Health Financial Systems	REHABILITATION HOSPIT	AL OF FT WAYNE	In Lieu	u of Form CMS-2552-10
This report is required by law (42 USC 1395g;				
payments made since the beginning of the cost	reporting period being	deemed overpayments (4	2 USC 1395g).	OMB NO. 0938-0050
				EXPI RES 03-31-2022
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COS	T REPORT CERTIFICATION	Provider CCN: 15-3030	Period: From 10/01/2020	Worksheet S Parts -
AND SETTLEMENT SUMMARY			To 09/30/2021	Date/Time Prepared:
				2/28/2022 4:29 pm
PART I - COST REPORT STATUS				
Provider 1. [X] Electronically prepared			Date: 2/28/20	22 Time: 4:29 pm
use only 2. [] Manually prepared cost				
3.[0]If this is an amended r 4.[F]Medicare Utilization.E	eport enter the number inter "F" for full or "L	of times the provider r "for low.	resubmitted this co	ost report
	Date Received:		NPR Date:	-
use only (1) As Submitted 7.	Contractor No.	11.	Contractor's Vendo	or Code: 4
(2) Settled without Audit 8.	[N] Initial Report for	or this Provider CCN 12.		
(3) Settled with Addit	[N] FINAL REPORT FOR	this provider con	number of tim	es reopened = 0-9.
(4) Reopened				
(5) Amended				
PART II - CERTIFICATION BY A CHIEF FINANCIAL	OFFICER OR ADMINISTRATO	R OR PROVIDER(S)		
MISREPRESENTATION OR FALSIFICATION OF ANY INF	ORMATION CONTAINED IN T	HIS COST REPORT MAY BE	PUNISHABLE BY CRIN	IINAL, CIVIL AND
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONME				
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRE		KICKBACK OR WERE OTHER	WISE ILLEGAL, CRIN	IINAL, CIVIL AND
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONM	ENI MAY RESULI.			
CERTIFICATION BY CHIEF FINANCIAL OFFI	CER OR ADMINISTRATOR OF	PROVI DER(S)		
I HEREBY CERTIFY that I have read the	above certification st	atement and that I have	e examined the acco	ompanyi ng
electronically filed or manually subm	itted cost report and s	submitted cost report ar	nd the Balance Shee	et and
Statement of Revenue and Expenses pre				
reporting period beginning 10/01/2020				
report and statement are true, correc				
accordance with applicable instructio regulations regarding the provision o				
report were provided in compliance wi			ruentined in this	SCUSE
report were provided in compitance wi	th such raws and regula			

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C SI GNATURE STATEMENT	
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

			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	219, 134	-892	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	219, 134	-892	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.

	TAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provi d	er CCN:		Period:		Workshe	eet S-2	2
						rom 10/01/2 o 09/30/2	2021	Part I Date/Ti		
	1.00	2.00		3.00		4	. 00	2/28/20)22 4:2	9 pm
	Hospital and Hospital Health Care Co			3.00		4	. 00			
00	Street: 7970 WEST JEFFERSON BOULEVARD									1.
00	City: FORT WAYNE	State: IN	Zip Code	e: 46804	4- County	: ALLEN				2.
		Component Name	CCN	CBSA				nt Syst		
			Number	Numbe	r Type	Certified		0, or		-
		1.00	2.00	3.00	4.00	5.00	V 6.00	XVIII 7.00		-
	Hospital and Hospital-Based Componen		2.00	3.00	4.00	5.00	0.00	7.00	0.00	
00	Hospi tal	REHABILITATION HOSPITAL OF FT WAYNE	153030	23060) 5	11/01/1993	Ν	Р	Р	3.
0	Subprovider - IPF	OF FI WATNE								4
0	Subprovider - IRF									5
0	Subprovider - (Other)									6
0	Swing Beds - SNF									7
0	Swing Beds - NF									8
0	Hospital-Based SNF									9
00										10
00 00										11
00										12
00										13
00										15
00									1	16
00	Hospital-Based (CMHC) I									17
00	5									18
00	Other									19
						From: 1.00		To 2. (-
00	Cost Reporting Period (mm/dd/yyyy)					10/01/20	20	09/30		20
00	Type of Control (see instructions)					4				21
				-	1.00	2.00		3. (00	1
	Inpatient PPS Information									
00	Does this facility qualify and is it	3 01 3			N	N				22
	disproportionate share hospital adjus §412.106? In column 1, enter "Y" for									
	facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" for									
01	Did this hospital receive interim un	compensated care payment	s for thi	s	Ν	N				22
	cost reporting period? Enter in colu									
	the portion of the cost reporting per	51								
	Enter in column 2, "Y" for yes or "N"			ost						
02	reporting period occurring on or after Is this a newly merged hospital that				Ν	N				22
02	payments to be determined at cost re				IN	IN IN				22
	Enter in column 1, "Y" for yes or "N									
	cost reporting period prior to Octob			yes						
	or "N" for no, for the portion of the	e cost reporting period	on or aft	er						
	October 1.									_
113	Did this hospital receive a geographic				N	N		N	l	22
05	adopted by CMS in FY2015? Enter in co									
05	for the portion of the cost reporting									
05	in column 2, "Y" for yes or "N" for			.						
05										
05	reporting period occurring on or after		0 hode (a							
00	Does this hospital contain at least	100 but not more than 49		r I						
00	Does this hospital contain at least counted in accordance with 42 CFR 41	100 but not more than 49		.		1		N	I	22
	Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	100 but not more than 49 2.105)? Enter in column	3, "Y" fo		N	N		IN		22
	Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph	100 but not more than 49 2.105)? Enter in column ic reclassification from	3, "Y" fo n urban to		Ν	N				
	Does this hospital contain at least counted in accordance with 42 CFR 412 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB	100 but not more than 49 2.105)? Enter in column ic reclassification from delineations for statis	3, "Y" fo n urban to stical are	as	Ν	N				
	Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph	100 but not more than 49 2.105)? Enter in column ic reclassification from delineations for statis column 1, "Y" for yes or	3, "Y" fo n urban to stical are "N" for	as no	Ν	N				
	Does this hospital contain at least counted in accordance with 42 CFR 41: yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in a for the portion of the cost reporting in column 2, "Y" for yes or "N" for	100 but not more than 49 2.105)? Enter in column ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th	3, "Y" fo n urban to stical are "N" for er 1. Ente ne cost	as no	Ν	N				
	Does this hospital contain at least counted in accordance with 42 CFR 41: yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in o for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or after	100 but not more than 49 2.105)? Enter in column delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr	3, "Y" fo n urban to stical are "N" for er 1. Ente ne cost ructions)	as no r	Ν	N				
	Does this hospital contain at least counted in accordance with 42 CFR 41: yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in of for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afte Does this hospital contain at least	100 but not more than 49 2.105)? Enter in column delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49	3, "Y" fo n urban to stical are "N" for er 1. Ente ne cost ructions) 29 beds (a	no rr s	Ν	N				
	Does this hospital contain at least counted in accordance with 42 CFR 41: yes or "N" for no. Did this hospital receive a geographi rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in a for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afte Does this hospital contain at least counted in accordance with 42 CFR 41:	100 but not more than 49 2.105)? Enter in column delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49	3, "Y" fo n urban to stical are "N" for er 1. Ente ne cost ructions) 29 beds (a	no rr s	Ν	N				
04	Does this hospital contain at least counted in accordance with 42 CFR 41: yes or "N" for no. Did this hospital receive a geographi rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in of for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afte Does this hospital contain at least counted in accordance with 42 CFR 41: yes or "N" for no.	100 but not more than 49 2.105)? Enter in column delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column	3, "Y" fo n urban to stical are "N" for er 1. Ente ne cost uctions) 9 beds (a n 3, "Y" f	as no r s for						11
04	Does this hospital contain at least counted in accordance with 42 CFR 41: yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41: yes or "N" for no. Which method is used to determine Met	100 but not more than 49 2.105)? Enter in column delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24	3, "Y" fo trical are "N" for r 1. Ente troctions) 99 beds (a a 3, "Y" f and/or 25	as no r s for		3 N				23
04	Does this hospital contain at least counted in accordance with 42 CFR 41: yes or "N" for no. Did this hospital receive a geographi rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in a for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afte Does this hospital contain at least counted in accordance with 42 CFR 41: yes or "N" for no. Which method is used to determine Mer below? In column 1, enter 1 if date of	100 but not more than 49 2.105)? Enter in column ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if censu	3, "Y" fo ourban to stical are c"N" for r 1. Ente ne cost ructions) 9 beds (a o 3, "Y" f and/or 25 is days, o	as no r s for or 3						23.
04	Does this hospital contain at least counted in accordance with 42 CFR 41: yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41: yes or "N" for no. Which method is used to determine Met	100 but not more than 49 2.105)? Enter in column ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if censu of identifying the days	3, "Y" fo nurban to stical are "N" for fr 1. Ente le cost ructions) 9 beds (a n 3, "Y" f and/or 25 is days, o in this c	as no r s for or 3						23

From 10021/2020 Pert II.	Health Financial Systems REHABILITATI					In Lieu	ı of For		
In-State In-State In-State In-State Dut-of state Out-of state Out-of model Out-of model Out-of state Out-of model Out-of state Out-of model Out-of model <th< td=""><td>HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA</td><td>TA II</td><td>Provider CC</td><td>CN: 15-3030</td><td>From 10/C</td><td></td><td>Part I Date/Ti</td><td>me Pre</td><td>pared:</td></th<>	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA II	Provider CC	CN: 15-3030	From 10/C		Part I Date/Ti	me Pre	pared:
4:00 [Firstisp provider is an IPSE hospital, enter the in-state Medical and all gible uppaid days in colum 2, in-state Medical and all gible uppaid days in colum 2, in-state Medical and all gible uppaid days in colum 2, in-state Medical and all gible uppaid days in colum 4, in-state Medical and all gible uppaid days in colum 6, in-state Medical and all gible uppaid days in colum 6, in-state Medical and days in colum 7, in-state Medical and days in colum 6, in-state Medical and days in colum 7, in-state Medical days in-state M		Medicaid paid days	Medi cai d el i gi bl e unpai d days	State Medicaid paid days	State Medi cai d el i gi bl e unpai d	HMO da	id 0° ys Mec c	ther li cai d lays	
In extrate Medicaid paid days in column 2, could by in column 2, could of a light expand days in column 3, could of a light expand days in column 3, could by in column 3, could by in column 4, medicaid paid days in column 4, could by in column 4, medicaid paid days in column 4, medicaid by in column 2, medicaid by in column 4, medicaid by in column 2, medicaid by in column 4, medicaid by in column 2, medicaid by in column 4, medicaid by in column 2, medicaid by in column 4, medicaid by in column 2, medicaid by in column 4, medicaid by in column 2, medicaid by in column 4, medicaid by in column 2, medicaid by in column 4, medicaid by in column 2, medicaid by in column 4, medicaid by in column 2, medicaid by in column 4, medicaid by in column 2, medicaid by in column 4, medicaid by in column 2, medicaid by in column 2, medicaid by in column 4, medicaid by in column 2, medicaid by in column 4, medicaid by in column 2, medicaid by in column 4, medicaid by	24.00 If this provider is an LPPS bospital enter the					5.00			24 00
Urban/Reral S bate of Ceogr 6:00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. T applicable. 1.00 2.00 7:00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter "1" for urban or "2" for rural. T applicable. 1.00 2.00 7:00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter "1" for urban or "2" for rural. T applicable. 1.00 2.00 15:00 If this is a sole community hospital (SCN), enter the number of periods SCH status in the cost in excess of one and enter subsequent dates. 0 35.00 6:00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods MDH status. 0 37.00 1:01 s this hospital a former MDH that is eligible for the MDH transitional payment in accordance with HY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 1.00 2.00 38.00 19:00 Does this facility qualify for the inpatient hospital payment adjustment for low volum N N N 39.00 1:00 2.00 1.00 2.00 1.00 2.00 10:00 Does this facility qualify for the inpati	 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid 					2,			25. 00
66.00 Enter 'your standard geographic classification (not wapp) status at the beginning of the cost reporting period. Enter "1' for urban or "2" for rural. If applicable, enter the effective date of the geographic classification in column 2. 1 26.00 7.00 Enter your standard geographic classification (not wapp) status at the end of the cost reporting period. Enter "1' for urban or "2" for rural. If applicable, enter the effective date of the geographic classification in column 2. 1 27.00 8.00 If this is a sole comminity hospital (SCI), enter the number of periods SCI status in of the cost reporting period. 10.00 2.00 36.00 16.00 If this is a bedicare dependent hospital (QUB), enter the number of periods MDH status is in effect in the cost reporting period. 1.00 2.00 36.00 17.01 It this hospital a former MDH that is eligible for the MDH transitional payment in accordance with P 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 37.00 38.00 10.00 Dest this facility qualify for the inpatient hospital payment adjustment for low volume N N N 39.00 10.00 Is in effect in the Core of the facility meet the mileage requirements in accordance with P 2016 (22)(1), (1), or (11)? Enter in column 2. "Y for yes or "N" for no. (see instructions) N N 40.00 10.00 Dest this facility eligible for effect in thecout dage requirements in accordance with P 2016 (22)(1									
cost réporting period. Énter 11° for urban or 22° for rural. 27.00 Co Enter your standard geographic calosification (ont wage) status at the end of the cost reporting period. Enter in colum 1, "1" for urban or 22° for rural. If applicable, enter the effective date of the geographic calosification in colum 2. 1 27.00 6:00 Enter applicable beginning and ending dates of SCH status. Subscript Line 36 for number of periods in excess of one and enter subsequent dates. 0 36.00 7:00 If this is a sole community hospital (GM), enter the number of periods NDH status 0 36.00 7:00 If this is a Medicare dependent hospital (MDH), enter the number of periods NDH status 0 37.00 7:01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with PY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 8:00 Breater applicable expendent hospital (MDH) (2)(1), (11), or (111)? Enter in column 2. "Y" for yes or "N" for no. (see instructions) N N 40.00 9:00 Does this facility qualify for the inpatient hospital payment for low volume hospital subject to the tAL2 CFR \$412.101(b)(2)(1), (11), or (111)? Enter in column 2. "Y" for yes or "N" for no. (see instructions) N N 40.00 0:00 Does this facility qualify for the inpatient hospital payment and pusters in a coordance with 42 CFR \$412.101(b)(2)(1), (11), or (111)? Enter in column 2. "Y" for	26.00 Enter your standard geographic classification (not wa	age) status	at the bec	ainnina of t		00 1	2. (00	26.00
effect in the cost reporting period. Beginning. Ending. 6:00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 1.00 2.00 7:01 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 7:01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with PY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 8:00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. 7/N 7/N 9:00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospital (MDI) (2) (2) (1) (1), or (11)? Enter in column 1 N N 39.00 19:00 Does this facility qualify and receive CR 412.010(b) (2) (2) (1), or (11)? Enter in column 2 "V" for yes or "N" for no. (see instructions) N N N 40.00 10:01 S of is facility qualify and receive Capital payment the mileage requirements in accordance with 42 CFR 412.010(b) (2) (2) (1) (1) or (11)? Enter in column 2 "V" for yes or "N" for no. (see instructions) V VVIII XIX 10:01 S of is facility qualify and receive Capital payment for disproportionate share in accordance N N N N N 10:00 Is of is facility qualify and re	 cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi 	r rural. age) status r "2" for r cation in	at the enc ural. If ap column 2.	d of the cos oplicable,	st	1			27.00
Beginning: Ending: 1.00 66.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36.00 77.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period. 37.00 77.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance wit hF 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 80 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N Y/N 97.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance wit h42 CFR \$412.101(b)(2)(1), (ii), or (ii)? Enter in column 2 'Y" for yes or "N" for no. (see instructions) N N N 40.00 90.00 Does this facility qualify and receive Capital accordance wit h42 CFR \$412.101(b)(2)(1), (ii), or (ii)? Enter in column 2 'Y" for yes or "N" for no in column 1, for discharges on or after Dotber 1. Enter "Y" for yes or "N" for no in colum 2, or discharges on or after Dotber 1. Enter "Y" for yes or "N" for no in columa 2, for discharges on or after Dotber 1. Enter "Y" for yes or "N" for no in columa 2, for discharges on or after Dotber 1. Enter "Y" for yes or "N" for no in columa 2, for discharges on or after Dotber 1. Enter "Y" for yes or "N" for no in		e number of	periods SC	CH status ir	1	0			35.00
60.00 Enter applicable beginning and ending dates of SCH status. Subscript Line 36 for number of periods in excess of one and enter subsequent dates. 36.00 71.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period. 37.00 71.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FV 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 81.00 If fina 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. V/N V/N 38.00 91.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume nogaticatione with 42 CFR 412.101(b)(2)(1), (1), (1), or (11)? Enter in column 1, '7' for yes or "N" for no. (see instructions) N N 40.00 91.00 Does this facility and receive capital adjustment? Enter "Y" for yes or "N" for no. (see instructions) N N 40.00 91.00 Does this facility and receive capital adjustment? Enter "Y" for yes or "N" for no. N N 40.00 91.00 Bits in accordance with 42 CFR 412.201(b)(2)(1), (1), or (11)? Enter in column 2, for discharges prior to October 1. Enter "Y" for yes or "N" for no. N N 40.00 91.00 Bits his facility d									
17.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period. 37.00 17.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FV 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions). 38.00 18.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 19.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b) (2) (i) (i) (i) (ii) (r) or (ii)? Enter in column 1 accordance with 42 CFR 412.101(b) (2) (i), (ii)? Enter in column 2 Y" for yes or "N" for no. (see instructions) N N 40.00 19.00 Does this facility qualify and receive Capital equivalent? Enter "Y" for yes or "N" for no. (see instructions) N N 40.00 10.00 Is this shospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no. N N N 45.00 15.00 Dest this facility qualify and receive Capital Degment exception for extraordinary circumstances N N N N 45.00 16.00 Is the Spital a involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. N N	36.00 Enter applicable beginning and ending dates of SCH st	tatus. Subs	cript line	36 for numb		00	2.0	0	36.00
7.01 Is this hospital a former M0H that is eligible for the M0H transitional payment in accordance with FY 2016 QPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 33.01 88.00 If fine 37 is 1, enter the beginning and ending dates of M0H status. If fine 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 38.00 99.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume N N N 39.00 10.00 1.00 2.00 N For yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR \$412.101(b)(2)(1), (ii), or (iii)? Enter in column 1. "Y" for yes or "N" for no in column 1, for discharges on or after 0ctober 1. Enter "Y" for yes or "N" for no in column 1, for discharges on or after 0ctober 1. (see instructions) N N 40.00 15.00 Does this facility qualify and receive Capital 1.00 2.00 3.00 15.00 Is facility qualify and receive Capital payment for disproportionate share in accordance N if facility tigible for additional payment?" for yes or "N" for no. N N N 45.00 10.02 15 this facility tigible for additional payment?" for yes or "N" for for. N N N 44.00 15.00 Does this facility editify and receive Capital payment?" for yes or "N" for no	37.00 If this is a Medicare dependent hospital (MDH), enter		r of period	ds MDH statu	IS	0			37.00
88.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is grater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. 38.00 97.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume N N N 39.00 97.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume N N N 39.00 97.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume N N N 40.00 97.01 Does this facility dualify for the hapting payment adjustment? Enter "Y" for yes or "N" for no. (see instructions) N N 40.00 97.01 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR \$412.0300 (become the compared to the the compared to th	37.01 Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo								37.01
Image: 1.00 2.00 19.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(1), (11), or (111)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(1), (11), or (111)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) N N 39.00 10.00 1.42 CFR 412.101(b)(2)(1), (11), or (111)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) N N 40.00 10.00 1.00 2.00 N N 40.00 10.00 1.00 2.00 N N 40.00 10.00 2.00 3.00 N N N 40.00 10.00 2.00 3.00 N N N N 45.00 10.00 2.01 1.00 2.00 3.00 N N N N 45.00 10.00 1.01 1.02 1.02 1.02 2.00 3.00 N N N N 45.00 15.00 Does this facility qualify and receive Capital payment for	38.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of								38.00
hospitals in accordance with 42 CFR §412.101(b)(2)(1), (ii), or (iii)? Enter in column 1 *Y" for yes or *N for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(1), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) N 40.00 00.00 01 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to 0ctober 1. Enter "Y" for yes or "N" for no in column 1, for discharges prior to 0ctober 1. Enter "Y" for yes or "N" for no in column 1, for discharges prior to 0ctober 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after 0ctober 1. (see instructions) V XVIII XIX 10.00 2.00 3.00 Prospective Payment System (PPS)-Capital V XVIII XIX 15.00 Does this facility eligible for additional payment exception for extraordinary circumstances N N N 45.00 N N N N N 46.00 Does this facility eligible for additional payment? Enter "Y" for yes or "N" for no. N N N 45.00 N N N N N N 45.00 N N N N N									-
10.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to 0ctober 1. Enter "Y" for yes or "N" for no in column 2, for discharges prior to 0ctober 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after 0ctober 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after 0ctober 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after 0ctober 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after 0ctober 1. Enter "Y" for yes or "N" for no in column 2, for discharges prior to 0ctober 1. Enter "Y" for yes or "N" for no. N N 40.00 Prospective Payment System (PPS)-Capital I.00 2.00 3.00 0 State 1111 (111) XIX 10.00 Is this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Sql12.320? (see instructions) N N N 45.00 16.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR Sql12.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 46.00 17.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N 48.00 16.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N 48.00 17.00 Is this a hospital involved in training residents in	39. 00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412. 101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412. 101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes N N							39.00	
V XVIII XIX 1.00 2.00 3.00 15.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions) N N N 45.00 16.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. N N N 46.00 17.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 48.00 16.00 Is this a new hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. N N N 48.00 16.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. N N N 48.00 16.00 Is this a new hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. N N N 48.00 17.00 Is this a noclumn 1. For column 2. if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no. N N 56.00 "N" for no in column	40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	per 1. Ente	r"Y" for y				Ν		40.00
Prospective Payment System (PPS)-Capital 15.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N 45.00 15.00 Dest this facility qualify and receive Capital payment for disproportionate share in accordance N N N 45.00 16.00 Is this facility eligible for additional payment exception for extraordinary circumstances N N N 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through N N N 46.00 18.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 48.00 18.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N 48.00 18.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or N N N N 48.00 18.00 Is this a nor column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs? Enter "Y" for yes or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? N S6.00 16.11 If line 56 is ye					·				-
with 42 CFR Section §412.320? (see instructions) N N N N A6.00 15 this facility eligible for additional payment exception for extraordinary circumstances N N N A6.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through N N N 46.00 Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 18.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N 48.00 18.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. 57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", complete Worksheet E-4. If column 2 is "Y", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 57.00 88.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as N 58.00				. ·					45.05
Pt. III.17.00Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.NNN47.0018.00Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.NNN48.0018.00Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.56.0057.0016If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2.57.0068.00If line 56 is yes, did this facility elect cost reimbursement for physicians' services asN58.0088.00If line 56 is yes, did this facility elect cost reimbursement for physicians' services asN58.00	with 42 CFR Section §412.320? (see instructions)								45.00
18.00 1s the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N N N 48.00 Teaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. 56.00 57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. N 58.00 88.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as N N 58.00	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	t. L, Pt. I	II and Wkst	t. L-1, Pt.	l through				
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. 56.00 57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. N 58.00 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. N 58.00	48.00 Is the facility electing full federal capital payment								47.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" 57.00 for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 if line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. N	56.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pr year, and are you are impacted by CR 11642 (or applic	e to column rograms in cable CRs)	1 is "Y", the prior y	or if this /ear or penu	hospital Iltimate	~ N			56.00
38.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. N 58.00	57.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N	period duri yes or "N th of this Y", complet	" for no ir cost report e Worksheet	n column 1. ting period?	lf column P Enter "Y				57.00
	58.00 If line 56 is yes, did this facility elect cost reim	oursement f	or physicia	ans' service	es as	N			58.00
	59.00 Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.		N			59.00

ealth Financial Systems REHABILITAT OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D		PITAL OF FT WAY Provider C	CN: 15-3030 F	Period: From 10/01/2020	u of Form CMS-2 Worksheet S-2 Part I	
				o 09/30/2021	Date/Time Pre 2/28/2022 4:2	
			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 co is "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in col	.85? (s Lumn 1. CR) NAHE	see If column 1	N			60. C
	Y/N	IME	Direct GME	IME	Direct GME	
1.00 Did your hospital receive FTE slots under ACA	1.00 N	2.00	3. 00	4.00	5.00 0.00	61.0
section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)						
1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61.0
instructions) 1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61.0
 ACA). (see instructions) 1.03 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 						61. C
instructions) 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61. 0
current cost reporting period. (see instructions). 1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61. (
 61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 						61. (
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61. *
 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. 1.20 Of the FTEs in line 61.05, specify each expanded 				0.00		61.2
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.						
					1.00	
ACA Provisions Affecting the Health Resources and Se 2.00 Enter the number of FTE residents that your hospital				iod for which	0.00	62. (
your hospital received HRSA PCRE funding (see instru 2.01 Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pro	ctions) a Teachi gram. (s	ng Health Cen see instructio	ter (THC) into		0.00	62. (
Teaching Hospitals that Claim Residents in Nonprovid 3.00 Has your facility trained residents in nonprovider s "Y" for yes or "N" for no in column 1. If yes, compl	ettings	during this c			N	63. (
		<u>v</u>	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 N	lonprovi d	der Settings	1.00 This base year	2.00 is your cost r	3.00 reporting	
<u>period that begins on or after July 1, 2009 and befor</u> E.00 Enter in column 1, if line 63 is yes, or your facili in the base year period, the number of unweighted no resident FTEs attributable to rotations occurring in	r <u>e June</u> ty trair n-primar all nor	30, 2010. ned residents ry care nprovider	0.0	_		64.
settings. Enter in column 2 the number of unweighte resident FTEs that trained in your hospital. Enter i of (column 1 divided by (column 1 + column 2)). (see	d non-pr n columr	n 3 the ratio				

	_EX IDENTIFICATION DA	ATA Provi der		eriod: om 10/01/2020	Worksheet S-2 Part I	
			To			epared:
	Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	Si te	4.00	E 00	_
.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	0 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 Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Settir	ngsEffective fo	r cost reporti	ng periods	
FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima al. Enter in column :	ry care resident 3 the ratio of	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	Ο. ΟΟ	0. 000000	5 67.0
				1.0	0 2.00 3.00	_
Inpatient Psychiatric Facility P			1.1			
.00 Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no		IPF), or does it con	itain an IPF subp	rovider? N		70.0
.00 If line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF	efore November 15, 2 lumn 2: Did this fac R 412.424 (d)(1)(iii	004? Enter "Y" for ility train resident)(D)? Enter "Y" for	yes or "N" for n s in a new teach yes or "N" for n	o. (see i ng o.	0	71. (
Column 3: If column 2 is Y, indi (see instructions)						H
	habilitation Facilit [,]	y (IRF), or does it	contain an IRF	Y		75.0

Health Financial Systems REHABILITATION HOS HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		YNE CN: 15-3030	In Lie Period: From 10/01/2020 To 09/30/2021	Date/Time Pre	2 epared:		
				2/28/2022 4:2	<u>29 pm</u>		
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for ye 81.00 Is this a LTCH co-located within another hospital for part "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00 81. 00		
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i 86.00 Did this facility establish a new Other subprovider (exclude 6112.40(f)(1)(1)(2) Chara WW for use and WW				N	85. 00 86. 00		
 §413. 40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospitals 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 	tal classified	under sectior	1	Ν	87.00		
			V 1.00	XI X 2.00	-		
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospi	tal carviace2 E	ntor "V" for	N	Ŷ	90.00		
yes or "N" for no in the applicable column.			N	Y	90.00		
full or in part? Enter "Y" for yes or "N" for no in the ap	olicable column	l.	IN .	N	91.00		
	instructions) Enter "Y" for yes or "N" for no in the applicable column.						
93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.	N	N	93.00				
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	o in the	N	N	94.00		
 95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for year applicable column. 	0. 00 N	0. 00 N	95.00 96.00				
97.00 If line 96 is "Y", enter the reduction percentage in the ap 98.00 Does title V or XIX follow Medicare (title XVIII) for the i stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y"							
98.01 Does title V or XIX follow Medicare (title XVIII) for the C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for	28.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 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 obed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes 	Y	Y	98.02				
 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y 				Ν	98.03		
 for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAI outpatient services cost? Enter "Y" for yes or "N" for no i 			N	Ν	98.04		
 in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add B Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in 				Y	98.05		
<pre>column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cos Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.</pre>			Y	Y	98.06		
Rural Providers 105.00Does this hospital qualify as a CAH?			N		105.00		
106.00 of this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	-inclusive met	hod of paymer			106.00		
107.00 Column 1: If line 105 is Y, is this facility eligible for a training programs? Enter "Y" for yes or "N" for no in colur Column 2: If column 1 is Y and line 70 or line 75 is Y, da	nn 1. (see ins	tructions)	N		107.00		
approved medical education program in the CAH's excluded l Enter "Y" for yes or "N" for no in column 2. (see instruct 108.00/s this a rural hospital gualifying for an exception to the	PF and/or IRF tions)	unit(s)?	2 N		108.00		
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.				D 1 1			
	Physi cal 1.00	Occupationa 2.00	3.00	Respi ratory 4.00	-		
109.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	e N	N	N	N	109.00		
				1.00			
110.00 Did this hospital participate in the Rural Community Hospi Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no.	lf yes,	Ν	110.00		

AITH FINANCIAL Systems REHABILITATION HOSPI DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC		Period:	eu of Form CMS Worksheet S-	
			From 10/01/2020 To 09/30/202		
			1.00	2.00	_
11.00 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 icipating in	eriod? Enter nter the column 2.	N	2.00	111. (
		1.00	2.00	3.00	_
12.00 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	oeriod? "Y", enter e	N			112. (
5.00 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 5) based on	N			0115.
6.00 Is this facility classified as a referral center? Enter "Y" f "N" for no.	5	Ν			116.
I7.00 Is this facility legally-required to carry malpractice insura "Y" for yes or "N" for no.	ance? Enter	Ν			117.0
8.00 Is the malpractice insurance a claims-made or occurrence poli if the policy is claim-made. Enter 2 if the policy is occurre	J		1		118.
		Premiums	Losses	Insurance	
		1.00	2.00	2.00	_
8.01 List amounts of malpractice premiums and paid losses:		1.00	2.00 0 48,68	3.00	0118.
			1.00	2.00	_
8. 02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein.			N		118.
9. 00 D0 NOT USE THIS LINE 0. 00 ls 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 qual Hold Harmless provision in ACA \$3121 and applicable amendment	column 1, "Y" alifies for th	for yes or e Outpatient		Ν	119. 120.
Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implan	ntable devices	charged to	N		121.
patients? Enter "Y" for yes or "N" for no. 2.00Does the cost report contain healthcare related taxes as defi					122.
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. Transplant Center Information	is "Y", enter	in column 2			-
5.00Does this facility operate a transplant center? Enter "Y" for	yes and "N"	for no. If	N		125.
yes, enter certification date(s) (mm/dd/yyyy) below.		ication date	. [126.
0.00 If this is a Medicare certified kidney transplant center, ent					127.
b. 00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2. 2.00 If this is a Medicare certified heart transplant center, enter	er the certifi				
 0.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date. 	er the certifi er the certifi	cation date			
 00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 	er the certifi er the certifi	cation date cation date	n		128.
 .00 If this is a Medicare certified kidney transplant center, entrin column 1 and termination date, if applicable, in column 2. .00 If this is a Medicare certified heart transplant center, enterin column 1 and termination date, if applicable, in column 2. .00 If this is a Medicare certified liver transplant center, enterin column 1 and termination date, if applicable, in column 2. .00 If this is a Medicare certified liver transplant center, enterin column 1 and termination date, if applicable, in column 2. .00 If this is a Medicare certified lung transplant center, enterin column 1 and termination date, if applicable, in column 2. 	er the certifi er the certifi ⁻ the certific	cation date cation date ation date i	n		128. 129.
 .00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2. .00 If this is a Medicare certified heart transplant center, enterin column 1 and termination date, if applicable, in column 2. .00 If this is a Medicare certified liver transplant center, enterin column 1 and termination date, if applicable, in column 2. .00 If this is a Medicare certified liver transplant center, enterin column 1 and termination date, if applicable, in column 2. .00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. .00 If this is a Medicare certified panceas transplant center, enter column 1 and termination date, if applicable, in column 2. 	er the certifi er the certifi the certific enter the cert umn 2.	cation date cation date ation date i ification	n		128. 129. 130.
 00 If this is a Medicare certified kidney transplant center, entrin column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified pancreas transplant center, enter in column 1 and termination date, if applicable, in colum 2. 	er the certifi er the certifi the certific enter the cert umn 2. enter the ce umn 2.	cation date cation date ation date i ification rtification	n		128. 129. 130. 131.
 5. 00 If this is a Medicare certified kidney transplant center, entilin column 1 and termination date, if applicable, in column 2. 7. 00 If this is a Medicare certified heart transplant center, entelin column 1 and termination date, if applicable, in column 2. 8. 00 If this is a Medicare certified liver transplant center, entelin column 1 and termination date, if applicable, in column 2. 8. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 9. 00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 9. 00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date, if applicable, in colum 1. 9. 00 If this is a Medicare certified intestinal transplant center, enter date in column 1 and termination date, if applicable, in colu 9. 00 If this is a Medicare certified intestinal transplant center, enter date in column 1 and termination date, if applicable, in colu 9. 00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colu 9. 00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in colu 9. 00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in colum 2. 9. 00 If this is an organ procurement organization (0PO), enter the 	er the certifi er the certific the certific enter the cert mn 2. enter the ce umn 2. er the certifi	cation date cation date ation date i ification rtification cation date	n		128. 129. 130. 131. 132. 133. 134.
 5. 00 If this is a Medicare certified kidney transplant center, entrin column 1 and termination date, if applicable, in column 2. 7. 00 If this is a Medicare certified heart transplant center, entrin column 1 and termination date, if applicable, in column 2. 8. 00 If this is a Medicare certified liver transplant center, entrin column 1 and termination date, if applicable, in column 2. 8. 00 If this is a Medicare certified liver transplant center, entrin column 1 and termination date, if applicable, in column 2. 9. 00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 9. 00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date, if applicable, in colum 1. 10. 00 If this is a Medicare certified intestinal transplant center, enter date in column 1 and termination date, if applicable, in colum 2. 10. 00 If this is a Medicare certified intestinal transplant center, enter in column 1 and termination date, if applicable, in colum 2. 10. 00 If this is a Medicare certified intestinal transplant center, enter in column 1 and termination date, if applicable, in colum 2. 10. 00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in colum 2. 10. 00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in colum 2. 	er the certifi er the certific the certific enter the cert mn 2. enter the ce umn 2. er the certifi	cation date cation date ation date i ification rtification cation date	n		128. 129. 130. 131. 132. 133.

INC. DERVICES SERVICES 142.00 142.00 State: TN Zip Code: 37067 143.00 143.00 City: FRANKLIN State: TN Zip Code: 37067 143.00 144.00 Are provider based physicians' costs included in Worksheet A? 1.00 1.00 1.00 1.00 144.00 FrankLin Services are claimed on Wkst. A. Line 74. are the costs for inpatient services only? Enter "Y" for yes or "N" for no in colum 1. If column 1 is no. does the dialysis facility include Welicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in colum 2. 145.00 145.00 146.00 No in colum 1. (Sec CMS Pub. 15-2, chapter 40, §4020) If N 146.00 147.00 Nas there a change in the statistical basis? Enter "Y" for yes or "N" for no. N N 146.00 149.00 Was there a change in the simplified cost finding method? Enter "Y" for yes or "N" for no. N N 147.00 149.00 Nas there a change in the simplified cost finding method? N N N N N N N N N N N N N	Health Financial Systems	REHABILITATION HO	SPITAL OF FT WAY	NE	In Lie	u of Form CMS-	-2552-10	
To 09/30/2021 Date STITE	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CC				2	
Intervent 1.00 2.00 3.00 If this facility is part of a chin organization, enter on lines 114 through 143 the name and address of the home office contractor name and contractor name. 3.00 141.00 141.00 Name: OK5/COMMUNT HEALTH SYSTEMS, INC. Contractor's Number: 10301 141.00 141.00 142.00 Strete: 4000 MERIDIAN BLVD P0 Box: SERVICES 142.00 143.00 143.00/Lity: FRANKLIN State: TN Zip Code: 37067 143.00 144.00/Are provider based physicians' costs included in Worksheet A? Y 144.00 Y 144.00 145.00/Lit costs for renal services are claimed on Wkst. A, line 74, are the costs for inporting period? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is period? Enter 'Y' for yes or 'N' for no in column 2. 166.00 166.00 146.00/as there a change in the statistical basis? Enter 'Y' for yes or 'N' for no. N N N 147.00 147.00/as there a change in the statistical basis? Enter 'Y' for yes or 'N' for no. N N 147.00 N 149.00 148.00/as there a change in the order of all cost finding method? Enter 'Y' for yes or 'N' for no. N N N N N N N <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>epared:</td>							epared:	
If this facility is part of a chain organization, enter on Lines 141 through 143 the name and address of the home office contractor name and contractor number. 141.00 141.00Name: Office and enter the home office contractor name and contractor number. 141.00 142.00Street: A000 MERIDIAN BLVD P0 Box: SERVICES 142.00 143.00City: FRANKLIN State: TN Zip Code: 37067 143.00 143.00City: FRANKLIN State: TN Zip Code: 37067 143.00 144.00Are provider based physicians' costs included in Worksheet A? Y Y144.00 145.00If Costs for renal services are claimed on Wkst. A, Line 74, are the costs for 1.00 2.00 145.00 145.00If costs for renal services only? Enter "Y" for yes or "N" for no in colum 1.1 no, does the dialysis facility include Medicare utilization for this cost report? N 146.00 146.00Kas there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147.00 N 147.00 148.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N N N N N N N 148.00 148.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N								
Indep office and enter the home office contractor name and contractor number. Interview Interview </td <td></td> <td></td> <td></td> <td>ugh 142 tho po</td> <td></td> <td>of the</td> <td></td>				ugh 142 tho po		of the		
111.00Name: Contractor's Name: BISCONSIN PHYSICIAN Contractor's Number: 10301 142.00Street: 4000 MENDIAN BLVD P0 Box: 12 p Code: 37067 143.00 143.00City: FRANKLIN State: TN Zip Code: 37067 143.00 144.00[Are provider based physicians' costs included in Worksheet A? Y 144.00 1.00 2.00 145.00[f costs for renal services are claimed on West. A. Line 74. are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1. Is no oses the dialysis facility include dicare utilization for this cost report? N 146.00 146.00[Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N N N 147.00 147.00[Was there a change in the order of all location? Enter "Y" for yes or "N" for no. N N N 147.00 148.00[Was there a change in the order of all location? Enter "Y" for yes or "N" for no. N N 147.00 149.00[Was there a change in the order of all location? Enter "Y" for yes or "N" for no. N N 147.00 140.00[Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N N N N N 147.00 14					lile allu auul ess	of the		
142.00[Street: 4000 MERIDIAN BLVD P0 Box: 143.00 142.00 143.00 145.00 1.00 2.00 144.00 145.00 1.00 2.00 145.00 100.00 2.00 145.00					r's Number: 1030)1	141.00	
143. 00[City: FRANKLIN State: TN Zip Code: 37067 143. 00 144. 00[Are provider based physicians' costs included in Worksheet A? 1.00 1.00 1.00 1.44. 00 145. 00[If costs for renal services are claimed on Wst. A. line 74, are the costs for in patient services on the previous of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. See CMS Pub. 15-2, chapter 40, \$4020) If Yes, enter the approval date (mm/dd/yyyy) in column 2. 146. 00 1.00 1.00 147. 00[Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no. N 147. 00 N 147. 00 148. 00[Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no. N 147. 00 148. 00[Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no. N 147. 00 149. 00[Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no. N 148. 00 149. 00[Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no. N N 149. 00 149. 00[Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no. N N N 149. 00 <t< td=""><td></td><td></td><td>SERVI CES</td><td></td><td></td><td></td><td></td></t<>			SERVI CES					
144.00/Are provider based physicians' costs included in Worksheet A? 1.00 144.00/Are provider based physicians' costs included in Worksheet A? Y 145.00/1f costs for renal services are claimed on Wkst. A. line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 145.00 146.00/Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See GMS Pub. 15-2, chapter 40, \$4020) If N 146.00 147.00/Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N N 147.00 149.00/Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147.00 N 147.00/Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 148.00 149.00/Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 148.00 149.00/Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 149.00 145.00/Subprovider - IFF N N N N 155.00 155.00/Subprovider - IFF N N N N 156.00 158.00 1			-	7. 0 1	0.70	- 7		
144.00/Are provider based physicians' costs included in Worksheet A? Y 144.00 145.00/1f costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no. does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 145.00 146.00/Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See GMS Pub. 15-2, chapter 40, §4020) If N 146.00 147.00/Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N N 147.00 149.00/Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147.00 148.00 149.00/Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 147.00 149.00/Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 148.00 150.00/Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 149.00 150.00/Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 149.00 150.00/Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N N N 150.00/Was there a change to the simp	143.00/CITY: FRANKLIN	State:	IN	ZI p Code:	3700		143.00	
144.00/Are provider based physicians' costs included in Worksheet A? Y 144.00 145.00/1f costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no. does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 145.00 146.00/Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See GMS Pub. 15-2, chapter 40, §4020) If N 146.00 147.00/Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N N 147.00 149.00/Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147.00 148.00 149.00/Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 147.00 149.00/Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 148.00 150.00/Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 149.00 150.00/Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 149.00 150.00/Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N N N 150.00/Was there a change to the simp						1.00	-	
145.001 f costs for renal services are claimed on Wkst. A. line 74, are the costs for incolumn 1. if column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 145.00 146.00Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If yes, enter the approval date (mm/dd/yyyy) in colum 2. 146.00 147.00Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147.00 148.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 147.00 149.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 147.00 149.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 147.00 149.00Was there a change in the order of allocation? N 147.00 149.00Was there a change in the order of allocation? N N 148.00 149.00Was there a change in the order of allocation? N N 148.00 150.00Lospital N N N N 149.00 150.00Subprovider - IPF N N N N N 159.00 150.00Subprovider - IRF N N	144.00 Are provider based physicians' costs	included in Workshee	t A?				144.00	
145.001 f costs for renal services are claimed on Wkst. A. line 74, are the costs for incolumn 1. if column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 145.00 146.00Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If yes, enter the approval date (mm/dd/yyyy) in colum 2. 146.00 147.00Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147.00 148.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 147.00 149.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 147.00 149.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 147.00 149.00Was there a change in the order of allocation? N 147.00 149.00Was there a change in the order of allocation? N N 148.00 149.00Was there a change in the order of allocation? N N 148.00 150.00Lospital N N N N 149.00 150.00Subprovider - IPF N N N N N 159.00 150.00Subprovider - IRF N N							_	
inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 146.00Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. N 146.00 147.00Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147.00 146.00 147.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 148.00Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 148.00 149.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 140.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 149.00 145.00E N N N N 149.00 150.00Hospital N N N N 155.00 150.00Hospital N N N N N 156.00 150.00Hospital N N N N N 160.0	145 001 f costs for ronal sorvices are claim	od on What A line	74 are the costs	for	1.00	2.00	145.00	
no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost all ocation methodology changed from the previously filed cost report? N Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of all ocation? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of all ocation? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of all ocation? Enter "Y" for yes or "N" for no. 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. 149.00 Was there a change to the simplified cost finding method? Inter "Y" for yes or "N" for no. 149.00 Was there a change to the simplified cost report? 150.00 Hospital 161.00 VI (See VI							145.00	
146. 00Has the cost all ocation methodol ogy changed from the previously Filed cost report? N 146. 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If N 146. 00 147. 00Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147. 00 148. 00Was there a change in the order of all ocation? Enter "Y" for yes or "N" for no. N 147. 00 149. 00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 147. 00 149. 00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 147. 00 149. 00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 149. 00 149. 00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 149. 00 149. 00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 149. 00 150. 00Hospital N N N N N 155. 00 151. 00 Subprovider - IPF N N N N N 155. 00 152. 00 SUBPROVIDER N N N N N 158. 00 152. 00 SUBPROVIDER	no, does the dialysis facility includ	e Medicare utilizati						
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If 147. 00Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147.00 148. 00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149. 00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 148.00 149. 00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 148.00 149. 00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 149.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR \$413.13) 155.00 156. 00Subprovider - IPF N N N N N 157.00 159. 00SNF N N N N N 160.00 161.00 165. 00SUBPROVIDER N N N N N N 165.00 165. 00L Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 166.00 166. 00L If line 165 is yes, for each campus hospital								
yes, enter the approval date (mm/dd/yyyy) in column 2. Image: column 2. 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147.00 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 147.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 149.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) N 155.00 155.00 Hospital N N N N N 156.00 156.00 Subprovider - 1PF N N N N 158.00 158.00 159.00 158.00 159.00 159.00 159.00 159.00 159.00 159.00 159.00 159.00 159.00 159.00 159.00 159.00 150.00 150.00 150.00 150.00 150.00 150.00 150.00 <td< td=""><td></td><td></td><td></td><td></td><td>N</td><td></td><td>146.00</td></td<>					N		146.00	
Image: Constraint of the statistical basis? Enter "Y" for yes or "N" for no. Image: Constraint of the statistical basis? Enter "Y" for yes or "N" for no. 147.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N N 149.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N N N N 150.05 Ubprovider - IPF N N N N N N 155.00 150.00 Subprovider - IRF N N N N N N N 157.00 160.00 Uhp Coll ER N N N N N N N N 160.00 <td></td> <td></td> <td></td> <td>10, 34020) 11</td> <td></td> <td></td> <td></td>				10, 34020) 11				
147. 00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147. 00 148. 00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148. 00 149. 00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 148. 00 149. 00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 148. 00 149. 00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148. 00 149. 00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N N 149. 00 149. 00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N N N 149. 00 149. 00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N N 149. 00 149. 00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N N 149. 00 150. 00 Subprovider - IPF N N N N N 155. 00 156. 00 Subprovider - IRF N N N N N 158. 00 160. 00 HOME HEALTH AGENCY N N								
148. 00/Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148. 00 149. 00/Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 149. 00 149. 00/Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 148. 00 149. 00/Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 40.00 Dees this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) N N 155. 00 155. 00/Bospital N N N N N N 155. 00 156. 00/Subprovider - IPF N N N N N 155. 00 157. 00/Subprovider - IRF N N N N N 158. 00 150. 00/BME HEALTH AGENCY N N N N N 165. 00 160. 00/HMC N N N N N 165. 00 165. 00	447.00						4.47.00	
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) N N N N N 155.00 55.00 Hospital N N N N N N N 155.00 155.00 Hospital N N N N N N 155.00 155.00 Subprovider - IPF N N N N N 155.00 159.00 SNF N N N N N 156.00 160.00 CMHC N N N N N N 165.00 161.00 CMHC N N N N N 165.00 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00<								
Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 155.00 Hospital N N N N N 155.00 156.00 Subprovider - IPF N N N N N 155.00 157.00 Subprovider - IRF N N N N N 155.00 158.00 SUBPROVIDER N N N N N 155.00 160.00 CMHC N N N N N 160.00 161.00 CMHC N N N N N 161.00 Ame County State Zip Code CBSA FTE/Campus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 166.00 5.00 166.00 5.00 165.00 <td col<="" td=""><td></td><td></td><td></td><td></td><td>no.</td><td>-</td><td>149.00</td></td>	<td></td> <td></td> <td></td> <td></td> <td>no.</td> <td>-</td> <td>149.00</td>					no.	-	149.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospital N N N N 155.00 156.00 Subprovider - IPF N N N N 155.00 156.00 Subprovider - IRF N N N N 155.00 159.00 SUBPROVIDER N N N N 158.00 159.00 SNF N N N N 158.00 160.00 HOME HEALTH AGENCY N N N 160.00 161.00 Multicampus N N N N 161.00 Multicampus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? 165.00 Enter "Y" for yes or "N" for no. 0 1.00 2.00 3.00 4.00 5.00 166.00 If Line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, 0 1.00 2.00 3.00 4.00 5.00		<u> </u>	-					
or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal N 165.00 161.00 CMHC N N N N 161.00 161.00 I61.00 I61.00 I61.00 I61.00 I61.00 I61.00 I61.00 I61.00 I65.00 I65.00 I65.00 I65.00								
155.00 Hospital N N N N N N N 155.00 156.00 Subprovider - IPF N 160.00 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
156.00 Subprovider - IPF N N N N N 156.00 157.00 Subprovider - IRF N N N N N N N 157.00 158.00 SUBPROVIDER N N N N N 157.00 158.00 159.00 SNF N N N N 159.00 158.00 160.00 OHME HEALTH AGENCY N N N N 161.00 161.00 CHHC N N N N 161.00 Inter "Y" for yes or "N" for no. Inter "Y" for yes or "N" for no. <							155 00	
158.00 SUBPROVIDER 158.00 159.00 SNF N N N N 159.00 160.00 HEALTH AGENCY N N N N N 160.00 161.00 CMHC N N N N N 160.00 Multicampus 1.00 Inter "Y" for yes or "N" for no. Mame County State Zip Code CBSA FTE/Campus 165.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 3, column 3, column 3, column 3, 0 1.00 2.00 3.00 4.00 5.00							156.00	
159.00 SNF N N N N N 159.00 160.00 HOME HEALTH AGENCY N N N N N N N 160.00 161.00 CMHC N N N N N N 160.00 Multicampus Multicampus I.00 I.00 I.00 I.00 I.00 Inter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 3, zip code in column 3, 0 1.00 2.00 3.00 4.00 5.00 166.00			N	N	N	N	157.00	
160.00 HOME HEALTH AGENCY N N N N 160.00 161.00 CMHC N N N N 160.00 Multicampus 1.00 Inter "Y" for yes or "N" for no. Multicampus N N N N 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 165.00 Enter "Y" for yes or "N" for no. 0 1.00 2.00 3.00 4.00 5.00 County State Zip Code CBSA FTE/Campus 166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 3, column 2, zip code in column 3, 0<								
161.00 CMHC N N N 161.00 Multicampus Multicampus 1.00 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Inter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 0 166.00 166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 1, state in column 3, column 2, zip code in column 3, 0								
Multicampus 1.00 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 3, 0 1.00 2.00 3.00 4.00 5.00			IN IN				161.00	
Multicampus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 3, 0 1.00 2.00 3.00 4.00 5.00				1	-			
Name County State Zip Code CBSA FTE/Campus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAS? N 165.00 Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 0 166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 3, zip code in column 3, 0						1.00		
Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, 0 1.00 2.00 3.00 4.00 0.00 166.00		s hospital that has	one or more campi	uses in differ	ent CBSAs2	N	165 00	
0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, 0 1.00 2.00 3.00 4.00 5.00					ent obsas:	IN IN	105.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, 0.00166.00				State Zip	Code CBSA			
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,		0	1.00	2.00 3	. 00 4. 00		04// 00	
0, county in column 1, state in column 2, zip code in column 3,						0.0	0166.00	
CBSA in column 4, FTE/Campus in								
column 5 (see instructions)				I I				
1.00						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act					Act			
					optor the	Y	167.00 168.00	
reasonable cost incurred for the HIT assets (see instructions)				e 107 IS Y),	enter the		168.00	
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship 168.01	168.01 If this provider is a CAH and is not	a meaningful user, d	bes this provider		a hardship		168.01	
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 9.99169.00 transition factor. (see instructions)		(line 167 is "Y") a	nd is not a CAH ((line 105 is "	N"), enter the	9.9	9169.00	
Beginning Ending					Beai nni na	Endi na		
1.00 2.00						<u> </u>	1	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170.00	5	nning date and endin	g date for the re	eporting			170.00	
period respectively (mm/dd/yyyy)	period respectively (mm/dd/yyyy)							
1.00 2.00					1.00	2 00	-	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in N 0171.00	171.00 If line 167 is "Y", does this provide	r have any days for	individuals enrol	led in			0171.00	
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter								
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			s, enter the numb	per or section				

	Financial Systems REHABILITATION HOSI TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Peri od:	u of Form CMS- Worksheet S-2	
03111	AL AND HOST THE HERETH GARE RETINDORSEMENT QUESTIONNALRE	in ovider c	cm. 13-3030	From 10/01/2020 To 09/30/2021	Part II Date/Time Pre	epared:
				Y/N	2/28/2022 4:1 Date	29 pm
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N	lfor all NO re	sponses. Ente	r all dates in t	the	
	mm/dd/yyyy format.					_
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
I. 00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c	column 2. (see				
			Y/N 1.00	Date 2.00	V/I 3.00	
2.00	Has the provider terminated participation in the Medicare F	Program? If	N 1.00	2.00	3.00	2. (
	yes, enter in column 2 the date of termination and in colum					
	voluntary or "I" for involuntary.					
8.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home of		N			3.
	or medical supply companies) that are related to the provid					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other	er similar				
	relationships? (see instructions)		Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports				L	
4.00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f		N			4.0
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
5.00	Are the cost report total expenses and total revenues diffe		N			5.0
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities				L	
5.00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	the provider	N		6.0
7.00	is the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see ir	structions		Ν		7.0
3.00	Were nursing programs and/or allied health programs approve		ed during the			8.0
	cost reporting period? If yes, see instructions.					9.0
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education N program in the current cost report? If yes, see instructions.					
10.00						
	cost reporting period? If yes, see instructions.					
11.00	Are GME cost directly assigned to cost centers other than I	& R in an App	proved	Ν		11. (
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1.00	
	Bad Debts		-		L	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			st roporting	Y N	12.0
13.00	period? If yes, submit copy.	billey change c	iuring this co	ist reporting	IN	15.0
14.00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	yes, see ins	tructions.	N	14. (
	Bed Complement				N	115 /
15.00	Did total beds available change from the prior cost reporti		yes, see finst rt A		N N	15.0
		Y/N	Date	Y/N	Date	
	1	1.00	2.00	3.00	4.00	
1/ 00	PS&R Data Was the cost report prepared using the PS&R Report only?	Y	02/22/2022	Y	02/22/2022	11.0
6.00	If either column 1 or 3 is yes, enter the paid-through	т	02/22/2022	T	02/22/2022	16. (
	date of the PS&R Report used in columns 2 and 4 . (see					
	instructions)					
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	N		N		17. (
	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		Ν		18. (
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	loost ranort? If was soo instructions		1		1	1
19, 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19 r
19.00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19.0

Health Financial System

REHABI LI TATI ON	HOSPI TAL	0F	FΤ	WAYNE

In Lieu of Form CMS-2552-10

Heal th	Financial Systems REHABILITATION HOS	PITAL OF FT WAY	(NE	In Lie	u of Form CMS	-2552-10					
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Provider C	CN: 15-3030	Period: From 10/01/2020	Worksheet S- Part II	2					
				To 09/30/2021	Date/Time Pr 2/28/2022 4:						
		Descri	ption	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.	N				21.00					
					1.00						
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCI	EPT CHILDRENS H	OSPLTALS)		1.00						
	Capital Related Cost										
22.00	Have assets been relifed for Medicare purposes? If yes, se					22.00					
23.00	Have changes occurred in the Medicare depreciation expense	due to apprais	als made duri	ng the cost		23.00					
04.00	reporting period? If yes, see instructions.					24.00					
24.00	5 5 1 51										
25.00	If yes, see instructions Have there been new capitalized leases entered into during	the cost renor	ting period?	If ves see		25.00					
20.00	instructions.	the cost repor	tring period:	11 ycs, see		20.00					
26.00	J										
27.00	instructions. Has the provider's capitalization policy changed during the	e cost reportin	a period? If	ves submit		27.00					
27.00	copy.		g por our ri	<i>J</i> ⁶⁶ , <i>6</i> 6 <i>6666666666666</i>		2/100					
	Interest Expense										
28.00	0 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.										
29.00	Did the provider have a funded depreciation account and/or	bond funds (De	bt Service Re	serve Fund)		29.00					
20.00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat	ructions				30.00					
30.00	instructions.	unity with new	debt? IT yes,	See		30.00					
31.00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see		31.00					
	instructions. Purchased Services										
32.00		rvi ces furni she	d through con	tractual		32.00					
	arrangements with suppliers of services? If yes, see instru										
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pertainin	g to competit	ive bidding? If		33.00					
	no, see instructions.					_					
24 00	Provider-Based Physicians Are services furnished at the provider facility under an a	rrangement with	providor bas	od physicians?		34.00					
34.00	If yes, see instructions.	i angement with	provider-bas	eu physicians?		34.00					
35.00	If line 34 is yes, were there new agreements or amended ex	isting agreemen	ts with the p	rovi der-based		35.00					
	physicians during the cost reporting period? If yes, see in		•								
				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?	n N		37.00					
07.00	If yes, see instructions.	repared by the				07.00					
38.00	If line 36 is yes, was the fiscal year end of the home of			Y	12/31/2020	38.00					
	the provider? If yes, enter in column 2 the fiscal year en	d of the home o	ffi ce.								
39.00		er chain compon	ents? If yes,	N		39.00					
40.00	see instructions. If line 36 is yes, did the provider render services to the	home office?	lf yes, see	Ν		40.00					
	instructions.										
		1.	00	2.	00						
	Cost Report Preparer Contact Information	I		l		-					
41.00		STEVEN		BAUER		41.00					
	held by the cost report preparer in columns 1, 2, and 3, respectively.										
42.00		COMMUNITY HEAL	TH SYSTEMS			42.00					
	preparer.										
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6159254320		STEVEN_BAUER@C	HS. NET	43.00					
	· · · · · · · · · · · · · · · · · · ·	1		T.							

Health Financial Systems	REHABILITATION HOSE	PITAL OF FT WAYNE		In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEN	IENT QUESTI ONNAI RE	Provider CCN:		Period:	Worksheet S-2		
				rom 10/01/2020 o 09/30/2021	Part II Date/Time Pre 2/28/2022 4:2		
				_			
		3.00					
Cost Report Preparer Contact Informat	i on						
41.00 Enter the first name, last name and t	he title/position	SENIOR REVENUE MA	NAGER			41.00	
held by the cost report preparer in c	olumns 1, 2, and 3,						
respecti vel y.							
42.00 Enter the employer/company name of th	e cost report					42.00	
preparer.							
43.00 Enter the telephone number and email	address of the cost					43.00	
report preparer in columns 1 and 2, r	especti vel y.						

	<u>Financial Systems</u> AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	<u>BILITATION HOSP</u> AL DATA	Provider CC		Peri od:	worksheet S-3	
					From 10/01/2020 To 09/30/2021	Part I Date/Time Pre 2/28/2022 4:2	
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	30. 00	36	13, 14	40 0.00	0	1.00
3.00 4.00 5.00 6.00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	3.00 4.00 5.00 6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		36	13, 14	40 0.00	0	7.00
8.00 9.00 10.00 11.00 12.00 13.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						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	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)		36	13, 1	40 0.00	0	14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00
24.00 24.10 25.00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC PURAL HEALTH CLINIC	30. 00					24.00 24.10 25.00
26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	89.00	36 0		0	0	26.00 26.25 27.00 28.00 30.00 31.00 32.00
33. 00 33. 01	LTCH non-covered days LTCH si te neutral days and di scharges						33. 00 33. 01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-3030		eriod: com 10/01/2020 o 09/30/2021	Worksheet S-3 Part I Date/Time Pre 2/28/2022 4:2	pared:	
		I/P Days	/ O/P Visits	/ Trips		Full Time Equivalents			
	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	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 HMO IRF Subprovider	5, 109 2, 086 0 0	316 2, 030 0 0		25			1.00 2.00 3.00 4.00	
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	0	0 0		0 0			5.00 6.00	
7.00 8.00 9.00 10.00 11.00 12.00 13.00	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	5, 109	316	12, 3:	25			7.00 8.00 9.00 10.00 11.00 12.00	
14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	5, 109 0	316 0	12, 3	25 0 0	0.00	115.85	14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00	
26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	0 0 0	0 0 0		0 0 0 0 0 0	0. 00 0. 00	0. 00 115. 85	•	
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges	0 0						33. 00 33. 01	

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-3030	Period: From 10/01/2020 To 09/30/2021	Worksheet S-3 Part I Date/Time Pre 2/28/2022 4:20	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
$\begin{array}{c} 1.\ 00\\ \\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ \\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 10\\ 25.\ 00\\ 26.\ 00\\ 26.\ 25\\ 27.\ 00\\ 28.\ 00\\ 29.\ 00\\ 30.\ 00\\ 31.\ 00\\ 32.\ 00\\ \end{array}$	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) 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 - IPF SUBPROVIDER - IPF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instructions)	0. 00 0. 00 0. 00	0	1.	37 23 49 151 0 0 37 23	990	$\begin{array}{c} 1.\ 00\\ \\ 2.\ 00\\ 3.\ 00\\ \\ 4.\ 00\\ \\ 5.\ 00\\ \\ 6.\ 00\\ \\ 7.\ 00\\ \\ 8.\ 00\\ \\ 9.\ 00\\ \\ 10.\ 00\\ \\ 11.\ 00\\ \\ 12.\ 00\\ \\ 13.\ 00\\ \\ 13.\ 00\\ \\ 13.\ 00\\ \\ 14.\ 00\\ \\ 15.\ 00\\ \\ 14.\ 00\\ \\ 15.\ 00\\ \\ 15.\ 00\\ \\ 22.\ 00\\ \\ 23.\ 00\\ \\ 24.\ 10\\ \\ 25.\ 00\\ \\ 26.\ 00\\ \\ 26.\ 00\\ \\ 27.\ 00\\ \\ 26.\$
32. 01 33. 00 33. 01	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0 0		32. 0 ² 33. 00 33. 0 ²

CLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider C		Period: From 10/01/2020	Worksheet A	
				To 09/30/2021	2/28/2022 4:2	
Cost Center Description	Sal ari es	Other	· ·	Reclassificati		
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00				col . 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS		057 507	057.50		F 10, 100	
00 00100 CAP REL COSTS-BLDG & FIXT		357, 537				
00 00200 CAP REL COSTS-MVBLE EQUI P		187, 881				
00 00400 EMPLOYEE BENEFITS DEPARTMENT	43, 631	33, 140				
01 00570 ADMI TTI NG	164, 755	233, 390				
02 00590 ADMIN AND GENERAL - OTHER	1, 241, 270	2, 793, 409				
00 00700 OPERATION OF PLANT	213, 815	663, 167				
00 00800 LAUNDRY & LINEN SERVICE	0	65, 644				
00 00900 HOUSEKEEPI NG	185, 414	36, 209				
. 00 01000 DI ETARY	469, 219	289, 912	759, 13		534, 490	10.
. 00 01100 CAFETERI A	0	0		0 224, 335	224, 335	11.
. 00 01300 NURSI NG ADMI NI STRATI ON	437, 963	62, 964	500, 92	7 - 324	500, 603	13
. 00 01400 CENTRAL SERVICES & SUPPLY	7, 571	79, 743	87, 31	4 -77, 622	9, 692	14
. 00 01500 PHARMACY	190, 918	528, 569	719, 48	7 -505, 417	214, 070	15
. 00 01600 MEDICAL RECORDS & LIBRARY	146, 618	111, 470	258, 08	-913	257, 175	16
. 00 01700 SOCIAL SERVICE	0	0		0 0	0	17.
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		•			
. 00 03000 ADULTS & PEDIATRICS	3, 388, 935	1, 136, 098	4, 525, 03	3 461, 823	4, 986, 856	30.
ANCILLARY SERVICE COST CENTERS						
. 00 05400 RADI OLOGY-DI AGNOSTI C	0	10, 486	10, 48	6 0	10, 486	1 54.
00 06000 LABORATORY	39, 958	47, 472	87, 43	0 0	87, 430	60
00 06500 RESPI RATORY THERAPY	9,079	24, 947				
00 06600 PHYSI CAL THERAPY	1,033,941	166, 071				
00 06700 OCCUPATI ONAL THERAPY	834, 309	69, 808				
. 00 06800 SPEECH PATHOLOGY	331, 644	38, 962				
. 00 06900 ELECTROCARDI OLOGY	36	145				
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 5,899		
. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 473, 174		
. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	110, 330	8, 558				
. 01 03950 HEMODIALYSIS & OTHER ANCILLARY	110, 330	176, 135				
SPECIAL PURPOSE COST CENTERS	U	170, 130	170,13	0	170, 133	1 /0
	0.040.404	7 101 717	15 071 10	2 554	15 071 (70	1110
8.00 SUBTOTALS (SUM OF LINES 1 through 117)	8, 849, 406	7, 121, 717	15, 971, 12	3 556	15, 971, 679	1118
NONREI MBURSABLE COST CENTERS	0.0	0 700	2.00	a == (0.407	100
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	260	3, 733				
4. 00 07950 NON-REI MBURSABLE COST	0	0		0 0		194
4. 01 07951 MARKETI NG/PUBLIC RELATIONS	0	0		0 0		194
4.0207952 TENANT LEASED SPACE	0	0		0 0		194
0.00 TOTAL (SUM OF LINES 118 through 199)	8, 849, 666	7, 125, 450	15, 975, 11	6 0	15, 975, 116	200

Heal th	Financial Systems REHA	BILITATION HOSPI	ITAL OF FT WAY	/NF	Inlie	u of Form CMS-2552-10
	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provider C		Peri od:	Worksheet A
NLULAS	STITCATION AND ADJUSTMENTS OF TREAD BREANCE O	I LAI LINGLO		CN. 13-3030	From 10/01/2020	WOI KSHEET A
					To 09/30/2021	Date/Time Prepared:
						2/28/2022 4:29 pm
	Cost Center Description		Net Expenses			
			or Allocation			
	T	6.00	7.00			
	GENERAL SERVICE COST CENTERS	I				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-25, 293	523, 116			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	40, 955	374, 705			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 126, 079			4.00
5.01	00570 ADMI TTI NG	0	397, 958			5.01
5.02	00590 ADMIN AND GENERAL - OTHER	119, 667	2, 433, 456			5.02
7.00	00700 OPERATION OF PLANT	-7,637	936, 385			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	65, 644			8.00
9.00	00900 HOUSEKEEPI NG	0	220, 512	1		9,00
10.00	01000 DI ETARY	0	534, 490	1		10.00
11.00	01100 CAFETERIA	-75, 205	149, 130			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	13,203	500, 603			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	9, 692	1		14.00
14.00	01500 PHARMACY	0	9, 092 214, 070			14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-12	257, 163	1		16.00
17.00	01700 SOCIAL SERVICE	0	0			17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	250.044	4 (0 (. 000	1		
30.00	03000 ADULTS & PEDI ATRI CS	-359, 964	4, 626, 892			30.00
	ANCI LLARY SERVICE COST CENTERS	d	10.101			
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	10, 486	1		54.00
60.00	06000 LABORATORY	0	87, 430	•		60.00
65.00	06500 RESPI RATORY THERAPY	0	20, 538	•		65.00
66.00	06600 PHYSI CAL THERAPY	0	1, 126, 870	1		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	904, 117			67.00
68.00	06800 SPEECH PATHOLOGY	0	370, 606			68.00
69.00	06900 ELECTROCARDI OLOGY	0	181			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	5, 899			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	473, 174			73.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	118, 859			76.00
76.01	03950 HEMODIALYSIS & OTHER ANCILLARY	0	176, 135			76.01
	SPECIAL PURPOSE COST CENTERS	· · · ·				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-307, 489	15, 664, 190			118.00
	NONREI MBURSABLE COST CENTERS	· · · ·				
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	3, 437			192.00
	07950 NON-REI MBURSABLE COST	0	0			194.00
	07951 MARKETI NG/PUBLI C RELATI ONS	0	0			194. 01
	07952 TENANT LEASED SPACE	0	0			194. 02
200.00		-307, 489	15, 667, 627			200.00
200.00		1 007,407	10,007,027	1		1200:00

Health Financial Systems RECLASSIFICATIONS

REHABI LI TATI ON	HOSPI TAL	0F	FΤ	WAYNE	

	Financial Systems	KLIIAL	BILITATION HOSP			eu of Form CMS-2552-10
(EULAS	SI FI CATI ONS			Provider CCN: 15-3	030 Peri od: From 10/01/2020 To 09/30/2021	
		Increases				
	Cost Center	Line #	Sal ary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 049, 528		1.00
	0		0	1,049,528		
	B - RENTAL AND LEASE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9, 322		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	145, 869		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
5.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
3.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
				155, 191		
	C - OTHER CAPITAL COSTS			100,171		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	27, 732		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	153, 818		2.00
00			— — — ö t	181, 550		2.00
	D - REPAIRS & MAINTENANCE COS	TS				
1.00	OPERATION OF PLANT	7.00	0	67, 040		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	Ö		4.00
5.00		0.00	0	0		5.00
5.00		0.00	0	Ö		6.00
7.00		0.00	0	Ö		7.00
3.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	Ő		10.00
10.00			0	67,040		10.00
	E - MEDI CAL SUPPLI ES	I	0	07, 040		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	5, 899		1.00
1.00	PATI ENT	71.00	0	5, 677		1.00
		+		5, 899		
	F - DRUGS CHARGED TO PATIENTS		0	3, 877		
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	473, 174		1.00
			of	473, 174		1.00
	G - PHYSICIAN DIRECTORS		0			
1.00	ADULTS & PEDIATRICS	30.00	0	473, 645		1.00
			— — —)	473, 645		1.00
	H – DIETARY		0	473,045		
1.00	CAFETERIA	11.00	138, 810	85, 525		1.00
			130,010	00.020		I I. UU
1.00			138, 810	85, 525		

REHABI LI TATI ON	HOSPI TAL	0F	FΤ	WAYNE	

CLAS	SI FI CATI ONS			Provider (CCN: 15-3030	Period: From 10/01/2020 To 09/30/2021	Worksheet A-6 Date/Time Prepar
		Decreases					2/28/2022 4:29 p
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref	-	
	6.00	7.00	8.00	9,00	10, 00	<u>·</u>	
	A - EMPLOYEE BENEFITS	1100	0100	7100	10100		
00	ADMIN AND GENERAL - OTHER	5.02	0	1,049,528		0	1
00			— — — o	1,049,528			
	B - RENTAL AND LEASE		U	1, 047, 320			
00	EMPLOYEE BENEFITS DEPARTMENT	4,00	0	220	1	0	1
00	ADMI TTI NG	5.01	0	187		0	2
00	ADMIN AND GENERAL - OTHER	5.01	0	8, 091		0	3
00	NURSING ADMINISTRATION	13.00	0	80		0	4
00	CENTRAL SERVICES & SUPPLY	14.00	0	53, 505		0	5
00	PHARMACY	14.00	0	30, 879		0	6
	MEDICAL RECORDS & LIBRARY	16.00	0			0	
00			0	913			7
00	ADULTS & PEDIATRICS	30.00	0	63		0	8
00	RESPI RATORY THERAPY	65.00	0	13, 016		0	9
. 00	PHYSI CAL THERAPY	66.00	0	48, 127		0	10
. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	76.00	0	29		0	11
~ ~	SERVICES	100.00					
00	PHYSICIANS' PRIVATE OFFICES	<u> </u>		81		0	12
	0		0	155, 191			
	C - OTHER CAPITAL COSTS						
00	ADMIN AND GENERAL - OTHER	5.02	0	181, 550		2	1
00		0.00	0	0		3	2
	0		0	181, 550			
	D - REPAIRS & MAINTENANCE COS				1		
00	ADMIN AND GENERAL - OTHER	5.02	0	8, 076		0	1
00	HOUSEKEEPI NG	9.00	0	1, 111		0	2
0C	DI ETARY	10.00	0	306		0	3
00	NURSING ADMINISTRATION	13.00	0	244		0	4
0C	CENTRAL SERVICES & SUPPLY	14.00	0	18, 218		0	5
00	PHARMACY	15.00	0	1, 364		0	6
00	ADULTS & PEDIATRICS	30.00	0	11, 759		0	7
00	RESPI RATORY THERAPY	65.00	0	472		0	8
00	PHYSICAL THERAPY	66.00	0	25, 015		0	ç
00	PHYSICIANS' PRIVATE OFFICES	192.00	0	475		0	10
	0 — — — — — — —	T	0	67,040		7	
	E - MEDICAL SUPPLIES		· · · · · · · · · · · · · · · · · · ·				
00	CENTRAL SERVICES & SUPPLY	14.00	0	5, 899		0	1
	0 — — — — — — —			5, 899		7	
	F - DRUGS CHARGED TO PATIENTS						
00	PHARMACY	15.00	0	473, 174		0	1
	0	+	<u>_</u>	473, 174		1	
	G - PHYSICIAN DIRECTORS	I	5		n		
00	ADMIN AND GENERAL - OTHER	5.02	0	473, 645		0	1
			— — — 	473, 645		7	'
	H - DIETARY		<u>्</u>	,, 5, 045	1	1	
00	DIETARY	10.00	138, 810	85, 525		0	1
00			138, 810	85, 525		4	

REHABILITATION HOSPITAL OF FT WAYNE Provider CCN: 15-3030

 In Lieu of Form CMS-2552-10

 Period:
 Worksheet A-7

 From 10/01/2020
 Part 1

					From 10/01/2020 To 09/30/2021	Date/Time Pre	
	·			Acquicitions		2/28/2022 4:2	9 pm
		Decimping	Purchases	Acquisitions Donation	Total	Dispession and	
		Begi nni ng Bal ances	Purchases	Donation	TOTAL	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		2.00	3.00	4.00	5.00	
1.00	Land	900, 000	0		0 0	0	1.00
2.00	Land Improvements	283, 590	3, 979		0 3, 979	-	2.00
3.00	Buildings and Fixtures	12, 325, 830	0, 777		0 0	663, 298	3.00
4.00	Building Improvements	316, 943	855, 861		0 855, 861		4.00
5.00	Fixed Equipment	010, 710	891, 944		0 891, 944		5.00
6.00	Movable Equipment	0	1,061,951		0 1,061,951		6.00
7.00	HIT designated Assets	7, 715	541, 232		0 541, 232		7.00
8.00	Subtotal (sum of lines 1-7)	13, 834, 078	3, 354, 967		0 3, 354, 967		8.00
9.00	Reconciling Items	0	0,001,707		0 0	0	9.00
10.00	Total (line 8 minus line 9)	13, 834, 078	3, 354, 967		0 3, 354, 967	-	
10100		Ending Balance	Fully		0 0,001,707	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	101.00
		Linding bar anoo	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES					
1.00	Land	900, 000	0				1.00
2.00	Land Improvements	287, 569	0				2.00
3.00	Buildings and Fixtures	11, 662, 532	0				3.00
4.00	Building Improvements	1, 172, 804	0				4.00
5.00	Fixed Equipment	648, 257	0				5.00
6.00	Movable Equipment	1, 061, 951	0				6.00
7.00	HIT designated Assets	548, 947	0				7.00
8.00	Subtotal (sum of lines 1-7)	16, 282, 060	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	16, 282, 060	0				10.00

Heal th	Financial Systems REHA	BILITATION HOSE	PITAL OF FT WAY	'NE	In Lieu of Form CMS-2552-10		
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-3030	Peri od:	Worksheet A-7	
					From 10/01/2020 To 09/30/2021	Date/Time Pre	pared:
			SU	IMMARY OF CAF	PI TAL	2/28/2022 4:2	9 pm
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)	· · · · · · · · · · · · · · · · · · ·	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	357, 537	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	175, 843	12, 038		0 0	0	2.00
3.00	Total (sum of lines 1-2)	533, 380	12, 038		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORE	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	357, 537				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	187, 881				2.00
3.00	Total (sum of lines 1-2)	0	545, 418				3.00

Heal th	n Financial Systems REHA	BILITATION HOSI	PITAL OF FT WAY	'NE	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	F	Period: From 10/01/2020 To 09/30/2021	Worksheet A-7 Part III Date/Time Prep 2/28/2022 4:29	bared:
		COMI	PUTATION OF RAT	-1 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1	1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		-			-	
1.00 2.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	13, 598, 579 7, 715	0	7, 71	0. 000567	0 0	1.00
3.00	Total (sum of lines 1-2)	13, 606, 294	L O TION OF OTHER C	13, 606, 294	1.000000 SUMMARY 0		3.00
		ALLUCA	ITON OF OTHER C	APTIAL	SUIVIIVIART	F CAPITAL	
	Cost Center Description	Taxes	Other Capital-Relate		Depreciation	Lease	
		6,00	d Costs 7.00	through 7) 8.00	9,00	10,00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		7.00	0.00	7.00	10.00	
1.00	CAP REL COSTS-BLDG & FIXT	0	0	(289, 355	9, 322	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(216, 798	157, 907	2.00
3.00	Total (sum of lines 1-2)	0	0	(506, 153	167, 229	3.00
			SL	IMMARY OF CAPI	TAL		
	Cost Center Description		Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	42, 889				523, 116	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	, s			374, 705	2.00
3.00	Total (sum of lines 1-2)	42, 889	27, 732	153, 818	3 0	897, 821	3.00

	Financial Systems HENTS TO EXPENSES	REHAE	BILITATION HOSP	PITAL OF FT WAYNE Provider CCN: 15-3030	In Lie Period:	u of Form CMS-2 Worksheet A-8	
					From 10/01/2020 To 09/30/2021	Date/Time Pre 2/28/2022 4:29	
				Expense Classification of To/From Which the Amount i		272072022 4.2	² piii
				TO/FIOIN WITCH THE AMOUNT I	s to be Aujusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1 00	· · · · · · · · · · · · · · · · · · ·	1.00	2.00	3. 00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1 00
	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)				1.00	0	1.00
	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		О		0.00	0	4.00
5.00	Refunds and rebates of		О		0.00	0	5.00
	expenses (chapter 8) Rental of provider space by		О		0.00	0	6.00
	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.00
:	stations excluded) (chapter 21)		J. J			0	
8.00	Television and radio service		О		0.00	0	8.00
	(chapter 21) Parking lot (chapter 21)		О		0.00	0	9.00
	Provi der-based physi ci an adjustment	A-8-2	-359, 964			0	10.00
11.00	Sale of scrap, waste, etc.		О		0.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	774, 533			0	12.00
	transactions (chapter 10) Laundry and linen service		О		0.00	0	13.00
	Cafeteria-employees and guests Rental of quarters to employee			CAFETERIA CAP REL COSTS-BLDG & FIXT	11.00 1.00	0	14.00 15.00
	and others	D					
	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
	patients Sale of drugs to other than		o		0.00	0	17.00
	patients Sale of medical records and	В	_12	MEDI CAL RECORDS & LI BRARY	16.00	0	18.00
	abstracts	D		MEDICAL RECORDS & EIDRART			
	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
	books, etc.) Vending machines	В	-947	ADMIN AND GENERAL - OTHER	5.02	0	20.00
21.00	Income from imposition of interest, finance or penalty		0		0.00	0	21.00
	charges (chapter 21)						
	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
1	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	01	PHYSICAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
	Utilization review - physicians' compensation		0	*** Cost Center Deleted **	* 114.00		25.00
	(chapter 21) Depreciation - CAP REL	А	-80 6130	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
	COSTS-BLDG & FLXT						
	Depreciation - CAP REL COSTS-MVBLE EQUIP	A		CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted **	* 19.00 0.00	0	28.00 29.00
30.00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67.00	0	30.00
	therapy costs in excess of limitation (chapter 14)						
	Hospice (non-distinct) (see instructions)		0/	ADULTS & PEDIATRICS	30.00		30. 99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest MISCELANEOUS INCOME	В	-21	ADMIN AND GENERAL - OTHER	5.02	0	33.00

Health Financial Systems	REHA	BILITATION HOS	PITAL OF FT WAYNE	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-3030	Peri od:	Worksheet A-8	
				From 10/01/2020		
				To 09/30/2021	Date/Time Pre 2/28/2022 4:2	
			Expense Classification of	n Worksheet A	2/20/2022 4.2	7 piii
			To/From Which the Amount i			
				s to be Aujusteu		
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	
33.01 MARKETING EXPENSE	A	-525, 610	ADMIN AND GENERAL - OTHER	5. 02	0	33.01
33.02 PATIENT TELEPHONE EXPENSE	A	-7, 224	ADMIN AND GENERAL - OTHER	5.02	0	33. 02
33.03 PATIENT TV CABLE EXPENSE	A	-7,637	OPERATION OF PLANT	7.00	0	33.03
33.04 PHYSICIAN RECRUITING EXPENSE	A	-6, 503	ADMIN AND GENERAL - OTHER	5.02	0	33.04
33.05 LOBBYING FEES SXPENSE	A	0	ADMIN AND GENERAL - OTHER	5.02	0	33.05
33. 06 CHARI TABLE CONTRI BUTI ONS	A	-821	ADMIN AND GENERAL - OTHER	5.02	0	33.06
50.00 TOTAL (sum of lines 1 thru 49		-307,489				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
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	REHABILITATION HO	SPITAL OF FT WAYNE	In Lie	eu of Form CMS-:	2552-10
STATEME	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 10/01/2020 To 09/30/2021		
	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 ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
1.00	0.00			0	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00		CAP REL COSTS-BLDG & FIXT	Capital-Related Interest	42, 889	0	4.00
4.01			PASI Capital Costs - Bldg &	72	0	4.01
4.02	2.00		PASI Capital Costs - Moveabl	9	0	4.02
4.03	5.02	ADMIN AND GENERAL - OTHER	PASI Operating Costs	6, 182	4, 140	4.03
4.04	5. 02	ADMIN AND GENERAL - OTHER	Shared Service Center Alloca			4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	New Capital - Building & Fix		0	4.05
4.06			New Capital - Movable Equipm		0	4.06
4.07		ADMIN AND GENERAL - OTHER	Non-Capital Home Office Cost			4.07
4.08			Malpractice Costs	48, 682		4.08
4.09			HIIM Allocation	0	61, 462	4.09
4.10	5. 02	ADMIN AND GENERAL - OTHER	PASI Lien Unit Collection Fe	0	1, 127	4.10
5.00	TOTALS (sum of lines 1-4).			1,021,589		5.00
	Transfer column 6, line 5 to				,	
	Worksheet A-8, column 2,					
	line 12.					
* The	amounts on Lines 1 4 (and sub	coninto oc ennrennieto) ene t	transformed in detail to Wark	chect A column	(Lines as	

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.

nus ne	t been posted to worksheet A,	corumna r unu/or z, the unou	it arrowable 3h	oura be marcated micoralin 4	or this part.	
				Related Organization(s) and/	or Home Office	
						1
						1
						L
	Symbol (1)	Name	Percentage of	Name	Percentage of	1
			Ownershi p		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В		0.00	COMMUNITY HEALT	100.00	6.00
7.00	В		0.00	LUTHERAN	100.00	7.00
8.00	G	HOSPI TAL LAUNDR	100.00	LAUNDRY	100.00	8.00
9.00	В		0.00	PASI	100.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or	NON-FINANCIAL				100.00
	non-financial) specify:					

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

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

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

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

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

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

lealth Financial Systems	REHABILITATION HOSPITA	AL OF FT WAYNE	In Lieu	ı of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FR DFFICE COSTS	OM RELATED ORGANIZATIONS AND HOME		From 10/01/2020 To 09/30/2021	Date/Time Prepared:
				1/10/1011 1.10 pm

			2/28/2022 4:3	29 pm
	Net	Wkst. A-7 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	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	42, 889	11		4.00
4.01	72	9		4.01
4.02	9	9		4.02
4.03	2,042	0		4.03
4.04	229, 670	0		4.04
4.05	21, 277	9		4.05
4.06	49, 493	9		4.06
4.07	532, 988	0		4.07
4.08	-41, 318	0		4.08
4.09	-61, 462			4.09
4.10	-1, 127			4.10
5.00	774, 533			5.00

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

Related Organization(s) and/or Home Office		
Type of Business		
6.00		
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HEALTHCARE	6.00
7.00	HOSPI TAL	7.00
8.00	CONSOL LAUNDRY	8.00
	DEBT COLLECTION	9.00
10.00		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.

ŀ

Heal th	Financial Syste	ems REF	ABILITATION HO	SPITAL OF FT WA	YNE	In Lie	eu of Form CMS-	2552-10
	R BASED PHYSIC				CCN: 15-3030	Period: From 10/01/2020 To 09/30/2021	Worksheet A-8 Date/Time Pre	3-2 epared:
		Cont. Conton (Dhumi ci ca	Tatal	Desterational	Durautialaur		2/28/2022 4:2	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component		Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	473, 645		193, 461	211, 500	1, 118	1.00
2.00	0.00	ADDETS & FEDIATRICS	473, 045				1, 118	
3.00	0.00		0				0	
4.00	0.00			0			0	4.00
4.00 5.00	0.00		0	0	-		0	5.00
6.00	0.00		0	0		0	0	6.00
7.00	0.00		0	0	, i i i i i i i i i i i i i i i i i i i	0	0	7.00
8.00	0.00		0			0	0	8.00
9.00	0.00		0	0		0	0	9,00
10.00	0.00		0	0		0	0	10.00
200.00	0.00		473, 645	280, 184	193, 461	0	-	200.00
-	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	200.00
	WKSL. A LINE #	I denti fi er		Unadjusted RCE			of Malpractice	
		raciterrer		Limit	Conti nui ng	Share of col.	Insurance	
					Education	12	i nou unoc	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	113, 681	5, 684	C	0	0	1.00
2.00	0.00		0	0	C	0	0	2.00
3.00	0.00		0	0	C	0	0	3.00
4.00	0.00		0	0	C	0	0	4.00
5.00	0.00		0	0	C	0	0	5.00
6.00	0.00		0	0	C	0	0	6.00
7.00	0.00		0	0	C	0	0	7.00
8.00	0.00		0	0	C	0	0	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00		0	0	C	0	0	10.00
200.00			113, 681	5, 684	C	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	0		79, 780			1.00
2.00	0.00		0	0		0		2.00
3.00	0.00		0	0				3.00
4.00	0.00		0	0	-			4.00
5.00	0.00		0	0	-	0		5.00
6.00	0.00		0	0		0		6.00
7.00	0.00		0	0	C	0		7.00
8.00	0.00		0	0	C	0		8.00
9.00	0.00		0	0	-	0		9.00
10.00	0.00		0	0	-	0		10.00
200.00			0	113, 681	79, 780	359, 964		200.00

REHABILITATION HOSPITAL OF FT WAYNE

COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-3030	Period: From 10/01/2020 To 09/30/2021	Worksheet B Part I Date/Time Pre 2/28/2022 4:2	
			CAPI TAL REI	ATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	ADMI TTI NG	
		0	1.00	2.00	4.00	5.01	
	GENERAL SERVICE COST CENTERS	Ū		2100		0101	
1.00	00100 CAP REL COSTS-BLDG & FIXT	523, 116	523, 116				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	374, 705		374, 70)5		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 126, 079	2, 110	1, 86	1, 130, 050		4.00
5.01	00570 ADMI TTI NG	397, 958	10, 870	9, 58	21, 143	439, 559	5.01
5. 02	00590 ADMIN AND GENERAL - OTHER	2, 433, 456	41, 171	36, 31	4 159, 288	0	5.02
7.00	00700 OPERATION OF PLANT	936, 385	95, 829	84, 52	25 27, 438	0	7.00
3.00	00800 LAUNDRY & LINEN SERVICE	65, 644	0		0 0	0	8.00
9.00	00900 HOUSEKEEPI NG	220, 512	10, 353	9, 13	23, 794	0	9.00
10.00	01000 DI ETARY	534, 490	0		0 42, 400	0	10.00
11.00	01100 CAFETERI A	149, 130	39, 999	35, 28	17, 813	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	500, 603	1, 120	98	56, 202	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	9, 692	7, 907	6, 97	4 972	0	14.00
15.00	01500 PHARMACY	214,070	3, 350	2, 95	24, 500	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	257, 163	3, 841	3, 38	18, 815	0	16.00
17.00	01700 SOCIAL SERVICE	0	2, 489	2, 19	06 0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS		_	_			
30. 00	03000 ADULTS & PEDIATRICS	4, 626, 892	66, 605	58, 74	434, 890	156, 295	30.00
	ANCILLARY SERVICE COST CENTERS		-				
54.00	05400 RADI OLOGY-DI AGNOSTI C	10, 486		3, 26		7, 576	54.00
50.00	06000 LABORATORY	87, 430			0 5, 128	21, 271	60.00
55.00	06500 RESPI RATORY THERAPY	20, 538		76	50 1, 165	117	65.00
6. 00	06600 PHYSI CAL THERAPY	1, 126, 870	86, 915	76, 66		67, 819	
57.00	06700 OCCUPATI ONAL THERAPY	904, 117	41, 033	36, 19	93 107, 064	68, 899	67.00
8.00	06800 SPEECH PATHOLOGY	370, 606	3, 109	2,74	42, 559	19, 748	
9.00	06900 ELECTROCARDI OLOGY	181	0		0 5	161	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 899	0		0 0	690	
73.00	07300 DRUGS CHARGED TO PATIENTS	473, 174	0		0 0	82, 503	
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	118, 859	3, 549	3, 13	30 14, 158	8, 378	76.00
76.01	03950 HEMODIALYSIS & OTHER ANCILLARY	176, 135	0		0 0	6, 102	76.0
	SPECIAL PURPOSE COST CENTERS						
118.00		15, 664, 190	424, 815	374, 70	1, 130, 017	439, 559	118.00
	NONREI MBURSABLE COST CENTERS			1			
	19200 PHYSI CI ANS' PRI VATE OFFI CES	3, 437	0		0 33		192.00
	07950 NON-REI MBURSABLE COST	0	0		0 0		194.00
	07951 MARKETING/PUBLIC RELATIONS	0	0		0 0		194. 01
	07952 TENANT LEASED SPACE	0	98, 301		0 0	0	194. 02
200.00							200. 00
201.00			0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	15, 667, 627	523, 116	374, 70	1, 130, 050	439, 559	202.00

Heal th	Financial Systems REHA	BILITATION HOSP	ITAL OF FT WAY	/NE	In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-3030 P	eriod:	Worksheet B	
				F	rom 10/01/2020	Part I	
				T	o 09/30/2021	Date/Time Pre	
						2/28/2022 4:2	9 pm
	Cost Center Description	Subtotal	ADMIN AND	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
			GENERAL -	PLANT	LINEN SERVICE		
			OTHER	7.00	0.00	0.00	
		5A. 01	5.02	7.00	8.00	9.00	
1 00	GENERAL SERVICE COST CENTERS						1 4 66
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG						5.01
5.02	OO590 ADMIN AND GENERAL - OTHER	2, 670, 229	2, 670, 229				5.02
7.00	00700 OPERATION OF PLANT	1, 144, 177	235, 063				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	65, 644	13, 486	0	79, 130		8.00
9.00	00900 HOUSEKEEPI NG	263, 791	54, 194	38, 268	0	356, 253	9.00
10.00	01000 DI ETARY	576, 890	118, 518	0	0	0	10.00
11.00	01100 CAFETERI A	242, 223	49, 763	147, 851	0	53, 878	11.00
13.00	01300 NURSING ADMINISTRATION	558, 913	114, 825	4, 139	0	1, 508	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	25, 545	5, 248			10, 650	
15.00	01500 PHARMACY	244, 875	50, 308			4, 513	•
	01600 MEDI CAL RECORDS & LI BRARY	283, 207	58, 183			5, 174	•
	01700 SOCIAL SERVICE	4, 685	963		-	3, 353	
	INPATIENT ROUTINE SERVICE COST CENTERS	1,000	,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0,000	
30.00	03000 ADULTS & PEDI ATRI CS	5, 343, 430	1, 097, 775	246, 195	44, 386	89, 716	30.00
	ANCI LLARY SERVI CE COST CENTERS						1
54.00	05400 RADI OLOGY-DI AGNOSTI C	25,033	5, 143	13, 690	0	4, 989	54.00
60, 00	06000 LABORATORY	113, 829	23, 385	0	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	23, 441	4, 816		0	1, 160	65.00
66.00	06600 PHYSI CAL THERAPY	1, 490, 949	306, 305			117,074	•
67.00	06700 OCCUPATI ONAL THERAPY	1, 157, 306	237, 760			55, 270	•
68.00	06800 SPEECH PATHOLOGY	438, 765	90, 141			4, 188	
69.00	06900 ELECTROCARDI OLOGY	347	71	0		0	•
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	6, 589	1, 354		0	0	
	07300 DRUGS CHARGED TO PATIENTS	555,677	114, 160		0	0	
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	148,074	30, 421		-	4, 780	
	03950 HEMODIALYSIS & OTHER ANCILLARY	182, 237	37, 439			4,700	•
70.01	SPECIAL PURPOSE COST CENTERS	102,237	57,437	0	0	0	70.01
118.00		15, 565, 856	2, 649, 321	1, 015, 886	79, 130	356, 253	1118 00
110.00	NONREI MBURSABLE COST CENTERS	13, 303, 030	2,047,321	1,013,000	77, 130	550, 255	1110.00
102 00	19200 PHYSI CLANS' PRI VATE OFFICES	3, 470	713	0	0	0	192.00
	07950 NON-REI MBURSABLE COST	3,470	0				192.00
	07950 NON-RET MBORSABLE COST 07951 MARKETI NG/PUBLI C RELATI ONS	0	0		-		194.00
	07951 MARKETING/POBLIC RELATIONS 07952 TENANT LEASED SPACE	98, 301	0	-	-		194.01
200.00			20, 195	303, 354	0	0	
	· · · · · · · · · · · · · · · · · · ·	0	~			0	200.00
201.00 202.00		0	2, 670, 229	1, 379, 240	70 120		201.00
202.00	I TOTAL (SUM TIMES TTO ENTOUGH 201)	15, 667, 627	2,070,229	1, 379, 240	79, 130	300, 253	1202. UU

Heal th	Financial Systems REHAL	BILITATION HOSPI	TAL OF FT WAY	/NE	In Lie	u of Form CMS-:	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-3030	Peri od:	Worksheet B	
					From 10/01/2020		
					To 09/30/2021	Date/Time Pre 2/28/2022 4:2	parea: 9 nm
	Cost Center Description	DI ETARY	CAFETERIA	NURSI NG	CENTRAL	PHARMACY	
	best best beschiption	DIEMar	on Elen n	ADMI NI STRATI C		1100000	
					SUPPLY		
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS	· · ·		•			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG						5.01
5.02	00590 ADMIN AND GENERAL - OTHER						5.02
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	695, 408					10.00
11.00	01100 CAFETERI A	0	493, 715				11.00
13.00	01300 NURSING ADMINISTRATION	0	35, 146	714, 53	1		13.00
	01400 CENTRAL SERVICES & SUPPLY	0	1, 050		0 71, 719		14.00
15.00	01500 PHARMACY	0	15, 257		0 101	327, 439	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	10, 192		0 49	0	16.00
17.00	01700 SOCIAL SERVICE	0	0		0 0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			•			1
	03000 ADULTS & PEDIATRICS	695, 408	260, 848	714, 53	1 59, 558	0	30.00
	ANCILLARY SERVICE COST CENTERS						
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60.00	06000 LABORATORY	0	7, 906		0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	741		0 3, 668	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	71, 960		0 4,054	0	66.00
	06700 OCCUPATI ONAL THERAPY	0	63, 189		0 1, 884	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	21, 125		0 390	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 2,005	0	71.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	327, 439	73.00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	6, 239		0 0	0	76.00
	03950 HEMODIALYSIS & OTHER ANCILLARY	0	0		0 0	0	76.01
	SPECIAL PURPOSE COST CENTERS						
118.00		695, 408	493, 653	714, 53	1 71, 709	327, 439	118.00
	NONREI MBURSABLE COST CENTERS			1	1		
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	62		0 10		192.00
	07950 NON-REI MBURSABLE COST	0	0		0 0		194.00
	07951 MARKETI NG/PUBLI C RELATI ONS	0	0		0 0		194.01
	07952 TENANT LEASED SPACE	0	0		0 0	0	194.02
200.00			-			_	200.00
201.00			0	744	0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	695, 408	493, 715	714, 53	1 71, 719	327, 439	202.00

Heal th	Fi nanci al	Systems	
COST A		CENEDAL	CED

In Lieu of Form CMS-2552-10

		BILITATION HUS	PITAL OF FI WAY		In Lie	eu of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-3030	Peri od:	Worksheet B	
					From 10/01/2020		
					To 09/30/2021		
	Cost Contor Description	MEDI CAL	SOCI AL SERVI CE	Subtotal	Intorn 0	2/28/2022 4:2 Total	<u>29 pili</u>
	Cost Center Description		SUCIAL SERVICE	Subtotal	Intern &		
		RECORDS &			Residents Cost		
		LI BRARY			& Post		
					Stepdown		
					Adjustments		
		16.00	17.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS	i .	1	r		1	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG						5.01
5.02	00590 ADMIN AND GENERAL - OTHER						5.02
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERIA						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	371,004					16.00
17.00	01700 SOCIAL SERVICE	0	18, 202				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	131, 954	18, 202	8, 702, 00	0 03	8, 702, 003	30.00
	ANCI LLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 393	0	55, 24	48 0	55, 248	54.00
60,00	06000 LABORATORY	17, 951		163, 0		163, 071	1
65.00	06500 RESPIRATORY THERAPY	99		37, 10		37, 109	
66.00	06600 PHYSI CAL THERAPY	57, 234		2, 385, 32		2, 385, 320	
67.00	06700 OCCUPATI ONAL THERAPY	58, 145	-	1, 743, 49		1, 743, 492	1
68.00	06800 SPEECH PATHOLOGY	16, 665					
				582, 70		582, 767	
69.00	06900 ELECTROCARDI OLOGY	136	-	55		554	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	583		10, 53		10, 531	1
73.00	07300 DRUGS CHARGED TO PATIENTS	69, 625		1, 066, 90			
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	7,070		209, 70			
76.01	03950 HEMODIALYSIS & OTHER ANCILLARY	5, 149	0	224, 82	25 0	224, 825	76.01
	SPECIAL PURPOSE COST CENTERS						
118.00		371,004	18, 202	15, 181, 52	22 0	15, 181, 522	2 118. 00
	NONREI MBURSABLE COST CENTERS						
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0 0	4, 2	55 0	4, 255	192.00
	07950 NON-REI MBURSABLE COST	0	0		0 0		194.00
	07951 MARKETI NG/PUBLIC RELATIONS	0	0		0 0		194.01
	07952 TENANT LEASED SPACE			481, 85	0		194.02
200.00		Ĭ	0	101,0	0 0		200.00
200.00	,	_	_		0 0		200.00
		371,004	18, 202	15, 667, 62	-		1
202.00	TOTAL (sum lines 118 through 201)	371,004	10, 202	10,007,02	2/ 0	15, 667, 627	1202.00

Heal th	Fina	nci a	al S	Syste	ems	
	TLON	0F	CAP	ΤΔΙ	RELATED	C

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

	I ON OF CAPITAL RELATED COSTS		Provider CO	CN: 15-3030 P F T	eriod: rom 10/01/2020 o 09/30/2021	Worksheet B Part II Date/Time Pre 2/28/2022 4:2	pared:
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL REI BLDG & FI XT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	ENERAL SERVICE COST CENTERS		-				
	0100 CAP REL COSTS-BLDG & FLXT						1.00
	0200 CAP REL COSTS-MVBLE EQUIP						2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT	0	_/		3, 971	3, 971	4.00
	10570 ADMI TTI NG	0	10, 870	9, 588	20, 458	74	5.01
	0590 ADMIN AND GENERAL - OTHER	0	41, 171	36, 314			
	0700 OPERATION OF PLANT	0	95, 829	84, 525	180, 354	96	7.00
	0800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
	10900 HOUSEKEEPI NG	0	10, 353	9, 132	19, 485	84	9.00
	1000 DI ETARY	0	0	0	0	149	10.00
	1100 CAFETERI A	0	39, 999	35, 281	75, 280	63	11.00
13.00 0	1300 NURSI NG ADMI NI STRATI ON	0	1, 120	988	2, 108	198	13.00
14.00 0	1400 CENTRAL SERVICES & SUPPLY	0	7, 907	6, 974	14, 881	3	14.00
15.00 0	1500 PHARMACY	0	3, 350	2, 955	6, 305	86	15.00
16.00 0	1600 MEDICAL RECORDS & LIBRARY	0	3, 841	3, 388	7, 229	66	16.00
17.00 0	1700 SOCIAL SERVICE	0	2, 489	2, 196	4, 685	0	17.00
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDI ATRI CS	0	66, 605	58, 748	125, 353	1, 528	30.00
	NCILLARY SERVICE COST CENTERS	1			1		
	15400 RADI OLOGY-DI AGNOSTI C	0	3, 704	3, 267		0	
	6000 LABORATORY	0	0	0	-	18	
	6500 RESPI RATORY THERAPY	0	861	760		4	65.00
	6600 PHYSI CAL THERAPY	0	86, 915	76, 662		466	1
	6700 OCCUPATI ONAL THERAPY	0	41, 033				
	6800 SPEECH PATHOLOGY	0	3, 109	2, 743	5, 852	150	
	6900 ELECTROCARDI OLOGY	0	0	0	0	0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	
	7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	3, 549	3, 130			
	3950 HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
	PECIAL PURPOSE COST CENTERS	-					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	424, 815	374, 705	799, 520	3, 9/1	118.00
	ONREI MBURSABLE COST CENTERS	-	-	-	-	-	
	9200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	-		192.00
	17950 NON-REI MBURSABLE COST	0	0	0	0		194.00
	7951 MARKETI NG/PUBLI C RELATI ONS	0	0 00	0	0		194.01
	17952 TENANT LEASED SPACE	0	98, 301	0	98, 301	0	194.02
200.00	Cross Foot Adjustments		_	_	0	_	200.00
201.00	Negative Cost Centers			0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	523, 116	374, 705	897, 821	3, 9/1	202.00

		BILITATION HOSPI				u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 10/01/2020 o 09/30/2021	Worksheet B Part II Date/Time Pre 2/28/2022 4:20	pared: 9 pm
	Cost Center Description	ADMI TTI NG	ADMIN AND	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	- p=
			GENERAL -	PLANT	LINEN SERVICE		
		5.01	OTHER	7.00	0.00	9.00	
	GENERAL SERVICE COST CENTERS	5.01	5.02	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
2.00	00200 CAP REL COSTS-MUBLE EQUIP						4.00
4.00 5.01	00570 ADMITTING	20 522					4.00 5.01
		20, 532	70.045				
5.02	00590 ADMIN AND GENERAL - OTHER	0	78, 045				5.02
7.00	00700 OPERATION OF PLANT	0	6, 871	187, 321	004		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	394	0	394	0/ 050	8.00
9.00	00900 HOUSEKEEPI NG	0	1, 584	5, 197	0	26, 350	9.00
10.00	01000 DI ETARY	0	3, 464	0	0	0	10.00
11.00	01100 CAFETERI A	0	1, 455		0	3, 985	
	01300 NURSING ADMINISTRATION	0	3, 356	562	0	112	13.00
	01400 CENTRAL SERVICES & SUPPLY	0	153	3, 969	0		14.00
	01500 PHARMACY	0	1, 470		0	334	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1, 701	1, 928	0	383	16.00
17.00	01700 SOCIAL SERVICE	0	28	1, 250	0	248	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			r	TT		
30.00	03000 ADULTS & PEDIATRICS	7, 285	32, 083	33, 437	221	6, 636	30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	354	150	1, 859	0	369	54.00
60.00	06000 LABORATORY	995	684	0	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	5	141	432	0	86	65.00
66.00	06600 PHYSI CAL THERAPY	3, 172	8, 953	43, 633	82	8, 657	66.00
67.00	06700 OCCUPATI ONAL THERAPY	3, 222	6, 950	20, 599	91	4, 088	67.00
68.00	06800 SPEECH PATHOLOGY	924	2, 635	1, 561	0	310	68.00
69.00	06900 ELECTROCARDI OLOGY	8	2	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	32	40	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 858	3, 337	0	0	0	73.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	392	889	1, 781	0	354	76.00
76.01	03950 HEMODIALYSIS & OTHER ANCILLARY	285	1, 094	0	0	0	76.01
	SPECIAL PURPOSE COST CENTERS						
118.00		20, 532	77, 434	137, 970	394	26, 350	118.00
	NONREI MBURSABLE COST CENTERS			I	1		
	19200 PHYSICIANS' PRIVATE OFFICES	0	21	0	0	-	192.00
	07950 NON-REI MBURSABLE COST	0	0	0	0	-	194.00
	07951 MARKETI NG/PUBLI C RELATI ONS	0	0	0	0	-	194.01
194.02	07952 TENANT LEASED SPACE	0	590	49, 351	0	0	194. 02
200.00	Cross Foot Adjustments						200.00
201.00		0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	20, 532	78, 045	187, 321	394	26, 350	202 00

Heal th	Financial Systems REHAI	BILITATION HOSPI	TAL OF FT WAY	YNE	In Lie	u of Form CMS-	2552-10
	TION OF CAPITAL RELATED COSTS		Provider C	CN: 15-3030	Period: From 10/01/2020 To 09/30/2021	Worksheet B Part II Date/Time Pre 2/28/2022 4:2	pared:
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI C	SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG						5.01
5.02	00590 ADMIN AND GENERAL - OTHER						5.02
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	3, 613					10.00
11.00	01100 CAFETERI A	0	100, 863	6			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	7,180	13, 51	6		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	215	j -	0 20, 009		14.00
15.00	01500 PHARMACY	0	3, 117		0 28	13, 022	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	2, 082		0 14	0	16.00
17.00	01700 SOCIAL SERVICE	0	C		0 0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	3, 613	53, 289	13, 51	6 16, 617	0	30.00
	ANCI LLARY SERVI CE COST CENTERS						1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C)	0 0	0	54.00
60.00	06000 LABORATORY	0	1, 615	j -	0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	151		0 1, 023	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	14, 701		0 1, 131	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	12, 909		0 525	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	4, 316		0 109	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 559	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	13, 022	73.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	1, 275		0 0	0	76.00
76.01	03950 HEMODIALYSIS & OTHER ANCILLARY	0	C		0 0	0	76.01
	SPECIAL PURPOSE COST CENTERS	I					1
118.00		3, 613	100, 850	13, 51	6 20,006	13, 022	118.00
	NONREI MBURSABLE COST CENTERS						
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	13		0 3	0	192.00
	07950 NON-REI MBURSABLE COST	0	C		0 0		194.00
	07951 MARKETI NG/PUBLI C RELATI ONS	0	C		0 0		194.01
	07952 TENANT LEASED SPACE	0	C		0 0		194.02
200.00		Ű					200.00
201.00		0	C		0 0	0	201.00
202.00	5	3, 613	100, 863	13, 51	6 20,009		202.00

Heal th	Fi nai	nci al	Syste	ems		
	TLON			DEL	ATED	

	TION OF CAPITAL RELATED COSTS		Provi der CC	CN: 15-3030	Period: From 10/01/2020 To 09/30/2021		epared:
	Cost Center Description	RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		
		16.00	17.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS		I				
	DO100 CAP REL COSTS-BLDG & FIXT						1.00
	DO200 CAP REL COSTS-MVBLE EQUIP						2.00
	DO400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	DO570 ADMI TTI NG						5.01
	DO590 ADMIN AND GENERAL - OTHER						5.02
	DO700 OPERATION OF PLANT						7.00
	DO800 LAUNDRY & LINEN SERVICE						8.00
	DO900 HOUSEKEEPI NG						9.00
	D1000 DI ETARY						10.00
	D1100 CAFETERI A						11.00
13.00 0	D1300 NURSI NG ADMI NI STRATI ON						13.00
14.00 C	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 C	D1500 PHARMACY						15.00
16.00 0	D1600 MEDICAL RECORDS & LIBRARY	13, 403					16.00
17.00 0	D1700 SOCIAL SERVICE	0	6, 211				17.00
1	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00 0	D3000 ADULTS & PEDIATRICS	4, 760	6, 211	304, 54	19 0	304, 549	30.00
A	ANCILLARY SERVICE COST CENTERS						
54.00 C	D5400 RADI OLOGY-DI AGNOSTI C	231	0	9, 93	34 0	9, 934	54.00
60.00 C	D6000 LABORATORY	649	0	3, 96	0 0	3, 961	60.00
65.00 C	06500 RESPI RATORY THERAPY	4	0	3, 46	07 0	3, 467	65.00
66.00 C	D6600 PHYSI CAL THERAPY	2,069	0	246, 44	1 0	246, 441	66.00
67.00 C	06700 OCCUPATI ONAL THERAPY	2, 102	0	128, 08	38 0	128, 088	67.00
68.00 C	D6800 SPEECH PATHOLOGY	603	0	16, 46	0 0	16, 460	68.00
69.00 C	06900 ELECTROCARDI OLOGY	5	0	1	5 0	15	69.00
71.00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	21	0	65	52 0	652	71.00
73.00 0	07300 DRUGS CHARGED TO PATIENTS	2, 517	0	22, 73	34 0	22, 734	73.00
76.00 0	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	256	0	11, 67	6 0	11, 676	76.00
76.01 0	03950 HEMODIALYSIS & OTHER ANCILLARY	186	0	1, 56	5 0	1, 565	76.01
S	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	13, 403	6, 211	749, 54	2 0	749, 542	118.00
N	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	3	37 0	37	192.00
	07950 NON-REI MBURSABLE COST	0	0		0 0		194.00
	07951 MARKETI NG/PUBLIC RELATI ONS	0	О		0 0	0	194.01
	07952 TENANT LEASED SPACE	0	0	148, 24			
200.00	Cross Foot Adjustments				0 0		200.00
	Negative Cost Centers	0			0 0		201.00
201.00		0	UI		0 0		1201.00

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

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

Cast Center Description CAPITAL RELATED COSTS ENFLOYEE	COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-3030		From 10/01/2020						
Cost Center Description CAPITAL RELATED COSTS BLD 6 & FIXT MMBLE FOUL (SQUARE FEED) MMBLE FOUL ENDING SULARE SULARE DESCRIPTION DESCRIPT					To 09/30/2021						
CRUCKER FEET CSOLARE FEET DEPARTMENT (CROSS SLALARE ES) CCRROSS CLARREES) 1.00 2.00 4.00 5.01 54.02 1.00 00000 (CAP FEL COSTS - MORE FOLIPE (CROSS) 1.00 2.00 4.00 5.01 54.02 2.00 00000 (CAP FEL COSTS - MORE FOLIP S (CROSS) 1.00 2.00 4.00 5.01 54.02 2.01 00000 (CAP FEL COSTS - MORE FOLIP S (CROSS) 1.00 2.00 6.00,035 6.7.401,160 2.00 5.01 00570 ADMI MAND CREMENL - OTHER 57.360 1.241,270 0.00 6.800,035 6.7.401,160 5.01 8.00,035 0.00000 CADRESTEREM NG 14.422 13.3,512 213.815 0.00 0.00 1.00 10.00		CAPITAL REL	ATED COSTS								
CRUCKER FEET CSOLARE FEET DEPARTMENT (CROSS SLALARE ES) CCRROSS CLARREES) 1.00 2.00 4.00 5.01 54.02 1.00 00000 (CAP FEL COSTS - MORE FOLIPE (CROSS) 1.00 2.00 4.00 5.01 54.02 2.00 00000 (CAP FEL COSTS - MORE FOLIP S (CROSS) 1.00 2.00 4.00 5.01 54.02 2.01 00000 (CAP FEL COSTS - MORE FOLIP S (CROSS) 1.00 2.00 6.00,035 6.7.401,160 2.00 5.01 00570 ADMI MAND CREMENL - OTHER 57.360 1.241,270 0.00 6.800,035 6.7.401,160 5.01 8.00,035 0.00000 CADRESTEREM NG 14.422 13.3,512 213.815 0.00 0.00 1.00 10.00	Cost Center Description	BLDG & FLXT	MVBLE FOULP	EMPLOYEE	ADMI TTI NG	Reconciliation					
Control Control <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>											
Elements Stand Stand 0 0.0000 (AP REL COST CENTERS 1.00 2.00 0.0000 (AP REL COSTS-MUDE & FLYT 228,820 5.01 5.01 2.00 2.00 0.0000 (AP REL COSTS-MUDE & EDUIP 2.940 5.91,844 8.86,035 4.00 8.00 6.7,00 0.00 6.00 0.00 6.00 0.00 6.00 0.00 6.00 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 0.00 0.00 0.00					CHARGES)						
Extrad SERVICE COST CENTERS 5.01 5A.02 1.00 00100 CAP REL COSTS-BUDG & FIXT 728,820 591,864 1.00 2.00 4.00 5.01 57.360 57.360 1.00 2.00 4.00 0.200 CMP RLC COSTS-BUDG & FIXT 2.00 4.00 0.000 CMP RLC COSTS-BUDG & FIXT 2.00 4.00 5.01 5.01 5.01 0.070 AMIT TM & CENERAL - 0THER 5.73.80 5.73.80 5.74.01,160 -2.670,229 5.03 0.00 0000 OHENDITY EDENETITS DEPARTINENT 2.940 5.73.80 5.73.80 1.75.71 0 -2.670,229 5.03 0.00 00000 OHENDITY EDENETITS DEPARTINENT 0 0.30.09 0 0 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00 1.00 0.00											
CHNERAL SERVICE COST CENTERS 1.00 000000 CAP REL COSTS-MUBLE COULP 728,820 591,864 2.00 0.00		1 00	2 00		5 01	5A 02					
2.00 00200 CAP. REL. COSTS-MUBLE EQUIP 591.864 4 4 4 4 4 591.864 4 6 5.01 00570 ADMITTING 15,144 15,144 15,144 164.755 6 7.00 -2.670.29 5.01 5.01 5.00 00700 OPERATION OF PLANT 133.512 133.512 213.815 0 -2.670.29 5.02 0.00 00000 OPERATION OF PLANT 133.512 133.512 133.512 133.414 0	GENERAL SERVICE COST CENTERS		2100		0.01	0/11/02					
4. 00 00400 EMPLOYEE DEMPITIS DEPARTMENT 2.940 8. 806, 035	1.00 00100 CAP REL COSTS-BLDG & FIXT	728, 820					1.00				
5. 01 00570 ADM TT NG 15. 144 15. 144 15. 144 164. 755 67. 401. 160 5. 01 0.00 00700 OPERATION OF PLANT 133. 512 133. 512 133. 512 133. 512 0 -2, 670. 29 5. 02 0.00 00000 OPERATION OF PLANT 133. 512 133. 512 133. 512 133. 512 0 -2, 670. 29 5. 02 0.00 00000 OPERATION OF PLANT 133. 512 133. 512 133. 512 133. 512 135. 514 0 -2, 670. 29 5. 02 0.00 00000 DIETARY 0 330. 409 0 0 10. 0 11. 00 1. 10. 0 1. 30. 0 13. 00 13. 0 0 13. 0 0 13. 0 0 13. 0 0 14. 00 14. 00 14. 00 14. 00 15. 00 15. 00 15. 00 15. 00 16. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 16. 00 17. 161. 56. 0 17. 161											
5. 02 00590 ADMI AND GENERAL - OTHER 57, 360 57, 360 1, 241, 270 0 -2, 670, 29 5, 02 0 7, 00 00 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>											
7. 00 00700 0PERATION OF PLANT 133, 512 130 130 130 130 130 130 130 130 130 130 130 130 130 130<											
8. 00 000000 LINEN SERVICE 0											
9.00 00900 HOUSEKEEPING 14,424 14,424 185,414 0 0 9.00 10.00 0100 OLETARY 0 330,409 0 0 10.00 13.00 01100 CAFTERIA SERVICES 55,728 538,810 0 0 11.00 13.00 01400 CENTRAL SERVICES & SUPPLY 11,016 11,016 7,571 0 0 14.00 15.00 01500 DHARMACY 4.668 4.668 146,618 0 0 16.00 10.00 000 ODULITS & PENICE 3,468 3,468 0 0 16.00 11.001 NE SERVICE COST CENTERS 92,796 3,388,935 23,969,062 0 60.00 00 03000 ODULITS & PENICE COST CENTERS 92,796 3,388,935 23,969,062 0 60.00 00 04000 LABRATORY 1,200 1,200 9,958 1,161,550 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>						-					
11.00 01100 CAFETERIA 55,728 138,810 0 0 11.00 13.00 01300 NURSI KG ADMINI STRATION 1.560 1.560 437,963 0 0 14.00 15.00 01500 PHARMACY 4.668 4.668 190,918 0 0 15.00 16.00 01600 MEDI CAL RECORDS & LIBRARY 5.352 5.352 146,618 0 0 0 0 0 0 16.00 16.00 16.00 16.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 16.00 16.00 16.00 0 17.00 0 <t< td=""><td></td><td>14, 424</td><td>14, 424</td><td>185, 41</td><td>4 0</td><td>0</td><td>9.00</td></t<>		14, 424	14, 424	185, 41	4 0	0	9.00				
13.00 01300 NURSI NG ADMINISTRATION 1.560 1.500 1437,963 0 0 13.00 14.00 01400 CENTRAL SERVICES S.UPPLY 11.016 1.510 0 <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td>0</td> <td>10.00</td>		0	0			0	10.00				
14.00 OI1400 CENTRAL SERVICES & SUPPLY 11,016 7,571 0 0 14.00 15.00 OI500 PHARMACY 4.668 10.0918 0 0 15.00 15.00 OI500 SOCI AL SERVICE 3.468 3,468 0						-					
15.00 O1500 PHARMACY 4.668 4.668 190.918 0 0 15.00 16.00 O1600 MEDICAL RECORDS & LIBRARY 5.352 5.352 146.618 0						-					
16.00 O1600 MEDICAL RECORDS & LIBRARY 5, 352 5, 352 146, 618 0 0 0 17.00 17.00 OTOO SOCIAL SERVICE 3, 468 3, 468 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>						-					
17.00 001700 SOCIAL SERVICE 3.468 3.468 0 0 0 17.00 30.00 O3000 ADULTS & PEDIATRICS 92,796 92,796 3.388,935 23,969,062 0 30.00 ARCILLARY SERVICE COST CENTERS 0 0 0 39.00 0 39.00 1,161,560 0 5,160 0 1,161,560 0 54.00 65.00 06500 RESPIRATORY THERAPY 1,200 1,200 9,079 17,986 0 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00						-					
30.00 03000 ADULTS & PEDIATRICS 92,796 3,388,935 23,969,062 0 30.00 ANCILLARY SERVICE COST CENTERS 0 0 39,958 3,261,439 0 60.00 65.00 06500 RESPI RATRY THERAPY 1,200 1,200 9,079 17,986 0 65.00 65.00 06500 RESPI RATRY THERAPY 1,21,092 1,033,941 10,388,544 0 66.00 66.00 06600 PWSI CAL THERAPY 121,092 1,332 43.32 331,644 3,027,876 0 68.00 69.00 06600 SPECH PATHOLOGY 4,332 4,332 331,644 3,027,876 0 68.00 71.00 010 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 12,649,980 71.00 73.00 76.00 03950 PSYCH HATRI C/PSYCHOLOGI CAL SERVICES 4,944 4,944 110,330 1,24,572 0 76.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>						-					
ANCILLARY SERVICE COST CENTERS 54.00 06400 RADIOLOGY-DIAGNOSTIC 5.160 0 1.161.560 0 54.00 06400 RADIOLOGY-DIAGNOSTIC 5.160 0 39,958 3.261,439 0 60.00 66.00 06500 RESPIRATORY 1.200 1.200 9,079 17,986 0 65.00 66.00 06500 RESPIRATORY 121,092 121,092 10,38,941 0 66.00 66.00 06500 SPECH PATHOLOGY 4332 331,644 3.027,876 68.00 66.00 06900 ELECTROCARDIOLOGY 4,332 4,332 331,644 3.027,876 68.00 67.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 10.249,980 73.00 73.00 07300 DRUGS CHARGED TO PATIENT 0 0 0 12,249,980 73.00 76.01 03550 PSYCHI ATRIC/PSYCHOLOGICAL SERVICES 4,944 4,944 10,330 1,284,572 0 76.01 9590 HEMDOLALS (SUM OF LINERS 1 through 117) 591,864 591,864 8,805,775 67.4						1					
64.00 Codol RADIOLOGY-DIACNOSTIC 5, 160 0 1, 161, 560 0 54, 00 60.00 Codol CABORATORY 0 0 39, 958 3, 261, 439 0 60.00 66.00 O6500 RESPI RATORY THERAPY 1, 200 1, 200 9, 079 17, 986 0 65.00 66.00 O6500 RESPI RATORY THERAPY 121, 092 1, 203, 941 10, 398, 544 0 66.00 67.00 COPOTIONAL THERAPY 57, 168 57, 168 834, 309 10, 564, 081 0 67.00 68.00 DEECH PATHOLOGY 4, 332 4, 332 331, 644 3, 027, 876 0 68.00 69.00 D6900 ELECTROCARDIOLOGY 0 0 105, 864 0 71.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 12, 2649, 980 0 73.00 76.01 3950 HEMODIALYSIS & 0THER MACILLARY 0 0 0 935, 539 0 76.00 78.00 SUBTOLALS SUBUTALS SUBUTALS SUBUTALS SUBUTALS S		92, 796	92, 796	3, 388, 93	5 23, 969, 062	0	30.00				
60.00 06000 LABORATORY 0 3, 261, 439 0 60.00 65.00 065000 RESPIRATORY THERAPY 1, 200 9, 079 17, 986 0 65.00 66.00 06600 PHYSICAL THERAPY 121, 092 121, 092 1, 033, 941 10, 398, 544 0 65.00 67.00 06700 0CCUPATIONAL THERAPY 57, 168 834, 309 10, 564, 081 0 66.00 68.00 06600 ELECTROCARDIOLOGY 4, 332 44, 332 331, 644 3, 027, 876 0 69.00 69.00 06900 ELECTROCARDIOLOGY 0 0 36 24, 657 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 12, 649, 980 0 73.00 73.00 03550 PSYCHALTRIC/PSYCHOLOGICAL SERVICES 4, 944 4, 944 110, 330 1, 284, 572 0 76.00 76.01 3350 PSYCHAL PURPOSE COST 0 0 0 0 12,		5 160	5 160		0 1 161 560	0	54 00				
65.00 06500 RESPIRATORY THERAPY 1,200 1,200 9,079 17,986 0 65.00 66.00 06600 PHYSI CAL THERAPY 121,092 121,092 1,033,941 10,398,544 0 66.00 67.00 0C0PATI IONAL THERAPY 57,168 57,168 834,309 10,564,081 0 67.00 69.00 06900 ELECTROCARDIOLOGY 4,332 4,332 331,644 3,027,876 0 68.00 67.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 12,649,980 73.00 76.00 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVICES 4,944 4,944 110,330 1,284,572 0 76.00 71.00 O1200 PURDSE COST CENTERS											
67.00 06700 0CCUPATIONAL THERAPY 57,168 57,168 834,309 10,564,081 0 67.00 68.00 06800 SPEECH PATHOLOGY 4,332 4,332 331,644 3,027,876 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 36 24,657 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 12,649,980 0 73.00 73.00 07300 DRUGS CHARGED TO PATIENT 0 0 0 12,649,980 0 73.00 76.00 3550 PSCHIATTIC/PSYCHOLOGICAL SERVICES 4,944 4,944 110,330 1,284,572 0 76.00 76.01 3950 HEMODIALYSIS & OTHER ANCILLARY 0 0 935,539 0 76.01 NONRE IMBURSABLE COST CENTERS 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 194.00 194.00 07950 NON-REI MBURSABLE COST 0 0 0 0 194.00 194.00		-	-								
68.00 06800 SPEECH PATHOLOGY 4,332 4,332 331,644 3,027,876 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 36 24,657 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 126,649,980 0 73.00 76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 4,944 4,944 110,330 1,284,572 0 76.00 950 HEMDIALYSIS & OTHER ANCILLARY 0 0 0 935,539 0 76.01 SPECIAL PURPOSE COST CENTERS 1through 117) 591,864 591,864 8,805,775 67,401,160 -2,670,229 118.00 192.00 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 194.01 07951 NON-REI MBURSABLE COST 0 0 0 0 194.01 194.01 07951 NARKEIN MICAPUBLIC RELATIONS 0 0 0 0 194.02 200.00 Cross Foot Adj ustments 0 0 0 0	66. 00 06600 PHYSI CAL THERAPY	121, 092	121, 092	1, 033, 94	1 10, 398, 544	0	66.00				
69.00 06900 ELECTROCARDIOLOGY 0 0 36 24,657 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 105,864 0 71.00 73.00 07300 RUSC CHARGED TO PATIENTS 0 0 0 12,649,980 0 73.00 76.01 03950 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 4,944 4,944 110,330 1,284,572 0 76.00 76.01 03950 HEMODIALYSIS & OTENTER 0 0 0 935,539 0 76.00 SUBTOTALS (SUM OF LINES 1 through 117) 591,864 591,864 8,805,775 67,401,160 -2,670,229 NOREI MBURSABLE COST CENTERS 118.00 NOREI MBURSABLE COST CENTERS 0 0 0 0 192.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 0 0 0 0 194.00 194.00 194.00 0 194.00 194.00 200.00 201.00											
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 105,864 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 12,649,980 0 73.00 76.00 03950 HEMOLIALYSIS & OTHER ANCILLARY 0 0 0 12,649,980 0 73.00 76.01 SPECIAL PURPOSE COST CENTERS 0 0 935,539 0 76.01 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 591,864 591,864 8,805,775 67,401,160 -2,670,229 118.00 NONREL MBURSABLE COST CENTERS 192.00 19200 PHYSI CIANS' PRI VATE OFFICES 0 0 0 0 0 192.00 192.00 0 194.01 194.01 194.01 194.01 0 194.01 0 194.01 0 194.01 0 194.01 0 194.02 0 0 0 0 0 0 194.01 0 194.01 0 194.02 0 194.01 0 194.01		4, 332									
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 12, 649, 980 0 73.00 76.00 03550 PSYCHI ATRIC/PSYCHOLOGICAL SERVICES 4, 944 4, 944 110, 330 12, 24, 572 0 76.00 76.01 03550 PENCIAL PURPOSE COST CENTERS 0 0 0 0 9355, 539 0 76.01 SUBTOTALS (SUM OF LINES 1 through 117) 591, 864 591, 864 8, 805, 775 67, 401, 160 -2, 670, 229 118.00 NONREI MBURSABLE COST CENTERS 192.00 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 192.00 0 192.00 0 192.00 0 192.00 0 194.00 0 194.00 0 194.00 0 194.00 194.00 194.00 194.00 194.00 194.02 0 0 0 0 0 0 0 0 194.02 194.02 194.02 194.02 194.02 194.02 194.02 136, 956 0 0 0 0 194.02 200.00 201.00 2		LENT	Ű			-					
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 4, 944 110, 330 1, 284, 572 0 76.00 76.01 03950 HEMODI ALYSI S & OTHER ANCI LLARY 0 0 0 935, 539 0 76.01 SPECIAL PURPOSE COST CENTERS 118.00 NONRE IMBURSABLE COST CENTERS 192.00 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 0 0 0 0 192.00 0 0 0 0 192.00 0 0 0 0 192.00 0 0 0 0 0 192.00 0 0 0 0 192.00 0 0 0 0 192.00 0 0 0 0 0 0 0 192.00 0		0	-								
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 591,864 591,864 8,805,775 67,401,160 -2,670,229 NONEL MBURSABLE COST CENTERS 192.00 192.00 0 0 0 192.00 192.00 PVRSICIANS' PRIVATE OFFICES 0 0 0 192.00 192.00 0 0 0 192.00 192.00 192.00 0 0 0 192.00 192.00 172.00 0 0 0 192.00 192.00 107951 MARKETI NG/PUBLIC RELATIONS 0 0 0 0 194.02 200.00 Colspan="4">Colspan="4"Colspan="4"Colspan="4">200.00 <th colspa<="" colspan="4" td=""><td></td><td>CES 4, 944</td><td>4, 944</td><td></td><td></td><td></td><td></td></th>	<td></td> <td>CES 4, 944</td> <td>4, 944</td> <td></td> <td></td> <td></td> <td></td>					CES 4, 944	4, 944				
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 591,864 591,864 8,805,775 67,401,160 -2,670,229 118.00 NONREI MBURSABLE COST CENTERS 0 0 260 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 0 0 194.00 0 0 0 0 194.00 0 0 0 0 194.00 0 0 0 0 0 194.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 194.00 0 194.00 0 0 0 0 0 0 0 0 0 0 194.00 0 0 0 194.00 0 0 0 194.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00 200.00 201.00 201.00 2	76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	0	0		0 935, 539	0	76.01				
NOREL MBURSABLE COST CENTERS 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 260 0 0192.00 194.00 07950 NON-REL MBURSABLE COST 0 0 0 0 0 0 0 194.00 194.01 07951 MARKETI NG/PUBLI C RELATIONS 0 0 0 0 0 194.01 194.02 07952 TENANT LEASED SPACE 136,956 0 0 0 0 194.02 200.00 Cross Foot Adjustments 200.00 200.00 201.00 202.00 201.00 202.00 202.00 201.00 202.00 202.00 203.00 201.00 203.00 203.00 204.00 205.00 1,1 10,0 50 439,559 202.00 204.00 205.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.717757 0.633093 0.128327 0.006522 203.00 204.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 206.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>											
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 260 0 0 192.00 194.00 07950 NON-REI MBURSABLE COST 0 </td <td></td> <td>gh 117) 591,864 </td> <td>591, 864</td> <td>8, 805, 77</td> <td>5 67, 401, 160</td> <td>-2, 670, 229</td> <td>118.00</td>		gh 117) 591,864	591, 864	8, 805, 77	5 67, 401, 160	-2, 670, 229	118.00				
194.00 07950 NON-REI MBURSABLE COST 0 0 0 0 194.00 194.01 07951 MARKETI NG/PUBLI C RELATIONS 0 0 0 0 194.01 194.02 07952 TENANT LEASED SPACE 136,956 0 0 0 194.02 200.00 Cross Foot Adj ustments 136,956 0 0 0 194.02 201.00 Negati ve Cost Centers 202.00 203.00 202.00 203.00 204.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 206.00 206.00 206.00 206.00 206.00 206.00 206.00 206.00 206.00 206.00 206.00 206.00 207.00		0	0	26		0	192 00				
194.01 07951 MARKETING/PUBLIC RELATIONS 0 0 0 0 194.01 194.02 07952 TENANT LEASED SPACE 136,956 0 0 0 194.02 200.00 Cross Foot Adjustments 136,956 0 0 0 0 194.02 201.00 Negative Cost Centers 200.00 201.00 202.00 202.00 202.00 202.00 202.00 202.00 202.00 202.00 202.00 202.00 203.00 203.00 203.00 201.00 203.00 203.00 204.00 205.00 0.006522 203.00 204.00 205.00 205.00 111 205.00 0.000451 0.000305 205.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 206.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>											
200.00 Cross Foot Adjustments 200.00 200.00 201.00 202.00 201.00 202.00 202.00 202.00 202.00 202.00 202.00 202.00 202.00 202.00 202.00 202.00 203.00 203.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 205.00 206.00 <		0	0		0 0						
201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 523,116 374,705 1,130,050 439,559 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.717757 0.633093 0.128327 0.006522 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 0.717757 0.633093 0.128327 0.006522 204.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.717757 0.603093 0.128327 0.000305 205.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.000451 0.0000451 0.000305 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. D, 207.00 207.00 207.00 207.00		136, 956	0		0 0	0					
202.00 Cost to be allocated (per Wkst. B, Part I) 523,116 374,705 1,130,050 439,559 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.717757 0.633093 0.128327 0.006522 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 0.717757 0.633093 0.128327 0.006522 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.717757 0.603093 0.000451 0.000305 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 0.000451 0.000305 205.00 207.00 NAHE unit cost multiplier (Wkst. D, 0.000451 0.000305 207.00	· · · · · · · · · · · · · · · · · · ·										
Part I) 0.717757 0.633093 0.128327 0.006522 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 0.717757 0.633093 0.128327 0.006522 203.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.717757 0.633093 0.128327 0.006522 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000451 0.000305 205.00 11) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 207.00 207.00	5	D 522 114	274 705	1 120 05	420 550						
203.00 Unit cost multiplier (Wkst. B, Part I) 0.717757 0.633093 0.128327 0.006522 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 0.717757 0.633093 0.128327 0.006522 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.717757 0.633093 0.128327 0.006522 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000451 0.000451 0.000305 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 207.00 207.00 207.00		В, 523, 116	374,705	1, 130, 05	439, 559		202.00				
204.00 Cost to be allocated (per Wkst. B, Part II) 3,971 20,532 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000451 0.000305 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 VAHE unit cost multiplier (Wkst. D, 207.00		Part I) 0.717757	0. 633093	0. 12832	7 0.006522		203.00				
205.00 Unit cost multiplier (Wkst. B, Part 0.000451 0.000305 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>											
11)206.00NAHE adjustment amount to be allocated (per Wkst. B-2)206.00207.00NAHE unit cost multiplier (Wkst. D,207.00											
206.00NAHE adjustment amount to be allocated (per Wkst. B-2)206.00207.00NAHE unit cost multiplier (Wkst. D,207.00		Part		0. 00045	1 0. 000305		205.00				
207.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00		located					206.00				
Parts III and IV)	207.00 NAHE unit cost multiplier (Wkst	. D,					207.00				
	Parts III and IV)		I			I	I				

Health Financial Systems REHA COST ALLOCATION - STATISTICAL BASIS		BILITATION HOS	Provider C		eri od:	u of Form CMS-: Worksheet B-1	
				F	rom 10/01/2020		
				1	09/30/2021	Date/Time Pre 2/28/2022 4:2	
	Cost Center Description	ADMIN AND	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	·	GENERAL -	PLANT	LINEN SERVICE		(MEALS SERVED)	
		OTHER	(SQUARE FEET)	(POUNDS OF			
		(ACCUM. COST)		LAUN)			
		5.02	7.00	8.00	9.00	10.00	
	ENERAL SERVICE COST CENTERS	-					1
	0100 CAP REL COSTS-BLDG & FIXT						1.00
	0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT						2.00
	0570 ADMITTING						4.00
	0590 ADMIN AND GENERAL - OTHER	12, 997, 398					5.0
	0700 OPERATION OF PLANT	1, 144, 177					7.0
	0800 LAUNDRY & LINEN SERVICE	65, 644		133, 494			8.00
	10900 HOUSEKEEPING	263, 791	14, 424	0			9.00
	1000 DI ETARY	576, 890			000, 101	74, 168	
	1100 CAFETERIA	242, 223		0	55, 728		
	1300 NURSI NG ADMI NI STRATI ON	558, 913		0	1, 560	0	
	1400 CENTRAL SERVICES & SUPPLY	25, 545		0	11, 016	-	1
	1500 PHARMACY	244, 875			4, 668	0	1
	1600 MEDI CAL RECORDS & LI BRARY	283, 207			5, 352	0	16.00
17.00 0	1700 SOCIAL SERVICE	4, 685	3, 468	0	3, 468	0	17.00
1	NPATIENT ROUTINE SERVICE COST CENTERS			•			1
30. 00 0	3000 ADULTS & PEDIATRICS	5, 343, 430	92, 796	74, 881	92, 796	74, 168	30.00
A	NCILLARY SERVICE COST CENTERS		-				
	5400 RADI OLOGY-DI AGNOSTI C	25,033	5, 160	0	5, 160	0	54.00
	6000 LABORATORY	113, 829		-	-	0	
	6500 RESPI RATORY THERAPY	23, 441			1,200		
	6600 PHYSI CAL THERAPY	1, 490, 949				0	
	6700 OCCUPATI ONAL THERAPY	1, 157, 306					
	6800 SPEECH PATHOLOGY	438, 765		0	.,	0	
	6900 ELECTROCARDI OLOGY	347		0	0	0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 589	0	0	0	0	
	7300 DRUGS CHARGED TO PATIENTS	555, 677	0	0	0	0	
	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 3950 HEMODI ALYSI S & OTHER ANCI LLARY	148,074			4, 944 0	0	
	PECIAL PURPOSE COST CENTERS	182, 237	0	0	0	0	1 /0.0
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	12, 895, 627	382, 908	133, 494	368, 484	74, 168	1118 00
	ONREI MBURSABLE COST CENTERS	12,075,027	302, 900	133, 474	500, 404	74,100	1110.00
	9200 PHYSI CI ANS' PRI VATE OFFI CES	3, 470	0	0	0	0	192.00
	17950 NON-REI MBURSABLE COST	0,170	0	0	0		194.00
	7951 MARKETING/PUBLIC RELATIONS	0	0	0	0		194.0
	17952 TENANT LEASED SPACE	98, 301	136, 956	0	0		194. 0
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	2, 670, 229	1, 379, 240	79, 130	356, 253	695, 408	202. 0
	Part I)	0 205442	2 452070	0. 592761	0 044007	9. 376119	202 0
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 205443 78, 045					203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	/8, 045	187, 321	394	26, 350	3, 013	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 006005	0. 360327	0. 002951	0. 071509	0. 048714	205. 00
06. 00	<pre>II) NAHE adjustment amount to be allocated</pre>						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

OST ALI	LOCATION - STATISTICAL BASIS		Provider CC	F	eriod: rom 10/01/2020	Worksheet B-1	
				T	o 09/30/2021	Date/Time Pre 2/28/2022 4:2	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(FTES)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
			(1)1/1001110	SUPPLY	REQUIS.)	LIBRARY	
			(NURSING	(COSTED		(GROSS	
		11.00	SALARIES)	REQUIS.)	15.00	CHARGES)	
C	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	16.00	
	DO100 CAP REL COSTS-BLDG & FIXT						1 1
	DO200 CAP REL COSTS-MVBLE EQUIP						2
00 0	DO400 EMPLOYEE BENEFITS DEPARTMENT						4
	DO570 ADMI TTI NG						5
	00590 ADMIN AND GENERAL - OTHER						5
	00700 OPERATION OF PLANT						1 7
00 0	DO800 LAUNDRY & LINEN SERVICE						6
	DO900 HOUSEKEEPI NG						9
	D1000 DI ETARY						10
. 00 0	D1100 CAFETERI A	7, 993					11
s. oo o	01300 NURSI NG ADMI NI STRATI ON	569	2, 900, 670				1:
	01400 CENTRAL SERVICES & SUPPLY	17		211, 060			14
	D1500 PHARMACY	247		297	473, 174		15
	01600 MEDI CAL RECORDS & LI BRARY	165		144	0	67, 401, 160	
	01700 SOCIAL SERVICE	0	1	0	0	0	
	NPATIENT ROUTINE SERVICE COST CENTERS						
. 00 0	03000 ADULTS & PEDI ATRI CS	4, 223	2, 900, 670	175, 275	0	23, 969, 062	30
	ANCILLARY SERVICE COST CENTERS				·		
	05400 RADI OLOGY-DI AGNOSTI C	0		0	0	1, 161, 560	
	06000 LABORATORY	128	0	0	0	3, 261, 439	60
	06500 RESPI RATORY THERAPY	12		10, 795	0	17, 986	
	06600 PHYSI CAL THERAPY	1, 165		11, 930	0	10, 398, 544	
	06700 OCCUPATI ONAL THERAPY	1, 023		5, 543	0	10, 564, 081	
	06800 SPEECH PATHOLOGY	342	0	1, 149	0	3, 027, 876	
	06900 ELECTROCARDI OLOGY	0	0	0	0	24, 657	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5, 899	0	105, 864	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	473, 174	12, 649, 980	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	101		0	0	1, 284, 572	
	03950 HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	935, 539	7
8.00	SPECIAL PURPOSE COST CENTERS	7, 992	2 000 (70	211 022	472 174	(7 401 1/0	1110
-	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1,992	2, 900, 670	211, 032	473, 174	67, 401, 160	
	19200 PHYSI CI ANS' PRI VATE OFFI CES	1	0	28	0	0	192
	07950 NON-REI MBURSABLE COST	0		0	0		194
	07951 MARKETI NG/PUBLI C RELATI ONS	0	0	0	0		194
	07952 TENANT LEASED SPACE	0	0	0	0		194
0.00	Cross Foot Adjustments			0		0	200
01.00	Negative Cost Centers						201
02.00	Cost to be allocated (per Wkst. B,	493, 715	714, 531	71, 719	327, 439	371, 004	
	Part I)						
03.00	Unit cost multiplier (Wkst. B, Part I)	61. 768422	0. 246333	0. 339804	0. 692005	0.005504	203
04.00	Cost to be allocated (per Wkst. B,	100, 863		20, 009	13, 022	13, 403	
	Part II)						
05.00	Unit cost multiplier (Wkst. B, Part	12. 618917	0. 004660	0. 094802	0. 027521	0.000199	205
	11)						
06.00	NAHE adjustment amount to be allocated						206
07.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						20
	INAME UNIT COST MULTIDILAR (WKST 1)	1	1				17(1)

In Lieu of Form CMS-2552-10

	LLOCATION - STATISTICAL BASIS	BILITATION HUSP	Provider CCN: 15-3030	Period: Worksheet	
C031 P	LECCATION - STATISTICAL DASIS			From 10/01/2020	D-1
				To 09/30/2021 Date/Time	
	Cost Center Description	SOCI AL SERVI CE		2/28/2022	4:29 pm
	Cost Center Description	SUCIAL SERVICE			
		(PATIENT DAYS			
		%)			
		17.00			
	GENERAL SERVICE COST CENTERS	l			
1.00	00100 CAP REL COSTS-BLDG & FLXT				1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT				2.00
4.00 5.01	00570 ADMITTING				4.00
5.01	00590 ADMIN AND GENERAL - OTHER				5.01
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPI NG				9.00
10.00	01000 DI ETARY				10.00
11.00	01100 CAFETERI A				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON				13.00
	01400 CENTRAL SERVICES & SUPPLY				14.00
	01500 PHARMACY				15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY				16.00
17.00	01700 SOCIAL SERVICE	12, 325			17.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10.005			
30.00	03000 ADULTS & PEDIATRICS	12, 325			30.00
54.00	ANCI LLARY SERVI CE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C	0			54.00
60.00	06000 LABORATORY	0			60.00
65.00	06500 RESPI RATORY THERAPY	0			65.00
66.00	06600 PHYSI CAL THERAPY	0			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0			67.00
68.00	06800 SPEECH PATHOLOGY	0			68.00
69.00	06900 ELECTROCARDI OLOGY	0			69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71.00
	07300 DRUGS CHARGED TO PATIENTS	0			73.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			76.00
76.01	03950 HEMODIALYSIS & OTHER ANCILLARY	0			76. 01
118.00	SPECIAL PURPOSE COST CENTERS	12, 325			110.00
110.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	12, 323			118.00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0			192.00
	07950 NON-REI MBURSABLE COST	0			194.00
194.01	07951 MARKETI NG/PUBLIC RELATIONS	0			194.01
194.02	07952 TENANT LEASED SPACE	0			194. 02
200.00					200.00
201.00					201.00
202.00		18, 202			202.00
202.00	Part I)	1 474004			202.00
203.00 204.00		1. 476836 6, 211			203.00 204.00
204. UU	Part II)	0,211			204.00
205.00		0. 503935			205.00
206.00					206.00
	(per Wkst. B-2)				
207.00					207.00
	Parts III and IV)	I I			1

Heal th	Financial Systems REF	ABILITATION HOSI	PITAL OF FT WAY	/NE	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C		Peri od:	Worksheet C	
					rom 10/01/2020	Part I	
					o 09/30/2021	Date/Time Pre 2/28/2022 4:2	pared:
			Title	XVIII	Hospi tal	272872022 4.2 PPS	9 pili
			nue		Costs	115	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	cost center beschiption	(from Wkst. B,	Adj.		Di sal I owance	10101 00313	
		Part I, col.	naj.		Di Sai i Owanee		
		26)					
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		•	•			
30.00	03000 ADULTS & PEDIATRICS	8, 702, 003		8, 702, 003	3 79, 780	8, 781, 783	30.00
	ANCI LLARY SERVI CE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	55, 248		55, 248	3 0	55, 248	54.00
60.00	06000 LABORATORY	163, 071		163, 071	0	163, 071	60.00
65.00	06500 RESPI RATORY THERAPY	37, 109	0	37, 109	9 0	37, 109	65.00
66.00	06600 PHYSI CAL THERAPY	2, 385, 320	0	2, 385, 320	0 0	2, 385, 320	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 743, 492	0	1, 743, 492	2 0	1, 743, 492	67.00
68.00	06800 SPEECH PATHOLOGY	582, 767	0	582, 767	7 0	582, 767	68.00
69.00	06900 ELECTROCARDI OLOGY	554		554	1 0	554	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 531		10, 531	0	10, 531	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 066, 901		1, 066, 901	0	1, 066, 901	73.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	209, 701		209, 701	0	209, 701	76.00
76.01	03950 HEMODIALYSIS & OTHER ANCILLARY	224, 825		224, 825	5 0	224, 825	76.01
200.00	Subtotal (see instructions)	15, 181, 522	0	15, 181, 522	2 79, 780	15, 261, 302	200.00
201.00		0		(D		201.00
202.00	Total (see instructions)	15, 181, 522	0	15, 181, 522	2 79, 780	15, 261, 302	202.00

	HABILITATION HOSP	-		In Lie Period:	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC			Worksheet C	
				From 10/01/2020 To 09/30/2021	Part I Date/Time Pre	narod
				10 09/30/2021	2/28/2022 4:2	9 nm
		Title	XVIII	Hospi tal	PPS	, bu
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	23, 969, 062		23, 969, 06	2		30.00
ANCI LLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 158, 660	2, 900	1, 161, 56	0 0. 047564	0.00000	54.00
60. 00 06000 LABORATORY	3, 258, 639	2, 800	3, 261, 43	9 0. 050000	0.00000	60.00
65. 00 06500 RESPI RATORY THERAPY	17, 986	0	17, 98	6 2. 063216	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	10, 398, 544	0	10, 398, 54	4 0. 229390	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	10, 564, 081	0	10, 564, 08	1 0. 165040	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	3, 027, 876	0	3, 027, 87	6 0. 192467	0.00000	68.00
69. 00 06900 ELECTROCARDI OLOGY	24, 657	0	24, 65	7 0. 022468	0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	73, 515	32, 349	105, 86	4 0. 099477	0.00000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	12, 635, 065	14, 915	12, 649, 98	0 0. 084340	0.00000	73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 281, 672	2, 900	1, 284, 57	2 0. 163246		
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	935, 539	0	935, 53	9 0. 240316	0.000000	76.01
200.00 Subtotal (see instructions)	67, 345, 296	55, 864	67, 401, 16	0		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	67, 345, 296	55, 864	67, 401, 16	0		202.00

Health Financial Systems REF	ABILITATION HOSPI	TAL OF FT WAYNE	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3030	Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Prepared: 2/28/2022 4:29 pm		
		Title XVIII	Hospi tal	PPS		
Cost Center Description	PPS Inpatient Ratio 11.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS				30,00		
ANCI LLARY SERVI CE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 047564			54.00		
60. 00 06000 LABORATORY	0. 050000			60.00		
65. 00 06500 RESPI RATORY THERAPY	2.063216			65.00		
66. 00 06600 PHYSI CAL THERAPY	0. 229390			66.00		
67.00 06700 OCCUPATIONAL THERAPY	0. 165040			67.00		
68.00 06800 SPEECH PATHOLOGY	0. 192467			68.00		
69. 00 06900 ELECTROCARDI OLOGY	0. 022468			69.00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 099477			71.00		
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 084340			73.00		
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 163246			76.00		
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	0. 240316			76.01		
200.00 Subtotal (see instructions)				200.00		
201.00 Less Observation Beds				201.00		
202.00 Total (see instructions)				202.00		

Health Financial Systems	REHABILITATION HOSE	PITAL OF FT WAY	'NE	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Pre 2/28/2022 4:2	
		Titl	e XIX	Hospi tal	PPS	·
				Costs		
Cost Center Description	(from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	26)	2.00	3.00	4, 00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	8, 702, 003		8, 702, 00	3 79, 780	8, 781, 783	30.00
ANCI LLARY SERVICE COST CENTERS	0,702,000		0,702,00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0,701,700	
54.00 05400 RADI OLOGY-DI AGNOSTI C	55, 248		55, 24	8 0	55, 248	54.00
60. 00 06000 LABORATORY	163, 071		163, 07		163, 071	60.00
65. 00 06500 RESPI RATORY THERAPY	37, 109	0	37, 10	9 0	37, 109	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 385, 320	0	2, 385, 320	0 0	2, 385, 320	66.00
67.00 06700 OCCUPATIONAL THERAPY	1, 743, 492	0	1, 743, 493	2 0	1, 743, 492	67.00
68.00 06800 SPEECH PATHOLOGY	582, 767	0	582, 76	7 0	582, 767	68.00
69. 00 06900 ELECTROCARDI OLOGY	554		55	4 0	554	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	NT 10, 531		10, 53	1 0	10, 531	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 066, 901		1, 066, 90	1 0	1, 066, 901	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CE	S 209, 701		209, 70	1 0	209, 701	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	224, 825		224, 82	5 0	224, 825	
200.00 Subtotal (see instructions)	15, 181, 522	0	15, 181, 52	2 79, 780		
201.00 Less Observation Beds	0		(C		201.00
202.00 Total (see instructions)	15, 181, 522	0	15, 181, 52	2 79, 780	15, 261, 302	202.00

	· · · · · · · · · · · · · · · · · · ·	ABILITATION HOSP	-		In Lie Period:	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CO			Worksheet C	
					From 10/01/2020 To 09/30/2021	Part I Date/Time Pre	narod
					10 077 307 2021	2/28/2022 4:2	9 pm
			Ti tl	e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			·	+ col. 7)	Rati o	Inpati ent	
						Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	23, 969, 062		23, 969, 06	2		30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 158, 660	2, 900	1, 161, 56	0 0. 047564	0.00000	54.00
60.00	06000 LABORATORY	3, 258, 639	2, 800	3, 261, 43	9 0. 050000	0.00000	60.00
65.00	06500 RESPI RATORY THERAPY	17, 986	0	17, 98	6 2. 063216	0.00000	65.00
	06600 PHYSI CAL THERAPY	10, 398, 544	0	10, 398, 54	4 0. 229390	0.00000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	10, 564, 081	0	10, 564, 08	1 0. 165040	0.00000	67.00
68.00	06800 SPEECH PATHOLOGY	3, 027, 876	0	3, 027, 87	6 0. 192467	0.00000	68.00
69.00	06900 ELECTROCARDI OLOGY	24, 657	0	24, 65	7 0. 022468	0.00000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	73, 515	32, 349	105, 86	4 0. 099477	0.00000	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12, 635, 065	14, 915	12, 649, 98	0 0. 084340	0.00000	73.00
76.00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 281, 672	2, 900	1, 284, 57	2 0. 163246	0.00000	76.00
76. 01	03950 HEMODIALYSIS & OTHER ANCILLARY	935, 539	0	935, 53	9 0. 240316	0.000000	76.01
200.00	Subtotal (see instructions)	67, 345, 296	55, 864	67, 401, 16	0		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	67, 345, 296	55, 864	67, 401, 16	0		202.00

Health Financial Systems REH.	ABILITATION HOSPI	TAL OF FT WAYNE	In Lieu of Form CMS-2552-		
COMPUTATION OF RATIO OF COSTS TO CHARGES	OMPUTATION OF RATIO OF COSTS TO CHARGES		Period: From 10/01/2020	Worksheet C Part I	
			To 09/30/2021	Date/Time Prepar 2/28/2022 4:29	red: pm
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS				3	30.00
ANCI LLARY SERVI CE COST CENTERS					
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 047564			5	54.00
60. 00 06000 LABORATORY	0. 050000			6	50.00
65. 00 06500 RESPI RATORY THERAPY	2.063216			6	55.00
66. 00 06600 PHYSI CAL THERAPY	0. 229390			6	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 165040			6	57.00
68.00 06800 SPEECH PATHOLOGY	0. 192467			6	58.00
69. 00 06900 ELECTROCARDI OLOGY	0. 022468			6	59.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.099477			7	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 084340			7	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 163246			7	76.00
76. 01 03950 HEMODI ALYSI S & OTHER ANCI LLARY	0, 240316			7	76. 01
200.00 Subtotal (see instructions)				20	00.00
201.00 Less Observation Beds					01.00
202.00 Total (see instructions)					02.00

Health Financial Systems REH	In Lieu of Form CMS-2552-10					
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R	ATIOS NET OF	Provider C	CN: 15-3030	Peri od:	Worksheet C	
REDUCTIONS FOR MEDICAID ONLY				From 10/01/2020		
				To 09/30/2021	Date/Time Pre 2/28/2022 4:2	
		Ti +1	e XIX	Hospi tal	PPS	9 pili
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
cost center bescription		(Wkst. B, Part			Reduction	
	I, col. 26)		Cost (col. 1		Amount	
	1, 001. 20)	11 001. 20)	col . 2)		, another t	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	55, 248	9, 934	45, 31	4 0	0	54.00
60. 00 06000 LABORATORY	163, 071	3, 961	159, 11	0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	37, 109	3, 467	33, 64	2 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 385, 320	246, 441	2, 138, 87	⁷ 9 0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	1, 743, 492	128, 088	1, 615, 40	04 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	582, 767	16, 460	566, 30	07 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	554	15	53	39 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 531	652	9, 87	0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 066, 901	22, 734	1, 044, 16	07 0	0	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	209, 701	11, 676	198, 02	25 0	0	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	224, 825	1, 565	223, 26	0 0	0	76.01
200.00 Subtotal (sum of lines 50 thru 199)	6, 479, 519	444, 993	6, 034, 52	26 0	0	200.00
201.00 Less Observation Beds	0	0		0 0	0	201.00
202.00 Total (line 200 minus line 201)	6, 479, 519	444, 993	6, 034, 52	26 0	0	202.00

Health Financial Systems REH/	ABILITATION HOSE	PITAL OF FT WAY	/NE	In Lieu of Form CMS-2552-10		
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA	ATIOS NET OF	Provider C		Period: From 10/01/2020	Worksheet C Part II	
REDUCTIONS FOR MEDICALD ONET				To 09/30/2021	Date/Time Pre 2/28/2022 4:2	
	_	Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		(Worksheet C,				
	Operating Cost		Ratio (col.	6		
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS	1					
54.00 05400 RADI OLOGY-DI AGNOSTI C	55, 248	1, 161, 560	0. 04756	54		54.00
60. 00 06000 LABORATORY	163, 071	3, 261, 439	0. 05000	00		60.00
65. 00 06500 RESPI RATORY THERAPY	37, 109	17, 986	2.06321	6		65.00
66. 00 06600 PHYSI CAL THERAPY	2, 385, 320	10, 398, 544	0. 22939	20		66.00
67.00 06700 OCCUPATI ONAL THERAPY	1, 743, 492	10, 564, 081	0. 16504	łO		67.00
68.00 06800 SPEECH PATHOLOGY	582, 767	3, 027, 876	0. 19246	57		68.00
69. 00 06900 ELECTROCARDI OLOGY	554	24, 657	0. 02246	8		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 531	105, 864	0. 09947	7		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,066,901	12, 649, 980	0. 08434	10		73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	209, 701	1, 284, 572	0. 16324	6		76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	224, 825	935, 539	0. 2403	6		76.01
200.00 Subtotal (sum of lines 50 thru 199)	6, 479, 519	43, 432, 098				200.00
201.00 Less Observation Beds	0	0				201.00
202.00 Total (line 200 minus line 201)	6, 479, 519	43, 432, 098				202.00

Health Financial Systems	REHABILITATION HOS	PITAL OF FT WAY	YNE	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI	APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Period: From 10/01/2020 To 09/30/2021		
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	÷	·			•	
30.00 ADULTS & PEDIATRICS	304, 549	0	304, 54	9 12, 325	24. 71	30.00
200.00 Total (lines 30 through 199)	304, 549		304, 54	9 12, 325		200.00
Cost Center Description	Inpatient Program days	Capital Cost (col. 5 x col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	5, 109 5, 109					30. 00 200. 00

APPORTI ONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-3030 Period: From 10/01/2020 To Worksheet D Part I I Date/Time Prepared: 2/28/2022 4: 29 protein Image: Cost Center Description Capital Related Cost (from Wkst. B, Part I I, col. 26) Total Charges Total Charges (From Wkst. C, Part I, col. 20) Ratio of Cost to Charges (col. 1 + col. 8) Inpatient Program (Col umn 3 x Col umn 4) Capital Costs (col umn 3 x Col umn 4) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 9,934 1,161,560 0.008552 400,412 3,424 54.00 66.00 0.6000 LABORATORY 3,961 3,261,439 0.001214 1,448,069 1,758 60.00 66.00 06500 RESPI RATORY THERAPY 3,467 17,966 0.192761 6,882 1,327 65.00 66.00 06300 SPECH PATHOLOGY 16,460 3,027,876 0.005436 1,031,999 5,610 68.00 66.00 06300 SPECH PATHOLOGY 15 24,657 0.000608 9,841 6 69,00 71.00	Health Financial Systems REH/	REHABILITATION HOSPITAL OF FT WAYNE					In Lieu of Form CMS-2552-10			
Image: Cost Center Description Capital Related Cost (from Wkst. C, C, Cost Center Description) Capital Related Cost (from Wkst. C, C, Cost Center Description) Total Charges (from Wkst. C, C, Cost Center Description) Capital Cost (from Wkst. C, C, Cost Center Description) Capital Cost (from Wkst. C, C, Cost Center Description) Capital Cost (from Wkst. C, C, Cost Center Description) Cost Center Description Capital Cost (from Wkst. C, C, Cost Center Description) Cost Center Description Capital Cost (from Wkst. C, C, Cost Center Description) Cost Center Description Capital Cost (from Wkst. C, C, Cost Center Description) Cost Center Description Capital Cost (from Wkst. C, C, Cost Center Description) Cost Center Description Capital Cost (from Wkst. C, C, Cost Center Description) Cost Center Description Capital Cost (from Wkst. C, C, Cost Center Description) Cost (from Wkst. Center Description) Co	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		From 10/01/2020	Part II Date/Time Pre				
ANCI LLARY SERVI CE COST CENTERS Program Column 3 x Column 4) 54.00 05400 RADI OLOGY-DI AGNOSTI C 9,934 1,161,560 0.008552 400,412 3,424 54.00 60.00 06500 LABORATORY 3,961 3,261,439 0.001214 1,448,069 1,758 60.00 66.00 06600 PHYSI CAL THERAPY 3,467 17,986 0.192761 6,882 1,327 65.00 66.00 06600 PHYSI CAL THERAPY 246,441 10,398,544 0.023700 4,384,277 103,907 66.00 67.00 06700 OCCUPATI ONAL THERAPY 128,088 10,564,081 0.012125 4,470,020 54,199 67.00 68.00 06800 SPEECH PATHOLOGY 16,460 3,027,876 0.005436 1,031,999 5,610 68.00 69.00 069000 LECTROCARDI OLOGY 15 24,657 0.000608 9,841 6 69.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		_	Title	XVIII	Hospi tal					
I.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS 9,934 1,161,560 0.008552 400,412 3,424 54.00 60.00 06000 LABORATORY 3,961 3,261,439 0.001214 1,448,069 1,758 60.00 65.00 06500 RASPI RATORY THERAPY 3,467 17,986 0.192761 6,882 1,327 65.00 66.00 06600 PHYSI CAL THERAPY 246,441 10,398,544 0.023700 4,384,277 103,907 66.00 67.00 06700 OCCUPATI ONAL THERAPY 128,088 10,564,081 0.012125 4,470,020 54,199 67.00 68.00 06800 SPECH PATHOLOGY 16,460 3,027,876 0.005436 1,031,999 5,610 68.00 69.00 06900 ELECTROCARDI OLOGY 15 24,657 0.000608 9,841 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 652 105,864 0.001797 4,711,350 8,466	Cost Center Description	Related Cost (from Wkst. B,	(from Wkst. C, Part I, col.	to Charges (col. 1 ÷ col	Program	(column 3 x				
ANCI LLARY SERVI CE COST CENTERS 54.00 05400 RADI OLOGY - DI AGNOSTI C 9, 934 1, 161, 560 0.008552 400, 412 3, 424 54.00 60.00 06000 LABORATORY 3, 961 3, 261, 439 0.001214 1, 448, 069 1, 758 60.00 65.00 06500 RESPI RATORY THERAPY 3, 467 17, 986 0.192761 6, 882 1, 327 65.00 66.00 06600 PHYSI CAL THERAPY 246, 441 10, 398, 544 0.023700 4, 384, 277 103, 907 66.00 67.00 06700 0CCUPATI ONAL THERAPY 128, 088 10, 564, 081 0.012125 4, 470, 020 54, 199 67.00 68.00 06800 SPEECH PATHOLOGY 16, 460 3, 027, 876 0.005436 1, 031, 999 5, 610 68.00 69.00 06900 ELECTROCARDI OLOGY 15 24, 657 0.000608 9, 841 6 69.00 71.00 07300 MEDI CAL										
54.00 05400 RADI OLOGY-DI AGNOSTI C 9, 934 1, 161, 560 0.008552 400, 412 3, 424 54.00 60.00 06000 LABORATORY 3, 961 3, 261, 439 0.001214 1, 448, 069 1, 758 60.00 65.00 06500 RESPI RATORY THERAPY 3, 467 17, 986 0.192761 6, 882 1, 327 65.00 66.00 06600 PHYSI CAL THERAPY 246, 441 10, 398, 544 0.023700 4, 384, 277 103, 907 66.00 67.00 06700 0CUPATI ONAL THERAPY 128, 088 10, 564, 081 0.012125 4, 470, 020 54, 199 67.00 68.00 06800 SPEECH PATHOLOGY 16, 460 3, 027, 876 0.005436 1, 031, 999 5, 610 68.00 69.00 06900 ELECTROCARDI OLOGY 15 24, 657 0.000608 9, 841 69.00 71.00 MDI MEI CAL SUPPLIES CHARGED TO PATI ENT 652 105, 864 0.006159 14, 765 91 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 22, 734 12, 649, 980 0.001797 4, 7		1.00	2.00	3.00	4.00	5.00				
60.0006000LABORATORY3, 9613, 261, 4390.0012141, 448, 0691, 75860.0065.0006500RESPI RATORY THERAPY3, 46717, 9860.1927616, 8821, 32765.0066.0006600PHYSI CAL THERAPY246, 44110, 398, 5440.0237004, 384, 277103, 90766.0067.00067000CCUPATI ONAL THERAPY128, 08810, 564, 0810.0121254, 470, 02054, 19967.0068.0006800SPEECH PATHOLOGY16, 4603, 027, 8760.0064361, 031, 9995, 61068.0069.0006900ELECTROCARDI OLOGY1524, 6570.0006089, 84169.0071.0007100MEDI CAL SUPPLIES CHARGED TO PATI ENT652105, 8640.00615914, 7659171.0073.0007300DRUGS CHARGED TO PATI ENTS22, 73412, 649, 9800.0017974, 711, 3508, 46673.0076.0003550PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES11, 6761, 284, 5720.009089495, 7104, 50676.0076.0103950HEMODI ALYSI S & OTHER ANCI LLARY1, 565935, 5390.001673464, 77077876.01		0.001								
65. 0006500RESPI RATORY THERAPY3, 46717, 9860. 1927616, 8821, 32765. 0066. 0006600PHYSI CAL THERAPY246, 44110, 398, 5440. 0237004, 384, 277103, 90766. 0067. 00067000CCUPATI ONAL THERAPY128, 08810, 564, 0810. 0121254, 470, 02054, 19967. 0068. 0006800SPEECH PATHOLOGY16, 4603, 027, 8760. 0054361, 031, 9995, 61068. 0069. 0006900ELECTROCARDI OLOGY1524, 6570. 0006089, 84169. 0071. 00O7100MEDI CAL SUPPLIES CHARGED TO PATI ENT652105, 8640. 00615914, 7659171. 0073. 0007300DRUGS CHARGED TO PATI ENTS22, 73412, 649, 9800. 0017974, 711, 3508, 46673. 0076. 0003550PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES11, 6761, 284, 5720. 009089495, 7104, 50676. 0076. 0103950HEMODI ALYSI S & OTHER ANCI LLARY1, 565935, 5390. 001673464, 77077876. 01										
66.00 06600 PHYSI CAL THERAPY 246, 441 10, 398, 544 0. 023700 4, 384, 277 103, 907 66.00 67.00 06700 OCCUPATI ONAL THERAPY 128, 088 10, 564, 081 0. 012125 4, 470, 020 54, 199 67.00 68.00 06800 SPEECH PATHOLOGY 16, 460 3, 027, 876 0. 005436 1, 031, 999 5, 610 68.00 69.00 06900 ELECTROCARDI OLOGY 15 24, 657 0. 006088 9, 841 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 652 105, 864 0. 006159 14, 765 91 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 22, 734 12, 649, 980 0. 001797 4, 711, 350 8, 466 73.00 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 11, 676 1, 284, 572 0. 009089 495, 710 4, 506 76.00 76.01 03950 HEMODI ALYSI S & OTHER ANCI LLARY 1, 565 935, 539 0.0										
67. 00067000CCUPATI ONAL THERAPY128,08810,564,0810.0121254,470,02054,19967. 0068. 0006800SPEECH PATHOLOGY16,4603,027,8760.0054361,031,9995,61068. 0069. 0006900ELECTROCARDI OLOGY1524,6570.0006089,841669. 0071. 0007100MEDI CAL SUPPLIES CHARGED TO PATI ENT652105,8640.0015914,7659171. 0073. 0007300DRUGS CHARGED TO PATI ENTS22,73412,649,9800.0017974,711,3508,46673. 0076. 0003550PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES11,6761,284,5720.009089495,7104,50676. 0076. 0103950HEMODI ALYSI S & OTHER ANCI LLARY1,565935,5390.001673464,77077876. 01										
68. 00 06800 SPEECH_PATHOLOGY 16, 460 3, 027, 876 0. 005436 1, 031, 999 5, 610 68. 00 69. 00 06900 ELECTROCARDI OLOGY 15 24, 657 0. 000608 9, 841 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 652 105, 864 0. 006159 14, 765 91 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 22, 734 12, 649, 980 0. 001797 4, 711, 350 8, 466 73. 00 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 11, 676 1, 284, 572 0. 009089 495, 710 4, 506 76. 00 76. 01 03950 HEMODI ALYSI S & OTHER ANCI LLARY 1, 565 935, 539 0. 001673 464, 770 778 76. 01										
69. 0006900ELECTROCARDI OLOGY1524, 6570. 0006089, 841669. 0071. 0007100MEDI CAL SUPPLI ES CHARGED TO PATI ENT652105, 8640. 00615914, 7659171. 0073. 0007300DRUGS CHARGED TO PATI ENTS22, 73412, 649, 9800. 0017974, 711, 3508, 46673. 0076. 0003550PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES11, 6761, 284, 5720. 009089495, 7104, 50676. 0076. 0103950HEMODI ALYSI S & OTHER ANCI LLARY1, 565935, 5390. 001673464, 77077876. 01		128, 088								
71. 0007100MEDI CAL SUPPLI ES CHARGED TO PATI ENT652105, 8640. 00615914, 7659171. 0073. 0007300DRUGS CHARGED TO PATI ENTS22, 73412, 649, 9800. 0017974, 711, 3508, 46673. 0076. 0003550PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES11, 6761, 284, 5720. 009089495, 7104, 50676. 0076. 0103950HEMODI ALYSI S & OTHER ANCI LLARY1, 565935, 5390. 001673464, 77077876. 01	68.00 06800 SPEECH PATHOLOGY	16, 460	3, 027, 876	0.00543	6 1, 031, 999	5, 610	68.00			
73. 00 07300 DRUGS CHARGED TO PATIENTS 22, 734 12, 649, 980 0. 001797 4, 711, 350 8, 466 73. 00 76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 11, 676 1, 284, 572 0. 009089 495, 710 4, 506 76. 00 76. 01 03950 HEMODI ALYSI S & OTHER ANCI LLARY 1, 565 935, 539 0. 001673 464, 770 778 76. 01	69. 00 06900 ELECTROCARDI OLOGY	15	24, 657	0. 00060	9, 841	6	69.00			
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 11, 676 1, 284, 572 0. 009089 495, 710 4, 506 76. 00 76. 01 03950 HEMODI ALYSI S & OTHER ANCI LLARY 1, 565 935, 539 0. 001673 464, 770 778 76. 01	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	652	105, 864	0. 00615	9 14, 765	91	71.00			
76. 01 03950 HEMODI ALYSI S & OTHER ANCI LLARY 1, 565 935, 539 0. 001673 464, 770 778 76. 01	73.00 07300 DRUGS CHARGED TO PATIENTS	22, 734	12, 649, 980	0.00179	4, 711, 350	8, 466	73.00			
	76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	11, 676	1, 284, 572	0. 00908	495, 710	4, 506	76.00			
	76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	1,565	935, 539	0.00167	3 464, 770	778	76.01			
	200.00 Total (lines 50 through 199)				17, 438, 095	184, 072	200. 00			

Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CMS-2						2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	rs Provider C		Period: From 10/01/2020 Fo 09/30/2021		
		Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdowr Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	28	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS 200. 00 Total (lines 30 through 199)	0	C		0 0 0 0	0	30.00 200.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 O3000 ADULTS & PEDI ATRI CS 200.00 Total (lines 30 through 199)	0	0	12, 32 12, 32			30.00 200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x <u>col. 8)</u> 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00 03000 ADULTS & PEDLATRICS 200.00 Total (Lines 30 through 199)	0					30. 00 200. 00

Health Financial Systems REHA	REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CMS-25				2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	6 Provider C	CN: 15-3030	Period: From 10/01/2020 To 09/30/2021		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Program Post-Stepdown	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
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	1	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	0	0		0 0	0	76.01
200.00 Total (lines 50 through 199)	0	0		0 0	0	200. 00

	th Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CM					2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	S Provider C		Period: From 10/01/2020 To 09/30/2021		
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 1, 161, 560	0. 000000	54.00
60. 00 06000 LABORATORY	0	0		0 3, 261, 439		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 17, 986	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 10, 398, 544	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 10, 564, 081	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 3, 027, 876	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0)	0 24, 657	0. 000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0 105, 864	0. 000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0 12, 649, 980	0.000000	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 1, 284, 572	0. 000000	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	0	0)	0 935, 539	0. 000000	76. 01
200.00 Total (lines 50 through 199)	0	0		0 43, 432, 098		200. 00

Health Financial Systems REHA	ABILITATION HOSP	In Lie	u of Form CMS-2	2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider CO	CN: 15-3030	Period: From 10/01/2020	Worksheet D Part IV	
				To 09/30/2021	Date/Time Pre	
		Titlo	XVIII	Hospi tal	2/28/2022 4: 2 PPS	9 pm
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpatient	Outpati ent	
cost center bescription						
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		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 SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	400, 412		0 1, 610	0	54.00
60. 00 06000 LABORATORY	0. 000000	1, 448, 069		0 69	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	6, 882	1	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	4, 384, 277	1	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	4, 470, 020	1	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	1, 031, 999	1	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	9, 841		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	14, 765		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	4, 711, 350		0 696	0	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	495, 710		0 1,360	0	76.00
76. 01 03950 HEMODIALYSIS & OTHER ANCILLARY	0. 000000	464, 770		0 0	0	76.01
200.00 Total (lines 50 through 199)	0.000000	17, 438, 095		0 3,735		200.00
	1 1	17, 430, 073	I	5,755		200.00

Health Financial Systems REHA	PITAL OF FT WAY	YNE	In Lie	u of Form CMS-	2552-10	
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-3030	Peri od:	Worksheet D	
				From 10/01/2020 To 09/30/2021		narod
				10 09/30/2021	2/28/2022 4:2	
		Title	e XVIII	Hospi tal	PPS	<u>, bui</u>
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 047564			0 0	77	54.00
60. 00 06000 LABORATORY	0. 050000			0 0	3	60.00
65. 00 06500 RESPI RATORY THERAPY	2.063216	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 229390	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 165040	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 192467	C		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 022468	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 099477	C		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 084340	696	,	0 7,717	59	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 163246	1, 360		0 0	222	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	0. 240316	0		0 0	0	76.01
200.00 Subtotal (see instructions)		3, 735		0 7,717	361	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		3, 735	1	0 7,717	361	202.00

Health Financial Systems RE	HABILITATION HOS	PITAL OF FT WAY	/NE	In Lie	u of Form CMS-25	552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provider C		Period: From 10/01/2020 To 09/30/2021	Worksheet D Part V Date/Time Prepa 2/28/2022 4:29	
			XVIII	Hospi tal	PPS	
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	sts Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
ANOT ELART SERVICE COST CLIVERS 54.00 OS400 RADI OLOGY-DI AGNOSTI C 60.00 O6000 LABORATORY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 73.00 07300 DRUGS CHARGED TO PATI ENTS 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.01 03950 HEMODI ALYSI S & OTHER ANCI LLARY 200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program 0nl y Charges Onl y Charges) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 651 0 0 0 651			2	54. 00 60. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 73. 00 76. 00 76. 01 200. 00 201. 00
202.00 Net Charges (line 200 - line 201)	c	651			2	02.00

Health Financial Systems	REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CM				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI	NMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 15-3030		Worksheet D Part I Date/Time Pre 2/28/2022 4:2	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	÷	•			•	
30. 00 ADULTS & PEDIATRICS	304, 549	0	304, 54	9 12, 325	24. 71	30.00
200.00 Total (lines 30 through 199)	304, 549		304, 54	9 12, 325		200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost				
		(col. 5 x col. 6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 ADULTS & PEDI ATRI CS	316					30.00
200.00 Total (lines 30 through 199)	316	7,808				200. 00

Health Financial Systems REHA	EHABILITATION HOSPITAL OF FT WAYNE In Lie				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-3030	Period: From 10/01/2020 To 09/30/2021		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Related Cost (from Wkst. B,	Total Charges (from Wkst. C, Part I, col.	to Charges	Program	Capital Costs (column 3 x column 4)	
	Part II, col. 26)	8)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	r			F		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 934	1, 161, 560	0.00855	2 15, 990	137	54.00
60. 00 06000 LABORATORY	3, 961	3, 261, 439	0.00121	4 91, 922	112	60.00
65. 00 06500 RESPI RATORY THERAPY	3, 467	17, 986	0. 19276	01 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	246, 441	10, 398, 544	0. 02370	0 249, 996	5, 925	66.00
67.00 06700 OCCUPATI ONAL THERAPY	128, 088	10, 564, 081	0. 01212	252, 394	3, 060	67.00
68.00 06800 SPEECH PATHOLOGY	16, 460	3, 027, 876	0.00543	49, 988	272	68.00
69. 00 06900 ELECTROCARDI OLOGY	15	24, 657	0.00060	8 586	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	652	105, 864	0.00615	i9 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	22, 734	12, 649, 980	0.00179	267, 344	480	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	11, 676	1, 284, 572	0. 00908	28, 703	261	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	1, 565	935, 539	0.00167	28, 341	47	76. 01
200.00 Total (lines 50 through 199)	444, 993	43, 432, 098		985, 264	10, 294	200. 00

Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CMS-29						2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS			Period: From 10/01/2020 Fo 09/30/2021	Date/Time Pre 2/28/2022 4:2	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	20	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS 200. 00 Total (lines 30 through 199)	0	C		0 0	0	30. 00 200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1	-		T		
30.00 O3000 ADULTS & PEDI ATRI CS 200.00 Total (lines 30 through 199)	0		12, 32 12, 32			30. 00 200. 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 & PEDLATRICS 200.00 Total (Lines 30 through 199)	0					30. 00 200. 00

Health Financial Systems REHA	REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CMS-255				2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	6 Provider C	CN: 15-3030	Period: From 10/01/2020 To 09/30/2021		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist	Program	Nursi ng Program	Post-Stepdown	Allied Health	
	Cost	Post-Stepdown Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
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
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0	0	76.00
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY	0	0		0 0	0	76.01
200.00 Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of	of form one E	552-10
	Worksheet D	
	Part IV Date/Time Prep	ared
	2/28/2022 4:29	
Title XIX Hospital	PPS	
Cost Center Description All Other Total Cost Total Total Charges Rati		
	to Charges	
	col. 5 ÷ col.	
4) col s. 2, 3, 8)	7)	
and 4)	(see	
	nstructions)	
4.00 5.00 6.00 7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 1, 161, 560		54.00
60. 00 06000 LABORATORY 0 0 3, 261, 439		60.00
65. 00 06500 RESPI RATORY THERAPY 0 0 17, 986		65.00
66. 00 06600 PHYSI CAL THERAPY 0 0 10, 398, 544	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 10, 564, 081	0.00000	67.00
68. 00 06800 SPEECH PATHOLOGY 0 0 3, 027, 876	0.00000	68.00
69. 00 06900 ELECTROCARDI OLOGY 0 0 24, 657	0.000000	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 105, 864	0.000000	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 12, 649, 980	0.000000	73.00
76. 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 1, 284, 572	0.000000	76.00
76. 01 03950 HEMODIALYSIS & OTHER ANCI LLARY 0 0 935, 539	0.000000	76.01
200.00 Total (lines 50 through 199) 0 0 43,432,098	2	200. 00

Health Financial Systems REHABILITATION HOSPITAL OF FT WAYNE In Lieu of Form CMS-2					2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2020 To 09/30/2021		narod
				10 09/ 30/ 2021	2/28/2022 4:2	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	15, 990		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	91, 922		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	249, 996		0 0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 000000	252, 394		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	49, 988		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	586		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	267, 344		0 0	0	73.00
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	28, 703		0 0	0	76.00
76. 01 03950 HEMODI ALYSI S & OTHER ANCI LLARY	0. 000000	28, 341		0 0	0	76.01
200.00 Total (lines 50 through 199)		985, 264		0 0	0	200.00
					•	•

REHABILITATION HOSPITAL OF FT WAYNE

In Lieu of Form CMS-2552-10

	Financial Systems REHABILITATION HOSPI	TAL OF FT WAYNE	In Lie	u of Form CMS-2	<u>2552-10</u>
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-3030	Peri od:	Worksheet D-1	
			From 10/01/2020 To 09/30/2021	Date/Time Pre	pared:
				2/28/2022 4:2	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				1
1.00	Inpatient days (including private room days and swing-bed day			12, 325	1.00
2.00	Inpatient days (including private room days, excluding swing-			12, 325	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ays). If you have only pr	rivate room days,	0	3.00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	(ave)		12, 325	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	12, 323	5.00
	reporting period	<i>y</i> , <i>c</i>		-	
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.00
7 00	reporting period (if calendar year, enter 0 on this line)			0	7 00
7.00	Total swing-bed NF type inpatient days (including private roc reporting period	om days) through December	31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private roo	om davs) after December 3	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)			-	
9.00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	5, 109	9.00
10.00	newborn days) (see instructions)			0	10.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct	only (including private r	com days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of		room davs) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e				
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	12.00
12 00	through December 31 of the cost reporting period	V oply (including privat	to room daya)	0	12 00
13.00	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
14.00	Medically necessary private room days applicable to the Progr			0	14.00
15.00	5 5 1	· 5 5	5 /	0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
47.00	SWING BED ADJUSTMENT		<u>C 11 1</u>	0.00	1 1 7 00
17.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through December 31 d	of the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18.00
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19.00
20.00	reporting period	a often December 21 of t	the east	0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es arter becember 31 01 1	the cost	0.00	20.00
21.00	Total general inpatient routine service cost (see instruction	าร)		8, 781, 783	21.00
22.00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line	0	22.00
	5 x line 17)				
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportir	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	na period (line	0	24.00
21.00	7 x line 19)		ng period (rine	0	21.00
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25.00
	x line 20)				
26.00 27.00	Total swing-bed cost (see instructions)	(line 21 minus line 24)		0 701 702	1
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 26)		8, 781, 783	27.00
28.00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)		5 /	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
32.00 33.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	ctions)	0.00 0.00	
35.00	Average per diem private room cost differential (line 34 x li			0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	8, 781, 783	37.00
					-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	IUSTMENTS			-
38.00	Adjusted general inpatient routine service cost per diem (see			712.52	38.00
		•			
39.00	Program general inpatient routine service cost (line 9 x line	38)		3, 640, 265	39.00
40.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39	ram (line 14 x line 35)		3, 640, 265 0 3, 640, 265	40.00

MPUI	ATION OF INPATIENT OPERATING COST		Prov	ider C	CN: 15-3030	Period: From 10/01/2020	u of Form CMS- Worksheet D-1	
						To 09/30/2021	2/28/2022 4:2	
	Cost Costas Decesistics	T-+-1	Tati		XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Tota Inpatien		Average Per Diem (col. 1 col. 2)	5	Program Cost (col. 3 x col. 4)	
		1.00	2.0	0	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)							42.
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT				1			43.
00	CORONARY CARE UNIT							44.
00	BURN INTENSIVE CARE UNIT							45.
00	SURGI CAL I NTENSI VE CARE UNI T							46.
00	OTHER SPECIAL CARE (SPECIFY)							47.
	Cost Center Description						1.00	
00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 2	200)			2, 639, 374	48.
	Total Program inpatient costs (sum of lines				ns)		6, 279, 639	
	PASS THROUGH COST ADJUSTMENTS	4			·			
00	Pass through costs applicable to Program inp	atient routine	servi ces	s (from	ı Wkst. D, su	m of Parts I and	126, 243	50
00) Dess through sects applieship to Drogram inp	ationt anaillar		oo (fr	am Witch D	our of Dorto II	104 072	E1
00	Pass through costs applicable to Program inp. and IV)	atient anciiar	y servic	les (Th	UNI WKSL. D, S	Sull OF PALES IT	184, 072	. D1
00	Total Program excludable cost (sum of lines	50 and 51)					310, 315	52
00	Total Program inpatient operating cost exclu	ding capital re	lated, r	non-phy	sician anest	netist, and	5, 969, 324	53
	medical education costs (line 49 minus line	52)						
00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						0	54
00	Target amount per discharge						0.00	
00	Target amount (line 54 x line 55)						0	
00	Difference between adjusted inpatient operat	ing cost and ta	rget amo	ount (I	ine 56 minus	line 53)	0	
00	Bonus payment (see instructions)						0	
00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi ng 1	996, u	ipdated and c	ompounded by the	0.00	59
00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by	/the m	arket basket		0.00	60
00	If line 53/54 is less than the lower of line					the amount by	0	
	which operating costs (line 53) are less that		s (lines	s 54 x	60), or 1% o ⁻	f the target		
00	amount (line 56), otherwise enter zero (see	instructions)						10
00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)				0	
00	PROGRAM INPATIENT ROUTINE SWING BED COST						0	
00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31	of the	cost report	ng period (See	0	64
~~	instructions)(title XVIII only)	+ C + D	01 -4					
00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of	the c	ost reporting	g period (See	0	65
00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus	line 6	5)(title XVI	ll only). For	0	66
	CAH (see instructions)					-		
00	Title V or XIX swing-bed NF inpatient routin	e costs through	Decembe	er 31 o	of the cost r	eporting period	0	67
00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	a costs after D	locombor	31 of	the cost ren	orting period	0	68
00	(line 13 x line 20)		ecember	51 01	the cost rep	bitting period		
00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67	+ line	68)		0	69
0.5	PART III - SKILLED NURSING FACILITY, OTHER NU							
00	Skilled nursing facility/other nursing facil)		70
00 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /u ÷	- i i ne	<i>∠)</i>			71
00	Medically necessary private room cost applic		ı (line 1	4 x li	ne 35)			73
00	Total Program general inpatient routine serv	ice costs (line	72 + li	ne 73)				74
00	Capital-related cost allocated to inpatient	routine service	costs ((from W	lorksheet B, I	Part 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		ost limi	tation	(line 78 mi)	nus line 79)		80
00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)					81
00 00	Reasonable inpatient routine service cost ilmitation (i							82
00	Program inpatient ancillary services (see in							84
00	Utilization review - physician compensation		ns)					85
00	Total Program inpatient operating costs (sum		rough 85	5)				86
00	PART IV - COMPUTATION OF OBSERVATION BED PASS							07
00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 21				0.00	87
00		S. Sm (IIIU ∠/ 7	- I I I I C Z J				0.00	1 00

Health Financial Systems REH/	ABILITATION HOSE	PITAL OF FT WAY	ΊΝΕ	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 10/01/2020	Worksheet D-1	
				To 09/30/2021		
		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	304, 549	8, 781, 783	0. 03468	0 0	0	90.00
91.00 Nursing Program cost	0	8, 781, 783	0.00000	0 0	0	91.00
92.00 Allied health cost	0	8, 781, 783	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	8, 781, 783	0.00000	0 C	0	93.00

REHABILITATION HOSPITAL OF ET WAYNE

		AL OF FT WAYNE		u of Form CMS-2	
COMPUTATION OF	INPATIENT OPERATING COST	Provider CCN: 15-3030	Period: From 10/01/2020	Worksheet D-1	
			To 09/30/2021	Date/Time Pre 2/28/2022 4:2	
		Title XIX	Hospi tal	PPS	
Со	st Center Description			1.00	
PART I -	ALL PROVIDER COMPONENTS			1.00	
I NPATI EN		avaluding nauharn)		12, 325	1.00
	nt days (including private room days and swing-bed days nt days (including private room days, excluding swing-l			12, 325	2.00
	room days (excluding swing-bed and observation bed day		ivate room days,	0	3.00
	complete this line.		-	40.005	
	vate room days (excluding swing-bed and observation be ving-bed SNF type inpatient days (including private roo		or 31 of the cost	12, 325 0	4.00 5.00
	ng period	Sin days) thi ough beceinse		0	5.00
6.00 Total sv	ving-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6.00
	ng period (if calendar year, enter 0 on this line) wing-bed NF type inpatient days (including private room	n davs) through Docombor	21 of the cost	0	7.00
	ng period	a days) thi ough becember	ST OF THE COST	0	7.00
8.00 Total sv	ving-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8.00
	ng period (if calendar year, enter 0 on this line)	the Dreamer (avaluding	owing had and	217	9.00
	<pre>npatient days including private room days applicable to days) (see instructions)</pre>	the Program (excluding	swing-bed and	316	9.00
10.00 Swing-be	ed SNF type inpatient days applicable to title XVIII o		oom days)	0	10.00
5	December 31 of the cost reporting period (see instructed SNE type		and dave) often	0	11 00
	ed SNF type inpatient days applicable to title XVIII on ~ 31 of the cost reporting period (if calendar year, en		oom days) after	0	11.00
12.00 Swing-be	ed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
	December 31 of the cost reporting period			0	10.00
	ed NF type inpatient days applicable to titles V or XIX ecember 31 of the cost reporting period (if calendar ye			0	13.00
14.00 Medi cal I	y necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14.00
	ursery days (title V or XIX only)			0	15.00
	days (title V or XIX only) D ADJUSTMENT			0	16.00
	e rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0.00	17.00
	ng period				
	e rate for swing-bed SNF services applicable to service ng period	es after December 31 of	the cost	0.00	18.00
19.00 Medicaio	rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19.00
	ng period 1 rate for swing-bed NF services applicable to service:	s after December 31 of t	he cost	0.00	20.00
	ng period			0.00	20100
	eneral inpatient routine service cost (see instructions			8, 781, 783	
22.00 Swing-be	ed cost applicable to SNF type services through December 17)	er 31 of the cost report	ing period (line	0	22.00
	ed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23.00
x line 1 24.00 Swing-be	·	a 21 of the east report:	ng paried (line	0	24.00
24.00 Swing-be	ed cost applicable to NF type services through December e 19)	ST OF THE COST TEPOLT	ng period (inne	0	24.00
	ed cost applicable to NF type services after December :	31 of the cost reporting	period (line 8	0	25.00
26.00 Total sv	20) ving-bed cost (see instructions)			0	26.00
	inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		8, 781, 783	
	ROOM DI FFERENTI AL ADJUSTMENT		<u> </u>		
	inpatient routine service charges (excluding swing-bed room charges (excluding swing-bed charges)	and observation bed cr	arges)	0	28.00 29.00
	vate room charges (excluding swing bed charges)			0	30.00
	inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	31.00
5	private room per diem charge (line 29 ÷ line 3)			0.00	32.00
	semi-private room per diem charge (line 30 ÷ line 4) per diem private room charge differential (line 32 min	us line 33)(see instruc	tions)	0.00 0.00	33.00 34.00
0	per diem private room cost differential (line 34 x lin	, ,		0.00	35.00
36.00 Private	room cost differential adjustment (line 3 x line 35)			0	36.00
	inpatient routine service cost net of swing-bed cost a s line 36)	and private room cost di	tterential (line	8, 781, 783	37.00
	- HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM	INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
	d general inpatient routine service cost per diem (see			712.52	38.00
U U	general inpatient routine service cost (line 9 x line y necessary private room cost applicable to the Progra	-		225, 156 0	39.00 40.00
	rogram general inpatient routine service cost (line 39			225, 156	•

OMPUTATION OF INPATIENT OPERATING COST					CN: 15-3030	Period: From 10/01/2020 To 09/30/2021		epare
		1			e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost		: Days	col. 2)	÷	Program Cost (col. 3 x col. 4)	
00	NUDSERV (title V & VIV and V)	1.00	2.00)	3.00	4.00	5.00	42.
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						<u> </u>	42.
. 00	INTENSIVE CARE UNIT							43.
. 00	CORONARY CARE UNIT							44.
00	BURN INTENSIVE CARE UNIT							45.
00	SURGI CAL I NTENSI VE CARE UNI T							46
00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description							47.
							1.00	
00	Program inpatient ancillary service cost (Wk						148, 038	48
00	Total Program inpatient costs (sum of lines -	41 through 48)(see instr	ructio	ns)		373, 194	49
00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	ationt routing	conviooc	(from	What D au	of Darte L and	7 909	50
00	(111)		Services	(11011	WKSL. D, SUN	I UI PALLS I ANU	7,808	50
00	Pass through costs applicable to Program inp	atient ancillar	y service	es (fr	om Wkst. D, s	sum of Parts II	10, 294	51
	and IV)							
. 00	Total Program excludable cost (sum of lines	,					18, 102	
. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line 5		nateu, no	л-рпу	sician anestr	ierist, and	355, 092	2 53
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					1	
00	Program di scharges							54
00	Target amount per discharge						0.00	
00	Target amount (line 54 x line 55)	ing post and to	maat amou	m+ (1	ing E(minug	Line E2)	0	
00 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	irget amot	ini (i	ine so minus	TThe 53)	0	
00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi na 19	996. u	odated and co	ompounded by the		
	market basket	510	J					
. 00	Lesser of lines 53/54 or 55 from prior year						0.00	
. 00	If line 53/54 is less than the lower of line						0	61
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (rines	54 X	50), OF 1% OF	the target		
. 00	Relief payment (see instructions)						0	62
. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)				0	63
00	PROGRAM INPATIENT ROUTINE SWING BED COST	ta thursunk Daar		£ +1				
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through bece		or the	cost reporti	ng period (see	0	64
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of	the c	ost reporting	period (See	0	65
	instructions)(title XVIII only)							
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus l	ine 6	5)(title XVII	l only). For	0	66
00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December	- 31 0	f the cost re	porting period	0	67
. 00	(line 12 x line 19)	e costs through	December	31.0	i the cost it	eporting period	0	/ ⁰ /
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 3	31 of	the cost repo	orting period	0	68
	(line 13 x line 20)						_	
. 00	Total title V or XIX swing-bed NF inpatient						0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil)		70
. 00	Adjusted general inpatient routine service c	-						71
00	Program routine service cost (line 9 x line	71)						72
. 00	Medically necessary private room cost applica				ne 35)			73
. 00 . 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				nrkshaat P	Part II column		74
. 00	26, line 45)	SULTIC SELVICE		i Ulli W	UNANCEL D, F	artir, curumn		1 ^{''}
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)						76
00	Program capital-related costs (line 9 x line							77
00	Inpatient routine service cost (line 74 minu:	,	rovidar		c)			78
00 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa					nus line 79)		79 80
00	Inpatient routine service cost per diem limit				(o / 0 mm			81
00	Inpatient routine service cost limitation ()					82
00	Reasonable inpatient routine service costs (is)					83
. 00	Program inpatient ancillary services (see in:		unc)					84
. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum							85
00	PART IV - COMPUTATION OF OBSERVATION BED PASS		n 50gr - 05,	,			1	
								87
00	Total observation bed days (see instructions Adjusted general inpatient routine cost per						0	101

Health Financial Systems REH.	ABILITATION HOSE	PITAL OF FT WAY	ΊΝΕ	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 10/01/2020	Worksheet D-1	
				To 09/30/2021		
		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	304, 549	8, 781, 783	0. 03468	0 0	0	90.00
91.00 Nursing Program cost	0	8, 781, 783	0.00000	0 0	0	91.00
92.00 Allied health cost	0	8, 781, 783	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	8, 781, 783	0. 00000	0 0	0	93.00

Health Financial Systems	REHABILITATION HOSPITAL OF FT WAY	/NE	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC		Period:	Worksheet D-3	
			From 10/01/2020 To 09/30/2021	Date/Time Pre 2/28/2022 4:2	
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cost		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1		
30. 00 03000 ADULTS & PEDI ATRI CS			9, 915, 231		30.00
ANCI LLARY SERVICE COST CENTERS		0.04754		10.015	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.04756			
60. 00 06000 LABORATORY		0.05000			
65. 00 06500 RESPI RATORY THERAPY		2.06321			
66.00 06600 PHYSI CAL THERAPY		0. 22939			
67.00 06700 OCCUPATI ONAL THERAPY		0. 16504			67.00
68.00 06800 SPEECH PATHOLOGY		0. 19246			
69. 00 06900 ELECTROCARDI OLOGY		0. 02246	-		69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT		0. 09947			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 08434			
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 16324			
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY		0. 24031			
200.00 Total (sum of lines 50 through 94 a			17, 438, 095	2, 639, 374	
201.00 Less PBP Clinic Laboratory Services			0		201.00
202.00 Net charges (line 200 minus line 20	1)		17, 438, 095		202.00

Health Financial Systems	REHABILITATION HOSPITAL OF FT WAY	'NE	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC		Peri od:	Worksheet D-3	
			From 10/01/2020 To 09/30/2021	Date/Time Pre	norod.
			10 09/30/2021	2/28/2022 4:2	
	Titl	e XIX	Hospi tal	PPS	<i>y</i> p
Cost Center Description		Ratio of Cost		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	1	I	
30. 00 03000 ADULTS & PEDI ATRI CS			550, 766		30.00
ANCI LLARY SERVI CE COST CENTERS			1	1	
54.00 05400 RADI OLOGY-DI AGNOSTI C		0.04756			
60. 00 06000 LABORATORY		0.05000			
65. 00 06500 RESPI RATORY THERAPY		2.06321			
66. 00 06600 PHYSI CAL THERAPY		0. 22939			
67.00 06700 OCCUPATI ONAL THERAPY		0. 16504			
68.00 06800 SPEECH PATHOLOGY		0. 19246			
69. 00 06900 ELECTROCARDI OLOGY		0. 02246		-	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	IT	0. 09947		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 08434			
76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 16324			
76.01 03950 HEMODIALYSIS & OTHER ANCILLARY		0. 24031			
200.00 Total (sum of lines 50 through 94			985, 264	148, 038	
201.00 Less PBP Clinic Laboratory Service			0		201.00
202.00 Net charges (line 200 minus line 2	201)		985, 264		202.00

	Financial Systems REHABILITATION HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT P	OF FT WAYNE rovider CCN: 15-3030	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
	• • • • • • • • • • • • • • • • • • • •		From 10/01/2020 To 09/30/2021	Part B Date/Time Pre	
		Title XVIII	Hospi tal	2/28/2022 4: 2 PPS	9 pm
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			651	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instruction OPPS payments	ons)		361 590	2.00 3.00
4.00	Outlier payment (see instructions)			0	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructi	ons)		0.000	5.00
6.00 7.00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0.00	6.00 7.00
8.00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	9.00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 651	10.00 11.00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			001	11.00
	Reasonabl e charges				
12.00 13.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	69)		/, /1/	12.00 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	, 07)		7, 717	
	Customary charges				
15. 00 16. 00	Aggregate amount actually collected from patients liable for pay Amounts that would have been realized from patients liable for p			0	15.00 16.00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	ayment for services c	n a chargebasi s	0	10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18. 00 19. 00	Total customary charges (see instructions)	if line 10 exceeds li	no 11) (coo	7, 717 7, 066	
19.00	Excess of customary charges over reasonable cost (complete only instructions)	IT THE 18 exceeds IT	ne II) (see	7,000	19.00
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			651	21.00
21.00	Interns and residents (see instructions)			001	
23.00	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			590	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)			50	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 2	24 (for CAH, see instr	uctions)	25	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu	us the sum of lines 22	and 23] (see	1, 166	27.00
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, line	÷ 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	,		0	
30.00	Subtotal (sum of lines 27 through 29)			1, 166	
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			0 1, 166	31.00 32.00
02100	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	5)		.,	02.00
	Composite rate ESRD (from Wkst. 1-5, line 11)				33.00
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	
36.00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		0	36.00
37.00	Subtotal (see instructions)			1, 166	
38.00 39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38.00 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			Ū	39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39. 98 39. 99	Partial or full credits received from manufacturers for replaced RECOVERY OF ACCELERATED DEPRECIATION	devices (see instruc	tions)	0	39.98 39.99
40.00	Subtotal (see instructions)			1, 166	
40. 01	Sequestration adjustment (see instructions)			0	40. 01
40.02	Demonstration payment adjustment amount after sequestration			0	40.02
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs Interim payments			2, 058	40.03 41.00
41.01	Interim payments-PARHM			_, :00	41.01
42.00	Tentative settlement (for contractors use only)			0	
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			-892	42.01 43.00
43.01	Balance due provider/program-PARHM (see instructions)			072	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	
	§115.2 TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	
93.00					

NALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-3030	Period: From 10/01/2020 To 09/30/2021	Worksheet E-1 Part I Date/Time Prep 2/28/2022 4:29	
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider 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 List separately each retroactive lump sum adjustment		9, 142, 61	8 0	2, 058 0	1. (2. (3. (
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
. 01	ADJUSTMENTS TO PROVIDER			0	0	3.0
. 02				0	0	3. (
03 04				0	0	3. 3.
. 04				0	0	3. 3.
00	Provider to Program					0.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52 53				0	0	3. 3.
53 54				0	0	3. 3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.
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) TO BE COMPLETED BY CONTRACTOR		9, 142, 61	8	2, 058	4.
00	List separately each tentative settlement payment after					5.
00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					0.
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.
02				0	0	5.
03				0	0	5.
- 0	Provider to Program				-	-
50 51	TENTATI VE TO PROGRAM			0	0	5 5
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1)2	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		219, 13		0 892	6.
)2)0	Total Medicare program liability (see instructions)		9, 361, 75	0	892 1, 166	6
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Contractor Number	NPR Date (Mo/Day/Yr)	/
		()	1.00	2.00	

Heal th	Financial Systems REHABILITATION	HOSPITAL OF FT WAYNE	In Lie	u of Form CMS	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-3030	Period: From 10/01/2020 To 09/30/2021		epared:
		Title XVIII	Hospi tal	PPS	_ , p
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPO				_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCU				_
1.00	Total hospital discharges as defined in AARA §4102 from		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6, sum of lir				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8, sum of lir	nes 1, 8 through 12, and 32.			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line	200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, co	ol. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchas line 168	se of certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructi	ons)			8.00
9.00	Sequestration adjustment amount (see instructions)	,			9.00
	Calculation of the HIT incentive payment after sequestr	ration (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instruction	าร)			30.00
	Other Adjustment (specify)	•			31.00
	Balance due provider (line 8 (or line 10) minus line 30) and line 31) (see instruction	ns)		32.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3030	Period: From 10/01/2020 To 09/30/2021	2/28/2022 4:20	pare
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1100	
00	Net Federal PPS Payment (see instructions)			8, 780, 703	1.
00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0271	2.
00	Inpatient Rehabilitation LIP Payments (see instructions)			566, 355	3.
00	Outlier Payments			137, 655	4.
00	Unweighted intern and resident FTE count in the most rec to November 15, 2004 (see instructions)		0 1	0.00	
01	Cap increases for the unweighted intern and resident FTE program or hospital closure, that would not be counted w CFR $\frac{1}{2}$ (24)(1)(iii)(F)(1) or (2) (see instructions)	vithout a temporary cap adjus ⁻		0.00	5.
00	New Teaching program adjustment. (see instructions)			0.00	
00	Current year's unweighted FTE count of I&R excluding FTE	in the new program growth	period of a "new	0.00	7.
00	teaching program" (see instructions) Current year's unweighted I&R FTE count for residents wi	thin the new program growth	period of a "new	0.00	8
	teaching program" (see instructions)				
00	Intern and resident count for IRF PPS medical education	adjustment (see instructions,		0.00	
). 00 1. 00	Average Daily Census (see instructions)			33. 767123	
2.00	Teaching Adjustment Factor (see instructions) Teaching Adjustment (see instructions)			0. 000000 0	
2.00				9, 484, 713	
4.00	Nursing and Allied Health Managed Care payments (see ins	struction)		9, 404, 713	
+. 00 5. 00				0	14
5.00		instructions)		0	16
7.00				9, 484, 713	
	Primary payer payments			18, 603	
9.00	31313			9, 466, 110	
0.00				59, 400	
1.00				9, 406, 710	
2.00	, , ,			44, 958	22
3.00	Subtotal (line 21 minus line 22)			9, 361, 752	23
4.00	Allowable bad debts (exclude bad debts for professional	<pre>services) (see instructions)</pre>		0	
5.00	Adjusted reimbursable bad debts (see instructions)			0	25
5.00	Allowable bad debts for dual eligible beneficiaries (see	e instructions)		0	26
7.00	Subtotal (sum of lines 23 and 25)			9, 361, 752	27
3.00	Direct graduate medical education payments (from Wkst. E	E-4, line 49)		0	28
9.00				0	
0. 00				0	
1.00				0	
1.50	Pioneer ACO demonstration payment adjustment (see instru	ictions)		0	
1.98	Recovery of accel erated depreciation.			0	31
1.99		ation		0 2/1 752	
2.00 2.01				9, 361, 752 0	
	Sequestration adjustment (see instructions)	lon		0	
2.02 3.00	Demonstration payment adjustment amount after sequestrat	.1011		9, 142, 618	
4.00	Interim payments Tentative settlement (for contractor use only)			9, 142, 018	33
+. 00 5. 00		32 02 33 and 34		219, 134	
5.00	Protested amounts (nonallowable cost report items) in ac §115.2	· · · · · ·	chapter 1,	57, 953	
	TO BE COMPLETED BY CONTRACTOR				
0. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			137, 655	50
1.00	Outlier reconciliation adjustment amount (see instruction	ons)		0	
	The rate used to calculate the Time Value of Money	···-,			52

CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-3030			From 10/01/2020 To 09/30/2021	Worksheet E-3 Part VII Date/Time Pre 2/28/2022 4:20	pare
		Title XIX	Hospi tal	PPS	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR X	TX SERVICES		-
. 00	COMPUTATION OF NET COST OF COVERED SERVICES		0		1
00	Medical and other services		0	0	2
00	Organ acquisition (certified transplant centers only)		0	0	3
00	Subtotal (sum of lines 1, 2 and 3)		0	0	4
00	Inpatient primary payer payments		0	0	5
00	Outpatient primary payer payments		, i i i i i i i i i i i i i i i i i i i	0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
. 00	Routine service charges		550, 766		8
. 00	Ancillary service charges		985, 264	0	9
	Organ acquisition charges, net of revenue		0		10
1.00	Incentive from target amount computation		0		11
2.00	Total reasonable charges (sum of lines 8 through 11)		1, 536, 030	0	12
3. 00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for	convisor on a charge	0	0	13
	basi s				
1.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 4		n 0	0	14
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0.000000	15	
	Total customary charges (see instructions)	1, 536, 030	0	16	
7.00	Excess of customary charges over reasonable cost (complete onl	1, 536, 030	0	17	
	line 4) (see instructions)				
8.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds lin	e 0	0	18
	16) (see instructions)	0			
				0	19
	Cost of physicians' services in a teaching hospital (see instr	-	0	0	20
1.00	Cost of covered services (enter the lesser of line 4 or line 1 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		-	0	21
2 00	Other than outlier payments	compreted for FF3 provi	0	0	22
	Outlier payments		0	0	23
	Program capital payments		0		24
5.00	Capital exception payments (see instructions)		0		25
	Routine and Ancillary service other pass through costs		0	0	26
7.00	Subtotal (sum of lines 22 through 26)		0	0	27
8. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28
9.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31
	Deducti bl es	0	0	32	
	Coinsurance	0	0		
	Allowable bad debts (see instructions) Utilization review	0	0	34	
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	37
	Subtotal (line 36 ± line 37)			0	
	Direct graduate medical education payments (from Wkst. E-4)	0	0	39	
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40
1.00	Interim payments		0	0	41
	Balance due provider/program (line 40 minus line 41)		0	0	
2.00					

	SHEET (If you are nonproprietary and do not maintain	Provider C	CN: 15-3030	Period: From 10/01/2020	Worksheet G	
na-ty Iy)	pe accounting records, complete the General Fund column			To 09/30/2021		
		General Fund	Specific Purpose Fund		Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
-	Cash on hand in banks	-22, 271		0 0	0	1 1
	Temporary investments	0		0 0	0	
00	Notes receivable	0		0 0	0	3
00	Accounts receivable	4, 007, 058		0 0	0	4
	Other receivable	0		0 0	0	
	Allowances for uncollectible notes and accounts receivable	-549, 742		0 0	0	6
	I nventory	22, 316		0 0	0	
	Prepaid expenses Other current assets	154, 962 2, 963		0 0	0	
	Due from other funds	2, 903		0 0	0	10
	Total current assets (sum of lines 1-10)	3, 615, 286		0 0	0	11
	FIXED ASSETS	0,010,200		<u> </u>	ŭ	1
	Land	900, 000		0 0	0	1 12
00	Land improvements	287, 568		0 0	0	13
	Accumulated depreciation	-194, 177		0 0	0	14
	Buildings	11, 662, 532		0 0	0	15
	Accumulated depreciation	-3, 546, 813		0 0	0	16
-	Leasehold improvements Accumulated depreciation	1, 259, 966		0 0	0	17
	Fi xed equi pment	-356, 209 575, 001		0 0	0	18
	Accumul ated depreciation	-219, 547		0 0	0	20
	Automobiles and trucks	113, 428		0 0	0	21
	Accumulated depreciation	-113, 428		0 0	0	22
	Major movable equipment	600, 900		0 0	0	23
00	Accumul ated depreciation	-328, 983		0 0	0	24
	Minor equipment depreciable	233, 838		0 0	0	25
	Accumulated depreciation	-156, 733		0 0	0	26
	HIT designated Assets	0		0 0	0	27
	Accumul ated depreciation	0		0 0 0 0	0	28
	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	10, 717, 343		0 0	0	30
	THER ASSETS	10, 717, 343	I	0 0	0	1
-	Investments	0		0 0	0	31
00	Deposits on Leases	0		0 0	0	32
. 00	Due from owners/officers	0		0 0	0	33
	Other assets	809, 023		0 0	0	34
	Total other assets (sum of lines 31-34)	809, 023		0 0	0	
	Total assets (sum of lines 11, 30, and 35)	15, 141, 652		0 0	0	36
	CURRENT LIABILITIES Accounts payable	470, 902		0 0	0	37
	Sal ari es, wages, and fees payable	1, 095, 474		0 0	0	38
	Payrol I taxes payable	87, 029		0 0	0	
	Notes and loans payable (short term)	44, 957		0 0	0	
	Deferred income	0		0 0	0	41
	Accelerated payments	0				42
	Due to other funds	10, 483, 428		0 0	0	
	Other current liabilities	739, 740		0 0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	12, 921, 530		0 0	0	45
. 00	LONG TERM LIABILITIES Mortgage payable	0		0 0	0	46
	Notes payable	105, 422		0 0	0	40
	Unsecured Loans			0 0	0	
	Other long term liabilities	0		0 0	0	
00	Total long term liabilities (sum of lines 46 thru 49)	105, 422		0 0	0	50
	Total liabilities (sum of lines 45 and 50)	13, 026, 952		0 0	0	51
-	CAPITAL ACCOUNTS					1
	General fund balance	2, 114, 700				52
	Specific purpose fund			0		53
	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted					54
	Governing body created - endowment fund balance - unrestricted					56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
. 00	Total fund balances (sum of lines 52 thru 58)	2, 114, 700		0 0	0	59
. 00	Total liabilities and fund balances (sum of lines 51 and	15, 141, 652	1	0 0	0	60

STATEMENT OF CHANGES IN FUND BALANCES		ABILITATION HOSPITAL OF FT WAYNE Provider CCN: 15-3		CN: 15-3030	5-3030 Period: From 10/C To 09/3		Worksheet G Date/Time Pr 2/28/2022 4:	гер	ared:
		General	Fund	Speci al	Pur	rpose Fund	Endowment Fur		
		1.00	2.00	3.00		4.00	5.00	+	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	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 sheet (line 11 minus line 18)		-2, 706, 425 4, 821, 125 2, 114, 700 2, 114, 700 2, 114, 700 0 2, 114, 700		0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0		0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 18.\ 00\\ 19.\ 00\end{array}$
		Endowment Fund	PI ant						
1.00	Fund balances at beginning of period	6.00	7.00	8.00	0			_	1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	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
$\begin{array}{c} 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$	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	0 0 0	0 0 0 0 0		000				10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN	. 13-3030		riod: om 10/01/2020 09/30/2021	Worksheet G-2 Parts I & II Date/Time Pre 2/28/2022 4:2	pared:
	Cost Center Description	_	Inpati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES General Inpatient Routine Services						-
1.00	Hospi tal		23, 969, 00	62		23, 969, 062	1 1.00
2.00	SUBPROVIDER - IPF		23, 909, 00	52		23, 707, 002	2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVI DER						4.00
5.00	Swing bed - SNF			0		0	
6.00	Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY						7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		23, 969, 00	62		23, 969, 062	10.00
	Intensive Care Type Inpatient Hospital Services						
11.00	INTENSIVE CARE UNIT						11.00
12.00	CORONARY CARE UNIT						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGICAL INTENSIVE CARE UNIT						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of	'lines		0		0	16.00
	11-15)						1
17.00	Total inpatient routine care services (sum of lines 10 and 16)	23, 969, 00		00.040	23, 969, 062	
18.00	Ancillary services		43, 399, 74		32, 349	43, 432, 098	
19.00	Outpatient services			0	0	0	
20.00	RURAL HEALTH CLINIC			0	0	0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	1 - · · · · ·
22.00 23.00	HOME HEALTH AGENCY AMBULANCE SERVICES						22.00
23.00	CMHC						23.00
24.00	AMBULATORY SURGICAL CENTER (D. P.)						24.00
26.00	HOSPICE						26.00
27.00	OTHER (SPECIFY)			0	0	0	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	67, 368, 8 [.]	11	32, 349	67, 401, 160	
20.00	G-3, line 1)	to wikst.	07, 300, 0	• •	52, 547	07,401,100	20.00
	PART II - OPERATING EXPENSES						1
29.00	Operating expenses (per Wkst. A, column 3, line 200)				15, 975, 116		29.00
30.00	ADD (SPECIFY)			0			30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECI FY)			0			37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				0			41.00
42.00	Total deductions (sum of lines 37-41)				0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4 to Wkst. G-3, line 4)	2)(transfer			15, 975, 116		43.00

STATEM	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-3030 Period:				
			From 10/01/2020		
			To 09/30/2021	Date/Time Prep 2/28/2022 4:29	
				2/20/2022 4.2	7 piii
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, I	ine 28)		67, 401, 160	1.00
2.00	Less contractual allowances and discounts on patients' acco			46, 778, 873	2.00
3.00	Net patient revenues (line 1 minus line 2)			20, 622, 287	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, lin	ne 43)		15, 975, 116	
5.00	Net income from service to patients (line 3 minus line 4)	,		4, 647, 171	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 communicati	on services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from laundry and linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to other	than patients			16.00
	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			0	1 .0. 0.
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
	Rental of vending machines			0	
22.00	Rental of hospital space			0	
23.00	Governmental appropriations			0	23.00
24.00	OTHER INCOME			173, 954	
24.50	COVI D-19 PHE Fundi ng			0	
	Total other income (sum of lines 6-24)			173, 954	
	Total (line 5 plus line 25)			4, 821, 125	
	OTHER EXPENSES (SPECIFY)			0	
	Total other expenses (sum of line 27 and subscripts)			0	20.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			4, 821, 125	29.00