69. 00 06900 ELECTROCARDI OLOGY		0. 03848			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 05383			1
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 08858		259, 641	
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 20982			
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY		0. 22526	7 516, 496		
200.00 Total (sum of lines 50 through 94 and 9			10, 979, 100		
201.00 Less PBP Clinic Laboratory Services-Pro	ogram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			10, 979, 100		202.00

Health Financial Systems	REHABILITATION HOSPITAL OF FT WAY	'NE	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC		Period:	Worksheet D-3	
			From 10/01/2017 To 09/30/2018	Date/Time Pre	narod.
			10 09/30/2016	2/25/2019 11:	
	Titl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cost	I npati ent	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			070.00/		
30. 00 03000 ADULTS & PEDI ATRI CS			272, 996		30.00
ANCI LLARY SERVI CE COST CENTERS		0.04404		(05	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.06634			
60. 00 06000 LABORATORY		0.074818			60.00
65. 00 06500 RESPI RATORY THERAPY		0. 935018			65.00
66. 00 06600 PHYSI CAL THERAPY		0. 239590			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 238112			67.00
68. 00 06800 SPEECH PATHOLOGY		0. 189060			
69. 00 06900 ELECTROCARDI OLOGY	IT.	0. 038484		0	69.00 71.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN		0. 053838			73.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 088588 0. 209823			
76. 01 03950 HEMODIALYSIS & OTHER ANCILLARY	5	0. 20982		2,017	76.00
	and $0($ through $00)$	0. 22520	488, 405	-	
			488, 405	86, 906	200.00
			488, 405		201.00
202.00 Net charges (line 200 minus line 2	2017	l	400, 405	l	202.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	F	Period: From 10/01/2017 To 09/30/2018	2/25/2019 11:	pared:
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5, 135, 601		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, write "NONE" or enter a zero		C, 122, 122		0	
3.00	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 3. 02	ADJUSTMENTS TO PROVIDER		(0	
3.02			(0	
3.03			(0	
3.05			(0	
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		C		0	
3.51			0		0	
3.52			0		0	
3.53 3.54			(0	
3. 99 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(0	
4.00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5, 135, 601		0	4.0
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
5. 01	Program to Provider TENTATIVE TO PROVIDER				0	5.0 [.]
5.01			(0	
5.03			C		0	
	Provider to Program					1
5.50	TENTATI VE TO PROGRAM		C		0	
5.51			0		0	
5.52 5.99	Subtatal (sum of lines E 01 E 40 minus sum of lines		(0	
0. 77	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		Ĺ		0	3.9
. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
. 01	SETTLEMENT TO PROVIDER		16, 034	L I	0	6.0
b. 02	SETTLEMENT TO PROGRAM		,		0	
7.00	Total Medicare program liability (see instructions)		5, 151, 635	5	0	
				Contractor Number	NPR Date (Mo/Day/Yr)	
		C)	1.00	2.00	

PART 111 - MEDICARE PART A SERVICES - IRF PPS 1.00 0 Net Federal PPS Payment (see instructions) 4, 663, 67 0.00 Medicare SSI ratio (IRF PPS only) (see instructions) 4, 663, 67 1.00 Dutlier Payment Rehabilitation LIP Payments (see instructions) 4, 663, 67 0.01 Dutlier Rehabilitation LIP Payments (see instructions) 2, 67 0.02 Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions) 0, 00 0.10 Car Fact 2, 424(d)(1)(1)(1)(F)(1) or (2) (see instructions) 0, 00 0.00 Current year's summighted FTE count of 18 Reculuding FTEs in the new program growth period of a "new teaching program" (see instructions) 0, 00 0.01 Current year's sumweighted FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 0, 00 1.00 Current year's sumweighted FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 0, 00 1.00 Car FPS Payment (see instructions) 0, 00 1.00 Car FPS Payment (see instructions) 0, 00 1.00 Car FPS Payment (see instructions) 0, 00 1.00 <th>DICARE PART A SERVICES - IRF PPS PS Payment (see instructions) ratio (IRF PPS only) (see instructions) abil itation LIP Payments (see instructions) retrr and resident FTE count in the most recent cost reporting period ending on or prior 5.2004 (see instructions) for the unwel ghted intern and resident FTE count for residents that were displaced by porgram adjustment. (see instructions) rum" (see instructions) sumedighted IRF FTE count for IRR excluding FTEs in the new program growth period of a "new ram" (see instructions) sumedighted IRF FTE count for residents within the new program growth period of a "new ram" (see instructions) sumedighted IRF FTE count for residents within the new program growth period of a "new ram" (see instructions) stemet (see instructions)</th> <th>CALCUL</th> <th>ATION OF REIMBURSEMENT SETTLEMENT</th> <th>Provi der CCN: 15-3030</th> <th>Period: From 10/01/2017 To 09/30/2018</th> <th>2/25/2019 11:</th> <th>pare</th>	DICARE PART A SERVICES - IRF PPS PS Payment (see instructions) ratio (IRF PPS only) (see instructions) abil itation LIP Payments (see instructions) retrr and resident FTE count in the most recent cost reporting period ending on or prior 5.2004 (see instructions) for the unwel ghted intern and resident FTE count for residents that were displaced by porgram adjustment. (see instructions) rum" (see instructions) sumedighted IRF FTE count for IRR excluding FTEs in the new program growth period of a "new ram" (see instructions) sumedighted IRF FTE count for residents within the new program growth period of a "new ram" (see instructions) sumedighted IRF FTE count for residents within the new program growth period of a "new ram" (see instructions) stemet (see instructions)	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-3030	Period: From 10/01/2017 To 09/30/2018	2/25/2019 11:	pare
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1.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)01.50Pioneer ACO demonstration payment adjustment (see instructions)01.99Demonstration payment adjustment amount before sequestration02.00Total amount payable to the provider (see instructions)5, 256, 7702.01Sequestration adjustment (see instructions)105, 1352.02Demonstration payment adjustment amount after sequestration03.00Interim payments5, 135, 6014.00Tentative settlement (for contractor use only)05.00Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)16, 034	ENTS (SEE INSTRUCTIONS) (SPECIFY)0emonstration payment adjustment (see instructions)0payment adjustment amount before sequestration0payable to the provider (see instructions)5, 256, 770adjustment (see instructions)105, 135payment adjustment amount after sequestration0nts5, 135, 601tlement (for contractor use only)0rovider/program (line 32 minus lines 32.01, 32.02, 33, and 34)16, 034unts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,26, 264					-	
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2. 01Sequestration adjustment (see instructions)105, 1352. 02Demonstration payment adjustment amount after sequestration03. 00Interim payments5, 135, 6015. 00Tentative settlement (for contractor use only)06. 00Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)16, 034	adj ustment (see instructions)105,13532payment adj ustment amount after sequestration032nts5,135,60133tl ement (for contractor use only)034rovider/program (line 32 minus lines 32.01, 32.02, 33, and 34)16,034unts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,26,264		1 3 3			-	
2. 02Demonstration payment adjustment amount after sequestration03. 00Interim payments5, 135, 6015. 00Tentative settlement (for contractor use only)05. 00Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)16, 034	payment adjustment amount after sequestration 0 32 nts 5,135,601 33 tlement (for contractor use only) 0 34 rovider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 16,034 35 unts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 26,264			1 <i>3 j</i>			
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I. 00Tentative settlement (for contractor use only)05. 00Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)16,034	tlement (for contractor use only)034rovider/program (line 32 minus lines 32.01, 32.02, 33, and 34)16,03435unts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,26,26436					-	
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	unts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 26,264 36			$(1 \ 32 \ 02 \ 33 \ and \ 34)$		Ű	
2.00 processes amounts (nonarrowable cost report remis) in according with own rub. 10^{-2} , 0 and 10 1					chanter 1		
\$115.2	ED BY CONTRACTOR	,. 00		accordance with ows rub. 15-2,		20, 204	

- 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money 53.00 Time Value of Money (see instructions) 198, 82650. 00051. 000. 0052. 00053. 00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3030	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part VII Date/Time Pre 2/25/2019 11:	pare
		Title XIX	Hospi tal	PPS	
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE COMPUTATION OF NET COST OF COVERED SERVICES	RVICES FOR TITLES V OR X	IX SERVICES		-
00	Inpatient hospital/SNF/NF services		0		1.
00	Medical and other services		0	0	
00	Organ acquisition (certified transplant centers only)		0	-	3
00	Subtotal (sum of lines 1, 2 and 3)		0	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
~~	Reasonable Charges		272.00/		
00 00	Routine service charges Ancillary service charges		272, 996 488, 405	0	8
0.00	Organ acquisition charges, net of revenue		488, 405	0	10
1.00	Incentive from target amount computation		0		11
	Total reasonable charges (sum of lines 8 through 11)		761, 401	0	
	CUSTOMARY CHARGES		701,101		1
3.00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13
1. 00	basis Amounts that would have been realized from patients liable fo	or payment for services c	in O	0	14
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0.000000	
	Total customary charges (see instructions)		761, 401	0	16
7.00	Excess of customary charges over reasonable cost (complete on line 4) (see instructions)	ily if line 16 exceeds	761, 401	0	17
B. 00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds lin		0	18
5. 00	16) (see instructions)			0	
9.00	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
1.00	Cost of covered services (enter the lesser of line 4 or line	16)	0	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provi	ders.		
	Other than outlier payments		0	0	
	Outlier payments		0	0	
4.00	Program capital payments		0		24
	Capital exception payments (see instructions)		0	0	25
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27)		0	0	
7.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	0	2,
0 00	Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31
2.00	Deducti bl es	,	0	0	32
	Coinsurance		0	0	
1.00	Allowable bad debts (see instructions)		0	0	34
5.00	Utilization review		0		35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	id 33)	0	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		0	0	
	Direct graduate medical education payments (from Wkst. E-4)		0	-	39
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
1.00	Interim payments		0	0	41
	Balance due provider/program (line 40 minus line 41)	man with CMC Dub 15 2	0	0	
3.00	Protested amounts (nonallowable cost report items) in accorda chapter 1, §115.2	INCE WITH CMS PUD 15-2,	0	0	43

	SHEET (If you are nonproprietary and do not maintain e accounting records, complete the General Fund column	Provider C	CN: 15-3030	Period: From 10/01/2017	Worksheet G	
na-typ nly)	e accounting records, complete the General Fund column			To 09/30/2018	Date/Time Pre 2/25/2019 11:	
		General Fund	Specific Purpose Func		Plant Fund	
CU	IRRENT ASSETS	1.00	2.00	3.00	4.00	
	ash on hand in banks	-42, 351		0 0	0	1 1
00 Te	emporary investments	0		0 0	0	2
00 No	otes receivable	0		0 0	0	3
00 Ac	ccounts receivable	2, 631, 929		0 0	0	4
	ther receivable	0		0 0	0	
	llowances for uncollectible notes and accounts receivable	-226, 298		0 0	0	
	nventory	15, 066		0 0	0	
	repaid expenses ther current assets	36, 118 862		0 0	0	
	ue from other funds	002		0 0	0	
	otal current assets (sum of lines 1-10)	2, 415, 326		0 0	0	
	XED ASSETS	2, 110, 020			0	1
	and	900, 000		0 0	0	1 12
. 00 La	and improvements	288, 293		0 0	0	13
. 00 Ac	ccumulated depreciation	-150, 412		0 0	0	14
	ui I di ngs	11, 662, 532		0 0	0	
	ccumulated depreciation	-2, 787, 160		0 0	0	
	easehold improvements	749, 595		0 0	0	
	ccumulated depreciation	-139, 264		0 0	0	
	ixed equipment ccumulated depreciation	606, 110 -88, 618		0 0 0 0	0	
	utomobiles and trucks	113, 428		0 0	0	
	ccumul ated depreciation	-113, 428		0 0	0	
	ajor movable equipment	619, 266		0 0	0	
	ccumulated depreciation	-184, 085		0 0	0	
5. OO 🛛 Mi	nor equipment depreciable	365, 710		0 0	0	25
	ccumulated depreciation	-269, 081		0 0	0	
	T designated Assets	0		0 0	0	
	ccumulated depreciation	0		0 0	0	
	inor equipment-nondepreciable	11 570 004		0 0	0	
	otal fixed assets (sum of lines 12-29) THER ASSETS	11, 572, 886	1	0 0	0	30
	nvestments	0		0 0	0	31
	eposits on Leases	0		0 0	0	
	ue from owners/officers	0		0 0	0	
4. 00 01	ther assets	548, 803		0 0	0	34
5.00 To	otal other assets (sum of lines 31-34)	548, 803		0 0	0	35
	otal assets (sum of lines 11, 30, and 35)	14, 537, 015		0 0	0	36
	JRRENT LI ABI LI TI ES			-	-	1
1	ccounts payable	282, 942		0 0	0	
	alaries, wages, and fees payable ayroll taxes payable	442, 832		0 0	0	
	btes and loans payable (short term)	0			0	
	eferred income	0		0 0	0	
	ccelerated payments	0				42
3.00 Du	ue to other funds	18, 710, 945		0 0	0	43
4. 00 01	ther current liabilities	193, 607		0 0	0	44
	otal current liabilities (sum of lines 37 thru 44)	19, 630, 326		0 0	0	45
	NG TERM LIABILITIES		1		-	I
	ortgage payable	0		0 0	0	
	otes payable	0		0 0	0	
	nsecured loans ther long term liabilities	0		0 0	0	
	otal long term liabilities (sum of lines 46 thru 49)	0		0 0	0	
	otal liabilities (sum of lines 45 and 50)	19, 630, 326		0 0		
	API TAL ACCOUNTS	, ,				1
	eneral fund balance	-5, 093, 311				52
	pecific purpose fund			0		53
	onor created - endowment fund balance - restricted			0		54
	onor created - endowment fund balance - unrestricted			0		55
	overning body created - endowment fund balance			0	-	56
	ant fund balance - invested in plant				0	
	ant fund balance - reserve for plant improvement, eplacement, and expansion				0	58
	otal fund balances (sum of lines 52 thru 58)	-5, 093, 311		0 0	0	59
	otal liabilities and fund balances (sum of lines 51 and	14, 537, 015		0 0	0	
		,,,	1	- I V	0	1 .

Health Financial Systems REHA STATEMENT OF CHANGES IN FUND BALANCES			TAL OF FT WAYNE Provider CCN: 15-3030		In Lie Period: From 10/01/2017 To 09/30/2018		Worksheet G-1 Date/Time Pre 2/25/2019 11:		pared:
		General	Fund	Speci al	Pur	pose Fund	Endowment Fu		
		1.00	2.00	3.00		4.00	5.00		
1.00	Fund balances at beginning of period	1.00	-4, 209, 633	3.00		4.00	5.00		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-883, 678			0			2.00
3.00	Total (sum of line 1 and line 2)		-5,093,311			0			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			0			10.00
11.00	Subtotal (line 3 plus line 10)		-5, 093, 311			0			11.00
12.00	Deductions (debit adjustments) (specify)	0			0				12.00
13.00		0			0				13.00
14.00		0			0				14.00
15.00 16.00		0			0				15.00 16.00
17.00		0			0				17.00
18.00	Total deductions (sum of lines 12-17)	0	0		0	0		4	18.00
19.00	Fund balance at end of period per balance		-5, 093, 311			0			19.00
	sheet (line 11 minus line 18)		0,0,0,0,011			0			
		Endowment Fund	PI ant	Fund					
		6.00	7.00	8.00					
1.00	Fund balances at beginning of period	0			0				1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)								2.00
	Total (sum of line 1 and line 2)				0				3.00
		0			U				4.00
4.00	Additions (credit adjustments) (specify)	0	0		0				5.00
4.00 5.00		0	0		U				
4.00 5.00 5.00		0	0		0				
4.00 5.00 6.00 7.00		0	0 0 0		U				7.00
4.00 5.00 6.00 7.00 3.00		0	0 0 0 0		U				7.0 8.0
4.00 5.00 5.00 7.00 3.00 9.00	Additions (credit adjustments) (specify)		0 0 0						7.00 8.00 9.00
4.00 5.00 5.00 7.00 8.00 9.00 10.00	Additions (credit adjustments) (specify) Total additions (sum of line 4-9)	0	0 0 0 0		0				7.0 8.0 9.0
4.00 5.00 5.00 7.00 8.00 9.00 10.00 11.00	Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		0 0 0 0 0						7.00 8.00 9.00 10.00 11.00
4.00 5.00 5.00 7.00 3.00 9.00 10.00 11.00 12.00	Additions (credit adjustments) (specify) Total additions (sum of line 4-9)				0				7.00 8.00 9.00 10.00 11.00 12.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		0 0 0 0 0		0				6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		0 0 0 0 0 0 0		0				7.00 8.00 9.00 10.00 11.00 12.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)				0				7.00 8.00 9.00 10.00 11.00 12.00 13.00
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	Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)				0				7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)				0				7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0			0 0				7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00

STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN	N: 15-3030	Peri od:		Worksheet G-2	
				From 10/0 To 09/3	1/2017 0/2018	Parts I & II Date/Time Pre	
	Cost Center Description		Inpati ent	Outpat	ient	2/25/2019 11: Total	
			1.00	2.0		3.00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Services						
1.00	Hospi tal		14, 857, 33	19		14, 857, 339	
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVIDER					_	4.00
5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - NF			0		0	6.00
7.00	SKILLED NURSING FACILITY						7.00
8.00 9.00	NURSING FACILITY OTHER LONG TERM CARE						9,00
9.00 10.00	Total general inpatient care services (sum of lines 1-9)		14, 857, 33	0		14, 857, 339	
10.00	Intensi ve Care Type Inpatient Hospital Services		14,057,50	7		14, 007, 339	10.00
11.00	INTENSIVE CARE UNIT						11.00
12.00	CORONARY CARE UNIT						12.00
13.00	BURN I NTENSI VE CARE UNI T						13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines		0		0	1
	11-15)			-		-	
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14, 857, 33	9		14, 857, 339	17.00
18.00	Ancillary services		26, 891, 73		23, 841	26, 915, 575	18.00
19.00	Outpatient services			0	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	СМНС						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPICE						26.00
27.00	OTHER (SPECIFY)			0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	41, 749, 07	3	23, 841	41, 772, 914	28.00
	G-3, line 1)						-
29.00	PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200)			12.4	62, 691		29.00
29.00 30.00	ADD (SPECIFY)			0 12,4	02, 091		30.00
30.00	ADD (SFECILI)			0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECIFY)			0	0		37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				0			41.00
42.00	Total deductions (sum of lines 37-41)				0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		12, 4	62, 691		43.00
	to Wkst. G-3, line 4)						

Heal th	Financial Systems REHABILITATION HOSPI	TAL OF FT WAYNE	In Lie	u of Form CMS-2	2552-10
STATEM	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-3030 Period:			Worksheet G-3	
			From 10/01/2017 To 09/30/2018	Date/Time Prep 2/25/2019 11:4	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			41, 772, 914	1.00
2.00	Less contractual allowances and discounts on patients' accounts			30, 297, 174	2.00
3.00	Net patient revenues (line 1 minus line 2)			11, 475, 740	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		12, 462, 691	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-986, 951	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00					8.00
9.00	Revenue from television and radio service			0	9.00
	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			0	11.00
	Parking lot receipts			0	12.00
	Revenue from laundry and linen service			0	13.00
	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER INCOME			103, 273	24.00
25.00	Total other income (sum of lines 6-24)			103, 273	25.00
26.00	Total (line 5 plus line 25)			-883, 678	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			-883, 678	29.00