

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report Date: 11/02/2015 Time: 13:07 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: _____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

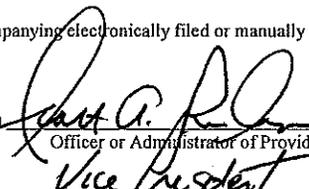
PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by

ECR Encryption: 11/02/2015 13:07
401yPOSAA16tcC3S9LkTTJ0uA6p.T0
dnJyb0oyAaqZ144eyYViz1Vvz4Fpzj
a3We0iOUJC0yppvw6

(Signed) 
 Officer or Administrator of Provider(s)
 Vice President
 Title
 11/2/15
 Date

PI Encryption: 11/02/2015 13:07
8EKPoY.rPatJpa3bGITxw9u0Gx9H.0
7f9JG0DdhHVDrvZwyXejmzlb:P:0ymk
s7dj0oi6xY0FYDFX

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
		1	PART A	PART B	4	5	
			2	3			
1	HOSPITAL		1,328,367				1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		1,328,367				200

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 for this information collection is 0938-0050. The time required to complete this 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 this 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

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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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 700 BROADWAY, 7TH FLOOR EAST	P.O. Box:				1
2	City: FORT WAYNE	State: IN	ZIP Code: 46802	County: ALLEN		2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	SSH - FORT WAYNE, INC.	15-2016	23060	2	07/01/1997	N	P	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2014	To: 06 / 30 / 2015		20
21	Type of control (see instructions)	4			21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, 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.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1						26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1						27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				36

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.		37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:
		38	

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PART I

39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	1	2	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
		V	XVIII	XIX
Prospective Payment System (PPS)-Capital		1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
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)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
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)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)			62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N		63
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WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
67							67

Inpatient Psychiatric Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	Y			80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N			81

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter 'Y' for yes or 'N' for no.	N			85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.				86
87	Is this hospital a 'subclass (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N			87

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WORKSHEET S-2
PART I

Title V and XIX Services		V 1	XIX 2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	N	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers		1	2		
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106	
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107	
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108	
		Physical	Occupational	Speech	Respiratory
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.		N	N	N
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	30,000,000	30,000,000		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	N			121

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N			125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.				134

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WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	HB0312	140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name: NAME: SELECT MEDICAL	Contractor's Name: NOVITAS SOLUTIONS INC.		Contractor's Number: 12001	141
142	Street: STREET: 4714 GETTYSBURG ROAD	P.O. Box:			142
143	City: CITY: MECHANICSBURG	State: PA	ZIP Code: 17055		143
144	Are provider based physicians' costs included in Worksheet A?	Y			144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y			145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N			147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N			148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N			149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII					
		Part A		Part B	Title V		Title XIX
		1	2	3	4		
155	Hospital	N	N	N	N	155	
156	Subprovider - IPF	N	N			156	
157	Subprovider - IRF	N	N			157	
158	Subprovider - Other					158	
159	SNF	N	N			159	
160	HHA	N	N			160	
161	CMHC		N			161	
161.10	CORF					161.10	

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N					165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)						166
	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	N				167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)					168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)					168.01
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)				N	171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N	Date	
Provider Organization and Operation		I	2	
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1
		Y/N	Date	V/I
		I	2	3
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N		2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3

		Y/N	Type	Date
Financial Data and Reports		I	2	3
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	C	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N		5

		Y/N	Y/N
Approved Educational Activities		I	2
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N	6
7	Are costs claimed for allied health programs? If yes, see instructions.	N	7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N	8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N	9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N	10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N	11

		Y/N
Bad Debts		Y
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N

		Y/N
Bed Complement		N
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data		I	2	3	4
16	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)	N		N	
17	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)	N		N	
18	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 the cost report? If yes, see instructions.	N		N	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	Y		N	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost		
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	27

Interest Expense		
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.	29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	31

Purchased Services		
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	33

Provider-Based Physicians		
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information			
41	First name: CODY	Last name: WAGNER	Title: REIMBURSEMENT ANALYST
42	Employer: SELECT MEDICAL		
43	Phone number: 717-884-7307	E-mail Address: CWWAGNER@SELECTMEDICAL.COM	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		1	2	3	4	5	6	7	8	
1	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)	30	32	11,680			4,352		7,171	1
2	HMO and other (see instructions)						1,109	77		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		32	11,680			4,352		7,171	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		32	11,680			4,352		7,171	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		32							27
28	Observation Bed Days									28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART 1

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	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)					174		267	1
2	HMO and other (see instructions)					36	4		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		69.44			174		267	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider 1								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		69.44						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassi- fication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	Total salaries (see instructions)	200	4,037,244		144,440.86		1
2	Non-physician anesthetist Part A						2
3	Non-physician anesthetest Part B						3
4	Physician-Part A - Administrative						4
4.01	Physician-Part A - Teaching						4.01
5	Physician-Part B						5
6	Non-physician-Part B						6
7	Interns & residents (in an approved program)	21					7
7.01	Contracted interns & residents (in an approved program)						7.01
8	Home office personnel						8
9	SNF	44					9
10	Excluded area salaries (see instructions)			40,434	929.52		10
OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)						11
12	Contract management and administrative services						12
13	Contract labor: Physician-Part A - Administrative	2,885			24.00		13
14	Home office salaries & wage-related costs						14
15	Home office: Physician Part A - Administrative						15
16	Home office & Contract Physicians Part A - Teaching						16
WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)						17
18	Wage-related costs (other)(see instructions)						18
19	Excluded areas						19
20	Non-physician anesthetist Part A						20
21	Non-physician anesthetist Part B						21
22	Physician Part A - Administrative						22
22.01	Physician Part A - Teaching						22.01
23	Physician Part B						23
24	Wage-related costs (RHC/FQHC)						24
25	Interns & residents (in an approved program)						25
OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		18,208		529.13		26
27	Administrative & General		682,834	-40,434	16,580.74		27
28	Administrative & General under contract (see instructions)						28
29	Maintenance & Repairs						29
30	Operation of Plant						30
31	Laundry & Linen Service						31
32	Housekeeping						32
33	Housekeeping under contract (see instructions)						33
34	Dietary		9,708		412.35		34
35	Dietary under contract (see instructions)						35
36	Cafeteria						36
37	Maintenance of Personnel						37
38	Nursing Administration		109,098		2,080.00		38
39	Central Services and Supply						39
40	Pharmacy						40
41	Medical Records & Medical Records Library		40,467		1,385.71		41
42	Social Service						42
43	Other General Service						43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		4,037,244		4,037,244	144,440.86	27.95	1
2	Excluded area salaries (see instructions)			40,434	40,434	929.52	43.50	2
3	Subtotal salaries (line 1 minus line 2)		4,037,244	-40,434	3,996,810	143,511.34	27.85	3
4	Subtotal other wages & related costs (see instructions)		2,885		2,885	24.00	120.21	4
5	Subtotal wage-related costs (see instructions)							5
6	Total (sum of lines 3 through 5)		4,040,129	-40,434	3,999,695	143,535.34	27.87	6
7	Total overhead cost (see instructions)		860,315	-40,434	819,881	20,987.93	39.06	7

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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

Part IV - Wage Related Cost

Part A - Core List

	Amount Reported
RETIREMENT COST	
1 401K Employer Contributions	1
2 Tax Sheltered Annuity (TSA) Employer Contribution	2
3 Nonqualified Defined Benefit Plan Cost (see instructions)	3
4 Qualified Defined Benefit Plan Cost (see instructions)	4
PLAN ADMINISTRATIVE COSTS (Paid to External Organization):	
5 401k/TSA Plan Administration Fees	5
6 Legal/Accounting/Management Fees-Pension Plan	6
7 Employee Managed Care Program Administration Fees	7
HEALTH AND INSURANCE COST	
8 Health Insurance (Purchased or Self Funded)	8
9 Prescription Drug Plan	9
10 Dental, Hearing and Vision Plan	10
11 Life Insurance (If employee is owner or beneficiary)	11
12 Accident Insurance (If employee is owner or beneficiary)	12
13 Disability Insurance (If employee is owner or beneficiary)	13
14 Long-Term Care Insurance (If employee is owner or beneficiary)	14
15 Workers' Compensation Insurance	15
16 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	16
TAXES	
17 FICA-Employers Portion Only	17
18 Medicare Taxes - Employers Portion Only	18
19 Unemployment Insurance	19
20 State or Federal Unemployment Taxes	20
OTHER	
21 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)	21
22 Day Care Costs and Allowances	22
23 Tuition Reimbursement	23
24 Total Wage Related cost (Sum of lines 1-23)	24

Part B - Other Than Core Related Cost

25 OTHER WAGE RELATED COSTS (SPECIFY)	25
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 1: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	Wage Index Fiscal Year Ending Date		1
2	Provider's Cost Reporting Period Used for Wage Index Year on Line 1 (FYB in Col. 1, FYE in Col. 2)		2
3	Midpoint of Provider's Cost Reporting Period Shown on Line 2, Adjusted to First of Month		3
4	Date Beginning the 3-Year Averaging Period (subtract 18 months from midpoint shown on Line 3)		4
5	Date Ending the 3-Year Averaging Period (add 18 months to midpoint shown on Line 3)		5
STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	Effective Date of Pension Plan		6
7	First Day of the Provider Cost Reporting Period Containing the Pension Plan Effective Date		7
8	Starting Date of the Adjusted Averaging Period (date on Line 7, adjusted to first of month)		8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	Beginning Date of Averaging Period from Line 4 or Line 8, as Applicable		9
10	Ending Date of Averaging Period from Line 5		10
11	Enter Provider Contributions Made During Averaging Period on Lines 9 & 10	DEPOSIT DATE(S)	CONTRIB-UTION(S)
12	Total Calendar Months Included in Averaging Period (36 unless Step 2 completed)		12
13	Total Contributions Made During Averaging Period		13
14	Average Monthly Contribution (Line 13 divided by Line 12)		14
15	Number of MOths in Provider Cost Reporting Period on Line 2		15
16	Average Pension Contributions (Line 14 times Line 15)		16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	Annual Prefunding Installment (see instructions)		17
18	Reportable Prefunding Installment ((Line 17 times Line 15) divided by 12)		18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)		19

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost			1
2	Hospital			2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

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HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

WORKSHEET S-5

RENAL DIALYSIS STATISTICS

	DESCRIPTION	Outpatient		Training		Home		
		Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list		11
12	Number of patients transplanted during the cost reporting period		12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider		13
14	Epoetin amount from Worksheet A for home dialysis program		14
15	Number of EPO units furnished relating to the renal dialysis department		15
16	Number of EPO units furnished relating to the home dialysis department		16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider		17
18	ARANESP amount from Worksheet A for home dialysis program		18
19	Number of ARANESP units furnished relating to the renal dialysis department		19
20	Number of ARANESP units furnished relating to the home dialysis department		20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable method(s))

21	MCP	INITIAL METHOD	
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	Erythropoiesis-Stimulating Agents (ESA) Statistics:	ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATION S	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOCA- TION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				441,991	441,991		441,991	1
2	00200	Cap Rel Costs-Mvble Equip		978,873	978,873	-721,966	256,907	21,400	278,307	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	18,208	2,237	20,445	10,314	30,759		30,759	4
5	00500	Administrative & General	682,834	912,581	1,595,415	31,563	1,626,978	136,382	1,763,360	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant				131,059	131,059		131,059	7
8	00800	Laundry & Linen Service		40,825	40,825		40,825		40,825	8
9	00900	Housekeeping		21,365	21,365	48,597	69,962		69,962	9
10	01000	Dietary	9,708	179,183	188,891		188,891		188,891	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	109,098	19,032	128,130		128,130		128,130	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Library	40,467	28,032	68,499		68,499	-34	68,465	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	2,208,626	822,818	3,031,444		3,031,444	-907	3,030,537	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room		805,345	805,345		805,345		805,345	50
54	05400	Radiology-Diagnostic		376,807	376,807		376,807		376,807	54
60	06000	Laboratory		545,396	545,396		545,396		545,396	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	449,591	187,016	636,607		636,607		636,607	65
66	06600	Physical Therapy	128,640	23,489	152,129		152,129		152,129	66
67	06700	Occupational Therapy	120,960	18,854	139,814		139,814		139,814	67
68	06800	Speech Pathology		18,162	18,162		18,162		18,162	68
69	06900	Electrocardiology		95,619	95,619		95,619		95,619	69
71	07100	Medical Supplies Charged to Patients	31,734	807,438	839,172		839,172		839,172	71
73	07300	Drugs Charged to Patients	237,378	622,141	859,519		859,519		859,519	73
74	07400	Renal Dialysis		177,989	177,989		177,989		177,989	74
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	4,037,244	6,683,202	10,720,446	-58,442	10,662,004	156,841	10,818,845	118
		NONREIMBURSABLE COST CENTERS								
194	07950	PROVIDER RELATIONS NRCC				58,442	58,442		58,442	194
194.0	07951	NRCC SUBLEASED SPACE								194.0
1										1
200		TOTAL (sum of lines 118-199)	4,037,244	6,683,202	10,720,446		10,720,446	156,841	10,877,287	200

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	FACILITY RENT	A	Cap Rel Costs-Bldg & Fixt	1		621,647	1
500	Total reclassifications					621,647	500
	Code Letter - A						
1	EMPLOYEE BENEFITS	B	Employee Benefits Department	4		10,314	1
500	Total reclassifications					10,314	500
	Code Letter - B						
1	OPERATION PORTION OF LEASE	C	Operation of Plant	7		131,059	1
2	OPERATION PORTION OF LEASE	C	Housekeeping	9		48,597	2
500	Total reclassifications					179,656	500
	Code Letter - C						
1	CAPITAL RECONCILIATION	D	Administrative & General	5		100,319	1
500	Total reclassifications					100,319	500
	Code Letter - D						
1	PROVIDER RELATIONS	E	PROVIDER RELATIONS NRCC	194	40,434	18,008	1
500	Total reclassifications				40,434	18,008	500
	Code Letter - E						
	GRAND TOTAL (Increases)				40,434	929,944	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	FACILITY RENT	A	Cap Rel Costs-Mvble Equip	2		621,647	10	1
500	Total reclassifications					621,647		500
	Code letter - A							
1	EMPLOYEE BENEFITS	B	Administrative & General	5		10,314		1
500	Total reclassifications					10,314		500
	Code letter - B							
1	OPERATION PORTION OF LEASE	C	Cap Rel Costs-Bldg & Fixt	1		131,059	10	1
2	OPERATION PORTION OF LEASE	C	Cap Rel Costs-Bldg & Fixt	1		48,597	10	2
500	Total reclassifications					179,656		500
	Code letter - C							
1	CAPITAL RECONCILIATION	D	Cap Rel Costs-Mvble Equip	2		100,319	12	1
500	Total reclassifications					100,319		500
	Code letter - D							
1	PROVIDER RELATIONS	E	Administrative & General	5	40,434	18,008		1
500	Total reclassifications				40,434	18,008		500
	Code letter - E							
	GRAND TOTAL (Decreases)				40,434	929,944		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets
			Purchases	Donation	Total			
		1	2	3	4	5	6	7
1	Land							1
2	Land Improvements							2
3	Buildings and Fixtures							3
4	Building Improvements	1,196,206	4,215		4,215		1,200,421	4
5	Fixed Equipment							5
6	Movable Equipment	1,185,833	55,380		55,380		1,241,213	6
7	HIT-designated Assets							7
8	Subtotal (sum of lines 1-7)	2,382,039	59,595		59,595		2,441,634	8
9	Reconciling Items							9
10	Total (line 7 minus line 9)	2,382,039	59,595		59,595		2,441,634	10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

	Description	SUMMARY OF CAPITAL						
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)
*		9	10	11	12	13	14	15
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip	176,946	621,647		100,319	78,005	1,956	978,873
3	Total (sum of lines 1-2)	176,946	621,647		100,319	78,005	1,956	978,873

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may

have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)
*		1	2	3	4	5	6	7	8
1	Cap Rel Costs-Bldg & Fi	1,200,421		1,200,421	0.491647				
2	Cap Rel Costs-Mvble Equip	1,241,213		1,241,213	0.508353				
3	Total (sum of lines 1-2)	2,441,634		2,441,634	1.000000				

	Description	SUMMARY OF CAPITAL						
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)
*		9	10	11	12	13	14	15
1	Cap Rel Costs-Bldg & Fixt		441,991					441,991
2	Cap Rel Costs-Mvble Equip	198,346				78,005	1,956	278,307
3	Total (sum of lines 1-2)	198,346	441,991			78,005	1,956	720,298

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications,

Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.
				COST CENTER	LINE#	
		1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2	2
3	Investment income-other (chapter 2)					3
4	Trade, quantity, and time discounts (chapter 8)					4
5	Refunds and rebates of expenses (chapter 8)					5
6	Rental of provider space by suppliers (chapter 8)					6
7	Telephone services (pay stations excl) (chapter 21)					7
8	Television and radio service (chapter 21)					8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-907			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	282,960			12
13	Laundry and linen service					13
14	Cafeteria - employees and guests					14
15	Rental of quarters to employees & others					15
16	Sale of medical and surgical supplies to other than patients					16
17	Sale of drugs to other than patients					17
18	Sale of medical records and abstracts					18
19	Nursing school (tuition,fees,books,etc.)					19
20	Vending machines					20
21	Income from imposition of interest, finance or penalty charges (chapter 21)					21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments					22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65	23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66	24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114	25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1	26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19	28
29	Physicians' assistant					29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67	30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68	31
32	CAH HIT Adj for Depreciation					32
33	BAD DEBT REMOVAL	A	-122,534	Administrative & General	5	33
34	MEDICAL RECORDS INCOME	B	-34	Medical Records & Library	16	34
35	OTHER PERSONNEL EXPENSE	A	-1,224	Administrative & General	5	35
36	AHA DUES	A	-718	Administrative & General	5	36
37	GIFTS	A	-702	Administrative & General	5	37
38						38
39						39
40						40
41						41
42						42
43						43
44						44
45						45
46						46
47						47
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		156,841			50

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

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	

(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.

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

WORKSHEET A-8-1

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS
OR CLAIMED HOME OFFICE COSTS:

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
1	2	3	4	5	6	7	
1	2	Cap Rel Costs-Mvble Equip	HOME OFFICE CAPITAL	21,400	21,400	9	
2	5	Administrative & General	HOME OFFICE ADMIN	441,196	179,636	2	
3						3	
4						4	
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			462,596	179,636	282,960	5

* The amounts on lines 1 through 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 have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
				Name	Percentage of Ownership	
	1	2	3	4	5	6
6	B			SELECT MEDICAL	100.00	HEALTHCARE
7						
8						
9						
10						

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

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
- G. Other (financial Or non-financial) specify:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics A	1,525		1,525	171,400	15	1,236	62	1
2	30	Adults & Pediatrics B	1,360		1,360	171,400	9	742	37	2
3	30	Adults & Pediatrics C	87,840		87,840	171,400	8,784	723,835	36,192	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	90,725		90,725		8,808	725,813	36,291	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowanc e	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics A					1,236	289	289	1
2	30	Adults & Pediatrics B					742	618	618	2
3	30	Adults & Pediatrics C					723,835			3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					725,813	907	907	200

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	441,991	441,991					1
2	Cap Rel Costs-Mvble Equip	278,307		278,307				2
4	Employee Benefits Department	30,759			30,759			4
5	Administrative & General	1,763,360	202,781	127,684	4,916	2,098,741	2,098,741	5
6	Maintenance & Repairs							6
7	Operation of Plant	131,059	2,562	1,613		135,234	32,331	7
8	Laundry & Linen Service	40,825	10,991	6,921		58,737	14,043	8
9	Housekeeping	69,962	1,820	1,146		72,928	17,435	9
10	Dietary	188,891	5,069	3,192	74	197,226	47,152	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	128,130	11,270	7,096	835	147,331	35,223	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	68,465	7,464	4,700	310	80,939	19,351	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,030,537	156,923	98,809	16,904	3,303,173	789,710	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	805,345				805,345	192,539	50
54	Radiology-Diagnostic	376,807				376,807	90,086	54
60	Laboratory	545,396				545,396	130,391	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	636,607			3,441	640,048	153,020	65
66	Physical Therapy	152,129	7,798	4,910	984	165,821	39,644	66
67	Occupational Therapy	139,814	6,016	3,788	926	150,544	35,991	67
68	Speech Pathology	18,162	3,323	2,093		23,578	5,637	68
69	Electrocardiology	95,619				95,619	22,860	69
71	Medical Supplies Charged to Patients	839,172	12,402	7,809	243	859,626	205,516	71
73	Drugs Charged to Patients	859,519	11,660	7,342	1,817	880,338	210,468	73
74	Renal Dialysis	177,989				177,989	42,553	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	10,818,845	440,079	277,103	30,450	10,815,420	2,083,950	118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS NRCC	58,442	1,912	1,204	309	61,867	14,791	194
194.0	NRCC SUBLEASED SPACE							194.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	10,877,287	441,991	278,307	30,759	10,877,287	2,098,741	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINISTRATION	MEDICAL RECORDS + LIBRARY	
		7	8	9	10	13	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	167,565						7
8	Laundry & Linen Service	7,783	80,563					8
9	Housekeeping	1,288		91,651				9
10	Dietary	3,589		2,075	250,042			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	7,980		4,614		195,148		13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	5,285		3,056			108,631	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	111,114	80,563	64,254	250,042	195,148	33,586	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room						3,851	50
54	Radiology-Diagnostic						3,019	54
60	Laboratory						4,272	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy						23,046	65
66	Physical Therapy	5,522		3,193			2,302	66
67	Occupational Therapy	4,259		2,463			1,455	67
68	Speech Pathology	2,353		1,361			234	68
69	Electrocardiology						5,378	69
71	Medical Supplies Charged to Patients	8,782		5,078			12,701	71
73	Drugs Charged to Patients	8,256		4,774			17,181	73
74	Renal Dialysis						1,606	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	166,211	80,563	90,868	250,042	195,148	108,631	118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS NRCC	1,354		783				194
194.0	NRCC SUBLEASED SPACE							194.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	167,565	80,563	91,651	250,042	195,148	108,631	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		24	25	26		
	GENERAL SERVICE COST CENTERS					
1	Cap Rel Costs-Bldg & Fixt					1
2	Cap Rel Costs-Mvble Equip					2
4	Employee Benefits Department					4
5	Administrative & General					5
6	Maintenance & Repairs					6
7	Operation of Plant					7
8	Laundry & Linen Service					8
9	Housekeeping					9
10	Dietary					10
11	Cafeteria					11
12	Maintenance of Personnel					12
13	Nursing Administration					13
14	Central Services & Supply					14
15	Pharmacy					15
16	Medical Records & Library					16
17	Social Service					17
19	Nonphysician Anesthetists					19
20	Nursing School					20
21	I&R Services-Salary & Fringes Apprvd					21
22	I&R Services-Other Prgm Costs Apprvd					22
23	Paramed Ed Prgm-(specify)					23
	INPATIENT ROUTINE SERV COST CENTERS					
30	Adults & Pediatrics	4,827,590		4,827,590		30
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	1,001,735		1,001,735		50
54	Radiology-Diagnostic	469,912		469,912		54
60	Laboratory	680,059		680,059		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	816,114		816,114		65
66	Physical Therapy	216,482		216,482		66
67	Occupational Therapy	194,712		194,712		67
68	Speech Pathology	33,163		33,163		68
69	Electrocardiology	123,857		123,857		69
71	Medical Supplies Charged to Patients	1,091,703		1,091,703		71
73	Drugs Charged to Patients	1,121,017		1,121,017		73
74	Renal Dialysis	222,148		222,148		74
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
	OTHER REIMBURSABLE COST CENTERS					
	SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (sum of lines 1-117)	10,798,492		10,798,492		118
	NONREIMBURSABLE COST CENTERS					
194	PROVIDER RELATIONS NRCC	78,795		78,795		194
194.0	NRCC SUBLEASED SPACE					194.0
1						1
200	Cross Foot Adjustments					200
201	Negative Cost Centers					201
202	TOTAL (sum of lines 118-201)	10,877,287		10,877,287		202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		202,781	127,684	330,465	330,465		5
6	Maintenance & Repairs							6
7	Operation of Plant		2,562	1,613	4,175	5,091	9,266	7
8	Laundry & Linen Service		10,991	6,921	17,912	2,211	430	8
9	Housekeeping		1,820	1,146	2,966	2,745	71	9
10	Dietary		5,069	3,192	8,261	7,425	198	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		11,270	7,096	18,366	5,546	441	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		7,464	4,700	12,164	3,047	292	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		156,923	98,809	255,732	124,345	6,145	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room					30,317		50
54	Radiology-Diagnostic					14,185		54
60	Laboratory					20,531		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	30,437			30,437	24,095		65
66	Physical Therapy		7,798	4,910	12,708	6,242	305	66
67	Occupational Therapy		6,016	3,788	9,804	5,667	236	67
68	Speech Pathology		3,323	2,093	5,416	888	130	68
69	Electrocardiology					3,600		69
71	Medical Supplies Charged to Patients	327,040	12,402	7,809	347,251	32,361	486	71
73	Drugs Charged to Patients	11,091	11,660	7,342	30,093	33,140	457	73
74	Renal Dialysis					6,700		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	368,568	440,079	277,103	1,085,750	328,136	9,191	118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS NRCC		1,912	1,204	3,116	2,329	75	194
194.0	NRCC SUBLEASED SPACE							194.0
I								I
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	368,568	441,991	278,307	1,088,866	330,465	9,266	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	NURSING ADMINIS- TRATION	MEDICAL RECORDS + LIBRARY	SUBTOTAL	
		8	9	10	13	16	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	20,553						8
9	Housekeeping		5,782					9
10	Dietary		131	16,015				10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		291		24,644			13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library		193			15,696		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	20,553	4,055	16,015	24,644	4,847	456,336	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room					557	30,874	50
54	Radiology-Diagnostic					436	14,621	54
60	Laboratory					618	21,149	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy					3,332	57,864	65
66	Physical Therapy		201			333	19,789	66
67	Occupational Therapy		155			210	16,072	67
68	Speech Pathology		86			34	6,554	68
69	Electrocardiology					777	4,377	69
71	Medical Supplies Charged to Patients		320			1,836	382,254	71
73	Drugs Charged to Patients		301			2,484	66,475	73
74	Renal Dialysis					232	6,932	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	20,553	5,733	16,015	24,644	15,696	1,083,297	118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS NRCC		49				5,569	194
194.0	NRCC SUBLEASED SPACE							194.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	20,553	5,782	16,015	24,644	15,696	1,088,866	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		25	26			
	GENERAL SERVICE COST CENTERS					
1	Cap Rel Costs-Bldg & Fixt					1
2	Cap Rel Costs-Mvble Equip					2
4	Employee Benefits Department					4
5	Administrative & General					5
6	Maintenance & Repairs					6
7	Operation of Plant					7
8	Laundry & Linen Service					8
9	Housekeeping					9
10	Dietary					10
11	Cafeteria					11
12	Maintenance of Personnel					12
13	Nursing Administration					13
14	Central Services & Supply					14
15	Pharmacy					15
16	Medical Records & Library					16
17	Social Service					17
19	Nonphysician Anesthetists					19
20	Nursing School					20
21	I&R Services-Salary & Fringes Apprvd					21
22	I&R Services-Other Prgm Costs Apprvd					22
23	Paramed Ed Prgm-(specify)					23
	INPATIENT ROUTINE SERV COST CENTERS					
30	Adults & Pediatrics		456,336			30
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		30,874			50
54	Radiology-Diagnostic		14,621			54
60	Laboratory		21,149			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		57,864			65
66	Physical Therapy		19,789			66
67	Occupational Therapy		16,072			67
68	Speech Pathology		6,554			68
69	Electrocardiology		4,377			69
71	Medical Supplies Charged to Patients		382,254			71
73	Drugs Charged to Patients		66,475			73
74	Renal Dialysis		6,932			74
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct Part)					92
	OTHER REIMBURSABLE COST CENTERS					
	SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (sum of lines 1-117)		1,083,297			118
	NONREIMBURSABLE COST CENTERS					
194	PROVIDER RELATIONS NRCC		5,569			194
194.0	NRCC SUBLEASED SPACE					194.0
1						1
200	Cross Foot Adjustments					200
201	Negative Cost Centers					201
202	TOTAL (sum of lines 118-201)		1,088,866			202

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT T GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	23,806						1
2	Cap Rel Costs-Mvble Equip		23,806					2
4	Employee Benefits Department			4,019,036				4
5	Administrative & General	10,922	10,922	642,400	-2,098,741	8,778,546		5
6	Maintenance & Repairs							6
7	Operation of Plant	138	138			135,234	12,746	7
8	Laundry & Linen Service	592	592			58,737	592	8
9	Housekeeping	98	98			72,928	98	9
10	Dietary	273	273	9,708		197,226	273	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	607	607	109,098		147,331	607	13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	402	402	40,467		80,939	402	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,452	8,452	2,208,626		3,303,173	8,452	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room					805,345		50
54	Radiology-Diagnostic					376,807		54
60	Laboratory					545,396		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			449,591		640,048		65
66	Physical Therapy	420	420	128,640		165,821	420	66
67	Occupational Therapy	324	324	120,960		150,544	324	67
68	Speech Pathology	179	179			23,578	179	68
69	Electrocardiology					95,619		69
71	Medical Supplies Charged to Patients	668	668	31,734		859,626	668	71
73	Drugs Charged to Patients	628	628	237,378		880,338	628	73
74	Renal Dialysis					177,989		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	23,703	23,703	3,978,602	-2,098,741	8,716,679	12,643	118
	NONREIMBURSABLE COST CENTERS							
194	PROVIDER RELATIONS NRCC	103	103	40,434		61,867	103	194
194.0	NRCC SUBLEASED SPACE							194.0
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	441,991	278,307	30,759		2,098,741	167,565	202
203	Unit Cost Multiplier (Wkst. B, Part I)	18.566370	11.690624	0.007653		0.239076	13.146477	203
204	Cost to be allocated (Per Wkst. B, Part II)					330,465	9,266	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.037645	0.726973	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY PATIENT DAYS	NURSING ADMINISTRATION NURSING FTE'S	MEDICAL RECORDS + LIBRARY GROSS REVENUE
	8	9	10	13	16

GENERAL SERVICE COST CENTERS						
1 Cap Rel Costs-Bldg & Fixt						1
2 Cap Rel Costs-Mvble Equip						2
4 Employee Benefits Department						4
5 Administrative & General						5
6 Maintenance & Repairs						6
7 Operation of Plant						7
8 Laundry & Linen Service	7,171					8
9 Housekeeping		12,056				9
10 Dietary		273	7,171			10
11 Cafeteria						11
12 Maintenance of Personnel						12
13 Nursing Administration		607		43		13
14 Central Services & Supply						14
15 Pharmacy						15
16 Medical Records & Library		402			30,851,633	16
17 Social Service						17
19 Nonphysician Anesthetists						19
20 Nursing School						20
21 I&R Services-Salary & Fringes Apprvd						21
22 I&R Services-Other Prgm Costs Apprvd						22
23 Paramed Ed Prgm-(Specify)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 Adults & Pediatrics	7,171	8,452	7,171	43	9,538,167	30
ANCILLARY SERVICE COST CENTERS						
50 Operating Room					1,093,798	50
54 Radiology-Diagnostic					857,344	54
60 Laboratory					1,213,252	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 Respiratory Therapy					6,545,389	65
66 Physical Therapy		420			653,854	66
67 Occupational Therapy		324			413,094	67
68 Speech Pathology		179			66,558	68
69 Electrocardiology					1,527,372	69
71 Medical Supplies Charged to Patients		668			3,607,115	71
73 Drugs Charged to Patients		628			4,879,708	73
74 Renal Dialysis					455,982	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
92 Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (sum of lines 1-117)	7,171	11,953	7,171	43	30,851,633	118
NONREIMBURSABLE COST CENTERS						
194 PROVIDER RELATIONS NRCC		103				194
194.0 NRCC SUBLEASED SPACE						194.0
200 Cross foot adjustments						200
201 Negative cost centers						201
202 Cost to be allocated (Per Wkst. B, Part I)	80,563	91,651	250,042	195,148	108,631	202
203 Unit Cost Multiplier (Wkst. B, Part I)	11.234556	7.602107	34.868498	4,538.325581	0.003521	203
204 Cost to be allocated (Per Wkst. B, Part II)	20,553	5,782	16,015	24,644	15,696	204
205 Unit Cost Multiplier (Wkst. B, Part II)	2.866127	0.479595	2.233301	573.116279	0.000509	205

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	4,827,590		4,827,590	907	4,828,497	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,001,735		1,001,735		1,001,735	50
54	Radiology-Diagnostic	469,912		469,912		469,912	54
60	Laboratory	680,059		680,059		680,059	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	816,114		816,114		816,114	65
66	Physical Therapy	216,482		216,482		216,482	66
67	Occupational Therapy	194,712		194,712		194,712	67
68	Speech Pathology	33,163		33,163		33,163	68
69	Electrocardiology	123,857		123,857		123,857	69
71	Medical Supplies Charged to Patients	1,091,703		1,091,703		1,091,703	71
73	Drugs Charged to Patients	1,121,017		1,121,017		1,121,017	73
74	Renal Dialysis	222,148		222,148		222,148	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	10,798,492		10,798,492	907	10,799,399	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	10,798,492		10,798,492		10,799,399	202

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	9,538,167		9,538,167				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,093,798		1,093,798	0.915832	0.915832	0.915832	50
54	Radiology-Diagnostic	857,344		857,344	0.548102	0.548102	0.548102	54
60	Laboratory	1,213,252		1,213,252	0.560526	0.560526	0.560526	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	6,545,389		6,545,389	0.124685	0.124685	0.124685	65
66	Physical Therapy	653,854		653,854	0.331086	0.331086	0.331086	66
67	Occupational Therapy	413,094		413,094	0.471350	0.471350	0.471350	67
68	Speech Pathology	66,558		66,558	0.498257	0.498257	0.498257	68
69	Electrocardiology	1,527,372		1,527,372	0.081092	0.081092	0.081092	69
71	Medical Supplies Charged to Patients	3,607,115		3,607,115	0.302653	0.302653	0.302653	71
73	Drugs Charged to Patients	4,879,708		4,879,708	0.229730	0.229730	0.229730	73
74	Renal Dialysis	455,982		455,982	0.487186	0.487186	0.487186	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	30,851,633		30,851,633				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	30,851,633		30,851,633				202

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 + col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	456,336		456,336	7,171	63.64	4,352	276,961	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	456,336		456,336	7,171		4,352	276,961	200

(A) Worksheet A line numbers

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-2016

WORKSHEET D
PART II

Check Title V Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	30,874	1,093,798	0.028226	677,091	19,112	50
54	Radiology-Diagnostic	14,621	857,344	0.017054	476,884	8,133	54
60	Laboratory	21,149	1,213,252	0.017432	728,074	12,692	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	57,864	6,545,389	0.008840	3,986,202	35,238	65
66	Physical Therapy	19,789	653,854	0.030265	377,820	11,435	66
67	Occupational Therapy	16,072	413,094	0.038906	240,215	9,346	67
68	Speech Pathology	6,554	66,558	0.098471	40,193	3,958	68
69	Electrocardiology	4,377	1,527,372	0.002866	918,422	2,632	69
71	Medical Supplies Charged to Pat	382,254	3,607,115	0.105972	2,107,063	223,290	71
73	Drugs Charged to Patients	66,475	4,879,708	0.013623	2,579,023	35,134	73
74	Renal Dialysis	6,932	455,982	0.015202	251,929	3,830	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	626,961	21,313,466		12,382,916	364,800	200

(A) Worksheet A line numbers

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics General Routine Care)					30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5+ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
		6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	7,171		4,352		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	7,171		4,352		200

(A) Worksheet A line numbers

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-2016

WORKSHEET D
PART IV

Check Title V Hospital SUB (Other) ICF/IID PFS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1	2	3	4	5	6
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
54	Radiology-Diagnostic						54
60	Laboratory						60
62.30	BLOOD CLOTTING FOR HEMOPHILJACS						62.30
65	Respiratory Therapy						65
66	Physical Therapy						66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology						69
71	Medical Supplies Charged to Pat						71
73	Drugs Charged to Patients						73
74	Renal Dialysis						74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)						200

(A) Worksheet A line numbers

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-2016

WORKSHEET D
PART IV

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	1,093,798			677,091				50
54	Radiology-Diagnostic	857,344			476,884				54
60	Laboratory	1,213,252			728,074				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	6,545,389			3,986,202				65
66	Physical Therapy	653,854			377,820				66
67	Occupational Therapy	413,094			240,215				67
68	Speech Pathology	66,558			40,193				68
69	Electrocardiology	1,527,372			918,422				69
71	Medical Supplies Charged to Pat	3,607,115			2,107,063				71
73	Drugs Charged to Patients	4,879,708			2,579,023				73
74	Renal Dialysis	455,982			251,929				74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	21,313,466			12,382,916				200

(A) Worksheet A line numbers

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-2016

WORKSHEET D
PART V

Check Title V - O/P Hospital SUB (Other) Swing Bed SNF
 Applicable Title XVIII, Part B IPF SNF Swing Bed NF
 Boxes: Title XIX - O/P IRF NF ICF/IID

(A)	Cost Center Description	Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.915832						50
54	Radiology-Diagnostic	0.548102						54
60	Laboratory	0.560526						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.124685						65
66	Physical Therapy	0.331086						66
67	Occupational Therapy	0.471350						67
68	Speech Pathology	0.498257						68
69	Electrocardiology	0.081092						69
71	Medical Supplies Charged to Pat	0.302653						71
73	Drugs Charged to Patients	0.229730						73
74	Renal Dialysis	0.487186						74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	456,336		456,336	7,171	63.64			30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	456,336		456,336	7,171				200

(A) Worksheet A line numbers

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 15-2016

WORKSHEET D
PART II

Check Title V Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)
		1	2	3	4	5
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	30,874	1,093,798	0.028226		50
54	Radiology-Diagnostic	14,621	857,344	0.017054		54
60	Laboratory	21,149	1,213,252	0.017432		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	57,864	6,545,389	0.008840		65
66	Physical Therapy	19,789	653,854	0.030265		66
67	Occupational Therapy	16,072	413,094	0.038906		67
68	Speech Pathology	6,554	66,558	0.098471		68
69	Electrocardiology	4,377	1,527,372	0.002866		69
71	Medical Supplies Charged to Pat	382,254	3,607,115	0.105972		71
73	Drugs Charged to Patients	66,475	4,879,708	0.013623		73
74	Renal Dialysis	6,932	455,982	0.015202		74
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
92	Observation Beds (Non-Distinct)					92
	OTHER REIMBURSABLE COST CENTERS					
200	Total (sum of lines 50-199)	626,961	21,313,466			200

(A) Worksheet A line numbers

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)
		1	2	3	4	5
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics General Routine Care)					30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Title V PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5+ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)
6		7		8	9
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics (General Routine Care)	7,171			30
31	Intensive Care Unit				31
32	Coronary Care Unit				32
33	Burn Intensive Care Unit				33
34	Surgical Intensive Care Unit				34
35	Other Special Care (specify)				35
40	Subprovider - IPF				40
41	Subprovider - IRF				41
42	Subprovider I				42
43	Nursery				43
44	Skilled Nursing Facility				44
45	Nursing Facility				45
200	Total (lines 30-199)	7,171			200

(A) Worksheet A line numbers

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-2016

WORKSHEET D
PART IV

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1 Non Physician Anesth- etist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
60	Laboratory							60
62,30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76,97	CARDIAC REHABILITATION							76.97
76,98	HYPERBARIC OXYGEN THERAPY							76.98
76,99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 15-2016

WORKSHEET D
PART IV

Check Title V Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5+ col. 7)	Outpatient Ratio of Cost to Charges (col. 6+ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	1,093,798							50
54	Radiology-Diagnostic	857,344							54
60	Laboratory	1,213,252							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	6,545,389							65
66	Physical Therapy	653,854							66
67	Occupational Therapy	413,094							67
68	Speech Pathology	66,558							68
69	Electrocardiology	1,527,372							69
71	Medical Supplies Charged to Pat	3,607,115							71
73	Drugs Charged to Patients	4,879,708							73
74	Renal Dialysis	455,982							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct)								92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	21,313,466							200

(A) Worksheet A line numbers

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 15-2016

WORKSHEET D
PART V

Check Title V - O/P Hospital SUB (Other) Swing Bed SNF
 Applicable Title XVIII, Part B IPF SNF Swing Bed NF
 Boxes: Title XIX - O/P IRF NF ICF/IID

(A)	Cost Center Description	Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.915832						50
54	Radiology-Diagnostic	0.548102						54
60	Laboratory	0.560526						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.124685						65
66	Physical Therapy	0.331086						66
67	Occupational Therapy	0.471350						67
68	Speech Pathology	0.498257						68
69	Electrocardiology	0.081092						69
71	Medical Supplies Charged to Pat	0.302653						71
73	Drugs Charged to Patients	0.229730						73
74	Renal Dialysis	0.487186						74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period: From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2016

WORKSHEET D-1
PART I

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFPRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,171	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,171	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	7,171	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,352	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	4,828,497	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,828,497	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,828,497	37

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2016

WORKSHEET D-1
PART II

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
							673.34	38
38	Adjusted general inpatient routine service cost per diem (see instructions)						673.34	38
39	Program general inpatient routine service cost (line 9 x line 38)						2,930,376	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)							40
41	Total Program general inpatient routine service cost (line 39 + line 40)						2,930,376	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
42	Nursery (Titles V and XIX only)							42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit							43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care (specify)							47

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						3,472,350	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						6,402,726	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						276,961	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						364,800	51
52	Total Program excludable cost (sum of lines 50 and 51)						641,761	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						5,760,965	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61
62	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incentive payment (see instructions)							63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)							64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)							65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)							66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2016

WORKSHEET D-1
PARTS III & IV

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)							87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						673.34	88
89	Observation bed cost (line 87 x line 88) (see instructions)							89
		Cost	Routine Cost (from line 27)	col. 1+col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)		
		1	2	3	4	5		
90	Capital-related cost							90
91	Nursing School							91
92	Allied Health							92
93	Other Medical Education							93

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2016

WORKSHEET D-1
PART I

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX - I/P IRF NF Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,171	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,171	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	7,171	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	4,828,497	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,828,497	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,828,497	37

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2016

WORKSHEET D-1
PART II

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	Adjusted general inpatient routine service cost per diem (see instructions)					673.34	38
39	Program general inpatient routine service cost (line 9 x line 38)						39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)						41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 + col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)						52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable inpatient cost plus incentive payment (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 15-2016

WORKSHEET D-1
PARTS III & IV

Check Title V - I/P Hospital SUB (Other) ICF/IID PPS
 Applicable Title XVIII, Part A IPF SNF TRFRA
 Boxes: Title XIX - I/P IRF NF Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1+col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-2016

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/IID Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		5,709,006		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.915832	677,091	620,102	50
54	Radiology-Diagnostic	0.548102	476,884	261,381	54
60	Laboratory	0.560526	728,074	408,104	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.124685	3,986,202	497,020	65
66	Physical Therapy	0.331086	377,820	125,091	66
67	Occupational Therapy	0.471350	240,215	113,225	67
68	Speech Pathology	0.498257	40,193	20,026	68
69	Electrocardiology	0.081092	918,422	74,477	69
71	Medical Supplies Charged to Patients	0.302653	2,107,063	637,709	71
73	Drugs Charged to Patients	0.229730	2,579,023	592,479	73
74	Renal Dialysis	0.487186	251,929	122,736	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		12,382,916	3,472,350	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		12,382,916		202

(A) Worksheet A line numbers

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 15-2016

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/IID Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.915832			50
54	Radiology-Diagnostic	0.548102			54
60	Laboratory	0.560526			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.124685			65
66	Physical Therapy	0.331086			66
67	Occupational Therapy	0.471350			67
68	Speech Pathology	0.498257			68
69	Electrocardiology	0.081092			69
71	Medical Supplies Charged to Patients	0.302653			71
73	Drugs Charged to Patients	0.229730			73
74	Renal Dialysis	0.487186			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-2016

WORKSHEET E
PART B

Check applicable box: Hospital IPF IRF SUB (Other) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 15-2016

WORKSHEET E-1
PART I

Check Hospital SUB (Other)
 Applicable IPF SNF
 Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	Total interim payments paid to provider		5,287,017			1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	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)	.01	05/01/2015	945,997		3.01
		.02				3.02
	Program	.03				3.03
	to	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51	01/29/2015	496,007		3.51
	Provider	.52				3.52
	to	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		449,990		3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			5,737,007		4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01				5.01
		.02				5.02
	Program	.03				5.03
	to	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	to	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01				6.01
		.02				6.02
7	Total Medicare program liability (see instructions)					7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: Hospital CAH

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)		1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)		2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)		3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	7,171	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)		5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)		6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPSS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART IV

Check Hospital
applicable box:

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	Net Federal PPS payment (see instructions)	7,048,727	1
2	Outlier payments	429,265	2
3	Total PPS payments (sum of lines 1 and 2)	7,477,992	3
4	Nursing and allied health managed care payments (see instructions)		4
5	Organ acquisition DO NOT USE THIS LINE		5
6	Cost of physicians' services in a teaching hospital (see instructions)		6
7	Subtotal (see instructions)	7,477,992	7
8	Primary payer payments	30,202	8
9	Subtotal (line 7 less line 8)	7,447,790	9
10	Deductibles	13,552	10
11	Subtotal (line 9 minus line 10)	7,434,238	11
12	Coinsurance	311,300	12
13	Subtotal (line 11 minus line 12)	7,122,938	13
14	Allowable bad debts (exclude bad debts for professional services) (see instructions)	133,272	14
15	Adjusted reimbursable bad debts (see instructions)	86,627	15
16	Allowable bad debts for dual eligible beneficiaries (see instructions)	110,404	16
17	Subtotal (sum of lines 13 and 15)	7,209,565	17
18	Direct graduate medical education payments (from Wkst. E-4, line 49)		18
19	Other pass through costs (see instructions)		19
20	Outlier payments reconciliation		20
21	Other adjustments (specify) (see instructions)		21
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		21.50
22	Total amount payable to the provider (see instructions)	7,209,565	22
22.01	Sequestration adjustment (see instructions)	144,191	22.01
23	Interim payments	5,737,007	23
24	Tentative settlement (for contractor use only)		24
25	Balance due provider/program (line 22 minus lines 22.01, 23 and 24)	1,328,367	25
26	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		26

TO BE COMPLETED BY CONTRACTOR

50	Original PPS payment and outlier amount from Wkst. E-3 Part IV, line 3 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the Time Value of Money (see instructions)		52
53	Time Value of Money (see instructions)		53

SSH - FORT WAYNE, INC. Provider CCN: 15-2016	In Lieu of Form CMS-2552-10	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/02/2015 Run Time: 13:07 Version: 2015.10 (10/27/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 15-2016

WORKSHEET E-3
PART VII

Check Title V Hospital NF PPS
 Applicable Title XIX SUB (Other) ICF/IID TEFRA
 Boxes: SNF Other

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES				
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
COMPUTATION OF LESSER OF COST OR CHARGES				
REASONABLE CHARGES				
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
CUSTOMARY CHARGES				
13	Amount actually collected from patients liable for payment for services on a charge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(c)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
PROSPECTIVE PAYMENT AMOUNT				
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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BALANCE SHEET

WORKSHEET G

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Assets (Omit Cents)		General Fund 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4	
CURRENT ASSETS						
1	Cash on hand and in banks					1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	1,946,103				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-118,374				6
7	Inventory					7
8	Prepaid expenses					8
9	Other current assets	68,346				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	1,896,075				11
FIXED ASSETS						
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	1,200,421				15
16	Accumulated depreciation	-1,157,987				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	1,241,213				23
24	Accumulated depreciation	-1,036,673				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	246,974				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers	17,819,132				33
34	Other assets	-597				34
35	Total other assets (sum of lines 31-34)	17,818,535				35
36	Total assets (sum of lines 11, 30 and 35)	19,961,584				36
Liabilities and Fund Balances (Omit Cents)						
		General Fund 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4	
CURRENT LIABILITIES						
37	Accounts payable	770,021				37
38	Salaries, wages and fees payable	254,301				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	-1,860,477				43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)	-836,155				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)					50
51	Total liabilities (sum of lines 45 and 50)	-836,155				51
CAPITAL ACCOUNTS						
52	General fund balance	20,797,739				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56

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BALANCE SHEET

WORKSHEET G

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets (Omit Cents)	1	2	3	4	
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	20,797,739				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	19,961,584				60

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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		19,870,051			1
2	Net income (loss) (from Worksheet G-3, line 29)		1,526,006			2
3	Total (sum of line 1 and line 2)		21,396,057			3
4	Additions (credit adjustments) (specify)					4
5	FUND BALANCE RECON	-598,318				5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		-598,318			10
11	Subtotal (line 3 plus line 10)		20,797,739			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		20,797,739			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	FUND BALANCE RECON					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	9,538,167		9,538,167	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	9,538,167		9,538,167	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	9,538,167		9,538,167	17
18	Ancillary services	21,313,465		21,313,465	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FOHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	30,851,632		30,851,632	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		10,720,446	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	**DEDUCT BAD DEBT EXPENSE**		-122,534	37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)		-122,534	42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		10,597,912	43

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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	30,851,632	1
2	Less contractual allowances and discounts on patients' accounts	18,125,245	2
3	Net patient revenues (line 1 minus line 2)	12,726,387	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	10,597,912	4
5	Net income from service to patients (line 3 minus line 4)	2,128,475	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to other than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	34	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hospital space		22
23	Governmental appropriations		23
24	Other (OTHER REVENUE)	9,940	24
24.0	Other (PHYSICIAN REVENUE)		24.0
1			1
25	Total other income (sum of lines 6-24)	9,974	25
26	Total (line 5 plus line 25)	2,138,449	26
27	Other expenses (MANAGEMENT FEE)	549,872	27
27.0	Other expenses (INTERCOMPANY INTEREST)	-10,497	27.0
1			1
27.0	Other expenses (TAXES)	73,070	27.0
2			2
27.0	Other expenses (MISC)	-2	27.0
3			3
28	Total other expenses (sum of line 27 and subscripts)	612,443	28
29	Net income (or loss) for the period (line 26 minus line 28)	1,526,006	29

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REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

	COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
		PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	Adults & Pediatrics	60.69						60.69	30
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	Operating Room	61.90						61.90	50
54	Radiology-Diagnostic	55.62						55.62	54
60	Laboratory	60.01						60.01	60
65	Respiratory Therapy	60.90						60.90	65
66	Physical Therapy	57.78						57.78	66
67	Occupational Therapy	58.15						58.15	67
68	Speech Pathology	60.39						60.39	68
69	Electrocardiology	60.13						60.13	69
71	Medical Supplies Charged to Pat	58.41						58.41	71
73	Drugs Charged to Patients	52.85						52.85	73
74	Renal Dialysis	55.25						55.25	74
200	TOTAL CHARGES	58.10						58.10	200

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REPORT 98 - COST ALLOCATION SUMMARY

	COST CENTERS	DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	441,991	4.06	-441,991	-14.07			1
2	Cap Rel Costs-Mvble Equip	278,307	2.56	-278,307	-8.86			2
3	Other Cap Rel Costs							3
4	Employee Benefits Department	30,759	0.28	-30,759	-0.98			4
5	Administrative & General	1,763,360	16.21	-1,763,360	-56.13			5
6	Maintenance & Repairs							6
7	Operation of Plant	131,059	1.20	-131,059	-4.17			7
8	Laundry & Linen Service	40,825	0.38	-40,825	-1.30			8
9	Housekeeping	69,962	0.64	-69,962	-2.23			9
10	Dietary	188,891	1.74	-188,891	-6.01			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	128,130	1.18	-128,130	-4.08			13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	68,465	0.63	-68,465	-2.18			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics	3,030,537	27.86	1,797,053	57.20	4,827,590	44.38	30
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	805,345	7.40	196,390	6.25	1,001,735	9.21	50
54	Radiology-Diagnostic	376,807	3.46	93,105	2.96	469,912	4.32	54
60	Laboratory	545,396	5.01	134,663	4.29	680,059	6.25	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	636,607	5.85	179,507	5.71	816,114	7.50	65
66	Physical Therapy	152,129	1.40	64,353	2.05	216,482	1.99	66
67	Occupational Therapy	139,814	1.29	54,898	1.75	194,712	1.79	67
68	Speech Pathology	18,162	0.17	15,001	0.48	33,163	0.30	68
69	Electrocardiology	95,619	0.88	28,238	0.90	123,857	1.14	69
71	Medical Supplies Charged to Patients	839,172	7.71	252,531	8.04	1,091,703	10.04	71
73	Drugs Charged to Patients	859,519	7.90	261,498	8.32	1,121,017	10.31	73
74	Renal Dialysis	177,989	1.64	44,159	1.41	222,148	2.04	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
SPECIAL PURPOSE COST CENTERS								
NONREIMBURSABLE COST CENTERS								
194	PROVIDER RELATIONS NRCC	58,442	0.54	20,353	0.65	78,795	0.72	194
194.01	NRCC SUBLEASED SPACE							194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL	10,877,287	100.00			10,877,287	100.00	202

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REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	30,874	1,093,798	0.028226	677,091	19,112	50
54	Radiology-Diagnostic	14,621	857,344	0.017054	476,884	8,133	54
60	Laboratory	21,149	1,213,252	0.017432	728,074	12,692	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	57,864	6,545,389	0.008840	3,986,202	35,238	65
66	Physical Therapy	19,789	653,854	0.030265	377,820	11,435	66
67	Occupational Therapy	16,072	413,094	0.038906	240,215	9,346	67
68	Speech Pathology	6,554	66,558	0.098471	40,193	3,958	68
69	Electrocardiology	4,377	1,527,372	0.002866	918,422	2,632	69
71	Medical Supplies Charged to Pat	382,254	3,607,115	0.105972	2,107,063	223,290	71
73	Drugs Charged to Patients	66,475	4,879,708	0.013623	2,579,023	35,134	73
74	Renal Dialysis	6,932	455,982	0.015202	251,929	3,830	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct)						92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL	626,961	21,313,466		12,382,916	364,800	200

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REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	SWING-BED ADJUSTMENT AMOUNT	REDUCED CAPITAL RELATED COST	TOTAL PATIENT DAYS	PER DIEM	INPATIENT PROGRAM DAYS	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics	456,336		456,336	7,171	63.64	4,352	276,961	30
200	TOTAL	456,336		456,336	7,171		4,352	276,961	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	276,961
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	364,800
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	641,761
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	174
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	4,352
PER DISCHARGE CAPITAL COSTS	3,688.28

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I. COST TO CHARGE RATIO FOR LTCH

1. TOTAL MEDICARE COSTS (Worksheet D-1, Part II, line 49 - (Worksheet D, Part III, column 9, lines 30-35 + Worksheet D, Part IV, column 11, line 200))	6,402,726
2. TOTAL MEDICARE CHARGES (Worksheet D-3, column 2, lines 30-35 + line 202)	18,091,922
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.354

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (Worksheet D, Part I, lines 30-35, column 7 + Worksheet D, Part II, line 200, column 5)	641,761
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.035

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (Worksheet D, Part V, columns 2, 2.01, 2.02 x column 1 less lines 61, 66-68, 74, 94, 95 & 96)	
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)	
3. RATIO OF COST TO CHARGES (line 1 / line 2)	