COBALT REHAB HOSPI TAL LOUI SVI LLE

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-3046 Worksheet S Peri od. From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: То 5/19/2022 8:45 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/19/2022 Time: 8:45 am] Manually prepared cost report use only 2. [] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. 3 0 Ē 4 [

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

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

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

 Contractor 5. use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S) 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 OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COBALT REHAB HOSPITAL LOUISVILLE (15-3046) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR CHECKBOX ELECTRONI C SIGNATURE STATEMENT 2 1 I have read and agree with the above certification 1 statement. I certify that I intend my electronic

	Kari	CK Stoper	signature on this certification be the legally binding equivalent of my original signature.	
2 Signatory Pr	inted Name	Karick Stober		2
3 Signatory Ti	tle	CFO		3
4 Date		(Dated when report is electronica		4
1 5400				

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	274, 636	0	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	274, 636	0	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DA		rovider (JUN: 15	F	Period: From 01/01/ Fo 12/31/	2021	Part I Date/Ti	me Pre	
	1.00				0				5/19/20		
	1.00 Hospital and Hospital Health Care Co		. 00	3.0	0		2	1.00			
0	Street: 2101 BROADWAY STREET	P0 Box:									1.
0	City: CLARKSVILLE	State: Component N		Code: 47	BSA	Count Provi der	y: Date	Pavme	nt Syst	em (P.	2.
			Numl		mber	Туре	Certified	Т,	0, or	N)	
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	Hospital and Hospital-Based Componen			00 3	. 00	4.00	5.00	0.00	7.00	0.00	
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)	Subprovider - IPF	LUUI SVILLE									4
C	Subprovider - IRF										5
))	Subprovider – (Other) Swing Beds – SNF										6
)	Swing Beds - NF										8
)	Hospital-Based SNF										9
00	Hospi tal -Based NF Hospi tal -Based OLTC										10
00	Hospi tal -Based HHA										12
	Separately Certified ASC										13
	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14
	Hospital-Based Health Clinic - FQHC										16
	Hospital-Based (CMHC) Hospital-Based (CORF)										17
	Renal Dialysis										18
00	Other								<u> </u>		19
							From: 1.00				-
00	Cost Reporting Period (mm/dd/yyyy)						01/01/20	021	12/31/		20
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						1.00	2.00		3. 0	00	
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OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D		LOUI SVI LLE Provi der CC		Peri od:		Works	brm CMS- heet S-2	
				From 01/ To 12/	01/2021 31/2021	Date/	l Time Pre <u>2022 8:4</u>	
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medic HMO d		Other edi cai d days	
	1.00	2.00	3.00	4.00	5.0		6.00	
 4.00 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. 5.00 If this provider is an IRF, enter the in-state Medicaid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, the in-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid days in column 4, the in-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 4. 	30			C		0 215	С	24.00
				Urban/	Rural S	Date c	of Geogr	
6.00 Enter your standard geographic classification (not w	ane) status	at the box	inning of t		00	2	. 00	26.00
 ou proting period. Enter "1" for urban or "2" for reporting period. Enter "1" for urban or "2" for reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassification 	r rural. age) status r "2" for r	at the enc ural. If ap	l of the cos		1			27.00
5.00 If this is a sole community hospital (SCH), enter th effect in the cost reporting period.	e number of	periods SC	H status ir	n	0	D		35.00
				Begi r	ini ng:	Enc	li ng:	
6.00 Enter applicable beginning and ending dates of SCH s	tatus Subs	crint line	26 for numb		00	2	. 00	36.0
of periods in excess of one and enter subsequent dat 7.00 f this is a Medicare dependent hospital (MDH), enter	es.	·			C			37.00
is in effect in the cost reporting period. 7.01 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f	he MDH tran	sitional pa	yment in					37.0
 instructions) 8.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates. 								38.00
enter subsequent dates.								
					/N	-	<u>//N</u>	-
9.00 Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (İi), or the mileage ii)? Enter	(iii)? Ent requiremer in column 2	er in colum hts in 2 "Y" for ye	1. Ime Inn es	/N 00 N	2	//N . 00 N	39.0
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HOSPI T	Financial Systems COBALT REHA AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider C	CN: 15-3046 P	eriod: rom 01/01/2021	u of Form CMS-2 Worksheet S-2 Part I	
					o 12/31/2021	Date/Time Pre 5/19/2022 8:4	
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
0. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. CR) NAHE	see If column 1	N			60. 00
		Y/N	IME	Direct GME	IME	Direct GME	
1 00		1.00	2.00	3.00	4.00	5.00	(1.0)
51.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61.00
51.01	column 1. (see instructions) 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						61. 0 ⁻
01. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 0
51.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
1. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61. 04
1. 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.0
01.06	61.04 minus line 61.03). (see instructions) 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)						61.0
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
51. 10	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. Enter in column 4, the direct GME FTE unweighted count.		1.00	2.00	3.00	4.00	61. 10
1. 20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0. 00	61.2
						1.00	
	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital				od for which	1	62.0
	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	tions) Teachi ram. (s	ng Health Cent see instruction	ter (THC) into			62. 0 [°]
63.00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co			N	63.0
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00 This base year	2.00 is your cost r	3.00 reporting	
	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted	re June y trair a-primar all nor	30, 2010. ned residents ry care nprovider	0. 00			64.0

OSPITAL AND HOSPITAL HEALTH CARE COMPL	.EX IDENTIFICATION DATA	Provider CC		riod: om 01/01/2021	Worksheet S-2 Part I	
			То	12/31/2021	Date/Time Pre 5/19/2022 8:4	
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs	FTEs in	$(col \cdot 3 + col \cdot$	
			Nonprovider Site	Hospi tal	4))	
-	1.00	2.00	3.00	4.00	5.00	1
.00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te	nospi tai	2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current ` beginning on or after July 1, 20		lonprovider Settings	sEffective fo	r cost reporti	ing periods	
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-primary al. Enter in column 3 t	care resident he ratio of	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
.00 Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00 0.000000	
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						
				1.0	0 2.00 3.00	
Inpatient Psychiatric Facility Pl	PS			1.0	0 2.00 3.00	
	ychiatric Facility (IPF), or does it conta	ain an IPF subp	rovider? N		70. (
		pproved CME teachir			0	71.0
Enter "Y" for yes or "N" for no. .00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFF Column 3: If column 2 is Y, indic (see instructions)	efore November 15, 2004 Lumn 2: Did this facili R 412.424 (d)(1)(iii)(D cate which program year	? Enter "Y" for ye ty train residents)? Enter "Y" for ye	in a new teach es or "N" for no	i ng p.		
.00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFF Column 3: If column 2 is Y, indic	efore November 15, 2004 lumn 2: Did this facili R 412.424 (d)(1)(iii)(D cate which program year y PPS	? Enter "Y" for ye ty train residents)? Enter "Y" for ye began during this	in a new teach es or "N" for no cost reporting	i ng p.		75.0

Health Financial Systems COBALT REHAB HOSPI TAL LOUI SVI LLE In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3046 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: То 12/31/2021 5/19/2022 8:45 am 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 Ν 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. Ν 85 00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87 00 Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. V XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Y Ν 90 00 ves or "N" for no in the applicable column. $|I\,s\,$ this hospital reimbursed for title V and/or XIX through the cost report either in 91 00 Ν Ν 91 00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 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. 92.00 Ν 92.00 93.00 Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν Ν 94 00 applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0 00 0 00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν Ν 96.00 applicable column 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97 00 0 00 0.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Ν Ν 98.00 stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Υ 98.01 98.01 Ν C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation Ν γ 98.02 bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) Ν 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 $\,$ for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and Ν 98.04 Ν in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in 98.05 γ 98.05 Ν column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Ν Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? Ν 105 00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) 107.00 column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Ν 108.00 Physi cal Occupati onal Speech Respi ratory 1 00 2 00 3 00 4 00 109.00 If this hospital qualifies as a CAH or a cost provider, are 109.00 therapy services provided by outside supplier? Enter " for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A 110.00 Ν Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e.

Heal th Financial Systems COBALT REHAB HOSPIT				eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC		Period: From 01/01/2021 To 12/31/2021	Date/Time Pr	epared:
				5/19/2022 8:	45 811
111.00 If this facility qualifies as a CAH, did it participate in th Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting p umn 1 is Y, e ticipating in	eriod? Enter enter the column 2.	1.00 N	2.00	111.00
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Healt demonstration for any portion of the current cost reporting p Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceas participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	period? "Y", enter e	N			112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93 for short term hospital or "98" percent for long term care (i psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) 3" percent ncludes s) based on	Ν			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" f "N" for no.	for yes or	Ν			116.00
117.00 Is this facility legally-required to carry malpractice insura "Y" for yes or "N" for no.	ance? Enter	Ν			117.00
118.00 Is the malpractice insurance a claims-made or occurrence poli if the policy is claim-made. Enter 2 if the policy is occurre	2		1		118.00
		Premi ums	2.00	I nsurance	_
118.01List amounts of malpractice premiums and paid losses:		3, 24)	0 118. 01
			1.00	2.00	_
118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA \$3121 and applicable amendment	ule listing co Harmless prov column 1, "Y" alifies for th	ost centers Mision in ACA for yes or We Outpatient	N	N	118. 02 119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00Did this facility incur and report costs for high cost implar	ntable devices	charged to	N		121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			Ν		122.00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" for	ves and "N"	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ent	ter the certif				126. 00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter	er the certifi	cation date			127.00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter	er the certifi	cation date			128.00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter		ation date in	n		129. 00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, e		ification			130. 00
date in column 1 and termination date, if applicable, in colu 31.00 If this is a Medicare certified intestinal transplant center,		erti fi cati on			131.00
date in column 1 and termination date, if applicable, in colu 32.00 If this is a Medicare certified islet transplant center, enter	umn 2. er the certifi				132.00
in column 1 and termination date, if applicable, in column 2. 33.00 Removed and reserved 34.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.		n column 1			133. 00 134. 00
All Providers 140.00 Are there any related organization or home office costs as de chapter 10? Enter "Y" for yes or "N" for no in column 1. If y			Y		140. 00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	COBALT REHAB H X IDENTIFICATION DATA		Provi der CC		F		/01/2021 /31/2021	u of Form CMS Worksheet S- Part I Date/Time Pr	2
								5/19/2022 8:	
1.00		2.00				<u> </u>	3.00		-
If this facility is part of a chai					he na	me and	address	of the	
home office and enter the home off 41.00Name: COBALT REHAB HOSPITALS	Contractor name an				actor	r's Num	ber: 0700)1	141.0
42.00 Street: 650 BEEBALM LANE STE 220	PO Box:	. 10011	145		actor	3 Num			142.0
43. 00 Ci ty: DALLAS	State:	ТΧ		ZipC	Code:		7504	4	143.0
								1.00	
44.00 Are provider based physicians' cos	ts included in Workshe	et A?						Y	144. (
						1	. 00	2.00	4.15.0
45.00 f costs for renal services are cl inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	for yes or "N" for no lude Medicare utilizat for no in column 2.	in co tion fo	olumn 1. lfc or this cost	olumn 1 i reportinç					145.0
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/c	column 1. (See CMS Pu) f		N		146. (
								1.00	-
47.00 Was there a change in the statisti	cal basis? Enter "Y" f	or ve	s or "N" for	no.				N 1.00	147.0
48.00 Was there a change in the order of								N	148.0
149.00 Was there a change to the simplifi					for i	no.		N	149.0
	<u>v</u>		Part A	Part			tle V	Title XIX	
			1.00	2.00			3.00	4.00	
Does this facility contain a provi									
or charges? Enter "Y" for yes or '	N" for no for each con	nponen			B. (See 42			_
55.00 Hospi tal			N	N			N	N	155.0
56.00 Subprovi der – IPF			N	N			N	N	156.0
57. 00 Subprovi der – IRF 58. 00 SUBPROVI DER			N	N			N	N	157.0
59. 00/SNF			N	N			N	N	158. 0 159. 0
60. 00 HOME HEALTH AGENCY			N	N			N	N	160. 0
161. 00 CMHC			IN .	N			N	N	161.0
61. 10 CORF				N			N	N	161.1
			I						
								1.00	
Multicampus								1	
165.00 Is this hospital part of a Multica	mpus hospital that has	s one o	or more campu	ses in di	ffere	ent CBS	As?	N	165.0
Enter "Y" for yes or "N" for no.	Nomo		County	Ctoto	7: 0	Code	CDCA	FTE/Campus	-
	Name 0		1. 00	State 2.00	<u> </u>	.00	CBSA 4.00	5.00	-
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)									0166.0
								1.00	-
Health Information Technology (HI) incentive in the Ame	eri can	Recovery and	Rei nves	tment	Act		1.00	
67.00 is this provider a meaningful user 68.00 if this provider is a CAH (line 10 reasonable cost incurred for the H	under §1886(n)? Ente 5 is "Y") and is a mea	er "Y" ani ngfu	for yes or " ul user (line	N" for no	Э.		the	N	167. (168. (
68.01 If this provider is a CAH and is r				qual i fy	for a	a hards	hi p		168. (
exception under §413.70(a)(6)(ii)?	'Enter "Y" for yes or	"N" fo	or no. (see i	nstructio	ons)				
69.00 If this provider is a meaningful u		and is	s not a CAH (line 105	is "I	N"), en	ter the	0.0	0169. (
transition factor. (see instruction	ins)					Dev	inning	Endire	
						<u>_</u>	i nni ng . 00	Endi ng 2. 00	-
70.00 Enter in columns 1 and 2 the EHR b	eqinning date and endi	ng dat	te for the re	portina		-	. 00	2.00	170.0
period respectively (mm/dd/yyyy)									
									_
						1	. 00	2.00	0 1 7 1
171.00 fline 167 is "Y", does this prov section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	eported on Wkst. S-3, mn 1. If column 1 is y	Pt. I,	line 2, col	. 6? Ente					0171.0

Heal th	Financial Systems COBALT REHAB HOSE	PI TAL LOUI SVI LL	.E	In Lie	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Peri od:	Worksheet S-2	
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	enared.
				10 12/31/2021	5/19/2022 8:4	
				Y/N	Date	
		-		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter M	N for all NO re	esponses. Enter	all dates in t	the	
	mm/dd/yyyy format.					-
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
1.00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of the change in a			IN IN		1.00
		(· · · ·	Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare I		N			2.00
	yes, enter in column 2 the date of termination and in colu	mn 3, "V" for				
	voluntary or "I" for involuntary.					
3.00	Is the provider involved in business transactions, includin		N			3.00
	contracts, with individuals or entities (e.g., chain home of modical supply comparing) that are related to the provide					
	or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and othe					
	relationships? (see instructions)					
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Cer	tified Public	Y	A		4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C"	for Compiled,				
	or "R" for Reviewed. Submit complete copy or enter date ava	ailable in				
	column 3. (see instructions) If no, see instructions.					
5.00	Are the cost report total expenses and total revenues diffe		N			5.00
	those on the filed financial statements? If yes, submit rea	conciliation.)/ /N		
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
6.00	Column 1: Are costs claimed for a nursing program? Column	2. If ves is	s the provider	N		6.00
0.00	is the legal operator of the program?	2. 11 900, 10				0.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		Ν		7.00
8.00	Were nursing programs and/or allied health programs approve		ved during the	Ν		8.00
	cost reporting period? If yes, see instructions.		5			
9.00	Are costs claimed for Interns and Residents in an approved	graduate medio	cal education	N		9.00
	program in the current cost report? If yes, see instruction					
10.00	Was an approved Intern and Resident GME program initiated (or renewed in t	the current	N		10.00
11 00	cost reporting period? If yes, see instructions.			N		11 00
11.00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	i & Rinan App	broved	N		11.00
	Treaching Program on worksheet A? IT yes, see Instructions.				Y/N	
					1.00	
	Bad Debts				1.00	
12.00	Is the provider seeking reimbursement for bad debts? If ye	s. see instruct	tions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection			st reporting	N	13.00
	period? If yes, submit copy.	5 5	5	1 5		
14.00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? I1	Fyes, see inst	tructions.	N	14.00
	Bed Complement					
15.00	Did total beds available change from the prior cost report				N	15.00
			rt A	-	t B	
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
16 00	PS&R Data Was the cost report prepared using the PS&R Report only?	Y	04/07/2022	N		16.00
16.00	If either column 1 or 3 is yes, enter the paid-through	T	04/07/2022	IN		10.00
	date of the PS&R Report used in columns 2 and 4 .(see					
	instructions)					
17.00	Was the cost report prepared using the PS&R Report for	N		Ν		17.00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18.00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
10.00	cost report? If yes, see instructions.	NI NI		N I		10.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.00
	Report data for corrections of other PS&R Report information? If yes, see instructions.					
	THIO MALION IT YES, SEE THSTIUCTIONS.	1	1	I	I	I

Health Financial Systems

COBALT REHAB HOSPITAL LOUISVILLE	E
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In Lieu of Form CMS-2552-10

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-3046	Period: From 01/01/2021	Worksheet S-2 Part II	
				To 12/31/2021	Date/Time Pre 5/19/2022 8:4	
		Descri	pti on	Y/N	Y/N	
		()	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
21 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4.00	21.00
21.00	records? If yes, see instructions.	IN IN		ÎN .		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)			
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense		als made duri	ng the cost	N N	22.00 23.00
24.00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter	porting period?	Ν	24.00		
25.00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repor	ting period?	lf yes, see	Ν	25.00
26.00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost reporti	ng period? I	fyes, see	Ν	26.00
27.00	instructions. Has the provider's capitalization policy changed during th	yes, submit	Ν	27.00		
	copy. Interest Expense					
	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	. 0	N	28.00		
	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst	ructions		,	N	29.00
	Has existing debt been replaced prior to its scheduled mat instructions.	5	5		N	30.00
31.00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes,	see	N	31.00
22 00	Purchased Services Have changes or new agreements occurred in patient care se	rvi cos furni sho	d through co	atractual	N	32.00
	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap	uctions.	Ū.		N	33.00
33.00	no, see instructions. Provi der-Based Physici ans				IN	- 55.00
34 00	Are services furnished at the provider facility under an a	rrangement with	provi der-ba	sed_physicians?	Y	34.00
01.00	If yes, see instructions.	i i dilgonoriti ili til	provider bu	bed physicians.		01.00
35.00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		ts with the p	provi der-based	Ν	35.00
				Y/N	Date	
				1.00	2.00	
36.00	Home Office Costs Were home office costs claimed on the cost report?			Y		36.00
	If line 36 is yes, has a home office cost statement been p	repared by the	home office?	Ý		37.00
38.00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year on			Y	08/31/2021	38.00
39.00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions.			Ν		39.00
40.00	If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see	Ν		40.00
			00			
	Cost Report Preparer Contact Information	2.	00			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	DAVI D		MULLER		41.00
42.00	respectively. Enter the employer/company name of the cost report	POST ACUTE MED	ICAL LLC			42.00
43.00	preparer. Enter the telephone number and email address of the cost	210-592-5381		DMULLER@PAMHEA	LTH. COM	43.00
	report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems COBALT REHA	B HOSE	PI TAL LOUI SVI LLE	In Lie	In Lieu of Form CMS-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provider CCN: 15-3046	Peri od:	Worksheet S-2		
				From 01/01/2021 To 12/31/2021		pared: 5 am	
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	on	VP OF REIMBURSEMENT			41.00	
	held by the cost report preparer in columns 1, 2, and	13,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost report					42.00	
	preparer.						
43.00	Enter the telephone number and email address of the o	cost				43.00	
	report preparer in columns 1 and 2, respectively.						

	Financial Systems COE TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	BALT REHAB HOSPI	Provi der CC		Peri od:	u of Form CMS-2 Worksheet S-3	
IIUSFI	AL AND HOSFITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	FIOVIDEI CC	N. 15-3040	From 01/01/2021	Part I	
					To 12/31/2021	Date/Time Pre 5/19/2022 8:4	
				I		I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	40	14, 60		0.00	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.0
3.00	HMO I PF Subprovi der						3.00
1.00	HMO I RF Subprovider						4.0
5.00	Hospital Adults & Peds. Swing Bed SNF					0	
5.00	Hospital Adults & Peds. Swing Bed NF					0	
7.00	Total Adults and Peds. (exclude observation		40	14,60	0.00	0	7.00
	beds) (see instructions)	21 00	0		0 0 00	0	
3.00		31.00	0		0 0.00	0	
9.00	CORONARY CARE UNIT	32.00	-			-	9.0
0.00	BURN INTENSIVE CARE UNIT	33.00	0		0 0.00	0	10.0
1.00	SURGICAL INTENSIVE CARE UNIT	34.00	0		0 0.00	0	11.0 12.0
12.00	OTHER SPECIAL CARE (SPECIFY) NURSERY	43.00				0	12.0
4.00	Total (see instructions)	43.00	40	14,60	0.00	0	14.00
5.00	CAH visits		40	14, 00	0.00	0	14.00
6.00	SUBPROVIDER - IPF	40, 00	o		0	0	16.00
7.00	SUBPROVI DER – I RF	40.00	0		0	0	17.0
8.00	SUBPROVIDER	11.00	Ŭ		0		18.0
9.00	SKILLED NURSING FACILITY	44.00	o		0	0	
20.00	NURSING FACILITY	45.00	0		0	0	20.0
21.00	OTHER LONG TERM CARE	46.00	0		0		21.0
2.00	HOME HEALTH AGENCY	101.00			-	0	22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)	115.00					23.0
24.00	HOSPICE	116.00	0		0		24.0
4.10	HOSPICE (non-distinct part)	30.00					24.1
5.00	CMHC - CMHC	99.00				0	25.0
5. 10	CMHC - CORF	99. 10				0	25.1
6. 00	RURAL HEALTH CLINIC	88.00				0	26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.2
7.00	Total (sum of lines 14-26)		40				27.0
8.00	Observation Bed Days					0	28.0
9.00	Ambul ance Trips						29.00
0. 00	Employee discount days (see instruction)						30.0
1.00	Employee discount days - IRF						31.0
2.00	Labor & delivery days (see instructions)		0		0		32.0
32.01	Total ancillary labor & delivery room						32.0
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
3. 01	LTCH site neutral days and discharges						33.0

HOSPI ⁻	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-3046	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part I Date/Time Pre 5/19/2022 8:4	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 15.00 15.00 20.00 21.00 21.00 21.00 22.00 23.00 24.00 24.00 25.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CORF RURAL HEALTH CLINIC	7, 344 888 0 0 0 7, 344 0 0 0 0 7, 344 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	215 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9, 4 9, 4 9, 4	43 0 0 43 0 0 0 0 0 0 0	60. 50 0. 00 0. 00	15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 25. 10
26. 25 27. 00 28. 00 29. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips	0	0		0 0.00 0.00		27.0 28.0 29.0
0.00 1.00 2.00 2.01	Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0	0		0 0 0 0		30. 0 31. 0 32. 0 32. 0
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges	0 0					33. 33.

HOSPIT	FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 15-		eriod: rom 01/01/2021 o 12/31/2021	Worksheet S-3 Part I Date/Time Pre 5/19/2022 8:4	
		Full Time			Di sch	arges		
	Component	Equivalents Nonpaid Workers	Title V	Titl	e XVIII	Title XIX	Total All Patients	
		11.00	12.00		3.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.0	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNI T CORONARY CARE UNI T SURGICAL INTENSI VE CARE UNI T SURGICAL INTENSI VE CARE UNI T OTHER SPECIAL CARE (SPECI FY) NURSERY Total (see instructions) CAH visits SUBPROVI DER - IPF SUBPROVI DER - I RF SUBPROVI DER - I RF SUBPROVI DER - I RF SUBPROVI DER SKI LLED NURSI NG FACI LI TY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CORF RURAL HEALTH CLINIC FEDERALLY QUALI FIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days - IRF	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0		0	689 689 0 0	20 0 0 0 0	824 824 0 0	1. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 15. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 21. 00 22. 00 23. 00 24. 00 25. 00 25. 00 26. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 20. 00 21. 00 21. 00 21. 00 21. 00 21. 00 21. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 31. 00
32.00 32.01 33.00	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0			32.00 32.01 33.00 33.01

LAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C		Period: From 01/01/2021	Worksheet A	
					To 12/31/2021	Date/Time Pre 5/19/2022 8:4	
	Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	1 Reclassificati ons (See A-6)	Reclassified Trial Balance (col.3+- col.4)	
		1.00	2.00	3.00	4.00	5.00	
~	GENERAL SERVICE COST CENTERS	1		1			1 1 0
00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		0 49, 713		0 0 3 520, 657	0 570, 370	
0	00300 OTHER CAP REL COSTS		410, 067			0	3.0
0	00400 EMPLOYEE BENEFITS DEPARTMENT	11, 510	239, 549			251, 059	
00	00500 ADMINI STRATI VE & GENERAL	1, 174, 664	4, 289, 338				
00 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	60, 361 0	298, 685 0	359, 04	6 0 0 99,609	359, 046	
0	00900 HOUSEKEEPING	136, 274	99,609	235, 88		136, 274	
00	01000 DI ETARY	246, 589	94, 328			340, 917	
00	01100 CAFETERI A	0	0		0 0	0	
00	01200 MAINTENANCE OF PERSONNEL	0	0	221 45	0 0	0	12.
00 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	221, 455 47, 099	0	221, 45 47, 09		221, 455 47, 099	
	01500 PHARMACY	128, 541	252, 429			128, 541	
00	01600 MEDICAL RECORDS & LIBRARY	46, 698	628			47, 326	
	01700 SOCIAL SERVICE	0	0		0 0	0	
	01851 OTHER GENERAL CC	0	0		0 0	0	
00 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM	0	0			0	19. 20.
00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	20.
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	22.
00	02300 PARAMED ED PRGM	0	0		0 0	0	23.
	INPATIENT ROUTINE SERVICE COST CENTERS						
00	03000 ADULTS & PEDIATRICS	1, 889, 877	720, 693	2, 610, 57		2, 674, 434	30.
00 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0	0		0 0	0	31
00	03300 BURN INTENSIVE CARE UNIT	0	0				33
00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 0	0	34
00	04000 SUBPROVI DER – I PF	0	0		0 0	0	40
00	04100 SUBPROVI DER – I RF	0	0		0 0	0	41.
00	04300 NURSERY	0	0		0 0	0	43.
00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0		0 0	0	44.
00 00	04600 OTHER LONG TERM CARE	0	0		0 0 0 0	0	
00	ANCI LLARY SERVICE COST CENTERS			1	<u> </u>	Ŭ	1 .0.
00	05000 OPERATI NG ROOM	0	0		0 0	0	
00	05100 RECOVERY ROOM	0	0		0 0	0	
00 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0		0 0	0	
	05400 RADI OLOGY-DI AGNOSTI C	0	53, 735	53, 73	5 0	53, 735	
	05500 RADI OLOGY-THERAPEUTI C	0	03,739		0 0	0	
	05600 RADI OI SOTOPE	0	0		0 0	0	
00	05700 CT SCAN	0	0		0 0	0	57
00		0	0		0 0	0	58
00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0	74	0 0	0748	59
00 01	06001 BLOOD LABORATORY	0	748	74		0	60 60
00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	Ŭ	0		0 0	0	61
00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	
00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63
00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	
00		1, 818	19, 658			21, 476	
00 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	543, 467 452, 548	9, 988 0	553, 45 452, 54		553, 455 452, 548	
	06800 SPEECH PATHOLOGY	198, 388	0	198, 38		198, 388	
	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 16, 385	16, 385	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 252 420	0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0 75, 941	75, 94	0 252, 429 1 -75, 941	252, 429	
	07500 ASC (NON-DI STI NCT PART)	0	, 3, ,41	, 3, 74	0 0	0	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	
	OUTPATIENT SERVICE COST CENTERS	 _					
	08800 RURAL HEALTH CLINIC	0	0		0 0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	
00 00	09000 CLINIC 09100 EMERGENCY	0	0			0	90. 91.
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	U	0		0	0	91.
00	OTHER REIMBURSABLE COST CENTERS			1		I	1 '2.
	09400 HOME PROGRAM DI ALYSI S	0	0		0 0		94

Health Financial Systems COE	BALT REHAB HOSPIT	AL LOUISVILL	E	In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-3046	Peri od:	Worksheet A	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	narod
				10 12/31/2021	5/19/2022 8:4	
Cost Center Description	Sal ari es	Other	Total (col.	1 Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)		
					(col. 3 +-	
	1.00		0.00	1.00	col . 4)	
95. 00 09500 AMBULANCE SERVI CES	1.00	2.00	3.00	4.00	5.00	95.00
95. 00 109500 AMBULANCE SERVICES 96. 00 109600 DURABLE MEDICAL EQUIP-RENTED	0	0			0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0			0	
98. 00 09850 OTHER REI MBURSABLE CC	0	0		0 0	0	
99. 00 09900 CMHC	0	0		0 0	0	
99. 10 09910 CORF	0	0		0 0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0)	0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0)	0 0	0	101.00
SPECIAL PURPOSE COST CENTERS			•			
105.00 10500 KIDNEY ACQUISITION	0	0		0 0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110.00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0		111.00
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		0 0		113.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		114. 00 115. 00
116. 00 11600 HOSPI CE	0	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	5, 159, 289	6, 615, 109	11, 774, 3	0 0	11, 774, 398	
NONREI MBURSABLE COST CENTERS	5, 157, 207	0,013,107	11,774,0	70 0	11, 774, 370	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
193.00 19300 NONPALD WORKERS	0	0		0 0		193.00
200.00 TOTAL (SUM OF LINES 118 through 199)	5, 159, 289	6, 615, 109	11, 774, 3	98 0	11, 774, 398	200. 00

Health Financial Systems	COBALT REHAB HOSPITA	L LOUI SVI LLE	In Lieu	」 of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALAN	NCE OF EXPENSES	Provider CCN: 15-3046	Period: From 01/01/2021	Worksheet A

				From 01/01/2021 To 12/31/2021 Date/Time Pr 5/19/2022 8:	
	Cost Center Description	Adjustments	Net Expenses		45 811
		(See A-8) 6.00	For Allocation 7.00	-	
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	0	0		1.00
2.00 3.00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS	37, 596	607, 966		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	251,059		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	-317,088	5,032,016		5.00
7.00	00700 OPERATION OF PLANT	0	359, 046		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	99, 609		8.00
9.00	00900 HOUSEKEEPI NG	0	136, 274		9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	0	340, 917 0		10.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	221, 455		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	47, 099		14.00
15.00	01500 PHARMACY	0	128, 541		15.00
	01600 MEDI CAL RECORDS & LI BRARY	1, 408	48, 734		16.00
17.00 18.00	01700 SOCIAL SERVICE 01851 OTHER GENERAL CC	0	0		17.00
	01900 NONPHYSI CI AN ANESTHETI STS	0	0		18.00
20.00	02000 NURSI NG PROGRAM	0	0		20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.00
23.00	02300 PARAMED ED PRGM	0	0		23.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	2 (74 424		- 20.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	2, 674, 434		30.00
32.00	03200 CORONARY CARE UNI T	0	0		32.00
	03300 BURN INTENSIVE CARE UNIT	0	0		33.00
34.00	03400 SURGI CAL INTENSI VE CARE UNI T	0	0		34.00
	04000 SUBPROVIDER - IPF	0	0		40.00
41.00	04100 SUBPROVIDER - IRF	0	0		41.00
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	0		43.00
45.00	04500 NURSING FACILITY	0	0		45.00
46.00	04600 OTHER LONG TERM CARE	0	0		46.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0		50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0		51.00 52.00
53.00	05300 ANESTHESI OLOGY	0	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	53, 735		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		55.00
56.00	05600 RADI OI SOTOPE	0	0		56.00
57.00	05700 CT SCAN 05800 MRI	0	0		57.00
58.00 59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		58.00 59.00
60.00	06000 LABORATORY	0	748		60.00
60. 01	06001 BLOOD LABORATORY	0	0		60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0		63.00 64.00
	06500 RESPI RATORY THERAPY	0	21, 476		65.00
66.00	06600 PHYSI CAL THERAPY	0	553, 455		66.00
	06700 OCCUPATI ONAL THERAPY	0	452, 548		67.00
68.00	06800 SPEECH PATHOLOGY	0	198, 388		68.00
		0	0		69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0 16, 385		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		10, 385 N		71.00
	07300 DRUGS CHARGED TO PATIENTS	0	252, 429		73.00
	07400 RENAL DI ALYSI S	0	0		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		75.00
77.00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0	0		77.00
80 00	OUTPATIENT SERVICE COST CENTERS		0		00 00
	08800 FEDERALLY QUALIFIED HEALTH CENTER	0	0		88.00 89.00
90.00	09000 CLINIC	0	0		90.00
	09100 EMERGENCY	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
_	OTHER REIMBURSABLE COST CENTERS				· · ·
	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	0		94.00
		0	0	1	95.00
95.00 96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00

Health Financial Systems COE	BALT REHAB HOSPI	TAL LOUI SVI LLE	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15-304		Worksheet A
			From 01/01/2021 To 12/31/2021	Date/Time Prepared:
			10 12/31/2021	5/19/2022 8:45 am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8) F	or Allocation		
	6.00	7.00		
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
98.00 09850 OTHER REIMBURSABLE CC	0	0		98.00
99. 00 09900 CMHC	0	0		99.00
99. 10 09910 CORF	0	0		99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.0010100 HOME HEALTH AGENCY	0	0		101. 00
SPECIAL PURPOSE COST CENTERS				
105.00 10500 KIDNEY ACQUISITION	0	0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0		107.00
108.00 10800 LUNG ACQUISITION	0	0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		111.00
113.00 11300 INTEREST EXPENSE	0	0		113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
116. 00 11600 H0SPI CE	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-278, 084	11, 496, 314		118. 00
NONREI MBURSABLE COST CENTERS	1			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191. 00 19100 RESEARCH	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192.00
193.00 19300 NONPALD WORKERS	0	0		193.00
200.00 TOTAL (SUM OF LINES 118 through 199)	-278, 084	11, 496, 314		200.00

Heal th	Financial Systems	CO	BALT REHAB HOSI	PITAL LOUISVIL	LE	In Lieu of Form CMS-2552-1		
RECLAS	SIFICATIONS			Provider (CCN: 15-3046	Peri od:	Worksheet A-	6
						From 01/01/2021 To 12/31/2021	Data /Tima Dr	onorod.
						To 12/31/2021	Date/Time Pr 5/19/2022 8:	45 am
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	A - MEDICAL SUPPLIES							
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	16, 385				1.00
	PATI ENT							
2.00		0.00	0	0	-			2.00
	TOTALS		0	16, 385				
	B - INTEREST ON LOANS							_
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	<u>110, 5</u> 90				1.00
	TOTALS		0	110, 590				
	C – LAUNDRY							_
1.00	LAUNDRY & LINEN SERVICE		0	99,609				1.00
	TOTALS		0	99, 609				
	D - DRUGS CHARGED TO PATIENTS							
1.00	DRUGS_CHARGED_TO_PATIENTS		0	252, 429				1.00
	TOTALS		0	252, 429				
	E – DIALYSIS							
1.00	ADULTS & PEDIATRICS		0	7 <u>5, 9</u> 41				1.00
	TOTALS		0	75, 941				
500.00	Grand Total: Increases		0	554, 954				500.00

Heal th	Financial Systems	COE	ALT REHAB HOSPI	TAL LOUISVIL	LE	In Lie	u of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provider (CCN: 15-3046	Period: From 01/01/2021 To 12/31/2021	Worksheet A- Date/Time Pr 5/19/2022 8:	epared:
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	Ē.		
	6.00	7.00	8.00	9.00	10.00			
	A - MEDICAL SUPPLIES							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	4, 308		0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	12, 077		0		2.00
	TOTALS	T	0	16, 385		1		
	B - INTEREST ON LOANS	·				·		
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	110, 590		11		1.00
	TOTALS	T	0	110, 590		1		1
	C – LAUNDRY	·				·		
1.00	HOUSEKEEPI NG	9.00	0	99, 609		0		1.00
	TOTALS	†	0	99,609		1		
	D - DRUGS CHARGED TO PATIENTS							
1.00	PHARMACY	15.00	0	252, 429		0		1.00
	TOTALS	+		252, 429		1		
	E - DIALYSIS	·						1
1.00	RENAL DI ALYSI S	74.00	0	75, 941		0		1.00
	TOTALS	+	— — — d	75, 941		1		1
500 00	Grand Total: Decreases		0	554, 954		-		500.00

	Financial Custome			F				
	Financial Systems COE ILIATION OF CAPITAL COSTS CENTERS	BALT REHAB HOSP	Provi der C	CN: 15-3046	Fro To	i od: m 01/01/2021 12/31/2021	u of Form CMS-2 Worksheet A-7 Part I Date/Time Pre 5/19/2022 8:4	pared:
				Acquisition	IS			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	0	0		0	0	0	1.00
2.00	Land Improvements	0	0		0	0	0	2.00
3.00	Buildings and Fixtures	0	0		0	0	0	3.00
4.00	Building Improvements	76, 484	156, 345		0	156, 345	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	32, 507	0		0	0	0	6.00
7.00	HIT designated Assets	54, 791	86, 228		0	86, 228	0	7.00
8.00	Subtotal (sum of lines 1-7)	163, 782	242, 573		0	242, 573	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	163, 782	242, 573		0	242, 573	0	10.00
		Ending Balance	Fully					
		-	Depreciated					
			Assets					
		6.00	7.00]				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	0	0					1.00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	0	0					3.00
4.00	Building Improvements	232, 829	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	32, 507	0					6.00
7.00	HIT designated Assets	141,019	0					7.00
8.00	Subtotal (sum of lines 1-7)	406, 355	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	406, 355	0					10.00
				1				

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-3046 Period: Form 01/01/2021 To 12/31/2021 Data File	Heal th Fi	inancial Systems COE	BALT REHAB HOSP	ITAL LOUISVILL	E	In Lie	u of Form CMS-2	2552-10	
Cost Center Description Depreciation Lease Interest instructions) Insurance (see instructions) Taxes (see instructions) 9.00 10.00 11.00 12.00 13.00 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 1.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 0 2.00 3.00 Total (sum of lines 1-2) 49,713 0 0 0 0 3.00 SUMMARY OF CAPITAL Cost Center Description 0 0 0 0 0 0 3.00 instructions) instructions) 14.00 15.00 15.00 1 1.00 0 0 0 0 1.00 1 1.00 instructions) instructions) 14.00 15.00 1 1.00 2.00 0 0 0 2.00 2.00 1.00	RECONCI L	I ATI ON OF CAPI TAL COSTS CENTERS	_	Provider C	CN: 15-3046	From 01/01/2021	Part II Date/Time Pre	pared:	
PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 0 0 1.00 12.00 13.00 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 0 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 49,713 0 0 0 0 2.00 3.00 Total (sum of lines 1-2) 49,713 0 0 0 0 3.00 Cost Center Description Other Total (1) (sum of cast (see instructions) Cost Center Description PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 Instructions) 14.00 15.00 PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 Costs-shibe & FIXT 0 0 0 1.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 1.00 2.00 CAP REL COSTS-BLDG & FIXT 0 0 2.00				S	UMMARY OF CAP	TAL			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 0		Cost Center Description	Depreciation	Lease	Interest				
1.00 CAP REL COSTS-BLDG & FIXT 0 <td< td=""><td></td><td></td><td>9.00</td><td>10.00</td><td>11.00</td><td>12.00</td><td>13.00</td><td></td></td<>			9.00	10.00	11.00	12.00	13.00		
2.00 CAP REL COSTS-MVBLE EQUIP 49,713 0 0 0 0 2.00 3.00 Total (sum of lines 1-2) 49,713 0 0 0 0 0 0 3.00 Cost Center Description Total (1) (sum of cols. 9 through 14) instructions) 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 1.00 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 1.00 2.00 49,713 0 0 0 2.00 1.00 2.00 1.00 2.00 0 0 0 2.00 1.00 2.00 1.00 1.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 <td>PA</td> <td>ART II - RECONCILIATION OF AMOUNTS FROM WORH</td> <td>SHEET A, COLUM</td> <td>N 2, LINES 1 a</td> <td>and 2</td> <td></td> <td></td> <td></td>	PA	ART II - RECONCILIATION OF AMOUNTS FROM WORH	SHEET A, COLUM	N 2, LINES 1 a	and 2				
3.00 Total (sum of lines 1-2) 49,713 0 0 0 0 3.00 SUMMARY OF CAPITAL Cost Center Description 0 0 0 0 0 0 0 0 3.00 Other Capital -Relate d Costs (see instructions) Total (1) (sum of cols. 9 through 14)	1.00 CA	AP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00	
Cost Center Description SUMMARY OF CAPITAL Other Total (1) (sum Capital -Relate of cols. 9 d Costs (see through 14) instructions) 14.00 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP	2.00 CA	AP REL COSTS-MVBLE EQUIP	49, 713	(D	0 0	0	2.00	
Cost Center Description Other Capital -Relate d Costs (see instructions) Total (1) (sum of cols. 9 through 14) 14.00 Total (1) (sum of cols. 9 through 14) PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 CAP REL COSTS-BLDG & FIXT 0 0 2.00 CAP REL COSTS-MVBLE EQUIP 0 49,713	3.00 To	otal (sum of lines 1-2)	49, 713	(0 0	0	3.00	
Capital-Relate d Costs (see instructions) of cols. 9 through 14) 14.00 through 14) 15.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP 0 0 0 0 49,713 1.00 2.00			SUMMARY O	F CAPITAL					
d Costs (see instructions) through 14) 14.00 15.00 14.00 15.00 14.00 15.00 100 CAP REL COSTS-BLDG & FIXT 0 0 2.00 CAP REL COSTS-MVBLE EQUIP 0 49,713		Cost Center Description	Other	Total (1) (sun	n				
instructions) instructions 14.00 15.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 0 0 2.00 CAP REL COSTS-MVBLE EQUIP 0 49,713			Capi tal -Rel ate	of cols. 9					
14.00 15.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 0 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 49,713 2.00			d Costs (see	through 14)					
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 0 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 49, 713 2.00			instructions)						
1.00 CAP REL COSTS-BLDG & FIXT 0 0 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 49, 713 2.00									
2. 00 CAP REL COSTS-MVBLE EQUI P 0 49, 713 2. 00	PA	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
	1.00 C/	AP REL COSTS-BLDG & FIXT	0	(0			1.00	
3.00 Total (sum of lines 1-2) 0 49,713 3.00	2.00 CA	AP REL COSTS-MVBLE EQUIP	0	49, 713	3			2.00	
	3.00 To	otal (sum of lines 1-2)	0	49, 713	3			3.00	

Heal th Fi	inancial Systems COE	BALT REHAB HOSP	ITAL LOUISVILL	E	In Lie	u of Form CMS-2	2552-10
RECONCI L	IATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Prep 5/19/2022 8:45	oared:
		COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	ART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS	1	1			
	AP REL COSTS-BLDG & FIXT	0			0 0. 000000		1.00
	AP REL COSTS-MVBLE EQUIP	32, 507		32, 50			2.00
3.00 To	otal (sum of lines 1-2)	32, 507		32, 50			3.00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other Capi tal -Rel ate	Total (sum of cols. 5	Depreciation	Lease	
			d Costs	through 7)			
		6.00	7.00	8.00	9.00	10.00	
PA	ART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS					
1.00 C/	AP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
2.00 C/	AP REL COSTS-MVBLE EQUIP	352, 251	0	410, 06	7 87, 309	0	2.00
3.00 To	otal (sum of lines 1-2)	352, 251	0	410, 06	7 87, 309	0	3.00
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capital-Relate d Costs (see instructions)	of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PA	ART III - RECONCILIATION OF CAPITAL COSTS CE						
	AP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
	AP REL COSTS-MVBLE EQUIP	110, 590	57, 816	352, 25	1 0	607, 966	2.00
3.00 To	otal (sum of lines 1-2)	110, 590					3.00
					,		

	Financial Systems MENTS TO EXPENSES	COB	ALT REHAB HOSP	ITAL LOUISVILLE Provider CCN: 15-3046	Peri od:	u of Form CMS-2 Worksheet A-8	2552-10
					From 01/01/2021 To 12/31/2021	Date/Time Pre	
				Expense Classification		5/19/2022 8:4	<u>5 am</u>
				To/From Which the Amount i	s to be Adjusted		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	1.00		1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.00
	stations excluded) (chapter 21)						
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 - 49, 329		0.00	0	9.00 10.00
11.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	597, 321			0	12.00
13.00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00
14.00 15.00	Cafeteria-employees and guests Rental of quarters to employee		0 0		0.00 0.00		14.00 15.00
16. 00	and others Sale of medical and surgical		0		0.00	0	16.00
	supplies to other than patients						
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	В	1, 408	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
20. 00	books, etc.) Vending machines		0		0.00	0	20.00
	Income from imposition of interest, finance or penalty	В	-134	ADMINISTRATIVE & GENERAL	5.00		
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22.00
221 00	overpayments and borrowings to repay Medicare overpayments		J. J. J. J. J. J. J. J. J. J. J. J. J. J			0	22100
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)		-				
25.00	Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114.00		25.00
26. 00	(chapter 21) Depreciation - CAP REL		Ω	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL			CAP REL COSTS-MVBLE EQUIP	2.00		
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist			NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0.00	0	29.00 30.00
30.00	therapy costs in excess of	A-0-3	0	UUUUFATIUNAL ITEKAPI	07.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
30 00	pathology costs in excess of limitation (chapter 14)		0		0.00	0	32 00
	CAH HIT Adjustment for Depreciation and Interest		0		0.00		32.00
33.00	BAD DEBT	A	-305, 948	ADMI NI STRATI VE & GENERAL	5.00	0	33.00

	Financial Systems	COB	ALI KEHAB HUSP	PI TAL LOUI SVI LLE		u of Form CMS-2	
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-3046	Period: From 01/01/2021	Worksheet A-8	
					To 12/31/2021	Date/Time Pre	pared [.]
					10 12/01/2021	5/19/2022 8:4	
				Expense Classification of	n Worksheet A		
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	CABLE	A	-13, 204	ADMI NI STRATI VE & GENERAL	5.00	0	34.00
	PHONE	A	-45,550	ADMI NI STRATI VE & GENERAL	5.00	0	35.00
35.01	SALES TAX	A		ADMI NI STRATI VE & GENERAL	5.00	0	35.01
35.02	ADVERTI SI NG	A		ADMI NI STRATI VE & GENERAL	5.00	0	35. 02
	DUES AND SUBSCRIPTIONS	A		ADMI NI STRATI VE & GENERAL	5.00	0	35.03
	DEFERRED RENT	A		ADMI NI STRATI VE & GENERAL	5.00	0	35.04
	START UP COTS	A	88, 828	ADMI NI STRATI VE & GENERAL	5.00	0	35.05
35.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.06
35.07	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35.07
	(3)						
35.08	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35.08
	(3)						
35.09	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35.09
25 10			0		0.00		35.10
35. 10	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.10
35. 11	OTHER ADJUSTMENTS (SPECIFY)		Ω		0.00	0	35.11
00.11	(3)		0		0.00		
35. 12	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35.12
	(3)		-				
50.00	TOTAL (sum of lines 1 thru 49)		-278, 084				50.00
	(Transfer to Worksheet A,						
	adumn (Line 200)						1

(Transfer to Worksheet A, column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1. (2) Basis for adjustment (see instructions). A. Costs - if cost, including applicable overhead, can be determined. B. Amount Received - if cost cannot be determined. (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	COBALT REHAB HOS	PI TAL LOUI SVI LLE	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-3046	Period: From 01/01/2021	Worksheet A-8	-1
OFFICE				To 12/31/2021	Date/Time Pre 5/19/2022 8:4	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	696, 301	136, 576	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPI TAL	37, 596	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			733, 897	136, 576	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

1103	110 נ	Deen	posteu te	worksneet	- Г,	cor unins	i anu.	01 2,	the	amouri		ouru be	indicated in c	Joi unin 4	or this part.	
												Rel ated	Organi zati on(s) and/o	or Home Office	
			Symbo	(1)			N	ame			Percentage of		Name		Percentage of	
			e jiilee	. (.)				amo			Ownershi p		Hamo		Ownershi p	
			1. (00			2	00			3.00		4.00		5.00	
		D IN						$\frac{1}{2}$								

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

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

6.00	В	0.00 COBALT REHABILI 24.00	6.00
7.00		0.00 0.00	7.00
8.00		0.00 0.00	8.00
9.00		0.00 0.00	9.00
10.00		0.00 0.00	10.00
100.00	6. Other (financial or		100.00
lr	non-financial) specify:		

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

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

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

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

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

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

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

Heal th Financ	ial Syste	ems		COBALT RE	HAB HOSPI TA	AL LOUISVI	LLE		In Lie	u of Form C	MS-2	2552-10
STATEMENT OF		SERVICES FRO	M RELATED	ORGANI ZATI ONS	AND HOME	Provi der	CCN:	15-3046	Period: From 01/01/2021	Worksheet	A-8	-1
UTTEL COSTS									To 12/31/2021	Date/Time 5/19/2022		
	Net	Wkst. A-7 Re	·.	·								

	Net	WKST. A-/ Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	559, 725	0		1.00
2.00	37, 596	9		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	597, 321			5.00
				•

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

nas no	L been posted to worksneet A,	corumns r and/or 2, the amount arrowable should be indicated in corumn 4 of this part.	
	Rel ated Organi zati on(s)		
	and/or Home Office		
	Type of Business		
	(00		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

Ternibui	Sement under title AVIII.	
6.00	MANAGEMENT CO	6.00
7.00 8.00		7.00
		8.00
9. 00 10. 00		9.00
10.00		10.00
100.00		100.00

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

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

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

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

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

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

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

	Financial Syste			COBALT REHAB HOS			In Li	eu of Form CMS-	
PROVI DE	R BASED PHYSICI	AN AD	JUSTMENT		Provi der	CCN: 15-3046	Period: From 01/01/2027 To 12/31/2027		epared:
	Wkst. A Line #	Со	st Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1.00		2.00	3.00	4.00	5.00	6.00	7.00	
1.00		DR. A		132, 964		0 132,96			1.00
2.00	5.00	DR. B		7,200		0 7,20			2.00
3.00	0.00			0		0	o c	0	3.00
4.00	0.00			0		0	o c	0	4.00
5.00	0.00			0		0	ol c	0	5.00
6.00	0.00			0		0	ol c	0	6.00
7.00	0.00			0		0	ol c	0	7.00
8.00	0.00			0		0	ol c	0	8.00
9.00	0.00			0		0	o c	0	9.00
10.00	0.00			0		0	ol c	0	10.00
200.00				140, 164		0 140, 16	4	958	200.00
	Wkst. A Line #	Со	st Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
			Identifier	Limit	Unadjusted RC	E Memberships &	Component	of Mal practi ce	
					Limit	Conti nui ng	Share of col.	Insurance	
						Educati on	12		
	1.00		2.00	8.00	9.00	12.00	13.00	14.00	
1.00		DR. A		90, 091	4, 50		o C	-	
2.00		DR. B		744			o C	-	
3.00	0.00			0		0	o C	0	
4.00	0.00			0		0	o C	0	
5.00	0.00			0		0	o C	0	
6.00	0.00			0		0	oj c	0	
7.00	0.00			0		0	0 0	0	
8.00	0.00			0		0	0 0	0	
9.00	0.00			0		0	0 0	0	
10.00	0.00			0		0	0 0	-	
200.00		0		90, 835			0 <u> </u>	0	200.00
	Wkst. A Line #	Co	st Center/Physician	Provi der	Adjusted RCE		Adjustment		
			l denti fi er	Component	Limit	Di sal I owance			
				Share of col. 14					
	1.00		2.00	15.00	16.00	17.00	18.00	-	
1.00		DR. A	2.00	0					1.00
2.00		DR. B		0					2.00
3.00	0, 00	DR. D		0				1	3.00
4.00	0.00			0		-			4,00
5.00	0.00					0			5.00
6.00	0.00			0		0			6.00
7.00	0.00			0		0			7.00
8.00	0.00			0		0			8.00
9.00	0.00			0		0			9,00
10.00	0.00			0		0			10.00
200.00	0.00			0		0	-		200.00
	I I					.,,02		1	

	Financial Systems CO LLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: com 01/01/2021 o 12/31/2021	Worksheet B Part I Date/Time Pre 5/19/2022 8:4	
			CAPI TAL REL	ATED COSTS		571772022 0.4	
	Cost Center Description	Net Expenses for Cost Allocation	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		(from Wkst A					
		<u>col.7)</u> 0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS		-				
00	00100 CAP REL COSTS-BLDG & FIXT	0	0	(07.0()			1.0
00 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	607, 966 251, 059	0	607, 966 2, 827	253, 886		2. C 4. C
00	00500 ADMI NI STRATI VE & GENERAL	5, 032, 016	0	120, 894	253, 880	5, 209, 183	5. C
00	00700 OPERATION OF PLANT	359,046	0	16, 226	3, 818	379,090	
00	00800 LAUNDRY & LINEN SERVICE	99, 609	0	8, 146	0	107, 755	8.0
00	00900 HOUSEKEEPI NG	136, 274	0	0	5, 300	141, 574	9.0
. 00	01000 DI ETARY	340, 917	0	38, 584	12, 777	392, 278	10.0
. 00	01100 CAFETERI A	0	0	0	0	0	11.0
. 00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	
	01300 NURSI NG ADMI NI STRATI ON	221, 455	0	0	0	221, 455	
	01400 CENTRAL SERVICES & SUPPLY	47,099	0	0	2, 286	49, 385	
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	128, 541 48, 734	0	10, 428 3, 350	0 5, 104	138, 969 57, 188	
	01700 SOCIAL SERVICE	48, 734	0	3, 35U A	5, 104 A	57, 188	1
	01851 OTHER GENERAL CC		0	0	0	0	17.0
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.0
	02000 NURSI NG PROGRAM	0	0	0	0	0	20.0
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.0
. 00	02300 PARAMED ED PRGM	0	0	0	0	0	23.0
	INPATIENT ROUTINE SERVICE COST CENTERS						
. 00	03000 ADULTS & PEDIATRICS	2, 674, 434	0	307, 494	94, 899	3, 076, 827	30.0
	03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.0
. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.0
. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	
. 00 . 00	04000 SUBPROVIDER - IPF	0	0	0	0	0	
. 00	04000 SUBPROVIDER - TPP	0	0	0	0	0	
. 00	04300 NURSERY	0	0	0	0	0	
. 00	04400 SKI LLED NURSI NG FACI LI TY	0	0	0	0	0	
. 00	04500 NURSING FACILITY	0	0	0	0	0	45.0
. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.0
	ANCI LLARY SERVI CE COST CENTERS	1					
. 00	05000 OPERATI NG ROOM	0	0	0	0	0	
. 00	05100 RECOVERY ROOM	0	0	0	0	0	51.0
00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 E2 725	0	0 6, 889	0	0 60, 624	
. 00 . 00	05500 RADI OLOGY-THERAPEUTI C	53, 735	0	0, 009	0	00, 024	1
. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56.0
00	05700 CT SCAN	0	0	0	0	0	57.0
. 00	05800 MRI	0	0	0	0	0	58.0
. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
. 00	06000 LABORATORY	748	0	1, 636	0	2, 384	60.0
. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60.0
. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0				0	61.0
. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.0
. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.0
. 00	06400 I NTRAVENOUS THERAPY	0	0	0		20 450	64.0
. 00 . 00	06500 RESPIRATORY THERAPY	21, 476	0	3, 328	4,854	29,658	65.0 66.0
00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	553, 455 452, 548	0	88, 164 0	33, 640 19, 028	675, 259 471, 576	
. 00	06800 SPEECH PATHOLOGY	198, 388	0	0	4, 510	202, 898	
	06900 ELECTROCARDI OLOGY	0	0	0	0	202, 070	69.0
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	16, 385	0	0	0	16, 385	
. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	252, 429	0	0	11, 397	263, 826	
. 00	07400 RENAL DIALYSIS	0	0	0	0	0	74.0
. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	
. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.0
~~	OUTPATIENT SERVICE COST CENTERS		-			2	
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
	09000 CLINIC	0	0	0	0	0	90.0
. 00	09100 EMERGENCY		0	~	~	0	91.0

Health Financial Systems COE	BALT REHAB HOSP	I TAL LOUI SVI LL	E	In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-3046	Peri od:	Worksheet B	
				From 01/01/2021 To 12/31/2021	Part I Date/Time Pre	enared [.]
i					5/19/2022 8:4	15 am
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
Cost center bescription	for Cost	DEDG & TTAT		BENEFITS	Subtotal	
	Allocation			DEPARTMENT		
	(from Wkst A					
	<u>col.7)</u>	1.00	2.00	4.00	4A	
OTHER REIMBURSABLE COST CENTERS	0	1.00	2.00	4.00	4A	
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0		94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0		
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE CC	0	0		0 0	0	
99.00 09900 CMHC	0	0		0 0	(
99.10 09910 CORF 100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0	(99.10
101.00 10100 HOME HEALTH AGENCY	0	0				101.00
SPECIAL PURPOSE COST CENTERS	0	0	l			101.00
105.00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	(105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		109.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0				111.00
113. 00 11300 I NTEREST EXPENSE	0	0		0		113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	11, 496, 314	0	607, 96	253, 886	11, 496, 314	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
193. 00 19300 NONPAI D WORKERS	Ő	0		0 0		193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	11, 496, 314	0	607, 96	253, 886	11, 496, 314	202.00

COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part I Date/Time Pre	pared.
	Cost Center Description	ADMI NI STRATI VE	ΟΡΕΡΔΤΙΟΝ ΟΕ	LAUNDRY &	HOUSEKEEPING	5/19/2022 8: 4 DI ETARY	5 am
		& GENERAL	PLANT	LINEN SERVICE			
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL	5, 209, 183					5.00
7.00	00700 OPERATION OF PLANT	314, 094	693, 184				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	89, 280	12, 066				8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	117, 301 325, 021	0 57, 147	0	258, 875 21, 720	796, 166	9.00
11.00	01100 CAFETERI A	0	0	0	21,720	0	
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
	01300 NURSING ADMINISTRATION	183, 486	0	0	0	0	
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	40, 918 115, 142	0 15, 445		0 5, 870	0	
	01600 MEDICAL RECORDS & LIBRARY	47, 383	4, 961	0	1, 886	0	
	01700 SOCIAL SERVICE	0	0	0	0	0	1
	01851 OTHER GENERAL CC	0	0	0	0	0	
	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM	0	0	0	0	0	19.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
23.00	02300 PARAMED ED PRGM	0	0	0	0	0	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 549, 294	455, 431	209, 101	173, 097	796, 166	30.00
30.00	03100 I NTENSI VE CARE UNI T	2, 349, 294	455, 451	209,101	0	/ 3 0, 100 0	1
32.00	03200 CORONARY CARE UNI T	0	0	0	0	0	1
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 40.00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	0	0	0	
40.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	1
43.00	04300 NURSERY	0	0	0	0	0	1
44.00	04400 SKI LLED NURSI NG FACI LI TY	0	0	0	0	0	
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0		0	0	1
40.00	ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	40.00
50.00	05000 OPERATI NG ROOM	0	0	0	0	0	50.00
	05100 RECOVERY ROOM	0	0	0	0	0	
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0		0	0	
	05400 RADI OLOGY-DI AGNOSTI C	50, 230	10, 203	0	3, 878	0	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	
57.00 58.00	05700 CT SCAN 05800 MRI	0			0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	00.00
60.00	06000 LABORATORY	1, 975	2, 423	0	921	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	61.00 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	
65.00		24, 573	4, 928	0	1,873	0	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	559, 484 390, 723	130, 580		49, 630	0	66.00 67.00
	06800 SPEECH PATHOLOGY	168, 111	0	0	0	0	
	06900 ELECTROCARDI OLOGY	0	0	0	0	0	
	07000 ELECTROENCEPHALOGRAPHY	10 57(0	0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	13, 576			0	0	
	07300 DRUGS CHARGED TO PATIENTS	218, 592	0	0	0	0	
74.00	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
	07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	
11.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
		0	0	0	0	0	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS			<u>I</u>	I I		1 2.00
	09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
		0	0	0	9	-	1
95.00	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	95.00

Health Financial Systems Co	DBALT REHAB HOSP	TAL LOUISVILL	E	In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
				rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre	narod
			· · · · · · · · · · · · · · · · · · ·	0 12/31/2021	5/19/2022 8:4	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7.00	8.00	9.00	10.00	
98.00 09850 OTHER REI MBURSABLE CC	0	0	C	0 0	0	98.00
99.00 09900 CMHC	0	0	C	0 0	0	99.00
99. 10 09910 CORF	0	0	C	0 0	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	C	0 0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	C	0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	C	0 0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0	C	0 0		106.00
107.00 10700 LIVER ACQUISITION	0	0	C	0 0		107.00
108.00 10800 LUNG ACQUISITION	0	0	C	0 0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0	C	0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	C	0 0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	C	0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	C	0 0	0	115.00
116. 00 11600 HOSPI CE	0	0	C	0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	5, 209, 183	693, 184	209, 101	258, 875	796, 166	118.00
NONREI MBURSABLE COST CENTERS	-					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0 0		190.00
191. 00 19100 RESEARCH	0	0	C	0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0 0		192.00
193.00 19300 NONPAI D WORKERS	0	0	C	0 0	0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	C	0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	5, 209, 183	693, 184	209, 101	258, 875	796, 166	202.00

COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part I Date/Time Pre	narod
	Cost Conton Decemintion		MAINTENANCE OF			5/19/2022 8:4	
	Cost Center Description	CAFETERI A	PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
	1	11.00	12.00	13.00	14.00	15.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERIA	(11.00
12.00 13.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION			404, 941			12.00 13.00
	01400 CENTRAL SERVICES & SUPPLY			0	90, 303		14.00
	01500 PHARMACY	0	c c	0	0	275, 426	
	01600 MEDICAL RECORDS & LIBRARY	(0	0	0	
17.00 18.00	01700 SOCIAL SERVICE 01851 OTHER GENERAL CC				0	0	
	01900 NONPHYSICIAN ANESTHETISTS	(0	0	
20.00	02000 NURSI NG PROGRAM			o o	0	0	20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0		0	0	0	
22.00	02200 I & SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM			, united and a second s	0	0	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS) C	<u> </u>	0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	(404, 941	0	0	30.00
	03100 I NTENSI VE CARE UNI T	(o c	, o	0	0	31.00
32.00	03200 CORONARY CARE UNIT	(0	0	0	
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT				0	0	
40.00	04000 SUBPROVIDER - IPF				0	0	
41.00	04100 SUBPROVI DER – I RF	(c c	0	0	0	
43.00	04300 NURSERY	(o c	0 0	0	0	
44.00	04400 SKI LLED NURSI NG FACI LI TY			0	0	0	
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE				0	0	
	ANCI LLARY SERVICE COST CENTERS			-	-1	-	
50.00	05000 OPERATI NG ROOM	(0	0	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM			0	0	0	
53.00	05300 ANESTHESI OLOGY				0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C			0	Ő	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	(o c	0 0	0	0	
56.00	05600 RADI OI SOTOPE	(0	0	0	
57.00 58.00	05700 CT SCAN 05800 MRI				0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON			0	0	0	
60.00	06000 LABORATORY	(o c	0	0	0	60.00
	06001 BLOOD LABORATORY	() C	0 0	0	0	60.01
61.00 62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	(0	0	61.00 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.				0	0	
64.00	06400 I NTRAVENOUS THERAPY	(o c	0 0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0		0	0	0	
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY			0	0	0	
67.00	06800 SPEECH PATHOLOGY				0	0	
	06900 ELECTROCARDI OLOGY			0	0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0) c	0	0	0	70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT			0	90, 303	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS				0	0 275, 426	
	07400 RENAL DIALYSIS				0	275, 420	1
75.00	07500 ASC (NON-DISTINCT PART)			0	Ō	0	75.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION) <u> </u>	0	0	0	77.00
00 00						0	00 00
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER				0	0	
90.00	09000 CLINIC			0	0	0	
91.00	09100 EMERGENCY	0) c	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
94.00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S			0	0	0	94.00
74.UU			-				
95.00	09500 AMBULANCE SERVICES	(0	0	0	95.00

Health Financial Systems COE	BALT REHAB HOSF	PITAL LOUISVILL	.E	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eri od:	Worksheet B	
				rom 01/01/2021	Part I	
			1	o 12/31/2021	Date/Time Pre 5/19/2022 8:4	
Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSING	CENTRAL	PHARMACY	
		PERSONNEL	ADMI NI STRATI ON	SERVICES &		
				SUPPLY		
	11.00	12.00	13.00	14.00	15.00	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C	0 0	0	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
98.00 09850 OTHER REIMBURSABLE CC	0	C	0 0	0	0	98.00
99. 00 09900 CMHC	0	C	0 0	0	0	99.00
99. 10 09910 CORF	0	C	0 0	0	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	C	0 0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	C	0 0	0	0	101.00
SPECIAL PURPOSE COST CENTERS		1	1			-
105.00 10500 KIDNEY ACQUISITION	0	C	0 0	0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	C	0 0	0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	C	0 0	0		107.00
108.00 10800 LUNG ACQUISITION	0	C	0 0	0		108.00
109.00 10900 PANCREAS ACQUISITION	0	C	0 0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	C	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	C	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C	0	0		115.00
116.00 11600 HOSPI CE	0	C	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	<u> </u>	404, 941	90, 303	275, 426	118.00
NONREI MBURSABLE COST CENTERS		1				1.00.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0		190.00
191.00 19100 RESEARCH	0		0	0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0		0	0		192.00
193. 00 19300 NONPAI D WORKERS	0		0	0	0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0			0 00 000		201.00
202.00 TOTAL (sum lines 118 through 201)	0	C	404, 941	90, 303	275, 426	202. OO

	Financial Systems CC NLLOCATION - GENERAL SERVICE COSTS	BALT REHAB HOSF		CN: 15-3046 F	Period: From 01/01/2021	w of Form CMS Worksheet B Part I	2002 1
					To 12/31/2021	Date/Time Pr 5/19/2022 8:	epared:
	· · · · · · · · · · · · · · · · · · ·			OTHER GENERAL		371772022 0.	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	SERVICE OTHER GENERAL CC	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	
		16.00	17.00	18.00	19.00	20.00	-
	GENERAL SERVICE COST CENTERS	T		1	1		
16.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	111, 418					1. 0 2. 0 4. 0 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 12. 0 13. 0 14. 0 15. 0 16. 0 17. 0
18. 00 19. 00 20. 00	01851 OTHER GENERAL CC 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS						18.00 19.00 20.00 21.00 22.00 23.00
30.00	03000 ADULTS & PEDIATRICS	63, 805					0 30.00
	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T		-				0 31.00 0 32.00
	03300 BURN I NTENSI VE CARE UNI T				-		0 33.0
34.00	03400 SURGICAL INTENSIVE CARE UNIT	C	C) (0 0		0 34.0
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF						0 40.0 0 41.0
43.00	04300 NURSERY						0 43.0
	04400 SKI LLED NURSI NG FACI LI TY				0 0		0 44.0
45.00	04500 NURSING FACILITY	0	c c		0 0		0 45.0
46.00	04600 OTHER LONG TERM CARE	C) C) (0 0		0 46.0
50.00	ANCI LLARY SERVICE COST CENTERS	C			0 0		0 50.0
	05100 RECOVERY ROOM						0 51.0
52.00	05200 DELIVERY ROOM & LABOR ROOM				0 0		0 52.0
53.00	05300 ANESTHESI OLOGY	C	C) (0 0		0 53.0
	05400 RADI OLOGY-DI AGNOSTI C	657	/ C		0 0		0 54.0
	05500 RADI OLOGY-THERAPEUTI C	C	C) (0 0		0 55.C
	05600 RADI OI SOTOPE 05700 CT SCAN						0 56.C 0 57.C
	05800 MRI						0 58.0
	05900 CARDI AC CATHETERI ZATI ON	C			0 0		0 59.0
60. 00	06000 LABORATORY	1, 767	/ C	0 0	0 0	(0 60. C
60. 01	06001 BLOOD LABORATORY	C	C	0 0	0 0		0 60.0
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL						61.0 0 62.0
	06300 BLOOD STORING, PROCESSING & TRANS.						0 63.0
	06400 I NTRAVENOUS THERAPY	C			0 0	(0 64.0
	06500 RESPI RATORY THERAPY	101			0 0	(0 65.0
	06600 PHYSI CAL THERAPY	14, 773) (0 0		0 66.0
		18, 189			0		0 67.0
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	2, 266					0 68.0 0 69.0
	07000 ELECTROENCEPHALOGRAPHY						0 70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	327					0 71.0
	07200 I MPL. DEV. CHARGED TO PATIENTS	C			0 0		0 72.0
	07300 DRUGS CHARGED TO PATIENTS	9, 533	C C		0 0		0 73.0
	07400 RENAL DI ALYSI S	C	C		0 0		0 74.0
15.00	07500 ASC (NON-DI STINCT PART) 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON						0 75.0 0 77.0
	OUTPATIENT SERVICE COST CENTERS		<u> </u>	́ч (<u> </u>
					0 0		0 88.0
77.00	08800 RURAL HEALTH CLINIC	0					
77. 00 88. 00			C) (0 0	(0 89.0
77.00 88.00 89.00 90.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC				0 0 0 0		0 89.0 0 90.0
77.00 88.00 89.00 90.00 91.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY				0 0 0 0 0 0		0 90.0 0 91.0
77.00 88.00 89.00 90.00 91.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC						0 90.0

Health Financial Systems CO	BALT REHAB HOSP	TAL LOUISVILL	E	In Lie	eu of Form CMS	-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2021 To 12/31/2021		repared: 45 am
			OTHER GENERAL	-		
Cast Canton Description	MEDI CAL	SOCI AL SERVI CE	SERVI CE	NONPHYSI CI AN	NURSI NG	
Cost Center Description	RECORDS &	SUCIAL SERVICE	CC	ANESTHETISTS	PROGRAM	
	LI BRARY			ANESTHEITSTS	TROOMAN	
	16.00	17.00	18.00	19.00	20.00	
95. 00 09500 AMBULANCE SERVICES	0			0 0		0 95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0)	0 0		0 96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0)	0 0		0 97.00
98.00 09850 OTHER REIMBURSABLE CC	0	0)	0 0		0 98.00
99. 00 09900 CMHC	0	0)	0 0		0 99.00
99. 10 09910 CORF	0	0)	0 0		0 99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0)	0 0		0 100. 00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0		0 101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0		0 0		0 105. 00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0		0 106. 00
107.00 10700 LIVER ACQUISITION	0	0		0 0		0 107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0		0 108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0		0 109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0)	0 0		0 110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0)	0 0		0 111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		0 115.00
116. 00 11600 HOSPI CE	0	0		0		0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	111, 418	0		0 0		0 118. 00
NONREI MBURSABLE COST CENTERS			1		1	_
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		0 190. 00
191. 00 19100 RESEARCH	0	0		0 0		0 191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		0 192.00
193. 00 19300 NONPAI D WORKERS	0	0		0 0		0 193.00
200.00 Cross Foot Adjustments		-		0		0 200. 00
201.00 Negative Cost Centers	0	0		0		0 201.00
202.00 TOTAL (sum lines 118 through 201)	111, 418	0	1	0 0	l	0 202.00

In Lieu of Form CMS-2552-10										
Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/19/2022 8:45 am									

					To 12/31/20		
		INTERNS &	RESI DENTS			5/19/2022 8:4	
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	t
		21.00	22.00	23.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS						
$\begin{array}{c} 1.00\\ 2.00\\ 4.00\\ 5.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ 20.00\\ 21.00\\ 23.00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01851 OTHER GENERAL CC 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PRORAM 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRM COSTS APPRV	0	0		0		1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			<u> </u>	0		23.00
30.00		0	0		0 7, 728, 0		30.00
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0	0		0	-) 31.00) 32.00
33.00	03300 BURN I NTENSI VE CARE UNI T	0	0		0		33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0	0 0	34.00
40.00	04000 SUBPROVIDER - IPF	0	0		0	-	40.00
41.00 43.00	04100 SUBPROVI DER – I RF	0	0		0	-	0 41.00 0 43.00
43.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	0		0		43.00
45.00	04500 NURSING FACILITY	0	0		0		45.00
46.00	04600 OTHER LONG TERM CARE	0	0		0	0 0	46.00
	ANCI LLARY SERVI CE COST CENTERS			I		- I	
50.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	0		0		50.00
51.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	-	0 51.00 0 52.00
53.00	05300 ANESTHESI OLOGY	0	0		0		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 125, 5		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	-	55.00
56.00	05600 RADI OI SOTOPE	0	0		0	0 0	56.00
	05700 CT SCAN 05800 MRI	0	0		0		0 57.00 0 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0		59.00
60.00	06000 LABORATORY	0	0		0 9,4	470 0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0 0	0 60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0	0	61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	-	0 62.00 0 63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0		0 61, 1		65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 1, 429, 1	726 (66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 880, 4		67.00
68.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0		0 373, 2		0 68.00 0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 120, !	-	71.00
72.00		0	0		0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 767, 3		73.00
74.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0		0		0 74.00 0 75.00
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	-	77.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0		0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		U	-) 89.00) 90.00
90.00 91.00		0	0		0	-	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART				-		92.00

Health Financial Systems CO	BALT REHAB HOSP	I TAL LOUI SVI LL	E		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-3046		riod: om 01/01/2021 12/31/2021	Worksheet B Part I Date/Time Pre 5/19/2022 8:4	pared: 5 am
	INTERNS &	RESI DENTS					
Cost Center Description	SERVI CES-SALAR Y & FRI NGES APPRV	SERVICES-OTHER PRGMCOSTS APPRV	PARAMED ED PRGM)	Subtotal	Intern & Residents Cost & Post Stepdown	
	21.00	22.00	22.00		24.00	Adjustments	
OTHER REIMBURSABLE COST CENTERS	21.00	22.00	23.00		24.00	25.00	
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0	0	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE CC	0	0		0	0	0	98.00
99. 00 09900 CMHC	0	0		0	0	0	99.00
99. 10 09910 CORF	0	0		0	0	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							1.05 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0	0		105.00
106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON	0	0		0	0		106.00 107.00
108. 00 10800 LUNG ACQUISITION	0	0		0	0		107.00
109. 00 10900 PANCREAS ACQUISITION	0	0		0	0		108.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0	0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0		õ	0		111.00
113.00 11300 I NTEREST EXPENSE		-		-	-		113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF							114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0	0	0	115.00
116. 00 11600 HOSPI CE				0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0	11, 496, 314	0	118.00
NONREI MBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0		190.00
191.00 19100 RESEARCH	0	0		0	0		191.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0	0		192.00
193.00 19300 NONPAID WORKERS	0	0		0	0		193.00
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0		0	0		200. 00 201. 00
201.00 Negative cost centers 202.00 TOTAL (sum lines 118 through 201)	0	0		0	11, 496, 314		201.00
	I U	0	I	9	11, 470, 514	0	1202.00

Heal th	Fi nanci al	Systems

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	COBALT REHAB HOSPI	Provider CCN: 15-3046	Peri od:	u of Form (Worksheet	
USI P	ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-3046	From 01/01/2021 To 12/31/2021	Part I Date/Time	
	Cost Conton Decorintian	Tatal			5/19/2022	
	Cost Center Description	Total 26.00				
	GENERAL SERVICE COST CENTERS					
. 00	00100 CAP REL COSTS-BLDG & FIXT					1
00	00200 CAP REL COSTS-MVBLE EQUIP					2
00	00400 EMPLOYEE BENEFITS DEPARTMENT					4
00 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT					5
00	00800 LAUNDRY & LINEN SERVICE					8
. 00	00900 HOUSEKEEPING					9
0. 00	01000 DI ETARY					10
	01100 CAFETERI A					11
	01200 MAINTENANCE OF PERSONNEL					12
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY					13
	01500 PHARMACY					14
	01600 MEDI CAL RECORDS & LI BRARY					16
	01700 SOCIAL SERVICE					17
	01851 OTHER GENERAL CC					18
	01900 NONPHYSI CI AN ANESTHETI STS					19
	02000 NURSI NG PROGRAM					20
	02100 I &R SERVI CES-SALARY & FRINGES APP 02200 I &R SERVI CES-OTHER PRGM COSTS APP					21
	02200 PARAMED ED PRGM	-RV				22
5.00	INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00	03000 ADULTS & PEDI ATRI CS	7, 728, 662				30
1. 00	03100 INTENSIVE CARE UNIT	0				31
	03200 CORONARY CARE UNI T	0				32
	03300 BURN INTENSIVE CARE UNIT	0				33
	03400 SURGI CAL INTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0				34
	04100 SUBPROVIDER - IRF	0				40
3.00	04300 NURSERY	0				43
	04400 SKILLED NURSING FACILITY	0				44
5.00	04500 NURSING FACILITY	0				45
6. 00	04600 OTHER LONG TERM CARE	0				46
0 00	ANCI LLARY SERVICE COST CENTERS	0				
	05000 OPERATING ROOM 05100 RECOVERY ROOM	0				50
	05200 DELIVERY ROOM & LABOR ROOM	0				52
	05300 ANESTHESI OLOGY	0				53
	05400 RADI OLOGY-DI AGNOSTI C	125, 592				54
	05500 RADI OLOGY-THERAPEUTI C	0				55
	05600 RADI OI SOTOPE	0				56
	05700 CT SCAN 05800 MRI	0				57
	05900 CARDI AC CATHETERI ZATI ON	0				59
	06000 LABORATORY	9, 470				60
	06001 BLOOD LABORATORY	0				60
1.00	06100 PBP CLINICAL LAB SERVICES-PRGM ON	NLY O				61
	06200 WHOLE BLOOD & PACKED RED BLOOD CE					62
	06300 BLOOD STORING, PROCESSING & TRANS					63
	06400 I NTRAVENOUS THERAPY	0				64
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	61, 133 1, 429, 726				66
	06700 OCCUPATI ONAL THERAPY	880, 488				67
	06800 SPEECH PATHOLOGY	373, 275				68
	06900 ELECTROCARDI OLOGY	0				69
	07000 ELECTROENCEPHALOGRAPHY	0				70
	07100 MEDI CAL SUPPLIES CHARGED TO PATIE					71
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 767, 377				72
	07400 RENAL DI ALYSI S	07,377				74
	07500 ASC (NON-DISTINCT PART)	0				75
	07700 ALLOGENEIC STEM CELL ACQUISITION	0				77
	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC	0				88
	08900 FEDERALLY QUALIFIED HEALTH CENTER					89
	09000 CLINIC 09100 EMERGENCY	0				90
	09200 OBSERVATION BEDS (NON-DISTINCT PA					91
00	OTHER REIMBURSABLE COST CENTERS					72
4.00	09400 HOME PROGRAM DI ALYSI S	0				94
	09500 AMBULANCE SERVICES	0				95
	09600 DURABLE MEDICAL EQUIP-RENTED	0				96
7.00	09700 DURABLE MEDI CAL EQUI P-SOLD 09850 OTHER REI MBURSABLE CC	0				97 98

Health Financial Systems COB	ALT REHAB HOSPIT	AL LOUI SVI LLE	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-3046	Peri od: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/19/2022 8:45 am
Cost Center Description	Total 26.00			
99. 00 09900 CMHC 99. 10 09910 CORF 100. 00 10000 I &R SERVICES-NOT APPRVD PRGM	0 0 0		·	99. 00 99. 10 100. 00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0			101.00
105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON	0			105. 00 106. 00 107. 00
108. 00 10900 EIVER ACQUISITION 108. 00 10900 PANCREAS ACQUISITION	0			107.00 108.00 109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON 111. 00 11100 I SLET ACQUI SI TI ON	0 0			110. 00 111. 00
113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0			113. 00 114. 00 115. 00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0 11, 496, 314			116.00 118.00
NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190. 00
191.00 19100 RESEARCH 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 193.00 19300 NONPALD WORKERS	0 0 0			191. 00 192. 00 193. 00
200.00Cross Foot Adjustments201.00Negative Cost Centers202.00TOTAL (sum Lines 118 through 201)	0 0 11, 496, 314			200. 00 201. 00 202. 00

	Financial Systems CC TION OF CAPITAL RELATED COSTS CONTRACT	DBALT REHAB HOSP	PTAL LOUISVILL Provider C	CN: 15-3046 Pe	eri od:	u of Form CMS-: Worksheet B	2552-10
				Tc	com 01/01/2021 12/31/2021	Part II Date/Time Pre 5/19/2022 8:4	
			CAPI TAL RE	LATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	1	0	1.00	2.00	2A	4.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINI STRATION			120, 894 16, 226 8, 146 0	2, 827 120, 894 16, 226 8, 146 0 38, 584 0 0 0	2, 827 627 43 0 59 142 0 0 0	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ \end{array}$
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01851 OTHER GENERAL CC 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I & SERVICES-SALARY & FRINGES APPRV 02200 I & SERVICES-OTHER PRGM COSTS APPRV			10, 428 3, 350 0 0 0 0 0 0 0	0 0 10, 428 3, 350 0 0 0 0 0 0 0 0 0	25 0 57 0 0 0 0 0 0 0	14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00
23.00	02300 PARAMED ED PRGM	0			0	0	•
30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00 46. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG FERM CARE MULLIARY SERVICE COST CENTERS				307, 494 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 056 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00
50 00	ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	50 00
70.00 71.00 72.00 73.00 74.00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0UTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C			$egin{array}{cccc} 0 & 0 & 0 & 0 & 0 & 0 & 0 & 0 & 0 & 0 $	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 57.\ 00\\ 59.\ 00\\ 60.\ 01\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 71.\ 00\\ 71.\ 00\\ 72.\ 00\\ 71.\ 00\\ 73.\ 00\\ 74.\ 00\\ 75.\ 00\\ 77.\ 00\\ 75.\ 00\\ 77.\ 00\\ 77.\ 00\\ 77.\ 00\\ 77.\ 00\\ 77.\ 00\\ 75.\ 00\\ 77.\ 00\\ 77.\ 00\\ 75.\ 00\\ 77.\ 00\\ 77.\ 00\\ 77.\ 00\\ 77.\ 00\\ 75.\ 00\\ 77.\ 00\\ 77.\ 00\\ 77.\ 00\\ 77.\ 00\\ 77.\ 00\\ 75.\ 00\\ 77.\ 00\\ 77.\ 00\\ 75.\ 00\\ 77.\ 00\\ 77.\ 00\\ 75.\ 00\\ 77.\ 00\\ 77.\ 00\\ 75.\ $
88.00 89.00 90.00 91.00 92.00		0 0 0	C C C	0	0 0 0 0	0 0 0	89.00 90.00

Health Financial Systems COE	BALT REHAB HOSP	I TAL LOUI SVI LL	E	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/19/2022 8:4	pared:
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	LATED COSTS	9 Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 98. 00 09850 OTHER REI MBURSABLE CC		000000000000000000000000000000000000000		0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	95.00 96.00 97.00
99. 00 09900 CMHC 99. 10 09910 CORE	0	0			0	99.00
100.00 10000 I &R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0	0		0 0 0 0	0	100. 00 101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0		0 0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	607, 9	66 607, 966	2, 827	118.00
NONREI MBURSABLE COST CENTERS			1			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
193. 00 19300 NONPAI D WORKERS	0	0		0 0	0	193.00
200.00 Cross Foot Adjustments		_		0	_	200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0	0	607, 9			201.00 202.00
202.00 TOTAL (Sum TIMES TTO THE OUGH 201)	l O	0	J 007, 9	66 607, 966	2,827	1202.00

Health Financial Systems (ALLOCATION OF CAPITAL RELATED COSTS	COBALT REHAB HOSP	Provider C	CN: 15-3046 P	<u>In Lie</u> eriod: rom 01/01/2021	worksheet B Part II	2552-10
				o 12/31/2021	Date/Time Pre	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	5/19/2022 8: 4 DI ETARY	5 am
	& GENERAL 5.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL	121, 521					4.00
7.00 00700 OPERATION OF PLANT	7, 327	23, 596				7.00
8.00 00800 LAUNDRY & LINEN SERVICE	2, 083	411				8.00
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY	2, 736 7, 582	0 1, 945	-	2, 795 235		9.00
11. 00 01100 CAFETERIA	0	0		233	48, 488	
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	4, 281	0	0	-	0	
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	955 2, 686	0 526	-	0 63	0	
16.00 01600 MEDICAL RECORDS & LIBRARY	1, 105	169	1	20	-	
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	
18.00 01851 OTHER GENERAL CC	0	0	0	0	0	
19. 00 01900 NONPHYSICIAN ANESTHETISTS 20. 00 02000 NURSING PROGRAM	0		0	0	0	
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
23. 00 02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23.00
30. 00 03000 ADULTS & PEDI ATRI CS	59, 470	15, 503	10, 640	1, 869	48, 488	30.00
31.00 03100 I NTENSI VE CARE UNI T	0	0	0		0	1
32. 00 03200 CORONARY CARE UNIT	0	0	0	0	0	
33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	
40. 00 04000 SUBPROVIDER - IPF	0	0	0	0	0	
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	
	0	0	0	0	0	
44. 00 04400 SKILLED NURSING FACILITY 45. 00 04500 NURSING FACILITY	0			0	0	
46. 00 04600 OTHER LONG TERM CARE	0	0	0	0		
ANCI LLARY SERVI CE COST CENTERS	-	-	-	-	-	
50. 00 05000 0PERATING ROOM 51. 00 05100 RECOVERY ROOM	0	0				
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0			-	
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 172	347	0	42	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0			0	0	
57. 00 05700 CT SCAN	0	0	0	0	0	
58.00 05800 MRI	0	0	0	0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	46	0 82	, °	0 10	0	
60. 01 06001 BLOOD LABORATORY	40	02	0	0	0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 INTRAVENOUS THERAPY	0			0	0	
65. 00 06500 RESPIRATORY THERAPY	573	168	0	20	-	
66. 00 06600 PHYSI CAL THERAPY	13, 052	4, 445	0	536		
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	9, 115 3, 922	0	0	0	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	3, 922	0	0	0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	317	0	0	0	0	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	5,099	0	0	0	0	
74. 00 07400 RENAL DIALYSIS	0	0	0	0	0	
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90. 00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS						92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0	0	0	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	'I U	0	0	97.00

Health Financial Systems CO	BALT REHAB HOSP	I TAL LOUI SVI LL	E	In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period:	Worksheet B	
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	narod
				10 12/31/2021	5/19/2022 8:4	
Cost Center Description	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5.00	7.00	8.00	9.00	10.00	
98.00 09850 OTHER REI MBURSABLE CC	0	0	(0 0	0	98.00
99. 00 09900 CMHC	0	0	(0 0	0	99.00
99. 10 09910 CORF	0	0	(0 0	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	(0 0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	(0 0	0	101.00
SPECIAL PURPOSE COST CENTERS			l			
105.00 10500 KIDNEY ACQUISITION	0	0	(0 0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	(0 0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0	(0 0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0	(0 0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0	(0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	(0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	(0 0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	(0 0		115.00
116. 00 11600 HOSPI CE	0	0	(0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	121, 521	23, 596	10, 640	2, 795	48, 488	118.00
NONREI MBURSABLE COST CENTERS	-	-		-1 -1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0		190.00
191. 00 19100 RESEARCH	0	0	(0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0 0		192.00
193. 00 19300 NONPAI D WORKERS	0	0	(0 0		193.00
200.00 Cross Foot Adjustments	_	_				200.00
201.00 Negative Cost Centers	0	0	(201.00
202.00 TOTAL (sum lines 118 through 201)	121, 521	23, 596	10, 640	2, 795	48, 488	202.00

-	Financial Systems COM TION OF CAPITAL RELATED COSTS	BALT REHAB HOSF	PITAL LOUISVILL Provider C	CN: 15-3046 Pe	eriod: rom 01/01/2021	J of Form CMS-: Worksheet B Part II Date/Time Pre 5/19/2022 8:4	pared:
	Cost Center Description	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
	CENEDAL SEDVICE COST CENTERS	11.00	12.00	13.00	14.00	15.00	
15. 00 16. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY			0	980 0 0	13, 703 0	16.00
18.00 19.00 20.00 21.00 22.00	01700 SOCIAL SERVICE 01851 OTHER GENERAL CC 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS		-	-	0 0 0 0 0 0 0	0 0 0 0 0 0 0	18.00 19.00 20.00 21.00 22.00
32.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03200 SURGICAL INTENSIVE CARE UNIT 03400 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS				0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00
$\begin{array}{c} 58. \ 00\\ 59. \ 00\\ 60. \ 00\\ 60. \ 01\\ 61. \ 00\\ 62. \ 00\\ 63. \ 00\\ 64. \ 00\\ 65. \ 00\\ 65. \ 00\\ 67. \ 00\\ 68. \ 00\\ 70. \ 00\\ 71. \ 00\\ 71. \ 00\\ 72. \ 00\\ 73. \ 00\\ 74. \ 00\\ 75. \ 00\\ 77. \ 00\end{array}$	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05200 RADIOLOGY AND & LABOR ROOM 05300 RADIOLOGY - DIAGNOSTIC 05500 RADIOLOGY - THERAPEUTIC 05500 RADIOLOGY - THERAPEUTIC 05600 RADIOLOGY - THERAPEUTIC 05700 CT SCAN 05800 MRI 05900 CARDIAC CATHETERIZATION 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES - PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 06900 ELECTROCARDIOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 07700 ALLOGENEIC STEM CELL ACQUISITION 0UTPATIENT SERVICE COST CENTERS				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		51.00 52.00 53.00 54.00 55.00 56.00 57.00 58.00 59.00 60.01 61.00 62.00 63.00 64.00 65.00 65.00 66.00 67.00 68.00 67.00 67.00 71.00 72.00 73.00 74.00 75.00 77.00
89.00 90.00 91.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART			0 0 0	0 0 0 0	0 0 0 0	89.00 90.00
95.00	OTHER REI MBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALVSI S 09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED			0	0 0 0	0 0 0	95.00

Health Financial Systems COE	BALT REHAB HOSF	<u>PI TAL LOUI SVI LL</u>		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2021	Worksheet B Part II	
				To 12/31/2021	Date/Time Pre	pared:
					5/19/2022 8:4	<u>5</u> am
Cost Center Description	CAFETERI A	MAINTENANCE OF		CENTRAL	PHARMACY	
		PERSONNEL	ADMI NI STRATI OI	N SERVICES & SUPPLY		
	11.00	12.00	13.00	14.00	15.00	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0 0) ()		0	97.00
98.00 09850 OTHER REIMBURSABLE CC	0	0		0	0	98.00
99. 00 09900 CMHC	0	0		0	0	99.00
99. 10 09910 CORF	0	0 0		0 0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0 0		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0		0 0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0) (0 0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0) (0 0		107.00
108.00 10800 LUNG ACQUISITION	0	0) (0 0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115.00
116.00 11600 HOSPI CE	0	0 0) (0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0 0	4, 28	1 980	13, 703	118.00
NONREI MBURSABLE COST CENTERS			1			100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
191.00 19100 RESEARCH	0	0				191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES						192.00 193.00
193.00 19300 NONPAID WORKERS 200.00 Cross Foot Adjustments		0			0	200.00
201.00 Negative Cost Centers					0	200.00
202.00 TOTAL (sum lines 118 through 201)			4, 28	1 980		201.00
	1 0	1 0	ή 4,20	1 300	15,705	202.00

	cial Systems C DF CAPITAL RELATED COSTS	OBALT REHAB HOSI		CN: 15-3046	<u>In Lie</u> Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pr	
					10 12/31/2021	5/19/2022 8:	
				OTHER GENERAL SERVI CE			
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	OTHER GENERAL		NURSI NG	
		RECORDS &		CC	ANESTHETI STS	PROGRAM	
		LI BRARY 16.00	17.00	18.00	19.00	20.00	-
GENER	AL SERVICE COST CENTERS						
	CAP REL COSTS-BLDG & FIXT						1.0
	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2.0
	ADMINISTRATIVE & GENERAL						5.0
	OPERATION OF PLANT						7.0
00800	LAUNDRY & LINEN SERVICE						8.0
	HOUSEKEEPING						9. (
	DI ETARY CAFETERI A						10.0
	MAINTENANCE OF PERSONNEL						12. (
	NURSI NG ADMI NI STRATI ON						13.
. 00 01400	CENTRAL SERVICES & SUPPLY						14.
	PHARMACY						15.
	MEDICAL RECORDS & LIBRARY	4, 701					16.
	SOCIAL SERVICE OTHER GENERAL CC	0					17.
	NONPHYSICIAN ANESTHETISTS				0 0		19.
	NURSI NG PROGRAM						0 20.
. 00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0			D		21.
	I&R SERVICES-OTHER PRGM COSTS APPRV	(-		22.
	PARAMED ED PRGM	() (<u>ן</u>		23.
	ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	2, 692	2 (30.
	INTENSIVE CARE UNIT	2,072					31.
	CORONARY CARE UNI T	0					32.
. 00 03300	BURN INTENSIVE CARE UNIT	0			D		33.
	SURGICAL INTENSIVE CARE UNIT	0		0 (D		34.
	SUBPROVIDER - IPF	(40.
	SUBPROVIDER – IRF NURSERY						41.
	SKILLED NURSING FACILITY						44.
	NURSING FACILITY	0	0 0		D		45.
	OTHER LONG TERM CARE	() (2		46.
	LARY SERVICE COST CENTERS OPERATING ROOM						50.
	RECOVERY ROOM						51.
	DELIVERY ROOM & LABOR ROOM	0					52.
00 05300	ANESTHESI OLOGY	0			D		53.
	RADI OLOGY-DI AGNOSTI C	28			C		54.
	RADI OLOGY-THERAPEUTI C	(55.
1 1	RADI OI SOTOPE CT SCAN						56.
00 05800							58.
	CARDI AC CATHETERI ZATI ON						59.
00 06000	LABORATORY	75	5 (D		60.
1 1	BLOOD LABORATORY	0	0 0		C		60.
1 1	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.
	WHOLE BLOOD & PACKED RED BLOOD CELL BLOOD STORING, PROCESSING & TRANS.						62.
1	INTRAVENOUS THERAPY						64.
	RESPI RATORY THERAPY	4					65.
1	PHYSI CAL THERAPY	623	s (D		66.
	OCCUPATIONAL THERAPY	767			D		67.
	SPEECH PATHOLOGY	96					68.
	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY) , (69. 70.
	MEDICAL SUPPLIES CHARGED TO PATIENT	14					70.
	IMPL. DEV. CHARGED TO PATIENTS						72
	DRUGS CHARGED TO PATIENTS	402	2 (כ		73.
	RENAL DI ALYSI S	0			2 D		74.
	ASC (NON-DISTINCT PART)	0					75.
	ALLOGENEIC STEM CELL ACQUISITION	() () (L	77.
	RURAL HEALTH CLINIC						88.
	FEDERALLY QUALIFIED HEALTH CENTER						89.
. 00 09000		0			D		90.
. 00 09100	EMERGENCY	0			כ		91.
. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.
	REIMBURSABLE COST CENTERS						

Health Financial Systems COE	BALT REHAB HOSP	PITAL LOUISVILL	E	In Lie	eu of Form CMS	6-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2021 To 12/31/2021		
			OTHER GENERA	L		
			SERVI CE			
Cost Center Description		SOCI AL SERVI CE			NURSI NG	
	RECORDS &		CC	ANESTHET I STS	PROGRAM	
	LIBRARY	17.00	10.00	10.00	20.00	
95. 00 09500 AMBULANCE SERVI CES	16.00	17.00	18.00	0	20.00	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			0		95.00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0			0		97.00
98. 00 09850 OTHER REIMBURSABLE CC	0			0		97.00
99. 00 109800 01HER RETMBURSABLE CC	0			0		98.00
99. 10 09910 CORF	0			0		99.00
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0			0		100.00
101.00 10000 HAR SERVICES-NOT APPRVD PRGM				0		101.00
SPECIAL PURPOSE COST CENTERS	0		/	0	L	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	1	0		105.00
106. 00 10600 HEART ACQUISITION	0			0		105.00
107. 00 10700 LI VER ACQUI SI TI ON	0			0		107.00
108. 00 10800 LUNG ACQUISITION	0			0		107.00
109. 00 10900 PANCREAS ACQUISITION	0			0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0			0		110,00
111. 00 11100 I SLET ACQUI SI TI ON	0			0		111.00
113. 00 11300 I NTEREST EXPENSE	0			0		113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115.00
116. 00 11600 HOSPI CE				0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	4, 701			0 0		0 118.00
NONREI MBURSABLE COST CENTERS	4,701		/	0 0	l	0110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
191. 00 19100 RESEARCH	0			0		191.00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0			0		192.00
193. 00 19300 NONPAI D WORKERS	0			0		193.00
200.00 Cross Foot Adjustments		Ĭ			1	0 200. 00
201.00 Negative Cost Centers	0	0		0 0		0 201.00
202.00 TOTAL (sum lines 118 through 201)	4, 701			0 0		0 202.00
(.,,,,,,,		I		1	

Heal th	Fina	nci al	Syste	ems		
				DEL	ATED	0

COBALT REHAB HOSPITAL LOUISVILLE

		BALT REHAB HOSP	ITAL LOUISVILLE	<u>E</u>	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2021	Worksheet B Part II	
					To 12/31/2021	Date/Time Pre 5/19/2022 8:4	
		INTERNS &	RESI DENTS				
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES APPRV	SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		21.00	22.00	23.00	24.00	25.00	
1 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT					I	1 00
16.00 17.00 18.00 19.00 20.00 21.00 22.00	00100 CAP REL COSTS-BLDG & FTXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI 01100 CAFETERIA 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 01400 CENTRAL SERVICES SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCI AL SERVICE 01851 OTHER GENERAL CC 01900 NONPHYSI CI AN ANESTHETISTS 02000 NURSI NG PROKAM 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02200 PARAMED ED PRM 02300<	0	0		0		$\begin{array}{c} 1. 00\\ 2. 00\\ 4. 00\\ 5. 00\\ 7. 00\\ 8. 00\\ 9. 00\\ 10. 00\\ 11. 00\\ 12. 00\\ 13. 00\\ 14. 00\\ 15. 00\\ 16. 00\\ 17. 00\\ 18. 00\\ 19. 00\\ 20. 00\\ 21. 00\\ 22. 00\\ 23. 00\end{array}$
23.00	INPATIENT ROUTINE SERVICE COST CENTERS						23.00
30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00 46. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE				451, 493 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	30.00 31.00 32.00 33.00 34.00 40.00 41.00 43.00 44.00 45.00 46.00
F0 00	ANCI LLARY SERVICE COST CENTERS	1			0	0	
$\begin{array}{c} 54.\ 00\\ 55.\ 00\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 59.\ 00\\ 60.\ 01\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 67.\ 00\\ 68.\ 00\\ 71.\ 00\\ 71.\ 00\\ 71.\ 00\\ 73.\ 00\\ 71.\ 00\\ 73.\ 00\\ 75.\ 00\\ 77.\ 00\\ 88.\ 00\\ \end{array}$	05000 OPERATI NG ROOM 05100 RECOVERY ROOM & LABOR ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 07700 ALLOGENI CE COST CENTERS 08800 RURAL HEALTH CLI NI C				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 53.\ 00\\ 54.\ 00\\ 55.\ 00\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 60.\ 01\\ 61.\ 00\\ 60.\ 01\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 71.\ 00\\ 71.\ 00\\ 73.\ 00\\ 77.\ 00\\ \end{array}$
89.00 90.00 91.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART					0 0 0 0	89.00 90.00 91.00

Health Financial Systems COE	BALT REHAB HOSP	TAL LOUISVILLI	E	In Lie	eu of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-3046	Period:	Worksheet B	
				From 01/01/2021 To 12/31/2021		nared
				10 12/31/2021	5/19/2022 8:4	
	INTERNS &	RESI DENTS				
Cost Center Description	SERVI CES-SALAR			Subtotal	Intern &	
	Y & FRI NGES APPRV	PRGM COSTS APPRV	PRGM		Residents Cost & Post	
	AFFIN	AFEKV			Stepdown	
					Adjustments	
	21.00	22.00	23.00	24.00	25.00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S				0	0 0	94.00
95. 00 09500 AMBULANCE SERVI CES				0	0 0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED				0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD				0	0	97.00
98.00 09850 OTHER REI MBURSABLE CC				0	0	98.00
99.00 09900 CMHC				0	0	99.00
99. 10 09910 CORF 100. 00 10000 L&R SERVICES-NOT APPRVD PRGM				0	0	99.10 100.00
101. 00/10100 HOME HEALTH AGENCY				0		100.00
SPECIAL PURPOSE COST CENTERS				0	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON				0	0	105.00
106.00 10600 HEART ACQUI SI TI ON				0		106.00
107.00 10700 LIVER ACQUISITION				0	0	107.00
108.00 10800 LUNG ACQUISITION				0	0	108.00
109.00 10900 PANCREAS ACQUI SI TI ON				0		109.00
110.00 11000 INTESTINAL ACQUISITION				0		110. 00
111.00 11100 I SLET ACQUI SI TI ON				0	0	111.00
113.00 11300 I NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVIEW-SNF				0		114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE				0		115. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 607, 966		118.00
NONREI MBURSABLE COST CENTERS	0	0		0 007,700		110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				0	0	190.00
191. 00 19100 RESEARCH				0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES				0	0	192.00
193.00 19300 NONPALD WORKERS				0		193.00
200.00 Cross Foot Adjustments	0	0		0 0		200. 00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	0		0 607, 966	0	202.00

		CIAL SYSTEMS	CUBALI REHAB HUSPI		In Lieu of Form CMS-	2002
ALLUUF	ATTON (OF CAPITAL RELATED COSTS		Provider CCN: 15-3046	Period:Worksheet BFrom 01/01/2021Part IITo12/31/2021Date/Time Pre	
		Cost Center Description	Total	,	5/19/2022 8: 4	45 am
	CENED	AL SERVICE COST CENTERS	26.00			-
1.00		CAP REL COSTS-BLDG & FIXT				1.0
2.00		CAP REL COSTS-MVBLE EQUIP				2.0
4.00		EMPLOYEE BENEFITS DEPARTMENT				4.0
5.00		ADMINISTRATIVE & GENERAL				5.0
7.00		OPERATION OF PLANT				7.0
8.00	00800	LAUNDRY & LINEN SERVICE				8.0
9.00	00900	HOUSEKEEPING				9.0
10.00	01000	DI ETARY				10.0
11.00	01100	CAFETERIA				11.0
		MAINTENANCE OF PERSONNEL				12. (
		NURSING ADMINISTRATION				13.0
		CENTRAL SERVICES & SUPPLY				14.0
						15.0
		MEDICAL RECORDS & LIBRARY				16. (
		SOCIAL SERVICE				17.0
		OTHER GENERAL CC NONPHYSICIAN ANESTHETISTS				19.0
		NURSI NG PROGRAM				20. (
		I &R SERVICES-SALARY & FRINGES APPRV				20.0
		I &R SERVICES-OTHER PRGM COSTS APPRV				21.
		PARAMED ED PRGM				23.
0.00	-	I ENT ROUTI NE SERVI CE COST CENTERS				_ 20.
30.00		ADULTS & PEDIATRICS	451, 493			30.
		INTENSIVE CARE UNIT	0			31.
		CORONARY CARE UNIT	0			32.
3.00	03300	BURN INTENSIVE CARE UNIT	0			33.
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0			34.
0.00	04000	SUBPROVIDER - IPF	0			40.
		SUBPROVIDER - IRF	0			41.
		NURSERY	0			43.
		SKILLED NURSING FACILITY	0			44.
		NURSING FACILITY	0			45.0
16.00		OTHER LONG TERM CARE	0			46. (
		LARY SERVICE COST CENTERS				
		OPERATING ROOM	0			50.0
		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	0			51.0
		ANESTHESI OLOGY	0			53.0
		RADI OLOGY-DI AGNOSTI C	8, 478			54.
		RADI OLOGY-THERAPEUTI C	0,470			55.
56.00		RADI OI SOTOPE	0			56.
		CT SCAN	0			57.
58.00	05800		0			58.
		CARDI AC CATHETERI ZATI ON	0			59.
50.00	06000	LABORATORY	1, 849			60.
60. 01	06001	BLOOD LABORATORY	0			60.
51.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY				61.
2.00		WHOLE BLOOD & PACKED RED BLOOD CELL	0			62.
		BLOOD STORING, PROCESSING & TRANS.	0			63.
64.00		INTRAVENOUS THERAPY	0			64.
			4, 147			65.
6.00		PHYSICAL THERAPY	107, 195			66.
		OCCUPATIONAL THERAPY	10, 094			67.
			4,068			68.
			0			69.
		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT	1, 311			70.
		IMPL. DEV. CHARGED TO PATIENTS	1, 311			72.
2.00		DRUGS CHARGED TO PATTENTS	19, 331			73.
		RENAL DIALYSIS	0			74.
		ASC (NON-DISTINCT PART)	0			75.
		ALLOGENEIC STEM CELL ACQUISITION	0			77.
20		TIENT SERVICE COST CENTERS				1
8. 00		RURAL HEALTH CLINIC	0			88.
		FEDERALLY QUALIFIED HEALTH CENTER	0			89.
		CLINIC	0			90.
		EMERGENCY	0			91.
2.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.
		REIMBURSABLE COST CENTERS				
4.00		HOME PROGRAM DI ALYSI S	0			94.
95.00	09500	AMBULANCE SERVICES	0			95.
	09600	DURABLE MEDICAL EQUIP-RENTED	0			96.
97.00	09700	DURABLE MEDICAL EQUIP-SOLD OTHER REIMBURSABLE CC	0			97.

Health Financial Systems COE	BALT REHAB HOSPIT	FAL LOUI SVI LLE	In Lieu	」of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 15-3046	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/19/2022 8:45 am
Cost Center Description	Total 26.00			
99.00 09900 CMHC	0			99.00
99. 10 09910 CORF	0			99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0			100.00
101.00 10100 HOME HEALTH AGENCY	0			101.00
SPECIAL PURPOSE COST CENTERS				
105.00 10500 KIDNEY ACQUISITION	0			105.00
106.00 10600 HEART ACQUI SI TI ON	0			106.00
107.00 10700 LIVER ACQUISITION	0			107.00
108.00 10800 LUNG ACQUISITION	0			108.00
109.00 10900 PANCREAS ACQUISITION	0			109.00
110.00 11000 INTESTINAL ACQUISITION	0			110.00
111.00 11100 I SLET ACQUI SI TI ON	0			111.00
113.00 11300 INTEREST EXPENSE				113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF				114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0			115.00
116. 00 11600 HOSPI CE	0			116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	607, 966			118.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
191. 00 19100 RESEARCH	0			191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			192.00
193. 00 19300 NONPALD WORKERS	0			193.00
200.00 Cross Foot Adjustments	0			200. 00
201.00 Negative Cost Centers	0			201.00
202.00 TOTAL (sum lines 118 through 201)	607, 966			202.00

In Lieu	u of Form CMS-2552-10
Period: From 01/01/2021	Worksheet B-1 Date/Time Prepared:
To 12/31/2021	Date/Time Prepared:

Cost Center Description Cost Auron RATE Uncluster FFED Uncluster FED Uncluster FFED <t< th=""><th></th><th></th><th></th><th></th><th>T</th><th>0 12/31/2021</th><th>Date/Time Pre 5/19/2022 8:4</th><th></th></t<>					T	0 12/31/2021	Date/Time Pre 5/19/2022 8:4	
CSUARLE FEEL3 CSUARLE			CAPI TAL REI	ATED COSTS			0. 4	
CSUARLE FEEL3 CSUARLE		Cost Conton Description				Decenciliation		
Low Del PARK INENT CACCUR. COST) 1.00 2.00 5///0005 5.0 5.00 1.00 0.00 6///0005 5.0 5.00 1.00 1.00 0.00 6///0005 5.0 5.00 1.00 0.00 0.000 6///0005 5.00 1.00 5.00 1.00 0.00 0.000 6///0005 5.00 5.00 5.00 1.00 0.00 0.000 0.000 0.000 1.000 5.00 5.00 1.00 0.00 0.0000		Cost Center Description				Reconciliation		
Image: service cost cost cost cost cost cost cost cost			(SEGARE LET)					
Different Service Corr partners 1.00 2.00 4.00 5.4 5.00 2.00 00000 CAP FEL CORTS-UNRE FOURT 54.629 5.669,530 1.00 2.00 0.00000 CAP FEL CORTS-UNRE FOURT 10,863 1.294,472 -5.799,113 6.207,1000 7.00 0.00000 CARTER AND INFORMATIVE & CENTRAL 10,863 1.294,472 -5.799,113 6.207,1000 7.00 0.00000 MODER AND INFORMATIVE & CENTRAL 10,843 1.481 0.00 0.111,1274 0.01 0.111,1274 0.01 0.111,1274 0.01 0.111,1274 0.01 0.111,1274 0.01 0.111,1274 0.01 0.01 0.01 0.01 0.01 0.010,010,011,011,010 0 0 0.01 0.01 0.01 0.01,011,011,011,010,					(GROSS		. ,	
DEREMI. SERVICE COST CENTERS 100 1 00 D0000 CAP REL COST APRELE EDUINATION 54, 629 54, 629 54, 629 54, 629 54, 629 200			1.00	2.00		EA	F 00	
100 00100 CAP FRE. COSTS-BLOG & FIXT 54.627 5.677 1.00 000 00200 DENUTYE BLEXT IS DEPARIMENT 1.98 1.285, 530 -5.209, 182 6.387, 737, 734 0.00 000 00200 DENUTYE BLEXT IS DEPARIMENT 1.985 1.285, 530 -5.209, 182 6.387, 747, 090 7.00 000000 DENUTYE BLEXT IS DEPARIMENT 1.985 1.895 0 0.07, 758 8.00 000000 DENUTYE BLEXT IS DEPARIMENT 1.985 1.897 0 100, 758 8.00 000000 DENUTYE 3.467 3.447 284, 825 0 0 0 100, 758 8.00 112, 00 0 0 0 0 0 0 112, 00 112, 00 113, 728 0 112, 00 113, 728 0 113, 728 0 114, 90 114, 90 114, 90 114, 90 116, 00 116, 00 116, 00 116, 00 116, 00 116, 00 116, 00 116, 00 116, 00 116, 00 116, 00 116, 00 </td <td></td> <td>GENERAL SERVICE COST CENTERS</td> <td>1.00</td> <td>2.00</td> <td>4.00</td> <td>AC</td> <td>5.00</td> <td></td>		GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	AC	5.00	
4.00 00:000 EURLOYCE ENERFITS DEPARTMENT 254 25, 65, 530 -5, 209, 883 -6, 40, 201 -5, 209, 883 -5, 209, 883 -5, 209, 883 -5, 209, 883 -5, 209, 883 -5, 209, 883 -5, 209, 883 -5, 209, 883 -1, 149, 863	1.00		54, 629					1.00
5.00 00000 ARMINISTRATIVE & GENERAL 10.865 10.264, 407 -5.20, 183 6, 283, 131 5, 00 8.00 000000 LAMARY A TIVE & STRVICT 7.23 7.23 18 0, 00 107, 75 18, 00 8.00 000000 LAMARY A TIVE & STRVICT 7.24 7.24 18 0, 1000 10000 1000 1000 <td></td> <td></td> <td></td> <td>54, 629</td> <td></td> <td></td> <td></td> <td></td>				54, 629				
7.00 00700 DEFEAT IN G.F.P.INT 1.458 8.5.108 0 3776.080 7.000 7.000 00701 7.000 00701 7.000 00701 7.000 00701 7.000 00701 7.000 00701 7.000 00701 7.000 00701 7.000 00701 7.000 00701 7.000 00701 7.000 00701 7.000 00701 7.000 00701 7.000 00701 7.000 00701 7.000 00701 7.000 00701 7.000 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>(007 404</td> <td></td>							(007 404	
8.00 00300 LUNDRY & LINEN SERVICE 732 732 0 0 107.755 8.00 9.00 00300 LUNDRY & LINEN SERVICE 0 0 111.1574 0 0 111.1574 0 0 111.0574 0 0 0 0 111.0574 0								
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	.2.00		1	I	1	1	I	, , 2, 00

COST MELOON	TION – STATISTICAL BASIS						
				CN: 15-3046	Period: From 01/01/2021	Worksheet B-1	
					To 12/31/2021	Date/Time Pre	
		CAPITAL REL	ATED COSTS			5/19/2022 8:4	15 am
		CAPITAL REL	ATED CUSIS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	:
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
			. ,	DEPARTMENT		(ACCUM. COST)	
				(GROSS		. ,	
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	REIMBURSABLE COST CENTERS		0				
	HOME PROGRAM DI ALYSI S	0	0		0 0	0	
		0	0		0 0	0	
	DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	
	OTHER REIMBURSABLE CC	0	0		0 0	0	
98.00 09850 99.00 09900		0	0		0 0	0	
99.00 09900 99.10 09910		0	0		0 0	0	
	I&R SERVICES-NOT APPRVD PRGM	0	0			-	100.0
	HOME HEALTH AGENCY	0	0		0 0		101.0
	AL PURPOSE COST CENTERS	<u> </u>	0		0 0	0	101.0
	KI DNEY ACQUISITION	0	0		0 0	0	105. 0
	HEART ACQUI SI TI ON	0	0		0 0		106.0
	LIVER ACQUISITION	0	0		0 0	0	107.0
108.00 10800	LUNG ACQUISITION	0	0		0 0	0	108. 0
109.00 10900	PANCREAS ACQUISITION	0	0		0 0	0	109.0
110.00 11000	INTESTINAL ACQUISITION	0	0		0 0	0	110. 0
111.00 11100	I SLET ACQUI SI TI ON	0	0		0 0	0	111.0
	INTEREST EXPENSE						113.0
	UTILIZATION REVIEW-SNF						114.0
	AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115. 0
116.0011600		0	0		0 0		116. 0
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	54, 629	54, 629	5, 659, 53	-5, 209, 183	6, 287, 131	118.0
	I MBURSABLE COST CENTERS		0			0	100.0
190. 00 19000 191. 00 19100	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 0 191. 0
	PHYSICIANS' PRIVATE OFFICES	0	0		0 0		191.0
	NONPAID WORKERS	0	0		0 0		192.0
200.00	Cross Foot Adjustments	0	0		0 0	0	200. 0
200.00	Negative Cost Centers						200.0
201.00	Cost to be allocated (per Wkst. B,	0	607, 966	253, 88	26	5, 209, 183	
102.00	Part I)	0	007,700	200,00		5, 207, 105	202.0
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	11. 128997	0. 04486	0	0. 828547	203. 0
204.00	Cost to be allocated (per Wkst. B,			2, 82		121, 521	
	Part II)					-	
205.00	Unit cost multiplier (Wkst. B, Part			0.00050	00	0. 019329	205. 0
	11)						
206.00	NAHE adjustment amount to be allocated						206. 0
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.0

	Financial Systems CO LLOCATION - STATISTICAL BASIS	BALT REHAB HOSP	Provider C	CN: 15-3046 F	Period:	u of Form CMS-: Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	5/19/2022 8: 4 CAFETERI A (GROSS SALARI ES)	
		7.00	8.00	9.00	10.00	11.00	
1 00	GENERAL SERVICE COST CENTERS	1			1		1 1 00
15.00 16.00 17.00 18.00 19.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-WVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAI NTENANCE OF PERSONNEL 01300 NURSING ADMINI STRATI ON 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVICE 01851 OTHER GENERAL CC 01900 NUNFISI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM 02100 I & SERVICES-SALARY & FRINGES APPRV 02200 I & SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM	42, 054 732 0 3, 467 0 0 0 0 937 301 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	100 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	41, 322	7 100 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 917, 041 0 50, 963 0 113, 783 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS		0			0	23.00
30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00 46. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	27, 630 0 0 0 0 0 0 0 0 0 0 0 0 0 0	100 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			2, 115, 432 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 30.\ 00\\ 31.\ 00\\ 32.\ 00\\ 33.\ 00\\ 34.\ 00\\ 40.\ 00\\ 41.\ 00\\ 43.\ 00\\ 44.\ 00\\ 45.\ 00\\ 46.\ 00\\ \end{array}$
57.00 58.00 59.00 60.01 61.00 62.00 63.00 64.00 65.00 65.00 66.00 67.00 68.00 70.00 71.00 72.00 73.00 75.00 77.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06000 LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 REDI CAL SUPPLIES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0UTPATI ENT SERVI CE COST CENTERS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	57. 00 58. 00 59. 00 60. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 0	0 0 0			0 0 0	88.00 89.00 90.00 91.00 92.00
94. 00 95. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0000	0			0	94. 00 95. 00

Health Financial Systems COM	BALT REHAB HOSP	I TAL LOUI SVI LL	E	In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				rom 01/01/2021		
				To 12/31/2021	Date/Time Pre 5/19/2022 8:4	epared:
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
Cost center bescription	PLANT	LINEN SERVICE		(MEALS SERVED)		
	(SQUARE FEET)	(POUNDS OF		(MERES SERVED)	SALARI ES)	
		LAUNDRY)				
	7.00	8.00	9.00	10.00	11.00	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	(96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	
98.00 09850 OTHER REIMBURSABLE CC	0	0		0 0	0	
99. 00 09900 CMHC	0	0		0 0	0	
99. 10 09910 CORF	0	0	(0	0	99, 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>		<u> </u>	<u> </u>	101100
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	(0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109. 00 10900 PANCREAS ACQUISITION	0	0		0 0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0		0		111.00
113.00 11300 I NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	(0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	42,054	100	41, 32	-		
NONREI MBURSABLE COST CENTERS	,			-		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		192.00
193. 00 19300 NONPALD WORKERS	0	0		0		193.00
200.00 Cross Foot Adjustments	0			, s	0	200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	693, 184	209, 101	258, 87	5 796, 166	0	202.00
Part I)	0,0,101	207,101	200, 07	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	16. 483188	2,091.010000	6. 264823	7, 961. 660000	0. 000000	203.00
204.00 Cost to be allocated (per Wkst. B,	23, 596					204.00
Part II)			_,		-	
205.00 Unit cost multiplier (Wkst. B, Part	0. 561088	106. 400000	0.067640	484.880000	0. 000000	205.00
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

	Financial Systems CO NLLOCATION - STATISTICAL BASIS		PITAL LOUISVILLE Provider CC	N: 15-3046	Period: From 01/01/2021	u of Form CMS-: Worksheet B-1	
					To 12/31/2021	Date/Time Pre 5/19/2022 8:4	
	Cost Center Description	MAINTENANCE OI PERSONNEL (NUMBER HOUSED)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUI S.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
		12.00	13.00	14.00	15.00	16.00	
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		1				1 1.
00 00 00 00 00 00 00 00 00 00 00 00 00	00200 CAP REL COSTS-MVBLE EQUI P 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01851 OTHER GENERAL CC 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM 02100 I & SERVI CES-SALARY & FRI NGES APPRV 02200 I & SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM				0 0 100 0	26, 100, 321 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 4. 5. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22.
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT) 100) 0		0 0 0 0	14, 947, 119 0	
	03200 CORONARY CARE UNI T				0 0	0	
	03300 BURN INTENSIVE CARE UNIT	(0 0		0 0	0	33
. 00). 00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF				0 0	0	34
. 00	04100 SUBPROVIDER - IRF				0 0	0	
3.00	04300 NURSERY	(0		0 0	0	
1.00	04400 SKILLED NURSING FACILITY	(0 0		0 0	0	44.
	04500 NURSING FACILITY	(-		0 0	0	
o. 00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	(0 0		0 0	0	46
. 00	05000 OPERATI NG ROOM	(o l		0 0	0	50
	05100 RECOVERY ROOM	(0 0		0 0	0	
. 00	05200 DELIVERY ROOM & LABOR ROOM	(0 0		0 0	0	52
00	05300 ANESTHESI OLOGY	(0		0 0	0	
			0		0 0	153, 989	
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE					0	1
	05700 CT SCAN					0	
	05800 MRI	(o o		0 0	0	
. 00	05900 CARDI AC CATHETERI ZATI ON	(0 0		0 0	0	59
		(0 0		0 0	413, 967	
	06001 BLOOD LABORATORY	(0		0 0	0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL				0 0	0	61 62
	06300 BLOOD STORING, PROCESSING & TRANS.				0 0	0	
		(0 0		0 0	0	
		(0 0		0 0	23, 722	
		(0 0		0 0	3, 460, 473	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY				0 0	4, 260, 783 530, 785	
						0 0 0 0 0	
	07000 ELECTROENCEPHALOGRAPHY				o o	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			10	0 0	76, 487	
. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	(0 0		0 0	0	72
	07300 DRUGS CHARGED TO PATIENTS	(0		0 100	2, 232, 996	
	07400 RENAL DI ALYSI S	(0		0 0	0	1
	07500 ASC (NON-DISTINCT PART)				0 0	0	
. 00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS		ן ע		0	0	77
.00	08800 RURAL HEALTH CLINIC	(ol ol		0 0	0	88
	08900 FEDERALLY QUALIFIED HEALTH CENTER		ol ol		0 0	0	
	09000 CLINIC				0 0	0	
. 00			1		al	-	1 01
. 00	09100 EMERGENCY	(0 0		0 0	0	
. 00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REI MBURSABLE COST CENTERS	(0		0 0	0	91 92

Health Financial Systems CO) BALT REHAB HOSF	PITAL LOUISVIII	F	Inlie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
				rom 01/01/2021		
			-	To 12/31/2021	Date/Time Pre	
				DUADNA OV	5/19/2022 8:4	5 am
Cost Center Description	MAINTENANCE OF		CENTRAL	PHARMACY	MEDICAL	
	PERSONNEL (NUMBER	ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED	RECORDS & LI BRARY	
	HOUSED)	(DIRECT NRSING	(COSTED	REQUIS.)	(GROSS CHAR	
	HOUSED)	HRS)	REQUIS.)		GES)	
	12.00	13.00	14.00	15.00	16.00	
95.00 09500 AMBULANCE SERVICES	12.00) 0		95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		-			-	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD			(0	
98. 00 09850 OTHER REIMBURSABLE CC			(0	
99. 00 09900 CMHC						
99. 10 09910 CORF					0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM						
101.00 10100 HOME HEALTH AGENCY			(-	101.00
SPECIAL PURPOSE COST CENTERS	(<u> </u>	l	0	0	101.00
105.00 10500 KIDNEY ACQUISITION		0	(0	0	105.00
106. 00 10600 HEART ACQUISTTION			(, ,		106.00
107. 00 10700 LIVER ACQUISITION			(, ,		107.00
			(, v		107.00
108.00 10800 LUNG ACQUISITION			(
109.00 10900 PANCREAS ACQUISITION			(109.00
110.00 11000 INTESTINAL ACQUISITION		0	(0		110.00
111.00 11100 I SLET ACQUI SI TI ON		0	(0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)		0	(, v		115.00
116.00 11600 HOSPI CE		0	(-		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	C	100	100	0 100	26, 100, 321	118.00
NONREI MBURSABLE COST CENTERS	1	1				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0 0		190.00
191.00 19100 RESEARCH	0	0	(, v		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	C	0	(0		192.00
193. 00 19300 NONPAI D WORKERS	C	0	(0 0	0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	C	404, 941	90, 303	3 275, 426	111, 418	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000000		903.03000			
204.00 Cost to be allocated (per Wkst. B,	C	4, 281	980	13, 703	4, 701	204.00
Part II)				407 00000		
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	42. 810000	9.80000	137.030000	0.000180	205.00
						201 00
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						207 00
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)	I.	1		I	I	I

Heal th Financial	Systems	
COST ALLOCATION	- STATI STI CAL	BASI S

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

COST	ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021		pared:
			OTHER GENERAL			5/19/2022 8:4 INTERNS &	5 am
			SERVI CE			RESI DENTS	
	Cost Center Description	SOCI AL SERVI CE	OTHER GENERAL CC	NONPHYSI CI AN ANESTHETI STS		SERVICES-SALAR Y & FRINGES	
		(TIME SPENT)	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	
				TIME)	TIME)	(ASSI GNED	
		17.00	19.00	10.00	20.00	TI ME)	
	GENERAL SERVICE COST CENTERS	17.00	18.00	19.00	20.00	21.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
5.00 7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 16.00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY						15.00 16.00
17.00	01700 SOCIAL SERVICE	0					17.00
18.00	01851 OTHER GENERAL CC	0	0				18.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0		19.00
20.00 21.00	02000 NURSI NG PROGRAM 02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0		0	0	20. 00 21. 00
21.00	02200 I &R SERVICES-SALARI & TRINGES AFRY 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0			0	22.00
23.00	02300 PARAMED ED PRGM	0	0				23.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	0			0	30. 00 31. 00
32.00	03200 CORONARY CARE UNIT	0	0		0 0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		0 0	0	34.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	0			0	40.00 41.00
43.00	04300 NURSERY	0	0		0 0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	44.00
45.00	04500 NURSING FACILITY	0	0		0 0	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	1	0 0	0	46.00
50.00	05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0				0	53.00 54.00
55.00		0	0		0 0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00 58.00	05700 CT SCAN 05800 MRI	0	0		0 0	0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0				0	58.00 59.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0	60.01
61.00 62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	0	61.00 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0)	0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	66.00
67.00 68.00	06800 SPEECH PATHOLOGY	0				0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS					0	72.00 73.00
74.00	07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
75.00		0	0		0 0	0	75.00
77.00		0	0	1	0 0	0	77.00
88.00	OUTPATIENT SERVICE COST CENTERS O8800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90.00		0	0	1	0 0	0	90.00
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	1	0	0	91.00 92.00
72.00	107200 0DSERVATION DEDS (NON-DISTINCT PART		I	1	1	I	72.00

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

Heal th Financial	Systems COE	BALT REHAB HOSF	PITAL LOUISVILL	E	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION	- STATISTICAL BASIS		Provider CO		Peri od:	Worksheet B-1	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/19/2022 8:4	
			OTHER GENERAL			INTERNS &	
			SERVI CE			RESI DENTS	
Cost	t Center Description	SOCIAL SERVICE	OTHER GENERAL	NONPHYSI CI AN	NURSI NG	SERVI CES-SALAR	
	•		СС	ANESTHETI STS	PROGRAM	Y & FRINGES	
		(TIME SPENT)	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	
		. ,		TIME)	TIME)	(ASSI GNED	
					,	TIME)	
		17.00	18.00	19.00	20.00	21.00	
	MBURSABLE COST CENTERS		_				
94.00 09400 HOME	E PROGRAM DIALYSIS	0	0	(0 0	0	94.00
95.00 09500 AMBL	ULANCE SERVICES	0	0	0	0 0	0	95.00
96.00 09600 DURA	ABLE MEDICAL EQUIP-RENTED	0	0	(0 0	0	96.00
97.00 09700 DURA	ABLE MEDICAL EQUIP-SOLD	0	0	(0 0	0	97.00
98.00 09850 OTHE	ER REIMBURSABLE CC	0	0	(0 0	0	98.00
99.00 09900 CMHC	C	0	0	0	0 0	0	99.00
99.10 09910 CORF	F	0	0	(0 0	0	99.10
100.00 10000 I &R	SERVICES-NOT APPRVD PRGM	0	0	(0 0	0	100.00
101.00 10100 HOME		0	0		0		101.00
	URPOSE COST CENTERS			·			
105.00 10500 KI DM		0	0	(0 0	0	105.00
106.00 10600 HEAF		0	0		0	0	106.00
107.00 10700 LI VE		0	0	(0	0	107.00
108.00 10800 LUNC		0	0	(0		108.00
	CREAS ACQUISITION	0	0		0		109.00
	ESTINAL ACQUISITION	0	0		0		110.00
111.0011100 I SLE		0	0		0		111.00
113.0011300 I NTE		-	-		-	-	113.00
	LIZATION REVIEW-SNF						114.00
	ULATORY SURGICAL CENTER (D. P.)	0	0		0	0	115.00
116.00 11600 HOSE		0	0		0	Ŭ	116.00
	TOTALS (SUM OF LINES 1 through 117)	0	-	0	-	0	118.00
	RSABLE COST CENTERS		<u> </u>		, <u> </u>	Ŭ	1110.00
	T, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0	0	190.00
191.0019100 RESE		0			-		191.00
	SI CI ANS' PRI VATE OFFI CES	0	0		0		192.00
193.00 19300 NONE		0	0		0		193.00
	ss Foot Adjustments				, c	Ŭ	200.00
	ative Cost Centers						201.00
5	t to be allocated (per Wkst. B,	0	0	(0	202.00
Part		0	0		0	0	202.00
	t cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0. 000000	0. 000000	0.000000	203 00
	t to be allocated (per Wkst. B,	0.000000		0.000000			203.00
	t II)						207.00
	t cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	205 00
		0.000000	0.000000	0.000000	0.000000	0.000000	200.00
	E adjustment amount to be allocated				0		206.00
	r Wkst. B-2)				0		
	E unit cost multiplier (Wkst. D,				0.000000		207.00
	ts III and IV)						
1 1.011		I.	1	1	1	1	1

	Financial Systems CC LLOCATION - STATISTICAL BASIS	BALT REHAB HOSP		E CN: 15-3046	Period: From 01/01/2021	u of Form CMS-2 Worksheet B-1	
					To 12/31/2021	Date/Time Pre	
	Cost Center Description	I NTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSI GNED TI ME)			5/19/2022 8: 4	5 am
		22.00	23.00				
	GENERAL SERVICE COST CENTERS						
$\begin{array}{c} 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-WUBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I & SERVICES-SALARY & FRINGES APPRV						1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 21.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
	02300 PARAMED ED PRGM		C				23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	C	•			30.00 31.00
	03200 CORONARY CARE UNIT	0	C				32.00
	03300 BURN INTENSIVE CARE UNIT	0	C				33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	C	•			34.00
	04000 SUBPROVI DER – I PF	0	C	•			40.00
	04100 SUBPROVIDER - IRF	0	C	•			41.00
	04300 NURSERY	0	C	•			43.00
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	C	•			44.00
46.00	04600 OTHER LONG TERM CARE	0	C	•			46.00
	ANCI LLARY SERVICE COST CENTERS		-				1
	05000 OPERATI NG ROOM	0	C	•			50.00
	05100 RECOVERY ROOM	0	C	•			51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	C				52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	C				53.00 54.00
	05500 RADI OLOGY-THERAPEUTI C	0	C				55.00
56.00	05600 RADI OI SOTOPE	0	C	1			56.00
	05700 CT SCAN	0	C				57.00
	05800 MRI	0	C	•			58.00
	05900 CARDI AC CATHETERI ZATI ON	0	C	•			59.00
	06000 LABORATORY 06001 BLOOD LABORATORY	0		•			60.00 60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C				61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C				62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	C				63.00
	06400 I NTRAVENOUS THERAPY	0	C				64.00
	06500 RESPIRATORY THERAPY	0	C				65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	C	•			66.00 67.00
	06800 SPEECH PATHOLOGY	0	C	1			68.00
	06900 ELECTROCARDI OLOGY	0	C	•			69.00
	07000 ELECTROENCEPHALOGRAPHY	0	C	•			70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	C	1			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	•			72.00
72 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	C				73.00
	UTTOURLINGE DIALISIS	0	C	1			75.00
74.00	07500 ASC (NON-DISTINCT PART)			1			
74.00 75.00	07500 ASC (NON-DISTINCT PART) 07700 ALLOGENEIC STEM CELL ACQUISITION	0	C	1			77.00
74.00 75.00 77.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0		1			1
74.00 75.00 77.00 88.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	C				88.00
74.00 75.00 77.00 88.00 89.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C				88. 00 89. 00
74.00 75.00 77.00 88.00 89.00 90.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	C				88.00

	CUDALI KENAD HUSP			Warkeheet D 1
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15	-3046 Period: From 01/01/2021	Worksheet B-1
			To 12/31/2021	Date/Time Prepared:
				5/19/2022 8:45 am
	INTERNS &			
	RESI DENTS			
Cost Center Description	SERVI CES-OTHER	PARAMED ED		
	PRGM COSTS	PRGM		
	APPRV	(ASSI GNED		
	(ASSI GNED	TIME)		
	TIME)			
	22.00	23.00		
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
95. 00 09500 AMBULANCE SERVICES	0	о		95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	о		96.00
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	o		97.00
98.00 09850 OTHER REIMBURSABLE CC	0	o		98.0
99. 00 09900 CMHC	0	ō		99.00
99. 10 09910 CORF	0	0		99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	o		100. 0
101. 00 10100 HOME HEALTH AGENCY	0	0		101. 0
SPECIAL PURPOSE COST CENTERS	0	0		101.0
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		105. 0
106. 00 10600 HEART ACQUI SI TI ON	0	0		106. 0
107. 00 10700 LIVER ACQUISITION	0	0		107. 0
	0	-		
108.00 10800 LUNG ACQUI SI TI ON	0	0		108.0
109.00 10900 PANCREAS ACQUISITION	0	0		109.0
110.00 11000 INTESTINAL ACQUISITION	0	0		110.0
111.00 11100 I SLET ACQUI SI TI ON	0	0		111.0
113.00 11300 INTEREST EXPENSE				113. 0
114.00 11400 UTILIZATION REVIEW-SNF				114. 0
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
116. 00 11600 HOSPI CE		0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through	n 117) 0	0		118.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTE	EN O	0		190. 00
191. 00 19100 RESEARCH	0	0		191.00
192.00 19200 PHYSICLANS' PRIVATE OFFICES	0	0		192.0
193.00 19300 NONPALD WORKERS	0	О		193. 0
200.00 Cross Foot Adjustments				200. 0
201.00 Negative Cost Centers				201. 0
202.00 Cost to be allocated (per Wkst. E	3. 0	0		202. 0
Part I)	.,	5		2021 01
203.00 Unit cost multiplier (Wkst. B, Pa	ort I) 0.000000	0. 000000		203.00
204.00 Cost to be allocated (per Wkst. E		0		204.00
Part II)	.,	Ŭ		204.00
205.00 Unit cost multiplier (Wkst. B, Pa	ort 0.000000	0. 000000		205.00
		0.00000		203.00
206.00 NAHE adjustment amount to be allo	cated	0		206.00
(per Wkst. B-2)				200.00
207.00 NAHE unit cost multiplier (Wkst.		0. 000000		207.00
Parts III and IV)	<i>U</i> ,	0.000000		207.00
Faits III dilu IV)	I I	I		I

Heal th	Fi nar	ci al	Syst	ems			
COMPLIE			DATIO	OF	COSTS	TO	

Health Financial Systems CO COMPUTATION OF RATIO OF COSTS TO CHARGES CO	BALT REHAB HOSP	Provider C		In Lie Period:	u of Form CMS- Worksheet C	2552-10
			F	rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre	pared:
		Title	e XVIII	Hospi tal	5/19/2022 8:4 PPS	<u>5 am</u>
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	<u>26)</u> 1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	7, 728, 662		7, 728, 662		7, 728, 662	
31.00 03100 I NTENSI VE CARE UNI T	0		C	-	0	
32. 00 03200 CORONARY CARE UNI T	0		0	0	0	
33. 00 03300 BURN I NTENSI VE CARE UNI T	0			0	0	
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF	0			0	0	
41. 00 04100 SUBPROVIDER - IRF	0			0	0	
43. 00 04300 NURSERY	0			0	0	
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0			0	0	
45.00 04500 NURSING FACILITY	0		c d	0	0	45.00
46.00 04600 OTHER LONG TERM CARE	0		C	0	0	46.00
ANCI LLARY SERVI CE COST CENTERS	1					
50. 00 05000 OPERATI NG ROOM	0		C	-	0	
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0			-	0	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI 0LOGY	0			-	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	125, 592		125, 592	-	125, 592	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0	0	0	•
56. 00 05600 RADI OI SOTOPE	0		c	0	0	56.00
57.00 05700 CT SCAN	0		C	0	0	57.00
58. 00 05800 MRI	0		C	-	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0	-	0	59.00
	9, 470		9, 470	0	9, 470	
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0	0	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	
64. 00 06400 I NTRAVENOUS THERAPY	0		c d	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	61, 133	0	61, 133	0	61, 133	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 429, 726	0	1, 429, 726		1, 429, 726	
67.00 06700 OCCUPATI ONAL THERAPY	880, 488	0	880, 488		880, 488	•
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	373, 275	0	373, 275 C		373, 275 0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	120, 591		120, 591	0	120, 591	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		c	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	767, 377		767, 377	0	767, 377	•
74.00 07400 RENAL DI ALYSI S	0		0	0	0	
75. 00 07500 ASC (NON-DISTINCT PART) 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0			0	0	
OUTPATIENT SERVICE COST CENTERS	0			<u>и</u> 0	0	//.00
88.00 08800 RURAL HEALTH CLINIC	0		C	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		C	0	0	89.00
90. 00 09000 CLINIC	0		C	0	0	
91.00 09100 EMERGENCY	0		0	-	0	•
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REIMBURSABLE COST CENTERS	0		C)	0	92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0		c	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0				0	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0		C	0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		c	0	0	
98.00 09850 OTHER REIMBURSABLE CC	0		C	0	0	
99. 00 09900 CMHC	0		0		0	•
99. 10 09910 CORF 100. 00 10000 I & SERVI CES-NOT APPRVD PRGM	0				0	99.10 100.00
101.00 10100 HOME HEALTH AGENCY	0					101.00
SPECIAL PURPOSE COST CENTERS			<u> </u>		0	
105.00 10500 KI DNEY ACQUI SI TI ON	0		C)	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0		c		0	106. 00
107.00 10700 LIVER ACQUISITION	0		C			107.00
108.00 10800 LUNG ACQUI SI TI ON	0		[C			108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0					109.00
110.00 11000 INTESTINAL ACQUISITION 111.00 11100 ISLET ACQUISITION	0					110. 00 111. 00
113. 00 11300 INTEREST EXPENSE					0	113.00
114. 0011400 UTI LI ZATI ON REVIEW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0		c)	0	115.00
116. 00 11600 HOSPI CE	0		C			116. 00
200.00 Subtotal (see instructions)	11, 496, 314	0	11, 496, 314	0	11, 496, 314	200.00

Heal th Fina	ncial Systems	COBALT REHAB HOSF	NTAL LOUISVILL	E	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider C	Provider CCN: 15-3046		Worksheet C		
					From 01/01/2021 To 12/31/2021	Part Date/Time Pre	pared.	
					10 12/01/2021	5/19/2022 8:4	5 am	
			Title	XVIII	Hospi tal	PPS		
					Costs			
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs		
		(from Wkst. B,	Adj.		Di sal I owance			
		Part I, col.						
		26)						
		1.00	2.00	3.00	4.00	5.00		
201.00	Less Observation Beds	0			0	0	201.00	
202.00	Total (see instructions)	11, 496, 314	0	11, 496, 31	14 0	11, 496, 314	202.00	

	Financial Systems COE ATION OF RATIO OF COSTS TO CHARGES	BALT REHAB HOSP	Provider C	LE CCN: 15-3046 e XVIII	In Lie Period: From 01/01/2021 To 12/31/2021 Hospital	w of Form CMS- Worksheet C Part I Date/Time Pre 5/19/2022 8:4 PPS	epared:
			Charges		nospital	1 115	
	Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	14, 947, 119		14 047 1	10		30.00
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	14, 947, 119		14, 947, 1	0		30.00
32.00	03200 CORONARY CARE UNIT	0			0		32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0			0		33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0			0		34.00
40.00	04000 SUBPROVIDER - IPF	0			0		40.00
41.00	04100 SUBPROVIDER - IRF 04300 NURSERY	0			0		41.00
43.00 44.00	04400 SKI LLED NURSI NG FACI LI TY	0			0		43.00
45.00	04500 NURSING FACILITY	0			0		45.00
46.00	04600 OTHER LONG TERM CARE	0			0		46.00
	ANCI LLARY SERVI CE COST CENTERS	1 1		I	1	1	
50.00	05000 OPERATING ROOM	0		0	0 0.00000		
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0			0 0.000000 0 0.000000		
53.00	05300 ANESTHESI OLOGY	0	(0	0 0.000000		
54.00	05400 RADI OLOGY-DI AGNOSTI C	153, 989	(0 153, 9		0.00000	
55.00	05500 RADI OLOGY-THERAPEUTI C	0		D	0 0. 000000		
56.00	05600 RADI OI SOTOPE	0	(0	0 0.00000		
57.00 58.00	05700 CT SCAN 05800 MRI	0	(0 0.000000 0 0.000000		
59.00	05900 CARDI AC CATHETERI ZATI ON	0	(0 0.000000		
60.00	06000 LABORATORY	413, 967	(0 413, 9			
60. 01	06001 BLOOD LABORATORY	0	(0	0 0. 000000	0. 000000	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	(0	0 0. 000000		
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	(0	0 0.000000		
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	(0 0.000000 0 0.000000		
65.00	06500 RESPI RATORY THERAPY	23, 722	(0 23, 7			
66.00	06600 PHYSI CAL THERAPY	3, 460, 473	(3, 460, 4			
67.00	06700 OCCUPATIONAL THERAPY	4, 260, 783	(0 4, 260, 7		0.00000	67.00
68.00	06800 SPEECH PATHOLOGY	530, 785	(0 530, 7		0.00000	
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	(0 0.000000 0 0.000000		
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	76, 487		0 76.4		0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	(0	0 0. 000000		
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 232, 996	(0 2, 232, 9	96 0. 343654		
74.00	07400 RENAL DI ALYSI S	0		0	0 0. 000000		
	07500 ASC (NON-DISTINCT PART) 07700 ALLOGENEIC STEM CELL ACQUISITION	0		0	0 0.000000		
77.00	OUTPATIENT SERVICE COST CENTERS	0		U	0 0.000000	0.000000	//.00
88.00	08800 RURAL HEALTH CLINIC	0	(0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(D	0		89.00
90.00	09000 CLINIC	0		0	0 0.00000		
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0	0 0.000000 0 0.000000		
72.00	OTHER REIMBURSABLE COST CENTERS	0	(<u> </u>	0.00000	0.00000	12.00
94.00	09400 HOME PROGRAM DI ALYSI S	0		0	0 0.000000		
95.00	09500 AMBULANCE SERVICES	0	(0	0 0.00000	0.00000	
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	(0	0 0.00000		
97.00 98.00	09700 DURABLE MEDI CAL EQUI P-SOLD 09850 OTHER REI MBURSABLE CC	0	(0 0. 000000 0 0. 000000		
98.00 99.00	09900 CMHC	0	(0 0.000000	0.00000	99.00
	09910 CORF	0	(0	0		99.10
	10000 I&R SERVICES-NOT APPRVD PRGM	0		D	0		100.00
101.00	10100 HOME HEALTH AGENCY	0	(0	0		101.00
105 00	SPECIAL PURPOSE COST CENTERS	0		0	0	[105.00
	10600 HEART ACQUISTION	0		0	0		106.00
	10700 LI VER ACQUI SI TI ON	0	(0	0		107.00
108.00	10800 LUNG ACQUISITION	0	(o	0		108.00
	10900 PANCREAS ACQUISITION	0	(0	0		109.00
	11000 INTESTINAL ACQUISITION	0	(0	0		110.00
	11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE	0	(U		111.00 113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	(o	0		115.00
	11600 HOSPI CE	0	(0	0		116.00
200.00		26, 100, 321	(0 26, 100, 3	21		200.00
201.00	Less Observation Beds			1			201.00

Health Financial Systems	COBALT REHAB HOSP	TAL LOUISVILL	E	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	Provider CCN: 15-3046		Worksheet C Part I	
				From 01/01/2021 To 12/31/2021	Date/Time Pro 5/19/2022 8:2	
		Title	e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
202.00 Total (see instructions)	26, 100, 321	0	26, 100, 32	1		202.00

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3046	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pr 5/19/2022 8:	repared: 45 am
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00	03000 ADULTS & PEDI ATRI CS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
32.00	03200 CORONARY CARE UNIT					32.00
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT					33.00 34.00
40.00	04000 SUBPROVIDER - IPF					40.00
40.00	04100 SUBPROVI DER – I RF					40.00
43.00	04300 NURSERY					43.00
44.00	04400 SKILLED NURSING FACILITY					44.00
45.00	04500 NURSING FACILITY					45.00
46.00	04600 OTHER LONG TERM CARE					46.00
	ANCI LLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000				50.00
51.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				51.00
52.00 53.00	05300 ANESTHESI OLOGY	0. 000000 0. 000000				52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 815591				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
56.00	05600 RADI OI SOTOPE	0. 000000				56.00
57.00	05700 CT SCAN	0.000000				57.00
58.00	05800 MRI	0. 000000				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
60.00	06000 LABORATORY	0. 022876				60.00
60. 01	06001 BLOOD LABORATORY	0. 000000				60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000				62.00
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0.000000				63.00 64.00
65.00	06500 RESPIRATORY THERAPY	2. 577059				65.00
66.00	06600 PHYSI CAL THERAPY	0. 413159				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 206649				67.00
68.00	06800 SPEECH PATHOLOGY	0. 703251				68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 576621				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 343654				73.00
74.00 75.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0.000000				74.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000				77.00
//.00	OUTPATIENT SERVICE COST CENTERS	0.000000				
88.00	08800 RURAL HEALTH CLINIC					88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER					89.00
90.00	09000 CLI NI C	0. 000000				90.00
91.00	09100 EMERGENCY	0. 000000				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
04 00	OTHER REIMBURSABLE COST CENTERS	0,000000				
94.00 95.00	09400 HOME PROGRAM DI ALYSI S	0. 000000 0. 000000				94.00
	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000				95.00 96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				97.00
	09850 OTHER REI MBURSABLE CC	0. 000000				98.00
	09900 CMHC					99.00
99. 10	09910 CORF					99.10
100.00	10000 I &R SERVICES-NOT APPRVD PRGM					100.00
101.00	10100 HOME HEALTH AGENCY					101.00
	SPECIAL PURPOSE COST CENTERS					
	10500 KI DNEY ACQUI SI TI ON					105.00
	10600 HEART ACQUI SI TI ON					106.00
	10700 LIVER ACQUISITION 10800 LUNG ACQUISITION					107.00 108.00
	10900 PANCREAS ACQUISITION					108.00
	11000 I NTESTI NAL ACQUI SI TI ON					110.00
	11100 I SLET ACQUI SI TI ON					111.00
	11300 I NTEREST EXPENSE					113.00
	11400 UTI LI ZATI ON REVI EW-SNF					114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)					115. OC
116.00	11600 HOSPI CE					116.00
200.00						200.00
	Less Observation Beds					201.00
201.00 202.00						202.00

Heal th	Fi nar	ci al	Syst	ems			
COMPLIE			DATIO	0F	COSTS	TO	

COMPUTATION OF RATIO OF COSTS TO CHARGES	DALI KENAD HUSPI	Provi der C	CN: 15-3046 P	eriod: rom 01/01/2021	Worksheet C Part I Date/Time Pre 5/19/2022 8:4	pared:
		Titl	e XIX	Hospi tal	PPS	1
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
INDATIENT DOUTINE SEDVICE COST CENTEDS	1.00	2.00	3.00	4.00	5.00	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T 33. 00 03300 BURN INTENSI VE CARE UNI T 34. 00 03400 SURGI CAL INTENSI VE CARE UNI T 34. 00 04000 SUBPROVI DER - IPF 41. 00 04100 SUBPROVI DER - IRF 43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY 45. 00 04500 NURSI NG FACI LI TY 46. 00 04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS ANCI LLARY SERVI CE COST CENTERS	7, 728, 662 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		7, 728, 662 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	7, 728, 662 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00 31.00 32.00 33.00 34.00 40.00 41.00 43.00 44.00 45.00 46.00
50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY-THERAPEUTI C 56.00 05600 RADI OLOGY-THERAPEUTI C 56.00 05600 RADI OLOGY-THERAPEUTI C 57.00 05700 CT SCAN 58.00 05800 MRI 59.00 05900 CARDI AC CATHETERI ZATI ON 60.01 06000 LABORATORY 61.00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 64.00 06400 INTRAVENOUS THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 06600 PHYSI CAL THERAPY 68.00 06800 SPECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 69.00 06900 ELECTROCARDI OLOGY </td <td>$\begin{smallmatrix} 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 125, 592 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\$</td> <td>0 0 0 0</td> <td>0 0 0 125, 592 0 0 0 0 9, 470 0 9, 470 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td> <td></td> <td>0 0 0 125, 592 0 0 0 0 9, 470 0 9, 470 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td> <td>66.00 67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00 75.00</td>	$ \begin{smallmatrix} 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 125, 592 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ $	0 0 0 0	0 0 0 125, 592 0 0 0 0 9, 470 0 9, 470 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 125, 592 0 0 0 0 9, 470 0 9, 470 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	66.00 67.00 68.00 69.00 70.00 71.00 72.00 73.00 74.00 75.00
OUTPATI ENT SERVICE COST CENTERS 88.00 OB800 RURAL HEALTH CLINIC 89.00 O8900 90.00 OB900 91.00 O9000 00100 EMERGENCY 92.00 OB2ERVATION BEDS (NON-DISTINCT PART OTHER REI MBURSABLE COST CENTERS	0 0 0 0		0 0 0 0 0	0 0 0	0 0 0 0 0	88.00 89.00 90.00 91.00 92.00
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 98. 00 09800 OTHER REI MBURSABLE CC 99. 00 09900 CMHC 99. 10 09910 CORF 100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM 101. 00 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS				0 0 0	0 0 0 0 0 0 0 0	94.00 95.00 96.00 97.00 98.00 99.00 99.10 100.00 101.00
105.00 10500 KI DNEY ACQUI SI TI ON 106.00 10600 HEART ACQUI SI TI ON 107.00 10700 LI VER ACQUI SI TI ON 108.00 10800 LUNG ACQUI SI TI ON 109.00 10900 PANCREAS ACQUI SI TI ON 100.00 INTESTI NAL ACQUI SI TI ON 110.00 INTESTI NAL ACQUI SI TI ON 111.00 ISLET ACQUI SI TI ON 113.00 INTEREST EXPENSE 114.00 UTI LI ZATI ON REVI EW-SNF 115.00 AMBULATORY SURGI CAL CENTER (D. P.) 116.00 ISPICE 200.00 Subtotal (see instructions)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	0 0 0 0 0 0 11, 496, 314		0 0 0 0 0 0	105.00 106.00 107.00 108.00 109.00 110.00 111.00 111.00 113.00 114.00 115.00 116.00 200.00

Health Fina	ancial Systems	COBALT REHAB HOSP	TAL LOUISVILL	E	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider C	CN: 15-3046	Period:	Worksheet C	
					From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/19/2022 8:4	pared: 5 am
			Titl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4.00	5.00	
201.00	Less Observation Beds	0			0	0	201.00
202.00	Total (see instructions)	11, 496, 314	0	11, 496, 3	14 0	11, 496, 314	202.00

	Financial Systems COM	BALT REHAB HOSP		<u> E</u> CCN: 15-3046	In Lie Period:	u of Form CMS- Worksheet C	2552-10
					From 01/01/2021 To 12/31/2021		
				le XIX	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient	
		6.00	7.00	8.00	9.00	Ratio 10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			-			
30.00	03000 ADULTS & PEDIATRICS	14, 947, 119		14, 947, 1			30.00
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0			0		31.00 32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0			0		33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0			0		34.00
40.00	04000 SUBPROVIDER - IPF	0			0		40.00
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	0			0		41.00
44.00	04400 SKILLED NURSING FACILITY	0			0		44.00
45.00	04500 NURSING FACILITY	0			0		45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0			0		46.00
50.00	05000 OPERATING ROOM	0	(0 0.000000	0. 000000	50.00
51.00	05100 RECOVERY ROOM	0	(0 0. 000000		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	(0 0.000000	0.00000	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 153, 989	() D 153, 98	0 0.000000 39 0.815591	0. 000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	153, 989	(0	0 0.000000	0. 000000	
56.00	05600 RADI OI SOTOPE	0	(D	0 0.000000		
57.00	05700 CT SCAN	0	(0 0.000000	0.00000	
58.00 59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	(0 0.000000 0 0.000000	0. 000000 0. 000000	
60.00	06000 LABORATORY	413, 967	(5 2 413, 9		0. 000000	
60. 01	06001 BLOOD LABORATORY	0	(c	0 0.000000	0. 000000	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	(0 0.000000	0.00000	
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	(0 0.000000 0 0.000000	0. 000000	
64.00	06400 I NTRAVENOUS THERAPY	0	(0 0.000000	0. 000000	
65.00	06500 RESPI RATORY THERAPY	23, 722	(23, 7		0. 000000	65.00
66.00	06600 PHYSI CAL THERAPY	3, 460, 473	(0, 100, 1		0.00000	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	4, 260, 783 530, 785	(0 4, 260, 78 0 530, 78		0. 000000	
69.00	06900 ELECTROCARDI OLOGY	0	(0	0 0.000000		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	(c	0 0.000000	0. 000000	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	76, 487	(76,48		0.00000	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	2, 232, 996	(2, 232, 9	0 0.000000 96 0.343654	0. 000000	
74.00	07400 RENAL DIALYSIS	0	(0	0 0.000000	0. 000000	
	07500 ASC (NON-DISTINCT PART)	0	(c	0 0. 000000		
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	(2	0 0.00000	0. 000000	77.00
88.00	OUTPATIENT SERVICE COST CENTERS	0	(0 0.000000	0. 000000	88.00
89.00	08900 FEDERALLY QUALI FIED HEALTH CENTER	0	(c	0 0.000000		
90.00	09000 CLINIC	0	(0 0.000000		
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	(0 0.000000 0 0.000000		
, <u>2</u> . 00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		<u>~1</u>	0.00000	0.00000	,2.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	(-	0 0.00000		
95.00 96.00	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0	(0 0.000000 0 0.000000	0. 000000 0. 000000	
96.00 97.00	09700 DURABLE MEDICAL EQUIP-RENTED	0	(- D	0 0.000000		
	09850 OTHER REIMBURSABLE CC	0	(D	0 0.000000		
	09900 CMHC	0	(c	0		99.00
		0	(0		99.10
	10000 I&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0	(0		100.00 101.00
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		- I	- II	L	
	10500 KI DNEY ACQUI SI TI ON	0	(2 <u> </u>	0		105.00
	10600 HEART ACQUISITION 10700 LIVER ACQUISITION	0	(0		106.00 107.00
	10800 LUNG ACQUISITION	0	(0		107.00
	10900 PANCREAS ACQUI SI TI ON	0	(c	0		109.00
	11000 INTESTINAL ACQUISITION	0	(2 2	0		110.00
	11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE	0	(J	U		111.00 113.00
	11400 UTILIZATION REVIEW-SNF						114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	(c	0		115.00
	11600 HOSPI CE	0	(0		116.00
200.00 201.00		26, 100, 321	(26, 100, 3	21		200.00 201.00
201.00				1		1	1201.00

Health Financial Systems	COBALT REHAB HOSP	TAL LOUISVILL	E	In Lie	u of Form CMS	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2021	Worksheet C Part I	
					Date/Time Pro 5/19/2022 8:2	
		Ti tl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
202.00 Total (see instructions)	26, 100, 321	0	26, 100, 32	1		202.00

		OBALT REHAB HOSPI		In Lie	u of Form CMS-	2552-1
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3046	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/19/2022 8:4	
			Title XIX	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Rati o 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
32.00	03200 CORONARY CARE UNI T					32.0
33.00	03300 BURN INTENSIVE CARE UNIT					33.0
4.00	03400 SURGI CAL I NTENSI VE CARE UNI T					34.0
0.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF					40.0
13.00	04300 NURSERY					41.0
14.00	04400 SKI LLED NURSI NG FACI LI TY					44.0
5.00	04500 NURSING FACILITY					45. C
46.00	04600 OTHER LONG TERM CARE					46.0
	ANCILLARY SERVICE COST CENTERS	- 1				
50.00	05000 OPERATING ROOM	0. 000000				50.0
1.00	05100 RECOVERY ROOM	0. 000000				51.0
2.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.0
3.00 4.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0. 000000 0. 815591				53. C
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.0
56.00	05600 RADI OLOGI - MERALEUTI C	0. 000000				56.0
57.00	05700 CT SCAN	0. 000000				57. C
58.00	05800 MRI	0. 000000				58. C
9.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.0
60.00	06000 LABORATORY	0. 022876				60. C
50.01	06001 BLOOD LABORATORY	0. 000000				60. C
51.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61.0
52.00 53.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000 0. 000000				62. C
54.00	06400 I NTRAVENOUS THERAPY	0. 000000				64.0
5.00	06500 RESPI RATORY THERAPY	2. 577059				65. C
6.00	06600 PHYSI CAL THERAPY	0. 413159				66. C
67.00	06700 OCCUPATI ONAL THERAPY	0. 206649				67.0
58.00	06800 SPEECH PATHOLOGY	0. 703251				68. C
69.00	06900 ELECTROCARDI OLOGY	0. 000000				69.0
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.0
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	1. 576621 0. 000000				71.0
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 343654				73.0
4.00	07400 RENAL DIALYSIS	0. 000000				74.0
75.00	07500 ASC (NON-DI STINCT PART)	0. 000000				75.0
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000				77.0
	OUTPATIENT SERVICE COST CENTERS					
38.00	08800 RURAL HEALTH CLINIC	0. 000000				88.0
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89.0
90.00 91.00	09000 CLINIC 09100 EMERGENCY	0. 000000 0. 000000				90. C
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.0
2.00	OTHER REIMBURSABLE COST CENTERS	0.000000				/2.0
94.00	09400 HOME PROGRAM DI ALYSI S	0. 000000				94.0
95.00	09500 AMBULANCE SERVI CES	0. 000000				95.0
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96.0
7.00	09700 DURABLE MEDI CAL EQUI P-SOLD	0. 000000				97.0
8.00	09850 OTHER REIMBURSABLE CC	0. 000000				98.0
	09900 CMHC 09910 CORF					99. C
	10000 I &R SERVICES-NOT APPRVD PRGM					100.0
	10100 HOME HEALTH AGENCY					101.0
	SPECIAL PURPOSE COST CENTERS					
05.00	10500 KIDNEY ACQUISITION					105. 0
	10600 HEART ACQUI SI TI ON					106. 0
	10700 LIVER ACQUISITION					107. (
	10800 LUNG ACQUISITION					108. (
	10900 PANCREAS ACQUISITION					109.0
	11000 INTESTINAL ACQUISITION					110.0
	11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE					111. (
	111300 INTEREST EXPENSE					114. (
	11500 AMBULATORY SURGICAL CENTER (D. P.)					115.0
15.00	11600 HOSPI CE					116.0
116.00 200.00	Subtotal (see instructions)					
	Subtotal (see instructions) Less Observation Beds					200. C 201. C 202. C

ALCULATION OF OUTPATIENT SERVICE COST TO CHARGE EDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF	Provi der C		Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 5/19/2022 8:4	pared: 5 am
Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Net of Capita	al Reduction	PPS Operating Cost Reduction Amount	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	-	1	1	- 1	1	
 0.00 05000 0PERATING ROOM 0.00 05100 RECOVERY ROOM 0.00 05200 DELIVERY ROOM & LABOR ROOM 0.00 05300 ANESTHESI OLOGY 0.00 05400 RADI OLOGY-DI AGNOSTIC 	0 0 0 0 125, 592	0 0 0				51.0 52.0
5. 00 05500 RADI OLOGY - THERAPEUTI C 5. 00 05500 RADI OLOGY - THERAPEUTI C 5. 00 05500 RADI OI SOTOPE 7. 00 05700 CT SCAN	0	0, 470 0 0 0)))	0 0 0 0 0 0		55.0 56.0
3. 00 05800 MRI 9. 00 05900 CARDI AC CATHETERI ZATI ON 9. 00 06000 LABORATORY CATHETERI ZATI ON	0 0 9, 470	0 0 1, 849		0 0 0 0 21 0	000000000000000000000000000000000000000	59. 0 60. 0
0.01 06001 BLOOD LABORATORY .00 06100 PBP CLI NI CAL LAB SERVICES-PRGM ONLY 2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 3.00 06300 BLOOD STORING, PROCESSING & TRANS. . 0.01 06400 INTRAVENOUS THERAPY . .						63.0
.00 06500 RESPI RATORY THERAPY .00 06600 PHYSI CAL THERAPY .00 06600 OCCUPATI ONAL THERAPY .00 06700 OCCUPATI ONAL THERAPY .00 06800 SPEECH PATHOLOGY	61, 133 1, 429, 726 880, 488 373, 275	107, 195 10, 094	1, 322, 53 870, 39	31 0 94 0	0	65.0 66.0 67.0
0.00 06900 ELECTROCARDI OLOGY 0.00 07000 ELECTROENCEPHALOGRAPHY .00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0 0 120, 591	1, 311		0 0 0 0	0	69.0 70.0 71.0
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 3. 00 07300 DRUGS CHARGED TO PATIENTS 4. 00 07400 RENAL DI ALYSI S S S O 07500 ASC (NON-DI STINCT PART)	0 767, 377 0 0	0		0 0 46 0 0 0 0 0	0 0 0	73. C 74. C
7. 00 07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	77.0
3. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	
D. OO O8900 FEDERALLY QUALIFIED HEALTH CENTER D. OO 09000 CLINIC	000000000000000000000000000000000000000	000000000000000000000000000000000000000		0 0 0 0 0 0	0	90. (91. (
2. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER RELIMBURSABLE COST CENTERS	0	-		0 0	-	
H. 00 09400 HOME PROGRAM DI ALYSI S 5. 00 09500 AMBULANCE SERVI CES 5. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 7. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	000000000000000000000000000000000000000	000000000000000000000000000000000000000			0 0 0	95. (96. (
00 09900 CMHC 0.00 09900 CMHC 0.00 09900 CMHC 0.10 09901 CORF	0			0 0 0 0 0 0 0 0	0	
00. 00 10000 I &R SERVI CES-NOT APPRVD PRGM 11. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	000	0	1	0 0 0 0	0	100. (101. (
)5. 00 10500 KI DNEY ACQUI SI TI ON)6. 00 10600 HEART ACQUI SI TI ON)7. 00 10700 LI VER ACQUI SI TI ON)8. 00 10800 LUNG ACQUI SI TI ON 9. 00 10900 PANCREAS ACQUI SI TI ON					0 0 0	105. (106. (107. (108. (109. (
92. 00 10900 PANCREAS ACCUTSTITUN 10. 00 11000 INTESTINAL ACQUISITION 11. 00 11100 ISLET ACQUISITION 33. 00 11300 INTEREST EXPENSE 4. 00 11400 UTILIZATION REVIEW-SNF	0				0	109. 110. 111. 113. 114.
15.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 16.00 11600 HOSPICE 10.00 Subtotal (sum of lines 50 thru 199)	0 0 3, 767, 652	0 0 156, 473	3, 611, 17	0 0 0 0 79 0	0	115. 116. 200.
D1.00Less Observation BedsD2.00Total (line 200 minus line 201)	0 3, 767, 652	0 156, 473	3, 611, 17	0 0 79 0		201. 202.

	ATION OF OUTPATIENT SERVICE COST TO CHARGE 10NS FOR MEDICAID ONLY	RATIOS NET OF	Provider C	CN: 15-3046	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part II Date/Time Pre 5/19/2022 8:4	epared: <u>45 am</u>
				e XIX	Hospi tal	PPS	
	Cost Center Description		Total Charges (Worksheet C,				
		Capital and Operating Cost					
		Reduction	8)	/ col . 7)	0		
		6.00	7.00	8.00			
	ANCI LLARY SERVICE COST CENTERS	0,00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0.00			
	05000 OPERATING ROOM	0	0	0.0000	00		50.0
	05100 RECOVERY ROOM	0	0	0.0000			51.0
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000			52.0
3.00	05300 ANESTHESI OLOGY	0	0	0.0000	00		53. C
4.00	05400 RADI OLOGY-DI AGNOSTI C	125, 592	153, 989	0. 8155	91		54.0
5.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0.0000	00		55.0
6.00	05600 RADI OI SOTOPE	0	0	0.0000	00		56.0
	05700 CT SCAN	0	0	0.0000	00		57.0
	05800 MRI	0	0	0.0000			58.0
	05900 CARDI AC CATHETERI ZATI ON	0	0	0.0000			59. C
	06000 LABORATORY	9, 470	413, 967	0. 0228			60.0
	06001 BLOOD LABORATORY	0	0	0.0000			60.0
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.0000			61.0
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0.0000			62.0
	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	0		0.0000			63. 0 64. 0
	06500 RESPIRATORY THERAPY	61, 133	23, 722	2.5770			65.0
	06600 PHYSI CAL THERAPY	1, 429, 726	3, 460, 473	0. 4131			66.0
	06700 OCCUPATI ONAL THERAPY	880, 488	4, 260, 783	0. 2066			67.0
	06800 SPEECH PATHOLOGY	373, 275	530, 785	0. 7032			68.0
	06900 ELECTROCARDI OLOGY	0	0000,700	0.0000			69.0
	07000 ELECTROENCEPHALOGRAPHY	0	o o	0.0000			70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	120, 591	76, 487	1. 5766			71.0
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.0000	00		72.0
3.00	07300 DRUGS CHARGED TO PATIENTS	767, 377	2, 232, 996	0.3436	54		73.0
	07400 RENAL DI ALYSI S	0	0	0.0000			74. C
	07500 ASC (NON-DI STINCT PART)	0	0	0.0000			75. C
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.0000	00		77. C
		0	0	0.0000	00		
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0.0000			88.0
	09000 CLINIC	0	0	0.0000			90.0
	09100 EMERGENCY	0	0	0.0000			91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.0000			92.0
	OTHER REIMBURSABLE COST CENTERS		•	•			
4.00	09400 HOME PROGRAM DI ALYSI S	0	0	0.0000	00		94. 0
5.00	09500 AMBULANCE SERVICES	0	0	0.0000	00		95.0
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.0000			96.0
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.0000			97.0
	09850 OTHER REIMBURSABLE CC	0	0	0.0000			98.0
	09900 CMHC	0	0	0.0000			99. (
	09910 CORF 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0.0000			99. ⁻ 100. (
	10000 Far Services-NOT APPROD PROM	0		0. 0000 0. 0000			100.0
	SPECIAL PURPOSE COST CENTERS	0	0	0.0000	00		
	10500 KI DNEY ACQUI SI TI ON	0	0	0.0000	00		105. 0
	10600 HEART ACQUI SI TI ON	0	o o	0.0000			106.0
	10700 LIVER ACQUISITION	0	0	0.0000			107.0
00.80	10800 LUNG ACQUISITION	0	0	0.0000	00		108. (
	10900 PANCREAS ACQUI SI TI ON	0	0	0.0000	00		109. (
	11000 INTESTINAL ACQUISITION	0	0	0.0000			110.
	11100 I SLET ACQUI SI TI ON	0	0	0.0000	00		111.
	11300 INTEREST EXPENSE						113.
	11400 UTI LI ZATI ON REVI EW-SNF						114.
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0.0000			115.0
	11600 HOSPICE	0	0	0.0000	00		116. (
00.00	Subtotal (sum of lines 50 thru 199)	3, 767, 652	11, 153, 202	1			200.0
01.00	Less Observation Beds	0					201.0

Health Financial Systems C	OBALT REHAB HOSP	ITAL LOUISVILL	.E	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C	CN: 15-3046	Peri od:	Worksheet D	
				From 01/01/2021 To 12/31/2021		pared:
					5/19/2022 8:4	
				Hospi tal	PPS	
Cost Center Description	Capital Related Cost	Swing Bed Adjustment	Reduced Capital	Total Patient Days	3 / col. 4)	
	(from Wkst. B,	Aujustillent	Related Cos		3 / COI. 4)	
	Part II, col.		(col. 1 - co			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	-		1			
30. 00 ADULTS & PEDIATRICS	451, 493	C	451, 4	93 9, 443	47.81	
31. 00 INTENSIVE CARE UNIT	0			0 0	0.00	
32. 00 CORONARY CARE UNIT	0			0 0	0.00	•
33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	•
40. 00 SUBPROVIDER - IPF	0	C		0 0	0.00	
41. 00 SUBPROVIDER - IRF	0				0.00	
43. 00 NURSERY	0	G		0 0	0.00	
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	
45.00 NURSING FACILITY	0			0 0	0.00	45.00
200.00 Total (lines 30 through 199)	451, 493		451, 4	93 9, 443		200.00
Cost Center Description	Inpati ent	Inpati ent				
	Program days	Program				
		Capital Cost (col. 5 x col.				
		(COL 5 X COL 6)				
	6.00	7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7100	1			
30. 00 ADULTS & PEDIATRICS	7, 344	351, 117	7			30.00
31.00 INTENSIVE CARE UNIT	0	C				31.00
32.00 CORONARY CARE UNI T	0	C	p			32.00
33.00 BURN INTENSIVE CARE UNIT	0	C				33.00
34. 00 SURGI CAL I NTENSI VE CARE UNI T	0	C	0			34.00
40. 00 SUBPROVI DER – I PF 41. 00 SUBPROVI DER – I RF	0	C				40.00
41.00 SUBPROVIDER - TRF 43.00 NURSERY	0					41.00
44. 00 SKILLED NURSING FACILITY	0					43.00
45. 00 NURSING FACILITY	0	c c				45.00
200.00 Total (lines 30 through 199)	7,344	351, 117	7			200.00
	,		1			

				From 01/01/2021	Part II	
				To 12/31/2021	Date/Time Pre 5/19/2022 8:4	pared:
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)	U U	· · ·	
	26)	, ,	, i			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	I	I	1	I	1	
D. 00 05000 OPERATING ROOM	0					
1.00 05100 RECOVERY ROOM	0	-			-	
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			0	52.00
3. 00 05300 ANESTHESI OLOGY	0	0	0.0000		0	53.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 478	153, 989			6, 549	54.00
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.0000	0 0	0	55.00
6. 00 05600 RADI 0I SOTOPE	0	0	0.0000	0 0	0	56.00
7.00 05700 CT SCAN	0	0	0.0000	0 0	0	57.00
8. 00 05800 MRI	0	c c	0.0000	0 0	0	58.00
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	c c	0.0000		0	59.00
D. 00 06000 LABORATORY	1, 849	413, 967				1
D. 01 06001 BLOOD LABORATORY	0				0	
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					, i i i i i i i i i i i i i i i i i i i	61.00
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0. 00000	0	0	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	-	1		0	
4. 00 06400 I NTRAVENOUS THERAPY	0	-	1		0	
5. 00 06500 RESPI RATORY THERAPY	4, 147	-				
6. 00 06600 PHYSI CAL THERAPY	107, 195					
7. 00 06700 OCCUPATI ONAL THERAPY	10, 094		1			
B. 00 06800 SPEECH PATHOLOGY	4, 068				2, 796	
9. 00 06900 ELECTROCARDI OLOGY	4,000	0				1
0. 00 07000 ELECTROENCEPHALOGRAPHY	0	-	1		0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 311	76, 487				
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 311	70,407	0.0000		I, 184	1
3. 00 07200 TWFL. DEV. CHARGED TO FATLENTS	19, 331	2, 232, 996				
4. 00 07400 RENAL DIALYSIS	19, 331		1			
5. 00 07500 ASC (NON-DI STI NCT PART)	0					
7. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0					
OUTPATIENT SERVICE COST CENTERS	0	0	0.0000		0	//.00
B. 00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0 0	0	88.00
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-			-	
0. 00 09000 CLINIC	0					1
1. 00 09100 EMERGENCY	0	-				
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					
OTHER REIMBURSABLE COST CENTERS	0		1 0.0000		0	72.00
4. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.0000	0 00	0	94.00
5. 00 09500 AMBULANCE SERVICES			0.00000			95.00
6. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	c	0. 00000		0	
	-	-			-	
7. 00 09700 DURABLE MEDICAL EQUIP-SOLD B. 00 09850 OTHER REIMBURSABLE CC	0	-			0	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	S Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/19/2022 8:4	pared:
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursing		Allied Health	All Other	
	Program	Program	Post-Stepdowr		Medi cal	
	Post-Stepdown	r r ogr am	Adjustments		Education Cost	
	Adjustments		Aujustilientis			
	1A	1.00	2A	2.00	3.00	
INDATIENT DOUTINE SEDVICE COST CENTEDS	IA	1.00	ZA	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		-	1		0	1 20 00
30. 00 03000 ADULTS & PEDI ATRI CS	0	C		0 0	0	
31.00 03100 INTENSIVE CARE UNIT	0	C		0 0	0	
2.00 03200 CORONARY CARE UNI T	0	C		0 0	0	32.00
3.00 03300 BURN INTENSIVE CARE UNIT	0	C		0 0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	C		0 0	0	34.00
40. 00 04000 SUBPROVIDER - IPF	0	C		o o	0	40.00
1. 00 04100 SUBPROVIDER - IRF	0	C		0 0	0	
3. 00 04300 NURSERY	0	C		0 0	0	
4.00 04400 SKILLED NURSING FACILITY	0				0	44.00
	0	C		0 0		
5.00 04500 NURSING FACILITY	0	C		0 0	_	45.00
200.00 Total (lines 30 through 199)	0	C)	0 0		200.00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	C	9,44	3 0.00	7, 344	1 зо. ос
31. 00 03100 I NTENSI VE CARE UNI T	Ŭ	C		0 0.00	0	
32. 00 03200 CORONARY CARE UNIT				0 0.00	0	
					-	
33.00 03300 BURN INTENSIVE CARE UNIT		C		0 0.00	0	
34.00 03400 SURGICAL INTENSIVE CARE UNIT		Ĺ	2	0 0.00	0	0.00
IO. 00 04000 SUBPROVI DER – I PF	0	C		0 0.00	0	
1. 00 04100 SUBPROVIDER – IRF	0	C		0.00	0	41.00
13. 00 04300 NURSERY		C		0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		C		0.00	0	44.00
15.00 04500 NURSING FACILITY		- (0 0.00	0	
200.00 Total (lines 30 through 199)		0	9,44			200.00
Cost Center Description	Inpati ent		7,44	5	7, 344	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
32.00 03200 CORONARY CARE UNIT	0					32.00
	0					33.00
33.00 03300 BURN INTENSIVE CARE UNIT	0					34.00
	, i i i i i i i i i i i i i i i i i i i					40.00
4.00 03400 SURGICAL INTENSIVE CARE UNIT	0					
44.00 03400 SURGI CAL INTENSIVE CARE UNIT 0.00 04000 SUBPROVIDER - IPF	0					
44. 00 03400 SURGI CAL INTENSI VE CARE UNIT 0. 00 04000 SUBPROVI DER - IPF 1. 00 04100 SUBPROVI DER - IRF	0					
34.00 O3400 SURGI CAL INTENSI VE CARE UNI T 40.00 04000 SUBPROVI DER - I PF \$1.00 04100 SUBPROVI DER - I RF \$1.00 04300 NURSERY - I RF	0					41.00
34.00 03400 SURGI CAL INTENSIVE CARE UNIT 10.00 04000 SUBPROVI DER - IPF 11.00 04100 SUBPROVI DER - IRF 13.00 04300 NURSERY 14.00 04400 SKI LLED NURSING FACILITY	0 0 0					43.00 44.00
34.00 O3400 SURGI CAL INTENSI VE CARE UNIT 10.00 04000 SUBPROVI DER - I PF 11.00 04100 SUBPROVI DER - I RF 13.00 04300 NURSERY - I RF	0					

	2		TAL LOUISVILL				u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	RVICE OTHER PASS	S Provider CC	JN: 15-3046		riod: om 01/01/2021 12/31/2021	Worksheet D Part IV Date/Time Prep 5/19/2022 8:45	
			Title	XVIII		Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng			Allied Health	
		Anestheti st	Program	Program		Post-Stepdown		
		Cost	Post-Stepdown Adjustments			Adjustments		
		1.00	2A	2.00		3A	3.00	
	ANCI LLARY SERVI CE COST CENTERS	1.00	28	2.00		54	3.00	
50.00	05000 OPERATI NG ROOM	0	0		0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0	Ő	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0		0	0	0	56.00
57.00	05700 CT SCAN	0	0		0	0	0	57.00
58.00	05800 MRI	0	0		0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60.00	06000 LABORATORY	0	0		0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
74.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0		0	0	0	74.00 75.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	0	77.00
77.00	OUTPATIENT SERVICE COST CENTERS	0	U		0	0	0	//.00
88.00	08800 RURAL HEALTH CLINIC	0	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0	89.00
90.00	09000 CLINIC	0	0		0	0	0	90.00
91.00	09100 EMERGENCY	0	0		0	0	Ő	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-		0	-	0	92.00
	OTHER REIMBURSABLE COST CENTERS				- 1			50
94.00	09400 HOME PROGRAM DI ALYSI S	0	0		0	0	0	94.00
95.00	09500 AMBULANCE SERVICES							95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	0	97.00
98.00	09850 OTHER REIMBURSABLE CC	0	0		0	0	0	98.00
	Total (lines 50 through 199)	0	0		0	0		200.00

Health Financial Systems	COBALT REHAB HOSE			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS	SERVICE OTHER PAS	S Provider C	CN: 15-3046	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre	pared:
					5/19/2022 8:4	5 am
			2 XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medical	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	E 00	6.00	7.00	instructions) 8.00	
ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	6.00	7.00	0.00	
50. 00 05000 OPERATI NG ROOM	0	C		0 0	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	0			0 0	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0.000000	
53. 00 05300 ANESTHESI OLOGY	0			0 0	0.000000	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0			-		•
55. 00 05500 RADI OLOGY - DI AGNOSTI C	0			0 153, 989	0.000000	
	0			0		
56. 00 05600 RADI 0I SOTOPE	0			0 0	0.000000	
57. 00 05700 CT SCAN	0	C		0 0	0.000000	
58.00 05800 MRI	0	C		0 0	0.000000	•
59.00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0.000000	
60. 00 06000 LABORATORY	0	C		0 413, 967	0.000000	•
60. 01 06001 BLOOD LABORATORY	0	C		0 0	0.000000	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0 0	0.000000	•
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0	0. 000000	
64.00 06400 INTRAVENOUS THERAPY	0	C		0 0	0. 000000	•
65. 00 06500 RESPI RATORY THERAPY	0	C		0 23, 722	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	C		0 3, 460, 473	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 4, 260, 783	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 530, 785	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0. 000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 76, 487	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 2, 232, 996	0.000000	73.00
74. 00 07400 RENAL DIALYSIS	0	C		0 0	0.000000	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	C		0 0	0.000000	75.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	C		0 0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS			_			
88.00 08800 RURAL HEALTH CLINIC	0	C		0 0	0.000000	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0	0.000000	89.00
90. 00 09000 CLINIC	0	C		0 0	0. 000000	90.00
91.00 09100 EMERGENCY	0	C		0 0	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C)	0 0	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	C		0 0	0.000000	94.00
95. 00 09500 AMBULANCE SERVICES						95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C)	0 0	0. 000000	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0 0	0. 000000	97.00
98.00 09850 OTHER REIMBURSABLE CC	0	C		0 0	0. 000000	98.00
200.00 Total (lines 50 through 199)	0	C		0 11, 153, 202		200.00
		•			•	•

HROUGH COSTS From 01/07/2021 To 12/37/2021 Part 1 W Det Time Propares (5/19/2022) Part 1 W DestTime Propares (Col . 6 + col. 7) MACI LLARY SERVICE COST CENTERS Impati ont (Col . 6 + col. 7) Impati ont (Col . 6 + col. 7) Propares (Col		BALT REHAB HOSPIT				u of Form CMS-2	2552-10
Title Title Title Title Pass Program Praci Coli Coli		RVI CE OTHER PASS	Provider C	CN: 15-3046		Date/Time Pre	
Image: Program Program			Title	× XVIII	Hospi tal		
to Charges (col. 6 Charges 7) Pass-Through Osts (col. 8) Charges Pass-Through Costs (col. 9) Pass-Through Costs (col. 9) MACI LLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 50.00 05000 DPERATI NG ROOM 0.000000 0 0 0 0 51.00 05100 RECOVERY ROOM & LABOR ROOM 0.000000 0 0 0 0 53.30 52.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.30 53.00 05500 RADI LOGY-THERAPEUTI C 0.000000 0 0 0 55.50 50.00 05500 RADI LOGY-THERAPEUTI C 0.000000 0 0 0 55.50 50.00 05500 NRI 0.000000 0 0 0 55.50 50.00 05500 NRI 0.000000 0 0 0 55.50 50.00 05500 NRI 0.000000 0 0 0 59.90 0.005000 IABLOAD CATHETERIZATION 0.000000 0 0 <td>Cost Center Description</td> <td>Outpati ent</td> <td>Inpati ent</td> <td>Inpati ent</td> <td>Outpati ent</td> <td>Outpati ent</td> <td></td>	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
Image: constraint of the second sec		Ratio of Cost	Program	Program	Program	Program	
T) x col. 10) x col. 12) ANCI LLARY SERVICE COST CENTERS 9.00 10.00 11.00 13.00 NO 05000 (DPERATI NE ROOM 0.000000 0 0 0.51 00 05000 PERATI NE ROOM 0.000000 0 0 0.51 00 05000 PERATI NE ROOM 0.000000 0 0 0.51 00 05000 PELVICEY ROOM & LABOR ROOM 0.000000 0 0 0.53 00 05300 ANESTHESI OLGGY 0.000000 0 0 0.54 55:00 05500 RADI OLGY-THERAPEUTI C 0.000000 0 0 0.55 56:00 05500 MRI 0.000000 0 0 0 55 59:00 0500 MRI 0.000000 0 <td></td> <td>to Charges</td> <td>Charges</td> <td>Pass-Through</td> <td>n Charges</td> <td>Pass-Through</td> <td></td>		to Charges	Charges	Pass-Through	n Charges	Pass-Through	
P. 00 10. 00 12. 00 13. 00 ANOLLLARY SERVICE COST CENTERS 0.000000 0		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
NRCLLARY SERVICE COST CENTERS Image: Center Cost Centers 00 000000000 PERATINE ROOM 0.0000000 0							
50.00 05000 0FORD 0 <		9.00	10.00	11.00	12.00	13.00	
51.00 DS100 RECOVERY ROOM A 0 0 0 0 0 51.00 S3.00 NESTHESI OLOGY 0.000000 0 0 0 53.00 S3.00 NESTHESI OLOGY 0.000000 0 0 0 53.00 S5.00 S5.00 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 55. 56.00 S5.00 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 55. 56.00 S5.00 CARDI AC CATHETERIZATI ON 0.000000 0 <td></td> <td></td> <td></td> <td>1</td> <td></td> <td>-</td> <td></td>				1		-	
52.00 OS200 DELLVERV ROOM & LABOR ROOM 0.000000 0 0 0 53.00 53.00 OS500 ARSTHESILOGY 0.000000 0 0 53.00 54.00 OS500 ARDIOLOCY-DLAGNOSTIC 0.000000 0 0 0 55.00 55.00 OS500 ARDIOLSCOTFE 0.000000 0 0 0 0 55.00 56.00 OS500 RADIOLSCOTFE 0.000000 0 0 0 55.00 57.00 OS500 RADIOLSCOTFE 0.000000 0 0 0 55.00 59.00 OS500 CARDIAC CATHETERIZATION 0.000000 0 0 0 0 0 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 63.0 64.00 65.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00			-			-	
53.00 OS300 AMESTHESI OLOGY 0.000000 0 0 0 53.30 54.00 OS400 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 54.30 55.00 OS500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 55.50 56.00 OS500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 56.50 57.00 OS700 CTSCAN 0.000000 0 0 0 58.50 59.00 OS900 CARDI AC CATHETERI ZATI ON 0.000000 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>51.00</td></t<>							51.00
54.00 05400 RADI LOGY-DI AGNOSTI C 0.000000 118,949 0 0 54.55 55.00 0500 RADI LOGY-THERAPEUTI C 0.000000 0 0 55.56 56.00 0500 RADI LOGY-THERAPEUTI C 0.000000 0 0 0 57.00 57.00 05700 CT SCAN 0.000000 0 0 0 57.56 58.00 DS500 MRI 0.000000 0 0 0 57.56 60.00 DS500 LARDRACA CATHETERI ZATI ON 0.000000 0 0 0 0 60.61 61.00 D6100 LABORATORY 0.000000 0 0 0 0 60.61 62.00 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0 0 0 64.62 63.00 06400 INTRAVENDIS THERAPY 0.000000 0 0 64.62 64.00 06400 INTRAVENDIS THERAPY 0.000000 2,617,92 0 0 65.66 65.00 06600 PHYSI GLAL THERAPY 0.0000000 2,617,92							
55.00 05500 RADI DLOGY-THERAPEUTI C 0.00000 0 0 55.00 0500 RADI DLOGY-THERAPEUTI C 0.000000 0 0 55.00 0500 RADI DLOGY-THERAPEUTI C 0.000000 0 0 0 55.00 55.00 55.00 05000 RADI AC CATHETERI ZATI ON 0.000000 0 0 0 0 57.00 57.00 57.00 57.00 57.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 50.00 59.00 50.00 59.00 50.00 59.00 50.00 59.00 50.00<			0		0	-	53.00
56.00 00 00 00 00 00 00 00 00 00 00 57.00 00 00 00 00 57.00 00			118, 949		-	-	54.00
57.00 05700 CT SCAN 0.000000 0 0 0 57.00 57.00 05.00 05.00 05.00 05.00 0<			0				55.00
58.00 OSB00 MRI 0.000000 0 0 0 57.00 05900 CARDIAC CATHETERIZATION 0.000000 345,906 0 0 0 66.00 66.00 66.00 0 67.00 66.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.			0			-	56.00
59.00 OS900 CARDIAC CATHETERIZATION 0.000000 0 0 0 59.00 60.00 06000 LABORATORY 0.000000 345,906 0 0 66.0 60.01 06001 BLOOD LABORATORY 0.000000 0 0 66.0 61.02 06200 DADOD LABORATORY 0.000000 0 0 66.0 62.00 06200 BLOOD X PACKED PED BLOOD CELL 0.000000 0 0 0 66.0 63.00 06300 BLOOD X PACKED PED BLOOD CELL 0.000000 0 0 0 64.0 65.00 06500 RESPI RATORY THERAPY 0.000000 3.492 0 0 66.0 66.00 06600 RESPI RATORY THERAPY 0.000000 3.492 0 0 66.0 67.00 06700 CLUPATIONAL THERAPY 0.000000 3.62.007 0 0 67.0 67.00 000000 0.000000 3.64.787 0 0 0 0			0				57.00
60.00 06000 LABORATORY 0.000000 345,906 0 <t< td=""><td></td><td>0. 000000</td><td>0</td><td></td><td>0 0</td><td>0</td><td>58.00</td></t<>		0. 000000	0		0 0	0	58.00
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62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0 0 0 62. 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 0 0 64. 64.00 06400 INTRAVENUS THERAPY 0.000000 0 0 0 64. 65.00 06500 RESPI RATORY THERAPY 0.000000 2, 617, 923 0 0 65. 66.00 000000 0, 25, 077 0 0 66. 68. 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 69.00 0 0 0 67.00 67.00 67.00 67.00 67.00 67.00 68.00 68.00 68.00 68.00 68.00 69.00 0 0 0 0 0 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 71.00 71.00 71.00 71.00 71.00 71.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00		0. 000000	0		0 0	0	60.01
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65.00 06500 RESPIRATORY THERAPY 0.000000 13,492 0 0 65. 66.00 06600 PHYSI CAL THERAPY 0.000000 2,617,923 0 0 66. 07.00 0COPUTI ONAL THERAPY 0.000000 3,252,007 0 0 67. 06800 SPEECH PATHOLOGY 0.000000 364,787 0 0 68. 07.00 COENCEPHALGRAPHY 0.000000 0 0 0 0 68. 07.00 ELECTROCARDIOLOGY 0.000000 0 0 0 0 0 70. 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 0 71. 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 72. 72. 0 0 74. 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 74. 75. 75. 75. 75. 75. 75. 75. 75. 75. 75. 75. 75. 75. 75. 75. 75. 75.	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
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67.00 06700 OCCUPATI ONAL THERAPY 0.000000 3, 252, 007 0 0 67. 68.00 06800 SPEECH PATHOLOGY 0.000000 364, 787 0 0 0 68. 69.00 OK800 SPEECH PATHOLOGY 0.000000 0	65. 00 06500 RESPI RATORY THERAPY	0. 000000	13, 492		0 0	0	65.00
68.00 06800 SPEECH PATHOLOGY 0.00000 364,787 0 0 68. 69.00 06900 ELECTROCARDI OLOGY 0.000000 <	66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 617, 923		0 0	0	66.00
69.00 06900 ELECTROCARDIOLOGY 0.00000 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 70.00 71.00 OTOO ELECTROEARDED TO PATIENT 0.000000 0 0 0 0 70.00 72.00 OTZO IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 0 0 0 73.00 73.00 07300 RENAL DIALYSIS 0.000000 0 0 0 0 74.00 07400 RENAL DIALYSIS 0.000000 0 0 0 73.70 0 0700 ASC (NON-DI STINCT PART) 0.000000 0 </td <td>67.00 06700 OCCUPATI ONAL THERAPY</td> <td>0. 000000</td> <td>3, 252, 007</td> <td></td> <td>0 0</td> <td>0</td> <td>67.00</td>	67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	3, 252, 007		0 0	0	67.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 70. 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 69,078 0 0 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 72. 73.00 DRUGS CHARGED TO PATI ENTS 0.000000 1,750,272 0 0 73. 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 0 73. 75.00 07500 ASC (NON-DI STI NCT PART) 0.000000 0 0 0 75. 77.00 07500 ALGENTIC EXTEM CELL ACQUI SI TI ON 0.000000 0 0 0 77. 0UTPATI ENT SERVICE COST CENTERS 0.000000 0 0 0 0 88. 89.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 90. 90.00 09000 C INIC 0.0000000 0 0 <td< td=""><td>68.00 06800 SPEECH PATHOLOGY</td><td>0. 000000</td><td>364, 787</td><td></td><td>0 0</td><td>0</td><td>68.00</td></td<>	68.00 06800 SPEECH PATHOLOGY	0. 000000	364, 787		0 0	0	68.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 69,078 0 0 0 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 0 72. 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 1,750,272 0 0 0 73. 74.00 O7400 RENAL DI ALYSI S 0.000000 0 0 0 74. 75.00 07500 ASC (NON-DI STI NCT PART) 0.000000 0 0 0 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0.000000 0 0 0 77. 010 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0.000000 0 0 0 0 77. 010 07800 REVICE COST CENTERS 0.000000 0 0 0 0 0 0 0 0 90. 90.00 0 0 0 0 90. 90. 0	69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 69,078 0 0 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 72. 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 1,750,272 0 0 0 73. 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 0 74. 75.00 07500 ASC (NON-DI STINCT PART) 0.000000 0 0 0 75. 77.00 07700 ALLOGENEI C STEM CELL ACOULSI TI ON 0.000000 0 0 0 77. 00 07500 ALCGENEI C COST CENTERS	70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 1,750,272 0 0 0 73. 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 0 0 74. 75.00 07500 ASC (NON-DI STINCT PART) 0.000000 0 0 0 0 75. 77.00 07700 ALLOGENEI C STEM CELL ACQUISITION 0.000000 0 0 0 0 77. 0UTPATI ENT SERVICE COST CENTERS 0.000000 0 0 0 0 88. 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88. 99.00 09000 CLINIC 0.000000 0 0 0 88. 90.00 09000 CLINIC 0.000000 0 0 0 90. 91. 91.00 09100 EMERGENCY 0.000000 0 0 0 92. 0THER REIMBURSABLE COST CENTERS 0.000000 0 0 0 94. 95. 95.0 96.00 09400 0 0 9	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	69, 078		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 1,750,272 0 0 0 73. 74.00 07400 RENAL DI ALYSI S 0.000000 0 0 0 0 74. 75.00 07500 ASC (NON-DI STINCT PART) 0.000000 0 0 0 0 75. 77.00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0.000000 0 0 0 0 77. 0UTPATI ENT SERVICE COST CENTERS 0.000000 0 0 0 0 88. 0 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88. 90.00 09000 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 89. 0 08800 0 0 0 0 89. 91.00 09100 EMERGENCY 0.000000 0 0 0 0 90. 91. 92.00 09500 AMBURSABLE COST CENTERS 0.000000 0 0 0 0 92. 0THER REI MBURSABLE COST CENTERS 0.000000	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
74.00 07400 RENAL DI ALYSI S 0.000000 0 0 0 74.00 75.00 07500 ASC (NON-DI STI NCT PART) 0.000000 0 0 0 0 75. 77.00 0700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0.000000 0 0 0 0 77. 0UTPATI ENT SERVICE COST CENTERS 0.000000 0 0 0 0 0 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 0 88.89.00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0.000000 0 0 0 89.00 09000 CLINIC 0.000000 0 0 0 90.00 90.00 90.00 0 0 0 90.00 91.00 92.0 09100 EMERGENCY 0.000000 0 0 0 0 90.00 91.00 92.0 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 0 0 0 92.0 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 0 0 92.0 09400 HOME PROGRAM DI ALYSI S 95.00 0 0 0		0. 000000	1, 750, 272		0 0	0	73.00
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0.00000 0 0 0 0 0 77. 0UTPATI ENT SERVICE COST CENTERS 0.00000 0 0 0 0 0 0 0 88. 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 88. 90. 00 09000 CLINIC 0.000000 0 0 0 89. 90. 00 09000 CLINIC 0.000000 0 0 0 90. 91. 00 09100 EMERGENCY 0.000000 0 0 0 91. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.000000 0 0 0 92. 0THER REI MBURSABLE COST CENTERS 0.000000 0 0 0 94. 95. 00 09500 AMBULANCE SERVICES 0 0.000000 96. 95. 96. 00 09400 DURABLE MEDI CAL EQUI P-RENTED 0.000000<					0 0	0	74.00
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0.00000 0 0 0 0 0 77. 0UTPATI ENT SERVICE COST CENTERS 0.00000 0 0 0 0 0 0 0 88. 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 88. 90. 00 09000 CLINIC 0.000000 0 0 0 89. 90. 00 09000 CLINIC 0.000000 0 0 0 90. 91. 00 09100 EMERGENCY 0.000000 0 0 0 91. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.000000 0 0 0 92. 0THER REI MBURSABLE COST CENTERS 0.000000 0 0 0 94. 95. 00 09500 AMBULANCE SERVICES 0 0.000000 96. 95. 96. 00 09400 DURABLE MEDI CAL EQUI P-RENTED 0.000000<	75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 0 88. 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 0 89. 90.00 09000 CLINIC 0.000000 0 0 0 0 90. 91.00 09100 EMERGENCY 0.000000 0 0 0 0 90. 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.000000 0 0 0 92. 0THER REI MBURSABLE COST CENTERS 0.000000 0 0 94.0 09400 HOME PROGRAM DI ALYSIS 0.000000 0 94. 95.00 9500 AMBULANCE SERVICES 95.00 96.00 0 0 0 95. 96.00 09600 DURABLE MEDICAL EQUI P-RENTED 0.000000 0 0 0 96. 97.00		0. 000000	0		0 0	0	77.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 0 89. 90.00 09000 CLINIC 0.000000 0 0 0 90. 91.00 09100 EMERGENCY 0.000000 0 0 0 0 90. 92.00 09SERVATION BEDS (NON-DISTINCT PART 0.000000 0 0 0 92. 010000 EMERGENCY 0.000000 0 0 0 92. 01000 D9200 DBSERVATION BEDS (NON-DISTINCT PART 0.000000 0 0 92. 01000 09400 HOME PROGRAM DIALYSIS 0.000000 0 0 94. 95.00 09500 AMBULANCE SERVICES 0.000000 0 0 94. 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 0 95. 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 0 97. 98.00	OUTPATIENT SERVICE COST CENTERS			•			1
90.00 09000 CLINIC 0.00000 0 0 0 90. 90. 91.00 09100 EMERGENCY 0.000000 0 0 0 91. 91. 92.00 09SERVATION BEDS (NON-DISTINCT PART 0.000000 0 0 0 0 92. 0THER REIMBURSABLE COST CENTERS 0.000000 0 0 0 94. 95.00 09500 AMBULANCE SERVICES 0.000000 0 0 94. 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 0 0 95. 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 0 0 0 97. 98.00 09850 OTHER REI MBURSABLE CC 0.000000 0 0 0 98.	88.00 08800 RURAL HEALTH CLINIC	0.000000	0	I	0 0	0	88.00
91.00 09100 EMERGENCY 0.000000 0 0 0 91. 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 0 0 0 0 92. 0THER REI MBURSABLE COST CENTERS 0.000000 0 0 0 94. 95.00 09400 HOME PROGRAM DI ALYSI S 0.000000 0 0 94. 95.00 09500 AMBULANCE SERVICES 0.000000 0 0 94. 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 0 0 95. 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 0 0 0 97. 98.00 09850 OTHER REI MBURSABLE CC 0.000000 0 0 0 98.	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	89.00
92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0.00000 0 0 0 0 92. OTHER REI MBURSABLE COST CENTERS 0.00000 0 0 0 94. 0 09400 HOME PROGRAM DI ALYSI S 94. 0 0 0 94. 95.00 09500 AMBULANCE SERVICES 95. 95. 95. 95.00 9600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 0 0 95. 95. 96.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 0 0 0 97. 98.00 09550 0THER REI MBURSABLE CC 0.000000 0 0 0 98.	90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0.00000 0 0 0 0 92. OTHER REI MBURSABLE COST CENTERS 0.00000 0 0 0 94. 94.00 09400 HOME PROGRAM DI ALYSI S 0.000000 0 94. 95.00 09500 AMBULANCE SERVICES 95. 95. 95.00 95.00 00 0 0 0 95. 95. 95. 95. 95.00 96.00 0 0 0 0 96.00 00 0 0 96.00 96.00 0.000000 0 0 0 97.00 97.00 97.00 0 0 0 97.00 98.00 09850 0THER REI MBURSABLE CC 0.000000 0 0 0 98.00 98.00 0 0 0 0 98.00	91. 00 09100 EMERGENCY	0, 000000	0		0 0	0	91.00
OTHER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0. 000000 0 0 0 94. 95. 00 09500 AMBULANCE SERVI CES 0. 000000 0 0 0 95. 95. 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 0 0 0 96. 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000 0 0 0 97. 98. 00 09850 OTHER REI MBURSABLE CC 0. 000000 0 0 0 98.			0			0	•
94. 00 09400 HOME PROGRAM DI ALYSI S 0.00000 0 0 0 94. 95. 00 09500 AMBULANCE SERVI CES 0 0 0 95. 95. 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 0 0 96. 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 0 0 0 97. 98. 00 09850 OTHER REI MBURSABLE CC 0.000000 0 0 0 0 98.						-	1
95.00 09500 AMBULANCE SERVICES 95. 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 0 96. 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 0 97. 98.00 09850 OTHER REI MBURSABLE CC 0.000000 0 0 0 98.		0. 000000	0		0 0	0	94.00
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 0 0 96. 96. 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 0 0 0 97. 98.00 09850 0THER REI MBURSABLE CC 0.000000 0 0 0 98. 0 98. 0 0 0 0 98. 0 0 0 0 98. 0 0 0 0 0 98. 0 <td></td> <td></td> <td></td> <td> </td> <td></td> <td></td> <td>95.00</td>							95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 0 0 0 97. 98. 00 09850 OTHER REI MBURSABLE CC 0.000000 0 0 0 98.		0. 000000	0		0 0	0	
98. 00 09850 OTHER REI MBURSABLE CC 0. 000000 0 0 0 98.			0				
			0		-		
200,001 FIDEAL CETTES SU LITEOUUN 1991 E 1 8,532,4141 UI 01 01 01200.	200.00 Total (lines 50 through 199)		8, 532, 414		0 0		200.00

	BALT REHAB HOSPI	TAL LOUI SVI LL	E	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-3046	Period: From 01/01/2021	Worksheet D Part V Date (Time Dre	norad
				To 12/31/2021	Date/Time Pre 5/19/2022 8:4	pared: 5 am
	· · ·	Title	XVIII	Hospi tal	PPS	
			Charges	-	Costs	
Cost Center Description	Cost to Charge PI			Cost	PPS Services	
		ervices (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C, Part I, col. 9	inst.)	Services Subject To	Services Not Subject To		
			Ded. & Coins	-		
			(see inst.)			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	0		0 0	-	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	-	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	-	52.00
53. 00 05300 ANESTHESI OLOGY	0.000000	0		0 0	-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 815591	0		0 0	-	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	-	55.00 56.00
57. 00 05700 CT_SCAN	0. 000000 0. 000000	0		0 0	-	
58. 00 05800 MRI	0. 000000	0		0 0	-	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	-	
60. 00 06000 LABORATORY	0. 022876	0		0 0	-	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0		
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	-		0 0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	2. 577059	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 413159	0		0 0	-	
67.00 06700 OCCUPATI ONAL THERAPY	0. 206649	0		0 0	-	67.00
68.00 06800 SPEECH PATHOLOGY	0. 703251	0		0 0	-	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	-	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0		0 0	-	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	1. 576621	0		0 0	-	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000 0. 343654	0		0 0	-	
74. 00 07400 RENAL DIALYSIS	0. 000000	0		0 0	-	
75. 00 07500 ASC (NON-DI STINCT PART)	0. 000000	0		0 0	-	75.00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0		
OUTPATIENT SERVICE COST CENTERS				-1 -		
88.00 08800 RURAL HEALTH CLINIC						88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	0		0 0		1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS				-		
94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000			0 0		94.00
95. 00 09500 AMBULANCE SERVICES	0. 000000	~		0	_	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0. 000000	0		0 0 0 0		96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 98. 00 09850 OTHER REIMBURSABLE CC	0. 000000 0. 000000	0		0 0 0 0		
200.00 Subtotal (see instructions)	0.000000	0		0 0		200.00
201.00 Less PBP Clinic Lab. Services-Program		0		0 0		200.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0		0 0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	AND VACCINE COST	Provider CC	:N: 15-3046	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/19/2022 8:4	
		Title	XVIII	Hospi tal	PPS	
	Costs					
Cost Center Description	Services S Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Gervices Not Subject To ed. & Coins. (see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS		-				4
50.00 05000 0PERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY-THERAPEUTI C 56.00 05600 RADI OI OSTOPE		0 0 0 0 0 0 0				50.00 51.00 52.00 53.00 54.00 55.00 56.00
57.00 05700 CT SCAN 58.00 05800 MRI 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 60.01 06001 BLOOD LABORATORY 61.00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY		0 0 0 0 0				57.00 58.00 59.00 60.00 60.01 61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 64.00 06400 I NTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY	0 0 0 0 0	0 0 0 0 0				62.00 63.00 64.00 65.00 66.00
67.00 06700 0CCUPATIONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDIOLOGY 70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV.						67.00 68.00 69.00 70.00 71.00 72.00
72:00 07200 DRUE DEV. CHARGED TO PATIENTS 73:00 07300 DRUGS CHARGED TO PATIENTS 74:00 74:00 74:00 75:00 07:00 ALCGENEIC STEM CELL ACQUISITION 07:00 ALLOGENEIC STEM CELL ACQUISITION 00/00 0/00 0/00 0/00 0/00 0/00 0/00 0/00 0/00 0/00 0/00 0/00 0/00 0/00	0 0 0 0	0 0 0 0				73.00 74.00 75.00 77.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90.00 09000 CLINIC 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 0	0 0 0				88.00 89.00 90.00 91.00 92.00
OTHER REI MBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S 95.00 09500 AMBULANCE SERVICES 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 98.00 09850 OTHER REI MBURSABLE CC 200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Progra	m 0	0 0 0 0 0				94. 00 95. 00 96. 00 97. 00 98. 00 200. 00 201. 00

Health Financial Systems	COBALT REHAB HOSP	I TAL LOUI SVI LL	.E	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT	AL COSTS	Provider C	CN: 15-3046	Peri od: From 01/01/2021 To 12/31/2021		
		T: +1	e XIX	Hospi tal	5/19/2022 8:4 PPS	5 am
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
cost center bescription	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	naj astiliont	Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	451, 493	C	451, 49	93 9, 443	47.81	30.00
31.00 INTENSIVE CARE UNIT	0			0 0	0.00	
32.00 CORONARY CARE UNIT	0			0 0	0.00	32.00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34.00
40. 00 SUBPROVIDER - IPF	0	C		0 0	0.00	
41. 00 SUBPROVIDER - IRF	0	C		0 0	0.00	41.00
43.00 NURSERY	0			0 0	0.00	43.00
44.00 SKILLED NURSING FACILITY	0			0 0		44.00
45.00 NURSING FACILITY	0			0 0		45.00
200.00 Total (lines 30 through 199)	451, 493		451, 49	93 9, 443		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	(6)	_			
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS	30	1, 434				30.00
31.00 INTENSIVE CARE UNIT	30	1, 434	1			31.00
32. 00 CORONARY CARE UNIT	0					32.00
33. 00 BURN INTENSIVE CARE UNIT	0					33.00
34. 00 SURGI CAL INTENSI VE CARE UNI T	0					34.00
40. 00 SUBPROVIDER - IPF	0					40.00
41. 00 SUBPROVIDER - IRF	0					40.00
43. 00 NURSERY	0					43.00
44. 00 SKILLED NURSING FACILITY	0					44.00
45. 00 NURSING FACILITY	0	0				45.00
200.00 Total (lines 30 through 199)	30	1, 434				200.00
		., 101	.1			

PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL CUSTS	Provider C	UN: 15-3046	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre	pared:
					5/19/2022 8:4	
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col . 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	<u>26)</u> 1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
0. 00 05000 OPERATING ROOM	0	0	0.0000	0 00	0	50.00
1. 00 05100 RECOVERY ROOM	0	-	1		0	
2. 00 05200 DELIVERY ROOM & LABOR ROOM	0	-			0	
3. 00 05300 ANESTHESI OLOGY	0				0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 478	153, 989			0	
5. 00 05500 RADI OLOGY-THERAPEUTI C	0, 1,0	100, 707	0.0000		0	55.00
6. 00 05600 RADI OLSOT MELAN ESTIC	0				0	
7. 00 05700 CT SCAN		-			0	1
8. 00 05800 MRI		-			0	
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	-			0	
0. 00 06000 LABORATORY	1, 849	-			5	
0. 01 06001 BLOOD LABORATORY	1,049				0	
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0.00000	0	0	61.00
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0. 00000	0	0	1
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		-			0	
4. 00 06400 INTRAVENOUS THERAPY		-			0	
	-	-				
5. 00 06500 RESPI RATORY THERAPY 6. 00 06600 PHYSI CAL THERAPY	4, 147				0	
	107, 195				441	66.00
7. 00 06700 OCCUPATI ONAL THERAPY	10, 094				41	67.00
8. 00 06800 SPEECH PATHOLOGY	4,068				0	
9. 00 06900 ELECTROCARDI OLOGY	0	-			0	
0.00 07000 ELECTROENCEPHALOGRAPHY	0	, s	0.0000.		0	
1. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	1, 311	76, 487			22	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0.0000		0	
3. 00 07300 DRUGS CHARGED TO PATIENTS	19, 331	2, 232, 996	1		71	73.00
4. 00 07400 RENAL DIALYSIS	0	-	0.0000.		0	
5. 00 07500 ASC (NON-DI STINCT PART)	0				0	
7. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.0000	0 00	0	77.00
0UTPATIENT SERVICE COST CENTERS 8.00 08800 RURAL HEALTH CLINIC	0	0	0.0000	0 00	0	88.00
9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		-			0	
0. 00 09000 CLINIC	0	-			0	
		-				
1.00 09100 EMERGENCY 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	U	<u> </u>	0.0000		0	92.00
4. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.0000	0 00	0	94.00
5. 00 09500 AMBULANCE SERVICES			0.0000	0	0	94.00
6. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	c c	0.0000	0 00	0	1
7. 00 09700 DURABLE MEDICAL EQUIP-RENTED		-				1
	I U	I U	0.0000	0 00	0	97.00
8. 00 09850 OTHER REIMBURSABLE CC	0	0	0.0000	0 00	0	98.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	₹ PASS THROUGH COST	S Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/19/2022 8:4	pared:
			e XIX	Hospi tal	PPS	o alli
Cost Center Description	Nursi ng	Nursing		Allied Health	All Other	
cost center bescription	Program	Program	Post-Stepdowr		Medi cal	
	Post-Stepdown	r i ogi alli	Adjustments	0031	Education Cost	
	Adjustments		Aujustilients			
	1AUJ US LINEITES	1 00	24	2.00	2 00	
		1.00	2A	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	0	C		0 0	0	
31. 00 03100 INTENSIVE CARE UNIT	0	C		0 0	0	
32.00 03200 CORONARY CARE UNI T	0	C		0 0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	C		0 0	0	33.00
4.00 03400 SURGICAL INTENSIVE CARE UNIT	0	C		0 0	0	34.00
IO. OO O4000 SUBPROVIDER - IPF	0	-		0 0	0	
1.00 04100 SUBPROVIDER - IRF	0			0 0	0	
	-	C		0 0	-	
13. 00 04300 NURSERY	0	Ĺ	2	0 0	0	
4.00 04400 SKILLED NURSING FACILITY	0	C		0 0		44.00
5.00 04500 NURSING FACILITY	0	C		0 0		45.00
00.00 Total (lines 30 through 199)	0	C		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
···· · · · · · · · · · · · · · · · · ·	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	Julyo		l'i ogi ulli bujo	
	i nstructi ons)					
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
			0.44	0 0 00		
30. 00 03000 ADULTS & PEDIATRICS	0	C			30	
1. 00 03100 I NTENSI VE CARE UNI T		C		0 0.00	0	31.00
2.00 03200 CORONARY CARE UNIT		C		0.00	0	32.00
3.00 03300 BURN INTENSIVE CARE UNIT		C		0.00	0	33.00
4.00 03400 SURGICAL INTENSIVE CARE UNIT		C		0.00	0	34.00
IO. 00 04000 SUBPROVI DER – I PF	o	C		0.00	0	40.00
11.00 04100 SUBPROVIDER - IRF	0	C		0 0.00	0	
13. 00 04300 NURSERY	0			0 0.00	0	
		C			-	
4.00 04400 SKILLED NURSING FACILITY		C		0 0.00	0	
15.00 04500 NURSING FACILITY		C		0 0.00	0	
00.00 Total (lines 30 through 199)		C	9, 44	3	30	200.00
Cost Center Description	Inpatient					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30. 00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
2.00 03200 CORONARY CARE UNIT	0					32.00
	0					33.00
						34.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	U					40.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					
44. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 0. 00 04000 SUBPROVI DER - I PF	0					41.00
84. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 10. 00 04000 SUBPROVI DER - I PF 11. 00 04100 SUBPROVI DER - I RF	0					•
34.00 03400 SURGI CAL INTENSIVE CARE UNIT 40.00 04000 SUBPROVI DER - IPF 41.00 04100 SUBPROVI DER - IRF 43.00 04300 NURSERY	0					41.00 43.00
34.00 03400 SURGI CAL INTENSI VE CARE UNIT 10.00 04000 SUBPROVI DER - IPF 11.00 04100 SUBPROVI DER - IRF 13.00 04300 NURSERY 14.00 04400 SKI LLED NURSI NG FACI LITY	000000000000000000000000000000000000000					43.00 44.00
4. 00 03400 SURGI CAL INTENSI VE CARE UNIT 0. 00 04000 SUBPROVI DER - I PF 1. 00 04100 SUBPROVI DER - I RF 3. 00 04300 NURSERY	0					43.00

Health Financial Systems CO	BALT REHAB HOSPI	TAL LOUI SVI LL	E		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider CC	CN: 15-3046	Peri From To	od: 01/01/2021 12/31/2021	Worksheet D Part IV Date/Time Prep 5/19/2022 8:45	
		Titl	e XIX	ŀ	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Pos	lied Health st-Stepdown djustments	Allied Health	
	1.00	2A	2.00		3A	3.00	
ANCI LLARY SERVICE COST CENTERS							
50.00 05000 OPERATI NG ROOM	0	0		0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0	0	0	56.00
57. 00 05700 CT SCAN	0	0		0	0	0	57.00
58. 00 05800 MRI	0	0		0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
	0	0		0	0	0	60.00
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0	0	0	60. 01 61. 00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	0	61.00 62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	Ō	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0	0	0	75.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0	0		0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0	89.00
90. 00 09000 CLINIC	0	0		0	0	0	90.00
91. 00 09100 EMERGENCY	0	0		0	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0			0		0	92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0	0	0	94.00 95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-KENTED	0	0		0	0	0	90.00 97.00
98.00 09850 OTHER REI MBURSABLE CC	0	0		0	0	0	97.00 98.00
200.00 Total (lines 50 through 199)	0	0		0	0		200.00
		-	1	- 1	-1	- 1	

	Financial Systems CO IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		S Provider C			Worksheet D	2552-10
	H COSTS	RVICE UTHER PAS	S Provider C		Period: From 01/01/2021	Part IV	
INKUUG	H CUSIS				To 12/31/2021	Date/Time Pre	pared:
						5/19/2022 8:4	5 am
				e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	cols. 2, 3, and 4)	8)	7)	
						(see instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVICE COST CENTERS	4.00	0.00	0.00	7.00	0.00	
50.00	05000 OPERATING ROOM	0	0		0 0	0.00000	50.00
51.00	05100 RECOVERY ROOM	0	0	(0 0	0.000000	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	l o	(0 0	0.00000	52.00
53.00	05300 ANESTHESI OLOGY	0	l o	(0 0	0.00000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 153, 989	0.000000	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(0 0	0.000000	•
56.00	05600 RADI OI SOTOPE	0	0	(0 0	0.000000	
57.00	05700 CT SCAN	0	0		0 0	0. 000000	
58.00	05800 MRI	0	0		0 0	0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0. 000000	
60.00	06000 LABORATORY	0	0		413,967	0. 000000	
60.01	06001 BLOOD LABORATORY	0	0		0 0	0. 000000	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				°	01000000	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0.000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0.000000	1
64.00	06400 INTRAVENOUS THERAPY	0	0	1	0 0	0.000000	
65.00	06500 RESPI RATORY THERAPY	0	0	(0 23, 722	0.000000	1
66.00	06600 PHYSI CAL THERAPY	0	0	(0 3, 460, 473	0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(4, 260, 783	0.000000	1
68.00	06800 SPEECH PATHOLOGY	0	0	(0 530, 785	0.000000	
69.00	06900 ELECTROCARDI OLOGY	0	0	(0 0	0.000000	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0 76, 487	0.000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0 0	0.000000	1
	07300 DRUGS CHARGED TO PATIENTS	0	0	(2, 232, 996	0.000000	
	07400 RENAL DI ALYSI S	0	0		0 0	0.000000	
	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0.000000	1
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	(0 0	0.000000	
	OUTPATIENT SERVICE COST CENTERS			1			
88.00	08800 RURAL HEALTH CLINIC	0	0	(0 0	0.00000	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0 0	0.00000	89.00
90.00	09000 CLI NI C	0	0	(0 0	0.000000	
91.00	09100 EMERGENCY	0	0	(0 0	0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0.000000	
	OTHER REIMBURSABLE COST CENTERS			`			1
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	(0 0	0.00000	94.00
95.00	09500 AMBULANCE SERVICES						95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0.00000	
96.00		1	1				
96.00 97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	(0 0	0.000000	97.00
	09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE CC	0	0		0 0 0 0	0.000000	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Disas di al a con				
THROUGH COSTS		Provi der Cu	CN: 15-3046	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/19/2022 8:4	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpatient	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	0.000000	0	1		0	50.00
50. 00 05000 OPERATING ROOM	0.00000	0		0 0	0	
51.00 05100 RECOVERY ROOM	0.00000	0		0 0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0.00000	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0.00000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0.000000	0		0 0	0	57.00
58. 00 05800 MRI	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	1, 131		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	14, 231		0 0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 000000	17, 262		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 260		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	8, 223		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS	- I					
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	89.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS				-1		
94. 00 09400 HOME PROGRAM DI ALYSI S	0.000000	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES						95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0		0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE CC	0. 000000	0		0 0	0	98.00
96. UU U965U UTHER RETMBURSABLE CC		-		0 0		

MPUT.	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-3046	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Pre 5/19/2022 8:4	pared
		Title XVIII	Hospi tal	PPS	1
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	(s excluding newborn)		9, 443	1 1.
00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			9,443	
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
	do not complete this line.		<u> </u>		
00	Semi-private room days (excluding swing-bed and observation b			9, 443	
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decembe	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			-	
00	Total swing-bed NF type inpatient days (including private roo	om days) through December	r 31 of the cost	0	7
	reporting period			0	
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December .	31 OF THE COST	0	8
00	Total inpatient days including private room days applicable t	to the Program (excluding	a swing-bed and	7, 344	9
-	newborn days) (see instructions)		,	.,	Ĺ
00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10
~~	through December 31 of the cost reporting period (see instruc			0	
00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		room days) after	0	11
00	Swing-bed NF type inpatient days applicable to titles V or XI		te room davs)	0	12
	through December 31 of the cost reporting period	, , , , , , , , , , , , , , , , , , ,			
00	Swing-bed NF type inpatient days applicable to titles V or XI $$			0	13
00	after December 31 of the cost reporting period (if calendar y			0	114
00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 d	of the cost	0.00	17
00	reporting period	an ofter December 21 of	the east	0.00	10
00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces aller December 31 01	the cost	0.00	18
00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19
	reporting period				
00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of 1	the cost	0.00	20
00	reporting period Total general inpatient routine service cost (see instruction)		7, 728, 662	21
	Swing-bed cost applicable to SNF type services through Decemb		ting period (line	0	
	5 x line 17)			-	
00	Swing-bed cost applicable to SNF type services after December	- 31 of the cost reportin	ng period (line 6	0	23
00	x line 18) Swing-bed cost applicable to NF type services through Decembe	or 21 of the cost reporti	na poriod (lino	0	24
00	7 x line 19)	a si ol the cost report	ng period (inne	0	24
00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
	x line 20)				
	Total swing-bed cost (see instructions)	(line 21 minus line 24)		0	
00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TTHE 21 MITHUS TITHE 26)		7, 728, 662	27
00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	28
	Private room charges (excluding swing-bed charges)		<u> </u>	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nue line 22) (coo inctrue	stions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x li	, ,	500157	0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	
	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	7, 728, 662	
	27 minus line 36)		•		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	UCTNENTS			-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			010 / F	20
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	-		818. 45 6, 010, 697	
	Trogram general impactent routine service cost (The 9 X IIIe			5, 510, 077	
-	Medically necessary private room cost applicable to the Progr	ram (line 14 x line 35)		0	40

JMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-3046	Period: From 01/01/2021 To 12/31/2021		
			T: +1 -	XVIII	Hoopi tal	5/19/2022 8:4	45 am
	Cost Center Description	Total	Total	Average Per	Hospital Program Days	PPS Program Cost	
		Inpatient Cost		Diem (col. 1		(col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	-
. 00	NURSERY (title V & XIX only)	1.00	2.00 C	3.00	4.00	5.00 0) 42.
. 00	Intensive Care Type Inpatient Hospital Units			0.0			1 '2
. 00	INTENSIVE CARE UNIT	0	C	0.0	0 0	0	43
. 00	CORONARY CARE UNIT	0	0			-	
. 00 . 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0	0.0			
. 00	OTHER SPECIAL CARE (SPECIFY)	0	0	0.0			40
	Cost Center Description	· · ·					
						1.00	
. 00	Program inpatient ancillary service cost (Wk			nc)		2, 860, 274	
. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(S		ins)		8, 870, 971	49
. 00	Pass through costs applicable to Program inp	atient routine s	ervices (from	Wkst. D, sum	of Parts I and	351, 117	7 50
. 00	Pass through costs applicable to Program inp.	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	118, 384	1 51
. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				469, 501	1 52
. 00	Total Program inpatient operating cost exclu		ated, non-phy	sician anesth	etist, and	8, 401, 470	
	medical education costs (line 49 minus line						
~~	TARGET AMOUNT AND LIMIT COMPUTATION						
. 00 . 00	Program discharges Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	-				0.00	
. 00							
. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report und	lated by the m	arket hasket		0.00	60
. 00	If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less that		(lines 54 x	60), or 1% of	the target		
	amount (line 56), otherwise enter zero (see	instructions)					
. 00 . 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (coo instruc	tions)				
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reporti	ng period (See	C	64
~ ~	instructions)(title XVIII only)						
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	er 31 of the c	ost reporting	period (See	C) 65
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVII	I only). For	0	66
	CAH (see instructions)	· · · · · · · · · · · · · · · · · · ·			<i>.</i>		
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	f the cost re	porting period	0	67
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	comber 31 of	the cost rend	orting period	C	68
. 00	(line 13 x line 20)		Celliber 31 01	the cost repo	n tring period		
. 00	Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	68)		0) 69
~~	PART III - SKILLED NURSING FACILITY, OTHER N					1	
. 00 . 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70
. 00	Program routine service cost (line 9 x line			-)			72
. 00	Medically necessary private room cost applic	,	(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine serv						74
. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, F	art II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital -related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minu						78
00	Aggregate charges to beneficiaries for exces	• •		· · ·			79
00	Total Program routine service costs for comp. Inpatient routine service cost per diem limi		SCIEMITATION	(IINe /8 mir	ius i i ne 79)		80
. 00	Inpatient routine service cost per drem frim						82
. 00	Reasonable inpatient routine service costs (83
. 00	Program inpatient ancillary services (see in						84
. 00	Utilization review - physician compensation	•					85
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS:		ougn 85)			L	86
. 00	Total observation bed days (see instructions					C	87
			1			0.00	
. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	1 00

Health Financial Systems CO	BALT REHAB HOSP	TAL LOUISVILL	E	In Lieu of Form CMS-2552-			
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2021	Worksheet D-1		
				To 12/31/2021	Date/Time Pre 5/19/2022 8:4	pared: 5 am	
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	451, 493	7, 728, 662	0. 05841	8 0	0	90.00	
91.00 Nursing Program cost	0	7, 728, 662	0. 00000	0 0	0	91.00	
92.00 Allied health cost	0	7, 728, 662	0. 00000	0 0	0	92.00	
93.00 All other Medical Education	0	7, 728, 662	0. 00000	0 0	0	93.00	

OBALT	REHAB	HOSPI TA	L	LOUI	S١	/I LLE		
			-					-

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-3046	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Pre 5/19/2022 8:4	pare
		Title XIX	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed day			9, 443	
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivato room dave	9, 443 0	
00	do not complete this line.	iys). Thiyou have only p	rivate room days,	0	
00	Semi-private room days (excluding swing-bed and observation b	ed days)		9, 443	4
00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decemb	er 31 of the cost	0	5
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m days) through Decembe	r 31 of the cost	0	7
00	reporting period	in days) through becembe	I SI OI LIE COST	0	'
00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	30	9
00	newborn days) (see instructions)			0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc	tions)	room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room davs) after	0	11
	December 31 of the cost reporting period (if calendar year, e				
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	12
~~	through December 31 of the cost reporting period	V I Z I I I I			1 4 9
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
00	Medically necessary private room days applicable to the Progr			0	14
. 00	Total nursery days (title V or XIX only)		aajoj	0	
. 00	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT		.		
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
. 00	reporting period			0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction))		7, 728, 662	21
. 00	Swing-bed cost applicable to SNF type services through Decemb		tina period (line	0	
	5 x line 17)		5 1 2 2 2		
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23
~~	x line 18)			0	
. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 (ine 19)	er 31 of the cost report	ing period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	0	25
	x line 20)	•	5 T X		
. 00	Total swing-bed cost (see instructions)				26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 728, 662	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and obsorvation bod c	hargos)	0	28
	Private room charges (excluding swing-bed charges)	and observation bed c	nar ges)	0	
. 00	Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	31
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)		-+!>	0.00	
00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		uti 0115)	0.00 0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	36
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	7, 728, 662	
	27 minus line 36)		、 ···	,	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			010 /5	1
. 00 . 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			818. 45 24, 554	
	Medically necessary private room cost applicable to the Progr	-		24, 554	
. 00					

MPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-3046	Period: From 01/01/2021	Worksheet D-1	
					To 12/31/2021	Date/Time Pre 5/19/2022 8:4	
	Cost Center Description	Total		e XIX Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription	Inpatient Cost				(col. 3 x col.	
		1.00	0.00	col . 2)	4.00	4)	
2. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.
. 00	Intensive Care Type Inpatient Hospital Units		0	0.0		0	42
. 00	INTENSIVE CARE UNIT	0	0	0.0	0 0	0	43
. 00	CORONARY CARE UNIT	0	0			-	
. 00 . 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0	0. (0. (0	
. 00	OTHER SPECIAL CARE (SPECIFY)	0	0	0.0	0		40
	Cost Center Description	· ·					
		-+ D 2 2	11 200)			1.00	10
. 00 . 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ns)		14, 286 38, 840	
. 00	PASS THROUGH COST ADJUSTMENTS			1137		30,040	4 T /
. 00	Pass through costs applicable to Program inp	atient routine s	ervices (from	Wkst. D, sum	of Parts I and	1, 434	50
00) Dass through costs applicable to Drogram inp	ationt ancillary	convious (fr	om Wkat D	um of Dorte II	E90	L E 1
. 00	Pass through costs applicable to Program inp. and IV)	attent and trary	Services (Tr	UNI WKSL. D, S	oum UI PAILS II	580	51
. 00	Total Program excludable cost (sum of lines					2, 014	
. 00	Total Program inpatient operating cost exclu		ated, non-phy	sician anesth	netist, and	36, 826	53
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
. 00	Program di scharges					0	54
. 00	Target amount per discharge					0.00	55
. 00	Target amount (line 54 x line 55)					0	
. 00 . 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
. 00							
market basket							59
. 00	Lesser of lines 53/54 or 55 from prior year				the emount by	0.00	
. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61
	amount (line 56), otherwise enter zero (see				the turget		
2.00	Relief payment (see instructions)					0	
. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see Instruc	tions)			0	63
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reporti	ng period (See	0	64
	instructions)(title XVIII only)						
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	r 31 of the c	ost reporting	period (See	0	65
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVII	l only). For	0	66
	CAH (see instructions)						
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	f the cost re	eporting period	0	67
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost rend	orting period	0	68
. 00	(line 13 x line 20)			the cost rope	and period		
. 00	Total title V or XIX swing-bed NF inpatient			,		0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70
. 00	Adjusted general inpatient routine service c						71
. 00	Program routine service cost (line 9 x line			,			72
. 00	Medically necessary private room cost applic			ne 35)			73
. 00 . 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient			orksheet B	Part II column		74
. 00	26, line 45)	Satine Selvice		UN NONCEL D, F	artir, corumn		/ '3
. 00	Per diem capital-related costs (line 75 ÷ li						76
. 00	Program capital -related costs (line 9 x line						77
. 00 . 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovider record	s)			78
. 00	Total Program routine service costs for comp	• •		· · · ·	nus line 79)		80
. 00	Inpatient routine service cost per diem limi	tati on			~		81
. 00	Inpatient routine service cost limitation (I						82
. 00 . 00	Reasonable inpatient routine service costs ()				83
. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		s)				84
. 00	Total Program inpatient operating costs (sum	•					86
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
	Listal shoomustion had doug (ass instructions)	1				0	87
7.00 8.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			0.00	

Health Financial Systems CO	BALT REHAB HOSP	I TAL LOUI SVI LL	E	In Lieu of Form CMS-2552-			
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2021	Worksheet D-1		
				To 12/31/2021	Date/Time Pre 5/19/2022 8:4	pared: 5 am	
		Titl	e XIX	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	451, 493	7, 728, 662	0. 05841	8 0	0	90.00	
91.00 Nursing Program cost	0	7, 728, 662	0.00000	0 0	0	91.00	
92.00 Allied health cost	0	7, 728, 662	0.00000	0 0	0	92.00	
93.00 All other Medical Education	0	7, 728, 662	0. 00000	0 0	0	93.00	

ATIENT ANCILLARY SERVICE COST APPORTIONMENT	ovider C	CN: 15-3046	Peri od: From 01/01/2021	Worksheet D-3	
			To 12/31/2021	Date/Time Pre 5/19/2022 8:4	
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program Charges	Program Costs (col. 1 x col.	
			ondriges	2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			ł
00 03000 ADULTS & PEDI ATRI CS			11, 698, 992		30.
00 03100 I NTENSI VE CARE UNI T			0		31.
00 03200 CORONARY CARE UNIT 00 03300 BURN INTENSIVE CARE UNIT			0		32
00 03400 SURGICAL INTENSIVE CARE UNIT			0		34
00 04000 SUBPROVIDER - IPF			0		40
00 04100 SUBPROVI DER - I RF			0		41
00 04300 NURSERY			0		43
ANCI LLARY SERVI CE COST CENTERS		1			
00 05000 OPERATING ROOM		0.0000	0 00	0	50
00 05100 RECOVERY ROOM		0. 00000	0 0	0	51
00 05200 DELIVERY ROOM & LABOR ROOM		0.00000	0 0	0	52
00 05300 ANESTHESI OLOGY		0.00000	0 0	0	53
00 05400 RADI OLOGY-DI AGNOSTI C		0. 81559	118, 949	97, 014	
00 05500 RADI OLOGY-THERAPEUTI C		0.00000		0	
00 05600 RADI 0I SOTOPE		0.00000		0	
00 05700 CT SCAN		0.00000		0	
00 05800 MRI		0.0000		0	
00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
00 06000 LABORATORY		0. 02287		7, 913	
01 06001 BLOOD LABORATORY		0.0000		0	
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.00000		0	
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	
00 06400 INTRAVENOUS THERAPY		0.00000		0	
00 06500 RESPIRATORY THERAPY		2. 57705		34, 770	
00 06600 PHYSI CAL THERAPY		0. 41315		1, 081, 618	
00 06700 OCCUPATI ONAL THERAPY		0. 20664		672, 024	
00 06800 SPEECH PATHOLOGY		0. 70325		256, 537	
00 06900 ELECTROCARDI OLOGY		0.00000		0	
00 07000 ELECTROENCEPHALOGRAPHY		0. 00000		0	70
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 57662	69, 078	108, 910	71
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000	0 0	0	72
00 07300 DRUGS CHARGED TO PATIENTS		0. 34365	1, 750, 272	601, 488	73
00 07400 RENAL DIALYSIS		0.00000		0	
00 07500 ASC (NON-DI STINCT PART)		0.00000		0	
00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON		0.0000	0 0	0	77
OUTPATIENT SERVICE COST CENTERS		0.0000		0	
00 08800 RURAL HEALTH CLINIC		0.00000		0	
00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 00 09000 CLI NI C		0.00000		0	
00 09100 EMERGENCY		0.00000			
00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.00000			
OTHER REI MBURSABLE COST CENTERS		0.00000	0	<u> </u>	1 12
00 09400 HOME PROGRAM DI ALYSI S		0.0000	0 0	0	94
00 09500 AMBULANCE SERVICES					95
00 09600 DURABLE MEDI CAL EQUI P-RENTED		0. 00000	0 0	0	
00 09700 DURABLE MEDICAL EQUI P-SOLD		0. 00000		0	
00 09850 OTHER REIMBURSABLE CC		0.00000		0	
0.00 Total (sum of lines 50 through 94 and 96 through 98)			8, 532, 414	2, 860, 274	
.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		0		201
Net charges (line 200 minus line 201)	-		8, 532, 414		202

	Financial Systems COBALT REHAB HOSPITA ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period:	u of Form CMS-2 Worksheet D-3	
INPAIL	ENT ANCILLARY SERVICE CUST APPORTIONMENT	Provider Co	JN: 15-3040	From 01/01/2021	worksneet D-3	
				To 12/31/2021	Date/Time Pre	
		Ti †I	e XIX	Hospi tal	5/19/2022 8: 4 PPS	ille c
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	03000 ADULTS & PEDI ATRI CS			47, 790		30. 00
31.00	03100 I NTENSI VE CARE UNI T			0		31.00
32.00	03200 CORONARY CARE UNI T			0		32.00
33.00	03300 BURN INTENSIVE CARE UNIT			0		33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T			0		34.00
40.00	04000 SUBPROVI DER – I PF			0		40.00
	04100 SUBPROVI DER – I RF			0		41.00
43.00	04300 NURSERY			0		43.00
F0 00	ANCI LLARY SERVICE COST CENTERS		0.0000	00 0	0	
	05000 OPERATING ROOM		0.0000		0	1
	05100 RECOVERY ROOM		0.0000		0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY		0.0000		0	
	05400 RADI OLOGY-DI AGNOSTI C		0. 0000 0. 8155		0	
	05500 RADI OLOGY-THERAPEUTI C		0.0000		0	•
	05600 RADI OLOGI - MILKAFLOTTIC		0.0000		0	
	05700 CT SCAN		0.0000		0	
	05800 MRI		0.0000		0	58.00
	05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
60.00	06000 LABORATORY		0. 0228		26	
	06001 BLOOD LABORATORY		0.0000		0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0	
	06300 BLOOD STORI NG, PROCESSI NG & TRANS.		0.0000		0	
	06400 INTRAVENOUS THERAPY		0.0000		0	64.00
	06500 RESPI RATORY THERAPY		2. 5770		0	
66.00	06600 PHYSI CAL THERAPY		0. 4131	59 14, 231	5, 880	66.0
67.00	06700 OCCUPATI ONAL THERAPY		0. 2066	49 17, 262	3, 567	67.0
68.00	06800 SPEECH PATHOLOGY		0. 7032	51 0	0	68.0
69.00	06900 ELECTROCARDI OLOGY		0.0000	00 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0.0000	00 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 5766	21 1, 260	1, 987	71.0
	07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	
	07300 DRUGS CHARGED TO PATIENTS		0. 3436		2, 826	
	07400 RENAL DI ALYSI S		0.0000		0	
	07500 ASC (NON-DI STINCT PART)		0.0000		0	
77.00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON		0.0000	00 0	0	77.00
00.00			0.0000	00	0	
	08800 RURAL HEALTH CLINIC		0.0000			
	08900 FEDERALLY_QUALI FI ED_HEALTH_CENTER 09000 CLI NI C		0.0000		0	89.00
	09100 EMERGENCY		0.0000			
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 0000 0. 0000		0	•
/2.00	OTHER REIMBURSABLE COST CENTERS		0.0000	001 0	0	72.00
94.00	09400 HOME PROGRAM DI ALYSI S		0.0000	00 0	0	94.00
	09500 AMBULANCE SERVICES		0.0000	0	0	95.00
96.00 96.00	09600 DURABLE MEDICAL EQUIP-RENTED		0.0000	00 0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD		0.0000		0	
	09850 OTHER REI MBURSABLE CC		0.0000		0	
200.00				42, 107	14, 286	
201.00		(line 61)		0		201.00
	Net charges (line 200 minus line 201)			-		

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3046	Peri od: From 01/01/2021 To 12/31/2021 Hospi tal	Worksheet E Part B Date/Time Pre 5/19/2022 8:4 PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)	uti ana)		0	
2.00 3.00	Medical and other services reimbursed under OPPS (see instruc OPPS payments	ctions)		0	
4.00	Outlier payment (see instructions)			0	
4.01	Outlier reconciliation amount (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instru	ictions)		0.000	1
6.00 7.00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0.00	
8.00	Transitional corridor payment (see instructions)			0.00	
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9.00
10.00	Organ acqui si ti ons			0	
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			0	11.00
	Reasonable charges				1
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for			0	1
	had such payment been made in accordance with 42 CFR §413.13(1 5	5		
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	1
18.00 19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds l	ing 11) (see	0	
19.00	instructions)	if y 11 11he 18 exceeds 1		0	19.00
20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds l	ine 18) (see	0	20.00
~ ~ ~	instructions)				
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			0	
22.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	1
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			-	
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lin	-	ructions)	0	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	-		0	1
	instructions)		[0]	_	
28.00	Direct graduate medical education payments (from Wkst. E-4, I	-		0	
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	1
31.00	Subtotal (sum of lines 27 through 29) Primary payer payments			0	
32.00	Subtotal (line 30 minus line 31)			0	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)				33.00
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	1
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	1
37.00	Subtotal (see instructions)			0	1
38.00	MSP-LCC reconciliation amount from PS&R			0	1
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction			0	39.00 39.50
39. 50 39. 97	Demonstration payment adjustment amount before sequestration			0	
39.98	Partial or full credits received from manufacturers for repla	nced devices (see instru	ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40.00	Subtotal (see instructions)			0	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	
40.02	Sequestration adjustment-PARHM pass-throughs			0	40.02
	Interim payments			0	1
41.01	Interim payments-PARHM				41.01
42.00 42.01	Tentative settlement (for contractors use only)			0	42.00
42.01	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			0	1
43.01	Balance due provider/program-PARHM (see instructions)				43.01
44.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	1
					1
90.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
90.00 91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money				92.00
93.00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			0	94.00

ANALY	NALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		-	Period: From 01/01/2021 Fo 12/31/2021	5/19/2022 8:4	pared:
			XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	тВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		12, 138, 30	5	0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			כ	0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER				0	
3.02 3.03					0	
3.03					0	
3.05					0	
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			C	0	
3.51				D	0	
3.52					0	
3.53 3.54					0	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	
	3. 50-3. 98)				-	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		12, 138, 30	5	0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider	II				
5.01	TENTATI VE TO PROVI DER			D	0	
5.02				D	0	
5.03					0	5.03
5.50	Provider to Program TENTATIVE TO PROGRAM				0	5.50
5.50	TENTATIVE TO PROGRAM				0	
5. 52				2	0	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			2	0	
5.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
5.01	SETTLEMENT TO PROVIDER		274, 63		0	
5.02	SETTLEMENT TO PROGRAM		12 412 04		0	
7.00	Total Medicare program liability (see instructions)		12, 412, 94	Contractor	NPR Date	7.00
		C)	Number 1.00	(Mo/Day/Yr) 2.00	
8.00	Name of Contractor)	1.00	2.00	8.00

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3046	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part III Date/Time Pre 5/19/2022 8:4	pare
		Title XVIII	Hospi tal	PPS	
				1.00	
1	PART III - MEDICARE PART A SERVICES - IRF PPS				
	Net Federal PPS Payment (see instructions)			12, 438, 301	1
	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0359	2
00	Inpatient Rehabilitation LIP Payments (see instructions))		258, 717	3
00	Outlier Payments			0	4
00	Unweighted intern and resident FTE count in the most red	cent cost reporting period e	nding on or prior	0.00	5
01	to November 15, 2004 (see instructions)		and the set of the set	0.00	-
01	Cap increases for the unweighted intern and resident FTE			0.00	5
	program or hospital closure, that would not be counted w		tment under 42		
00	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions))		0.00	4
00	New Teaching program adjustment. (see instructions)	Ec in the new program growth	pariad of a "now	0.00 0.00	6
00	Current year's unweighted FTE count of I&R excluding FTE	es fill the new program growth	period of a new	0.00	
00	teaching program" (see instructions) Current year's unweighted I&R FTE count for residents wi	ithin the new program growth	poriod of a "now	0.00	8
00	teaching program" (see instructions)		period of a new	0.00	
00	Intern and resident count for IRF PPS medical education	adjustment (see instructions)	0.00	Ģ
	Average Daily Census (see instructions))	25.871233	
	Teaching Adjustment Factor (see instructions)			0. 000000	
	Teaching Adjustment (see instructions)			0	12
	Total PPS Payment (see instructions)			12, 697, 018	
	Nursing and Allied Health Managed Care payments (see ins	struction)		0	14
	Organ acquisition (DO NOT USE THIS LINE)			0	15
	Cost of physicians' services in a teaching hospital (see	e instructions)		0	
	Subtotal (see instructions)			12, 697, 018	
	Primary payer payments			29, 214	
	Subtotal (line 17 less line 18).			12, 667, 804	
	Deducti bl es			194, 328	
	Subtotal (line 19 minus line 20)			12, 473, 476	
	Coi nsurance			77, 168	
	Subtotal (line 21 minus line 22)			12, 396, 308	
	Allowable bad debts (exclude bad debts for professional	services) (see instructions)		25, 590	
	Adjusted reimbursable bad debts (see instructions)			16, 634	
	Allowable bad debts for dual eligible beneficiaries (see	e instructions)		25, 590	
	Subtotal (sum of lines 23 and 25)			12, 412, 942	
	Direct graduate medical education payments (from Wkst. E	F-4 line 49)		0	28
	Other pass through costs (see instructions)	,,		0	29
	Outlier payments reconciliation			0	30
	OTHER ADJUSTMENTS			0	31
	Pioneer ACO demonstration payment adjustment (see instru	uctions)		0	3
	Recovery of accelerated depreciation.			0	3
	Demonstration payment adjustment amount before sequestra	ation		0	3
	Total amount payable to the provider (see instructions)			12, 412, 942	32
	Sequestration adjustment (see instructions)			0	32
	Demonstration payment adjustment amount after sequestrat	ti on		0	
	Interim payments			12, 138, 306	
	Tentative settlement (for contractor use only)			0	34
	Balance due provider/program (line 32 minus lines 32.01,	, 32.02, 33, and 34)		274, 636	
	Protested amounts (nonallowable cost report items) in ad		chapter 1,	0	
-	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount from Wkst. E-3, Pt. III, line 4			0	50
. 00	Outlier reconciliation adjustment amount (see instruction	ons)		0	51
. 00	The rate used to calculate the Time Value of Money			0.00	52
. 00	Time Value of Money (see instructions)			0	53
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 202	20 AND BEGINNING BEFORE THE E	ND OF THE COVID-19	PHE	

LCULA	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3046	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Pre	
			10 12/31/2021	5/19/2022 8:4	5 an
		Title XIX	Hospi tal	PPS	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	/ICES FOR TITLES V OR >	KIX SERVICES		4
	COMPUTATION OF NET COST OF COVERED SERVICES		-	-	l .
	Inpatient hospital/SNF/NF services		0		1
	Medical and other services		0	0	2
	Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)		0	0	
	Inpatient primary payer payments		0	0	5
	Outpatient primary payer payments		0	0	6
	Subtotal (line 4 less sum of lines 5 and 6)		0	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
[Reasonabl e Charges				
	Routine service charges		47, 790		8
	Ancillary service charges		42, 107	0	
	Organ acquisition charges, net of revenue		0		10
	Incentive from target amount computation		0		11
	Total reasonable charges (sum of lines 8 through 11)		89, 897	0	12
	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for	sorvicos on a chargo	0	0	13
	basis	services on a charge	0	0	13
	Amounts that would have been realized from patients liable for	payment for services of	on O	0	14
	a charge basis had such payment been made in accordance with 42		-	-	
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	15
. 00	Total customary charges (see instructions)		89, 897	0	16
	Excess of customary charges over reasonable cost (complete only	/ifline 16 exceeds	89, 897	0	17
	line 4) (see instructions)			_	
3. 00	Excess of reasonable cost over customary charges (complete only	/if line 4 exceeds lin	ne 0	0	18
. 00	16) (see instructions)		0	0	19
	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	
	Cost of covered services (enter the lesser of line 4 or line 16		0	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be o		-	0	2'
	Other than outlier payments		9, 997	0	22
	Outlier payments		0	0	
	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		25
. 00	Routine and Ancillary service other pass through costs		0	0	26
	Subtotal (sum of lines 22 through 26)		9, 997	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		9, 997	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	0	1 20
	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		9, 997	0	30
	Deductiblies		3, 337	0	32
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review		0	, U	35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	9, 997	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
. 00	Subtotal (line 36 ± line 37)		9, 997	0	38
	Direct graduate medical education payments (from Wkst. E-4)		0		39
	Total amount payable to the provider (sum of lines 38 and 39)		9, 997	0	40
	Interim payments		9, 997	0	41
	Balance due provider/program (line 40 minus line 41)		0	0	
. 00	Protested amounts (nonallowable cost report items) in accordance chapter 1, §115.2	ce with CMS Pub 15-2,	0	0	43

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DO Product DO Ott DO Dut DO Dut OO Land OO Acco OO To OO To OO Acco OO Acco OO Acco OO	repaid expenses ther current assets je from other funds otal current assets (sum of lines 1-10) XED ASSETS and and improvements ccumulated depreciation jildings ccumulated depreciation easehold improvements ccumulated depreciation xed equipment ccumulated depreciation jor movable equipment ccumulated depreciation ajor movable equipment ccumulated depreciation nor equipment depreciable ccumulated depreciation T designated Assets	-153, 179 0 1, 772, 624 0 0 0 0 0 232, 829 -14, 107 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			
DO Oth 00 Due 00 Due 00 Lan 00 Acc 00 Acc 00 Acc 00 Acc 00 Acc 00 Mai 00 Acc 00 Mai 00 Acc 00 Min 00 Acc 00 Min 00 Deg 00 Due 00 Due 00 To 00 To 00 To 00 To 00 No 00 No 00 No 00 No	ther current assets je from other funds otal current assets (sum of lines 1-10) XED ASSETS and and improvements ccumulated depreciation uildings ccumulated depreciation ccumulated depreciation xed equipment ccumulated depreciation utomobiles and trucks ccumulated depreciation aj or movable equipment ccumulated depreciation nor equipment depreciable ccumulated depreciation T designated Assets	1, 772, 624 1, 772, 624 0 0 0 0 0 232, 829 -14, 107 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			
00 Duc 00 Io 00 Lar 00 Acc 00 Bui 00 Acc 00 Bui 00 Acc 00 Acc 00 Acc 00 Acc 00 Acc 00 Acc 00 Mai 00 Acc 00 Mir 00 Acc 00 Mir 00 CIF 00 Irr 00 Deg 00 Irr 00 Deg 00 Irr 00 Deg 00 To 00 To 00 CUF 00 Acc 00 CUF 00 No 00 No 00 CUF 00 No	ue from other funds otal current assets (sum of lines 1-10) XED ASSETS and and improvements ccumul ated depreciation uildings ccumul ated depreciation assehold improvements ccumul ated depreciation xed equipment ccumul ated depreciation utomobiles and trucks ccumul ated depreciation aj or movable equipment ccumul ated depreciation nor equipment depreciable ccumul ated depreciation T designated Assets	232, 829 -14, 107 0 0 232, 829 -14, 107 0 0 0 27, 928 -7, 461 0 0 141, 019			
OO To: FLX 00 Lar 00 Lar 00 Lar 00 Acc 00 Building 00 Acc 00 Mir 00 Mir 00 Dir 00 Dir 00 Dir 00 To: 00 To: 00 To: 00 To: 00 CUF 00 No: 00 No: <	btal current assets (sum of lines 1-10) XED ASSETS and and improvements ccumul ated depreciation illdings ccumul ated depreciation easehold improvements ccumul ated depreciation xed equipment ccumul ated depreciation itomobiles and trucks ccumul ated depreciation ajor movable equipment ccumul ated depreciation nor equipment depreciable ccumul ated depreciation T designated Assets	232, 829 -14, 107 0 0 232, 829 -14, 107 0 0 0 27, 928 -7, 461 0 0 141, 019			
FLX 00 Lar 00 Lar 00 Acc 00 Bui 00 Acc 00 Min 00 Acc 00 Min 00 Acc 00 Min 00 To 00 To 00 Dua 00 Dua 00 To 00 CUF 00 No 00 No 00 No 00 Do 00 Do 00 <	XED ASSETS and and improvements ccumul ated depreciation uildings ccumul ated depreciation easehold improvements ccumul ated depreciation xed equipment ccumul ated depreciation utomobiles and trucks ccumul ated depreciation ajor movable equipment ccumul ated depreciation nor equipment depreciable ccumul ated depreciation nor equipment depreciable ccumul ated depreciation T designated Assets	232, 829 -14, 107 0 0 232, 829 -14, 107 0 0 0 27, 928 -7, 461 0 0 141, 019			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
00 Lar 00 Lar 00 Acc 00 Bui 00 Acc 00 Lar 00 Acc 00 Min 00 Acc 00 Min 00 To 00 CUF 00 No 00 CUF 00 Do 00 CUF 00 </td <td>and and improvements ccumul ated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation xed equipment ccumulated depreciation utomobiles and trucks ccumulated depreciation ajor movable equipment ccumulated depreciation nor equipment depreciable ccumulated depreciation T designated Assets</td> <td>0 0 232, 829 -14, 107 0 0 0 27, 928 -7, 461 0 0 141, 019</td> <td></td> <td></td> <td>0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td>	and and improvements ccumul ated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation xed equipment ccumulated depreciation utomobiles and trucks ccumulated depreciation ajor movable equipment ccumulated depreciation nor equipment depreciable ccumulated depreciation T designated Assets	0 0 232, 829 -14, 107 0 0 0 27, 928 -7, 461 0 0 141, 019			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
00 Lai 00 Acc 00 Bui 00 Acc 00 Min 00 Acc 00 Min 00 Acc 00 Min 00 Doi 00 CuF 00 Acc 00 Acc 00 Acc 00 Acc 00 Acc 00 Acc	and improvements ccumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation xed equipment ccumulated depreciation utomobiles and trucks ccumulated depreciation ajor movable equipment ccumulated depreciation nor equipment depreciable ccumulated depreciation T designated Assets	0 0 232, 829 -14, 107 0 0 0 27, 928 -7, 461 0 0 141, 019			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
00 Acc 00 Bui 00 Acc 00 Mai 00 Acc 00 Min 00 Acc 00 Min 00 Cor 00 Inn 00 Dug 00 Cor 00 Dug 00 To 00 To 00 To 00 Cor 00 Cor 00 Cor 00 Sal 00 Dor 00 Cor 00 Sal 00 Dor 00 Dor 00 Dor 00 Dor <tr< td=""><td>accumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation xed equipment ccumulated depreciation utomobiles and trucks ccumulated depreciation ajor movable equipment ccumulated depreciation nor equipment depreciable ccumulated depreciation T designated Assets</td><td>0 0 232, 829 -14, 107 0 0 0 27, 928 -7, 461 0 0 141, 019</td><td></td><td></td><td>0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td></tr<>	accumulated depreciation uildings ccumulated depreciation easehold improvements ccumulated depreciation xed equipment ccumulated depreciation utomobiles and trucks ccumulated depreciation ajor movable equipment ccumulated depreciation nor equipment depreciable ccumulated depreciation T designated Assets	0 0 232, 829 -14, 107 0 0 0 27, 928 -7, 461 0 0 141, 019			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
00 Bui 00 Acc 00 Mai 00 Acc 00 Mi 00 Cor 00 Mi 00 Dep 00 Du 00 Di 00 Do 00 Do 00 Do 00 Do 00 To 00 To 00 CUF 00 Acc 00 Acc 00 Cu 00 Acc 00 Acc 00 Acc 00 Acc 00 Do 00 Do	uildings ccumulated depreciation aasehold improvements ccumulated depreciation xed equipment ccumulated depreciation utomobiles and trucks ccumulated depreciation ajor movable equipment ccumulated depreciation nor equipment depreciable ccumulated depreciation T designated Assets	-14, 107 0 0 0 27, 928 -7, 461 0 141, 019			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
00 Acc 00 Lea 00 Acc 00 Min 00 Acc 00 Min 00 Doi 00 Doi 00 Doi 00 Doi 00 To: 00 CUF 00 No: 00 Pa: 00 No: 00 No: 00 Doi 00 No: 00 No:	ccumulated depreciation easehold improvements ccumulated depreciation xed equipment ccumulated depreciation utomobiles and trucks ccumulated depreciation ajor movable equipment ccumulated depreciation nor equipment depreciable ccumulated depreciation T designated Assets	-14, 107 0 0 0 27, 928 -7, 461 0 141, 019			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
00 Lea 00 Acc 00 Maj 00 Acc 00 Min 00 Acc 00 Min 00 Acc 00 Min 00 Do 00 Inv 00 Do 00 Do 00 Do 00 Do 00 Do 00 To 00 Do 00 To 00 To 00 To 00 CUF 00 Acc 00 Pa 00 No 00 Do 00 Do 00 Do <td< td=""><td>easehold improvements ccumulated depreciation xed equipment ccumulated depreciation utomobiles and trucks ccumulated depreciation ajor movable equipment ccumulated depreciation nor equipment depreciable ccumulated depreciation T designated Assets</td><td>-14, 107 0 0 0 27, 928 -7, 461 0 141, 019</td><td></td><td></td><td>0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td></td<>	easehold improvements ccumulated depreciation xed equipment ccumulated depreciation utomobiles and trucks ccumulated depreciation ajor movable equipment ccumulated depreciation nor equipment depreciable ccumulated depreciation T designated Assets	-14, 107 0 0 0 27, 928 -7, 461 0 141, 019			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
00 Fi :: 00 Acc 00 Dir 00 To: 00 CUF 00 No: 00 No: 00 No: 00 Do: 00 Do: 00 No: 00 Do: 00 Do: 00 Do: 00 Do:	xed equipment ccumulated depreciation utomobiles and trucks ccumulated depreciation ajor movable equipment ccumulated depreciation nor equipment depreciable ccumulated depreciation T designated Assets	0 0 0 27, 928 -7, 461 0 141, 019			0 0 0 0 0 0 0 0 0 0 0 0
00 Acc 00 Aur 00 Acc 00 Maj 00 Acc 00 Mai 00 Acc 00 Mai 00 Acc 00 Min 00 To 00 To 00 Du 00 Du 00 Du 00 To 00 To 00 CUF 00 Acc 00 To 00 To 00 Acc 00 Acc 00 Acc 00 Acc 00 Acc 00 No 00 Do 00 Do 00 Do 00 Do 00 Do 00 Acc 00 Acc <t< td=""><td>ccumulated depreciation utomobiles and trucks ccumulated depreciation ajor movable equipment ccumulated depreciation nor equipment depreciable ccumulated depreciation T designated Assets</td><td>-7, 461 C 0 141, 019</td><td></td><td>0 0 0 0 0 0 0</td><td>0 0 0 0 0 0 0 0 0 0 0</td></t<>	ccumulated depreciation utomobiles and trucks ccumulated depreciation ajor movable equipment ccumulated depreciation nor equipment depreciable ccumulated depreciation T designated Assets	-7, 461 C 0 141, 019		0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0
00 Aur 00 Acc 00 Maj 00 Acc 00 Min 00 Acc 00 Min 00 Acc 00 Hin 00 Constant 00 To 00 To 00 To 00 To 00 To 00 To 00 Acc 00 To 00 Cuff 00 Acc 00 To 00 Acc 00 Acc 00 Acc 00 Acc 00 Do 00 Acc 00 Acc	utomobiles and trucks ccumulated depreciation ajor movable equipment ccumulated depreciation nor equipment depreciable ccumulated depreciation T designated Assets	-7, 461 C 0 141, 019		0 0 0 0 0 0	0 0 0 0 0 0 0 0
00 Acc 00 Maj 00 Acc 00 Min 00 Acc 00 Min 00 Acc 00 Hin 00 Acc 00 Hin 00 Acc 00 Min 00 Don 00 Don 00 Don 00 Don 00 Don 00 Tor 00 Don 00 Don 00 Acc 00 Acc 00 Acc 00 Pa 00 Nor 00 Don 00 Don 00 Don 00 Don 00 Don 00 Acc	ccumulated depreciation ajor movable equipment ccumulated depreciation nor equipment depreciable ccumulated depreciation T designated Assets	-7, 461 C 0 141, 019		0 0 0 0	0 0 0 0 0 0
00 Maj 00 Acc 00 Mi 00 Acc 00 Acc 00 Hi 00 Acc 00 Acc 00 Acc 00 Acc 00 Acc 00 Mi 00 Do 00 Do 00 Do 00 Do 00 To 00 Acc 00 Pa 00 No 00 Do 00 Do 00 Do 00 Do 00 Do 00 Acc	ajor movable equipment ccumulated depreciation nor equipment depreciable ccumulated depreciation T designated Assets	-7, 461 C 0 141, 019	3 0 0 0 0 0 0 0	0 0 0 0	0 0 0 0 0
00 Acc 00 Min 00 Acc 00 Hi 00 Acc 00 Hi 00 Min 00 Acc 00 Min 00 To 00 To 00 Dir 00 Dir 00 Dir 00 Dir 00 To 00 To 00 To 00 To 00 To 00 To 00 Acc 00 Acc 00 No 00 Pa: 00 Do 00 Do 00 Do 00 Do 00 Do 00 Do 00 Acc	ccumul ated depreciation nor equipment depreciable ccumul ated depreciation T designated Assets	-7, 461 C 0 141, 019	0 0 0 0		0 0 0 0
00 Min 00 Acc 00 H 00 Acc 00 Min 00 To 00 To 00 Inv 00 Do 00 To 00 To 00 To 00 CUF 00 Acc 00 To 00 Acc 00 Acc 00 Acc 00 Acc 00 Acc 00 Acc 00 Do 00 Acc 00 Acc	nor equipment depreciable ccumulated depreciation T designated Assets	0 0 141, 019	0 0 0 0	0 0 0	0 0 0
00 Acc 00 HI 00 Acc 00 To 00 To 00 Inv 00 Dep 00 Du 00 Dep 00 Du 00 To 00 CUF 00 Acc 00 Acc 00 Acc 00 Acc 00 Acc 00 Dep 00 Acc 00 Dep 00 Acc	ccumulated depreciation T designated Assets		0	0	0
00 HI 00 Acc 00 Min 00 To 00 Inv 00 Dep 00 Dep 00 Dep 00 Oth 00 To 00 Dep 00 Oth 00 Acc 00 Acc 00 Acc 00 No 00 No 00 No 00 Dep 00 Acc 00 No 00 No 00 No 00 No 00 No 00 Acc	T designated Assets		~ ~ ~ ~ ~ ~	0	0
00 Acc 00 Min 00 To 01 To 00 Im 00 Deg 00 Dom 00 To 00 To 00 To 00 To 00 To 00 Acc 00 No 00 Pay 00 No 00 Deg 00 Acc 00 Do 00 Do 00 Acc 00 Acc			· 0		-
00 Min 00 To: 00 To: 00 Inv 00 Deg 00 Do: 00 00 00 To: 00 To: 00 To: 00 To: 00 Acc 00 No: 00 No: 00 Do: 00 No: 00 No: 00 No:		-20, 937		0	0
To 0TH 00	nor equipment-nondepreciable	4, 579		0	0
OTH 00 Im 00 Dep 00 Deq 00 Dud 00 To 00 To 00 To 00 CUF 00 Acc 00 Pay 00 No 00 Det 00 Acc 00 Acc	otal fixed assets (sum of lines 12-29)	355, 830		0	0
00 I m 00 Dep 00 Due 00 Due 00 To 00 To 00 CUF 00 Acc 00 No 00 Der 00 Der 00 Acc	THER ASSETS	000,000	<u> </u>		
00 Due 00 0tl 00 To 00 To 00 CUF 00 Acc 00 Sal 00 Pay 00 No 00 Def 00 Acc	nvestments	C	0 0	0	0
00 011 00 To: 00 To: 00 CUF 00 Acc 00 Sal 00 Pay 00 No: 00 Det 00 Acc	eposits on Leases	0	0 0	0	0
00 To: 00 To: 00 To: 00 Acc 00 Sal 00 Pay 00 No: 00 Det 00 Acc	ue from owners/officers	0	0 0	0	0
OO To: CUF CUF 00 Acc 00 Sal 00 Pay 00 No 00 Det 00 Acc	ther assets	19, 444, 283	3 0	0	0
CUF 00 Acc 00 Sal 00 Pay 00 No 00 Det	otal other assets (sum of lines 31-34)	19, 444, 283		0	0
00 Acc 00 Sal 00 Pay 00 No 00 Det 00 Acc	otal assets (sum of lines 11, 30, and 35)	21, 572, 737	0 0	0	0
00 Sal 00 Pay 00 No 00 Det 00 Acc	IRRENT LI ABI LI TI ES		-	-	
00 Pay 00 No 00 Det 00 Acc	ccounts payable	240, 064		0	0
00 No 00 De 00 Acc	al aries, wages, and fees payable	315, 950	0	0	0
00 Det	ayroll taxes payable			0	0
00 Ac	otes and Loans payable (short term)			0	0
	eferred income ccelerated payments			0	0
	ue to other funds	18, 528, 436	0	о	0
	ther current liabilities	1, 414, 678		0	0
	otal current liabilities (sum of lines 37 thru 44)	20, 499, 128		0	0
	NG TERM LIABILITIES	20, 177, 120	<u> </u>		
	ortgage payable	C	0 0	0	0
	otes payable	316, 319	0	0	0
	nsecured Loans	0	0	0	0
	ther long term liabilities	0	0 0	0	0
	otal long term liabilities (sum of lines 46 thru 49)	316, 319		0	0
	otal liabilities (sum of lines 45 and 50)	20, 815, 447	/ 0	0	0
	PITAL ACCOUNTS				
	eneral fund balance	757, 290			
	Decitic purpose tund		0	_	
	pecific purpose fund			0	
	onor created - endowment fund balance - restricted	1	1	0	
	onor created - endowment fund balance - restricted onor created - endowment fund balance - unrestricted		1	0	0
	onor created - endowment fund balance - restricted onor created - endowment fund balance - unrestricted overning body created - endowment fund balance				0
	onor created - endowment fund balance - restricted onor created - endowment fund balance - unrestricted overning body created - endowment fund balance ant fund balance - invested in plant				11
	phor created - endowment fund balance - restricted phor created - endowment fund balance - unrestricted poverning body created - endowment fund balance ant fund balance - invested in plant ant fund balance - reserve for plant improvement,				0
00 To	onor created - endowment fund balance - restricted onor created - endowment fund balance - unrestricted overning body created - endowment fund balance ant fund balance - invested in plant	757, 290		0	0

	Financial Systems COI ENT OF CHANGES IN FUND BALANCES	BALT REHAB HOSPI	Provi der CC		Peri od:	eu of Form CMS-2 Worksheet G-1	
					From 01/01/2021 To 12/31/2021		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5, 00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance		-2, 414, 724 3, 172, 014 757, 290 0 757, 290 0 757, 290				5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	00	0 0 0 0 0 0 0		0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0 0		18.0 19.0

Heal th	Financial Systems COBALT REHAB HOSPITA	L LOUI SVI LLE	E	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet G-2 Parts I & II Date/Time Pre 5/19/2022 8:4	pared:
	Cost Center Description	-	Inpati ent	Outpatient	Total	
	PART I – PATIENT REVENUES		1.00	2.00	3.00	
	General Inpatient Routine Services					
1.00	Hospi tal		14, 947, 1	19	14, 947, 119	1.00
2.00	SUBPROVIDER - IPF			0	0	2.00
3.00	SUBPROVIDER - IRF			0	0	3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00 8.00	SKILLED NURSING FACILITY NURSING FACILITY			0	0	7.00 8.00
9.00	OTHER LONG TERM CARE			0	0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		14, 947, 1	0	14, 947, 119	
101.00	Intensive Care Type Inpatient Hospital Services	I	, , ., .	. ,	, ,,,	10100
11.00	INTENSIVE CARE UNIT			0	0	11.00
12.00	CORONARY CARE UNIT			0	0	12.00
13.00	BURN INTENSIVE CARE UNIT			0	0	13.00
14.00	SURGI CAL INTENSI VE CARE UNI T			0	0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				_	15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines		0	0	16.00
17.00	11-15) Total inpatient routine care services (sum of lines 10 and 16)	\ \	14, 947, 1	10	14, 947, 119	17.00
18.00	Ancillary services	,	11, 153, 2		11, 153, 202	18.00
19.00	Outpati ent services		11, 155, 2	0 0	0	19.00
20.00	RURAL HEALTH CLINIC			0 0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY			0	0	22.00
23.00	AMBULANCE SERVICES			0 0	0	23.00
24.00	СМНС			0	0	24.00
24.10	CORF			0 0	0	24.10
25.00	AMBULATORY SURGI CAL CENTER (D. P.)			0 0	0	25.00
26.00 27.00	HOSPI CE OTHER (SPECI FY)			0 0	0	26.00 27.00
27.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	26, 100, 3	-	26, 100, 321	27.00
20.00	G-3, line 1)	to wkst.	20, 100, 5	21 0	20, 100, 321	20.00
	PART II - OPERATING EXPENSES	1				
29.00	Operating expenses (per Wkst. A, column 3, line 200)			11, 774, 398		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00 35.00				0		34.00 35.00
35.00	Total additions (sum of lines 30-35)			0		35.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42	2)(transfer		11, 774, 398		43.00
	to Wkst. G-3, line 4)					

Heal th	Financial Systems COBALT REHAB HOSPITA	AL LOUISVILLE	In Lie	u of Form CMS-2	2552-10	
STATEM	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-3046	Peri od: From 01/01/2021 To 12/31/2021	Worksheet G-3 Date/Time Prep 5/19/2022 8:45		
				1.00		
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	e 28)		26, 100, 321	1.00	
2.00	Less contractual allowances and discounts on patients' account			11, 152, 636	2.00	
3.00	Net patient revenues (line 1 minus line 2)			14, 947, 685	3.00	
4.00						
5.00						
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc			0	6.00	
7.00	Income from investments			0	7.00	
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8.00	
9.00	Revenue from television and radio service			0	9.00	
10.00	Purchase di scounts			0	10.00	
11.00	Rebates and refunds of expenses			0	11.00	
12.00	Parking lot receipts			0	12.00	
13.00	Revenue from Laundry and Linen service			0	13.00	
14.00	Revenue from meals sold to employees and guests			0	14.00	
15.00	Revenue from rental of living quarters			0	15.00	
16.00	Revenue from sale of medical and surgical supplies to other the	han patients		0	16.00	
17.00	Revenue from sale of drugs to other than patients			0	17.00	
18.00	Revenue from sale of medical records and abstracts			0	18.00	
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00	
21.00	Rental of vending machines			0	21.00	
22.00	Rental of hospital space			0	22.00	
23.00	Governmental appropriations			0	23.00	
24.00	OTHER REVENUE			-1, 273	24.00	
24.50	COVI D-19 PHE Fundi ng			0	24.50	
25.00	Total other income (sum of lines 6-24)			-1, 273	25.00	
	Total (line 5 plus line 25)			3, 172, 014	26.00	
	OTHER EXPENSES (SPECIFY)			0	27.00	
	Total other expenses (sum of line 27 and subscripts)			0	28.00	
29.00	Net income (or loss) for the period (line 26 minus line 28)			3, 172, 014	29.00	