PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY STROKE AND REHABILITATION (15-3045) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC	
		1	2	SIGNATURE STATEMENT	
1	Mary	ı F. Sudicky	Υ	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	Mary F. Sudicky			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		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	HOSPITAL	0	44,956	5,992	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	44,956	5,992	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3045 Period: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/20/2023 2:34 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 10215 BROADWAY PO Box: 1.00 2.00 City: CROWN POINT State: IN Zip Code: 46307 County: LAKE 2.00 Component Name CCN CBSA Provider Date Payment System (P, T, 0, or N) Number Number Туре Certified V XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COMMUNITY STROKE AND 153045 23844 5 08/30/2019 3.00 Hospital REHABIL TTATION Subprovider - IPF 4.00 4.00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7.00 8.00 Swing Beds - NF 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospital-Based NF 10.00 11.00 11.00 Hospital-Based OLTC 12.00 Hospital-Based HHA 12.00 13.00 Separately Certified ASC 13.00 14.00 Hospital-Based Hospice 14.00 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2022 06/30/2023 20.00 21.00 Type of Control (see instructions) 21.00 2 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Ν Ν for the portion of the cost reporting period occurring prior to October

1. Enter in column 2, "Y" for yes or "N" for no for the portion of the
cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be 22.02 Ν Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 23.00 3 Ν below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

	Financial Systems COMMUNITY ST CAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		EHABILITATI Provider CC		Period: From 07	/01/2022	Worksl Part		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	/30/2023 Medic HMO d	11/20, aid ays Me	Fime Pre /2023 2: Other edicaid days	gared: 34 pm
24.00		1.00	2.00	3.00	4.00	5.0		6.00	24.00
	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 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 eligible unpaid 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.	40			2		548		24.00
						/Rural S			
36.00	Enter your standard geographic classification (not w	222) 5424115	a+ +ba baa	inning of a		.00	2	.00	26.00
27.00	cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter the	r rural. age) status r "2" for r ication in	at the end ural. If ap column 2.	of the cospolicable,	st	1	L L		27.00
	effect in the cost reporting period.				Regi	nning:	Fnc	ling:	
						.00		.00	1
36.00	Enter applicable beginning and ending dates of SCH s		cript line	36 for numb	per				36.00
37 00	of periods in excess of one and enter subsequent date. If this is a Medicare dependent hospital (MDH) enter		r of period	ls MDH stati	ıs	(37.00
	00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status of is in effect in the cost reporting period. 01 Is this hospital a former MDH that is eligible for the MDH transitional payment in								
38.00	accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 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	f periods i	n excess of	one and					
	enter subsequent dates.					//N	\ \	//N	
						.00		.00	1
39.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent	er in colur nts in	ıme ın	N		N	39.00
40.00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1	ber 1. Ente	r "Y" for y			N		N	40.00
						V	XVII		
	Prospective Payment System (PPS)-Capital					1.0	0 2.00	3.00	
45.00	Does this facility qualify and receive Capital payme	nt for disp	roportionat	e share in	accordanc	e N	N	N	45.00
46.00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks					N	N	N	46.00
47.00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS	canital? -	ntar "V for	VAC OF "N	' for ro	N	N	N	47.00
	Is the facility electing full federal capital paymen					N N	N	N	48.00
	Teaching Hospitals		-						
56.00	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to convolved in training residents in approved GME programd are you are impacted by CR 11642 (or applicable of the program of the	"Y ["] for yes r 27, 2020, olumn 1 is ams in the CRs) MA dir	or "N" for under 42 C "Y", or if prior year	no in colu CFR 413.78(b this hospit or penultin	umn 1. For b)(2), see tal was nate year,				56.00
	"Y" for yes; otherwise, enter "N" for no in column 2 For cost reporting periods beginning prior to Decembis this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this "N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFW which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not complif line 56 is yes, did this facility elect cost reimly	er 27, 2020 residents n column 1. cost report e Worksheet applicable R 413.77(e on duty, i ete column	in approved If column ing period? E-4. If co . For cost)(1)(iv) an f the respo 2, and comp	I GME progra 1 is "Y", (2 Enter "Y' plumn 2 is ' reporting p nd (v), rega onse to line plete Worksh	ams trained that the tr	d or			57.00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. D-5.						

	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 Ser	rvices Administration	(HRSA)			
62.00	Enter the number of FTE residents that your hospital	trained in this cost	reporting peri	od for which	0.00	62.00
	your hospital received HRSA PCRE funding (see instruc	ctions)				
62.01	Enter the number of FTE residents that rotated from a	a Teaching Health Cent	er (THC) into	your hospital	0.00	62.01
	during in this cost reporting period of HRSA THC prog	gram. (see instruction	s)			
	Teaching Hospitals that Claim Residents in Nonprovide	er Settings				
63.00	Has your facility trained residents in nonprovider se	ettings during this co	st reporting p	eriod? Enter	N	63.00
	"Y" for yes or "N" for no in column 1. If yes, comple	ete lines 64 through 6	7. (see instru	ctions)		

0.00

0.00 61.20

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

program specialty, if any, and the number of FTE

61.20 Of the FTEs in line 61.05, specify each expanded

FTE unweighted count.

Health	Financial Systems	COMMUNITY ST	ROKE AND	REHABII ΤΤΔΤΤ	CON	Tn lie	eu of Form CMS-2	2552-10
	THEALTH CARE COMP			Provider CC	CN: 15-3045	Period: From 07/01/2022 To 06/30/2023	Worksheet S-2 Part I	pared:
					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 Base Yea				This base yea	r is your cost ı	reporting	
64.00	period that begins on or after I Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	ty trained n-primary all nonpo d non-prim n column :	d residents care rovider mary care 3 the ratio	0.0	0.00	0.000000	64.00
	or (corumn i arvided by (corumn	Program Name		ram Code	Unweighted	Unweighted	Ratio (col. 3/	
		.3			FTES Nonprovider Site	FTES in Hospital	(col. 3 + col. 4))	
		1.00		2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 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))	65.00
	Section 5504 of the ACA Current	Voor ETE Posidonts i	n Nonnroy	iden Setting	1.00	2.00	3.00	
	beginning on or after July 1, 20		nonprov	ruer secting	SEllective	for cost report	ing perious	
66.00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primal ccurring in all nonpl unweighted non-primal al. Enter in column	rovider so ry care ro 3 the rat	ettings. esident io of	0.0	0.00	0.000000	66.00
		Program Name		ram Code	Unweighted FTEs Nonprovider Site	Unweighted FTES in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
67.00	Enton in column 1 the constant	1.00		2.00	3.00	4.00	5.00	67.00
07.00	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	, 0.00000	07.00

	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.							
			Approved for Permanent Adjustment (Y/N) 1.00	Number of Approved Permanent Adjustments 2.00				
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFF amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete complexes (see instructions) Column 2: Enter the number of approved permanent adjustments.	ol. 2 and line			88.00			
		No.	Effective Date	Permanent Adjustment Amount Per Discharge				
		1.00	2.00	3.00				
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		C	89.00			
			V	XIX				
			1.00	2.00				
	Title V and XIX Services							
	Does this facility have title V and/or XIX inpatient hospital services? Eryes or "N" for no in the applicable column.		N	Y	90.00			
	Is this hospital reimbursed for title V and/or XIX through the cost report full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00			
	Are title XIX NF patients occupying title XVIII SNF beds (dual certificationstructions) Enter "Y" for yes or "N" for no in the applicable column.	,		N	92.00			
	Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column.		N	N	93.00			
	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no applicable column.		N	N	94.00			
	If line 94 is "Y", enter the reduction percentage in the applicable column		0.00	0.00	95.00			
	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no applicable column.		N	N	96.00			
4/ ()()	If line 96 is "Y", enter the reduction percentage in the applicable column	n.	0.00	0.00	97.00			

Health Financial Systems COMMUNITY STROKE A	ND REHABILITAT	ION	In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	F	Period: From 07/01/2022 To 06/30/2023	Worksheet S- Part I Date/Time Pr	
				11/20/2023 2	2:34 pm
			V	XIX	
98.00 Does title V or XIX follow Medicare (title XVIII) for the i	ntarns and ras	idents nost	1.00 N	2.00 N	98.00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.	for yes or "N"	for no in		N	
98.01 Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.			N	Y	98.01
98.02 Does title V or XIX follow Medicare (title XVIII) for the country bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.			N	Y	98.02
98.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.			N	N	98.03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.			N	N	98.04
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 column 2 for title XIX.			N	Y	98.05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			N	N	98.06
Rural Providers					
105.00 Does this hospital qualify as a CAH?			N		105.00
106.00 If this facility qualifies as a CAH, has it elected the all	-inclusive met	hod of payment			106.00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for c	ost reimbursem	ent for T&R			107.00
training programs? Enter "Y" for yes or "N" for no in colum	n 1. (see ins	tructions)			107.00
Column 2: If column 1 is Y and line 70 or line 75 is Y, do					
approved medical education program in the CAH's excluded I		unit(s)?			
Enter "Y" for yes or "N" for no in column 2. (see instruct 108.00 Is this a rural hospital qualifying for an exception to the	.10115) · CRNA fee sche	dule? See 42	N		108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					200.00
	Physical	Occupational		Respiratory	_
109.00 If this hospital qualifies as a CAH or a cost provider, are	1.00	2.00	3.00	4.00	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
				1.00	
110.00 pid this hospital participate in the Rural Community Hospit	al Demonstrati	on project (§4	10A	N 1.00	110.00
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. I	f yes,		
			1.00	2.00	-
111.00 If this facility qualifies as a CAH, did it participate in			N		111.00
Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.	column 1 is Y, articipating in	enter the column 2.			
1. 2. 66.6 108.61 56.1.666.					
110 000 11 11 1 1 1 1 1 1 1 1 1 1 1 1 1	7.1 1.7	1.00	2.00	3.00	112
112.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce	eporting column 1 is pating in the	N			112.00
participation in the demonstration, if applicable.					_
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes o	r "N" for no	N			0115.00
in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub.15-1, chapter 22, §2208.1.	B, or E only) 93" percent (includes	N			0113.00
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.		N			116.00
117.00 Is this facility legally-required to carry malpractice insu "Y" for yes or "N" for no.		Y			117.00
118.00 Is the malpractice insurance a claims-made or occurrence po if the policy is claim-made. Enter 2 if the policy is occur			1		118.00

			From 07/01/ To 06/30/	/2022 /2023	Worksheet S- Part I Date/Time Pi 11/20/2023 2	repared
	Pi	remiums	Losses	S	Insurance	
		1.00	2.00		3.00	
L8.01 List amounts of malpractice premiums and paid losses:		1.00	1	0	3.00	0118.0
	·					
L8.02 Are malpractice premiums and paid losses reported in a cost ce	ntor other than	+ho	1.00 N		2.00	118.0
Administrative and General? If yes, submit supporting scheduld and amounts contained therein. 19.00 DO NOT USE THIS LINE			N			119.0
20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in Co "N" for no. Is this a rural hospital with < 100 beds that qual- Hold Harmless provision in ACA §3121 and applicable amendments' Enter in column 2, "Y" for yes or "N" for no.	olumn 1, "Y" for ifies for the Ou? (see instruction)	yes or tpatient ons)			N	120.0
21.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no.	able devices cha	rged to	N			121.0
22.00 Does the cost report contain healthcare related taxes as define Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included.						122.0
23.00 Did the facility and/or its subproviders (if applicable) purchaservices, e.g., legal, accounting, tax preparation, bookkeeping management/consulting services, from an unrelated organization	g, payroll, and/	or	Y		Υ	123.0
for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., good professional services expenses, for services purchased from unlocated in a CBSA outside of the main hospital CBSA? In column "N" for no.	reater than 50% related organiza	of total tions				
Certified Transplant Center Information						
25.00 Does this facility operate a Medicare-certified transplant cenard "N" for no. If yes, enter certification date(s) (mm/dd/yyy		or yes	N			125.0
26.00If this is a Medicare-certified kidney transplant program, ento		tion date	e			126.0
in column 1 and termination date, if applicable, in column 2.						
27.00 If this is a Medicare-certified heart transplant program, enter in column 1 and termination date, if applicable, in column 2.	r the certificat	ion date				127.
28.00If this is a Medicare-certified liver transplant program, enter	r the certificat	ion date				128.0
in column 1 and termination date, if applicable, in column 2.						
29.00 If this is a Medicare-certified lung transplant program, enter in column 1 and termination date, if applicable, in column 2.	the certificati	on date				129.0
30.00If this is a Medicare-certified pancreas transplant program, e	nter the certifi	cation				130.
date in column 1 and termination date, if applicable, in column						1200
31.00 If this is a Medicare-certified intestinal transplant program,		fication				131.
date in column 1 and termination date, if applicable, in column 32.00 If this is a Medicare-certified islet transplant program, enter		ion data				132.
in column 1 and termination date, if applicable, in column 2.	the ceremical	Ton date				132.
33.00 Removed and reserved						133.
34.00 If this is a hospital-based organ procurement organization (OPC	O), enter the OP	0 number				134.
in column 1 and termination date, if applicable, in column 2. All Providers						
40.00 Are there any related organization or home office costs as def- chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes are claimed, enter in column 2 the home office chain number. (s, and home offi	ce costs			15н054	140.
1.00 2.00 If this facility is part of a chain organization, enter on lin	os 141 +hnough 1	12 +ha -		00	of the	
home office and enter the home office contractor name and cont		ciie n	alle allu add	1655 0	, tile	
1.00 Name: COMMUNITY FOUNDATION OF NW IN, Contractor's Name: WPS	C	Contracto	or's Number:	: 08001	-	141.
INC. 12.00 Street:10010 DONALD S POWERS DRIVE STE PO BOX:						142.
201	-	zin Codo		46321		1/12
13.00 City: MUNSTER State: IN		Zip Code:	•	40321	-	143.
					1.00	
14.00 Are provider based physicians' costs included in Worksheet A?					Y	144.
			1.00		2.00	
15.00 If costs for renal services are claimed on Wkst. A, line 74, a	re the costs for		Y		2.00	145.
inpatient services only? Enter "Y" for yes or "N" for no in co	lumn 1. If colum	n 1 is				
no, does the dialysis facility include Medicare utilization for period? Enter "Y" for yes or "N" for no in column 2.	•					146.

Health Financial Systems	COMMUNITY STE	ROKE AND	REHABILITATI	ON		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DAT	ТА			iod: n 07/01/2022 06/30/2023			
							1.00	\dashv
147.00 was there a change in the statist	cal basis? Enter "Y	" for ye	s or "N" for	no.			N	147.00
148.00 was there a change in the order of	allocation? Enter	"Y" for	yes or "N" fo	r no.			N	148.00
149.00 was there a change to the simplif	ed cost finding met	hod? Ent	er "Y" for ye	s or "N" f	for no.		N	149.00
			Part A	Part E	3	Title V	Title XIX	
			1.00	2.00		3.00	4.00	
Does this facility contain a provor charges? Enter "Y" for yes or '								
155.00 Hospital			N	N		N	N	155.00
156.00 Subprovider - IPF			N	N		N	N	156.00
157.00 Subprovider - IRF			N	N		N	N	157.00
158.00 SUBPROVIDER								158.00
159.00 SNF			N	N		N	N	159.00
160.00 HOME HEALTH AGENCY			N	N		N	N	160.00
161.00 CMHC				N		N	N	161.00
							1.00	
Multicampus								
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	umpus hospital that	has one	or more campu	ises in dif	fferent	: CBSAs?	N	165.00
	Name		County	State	Zip Co	de 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, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.0	00166.00
							1.00	+
Health Information Technology (HI) incentive in the	American	Recovery and	Reinvestr	ment Ac	ct		
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	under §1886(n)? E 5 is "Y") and is a	nter "Y" meaningf	for yes or " ul user (line	'N" for no.			Y	167.00 168.00
168.01 If this provider is a CAH and is rexception under §413.70(a)(6)(ii)?	ot a meaningful use	r, does	this provider			ardship		168.01
169.00 If this provider is a meaningful utransition factor. (see instruction	ıser (line 167 is "Y					, enter the	9.	99169.00
						Beginning	Ending	
						1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR begins period respectively (mm/dd/yyyy)	eginning date and e	nding da	te for the re	porting				170.00
						1.00	2.00	
171.00 If line 167 is "Y", does this prov	rider have any days	for indi	viduals enrol	led in		N N	2.00	0171.00
section 1876 Medicare cost plans i "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	eported on Wkst. S- umn 1. If column 1 i	3, Pt. I	, line 2, col	. 6? Enter				1.50

	Financial Systems COMMUNITY STROKE AN AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-3045	Period: From 07/01/2022 To 06/30/2023	u of Form CMS- Worksheet S- Part II Date/Time Pro 11/20/2023 2	2 epared:
				Y/N	Date	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	MENT OUESTIONN	IAIRE	1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in t	he	
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			N		1.0
	reporting period: If yes, enter the date of the change in t	01uiiii 2. (3ee	Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, includin	n 3, "V" for	N N			3.0
00	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	N			3.00
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava	or Compiled,	Y	A		4.00
00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.0
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	•	the provide	r N		6.0
	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		ved during th	e N		7.0 8.0
	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o	S.		N N		9.0
	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.			N		11.0
	reaching rrogram on worksheet A. 11 yes, see mistractions.				Y/N	
					1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	saa instruct	ions		Y	12.0
.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.	olicy change o	during this c		N	13.0
.00	If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement	nce amounts wa	ilved? If yes	, see	N	14.0
.00	Did total beds available change from the prior cost reporti				N	15.0
		Par Y/N	t A Date	Par Y/N	t B Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.0
00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/26/2023	Y	09/26/2023	17.0
.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.0
.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

OSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		ND REHABILITATIO Provider CCN		Period: From 07/01/2022 To 06/30/2023	u of Form CMS- Worksheet S-2 Part II Date/Time Pre 11/20/2023 2:	pared
		Descrip	tion	Y/N	Y/N	
		0		1.00	3.00	
0.00	If line 16 or 17 is yes, were adjustments made to PS&R			N	N	20.0
	Report data for Other? Describe the other adjustments:	V /N	Date	V /N	Data	
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	-
1.00	was the cost report prepared only using the provider's	N 1.00	2.00	3.00 N	4.00	21.0
1.00	records? If yes, see instructions.	IN IN		N		21.
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	DT CHTI DRENS HO	CP IATTO		1.00	
	Capital Related Cost	FI CHILDRENS NO.	OF I I ALS)			1
.00	Have assets been relifed for Medicare purposes? If yes, see	instructions				22.
.00	Have changes occurred in the Medicare depreciation expense	due to appraisa	ls made du	ring the cost		23.
	reporting period? If yes, see instructions.					
1.00	Were new leases and/or amendments to existing leases entere	ed into during t	his cost r	eporting period?		24.
.00	If yes, see instructions Have there been new capitalized leases entered into during	the cost renert	ing poried	7 If yes soo		25.
.00	instructions.	the cost report	ing period	: II yes, see		23.
.00	Were assets subject to Sec.2314 of DEFRA acquired during th	ne cost reportin	g period?	If yes, see		26.
	instructions.		5 Po. 10011			
.00	Has the provider's capitalization policy changed during the	cost reporting	period? I	f yes, submit		27.
	copy.					
- 00	Interest Expense					1
.00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	iterea into aurii	ng the cos	t reporting		28.
.00	Did the provider have a funded depreciation account and/or	hand funds (Deh	t Service	Reserve Fund)		29.
.00	treated as a funded depreciation account? If yes, see instr		c service i	keserve runu)		23.
.00	Has existing debt been replaced prior to its scheduled matu		ebt? If ye	s, see		30.
	instructions.	•	,	,		
L.00	Has debt been recalled before scheduled maturity without is	ssuance of new d	ebt? If ye:	s, see		31.
	instructions.					
	Purchased Services	nuicos filmaishad	+hannah a	ant na ctua 1		22
2.00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		chrough C	ontractual		32.
3.00	If line 32 is yes, were the requirements of Sec. 2135.2 app		to compet	itive bidding? If		33.
	no, see instructions.	orrea per earning	20 compee	.c.ve s.aag. 1.		"
	Provider-Based Physicians					
1.00	Were services furnished at the provider facility under an a	arrangement with	provider-	based physicians?		34.
	If yes, see instructions.					
5.00	If line 34 is yes, were there new agreements or amended exi		s with the	provider-based		35.
	physicians during the cost reporting period? If yes, see in	istructions.		Y/N	Date	
				1.00	2.00	
	Home Office Costs					
5.00	were home office costs claimed on the cost report?					36.
.00	If line 36 is yes, has a home office cost statement been pr	repared by the h	ome office	?		37.
	If yes, see instructions.					
3.00	If line 36 is yes , was the fiscal year end of the home off			†		38.
00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			c		39.
	see instructions.	enarm componer	1103. II ye.	3,		33.
0.00	If line 36 is yes, did the provider render services to the	home office? I	f yes, see			40.
	instructions.	_				
		1.0	•			-
		1.00	J	2.	00	
	Cost Benort Brenzer Contact Information			WOEDNED		41.
00	Cost Report Preparer Contact Information	CATHERINE				
00	Enter the first name, last name and the title/position	CATHERINE		WOERNER		
00		CATHERINE		WOERNER		71.
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CATHERINE COMMUNITY FOUNDA	ATION OF N			42.
L.00 2.00 3.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.		ATION OF N			

Health F	inancial Systems COMM	MUNITY	STROKE	AND	REHABILITAT	ION		In Lie	u of Form CMS-	2552-10
HOSPITAL	. AND HOSPITAL HEALTH CARE REIMBURSEMENT QUI	STION	NAIRE		Provider (CCN: 15-3045	Peri From To	od: 07/01/2022 06/30/2023		pared:
					3	.00				
Co	ost Report Preparer Contact Information									
	nter the first name, last name and the titl			RE:	MBURSEMENT	MANAGER				41.00
h	eld by the cost report preparer in columns	1, 2,	and 3,							
r	espectively.									
42.00 E	inter the employer/company name of the cost	repor	t							42.00
р	reparer.									
43.00 E	nter the telephone number and email address	of the	he cost							43.00
r	eport preparer in columns 1 and 2, respecti	vely.								

 Health Financial Systems
 COMMUNITY ST

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3045

					0 00, 50, 2025	11/20/2023 2:	34 pm
						I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		Line No.		Available			
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	35	12,775	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF_Subprovider					_	4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		35	12,775	0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	0	(0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		35	12,775	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	0	(0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		35				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	(32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges		İ				33.01
	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	(0	34.00
	, , ,		- 1		'	- 1	

 Health Financial Systems
 COMMUNITY ST

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3045

Period: Worksheet S-3 From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/20/2023 2:34 pm

		_				11/20/2023 2:	34 pm
		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	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	6,129	40	9,674			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1,698	617				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	6 120	0	0 674			6.00
7.00	Total Adults and Peds. (exclude observation	6,129	40	9,674			7.00
8.00	beds) (see instructions)	0		0			8.00
9.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	١	Ų	U			9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00							12.00
13.00	, ,		0	0			13.00
14.00		6,129	40	9,674	0.00	137.00	
15.00		0,123	0	3,077	0.00	157.00	15.00
15.10	REH hours and visits	Ŭ	Ĭ	Č			15.10
16.00							16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	
18.00							18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00							26.00
26.25		0	0	0			
	Total (sum of lines 14-26)				0.00	137.00	
28.00	,		0	0			28.00
29.00	the state of the s	0					29.00
30.00				0			30.00
31.00	1	_	_	0			31.00
32.00		0	0	0			32.00
32.01	Total ancillary labor & delivery room			0			32.01
22.00	outpatient days (see instructions)						22.00
	LTCH non-covered days	0					33.00
	LTCH site neutral days and discharges	0	0	0			33.01 34.00
34.00	Temporary Expansion COVID-19 PHE Acute Care	ı o	υĮ	0	1	I	34.00

 Health Financial Systems
 COMMUNITY ST

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3045

Period: worksheet S-3 From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared:

Full Time Educivalents Nonpaid Workers Title V Title XVIII Title XIX Total All Patients Nonpaid Workers Title V Title XVIII Title XIX Total All Patients Nonpaid						00/30/2023	11/20/2023 2:	
PART I - STATISTICAL DATA 11.00 12.00 13.00 14.00 15.00 15.00 16.00 15.00					Disch	arges		·
PART I - STATISTICAL DATA		Component					Patients	
1.00 Hospital Adults & Peds. (Columns 5, 6, 7 and 8 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) 153 56 2.00 150 153 153 156 2.00 150			11.00	12.00	13.00	14.00	15.00	
8 exclude swing Bed, observation Bed and Hospice days)(see instructions for col. 2 for the portion of LOP room available beds) 153 56 2.00 153 56 2.00 153 56 2.00 154 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 155 1								
2.00	1.00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2		(563	3	887	1.00
MMO IPF Subprovider	2.00				153	56		2.00
MMO IRF Subprovider					255			
5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 6.		·				0		
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 7.0		·				Ĭ		
Total Adults and Peds. (exclude observation beds) (see instructions)								
9.00 CORONARY CARE UNIT 10.00 10		Total Adults and Peds. (exclude observation						
10.00 SURN INTENSIVE CARE UNIT 10.00 11.00 1	8.00	INTENSIVE CARE UNIT						8.00
11.00 SURGICAL INTENSIVE CARE (SPECIFY)	9.00	CORONARY CARE UNIT						9.00
12.00 OTHER SPECIAL CARE (SPECIFY)	10.00	BURN INTENSIVE CARE UNIT						10.00
13.00 NURSERY 13.00 14.00 70tal (see instructions) 0.00 0 563 3 887 14.00 15.00 15.10 REH hours and visits 15.00 15.10 REH hours and visits 15.10 16.00 17.00 18.00 18.00 19.00 17.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00	11.00	SURGICAL INTENSIVE CARE UNIT						11.00
14.00 Total (see instructions) 15.00 CAH visits 15.10 REH hours and visits 15.10 REH hours and visits 15.10 REH ours and visits	12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
15.00 CAH visits 15.10 REH hours and visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.10 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.02 RURAL HEALTH CLINIC 26.03 RURAL HEALTH CLINIC 26.04 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges	13.00	NURSERY						13.00
15.10 REH hours and visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER 19.00 SKILLED NURSING FACILITY 19.00 ON UNESING FACILITY 20.00 ONTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.10 HOSPICE 24.10 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 27.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges 15.10 16.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14.00	Total (see instructions)	0.00	(563	3	887	14.00
16.00 SUBPROVIDER - IPF	15.00	CAH visits						15.00
17.00 SUBPROVIDER - IRF 0.00 0 0 0 17.00 18.00	15.10	REH hours and visits						15.10
18.00 19.00 SKILLED NURSING FACILITY 19.00 20.00 2	16.00	SUBPROVIDER - IPF						16.00
19.00 SKILLED NURSING FACILITY 19.00 20.00 20.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 22.	17.00	SUBPROVIDER - IRF	0.00	(0	0	0	17.00
20.00 NURSING FACILITY 20.00 21.00 21.00 22.	18.00	SUBPROVIDER						
21.00		SKILLED NURSING FACILITY						
22.00 23.00 AMBULATORY SURGICAL CENTER (D.P.) 23.00 24.00 HOSPICE HOSPICE (non-distinct part) 25.00 CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) 0.00 0bservation Bed Days 29.00 Ambulance Trips 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) Employee discount days (see instructions) 32.00 Total ancillary labor & delivery one outpatient days (see instructions) LTCH non-covered days 33.00 LTCH site neutral days and discharges 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 22.00 23.00 25.00 26.00 26.05 27.00 26.05 27.00 26.05 27.00 27.00 28.00 29.00 30.00 29.00 30.00 31.00 Employee discount days (see instructions) 31.00 32.01 33.00 33.01 LTCH site neutral days and discharges		NURSING FACILITY						
23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges 23.00 24.00 25.00 26.00 26.00 27.00 28.00 29.00 30.00 29.00 30.00 29.00 30.00 31.00 31.00 32.01 33.00 33.00 33.00 33.01		OTHER LONG TERM CARE						
24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 26.25 FEDERALLY QUALIFIED HEALTH CENTER 26.00 Observation Bed Days 29.00 Ambulance Trips 29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges		HOME HEALTH AGENCY						
24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.05 FEDERALLY QUALIFIED HEALTH CENTER 26.05 77.00 Total (sum of lines 14-26) 27.00 Observation Bed Days 28.00 Observation Bed Days 29.00 Ambulance Trips 29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges		AMBULATORY SURGICAL CENTER (D.P.)						
25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 FEDERALLY QUALIFIED HEALTH CENTER 26.25 27.00 Total (sum of lines 14-26) 27.00 Observation Bed Days 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges 25.00 26.00 26.25 0.00 27.00 28.00 29.00 30.00 31.00 31.00 31.00 31.00 32.01 33.00 33.01		HOSPICE						
26.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 7.00 26.25 Total (sum of lines 14-26) 0.00 28.00 Observation Bed Days 29.00 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) 31.00 LTCH non-covered days LTCH site neutral days and discharges 26.00 26.25 0.00 27.00 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 20.00 2								
26.25 27.00 Total (sum of lines 14-26) 0.00 28.00 Observation Bed Days 29.00 Ambulance Trips 29.00 30.00 Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) 32.00 Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days 33.00 LTCH site neutral days and discharges								
27.00 Total (sum of lines 14-26) 0.00 28.00 Observation Bed Days 29.00 Ambulance Trips 29.00 30.00 Employee discount days (see instruction) Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 31.00 LTCH non-covered days 0 33.00 33.01 LTCH site neutral days and discharges 0 0 33.01								
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 LTCH non-covered days 31.00 LTCH site neutral days and discharges 28.00 29.00 30.00 31.00 31.00 31.00 32.01 33.00 33.01		1						ı
29.00 Ambulance Trips 29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days 33.00 LTCH site neutral days and discharges 29.00 30.00 31.00 31.00 32.01 33.00 33.01			0.00					
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days 33.00 LTCH site neutral days and discharges 30.00 31.00								
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 31.00 31.00 32.01 0 33.00		·						
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 32.00 32.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 32.01 0 32.01 0 33.00 33.01								
outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 33.01								
33.01 LTCH site neutral days and discharges 0 33.01		outpatient days (see instructions)						
	33.00	LTCH non-covered days			0			33.00
24.00	33.01	LTCH site neutral days and discharges			0			33.01
34.00 Temporary Expansion COVID-19 PHE Acute Care	34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-3045 Period: Worksheet A From 07/01/2022 06/30/2023 Date/Time Prepared: To 11/20/2023 2:34 pm Reclassified Cost Center Description Salaries Total (col. 1 Reclassificati Other + col. 2) ons (See A-6) Trial Balance (col. 3 +col. 4) 1.00 2.00 4.00 3.00 5.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 2,528,786 2,528,786 32,664 2,561,450 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 1,394,259 1,394,259 3,136 1,397,395 2.00 3.00 00300 OTHER CAP REL COSTS 0 3.00 0 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 84,980 1,161,811 1,246,791 1,246,791 4.00 0 5.01 00560 PURCHASING RECEIVING AND STORES 65,599 29,159 94,758 0 94,758 5.01 45,876 386,530 00570 ADMITTING 340,654 5.02 5.02 0 386,530 5.03 00580 CASHIERING/ACCOUNTS RECEIVABLE Λ Λ 5.03 5.04 00590 OTHER ADMINISTRATIVE & GENERAL 1,013,191 4,276,486 5,289,677 -35.800 5.253.877 5.04 7.00 00700 OPERATION OF PLANT 159,798 980,451 1,140,249 1,140,249 7.00 96,535 8.00 00800 LAUNDRY & LINEN SERVICE 96,535 96,535 8.00 0 9.00 00900 HOUSEKEEPING 243,374 311,972 555,346 0 555,346 9.00 10.00 01000 DIETARY 461,322 295,629 756,951 -187,898 569,053 10.00 01100 CAFETERIA 187,898 11.00 0 187,898 11.00 01300 NURSING ADMINISTRATION 22,036 132,964 13.00 110,928 0 132,964 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 14.00 15.00 01500 PHARMACY 0 0 0 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 0 0 0 16.00 0 17.00 01700 SOCIAL SERVICE 0 0 0 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 4,121,971 1,746,678 5,868,649 5,868,649 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 0 0 31.00 41.00 04100 SUBPROVIDER - IRF 0 0 0 0 0 41.00 43.00 04300 NURSERY 0 0 0 43.00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 50.00 51.00 | 05100 RECOVERY ROOM 0 0 0 0 51.00 0 53.00 05300 ANESTHESIOLOGY 0 0 0 0 53.00 54.00 05400 RADTOLOGY-DTAGNOSTIC 360,084 184,361 0 544,445 54.00 544.445 55.00 | 05500 RADIOLOGY-THERAPEUTIC 0 0 55.00 05600 RADIOISOTOPE 90,797 132,099 222,896 0 222,896 56.00 56.00 57.00 05700 CT SCAN 208,665 166,470 375,135 0 375,135 57.00 58.00 113,483 149,564 263,047 0 05800 MRI 58.00 263,047 60.00 06000 LABORATORY 410,712 619,480 1,030,192 0 1,030,192 60.00 0 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 13,215 13,215 13,215 63.00 0 65.00 06500 RESPIRATORY THERAPY 282,183 55,818 338.001 338,001 65.00 66.00 06600 PHYSICAL THERAPY 1.025.554 1.190.270 2.215.824 2.215.824 66.00 67.00 06700 OCCUPATIONAL THERAPY 148,398 963,099 1,111,497 0 1,111,497 67.00 68.00 06800 SPEECH PATHOLOGY 103,251 226,293 329,544 0 329,544 68.00 0 06900 ELECTROCARDIOLOGY 141.003 141,003 69.00 101,651 39,352 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 25,543 7.121 32,664 32,664 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 129,307 129,307 0 129,307 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 359,158 07300 DRUGS CHARGED TO PATIENTS 0 73.00 206,962 566,120 566,120 73.00 74.00 07400 RENAL DIALYSIS 95,743 95,743 95,743 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 98,722 28,555 127,277 0 127,277 90.00 09000 CLINIC 91.00 09100 EMERGENCY 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 27,027,405 118.00 118.00 9,777,822 17,249,583 27,027,405 0 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 191.00 19100 RESEARCH 0 0 0 0 191.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 0 0 0 194.00 07950 OTHER NONREIMBURSABLE DEPARTMENTS 0 0 0 0 194.00 194.01 07951 ADVERTISING 64.096 64.096 64,096 194.01 27,091,501 200.00 9.777.822 200.00 TOTAL (SUM OF LINES 118 through 199) 17.313.679 27.091.501

	· · · · · · · · · · · · · · · · · · ·		ND REHABILITAT			u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-3045	Period: From 07/01/2022	Worksheet A	
					To 06/30/2023	Date/Time Pre 11/20/2023 2:	
	Cost Center Description	Adjustments	Net Expenses			11/20/2023 2.	J- piii
		(See A-8)	For Allocation				
		6.00	7.00				
1 00	GENERAL SERVICE COST CENTERS	9 107	2 560 647	,			1.00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	8,197 120,943					2.00
3.00	00300 OTHER CAP REL COSTS	120,943	1,310,330				3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	217,728	1,464,519				4.00
5.01	00560 PURCHASING RECEIVING AND STORES	0	94,758	1			5.01
5.02	00570 ADMITTING	0	386,530	1			5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE	288,579					5.03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL	-1,770,711	3,483,166	5			5.04
7.00	00700 OPERATION OF PLANT	0	1,140,249				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	96,535				8.00
9.00	00900 HOUSEKEEPING	0	555,346	6			9.00
10.00	01000 DIETARY	0	569,053	1			10.00
11.00	01100 CAFETERIA	-122,587					11.00
13.00	01300 NURSING ADMINISTRATION	0	132,964	+			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0)			14.00
15.00	01500 PHARMACY	0	0	2			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	222,584	1	1			16.00
17.00	01700 SOCIAL SERVICE	0	0)			17.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	5,868,649	1			30.00
31.00	03100 INTENSIVE CARE UNIT	0	1 ' '	1			31.00
41.00	04100 SUBPROVIDER - IRF	0		1			41.00
43.00	04300 NURSERY	Ö		1			43.00
.5.00	ANCILLARY SERVICE COST CENTERS		1	1			1 .5.00
50.00	05000 OPERATING ROOM	0	0				50.00
51.00	05100 RECOVERY ROOM	0	0				51.00
53.00	05300 ANESTHESIOLOGY	0	0				53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-1,440	543,005				54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0)			55.00
56.00	05600 RADIOISOTOPE	0		1			56.00
57.00	05700 CT SCAN	-2,525		1			57.00
58.00	05800 MRI	-990	1	1			58.00
60.00	06000 LABORATORY	-261					60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0		1			63.00
65.00	06500 RESPIRATORY THERAPY	0		1			65.00
66.00 67.00	06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY	0	2,215,824	1			66.00
68.00	06800 SPEECH PATHOLOGY	0	1,111,497 329,544				67.00
69.00	06900 ELECTROCARDIOLOGY	0	141,003	1			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	32,664				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	129,307				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	566,120				73.00
	07400 RENAL DIALYSIS	0					74.00
	OUTPATIENT SERVICE COST CENTERS	'		•			1
90.00	09000 CLINIC	0	127,277	'			90.00
	09100 EMERGENCY	0	0)			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						4
118.00	` ` `	-1,040,483	25,986,922	!			118.00
100 0	NONREIMBURSABLE COST CENTERS						100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	!			190.00
	19100 RESEARCH						191.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NONREIMBURSABLE DEPARTMENTS						192.00 194.00
	07951 ADVERTISING		64,096				194.00
200.00		-1,040,483	1	1			200.00
200.00	1.0171E (30H OF EIRES 110 CHI OUGH 133)	1,070,400	20,051,010	1			1-00.00

Health Financial Systems	COMMUNITY STROKE AND	REHABILITATION	In Lie	u of Form CMS-2552-10
RECLASSIFICATIONS		Provider CCN: 15-3045	Period: From 07/01/2022	Worksheet A-6
				Date/Time Prepared:

						11/20/2023 2	:34 pm
		Increases					
	Cost Center	Line #	Salary	Other			
	2.00	3.00	4.00	5.00			
	A - RECLASS BUILDING INSURANCE	CE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	32,664			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,136			2.00
	0		0	35,800			
	B - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	114,514	73,384			1.00
	0		114,514	73,384			
500.00	Grand Total: Increases		114,514	109,184			500.00

 Health Financial Systems
 COMMUNITY STROKE AND REHABILITATION
 In Lieu of Form CMS-2552-10

 RECLASSIFICATIONS
 Provider CCN: 15-3045
 Period: From 07/01/2022
 Worksheet A-6

	07/01/2022 06/30/2023	Date/Time Pre 11/20/2023 2:	

						11/20/2023 2	:34 pm_		
		Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.				
	6.00	7.00	8.00	9.00	10.00				
	A - RECLASS BUILDING INSURANCE								
1.00	OTHER ADMINISTRATIVE &	5.04	0	35,800	12		1.00		
	GENERAL								
2.00		0.00	0	0	12		2.00		
	0		0	35,800			_		
	B - CAFETERIA RECLASS								
1.00	DIETARY	10.00	114,514	73,384	0		1.00		
	0		114,514	73,384					
500.00	Grand Total: Decreases		114,514	109,184			500.00		

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-3045

Period: worksheet A-7
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared:

Beginning Balances						0 00, 30, 2023	11/20/2023 2:	34 pm
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES					Acquisitions			
1.00 2.00 3.00 4.00 5.00			Beginning	Purchases	Donation	Total	Disposals and	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			Balances				Retirements	
Land			1.00	2.00	3.00	4.00	5.00	
2.00 Land Improvements								
3.00 Buildings and Fixtures	1.00		1,863,072	0	0	0	0	1.00
4.00 Building Improvements 0 0 0 0 0 0 0 0 0		Land Improvements	0	0	0	0	0	2.00
Fixed Equipment	3.00	Buildings and Fixtures	49,402,370	59,161	0	59,161	0	3.00
Movable Equipment	4.00	Building Improvements	0	0	0	0	0	4.00
7.00 HIT designated Assets 0 0 0 0 0 0 0 7.00 8.00 8.00 Subtotal (sum of lines 1-7) 60,270,568 468,623 0 468,623 0 8.00 9.00 Reconciling Items 0 0 0 0 0 0 0 0 0 9.00 10.00 Total (line 8 minus line 9) 60,270,568 468,623 0 468,623 0 10.00 Fully Depreciated Assets 6.00 7.00 Fully Depreciated Assets 6.00 7.00 10.00	5.00	Fixed Equipment	0	0	0	0	0	5.00
8.00 Subtotal (sum of lines 1-7) 60,270,568 468,623 0 468,623 0 0 0 0 0 0 0 0 0	6.00	Movable Equipment	9,005,126	409,462	0	409,462	0	6.00
9.00 Reconciling Items	7.00	HIT designated Assets	0	0	0	0	0	7.00
Total (line 8 minus line 9) 60,270,568 468,623 0 468,623 0 10.00	8.00	Subtotal (sum of lines 1-7)	60,270,568	468,623	0	468,623	0	8.00
Ending Balance	9.00	Reconciling Items	0	0	0	0	0	9.00
Depreciated Assets	10.00	Total (line 8 minus line 9)	60,270,568	468,623	0	468,623	0	10.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			Ending Balance	Fully				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES				Depreciated				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00 Land 1,863,072 0 2.00 Land Improvements 0 0 3.00 Buildings and Fixtures 49,461,531 0 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 0 0 5.00 6.00 Movable Equipment 9,414,588 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 60,739,191 0 8.00 9.00 Reconciling Items 0 0 9.00			6.00	7.00				
2.00 Land Improvements 0 0 3.00 Buildings and Fixtures 49,461,531 0 4.00 Building Improvements 0 0 5.00 Fixed Equipment 0 0 6.00 Movable Equipment 9,414,588 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 60,739,191 0 8.00 9.00 Reconciling Items 0 0 9.00								
3.00 Buildings and Fixtures 49,461,531 0 4.00 Building Improvements 0 0 0 4.00 5.00 Fixed Equipment 0 0 0 5.00 Movable Equipment 9,414,588 0 6.00 7.00 HIT designated Assets 0 0 0 7.00 Subtotal (sum of lines 1-7) 60,739,191 0 8.00 Reconciling Items 0 0 0 9.00	1.00	Land	1,863,072	0				1.00
4.00 Building Improvements 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Land Improvements	0	0				2.00
5.00 Fixed Equipment 0 0 6.00 Movable Equipment 9,414,588 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 60,739,191 0 8.00 9.00 Reconciling Items 0 0 9.00	3.00	Buildings and Fixtures	49,461,531	0				3.00
6.00 Movable Equipment 9,414,588 0 6.00 7.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 60,739,191 0 8.00 9.00 Reconciling Items 0 0 9.00	4.00	Building Improvements	0	0				4.00
7.00 HIT designated Assets 0 0 0 0 8.00 Subtotal (sum of lines 1-7) 60,739,191 0 8.00 9.00 Reconciling Items 0 0 0 9.00	5.00	Fixed Equipment	0	0				5.00
8.00 Subtotal (sum of lines 1-7) 60,739,191 0 8.00 9.00 Reconciling Items 0 0 9.00	6.00	Movable Equipment	9,414,588	0				6.00
9.00 Reconciling Items 0 0 9.00	7.00	HIT designated Assets	0	0				7.00
	8.00	Subtotal (sum of lines 1-7)	60,739,191	0				8.00
10 00 Total (line 8 minus line 9) 60 739 101 0	9.00	Reconciling Items	0	0				9.00
10.00 Total (Time o minus Time o) 00,753,151 0	10.00	Total (line 8 minus line 9)	60,739,191	0				10.00

Health Financial Systems	COMMUNITY STROKE AND REHABILITATION	In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 15-3045	Period: Worksheet A-7

					From 07/01/2022 Fo 06/30/2023		pared: 34 pm
			Su	MMARY OF CAPI	TAL	, , , , , , , , , , , , , , , , , , , ,	
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	2,528,786	0	(0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,353,298	40,961	(0	0	2.00
3.00	Total (sum of lines 1-2)	3,882,084	40,961	(0	0	3.00
SUMMARY OF CAPITAL							
	Cost Center Description	Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM					
1.00	CAP REL COSTS-BLDG & FIXT	0	2,528,786				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,394,259				2.00
3.00	Total (sum of lines 1-2)	0	3,923,045				3.00

неа	lth Financial Systems COMMU	UNITY STROKE AM	ND REHABILITATI	ON	In Lie	u of Form CMS-2	2552-10
REG	CONCILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 07/01/2022 To 06/30/2023		pared:
		COMI	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.0	OO CAP REL COSTS-BLDG & FIXT	51,324,603	0	51,324,60	3 0.845000	0	1.00
2.0	OO CAP REL COSTS-MVBLE EQUIP	9,414,588	0	9,414,58	8 0.155000	0	2.00
3.0	OO Total (sum of lines 1-2)	60,739,191	0	60,739,19	1.000000	0	3.00
		ALLOCA	TION OF OTHER (CAPITAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other Capital-Relate	Total (sum of cols. 5	Depreciation	Lease	

	PART III - RECONCILIATION OF CAPITAL COSTS CE	41EK2					
1	.00 CAP REL COSTS-BLDG & FIXT	51,324,603	0	51,324,603	0.845000	0	1.00
2	.00 CAP REL COSTS-MVBLE EQUIP	9,414,588	0	9,414,588	0.155000	0	2.00
3	.00 Total (sum of lines 1-2)	60,739,191	0	60,739,191	1.000000	0	3.00
		ALLOCA ⁻	TION OF OTHER O	CAPITAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capital-Relate	cols. 5			
			d Costs	through 7)			
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CEN	NTERS					
1	.00 CAP REL COSTS-BLDG & FIXT	0	0	0	2,536,983	0	1.00
2	.00 CAP REL COSTS-MVBLE EQUIP	0	0	0	1,474,241	40,961	2.00
3	.00 Total (sum of lines 1-2)	0	0	0	4,011,224	40,961	3.00
			SU	MMARY OF CAPIT	AL		
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capital-Relate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CEN	NTERS					
1	.00 CAP REL COSTS-BLDG & FIXT	0	32,664	0	0	2,569,647	1.00
2	.00 CAP REL COSTS-MVBLE EQUIP	0	3,136	0	0	1,518,338	2.00
3	.00 Total (sum of lines 1-2)	0	35,800	0	0	4,087,985	3.00

				T-	06/30/2023	Date/Time Prep 11/20/2023 2:3	
				Expense Classification on	Worksheet A	11/20/2023 2.3	94 рііі
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00	4.00	5.00	1.00
1.00	COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	ď	1.00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	О	3.00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
4.00	discounts (chapter 8)				0.00		4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.00
	stations excluded) (chapter				0.00		
8.00	21) Television and radio service		0		0.00	o	8.00
	(chapter 21)						
9.00 10.00	Parking lot (chapter 21) Provider-based physician	A-8-2	-4,955		0.00	0	9.00 10.00
	adjustment				0.00		
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-908,194			0	12.00
13.00	Laundry and linen service		0		0.00	О	13.00
14.00	Cafeteria-employees and guests	1	0		0.00		14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
	patients						
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and		0		0.00	0	18.00
19.00	abstracts Nursing and allied health		0		0.00	О	19.00
	education (tuition, fees, books, etc.)						
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty		0		0.00	0	21.00
	charges (chapter 21)						
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
	repay Medicare overpayments						
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical	A-8-3		PHYSICAL THERAPY	66.00		24.00
24.00	therapy costs in excess of	A-6-3	0	PHISICAL THERAPT	00.00		24.00
25.00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114.00		25.00
23.00	physicians' compensation			cost center bereted	111100		23100
26.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	o	26.00
	COSTS-BLDG & FIXT						
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 30.00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0.00 67.00		29.00 30.00
	therapy costs in excess of limitation (chapter 14)						
30.99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	instructions) Adjustment for speech	A-8-3	n	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of				33.30		
32.00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.00
33 00	Depreciation and Interest OTHER REVENUE	В	_110	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
	10EN NEVENUE	1 5	1 -110	DERELITS DEFARIMENT	7.00	ı Vı	33.00

неаlth	Financial Systems	COMMI	UNITY STROKE A	ND REHABILITATION	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-3045	Period: From 07/01/2022 To 06/30/2023		pared:
				Expense Classification of To/From Which the Amount i			J
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	OTHER REVENUE	В		OTHER ADMINISTRATIVE & GENERAL	5.04	0	33.01
33.02	OTHER REVENUE	В	-122,587	CAFETERIA	11.00	0	33.02
33.03	TAXABLE LABS	A	-261	LABORATORY	60.00	0	33.03
33.04	PATIENT TV DEPRECIATION	A	-4,480	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,040,483				50.00

⁽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.

OFFICE COSTS

				то 06/30/2023	Date/Time Pre 11/20/2023 2:	
	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	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1.00		OTHER ADMINISTRATIVE & GENER		0	816,847	1.00
2.00	1	OTHER ADMINISTRATIVE & GENER	1	1	2,900,903	
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOC-BLDG	8,197	0	3.00
3.01	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOC-EQUIP	125,423		3.01
3.02	5.04	OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOC-SALARIES	996,012	0	3.02
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOC-BENEFITS	217,838	0	3.03
3.04	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE ALLOC-MEDICAL RE	222,584	0	3.04
3.05	5.04	OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOC-REIMBURSEM	8,317	0	3.05
3.06	5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE ALLOC-PATIENT AC	288,579	0	3.06
3.07	5.04	OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOC-OTHER NON	942,606	0	3.07
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			2,809,556	3,717,750	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	0.00 CFNI 100.0	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

Health	Financial Syste	ems			COMMUNITY	STROKE AND	REHABILIT	ATION	In Lie	u of Form CMS-	2552-10
STATEME	ENT OF COSTS OF	SERVICES	FROM	RELATED	ORGANIZATION	S AND HOME	Provider	CCN: 15-3045	Period:	Worksheet A-8	3-1
OFFICE	COSTS								From 07/01/2022 To 06/30/2023	Date/Time Pre	nared:
									10 00/30/2023	11/20/2023 2:	34 pm
	Net	Wkst. A-7	Ref.								
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6.00	7.00									
	A. COSTS INCUR	RED AND AD	JUSTM	IENTS REC	QUIRED AS A R	ESULT OF TRA	ANSACTIONS	WITH RELATED	ORGANIZATIONS OR (CLAIMED	
	HOME OFFICE CO	STS:									
1.00	-816,847		0								1.00
2.00	-2,900,903		0								2.00
3.00	8,197		9								3.00
3.01	125,423		9								3.01
3.02	996,012		0								3.02
3.03	217,838		0								3.03
3.04	222,584		0								3.04
3.05	8,317		0								3.05
3 06	288 579		٥								3 06

5.00 | -908,194 | 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.

3.07

4.00

mas	not been posted to worksheet A,	cordinis I and or 2, the amount arrowable should be mareated in cordini 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATE	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

i e illibu	i sement under title Aviii.		
6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			.0.00
100.00		100	0.00

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

0

3.07

4.00

942,606

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-3045

							11/20/2023 2:	34 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professional	Provider	RCE Amount	Physician/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
				· ·	·		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		RADIOLOGY-DIAGNOSTIC	1,440	1,440	0		0	1.00
2.00	57.00	CT SCAN	2,525			0	0	2.00
3.00	58.00		990			0	0	1
4.00	0.00		0	0		0	0	1
5.00	0.00		0	0	0	0	0	1
6.00	0.00		l o	ĺ	0	0	0	
7.00	0.00		١	0		0	0	
8.00	0.00		0			0	0	1
9.00	0.00			0		0	0	9.00
10.00	0.00		0	0		0	0	
200.00	0.00		4 055	4,955	0	0	ľ	1
	viliant A Librar #	Cook Cooks / Dharisin	4,955			Burning dan	0	
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit		Cost of		Physician Cost	
		Identifier	Limit		Memberships & Continuing	Component Share of col.	of Malpractice	
				Limit			Insurance	
	1.00	2.00	0.00	9.00	Education 12.00	12 13.00	14.00	
1 00	1.00	2.00	8.00	9.00			14.00	1.00
1.00 2.00		RADIOLOGY-DIAGNOSTIC CT SCAN	0	0	_	0	0	1
			0	0	0	0	1	
3.00	58.00		0	0	0	0	0	
4.00	0.00		0	0	0	0	0	
5.00	0.00		0	0	0	0	0	
6.00	0.00		0	0	0	0	0	
7.00	0.00		0	0	0	0	0	
8.00	0.00		0	0	0	0	0	
9.00	0.00		0	0	0	0	0	,
10.00	0.00		0	0	0	0	0	
200.00			0	0	0	0	0	200.00
	Wkst. A Line #		Provider	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Disallowance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		RADIOLOGY-DIAGNOSTIC	0	0	•	,		1.00
2.00		CT SCAN	0	0	0	-,		2.00
3.00	58.00		0	0	0	990		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	4,955		200.00
		ı		'	'	, 555	1	

64,096 194.01

26,051,018 202.00

0 200.00

0 201.00

0

1,518,338

0

1,469,818

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-3045 Period: Worksheet B From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/20/2023 2:34 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP EMPLOYEE Subtotal Cost Center Description Net Expenses for Cost BENEFITS Allocation DEPARTMENT (from Wkst A col. 7) 1.00 2.00 4.00 4A GENERAL SERVICE COST CENTERS 1.00 1.00 2.569.647 2.569.647 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 1,518,338 1,518,338 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1,464,519 4,051 1,248 1,469,818 4.00 9,947 5.01 00560 PURCHASING RECEIVING AND STORES 94,758 40,686 1,242 5.01 146.633 5.02 00570 ADMITTING 386,530 22,692 18,945 51,657 479,824 5.02 5.03 00580 CASHIERING/ACCOUNTS RECEIVABLE 288,579 0 288,579 5.03 5.04 00590 OTHER ADMINISTRATIVE & GENERAL 3,483,166 48,067 243,942 153,640 3,928,815 5.04 7.00 00700 OPERATION OF PLANT 1.140.249 26,097 1,536,246 7.00 345,668 24,232 8.00 00800 LAUNDRY & LINEN SERVICE 96,535 96,535 8.00 00900 HOUSEKEEPING 555,346 48,291 4,178 36,905 9.00 644,720 9.00 01000 DIETARY 569,053 82,142 96,835 52,590 800,620 10.00 10.00 65,311 44,041 17,365 11.00 01100 CAFETERIA 41,501 168,218 11.00 13.00 01300 NURSING ADMINISTRATION 132,964 3,927 0 16,821 153,712 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 14.00 01500 PHARMACY 0 15.00 0 15.00 0 0 16.00 01600 MEDICAL RECORDS & LIBRARY 222,584 2,535 0 0 225,119 16.00 01700 SOCIAL SERVICE 17.00 17.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 303,646 30.00 03000 ADULTS & PEDIATRICS 5,868,649 871,403 625,053 7,668,751 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 04100 SUBPROVIDER - IRF 0 41.00 41.00 0 0 0 0 04300 NURSERY 0 0 0 0 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0 0 51.00 53.00 05300 ANESTHESIOLOGY 0 0 0 0 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 543,005 103,865 201,672 54,603 903,145 54.00 55.00 05500 RADIOLOGY-THERAPEUTIC 55.00 56.00 05600 RADIOISOTOPE 222,896 7,854 36,572 13,768 281,090 56.00 05700 CT SCAN 372,610 17,224 69,331 490,807 57.00 31,642 57 00 58.00 | 05800 MRI 262,057 42,624 133,714 17,209 455,604 58.00 1,029,931 1,189,319 60.00 06000 LABORATORY 55,623 41,485 62,280 60.00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 13.215 13.215 63.00 06500 RESPIRATORY THERAPY 338,001 15,541 42,790 65.00 396,332 65.00 66.00 06600 PHYSICAL THERAPY 2,215,824 163,191 201,378 155,515 2,735,908 66.00 67.00 06700 OCCUPATIONAL THERAPY 1,111,497 10,314 6,374 22,503 1,150,688 67.00 06800 SPEECH PATHOLOGY 3,338 15,657 360.096 68.00 329,544 11.557 68.00 69.00 06900 ELECTROCARDIOLOGY 141,003 10,439 24,012 15,414 190,868 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 32,664 11,196 3,873 47,733 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 129,307 0 0 129,307 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 566,120 2,933 35,865 31,384 636,302 73.00 07400 RENAL DIALYSIS 74.00 95,743 14,018 226 109,987 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 127.277 4.449 0 14.970 146.696 91.00 09100 EMERGENCY 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS 25,986,922 1,957,594 1,518,338 1,469,818 25,374,869 118.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 612,053 0 0 612,053 192.00 0 194.00 07950 OTHER NONREIMBURSABLE DEPARTMENTS 0 0 194.00

64.096

2,569,647

26,051,018

194.01 07951 ADVERTISING

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

200.00

201.00

202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3045

Period: Worksheet B From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/20/2023 2:34 pm

				10	00/30/2023	11/20/2023 2:	
	Cost Center Description	PURCHASING	ADMITTING	CASHIERING/ACC	Subtotal	OTHER	•
		RECEIVING AND		OUNTS		ADMINISTRATIVE	
		STORES		RECEIVABLE		& GENERAL	
		5.01	5.02	5.03	5A.03	5.04	
	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	00560 PURCHASING RECEIVING AND STORES	146,633					5.01
5.02	00570 ADMITTING	2,716	482,540	1			5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE	1,634	0	290,213			5.03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL	22,241	0	0	3,951,056	3,951,056	5.04
7.00	00700 OPERATION OF PLANT	8,697	0	0	1,544,943	276,206	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	546	0	0	97,081	17,356	8.00
9.00	00900 HOUSEKEEPING	3,650	0	0	648,370	115,916	9.00
10.00	01000 DIETARY	4,532	0	0	805,152	143,946	10.00
11.00	01100 CAFETERIA	952	0	0	169,170	30,244	11.00
13.00	01300 NURSING ADMINISTRATION	870	0	0	154,582	27,636	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500 PHARMACY	0	0	0	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1,274	0	0	226,393	40,475	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	42 401	04.012	56,560	7 062 724	1 405 700	20.00
30.00	03000 ADULTS & PEDIATRICS	43,401	94,013	56,569	7,862,734	1,405,709	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100 SUBPROVIDER - IRF	0	0	1	0	0	41.00
43.00	04300 NURSERY	0	0	0	U	0	43.00
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,113	49,095	29,524	986,877	176,435	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	3,113	45,055	23,324	000,077	0	55.00
56.00	05600 RADIOISOTOPE	1,591	19,810	11,913	314,404	56,209	56.00
57.00	05700 CT SCAN	2,778	40,389		558,263	99,807	57.00
58.00	05800 MRI	2,579	39,698		521,753	93,280	58.00
60.00	06000 LABORATORY	6,733	68,082		1,305,075	233,323	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	75	973		14,848	2,655	63.00
65.00	06500 RESPIRATORY THERAPY	2,244	8,637	1	412,407	73,731	65.00
66.00	06600 PHYSICAL THERAPY	15,488	50,104		2,831,630	506,242	66.00
67.00	06700 OCCUPATIONAL THERAPY	6,514	30,596		1,206,197	215,645	67.00
68.00	06800 SPEECH PATHOLOGY	2,039	8,110		375,122	67,065	68.00
69.00	06900 ELECTROCARDIOLOGY	1,081	29,135		238,604	42,658	
70.00	07000 ELECTROENCEPHALOGRAPHY	270	14,202		70,746	12,648	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	732	2,906		134,693	24,081	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,602	23,948	14,401	678,253	121,259	73.00
74.00	07400 RENAL DIALYSIS	623	2,600		114,774	20,519	74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	830	242	146	147,914	26,444	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	142,805	482,540	290,213	25,371,041	3,829,489	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19100 RESEARCH	0	0	0	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	3,465	0	0	615,518	110,043	
	07950 OTHER NONREIMBURSABLE DEPARTMENTS	0	0	0	0		194.00
	U07951 ADVERTISING	363	0	0	64,459	11,524	
200.00					0		200.00
201.00		0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	146,633	482,540	290,213	26,051,018	3,951,056	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3045

Period: Worksheet B From 07/01/2022 To 06/30/2023 Date/Time Prepared: 11/20/2023 2:34 pm

						11/20/2023 2:	34 L
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DIETARY	CAFETERIA	
		PLANT	LINEN SERVICE	0.00	10.00	11 00	
		7.00	8.00	9.00	10.00	11.00	
00	GENERAL SERVICE COST CENTERS				T		-
00	00100 CAP REL COSTS-BLDG & FIXT						1
00	00200 CAP REL COSTS-MVBLE EQUIP						2
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4
01	00560 PURCHASING RECEIVING AND STORES						5
02	00570 ADMITTING						5
03	00580 CASHIERING/ACCOUNTS RECEIVABLE						5
04	00590 OTHER ADMINISTRATIVE & GENERAL						5
00	00700 OPERATION OF PLANT	1,821,149					7
00	00800 LAUNDRY & LINEN SERVICE	0	114,437				8
00	00900 HOUSEKEEPING	41,710	0	805,996			9
.00	01000 DIETARY	70,948	0	32,136	1,052,182		10
.00	01100 CAFETERIA	38,039	0	17,230	0	254,683	11
.00	01300 NURSING ADMINISTRATION	3,392	0	1,536	0	3,813	
.00	01400 CENTRAL SERVICES & SUPPLY	0,552	0	2,330	0	0	
	01500 PHARMACY	0	Õ	Ŏ	o o	0	
.00	01600 MEDICAL RECORDS & LIBRARY	2,190	0	992	0	0	
		2,190	0	0	0	0	
.00	INPATIENT ROUTINE SERVICE COST CENTERS	l o	U	U	U _I	0	1 1/
.00		752,653	114,437	340,915	1,052,182	141,696	30
.00		732,033	114,437	340,313	1,032,162	,	
	03100 INTENSIVE CARE UNIT	0	0	0	0	0	
00	04100 SUBPROVIDER - IRF	0	0	0	0	0	
.00	04300 NURSERY	0	0	0	U	0	43
00	ANCILLARY SERVICE COST CENTERS				٥١		-
	05000 OPERATING ROOM	0	0	0	0	0	
00	05100 RECOVERY ROOM	0	0	0	0	0	1 -
	05300 ANESTHESIOLOGY	0	0	0	0	0	
00	05400 RADIOLOGY-DIAGNOSTIC	89,710	0	40,634	0	12,378	
.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	
.00	05600 RADIOISOTOPE	6,784	0	3,073	0	3,121	. 56
00	05700 CT SCAN	14,877	0	6,738	0	7,173	
00	05800 MRI	36,816	0	16,676	0	3,901	. 58
.00	06000 LABORATORY	48,043	0	21,761	0	14,118	60
.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63
00	06500 RESPIRATORY THERAPY	0	0	0	0	9,700	6
00	06600 PHYSICAL THERAPY	140,952	0	63,844	0	35,253	6
00	06700 OCCUPATIONAL THERAPY	8,909	0	4,035	0	5,101	
00	06800 SPEECH PATHOLOGY	9,982	0	4,521	0	3,549	
00	06900 ELECTROCARDIOLOGY	9,016	0	4,084	0	3,494	
00	07000 ELECTROENCEPHALOGRAPHY	3,010	Ô	1,001	o o	878	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0,0	
00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	2 522	0	1 147	0		
	1	2,533	0	1,147	0	7,114	
		12,107	0	5,484	0	0	74
	OUTPATIENT SERVICE COST CENTERS	3 043		1 740	ما	2 204	1
00	09000 CLINIC	3,843	0	1,740	0	3,394	
00	09100 EMERGENCY	0	0	0	0	0	
00	09200 OBSERVATION BEDS (NON-DISTINCT PART						9
	SPECIAL PURPOSE COST CENTERS						4
.00	3 7	1,292,504	114,437	566,546	1,052,182	254,683	1118
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190
	19100 RESEARCH	0	0	0	0		19:
.00	19200 PHYSICIANS' PRIVATE OFFICES	528,645	0	239,450	0	0	192
	07950 OTHER NONREIMBURSABLE DEPARTMENTS	0	0	0	0	0	194
	107951 ADVERTISING	0	0	0	0		194
		1	ı .			ŭ	200
	JI Cross Foot Adjustments						
0.00 L.00		0	0	n	n	n	201

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3045

Period: Worksheet B From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared:

					10 06/30/2023	11/20/2023 2:	
	Cost Center Description	NURSING	CENTRAL	PHARMACY	MEDICAL	SOCIAL SERVICE	
		ADMINISTRATION	SERVICES &		RECORDS &		
		10.00	SUPPLY	1	LIBRARY	15.00	
		13.00	14.00	15.00	16.00	17.00	
1 00	GENERAL SERVICE COST CENTERS					1	1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560 PURCHASING RECEIVING AND STORES						5.01
5.02	00570 ADMITTING						5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL						5.04
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00
10.00	01000 DIETARY						9.00
11.00	01100 CAFETERIA						11.00
13.00	01300 NURSING ADMINISTRATION	190,959					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	190,939	0				14.00
15.00	01500 PHARMACY		0		0		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		0		0 270,050		16.00
17.00	01700 SOCIAL SERVICE	0	0		0 270,030	o o	17.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			<u> </u>	<u>, </u>	17.00
30.00	03000 ADULTS & PEDIATRICS	173,820	0		0 52,657	7 0	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
41.00	04100 SUBPROVIDER - IRF	0	0		0	o o	41.00
43.00	04300 NURSERY	0	0		0 0	0	43.00
	ANCILLARY SERVICE COST CENTERS				.		
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0		0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		0 27,470	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0		0	0	55.00
56.00	05600 RADIOISOTOPE	0	0		0 11,084		56.00
57.00	05700 CT SCAN	0	0		0 22,599	1	57.00
58.00	05800 MRI	0	0		0 22,212	1	58.00
60.00	06000 LABORATORY	0	0		0 38,094	1	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 545	1	63.00
65.00	06500 RESPIRATORY THERAPY	11,899	0		0 4,832	1	65.00
66.00	06600 PHYSICAL THERAPY	0	0		0 28,034	1	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 17,119	1	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 4,538	1	68.00
69.00 70.00	06900 ELECTROCARDIOLOGY	1,077	0		0 16,302	1	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,077	0		0 7,947 0 1,626	1	70.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 1,626		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 13,400		73.00
74.00	07400 RENAL DIALYSIS	0	0		0 1,455	1	74.00
7 1100	OUTPATIENT SERVICE COST CENTERS	<u> </u>			1,133		7 1100
90.00	09000 CLINIC	4,163	0		0 136	5 0	90.00
	09100 EMERGENCY	0	0		0 0	1	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		-				92.00
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	,		'		
118.00		190,959	0		0 270,050	0	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191.00	19100 RESEARCH	0	0		0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0		192.00
194.00	07950 OTHER NONREIMBURSABLE DEPARTMENTS	0	0		0		194.00
	07951 ADVERTISING	0	0		0) 0	194.01
200.00							200.00
201.00		0	0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	190,959	0		0 270,050	۱ 0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3045

Period: Worksheet B From 07/01/2022 Part I To 06/30/2023 Date/Time Prepared:

					10 06/30/2023 Date/Time Pi 11/20/2023 2	
	Cost Center Description	Subtotal	Intern &	Total		
	·		Residents Cost			
			& Post			
			Stepdown			
			Adjustments			
	CENTERAL CERVITCE COCT CENTERS	24.00	25.00	26.00		
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 CAP REL COSTS-BLDG & FIXT					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560 PURCHASING RECEIVING AND STORES					5.01
5.02	00570 ADMITTING					5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL					5.04
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 DIETARY					10.00
11.00	01100 CAFETERIA					11.00
13.00	01300 NURSING ADMINISTRATION					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15.00	01500 PHARMACY					15.00
16.00	01600 MEDICAL RECORDS & LIBRARY					16.00
17.00	01700 SOCIAL SERVICE					17.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS	11,896,803	0	11,896,80	3	30.00
	03100 INTENSIVE CARE UNIT	0	0		0	31.00
	04100 SUBPROVIDER - IRF	0	0		0	41.00
	04300 NURSERY	0	0		0	43.00
	ANCILLARY SERVICE COST CENTERS	0	0		0	F0 00
	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	0		0	50.00
	05300 ANESTHESIOLOGY	0	0		0	53.00
	05400 RADIOLOGY-DIAGNOSTIC	1,333,504	0	1,333,50	4	54.00
	05500 RADIOLOGY-THERAPEUTIC	1,333,304	0	1,333,30	0	55.00
	05600 RADIOISOTOPE	394,675	0	394,67	5	56.00
	05700 CT SCAN	709,457	0	709,45		57.00
	05800 MRI	694,638	0	694,63		58.00
60.00	06000 LABORATORY	1,660,414	0	1,660,41		60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	18,048	0	18,04		63.00
65.00	06500 RESPIRATORY THERAPY	512,569	0	512,56		65.00
	06600 PHYSICAL THERAPY	3,605,955	0	3,605,95		66.00
67.00	06700 OCCUPATIONAL THERAPY	1,457,006	0	1,457,00		67.00
	06800 SPEECH PATHOLOGY	464,777	0	464,77	7	68.00
69.00	06900 ELECTROCARDIOLOGY	314,158	0	314,15	8	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	93,296	0	93,29	6	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	160,400	0	160,40	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	823,706	0	823,70		73.00
	07400 RENAL DIALYSIS	154,339	0	154,33	9	74.00
	OUTPATIENT SERVICE COST CENTERS	407.624		407.63		
	09000 CLINIC	187,634	0	187,63	4	90.00
	09100 EMERGENCY	0	0		0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		U			92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	24,481,379	0	24,481,37	٥	118.00
	NONREIMBURSABLE COST CENTERS	24,401,379	U	24,401,37	9	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	n	n		0	190.00
191.00	19100 RESEARCH	0	0		ŏ	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1,493,656	0	1,493,65	6	192.00
	07950 OTHER NONREIMBURSABLE DEPARTMENTS	0	0	,, 00	0	194.00
	07951 ADVERTISING	75,983	0	75,98	3	194.01
200.00		0	0	, , ,	0	200.00
201.00		0	0		0	201.00
202.00	TOTAL (sum lines 118 through 201)	26,051,018	0	26,051,01	8	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3045

Period:

From 07/01/2022 Part II Date/Time Prepared: 06/30/2023 11/20/2023 2:34 pm CAPITAL RELATED COSTS Directly BLDG & FIXT MVBLE EQUIP Subtotal **EMPLOYEE** Cost Center Description Assigned New BENEFITS Capital DEPARTMENT Related Costs 0 1.00 2.00 2A 4.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4,051 1,248 5,299 5,299 4.00 0 5.01 00560 PURCHASING RECEIVING AND STORES 0 40,686 1,242 41,928 36 5.01 00570 ADMITTING 0 5.02 22,692 18,945 41,637 186 5.02 0 5.03 00580 CASHIERING/ACCOUNTS RECEIVABLE 0 0 5.03 5.04 00590 OTHER ADMINISTRATIVE & GENERAL 0 48,067 243,942 292,009 554 5.04 26,097 00700 OPERATION OF PLANT 0 345,668 87 7.00 7.00 371.765 00800 LAUNDRY & LINEN SERVICE 0 8.00 0 8.00 9.00 00900 HOUSEKEEPING 0 48,291 4,178 52,469 133 9.00 0 10.00 01000 DIETARY 82,142 96,835 178,977 190 10.00 0 01100 CAFFTERTA 44,041 11.00 41,501 85.542 63 11.00 13.00 01300 NURSING ADMINISTRATION 0 3,927 0 3,927 61 13.00 01400 CENTRAL SERVICES & SUPPLY 0 0 14.00 14.00 C 0 0 15.00 0 01500 PHARMACY 0 15.00 0 0 16.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 2,535 2,535 0 17.00 01700 SOCIAL SERVICE 0 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 0 871,403 303,646 1,175,049 2,252 30.00 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 0 31.00 0 0 0 0 31.00 41.00 04100 SUBPROVIDER - IRF 0 0 0 0 0 41.00 43.00 04300 NURSERY 0 0 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROOM 0 0 0 0 05100 RECOVERY ROOM 0 0 0 0 51.00 51.00 0 0 53.00 05300 ANESTHESIOLOGY 0 53.00 05400 RADIOLOGY-DIAGNOSTIC 0 103,865 305,537 197 54.00 201,672 54.00 05500 RADIOLOGY-THERAPEUTIC 55.00 0 Λ 55.00 05600 RADIOISOTOPE 0 7,854 44,426 56.00 56.00 36.572 50 0 57.00 05700 CT SCAN 17,224 69,331 86,555 114 57.00 0 05800 MRT 133.714 176,338 58.00 42.624 62 58.00 0 60.00 06000 LABORATORY 55,623 41,485 97,108 225 60.00 0 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 0 63.00 |06500|RESPIRATORY THERAPY 0 65.00 15,541 15,541 154 65.00 66.00 06600 PHYSICAL THERAPY 163,191 201,378 364,569 561 66.00 6,374 16,688 67.00 06700 OCCUPATIONAL THERAPY 0 10,314 81 67.00 06800 SPEECH PATHOLOGY 0 3,338 14,895 68.00 68.00 11.557 56 0 69 00 06900 ELECTROCARDIOLOGY 10,439 24,012 34,451 56 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 C 11,196 11,196 14 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 0 2.933 38,798 73.00 35,865 113 73.00 74.00 07400 RENAL DIALYSIS 14,018 226 14,244 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 0 4,449 4.449 54 90.00 09000 CL TNTC 0 91.00 09100 EMERGENCY 0 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 5,299 118.00 0 1,957,594 1,518,338 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 3,475,932 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 0 191.00 19100 RESEARCH 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 612,053 0 612,053 0 192.00 194.00 07950 OTHER NONREIMBURSABLE DEPARTMENTS 0 0 0 0 194.00 194.01 07951 ADVERTISING 0 0 0 0 194.01 200.00 Cross Foot Adjustments 0 200.00 0|201.00 201.00 Negative Cost Centers

0

2,569,647

1,518,338

4,087,985

5,299 202.00

TOTAL (sum lines 118 through 201)

202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3045

Period: Worksheet B From 07/01/2022 Part II Date/Time Prepared: 11/20/2023 2:34 pm

						11/20/2023 2:	34 pm
	Cost Center Description	PURCHASING	ADMITTING	CASHIERING/ACC	OTHER	OPERATION OF	
		RECEIVING AND		OUNTS	ADMINISTRATIVE	PLANT	
		STORES		RECEIVABLE	& GENERAL		
		5.01	5.02	5.03	5.04	7.00	
	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	00560 PURCHASING RECEIVING AND STORES	41,964					5.01
5.02	00570 ADMITTING	777	42,600				5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE	467	0	467	'		5.03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL	6,365	0	[C	298,928		5.04
7.00	00700 OPERATION OF PLANT	2,489	0	C	20,897	395,238	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	156	0	C	1,313	0	8.00
9.00	00900 HOUSEKEEPING	1,044	0	C	8,770	9,052	9.00
10.00	01000 DIETARY	1,297	0	C	10,890	15,398	10.00
11.00	01100 CAFETERIA	273	0	[c	2,288	8,256	11.00
13.00	01300 NURSING ADMINISTRATION	249	0	[c	2,091	736	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	l	0	0	14.00
15.00	01500 PHARMACY	0	0	l c	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	365	0	l c	3,062	475	16.00
17.00	01700 SOCIAL SERVICE	0	0	l c		0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· ·		•	'		
30.00	03000 ADULTS & PEDIATRICS	12,424	8,288	120	106,357	163,345	30.00
31.00	03100 INTENSIVE CARE UNIT	0	. 0	l c		0	31.00
41.00	04100 SUBPROVIDER - IRF	0	0	l d	0	0	41.00
43.00	04300 NURSERY	0	0	ĺ	1	0	43.00
	ANCILLARY SERVICE COST CENTERS		-		-		
50.00	05000 OPERATING ROOM	0	0	C	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	ĺ		0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	ĺ	-	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,463	4,336	1	1	19,470	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	1,330	l c		0	55.00
56.00	05600 RADIOISOTOPE	455	1,749	1	1	1,472	56.00
57.00	05700 CT SCAN	795	3,567	36		3,229	57.00
58.00	05800 MRI	738	3,506			7,990	58.00
60.00	06000 LABORATORY	1,927	6,012	61		10,427	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	21	86		· ·	10,427	63.00
65.00	06500 RESPIRATORY THERAPY	642	763	8		0	65.00
66.00	06600 PHYSICAL THERAPY						66.00
		4,432	4,425	45		30,590	
67.00	06700 OCCUPATIONAL THERAPY	1,864	2,702	27		1,933	67.00
68.00	06800 SPEECH PATHOLOGY	583	716		- , -	2,166	68.00
69.00	06900 ELECTROCARDIOLOGY	309	2,573	26		1,957	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	77	1,254	13		0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	209	257	3	1,822	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,031	2,115			550	73.00
74.00	07400 RENAL DIALYSIS	178	230		1,552	2,628	74.00
00.00	OUTPATIENT SERVICE COST CENTERS	220	2.1		2 001	024	00 00
90.00	09000 CLINIC	238	21	C	,	834	90.00
91.00	09100 EMERGENCY	0	0	C	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
440.00	SPECIAL PURPOSE COST CENTERS	10.000	12.500	1	200 724	200 500	440.00
118.00	122 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	40,868	42,600	467	289,731	280,508	118.00
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
	19100 RESEARCH	0	0	1	1		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	992	0	[C	8,325	114,730	
194.00	07950 OTHER NONREIMBURSABLE DEPARTMENTS	0	0	C	1		194.00
	07951 ADVERTISING	104	0	[C	872	0	194.01
200.00							200.00
201.00		0	0	(-		201.00
202.00	TOTAL (sum lines 118 through 201)	41,964	42,600	467	298,928	395,238	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3045

Period: Worksheet B From 07/01/2022 Part II To 06/30/2023 Date/Time Prepared:

11/20/2023 2:34 pm Cost Center Description LAUNDRY & HOUSEKEEPING DIETARY CAFETERIA NURSING LINEN SERVICE ADMINISTRATION 9.00 10.00 11.00 13.00 8.00 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 00560 PURCHASING RECEIVING AND STORES 5.01 5.02 00570 ADMITTING 5.02 5.03 00580 CASHIERING/ACCOUNTS RECEIVABLE 5.03 5.04 00590 OTHER ADMINISTRATIVE & GENERAL 5.04 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 1,469 8.00 00900 HOUSEKEEPING 9.00 0 71,468 9.00 01000 DIETARY 10.00 0 2,850 209,602 10.00 11.00 01100 CAFETERIA 0 1,528 97,950 11.00 13.00 01300 NURSING ADMINISTRATION 0 136 0 1,467 8,667 13.00 01400 CENTRAL SERVICES & SUPPLY 0 0 14.00 14.00 C 0 0 15.00 01500 PHARMACY 0 15.00 0 0 0 16.00 01600 MEDICAL RECORDS & LIBRARY 0 88 0 0 0 16.00 17.00 17.00 01700 SOCIAL SERVICE 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 209,602 7,889 30.00 03000 ADULTS & PEDIATRICS 1.469 30.229 54.493 31.00 03100 INTENSIVE CARE UNIT 31.00 0 41.00 04100 SUBPROVIDER - IRF 0 0 0 0 0 41.00 04300 NURSERY 43.00 0 0 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0 0 50.00 0 51.00 | 05100 RECOVERY ROOM 0 0 51.00 0 0 0 53.00 05300 ANESTHESIOLOGY n 0 53.00 0 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 3,603 4,761 0 54.00 05500 RADIOLOGY-THERAPEUTIC 0 55.00 55.00 0 0 56.00 05600 RADIOISOTOPE 272 1.200 56.00 0 05700 CT SCAN 0 0 57.00 597 2,759 0 57.00 0 58.00 05800 MRI 0 1,479 1,500 0 58.00 0 0 60.00 06000 LABORATORY 1,930 5,430 0 60.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 0 63.00 0 63.00 0 0 06500 RESPIRATORY THERAPY 0 3,731 65.00 540 65.00 06600 PHYSICAL THERAPY 0 5,661 0 13,559 0 66.00 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 358 0 1.962 0 67.00 0 0 06800 SPEECH PATHOLOGY 68.00 401 1,365 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 362 0 1,344 0 69.00 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 338 49 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.00 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS C 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 102 0 2,736 0 73.00 73.00 74.00 07400 RENAL DIALYSIS 0 486 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 154 0 1,305 189 90.00 91.00 09100 EMERGENCY 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,469 50,236 209,602 97,950 8,667 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 0 0 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 21,232 194.00 07950 OTHER NONREIMBURSABLE DEPARTMENTS 0 0 0 0 194.00 194.01 07951 ADVERTISING 0 0 194.01 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 1,469 71,468 209,602 97,950 8,667 202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3045

Period: Worksheet B From 07/01/2022 Part II Date/Time Prepared: 11/20/2023 2:34 pm

						11/20/2023 2:	34 pm
	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		14.00	15.00	16.00	17.00	24.00	
	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	00560 PURCHASING RECEIVING AND STORES						5.01
5.02	00570 ADMITTING						5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL						5.04
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 DIETARY						10.00
11.00	1 1						11.00
13.00	1 1						13.00
14.00	1 1	0					14.00
		0	0				ł
15.00	1 1	0	0	C 531	_		15.00
16.00	1 1	0	0	6,525	1		16.00
17.00		0	0	(0		17.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		0	1 24		1 772 765	30.00
30.00	1 1	0	0	·	I I	1,772,765	30.00
31.00	1 1	0	0	(1	0	31.00
41.00	1 1	0	0		1	0	41.00
43.00		0	0	(0	0	43.00
F0 00	ANCILLARY SERVICE COST CENTERS						
50.00	1 1	0	0	(0	50.00
51.00		0	0	(0	51.00
53.00		0	0	(1 1	0	53.00
54.00	1 1	0	0	667	1	353,426	
55.00		0	0	(0	55.00
56.00		0	0	269		54,164	
57.00	1 1	0	0	549		105,752	57.00
58.00	1 1	0	0	539	1	199,244	1
60.00	1 1	0	0	925		141,697	1
63.00	1 1 1	0	0	13		322	63.00
65.00	1 1	0	0	117		27,074	65.00
66.00		0	0	683	니 이	462,824	66.00
67.00	1 1	0	0	416	0	42,346	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	110	0	25,373	68.00
69.00		0	0	396	6 0	44,701	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	193	0	14,091	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	39	0	2,330	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	325	0	54,965	73.00
74.00	07400 RENAL DIALYSIS	0	0	3.5	0	19,355	74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0		0	9,248	90.00
91.00	09100 EMERGENCY	0	0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		0	0	6,525	0	3,329,677	118.00
	NONREIMBURSABLE COST CENTERS				· · · · · · · · · · · · · · · · · · ·		ĺ
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	0	190.00
	0 19100 RESEARCH	0	0		ol ol	0	191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		o o	757,332	
	07950 OTHER NONREIMBURSABLE DEPARTMENTS	o	0				194.00
194.0	1 07951 ADVERTISING	Ö	0		ام		194.01
200.00		Ĭ	Ŭ	1			200.00
201.0		0	0		ا ا		201.00
202.0		ő	0	6,52	s ol	4,087,985	
_32.0		۹۱	o ₁	, 0,32.	٦	.,00.,000	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3045

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared:

				To 06/30/2023	Date/Time Prepared:
	Cost Center Description	Intern &	Total		11/20/2023 2:34 pm
		Residents Cost			
		& Post			
		Stepdown Adjustments			
		25.00	26.00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT				2.00
5.01	00560 PURCHASING RECEIVING AND STORES				5.01
5.02	00570 ADMITTING				5.02
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL				5.04
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00 10.00	00900 HOUSEKEEPING 01000 DIETARY				9.00
11.00	01100 CAFETERIA				11.00
13.00	01300 NURSING ADMINISTRATION				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY				14.00
15.00	01500 PHARMACY				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY				16.00
17.00	01700 SOCIAL SERVICE				17.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		1 772 765		20.00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	1,772,765		30.00
41.00	04100 SUBPROVIDER - IRF	0	0		41.00
43.00	04300 NURSERY	0	Ö		43.00
	ANCILLARY SERVICE COST CENTERS		- 1		
50.00	05000 OPERATING ROOM	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0		51.00
53.00	05300 ANESTHESIOLOGY	0	252 426		53.00
54.00 55.00	05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC		353,426		54.00
56.00	05600 RADIOISOTOPE	0	54,164		56.00
57.00	05700 CT SCAN	o	105,752		57.00
58.00	05800 MRI	0	199,244		58.00
60.00	06000 LABORATORY	0	141,697		60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	322		63.00
65.00	06500 RESPIRATORY THERAPY	0	27,074		65.00
66.00 67.00	06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY	0	462,824 42,346		66.00
68.00	06800 SPEECH PATHOLOGY		25,373		68.00
69.00	06900 ELECTROCARDIOLOGY	o o	44,701		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	14,091		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,330		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	54,965		73.00
74.00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	19,355		74.00
90.00	09000 CLINIC	0	9,248		90.00
91.00	09100 EMERGENCY	o	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
	SPECIAL PURPOSE COST CENTERS				
118.00	,	0	3,329,677		118.00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00 191.00
	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES	0	757,332		192.00
	07950 OTHER NONREIMBURSABLE DEPARTMENTS	o o	0		194.00
194.01	L 07951 ADVERTISING	0	976		194.01
200.00		0	o		200.00
201.00		0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	4,087,985		202.00

Provider CCN: 15-3045

Period: worksheet B-1 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

					0 06/30/2023	Date/Time Pre 11/20/2023 2:	
		CAPITAL REI	LATED COSTS			, , , , , , , , , , , , , , , , , , , ,	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliation	PURCHASING RECEIVING AND STORES (ACCUM. COST)	
				SALARIES)			
	T	1.00	2.00	4.00	5A.01	5.01	
1 00	GENERAL SERVICE COST CENTERS	103,390	I	I			1.00
1.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	103,390					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	163	4,522,831 3,719				4.00
5.01	00560 PURCHASING RECEIVING AND STORES	1,637				25,904,385	1
5.02	00570 ADMITTING	913		1		479,824	1
5.03	00580 CASHIERING/ACCOUNTS RECEIVABLE	0	0	1	_	288,579	
5.04	00590 OTHER ADMINISTRATIVE & GENERAL	1,934	726,656	1,013,191	0	3,928,815	5.04
7.00	00700 OPERATION OF PLANT	13,908	77,737	159,798	0	1,536,246	
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	96,535	
9.00	00900 HOUSEKEEPING	1,943		1		644,720	
10.00	01000 DIETARY	3,305		1		800,620	
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	1,772 158				168,218 153,712	
14.00	01400 CENTRAL SERVICES & SUPPLY	138	0	110,926	0	0	1
15.00	01500 PHARMACY	0	0	Ö	0	ő	ı
16.00	01600 MEDICAL RECORDS & LIBRARY	102	0	0	0	225,119	
17.00	01700 SOCIAL SERVICE	0	0	O	0	0	ı
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	35,061	904,499	4,121,971	. 0	7,668,751	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	
41.00	04100 SUBPROVIDER - IRF	0	0		0	0	
43.00	04300 NURSERY	0	0	0	0	0	43.00
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	1	0	0	
53.00	05300 ANESTHESIOLOGY	0	0		0	0	53.00
	05400 RADIOLOGY-DIAGNOSTIC	4,179	600,742	360,084	0	903,145	
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	1
56.00	05600 RADIOISOTOPE	316	108,940	90,797	0	281,090	56.00
57.00	05700 CT SCAN	693	206,525	208,665	0	490,807	57.00
58.00	05800 MRI	1,715				455,604	
60.00	06000 LABORATORY	2,238	123,575	410,712	0	1,189,319	
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	202 103	0	13,215	
65.00 66.00	06500 RESPIRATORY THERAPY	0	46,295	1		396,332	
67.00	06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY	6,566 415				2,735,908 1,150,688	
68.00	06800 SPEECH PATHOLOGY	465		1		360,096	
69.00	06900 ELECTROCARDIOLOGY	420	1			190,868	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	33,350	1		47,733	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	129,307	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	118				050,502	
74.00	07400 RENAL DIALYSIS	564	672	0	0	109,987	74.00
	OUTPATIENT SERVICE COST CENTERS	470	1	00 700		110.000	
	09000 CLINIC	179	0		0	· '	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	91.00 92.00
92.00	SPECIAL PURPOSE COST CENTERS		<u> </u>				92.00
118.00		78,764	4,522,831	9,692,842	-146,633	25,228,236	118.00
	NONREIMBURSABLE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,		.,	., ., .	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100 RESEARCH	0	0	0	0	0	191.00
	19200 PHYSICIANS' PRIVATE OFFICES	24,626	0	0	0	612,053	
	07950 OTHER NONREIMBURSABLE DEPARTMENTS	0	0	0	0		194.00
	07951 ADVERTISING	0	0	0	0	64,096	194.01
200.00							200.00
201.00		2 560 647	1 510 220	1 460 010		146 622	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,569,647	1,518,338	1,469,818		146,633	202.00
203.00		24.853922	0.335705	0.151640		0.005661	203.00
204.00		2 033322	0.5557.05	5,299			204.00
	Part II)			, , , ,		,	
205.00				0.000547		0.001620	205.00
265	II)						205 5 -
206.00							206.00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.00
207.00	Parts III and IV)						207.00
	1 1. 0. 00 111 4114 117	1	I	1		1	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3045 Period: From 07/01/2022 To 06/30/2023 Date/Time Prepared:

				Т	o 06/30/2023	Date/Time Pre 11/20/2023 2:	
	Cost Center Description		CASHIERING/ACC	Reconciliation		OPERATION OF	J .
		(GROSS CHAR GES)	OUNTS RECEIVABLE		ADMINISTRATIVE & GENERAL		
		GE3)	(GROSS CHAR		(ACCUM. COST)	(SQUARE FEET)	
			GES)				
		5.02	5.03	5A.04	5.04	7.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			1			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560 PURCHASING RECEIVING AND STORES						5.01
5.02 5.03	00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE	86,267,653	96 267 652				5.02 5.03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL	0	86,267,653	-3,951,056	22,099,962		5.04
7.00	00700 OPERATION OF PLANT	0	0	3,332,336	1,544,943	84,835	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	C	97,081	0	8.00
9.00	00900 HOUSEKEEPING	0	0		648,370	1	9.00
10.00 11.00	01000 DIETARY 01100 CAFETERIA	0	0		805,152 169,170	3,305 1,772	10.00
13.00	01300 NURSING ADMINISTRATION	0	0		154,582	158	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	C	0	0	14.00
15.00	01500 PHARMACY	0	0	(0	0	15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0		226,393	102	16.00 17.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			,, 0		17.00
30.00	03000 ADULTS & PEDIATRICS	16,813,375	16,813,375	(7,862,734	35,061	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	(0	0	31.00
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	0	0		1	0	41.00 43.00
43.00	ANCILLARY SERVICE COST CENTERS	<u> </u>			,, ,		73.00
50.00	05000 OPERATING ROOM	0	0	(0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	(0	0	51.00
53.00 54.00	05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC	8,776,321	8,776,321		986,877	0 4,179	53.00 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0,770,321	0,770,321		0	0	55.00
56.00	05600 RADIOISOTOPE	3,541,242	3,541,242		314,404	316	56.00
57.00	05700 CT SCAN	7,220,144	7,220,144	1	558,263	693	57.00
58.00	05800 MRI	7,096,449	7,096,449	1	322,.33	1,715	58.00
60.00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING, & TRANS.	12,170,470 173,984	12,170,470 173,984	1	1,305,075 14,848	2,238 0	60.00
65.00	06500 RESPIRATORY THERAPY	1,543,906	1,543,906			ő	65.00
66.00	06600 PHYSICAL THERAPY	8,956,691	8,956,691		, ,		
67.00	06700 OCCUPATIONAL THERAPY	5,469,417	5,469,417	1	1,200,137	415	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY	1,449,854 5,208,221	1,449,854 5,208,221		375,122 238,604	465 420	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2,538,873	2,538,873		70,746		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	519,537	519,537	1	134,693	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	4,281,061 464,776	4,281,061 464,776	1	678,253 114,774	118 564	73.00
74.00	OUTPATIENT SERVICE COST CENTERS	404,770	404,770		114,774	304	74.00
90.00	09000 CLINIC	43,332	43,332	(147,914	179	90.00
91.00	09100 EMERGENCY	0	0	(0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
118.00		86,267,653	86,267,653	-3,951,056	21,419,985	60.209	118.00
	NONREIMBURSABLE COST CENTERS				, , , , , , , ,	,	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1			190.00
	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES	0	0	1			191.00 192.00
	07950 OTHER NONREIMBURSABLE DEPARTMENTS	0	0		0 013,318		194.00
	07951 ADVERTISING	0	0	d	64,459		194.01
200.00	1 1						200.00
201.00		102 540	200 212		2 051 056	1,821,149	201.00
202.00	Part I)	482,540	290,213		3,951,056	1,021,149	202.00
203.00	1 1 2 2	0.005594	0.003364		0.178781	21.466953	203.00
204.00		42,600	467		298,928	395,238	204.00
205.00	Part II) Unit cost multiplier (Wkst. B, Part	0.000494	0.000005		0.013526	4.658903	205 00
203.00	II)	0.000494	0.000003		0.013326	7.030303	203.00
206.00	NAHE adjustment amount to be allocated						206.00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.00
207.00	Parts III and IV)						207.00
		. '			•	•	•

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3045

Period: Worksheet B-1 From 07/01/2022 06/30/2023 Date/Time Prepared:

11/20/2023 2:34 pm Cost Center Description LAUNDRY & HOUSEKEEPING CAFETERIA **DIETARY** NURSING LINEN SERVICE (SQUARE FEET) (MEALS SERVED) (GROSS ADMINISTRATION (TOTAL PATI SALARIES) ENT DAYS) (NURSING SA LARIES) 8.00 9.00 10.00 11.00 13.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00560 PURCHASING RECEIVING AND STORES 5.01 00570 ADMITTING 5.02 5.02 5.03 5.03 00580 CASHIERING/ACCOUNTS RECEIVABLE 5.04 00590 OTHER ADMINISTRATIVE & GENERAL 5.04 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 9.674 8.00 8.00 9.00 00900 HOUSEKEEPING 0 82,892 9.00 10.00 01000 DIETARY 0 3,305 30,846 10.00 11.00 01100 CAFETERIA 0 1,772 0 7,408,904 11.00 01300 NURSING ADMINISTRATION 4,528,420 0 110,928 13.00 0 13.00 158 14.00 01400 CENTRAL SERVICES & SUPPLY 0 C 0 0 14.00 0 0 15.00 01500 PHARMACY 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 0 16.00 102 0 0 16.00 17.00 01700 SOCIAL SERVICE 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 9,674 35,061 30,846 4,121,971 4,121,971 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 0 31.00 41.00 04100 SUBPROVIDER - IRF 0 0 0 0 0 41.00 04300 NURSERY 0 43.00 43.00 0 0 0 0 ANCILLARY SERVICE COST CENTERS 50.00 0 0 50.00 05000 OPERATING ROOM 0 0 51.00 05100 RECOVERY ROOM 0 n 0 0 0 51.00 0 0 53.00 05300 ANESTHESIOLOGY 0 0 53.00 0 0 360,084 54.00 05400 RADIOLOGY-DIAGNOSTIC 4,179 0 54.00 0 0 55.00 05500 RADIOLOGY-THERAPEUTIC 0 55.00 56.00 05600 RADIOISOTOPE 0 316 0 90,797 56.00 0 0 208,665 57.00 05700 CT SCAN 693 57.00 58.00 05800 MRI 0 1,715 0 113,483 0 58.00 0 0 60.00 06000 LABORATORY 2,238 410,712 Λ 60.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 63.00 0 63.00 0 0 65.00 06500 RESPIRATORY THERAPY 282,183 282,183 65.00 0 6,566 0 66.00 06600 PHYSICAL THERAPY 1,025,554 66.00 0 0 67.00 06700 OCCUPATIONAL THERAPY 415 148,398 Λ 67.00 68.00 06800 SPEECH PATHOLOGY 0 465 103,251 0 68.00 06900 ELECTROCARDIOLOGY 0 101,651 69.00 420 69.00 0 25,543 07000 ELECTROENCEPHALOGRAPHY 0 25,543 70.00 C 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 C 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 0 206,962 73.00 118 0 73.00 74.00 07400 RENAL DIALYSIS 564 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 0 179 0 98,722 98,723 90.00 09000 CLINIC 09100 EMERGENCY 0 91.00 91.00 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 9,674 30,846 4,528,420 118.00 118.00 58,266 7,408,904 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 191.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 ol 0 192.00 24,626 194.00 07950 OTHER NONREIMBURSABLE DEPARTMENTS 0 0 0 0 194.00 194.01 07951 ADVERTISING 0 0 0 0 194.01 200.00 Cross Foot Adjustments 200.00 201.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, 114,437 805,996 1,052,182 254,683 190,959 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 11.829336 9.723447 34.110809 0.034375 0.042169 203.00 204.00 Cost to be allocated (per Wkst. B, 209,602 97,950 8,667 204.00 1,469 71,468 Part II) 0.001914 205.00 205.00 Unit cost multiplier (Wkst. B, Part 0.151850 0.862182 6.795111 0.013221 II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

In Lieu of Form CMS-2552-10

Period: Worksheet B-1
From 07/01/2022
TO 06/30/2023 Date (Time To be a continuo de la continuo de Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3045

					o 06/30/2023	Date/Time Prepared:
	Cost Center Description	CENTRAL	PHARMACY	MEDICAL	SOCIAL SERVICE	11/20/2023 2:34 pm
	·	SERVICES &	(COSTED	RECORDS &	(
		SUPPLY (COSTED	REQUIS.)	LIBRARY (GROSS CHAR	(TIME SPENT)	
		REQUIS.)		GES)		
	I	14.00	15.00	16.00	17.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			T		1.00
2.00	00200 CAP REL COSTS BEDG & FIXT					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	[4.00
5.01	00560 PURCHASING RECEIVING AND STORES					5.01
5.02 5.03	00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE					5.02 5.03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL					5.04
7.00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00 10.00	00900 HOUSEKEEPING 01000 DIETARY					9.00
11.00	01100 CAFETERIA					11.00
13.00	01300 NURSING ADMINISTRATION	_				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0			14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0	86,267,653		15.00 16.00
17.00	01700 SOCIAL SERVICE	o o	0			
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	0		_	30.00 31.00
41.00	04100 SUBPROVIDER - IRF	0	0		1	41.00
43.00	04300 NURSERY	0	0	•	1	43.00
	ANCILLARY SERVICE COST CENTERS					50.00
50.00 51.00	05000 OPERATING ROOM	0	0	1		50.00 51.00
	05100 RECOVERY ROOM 05300 ANESTHESIOLOGY	0	0		0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	8,776,321	. 0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	C	0	55.00
56.00	05600 RADIOISOTOPE	0	0	3,541,242	1	56.00
57.00 58.00	05700 CT SCAN		0	7,220,144 7,096,449		57.00 58.00
60.00	06000 LABORATORY	o o	0	12,170,470	1	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	173,984	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	1,543,906	1	65.00
66.00 67.00	06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY		0	8,956,691 5,469,417	1	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	1,449,854	1	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	5,208,221	1	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	2,538,873		70.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	519,537	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	o o	0	4,281,061	. 0	73.00
74.00	07400 RENAL DIALYSIS	0	0	464,776	0	74.00
00 00	OUTPATIENT SERVICE COST CENTERS	O	0	42 222	0	90.00
	09000 CLINIC 09100 EMERGENCY	0	0	43,332	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART					92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	O	0	86,267,653	0	118.00
110.00	NONREIMBURSABLE COST CENTERS) U	0	80,207,033	0	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			
	19100 RESEARCH	0	0		1	
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NONREIMBURSABLE DEPARTMENTS	0	0	C		192.00 194.00
	07951 ADVERTISING	0	0		0	194.01
200.00	1 1					200.00
201.00			•	370 050		201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	0	270,050	0	202.00
203.00		0.000000	0.000000	0.003130	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B,	0	0	6,525	1	204.00
205 00	Part II)	0.000000	0 000000	0 000070	0.00000	305.00
205.00	Unit cost multiplier (Wkst. B, Part	0.000000	0.000000	0.000076	0.000000	205.00
206.00	NAHE adjustment amount to be allocated					206.00
207.00	(per Wkst. B-2)					207.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00
		. 1			. '	ı

COMPO	TATION OF NATIO OF COSTS TO CHANGES		riovidei c		From 07/01/2022 To 06/30/2023	Part I Date/Time Pre 11/20/2023 2:	pared: 34 pm
			Title	XVIII	Hospital	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from WkstB,	Adj.		Disallowance		
		Part I, col.					
		26)	2.00	2.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	11 000 003		11 000 00	اماد	11 000 002	30.00
30.00	03100 INTENSIVE CARE UNIT	11,896,803		11,896,80	0	11,896,803	
31.00 41.00	04100 SUBPROVIDER - IRF	0			0	0	
43.00	04100 SUBPROVIDER - IRF	0			0	0	
43.00	ANCILLARY SERVICE COST CENTERS	l 0			U U	U	43.00
50.00	05000 OPERATING ROOM	0		I	0	0	50.00
51.00	05100 RECOVERY ROOM				0	0	
53.00	05300 ANESTHESIOLOGY	ő			0	0	
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,333,504		1,333,50	4 0	1,333,504	
55.00	05500 RADIOLOGY-THERAPEUTIC	2,333,331		1,333,30	0 0	0	
56.00	05600 RADIOISOTOPE	394,675		394,67	5 0	394,675	
57.00	05700 CT SCAN	709,457		709,45		709,457	
58.00	05800 MRI	694,638		694,63		694,638	
60.00	06000 LABORATORY	1,660,414		1,660,41	.4 0	1,660,414	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	18,048		18,04	8 0	18,048	
65.00	06500 RESPIRATORY THERAPY	512,569	0	512,56	9 0	512,569	65.00
66.00	06600 PHYSICAL THERAPY	3,605,955	0	3,605,95	5 0	3,605,955	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,457,006	0	1,457,00	0	1,457,006	67.00
68.00	06800 SPEECH PATHOLOGY	464,777	0	464,77	7 0	464,777	68.00
69.00	06900 ELECTROCARDIOLOGY	314,158		314,15	8 0	314,158	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	93,296		93,29	0	93,296	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	160,400		160,40	0	160,400	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	0	1 - 1 - 1
73.00	07300 DRUGS CHARGED TO PATIENTS	823,706		823,70		823,706	
74.00	07400 RENAL DIALYSIS	154,339		154,33	9 0	154,339	74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	187,634		187,63	4 0	187,634	
91.00	09100 EMERGENCY	0			0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	_	24 404 5-	0	0	1 22.00
200.00		24,481,379	0	24,481,37	9 0	24,481,379	
201.00		0		24 405 37	U		201.00
202.00	Total (see instructions)	24,481,379	0	24,481,37	9 0	24,481,379	202.00

Health Financial Systems COMMUNITY STROKE AND REHABILITATION In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-3045

Period:
From 07/01/2022
To 06/30/2023

Date/Time Prepared:
11/20/2023 2:34 pm

PPS

Charges
Cost Center Description

Inpatient
Outpatient
Outpatient
Total (col. 6 + col. 7)
Ratio
Inpatient
Ratio
Ratio
Rehabilitation
From CMS-2552-10

Worksheet C
Part I
Date/Time Prepared:
11/20/2023 2:34 pm

PPS

Charges
Inpatient
Ratio
Ratio
Ratio

			Charges				
	Cost Center Description	Inpatient	Outpatient	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	16,813,375		16,813,375			30.00
31.00	03100 INTENSIVE CARE UNIT	0		0			31.00
41.00	04100 SUBPROVIDER - IRF	0		0			41.00
43.00	04300 NURSERY	0		0			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	441,658	8,334,663	8,776,321	0.151943	0.000000	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00	05600 RADIOISOTOPE	20,677	3,520,565	3,541,242	0.111451	0.000000	56.00
57.00	05700 CT SCAN	664,876	6,555,268	7,220,144	0.098261	0.000000	57.00
58.00	05800 MRI	172,627	6,923,822	7,096,449	0.097885	0.000000	58.00
60.00	06000 LABORATORY	2,393,058	9,777,412	12,170,470	0.136430	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	50,987	122,997	173,984	0.103734	0.000000	63.00
65.00	06500 RESPIRATORY THERAPY	1,026,031	517,875	1,543,906	0.331995	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	4,511,094	4,445,597	8,956,691	0.402599	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	4,621,168	848,249	5,469,417	0.266391	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	925,178	524,676	1,449,854	0.320568	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	192,751	5,015,470	5,208,221	0.060320	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	5,645	2,533,228	2,538,873	0.036747	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	519,437	100	519,537	0.308736	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,837,566	443,495	4,281,061	0.192407	0.000000	73.00
74.00	07400 RENAL DIALYSIS	464,776	0	464,776	0.332072	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		· · · · · · · · · · · · · · · · · · ·	'		
90.00	09000 CLINIC	43,332	0	43,332	4.330149	0.000000	90.00
91.00	09100 EMERGENCY	o	0	0	0.000000	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0	0	0.000000	0.000000	
200.00		36,704,236	49,563,417	86,267,653			200.00
201.00		' '	, ,	, , , , , , , , , , , , , , , , , , , ,			201.00
202.00	1	36,704,236	49,563,417	86,267,653			202.00

Health Financial Systems	COMMUNITY STROKE AND	REHABILITATION	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3045	From 07/01/2022	Worksheet C Part I Date/Time Prepared:

			11, 11, 11, 11	11/20/2023 2:34 pm
		Title XVIII	Hospital	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
41.00 04100 SUBPROVIDER - IRF				41.00
43.00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0.000000			50.00
51.00 05100 RECOVERY ROOM	0.000000			51.00
53.00 05300 ANESTHESIOLOGY	0.000000			53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.151943			54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00 05600 RADIOISOTOPE	0.111451			56.00
57.00 05700 CT SCAN	0.098261			57.00
58.00 05800 MRI	0.097885			58.00
60.00 06000 LABORATORY	0.136430			60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0.103734			63.00
65.00 06500 RESPIRATORY THERAPY	0.331995			65.00
66.00 06600 PHYSICAL THERAPY	0.402599			66.00
67.00 06700 OCCUPATIONAL THERAPY	0.266391			67.00
68.00 06800 SPEECH PATHOLOGY	0.320568			68.00
69.00 06900 ELECTROCARDIOLOGY	0.060320			69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.036747			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.308736			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.192407			73.00
74.00 07400 RENAL DIALYSIS	0.332072			74.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	4.330149			90.00
91.00 09100 EMERGENCY	0.000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Worksheet C
Part I
Date/Time Prepared:
11/20/2023 2:34 pm Period: From 07/01/2022 To 06/30/2023 Title XIX Hospital PPS Costs Total Cost Therapy Limit (from Wkst. B, Adj. Total Costs Cost Center Description Total Costs RCE Disallowance

		(Trom WKSt. B,	Adj.		Disallowance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				-1		
	03000 ADULTS & PEDIATRICS	11,896,803		11,896,803	0	11,896,803	30.00
	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
	04100 SUBPROVIDER - IRF	0		0	0	0	41.00
43.00	04300 NURSERY	0		0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0		0	0	0	50.00
51.00	05100 RECOVERY ROOM	0		0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,333,504		1,333,504	0	1,333,504	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00	05600 RADIOISOTOPE	394,675		394,675	0	394,675	56.00
57.00	05700 CT SCAN	709,457		709,457	0	709,457	57.00
58.00	05800 MRI	694,638		694,638	0	694,638	58.00
60.00	06000 LABORATORY	1,660,414		1,660,414	0	1,660,414	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	18,048		18,048	0	18,048	63.00
65.00	06500 RESPIRATORY THERAPY	512,569	0	512,569	0	512,569	65.00
66.00	06600 PHYSICAL THERAPY	3,605,955	0	3,605,955	0	3,605,955	66.00
	06700 OCCUPATIONAL THERAPY	1,457,006	0	1,457,006	0	1,457,006	
68.00	06800 SPEECH PATHOLOGY	464,777	0	464,777	0	464,777	68.00
69.00	06900 ELECTROCARDIOLOGY	314,158		314,158	ol	314,158	69.00
	07000 ELECTROENCEPHALOGRAPHY	93,296		93,296	ol	93,296	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	160,400		160,400	o	160,400	•
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	ol	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	823,706		823,706	o	823,706	ı
	07400 RENAL DIALYSIS	154,339		154,339	0	154,339	ł
	OUTPATIENT SERVICE COST CENTERS	, , , , , , , ,		, , , , , , ,	-1	,	
90.00	09000 CLINIC	187,634		187,634	0	187,634	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		24,481,379	0	24,481,379	o	24,481,379	
201.00		0	ŭ	0			201.00
202.00		24,481,379	0	24,481,379	0	24,481,379	
	1 (, ,	· ·	, ,	٩	,,	

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3045 Period: Worksheet C From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/20/2023 2:34 pm Title XIX Hospital PPS Charges Cost Center Description Inpatient Outpatient Total (col. 6 Cost or Other TEFRA Inpatient + col. 7) Ratio Ratio 7.00 6.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 16,813,375 16,813,375 30.00 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 0 31.00 41.00 04100 SUBPROVIDER - IRF 0 0 41.00 43.00 04300 NURSERY 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0.000000 0.000000 50.00 51.00 05100 RECOVERY ROOM 0 0 0.000000 0.000000 51.00 0.000000 0.000000 53.00 05300 ANESTHESIOLOGY 53.00 0 0 0.000000 8,776,321 54.00 | 05400 RADIOLOGY-DIAGNOSTIC 441,658 8,334,663 0.151943 54.00 55.00 05500 RADIOLOGY-THERAPEUTIC 0.000000 0.000000 55.00 56.00 | 05600 RADIOISOTOPE 20,677 3,520,565 3,541,242 0.111451 0.000000 56.00 05700 CT SCAN 57.00 7,220,144 0.000000 57.00 664,876 6,555,268 0.098261 58.00 05800 MRI 172,627 6,923,822 7,096,449 0.097885 0.000000 58.00 60.00 06000 LABORATORY 2,393,058 9,777,412 12,170,470 0.136430 0.000000 60.00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 50,987 122,997 173,984 0.103734 0.000000 63.00 06500 RESPIRATORY THERAPY 1,026,031 517,875 1.543.906 0.331995 0.000000 65.00 65.00 66.00 06600 PHYSICAL THERAPY 4,511,094 4,445,597 8,956,691 0.402599 0.000000 66.00 06700 OCCUPATIONAL THERAPY 848,249 5,469,417 0.266391 0.000000 67.00 4,621,168 67.00 1,449,854 0.000000 68.00 06800 SPEECH PATHOLOGY 925.178 524.676 0.320568 68.00 69.00 06900 ELECTROCARDIOLOGY 192,751 5,015,470 5,208,221 0.060320 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 5,645 2,533,228 2,538,873 0.036747 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 519,437 100 519,537 0.308736 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0.000000 72.00 0 0 0 3,837,566 73.00 07300 DRUGS CHARGED TO PATIENTS 443,495 4,281,061 0.192407 0.000000 73.00 07400 RENAL DIALYSIS 464,776 0.332072 0.000000 74.00 74.00 464,776 OUTPATIENT SERVICE COST CENTERS 90.00 4.330149 0.000000 90.00 09000 CLINIC 43,332 0 43,332 91.00 | 09100 | EMERGENCY 0.000000 0.000000 91.00 0.000000 0.000000 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00

36,704,236

36,704,236

49,563,417

49,563,417

86,267,653

86,267,653

200.00

201.00

202.00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

				10 06/30/2023	11/20/2023 2:	
			Title XIX	Hospital	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
	T	11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
	03100 INTENSIVE CARE UNIT					31.00
	04100 SUBPROVIDER - IRF					41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	0.000000				50.00
	05100 RECOVERY ROOM	0.000000				51.00
	05300 ANESTHESIOLOGY	0.000000				53.00
	05400 RADIOLOGY-DIAGNOSTIC	0.151943				54.00
	05500 RADIOLOGY-THERAPEUTIC	0.000000				55.00
	05600 RADIOISOTOPE	0.111451				56.00
	05700 CT SCAN	0.098261				57.00
	05800 MRI	0.097885				58.00
	06000 LABORATORY	0.136430				60.00
	06300 BLOOD STORING, PROCESSING, & TRANS.	0.103734				63.00
	06500 RESPIRATORY THERAPY	0.331995				65.00
	06600 PHYSICAL THERAPY	0.402599				66.00
	06700 OCCUPATIONAL THERAPY	0.266391				67.00
	06800 SPEECH PATHOLOGY	0.320568				68.00
	06900 ELECTROCARDIOLOGY	0.060320				69.00
	07000 ELECTROENCEPHALOGRAPHY	0.036747				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.308736				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000				72.00
	07300 DRUGS CHARGED TO PATIENTS	0.192407				73.00
74.00	07400 RENAL DIALYSIS	0.332072				74.00
00 00	OUTPATIENT SERVICE COST CENTERS	4 220140				00 00
	09000 CLINIC 09100 EMERGENCY	4.330149 0.000000				90.00
						92.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000				200.00
200.00						
201.00						201.00
202.00	Total (see instructions)					202.00

REDUCTIONS FOR MEDICAID ONLY

Period: worksheet C From 07/01/2022 Part II To 06/30/2023 Date/Time Prepared:

				'	0 00/30/2023	11/20/2023 2:	
				e XIX	Hospital	PPS	
	Cost Center Description			Operating Cost		Operating Cost	
		(Wkst. B, Part)				Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS	-					
	05000 OPERATING ROOM	0	0		0	0	50.00
	05100 RECOVERY ROOM	0	0		0	0	51.00
	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
	05400 RADIOLOGY-DIAGNOSTIC	1,333,504	353,426	980,078	0	0	54.00
	05500 RADIOLOGY-THERAPEUTIC	0	0	240 544	0	0	55.00
	05600 RADIOISOTOPE	394,675	54,164			0	56.00
	05700 CT SCAN	709,457	105,752			0	57.00
	05800 MRI	694,638	199,244			0	58.00
	06000 LABORATORY	1,660,414	141,697			0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	18,048	322	, ,		0	63.00
	06500 RESPIRATORY THERAPY	512,569	27,074			0	65.00
	06600 PHYSICAL THERAPY	3,605,955	462,824			0	66.00
	06700 OCCUPATIONAL THERAPY	1,457,006	42,346			0	67.00
	06800 SPEECH PATHOLOGY	464,777	25,373			0	68.00
	06900 ELECTROCARDIOLOGY	314,158	44,701			0	69.00
	07000 ELECTROENCEPHALOGRAPHY	93,296	14,091			0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	160,400	2,330	158,070	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	823,706	54,965			0	73.00
74.00	07400 RENAL DIALYSIS	154,339	19,355	134,984	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	187,634	9,248	178,386	0	0	90.00
	09100 EMERGENCY	0	0	C	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(0	0	92.00
200.00		12,584,576	1,556,912	11,027,664	0		200.00
201.00		0	0	(0		201.00
202.00	Total (line 200 minus line 201)	12,584,576	1,556,912	11,027,664	0	0	202.00

Period: | Worksheet C From 07/01/2022 | Part II To 06/30/2023 | Date/Time Prepared: 11/20/2023 2:34 pm REDUCTIONS FOR MEDICAID ONLY

						11/20/2023 2:34 pm
			Titl	e XIX	Hospital	PPS
	Cost Center Description		Total Charges			
			(Worksheet C,			
		Operating Cost			6	
		Reduction	8)	/ col. 7)		
		6.00	7.00	8.00		
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	0	0	0.00000		50.00
	05100 RECOVERY ROOM	0	0	0.00000		51.00
	05300 ANESTHESIOLOGY	0	0	0.00000	00	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,333,504	8,776,321	0.15194	13	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.00000	00	55.00
56.00	05600 RADIOISOTOPE	394,675	3,541,242	0.11145	51	56.00
57.00	05700 CT SCAN	709,457	7,220,144	0.09826	51	57.00
58.00	05800 MRI	694,638	7,096,449	0.09788	35	58.00
60.00	06000 LABORATORY	1,660,414	12,170,470	0.13643	30	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	18,048	173,984	0.10373	34	63.00
65.00	06500 RESPIRATORY THERAPY	512,569	1,543,906	0.33199	95	65.00
66.00	06600 PHYSICAL THERAPY	3,605,955	8,956,691	0.40259	99	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,457,006	5,469,417	0.26639	91	67.00
68.00	06800 SPEECH PATHOLOGY	464,777	1,449,854	0.32056	58	68.00
69.00	06900 ELECTROCARDIOLOGY	314,158	5,208,221	0.06032	20	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	93,296	2,538,873	0.03674	17	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	160,400	519,537	0.30873	36	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000	00	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	823,706	4,281,061	0.19240)7	73.00
74.00	07400 RENAL DIALYSIS	154,339	464,776	0.33207	72	74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	187,634	43,332	4.33014	19	90.00
91.00	09100 EMERGENCY	0	0	0.00000	00	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.00000	00	92.00
200.00	Subtotal (sum of lines 50 thru 199)	12,584,576	69,454,278			200.00
201.00	Less Observation Beds	0	0)		201.00
202.00	Total (line 200 minus line 201)	12,584,576	69,454,278			202.00

Health	Financial Systems C	OMMUNITY STROKE AN	ND REHABILITAT:	ION	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL CO		AL COSTS		Provider CCN: 15-3045		Worksheet D Part I Date/Time Pre 11/20/2023 2:	pared: 34 pm
				XVIII	Hospital	PPS	
	Cost Center Description	Capital	Swing Bed	Reduced	Total Patient	Per Diem (col.	
		Related Cost	Adjustment	Capital	Days	3 / col. 4)	
		(from Wkst. B,		Related Cost			
		Part II, col.		(col. 1 - col			
		26)		2)			
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,772,765	0	1,772,76	5 9,674	183.25	30.00
31.00	INTENSIVE CARE UNIT	0			0	0.00	31.00
41.00	SUBPROVIDER - IRF	0	0		0	0.00	41.00
43.00	NURSERY	0			0	0.00	43.00
200.00	Total (lines 30 through 199)	1,772,765		1,772,76	9,674		200.00
	Cost Center Description	Inpatient	Inpatient				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
			6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,129	1,123,139				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
41.00	SUBPROVIDER - IRF	0	0)			41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	6,129	1,123,139	o			200.00

Health Financial Systems COMMUNITY STROKE AND REHABILITATION In Lieu of Form CMS-2552-						
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-3045			Period:	Worksheet D		
			From 07/01/2022	Part II		
				то 06/30/2023	Date/Time Pre 11/20/2023 2:	pareu: 34 nm
		Title	2 XVIII	Hospital	PPS	3 i piii
Cost Center Description	Capital	Total Charges		t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0.00000		0	50.00
51.00 05100 RECOVERY ROOM	0	0	0.00000	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0.00000		0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	353,426	8,776,321			11,449	
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0.00000	0	0	55.00
56.00 05600 RADIOISOTOPE	54,164	3,541,242	0.01529	5 15,034	230	56.00
57.00 05700 CT SCAN	105,752	7,220,144	0.01464	7 379,525	5,559	57.00
58.00 05800 MRI	199,244	7,096,449	0.02807	7 70,605	1,982	58.00
60.00 06000 LABORATORY	141,697	12,170,470	0.01164	3 1,609,929	18,744	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	322	173,984	0.00185	1 15,540	29	63.00
65.00 06500 RESPIRATORY THERAPY	27,074	1,543,906	0.01753	6 751,106	13,171	65.00
66.00 06600 PHYSICAL THERAPY	462,824	8,956,691	0.05167	4 2,867,828	148,192	66.00
67.00 06700 OCCUPATIONAL THERAPY	42,346	5,469,417	0.00774	2,921,895	22,621	67.00
68.00 06800 SPEECH PATHOLOGY	25,373	1,449,854	0.01750	0 537,149	9,400	68.00
69.00 06900 ELECTROCARDIOLOGY	44,701	5,208,221	0.00858	3 127,025	1,090	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	14,091	2,538,873	0.00555	0 3,387	19	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,330	519,537	0.00448	5 386,357	1,733	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	54,965	4,281,061	0.01283	9 2,482,668	31,875	73.00
74.00 07400 RENAL DIALYSIS	19,355	464,776	0.04164	4 322,704	13,439	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	9,248	43,332	0.21342	2 0	0	90.00
91.00 09100 EMERGENCY	0	0	0.00000	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.00000	0	0	92.00
200.00 Total (lines 50 through 199)	1,556,912	69,454,278		12,775,058	279,533	200.00

Health Financial Systems	COMMUNITY STROKE AND REHABILITATION	In Lieu of Form CMS-2552-10
		2045

Health Financial Systems CO	MMUNITY STROKE A	ND REHABILITAT	ION	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS		F	Period: From 07/01/2022 To 06/30/2023	Date/Time Pre 11/20/2023 2:	pared: 34 pm
			XVIII	Hospital	PPS	
Cost Center Description	Nursing	Nursing	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medical	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	0) (0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0) c) (0	0	31.00
41.00 04100 SUBPROVIDER - IRF	0) c) (0	0	41.00
43.00 04300 NURSERY	0) c) (0	0	43.00
200.00 Total (lines 30 through 199)	0	o		0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	0	9,674	0.00	6,129	30.00
31.00 03100 INTENSIVE CARE UNIT		C) (0.00	0	31.00
41.00 04100 SUBPROVIDER - IRF	0) c) (0.00	0	41.00
43.00 04300 NURSERY) (0.00	0	43.00
200.00 Total (lines 30 through 199)			9,674	1	6,129	200.00
Cost Center Description	Inpatient					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	co1. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
41.00 04100 SUBPROVIDER - IRF	0					41.00
43.00 04300 NURSERY						43.00
200.00 Total (lines 30 through 199)						200.00
1	'	1				

THROUGH COSTS 06/30/2023 Date/Time Prepared: 11/20/2023 2:34 pm Title XVIII Hospital Non Physician Nursing Allied Health Allied Health Cost Center Description Nursing Anesthetist Post-Stepdown Program Program Post-Stepdown Adjustments Cost Adjustments 1.00 2A 2.00 3A 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 50.00 0 0 51.00 | 05100 RECOVERY ROOM 0 51.00 0 0 53.00 05300 ANESTHESIOLOGY 0 0 0 0 0 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 0 54.00 0 0 55.00 05500 RADIOLOGY-THERAPEUTIC 0 55.00 0 0 56.00 | 05600 RADIOISOTOPE 0 56.00 57.00 05700 CT SCAN 0 0 0 0 0 0 0 0 0 0 0 0 0 57.00 58.00 05800 MRI 0 58.00 0 60.00 | 06000 | LABORATORY 0 0 60.00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 65.00 0 66.00 66.00 06600 PHYSICAL THERAPY 0 0 67.00 06700 OCCUPATIONAL THERAPY 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 69.00 0 0 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 0 0 07400 RENAL DIALYSIS 0 0 0 0 74.00 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 90.00 0 0 0 0 0 91.00 09100 EMERGENCY 0 0 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 0

0

0 200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	COMMUNITY STROKE AND	REHABILITATION	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-3045		Worksheet D
TURQUEU COSTS			From 07/01/2022	Part TV

	H COSTS	RVICE UTHER PAS:		-	From 07/01/2022 Fo 06/30/2023	Date/Time Prep 11/20/2023 2:	
				XVIII	Hospital	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medical	(sum of cols.	Outpatient	(from WkstC,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	cols. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	5.00	6.00	7.00	instructions)	
		4.00	5.00	6.00	7.00	8.00	
50.00	ANCILLARY SERVICE COST CENTERS			ı		0.000000	F0 00
	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	0		0	0.000000	50.00 51.00
		0	0		0	0.000000	
	05300 ANESTHESIOLOGY	0	0		0 776 221		
	05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC	0	0		8,776,321	0.000000	
	05600 RADIOLOGY-THERAPEUTIC	0	0		2 541 242		56.00
	05700 CT SCAN	0	0		3,541,242		
	05800 MRI	0	0		7,220,144		
		0	0		7,096,449		
	06000 LABORATORY	0	0		12,170,470		
	06300 BLOOD STORING, PROCESSING, & TRANS. 06500 RESPIRATORY THERAPY	0	0		173,984		
	06600 PHYSICAL THERAPY	0	0		1,543,906		
	06700 OCCUPATIONAL THERAPY	0	0		8,956,691		
	06800 SPEECH PATHOLOGY	0	0		5,469,417		
	06900 ELECTROCARDIOLOGY	0	0		1,449,854 5,208,221		
	07000 ELECTROENCEPHALOGRAPHY	0	0		2,538,873		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		519,537		
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0) 319,337	0.000000	
	07300 DRUGS CHARGED TO PATIENTS	0	0		4,281,061		
	07400 RENAL DIALYSIS	0	0		464,776		
74.00	OUTPATIENT SERVICE COST CENTERS	0	0	'	704,770	0.000000	74.00
90.00	09000 CLINIC	0	0		43,332	0.000000	90.00
	09100 EMERGENCY	0	١		75,552	0.000000	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	١			0.000000	
200.00	,	0	١		69,454,278	1	200.00
200.00	1 Total (Times 30 till ough 133)	1	·	1	03,434,270	1	1200.00

Health Financial Systems	COMMUNITY STROKE AND	REHABILITATION	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-3045		Worksheet D
THROUGH COSTS			From 07/01/2022	Part IV

THROUGH COSTS		Trovider ex		From 07/01/2022 To 06/30/2023	Part IV Date/Time Prepared: 11/20/2023 2:34 pm		
				XVIII	Hospital	PPS	
	Cost Center Description	Outpatient	Inpatient	Inpatient	Outpatient	Outpatient	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
		7)	10.00	x col. 10)	12.00	x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
F0 00	ANCILLARY SERVICE COST CENTERS	0.00000					F0 00
	05000 OPERATING ROOM	0.000000	0	<u>'</u>	0	0	50.00
	05100 RECOVERY ROOM	0.000000	0	<u>'</u>	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.000000	204 206		0 2 012 506	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	284,306	?	0 2,012,586	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	15.024	1	0 1 122 600	0	55.00
	05600 RADIOISOTOPE	0.000000	15,034	1	0 1,122,690		56.00
	05700 CT SCAN	0.000000	379,525	1	0 2,539,486		57.00
58.00	05800 MRI	0.000000	70,605		0 2,046,793		58.00
60.00	06000 LABORATORY	0.000000	1,609,929		0 451,849	0	60.00
	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000	15,540		0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	751,106		0 166,220	0	65.00
	06600 PHYSICAL THERAPY	0.000000	2,867,828		0 50	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	2,921,895	1	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	537,149	1	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	127,025	1	0 1,619,262	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	3,387	•	0 620,810	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	386,357	1	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0)	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0.000000	2,482,668		0 182,386	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	322,704		0 0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0.000000	0)	0	0	90.00
	09100 EMERGENCY	0.000000	0)	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0)	0	0	92.00
200.00	Total (lines 50 through 199)		12,775,058	5	0 10,762,132	0	200.00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY STROKE AND REHABILITATION APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-3045 Period: Worksheet D From 07/01/2022 Part V Date/Time Prepared: 06/30/2023 11/20/2023 2:34 pm Title XVIII Hospital Charges Costs Cost to Charge PPS Reimbursed Cost Center Description Cost Cost PPS Services Reimbursed Ratio From Services (see Reimbursed (see inst.) Worksheet C, inst.) Services Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 3.00 1.00 2.00 5.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 51.00 0 0.000000 0 0 53.00 05300 ANESTHESIOLOGY 53.00 0 0 0 54.00 | 05400 RADIOLOGY-DIAGNOSTIC 0.151943 2,012,586 0 305,798 54.00 55.00 05500 RADIOLOGY-THERAPEUTIC 0.000000 0 0 0 55.00 0 0 56.00 05600 RADIOISOTOPE 0.111451 125,125 1,122,690 56.00 0 0 57.00 05700 CT SCAN 0.098261 2,539,486 249,532 57.00 58.00 05800 MRI 0.097885 2,046,793 0 0 200,350 58.00 0 0 60.00 06000 LABORATORY 0.136430 451,849 61,646 60.00 0 0 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 0.103734 63.00 0 0 65.00 06500 RESPIRATORY THERAPY 0.331995 166,220 0 55,184 65.00 66.00 06600 PHYSICAL THERAPY 0.402599 50 0 0 20 66.00 0 0 67.00 06700 OCCUPATIONAL THERAPY 0.266391 67.00 0 0 0 68.00 06800 SPEECH PATHOLOGY 68.00 0.320568 0 69.00 06900 ELECTROCARDIOLOGY 0.060320 1,619,262 0 0 97,674 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.036747 620,810 0 22,813 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.308736 0 0 0 71.00 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 0 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.192407 182,386 7,838 35,092 73.00 07400 RENAL DIALYSIS 0 74.00 0.332072 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 4.330149 0 0 0 91.00 09100 EMERGENCY 0.000000 0 0 0 91.00 C 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 0 7,838 1,153,234 200.00 200.00 Subtotal (see instructions) 10,762,132 0

201.00

1,153,234 202.00

0

7,838

10,762,132

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

Health Financial Systems COMMUNITY STROKE A
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-3045 Period: Worksheet D From 07/01/2022 Part V

					To 06/30/2023	Date/Time Prepared: 11/20/2023 2:34 pm
			Title	XVIII	Hospital	PPS
	·	Cos	its			
	Cost Center Description	Cost	Cost			
		Reimbursed	Reimbursed			
		Services	Services Not			
		Subject To	Subject To			
		Ded. & Coins.	Ded. & Coins.			
		(see inst.)	(see inst.)			
	ANGELLARY GERVEGE COST GENTERS	6.00	7.00			
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		0	I		50.00
51.00	05100 RECOVERY ROOM	0	0			51.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
	05500 RADIOLOGY-THERAPEUTIC	0	0			55.00
56.00	05600 RADIOISOTOPE	0	0			56.00
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MRI	0	0			58.00
60.00	06000 LABORATORY	0	0			60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0			63.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,508			73.00
74.00	07400 RENAL DIALYSIS	0	0			74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0			90.00
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.00
200.00		0	1,508			200.00
201.00		0				201.00
202 21	Only Charges		1 500			202 00
202.00	Net Charges (line 200 - line 201)	0	1,508			202.00

Health	Financial Systems	COMMUNITY STROKE AN	ND REHABILITAT	ION	In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ROUTINE SERVICE CAP	ITAL COSTS		-	Period: From 07/01/2022 Fo 06/30/2023		
				le XIX	Hospital	PPS	
	Cost Center Description	Capital	Swing Bed	Reduced		Per Diem (col.	
		Related Cost	Adjustment	Capital	Days	3 / col. 4)	
		(from Wkst. B,		Related Cost			
		Part II, col.		(col. 1 - col			
		26)		2)			
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,772,765	0	1,772,76	9,674	1	ı
31.00	INTENSIVE CARE UNIT	0			0	0.00	
41.00	SUBPROVIDER - IRF	0	0)	0	0.00	41.00
43.00	NURSERY	0			0	0.00	43.00
200.00	Total (lines 30 through 199)	1,772,765		1,772,76	9,674		200.00
	Cost Center Description	Inpatient	Inpatient				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
			6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	40	7,330)			30.00
31.00	INTENSIVE CARE UNIT	0	0)			31.00
41.00	SUBPROVIDER - IRF	0	0)			41.00
43.00	NURSERY	0	0)			43.00
200.00	Total (lines 30 through 199)	40	7,330)			200.00

Health Financial Systems COMM	UNITY STROKE A	ND REHABILITAT	ION	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA			Period: From 07/01/2022 To 06/30/2023	11/20/2023 2:		
			e XIX	Hospital	PPS	
Cost Center Description	Capital	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			l. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0.00000		0	50.00
51.00 05100 RECOVERY ROOM	0	0	0.00000		0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0.00000		0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	353,426	8,776,321	0.0402	70 0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0.00000	00	0	55.00
56.00 05600 RADIOISOTOPE	54,164	3,541,242	0.01529	95 0	0	56.00
57.00 05700 CT SCAN	105,752	7,220,144	0.01464	17 0	0	57.00
58.00 05800 MRI	199,244	7,096,449	0.0280	77 0	0	58.00
60.00 06000 LABORATORY	141,697	12,170,470	0.01164	1,934	23	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	322	173,984	0.0018	51 0	0	63.00
65.00 06500 RESPIRATORY THERAPY	27,074	1,543,906	0.0175	36	0	65.00
66.00 06600 PHYSICAL THERAPY	462,824	8,956,691	0.0516	74 6,515	337	66.00
67.00 06700 OCCUPATIONAL THERAPY	42,346	5,469,417	0.00774	6,000	46	67.00
68.00 06800 SPEECH PATHOLOGY	25,373	1,449,854	0.01750	00	0	68.00
69.00 06900 ELECTROCARDIOLOGY	44,701	5,208,221	0.00858	33 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	14,091	2,538,873	0.0055	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,330	519,537	0.00448	35 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000	00	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	54,965	4,281,061	0.0128	2,201	28	73.00
74.00 07400 RENAL DIALYSIS	19,355	464,776	0.04164		0	74.00
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			<u>'</u>		
90.00 09000 CLINIC	9,248	43,332	0.21342	22 0	0	90.00
91.00 09100 EMERGENCY	0	0	0.00000	00	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.00000	00	0	92.00
200.00 Total (lines 50 through 199)	1,556,912	69,454,278		16,650	434	200.00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, , .	, , , ,	1	,		

Health Financial Systems	COMMUNITY STROKE AND	REHABILITATION		In Lieu of Form CMS-2552-10
ADDODITONMENT OF TARATTERE BOUTTAIN	CERVICE OTHER DACK THROUGH COCTO	Drovidor CCN: 15 2045	Donied	Workshoot D

Health Financial Systems CC	OMMUNITY STROKE A	ND REHABILITAT	ION	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS		F	Period: From 07/01/2022 To 06/30/2023	11/20/2023 2:	pared: 34 pm
			le XIX	Hospital	PPS	
Cost Center Description	Nursing	Nursing		Allied Health	All Other	
	Program	Program	Post-Stepdown		Medical	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	0) (0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0) (0	0	31.00
41.00 04100 SUBPROVIDER - IRF	0	0) (0	0	41.00
43.00 04300 NURSERY	0	C) (0	0	43.00
200.00 Total (lines 30 through 199)	0	o c) (0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	0	9,674	0.00	40	30.00
31.00 03100 INTENSIVE CARE UNIT		C) (0.00	0	31.00
41.00 04100 SUBPROVIDER - IRF	0	C) (0.00	0	41.00
43.00 04300 NURSERY		C) (0.00	0	43.00
200.00 Total (lines 30 through 199)		l c	9,674	1	40	200.00
Cost Center Description	Inpatient				•	
·	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00	1				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT						31.00
41.00 04100 SUBPROVIDER - IRF						41.00
43.00 04300 NURSERY						43.00
200.00 Total (lines 30 through 199)						200.00
	1	1				1-20.00

Period: Worksheet D From 07/01/2022 Part IV To 06/30/2023 Date/Time Prepared: THROUGH COSTS

				10 00/30/2023	11/20/2023 2:	
		Titl	le XIX	Hospital	PPS	
Cost Center Description	Non Physician	Nursing	Nursing	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS				-		
50.00 05000 OPERATING ROOM	0	0)	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0)	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0)	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0)	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0)	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0		0	0	56.00
57.00 05700 CT SCAN	0	0		0	0	57.00
58.00 05800 MRI	0	0		0	0	58.00
60.00 06000 LABORATORY	0	0		0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0		0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0		0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
74.00 07400 RENAL DIALYSIS	0) 0		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS				-	_	
90.00 09000 CLINIC	0	0		0	0	
91.00 09100 EMERGENCY	0	0	'l	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2		0	0	92.00
200.00 Total (lines 50 through 199)	0	il O	יו	υ 0	1 0	200.00

Health Financial Systems	COMMUNITY STROKE AND	REHABILITATION	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-3045	Period:	Worksheet D
			From 07/01/2022	Dart TV

THROUGH COSTS From 07/01/2022 | Part IV To 06/30/2023 | Date/Time Prepared: 11/20/2023 2:34 pm Title XIX Hospital Total Charges Ratio of Cost All Other Cost Center Description Total Cost Total (sum of cols. to Charges Medical (from Wkst. C, Outpatient Education Cost 1, 2, 3, and 4) Cost (sum of Part I, col. $(col. 5 \div col.$ 8) cols. 2, 3, 7) and 4) (see instructions) 4.00 6.00 5.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 0.000000 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 0.000000 51.00 53.00 05300 ANESTHESIOLOGY 0 0 0 0 0 0.000000 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 8,776,321 0.000000 54.00 55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0.000000 55.00 56.00 | 05600 RADIOISOTOPE 0 3,541,242 0.000000 56.00 0 7,220,144 57.00 05700 CT SCAN 0 0 0 0.000000 57.00 0 58.00 | 05800 MRI 0.000000 0 7,096,449 58.00 60.00 | 06000 | LABORATORY 12,170,470 0.000000 60.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 0.000000 63.00 0 0 173,984 63.00 65.00 06500 RESPIRATORY THERAPY 1,543,906 0.000000 0 65.00 66.00 06600 PHYSICAL THERAPY 8,956,691 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 0 0 5,469,417 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 1,449,854 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0.000000 5,208,221 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 2,538,873 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 519,537 0.000000 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0.000000 72.00 0 07300 DRUGS CHARGED TO PATIENTS 4,281,061 0.000000 73.00 0 73.00 74.00 07400 RENAL DIALYSIS 0 464,776 0.000000 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0.000000 43,332 90.00 91.00 | 09100 | EMERGENCY 0 0 0 0 0.000000 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0.000000 92.00 0 200.00 Total (lines 50 through 199) 69,454,278 200.00

Health Financial Systems	COMMUNITY STROKE AND	REHABILITATION	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	IT ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-3045		Worksheet D
THROUGH COSTS			From 07/01/2022	Part IV

	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	KVICE OTHER PASS	Provider Co		From 07/01/2022 To 06/30/2023	Part IV Date/Time Pre 11/20/2023 2:	
				e XIX	Hospital	PPS	
	Cost Center Description	Outpatient	Inpatient	Inpatient	Outpatient	Outpatient	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
		7)	10.00	x col. 10)	12.00	x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
FO 00	ANCILLARY SERVICE COST CENTERS	0.000000		I	0	0	F0 00
	05000 OPERATING ROOM	0.000000	0		0	0	50.00
	05100 RECOVERY ROOM	0.000000	0		0	0	51.00
	05300 ANESTHESIOLOGY	0.000000	0		0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0		0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0		0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0		0	0	56.00
57.00	05700 CT SCAN	0.000000	0		0	0	57.00
58.00	05800 MRI	0.000000	1 024		0	0	58.00
60.00	06000 LABORATORY	0.000000	1,934		0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000	0		0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0		0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	6,515		0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	6,000		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0		0	0	68.00
	06900 ELECTROCARDIOLOGY	0.000000	0		0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0.000000	0		0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0		0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0.000000	2,201		0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0		0 0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0.000000	0		0	0	50.00
	09100 EMERGENCY	0.000000	0		0	0	1 32.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0		0	0	
200.00	Total (lines 50 through 199)		16,650		0	0	200.00

Health Financial Systems	COMMUNITY STROKE AND	REHABILITATION	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3045	Period: From 07/01/2022 To 06/30/2023	Date/Time Prepared:
				11/20/2023 2:34 pm
		Ti+lo V//TTT	⊔ocni+al	DDC

		Title XVIII	Hospital	11/20/2023 2: PPS	34 pm
	Cost Center Description	TICIE AVIII	ΠΟΣΡΙΤΩΙ	FF3	
				1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00 2.00	Inpatient days (including private room days and swing-bed day: Inpatient days (including private room days, excluding swing-l	,		9,674 9,674	1.00
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.		ivate room days,	0	3.00
4.00 5.00	Semi-private room days (excluding swing-bed and observation bed days)				4.00 5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private roo			0	6.00
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7.00
8.00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8.00
9.00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	6,129	9.00
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10.00
11.00	through December 31 of the cost reporting period (see instructions) swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period		e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar y			0	13.00
14.00 15.00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)			0	14.00 15.00
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
17.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00					19.00
20.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of the	ne cost		20.00
21.00 22.00	Total general inpatient routine service cost (see instruction: Swing-bed cost applicable to SNF type services through Decembe		ing period (line	11,896,803 0	21.00 22.00
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23.00
24.00	x line 18) Swing-bed cost applicable to NF type services through December 7 1 10 10	31 of the cost reporti	ng period (line	0	24.00
25.00	7 x line 19) Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25.00
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 11,896,803	26.00 27.00
22.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		,		
28.00 29.00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	28.00
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	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line			0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	•		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	11,896,803	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		I		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see			1,229.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line			7,537,260	39.00
40.00	Medically necessary private room cost applicable to the Progra			0	40.00
	Total Program general inpatient routine service cost (line 39			7,537,260	

Health	Financial Systems COMM	UNITY STROKE AND	REHABILITAT	ION	In_Lie	u of Form CMS-	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider (CCN: 15-3045	Period: From 07/01/2022 To 06/30/2023	Date/Time Pre	pared:
			Titl	e XVIII	Hospital	11/20/2023 2: PPS	34 pili
	Cost Center Description	Total	Total	Average Pe		Program Cost	
		Inpatient CostI		col. 2)		(col. 3 x col. 4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
	Intensive Care Type Inpatient Hospital Units	U	<u>'</u>	<u> </u>	00 0	0	42.00
	INTENSIVE CARE UNIT	0	-	0 0.	00 0	0	43.00
44.00	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wk	st D=3 col 3	line 200)			3,376,753	48.00
	Program inpatient cellular therapy acquisiti			TTT. line 10	. column 1)	0,570,733	1
	Total Program inpatient costs (sum of lines				, сотани 1)	10,914,013	
	PASS THROUGH COST ADJUSTMENTS	<u>_</u>				, , , , , , , , , , , , , , , , , , , ,	
50.00	Pass through costs applicable to Program inp	atient routine s	ervices (fro	m Wkst. D, su	m of Parts I and	1,123,139	50.00
F1 00	III)					270 522	F1 00
51.00	Pass through costs applicable to Program inp and IV)	atient ancillary	services (T	rom wkst. D,	sum of Parts II	279,533	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				1,402,672	52.00
	Total Program inpatient operating cost exclu		ated, non-ph	ysician anest	hetist, and	9,511,341	
	medical education costs (line 49 minus line		, ,		,		
	TARGET AMOUNT AND LIMIT COMPUTATION						1
	Program discharges					0	1
	Target amount per discharge						55.00
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor use only)						55.01 55.02
						0.00	1
	Target amount (line 54 x sum of lines 55, 55.01, and 55.02) Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0		
	Bonus payment (see instructions)	9	, , , , , , , , , , , , , , , , , , ,			0	1
59.00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rep	orting period	ending 1996,	0.00	59.00
	updated and compounded by the market basket)	3. 55.6			1 . 1		
60.00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from	prior year	cost report,	updated by the	0.00	60.00
61.00	Continuous improvement bonus payment (if lin	e 53 ± line 54 i	s loss than	the lowest of	lines 55 nlus	0	61.00
01.00	55.01, or line 59, or line 60, enter the les					Ĭ	01.00
	53) are less than expected costs (lines 54 x						
	enter zero. (see instructions)		_				
	Relief payment (see instructions)					0	1
63.00	Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	her 31 of th	e cost renort	ing period (See	0	64.00
0.100	instructions)(title XVIII only)	co ciii ougii becciii		с соос . сро. с	g peou (500		000
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the	cost reportin	g period (See	0	65.00
	<pre>instructions)(title XVIII only)</pre>					_	
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line	65)(title XVI	II only); for	0	66.00
67.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	o cocto through	Docombon 21	of the cost n	onorting poriod	0	67.00
07.00	(line 12 x line 19)	e costs tillough	pecember 31	or the cost i	eporting period	0	07.00
68.00	Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost rep	orting period	0	68.00
	(line 13 x line 20)						
69.00	Total title V or XIX swing-bed NF inpatient					0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N				`	I	70.00
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c)		70.00
	Program routine service cost (line 9 x line		70 - Tille	-)			72.00
	Medically necessary private room cost applic		(line 14 x l	ine 35)			73.00
	Total Program general inpatient routine serv	-					74.00
75.00	Capital-related cost allocated to inpatient				Part II, column		75.00
	26, line 45)						_
	Per diem capital-related costs (line 75 ÷ li						76.00
	Program capital-related costs (line 9 x line						77.00
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovider recor	ds)			79.00
	Total Program routine service costs for comp	S COSCS (110m pr	O + 1 4 C 1 C C U	u -)		I .	1 , 5.00

Health	Financial Systems COMM	MUNITY STROKE A	ND REHABILITATI	ON	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider Co		Period:	Worksheet D-1	
					From 07/01/2022 To 06/30/2023	Date/Time Pre 11/20/2023 2:	
		,	Title	XVIII	Hospital	PPS	
	Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
			(from line 21)	column 2	Observation	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	1,772,765	11,896,803	0.14901	2 0	0	90.00
91.00	Nursing Program cost	0	11,896,803	0.00000	0	0	91.00
92.00	Allied health cost	0	11,896,803	0.00000	0	0	92.00
93.00	All other Medical Education	0	11,896,803	0.00000	0 0	0	93.00

Health Financial Systems	COMMUNITY STROKE AND	REHABILITATION	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3045	Period: From 07/01/2022 To 06/30/2023	Worksheet D-1 Date/Time Prepared: 11/20/2023 2:34 pm
		Title YTY	Hosnital	DDC

PART I - ALL PROVIDER COMPONENTS 1.00			Title XIX	Hospital	11/20/2023 2: PPS	34 pm
PART I - ALL PROVIDER COMPONENTS		Cost Center Description	TILLE XIX	ноѕртсат	PPS	
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7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	24.00		21 . 6 . 1			24.00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 x line 20) 0 26.00 10 26.00 27.00 26.00 27.00 27.00 26.00 27.00 26.00 27.00 26.00 27.00 26.00 27.00 26.00 27.00 26.00 27.00 26.00 27.00 26.00 27.00 26.00 27.00 26.00 27.00	24.00		r 31 of the cost reporti	ng period (line	0	24.00
Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERNITAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost	25.00		31 of the cost reporting	period (line 8	0	25.00
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37.00) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00						
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 11,896,803) The program inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost per diem (see instructions) Medically necessary private room cost applicable to the Program (line 14 x line 35) O 40.00			(line 21 minus line 26)		-	
Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 11,896,803) 7.00 Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27.00		(Title 21 millus Title 20)		11,890,803	27.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 11,896,803) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0.0000000 31.00 32.00 32.00 32.00 32.00 32.00 33.00 34.00 35.00 37.00 37.00 37.00 38.00 37.00	28.00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28.00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.000 32.00 32.00 32.00 32.00 32.00 34.00 34.00 34.00 35.00 36.00 37.00 40.00						
Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 34.00 35.00 40.00			· lino 28)			
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 11,896,803 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 33.00 36.00 35.00 37.00 37.00 38.00 49.191 39.00		, , ,	- Title 28)			
Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 34.00 35.00 36.00 37						
Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 35.00 36.00 37.00	34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 49,191 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				ŕ		
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 49,191 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 49,191 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37.00	,	and private room cost di	fferential (line	11,896,803	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 49,191 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
Adjusted general inpatient routine service cost per diem (see instructions) 1,229.77 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 49,191 39.00 40.00			JSTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 49,191 39.00 40.00	38.00				1.229.77	38.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 49,191 41.00	40.00	Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)			
	41.00	Total Program general inpatient routine service cost (line 39	+ line 40)		49,191	41.00

	Financial Systems C ATION OF INPATIENT OPERATING COST	OMMUNITY STROKE A			Period:	wof Form CMS-2 Worksheet D-1	
COMPUT	ATION OF INFATIENT OPERATING COST		Provider C	F	rom 07/01/2022		
				Т	o 06/30/2023	Date/Time Pre 11/20/2023 2:	
			Titl	le XIX	Hospital	PPS	5 i piii
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷		(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	C	0	0.00	0	0	42.00
42.00	Intensive Care Type Inpatient Hospital Uni	its		0.00	0	0	42.00
44.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0.00	0	0	43.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	cost center bescription					1.00	
48.00	Program inpatient ancillary service cost					4,908	48.00
	Program inpatient cellular therapy acquis	•	,	, ,	column 1)	0	
49.00	Total Program inpatient costs (sum of line PASS THROUGH COST ADJUSTMENTS	es 41 through 48.0	Ol)(see instruc	ctions)		54,099	49.00
50.00	Pass through costs applicable to Program	inpatient routine	services (from	n Wkst. D, sum	of Parts I and	7,330	50.00
	III)	·					
51.00	Pass through costs applicable to Program and IV)	inpatient ancilla	ry services (fr	om Wkst. D, su	m of Parts II	434	51.00
52.00	Total Program excludable cost (sum of line	es 50 and 51)				7,764	52.00
	Total Program inpatient operating cost ex	cluding capital re	elated, non-phy	sician anesthe	tist, and	46,335	
	medical education costs (line 49 minus li	ne 52)					
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge	1	55.00				
	Permanent adjustment amount per discharge		55.01				
	Adjustment amount per discharge (contract	0.00	55.02 56.00				
	Target amount (line 54 x sum of lines 55, 55.01, and 55.02) Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00							59.00
60.00	updated and compounded by the market bask Expected costs (lesser of line 53 ÷ line		om nrior vear o	rost renort un	dated by the	0.00	60.00
00.00	market basket)	51, 01 1111e 55 111	om prior year e		dated by the	0.00	00.00
61.00	Continuous improvement bonus payment (if					0	61.00
	55.01, or line 59, or line 60, enter the 53) are less than expected costs (lines 54)						
	enter zero. (see instructions)	+ X 00), 01 1 % 0	i the target an	louite (Title 50)	, otherwise		
	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive particles PROGRAM INPATIENT ROUTINE SWING BED COST		uctions)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine		ember 31 of the	cost reportin	g period (See	0	64.00
	<pre>instructions)(title XVIII only)</pre>	-		•			
65.00	Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs after Deceml	per 31 of the c	cost reporting	period (See	0	65.00
66.00	Total Medicare swing-bed SNF inpatient ro	utine costs (line	64 plus line 6	S5)(title XVIII	only): for	0	66.00
	CAH, see instructions						
67.00	Title V or XIX swing-bed NF inpatient rou	tine costs through	n December 31 o	of the cost rep	orting period	0	67.00
68.00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient rou</pre>	tine costs after I	December 31 of	the cost repor	ting period	0	68.00
00.00	(line 13 x line 20)		320032 0.	се сове геро.	eg peea		
69.00	Total title V or XIX swing-bed NF inpatie					0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER Skilled nursing facility/other nursing fac					Γ	70.00
	Adjusted general inpatient routine service						71.00
72.00	Program routine service cost (line 9 x li	ne 71)					72.00
	Medically necessary private room cost app	-					73.00
75.00	Total Program general inpatient routine so Capital-related cost allocated to inpatien				rt II column		74.00
, 5.00	26, line 45)	are routine service	C COSCS (IIOIII W	.o. Koneet B, Pa	c ii, corumii		, 3.00
76.00	Per diem capital-related costs (line 75 \div						76.00
	Program capital-related costs (line 9 x 1						77.00
78.00 79.00	Inpatient routine service cost (line 74 m Aggregate charges to beneficiaries for ex		provider record	ds)			78.00 79.00
					is line 70)		80.00
80.00	Total Program routine service costs for co	ulipai isuli tu tile i	cost illilitation	i (iiiie 76 miiiu	13 1111e <i>13)</i>	l	00.00
80.00 81.00 82.00	Inpatient routine service costs for Continuation routine service cost per diem l'Inpatient routine service cost limitation	imitation		i (iiie 76 miiiu	13 TITLE 79)		81.00 82.00

83.00 84.00

85.00 86.00

0 87.00 0.00 88.00 0 89.00

85.00 86.00

83.00 Reasonable inpatient routine service costs (see instructions)
84.00 Program inpatient ancillary services (see instructions)

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

Total observation bed days (see instructions)

Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)

99.00 observation bed cost (line 87 x line 88) (see instructions)

Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)

Health	Financial Systems COMM	MUNITY STROKE A	ND REHABILITATI	ON	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider Co		Period:	Worksheet D-1	
					From 07/01/2022 To 06/30/2023	Date/Time Pre 11/20/2023 2:	
			Titl	e XIX	Hospital	PPS	
	Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
			(from line 21)	column 2	Observation	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	1,772,765	11,896,803	0.14901	2 0	0	90.00
91.00	Nursing Program cost	0	11,896,803	0.00000	0	0	91.00
92.00	Allied health cost	0	11,896,803	0.00000	0	0	92.00
93.00	All other Medical Education	0	11,896,803	0.00000	0 0	0	93.00

lealth Financial Systems	COMMUNITY S	STROKE A	ND	REHABILITATI	ON	In Lie	u of Form CMS-2	2552-1
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	-			Provider Co		Period: From 07/01/2022 To 06/30/2023	Worksheet D-3 Date/Time Prep 11/20/2023 2:3	
				Title	XVIII	Hospital	PPS	
Cost Center Description					Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col.	
					1 00	2 00	2)	

		Title	XVIII	Hospital	PPS	
	Cost Center Description		Ratio of Cost	Inpatient	Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00				10,602,303		30.00
31.00	03100 INTENSIVE CARE UNIT			0		31.00
41.00	04100 SUBPROVIDER - IRF			0		41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0.000000	0	0	
51.00			0.000000	0	0	51.00
53.00	05300 ANESTHESIOLOGY		0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		0.151943	284,306	43,198	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE		0.111451	15,034	1,676	56.00
57.00	05700 CT SCAN		0.098261	379,525	37,293	57.00
58.00	05800 MRI		0.097885	70,605	6,911	58.00
60.00	06000 LABORATORY		0.136430	1,609,929	219,643	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.		0.103734	15,540	1,612	63.00
65.00	06500 RESPIRATORY THERAPY		0.331995	751,106	249,363	65.00
66.00	06600 PHYSICAL THERAPY		0.402599	2,867,828	1,154,585	66.00
67.00	06700 OCCUPATIONAL THERAPY		0.266391	2,921,895	778,367	67.00
68.00	06800 SPEECH PATHOLOGY		0.320568	537,149	172,193	68.00
69.00	06900 ELECTROCARDIOLOGY		0.060320	127,025	7,662	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0.036747	3,387	124	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.308736	386,357	119,282	71.00
72.00			0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0.192407	2,482,668	477,683	73.00
74.00	07400 RENAL DIALYSIS		0.332072	322,704	107,161	74.00
	OUTPATIENT SERVICE COST CENTERS			,	,	
90.00	09000 CLINIC		4.330149	0	0	90.00
91.00	09100 EMERGENCY		0.000000	0	0	91.00
92.00			0.000000	0	0	92.00
200.00				12,775,058	3,376,753	200.00
201.00		(line 61)		0		201.00
202.00				12,775,058		202.00

Health Financial Systems	COMMUNITY	STROKE	AND	REHABILITA	TION		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIO	NMENT			Provider	CCN: 15-304		eriod: rom 07/01/2022 o 06/30/2023	Worksheet D-3 Date/Time Pre 11/20/2023 2:	pared:
				Ti	tle XIX		Hospital	PPS	
Cost Center Description					Ratio of	Cost	Inpatient	Inpatient	

				To 06/30/2023	Date/Time Pre 11/20/2023 2:	
		Title	e XIX	Hospital	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS			21 012		30.00
	03000 ADULTS & PEDIATRICS			21,012		30.00
	03100 INTENSIVE CARE UNIT			0		31.00
41.00	04100 SUBPROVIDER - IRF			0		41.00
43.00	04300 NURSERY			0		43.00
FO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		0.00000	10	0	50.00
	05100 RECOVERY ROOM		0.00000		0	51.00
	05300 ANESTHESIOLOGY		0.00000		0	53.00
	05400 RADIOLOGY-DIAGNOSTIC		0.15194		0	54.00
	05500 RADIOLOGY-THERAPEUTIC		0.13192		0	55.00
	05600 RADIOISOTOPE		0.11145		0	56.00
57.00	05700 CT SCAN		0.11143		0	57.00
58.00	05800 MRI		0.09828		0	58.00
60.00	06000 LABORATORY		0.09788		264	60.00
				,	264	63.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.		0.10373 0.33199		0	65.00
66.00	06500 RESPIRATORY THERAPY		0.33199			
67.00	06600 PHYSICAL THERAPY		0.4023	- ,	2,623 1,598	
68.00	06700 OCCUPATIONAL THERAPY		0.32056		1,596	68.00
69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY		0.06032		0	69.00
	07000 ELECTROCARDIOLOGY		0.03674		0	70.00
			0.30873		0	70.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0.19240		423	73.00
	07400 RENAL DIALYSIS		0.33207		1 423	74.00
74.00	OUTPATIENT SERVICE COST CENTERS		0.33207	2 0	0	74.00
90.00			4.33014	19 0	0	90.00
91.00	09100 EMERGENCY		0.00000		ő	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0.00000		0	92.00
200.00			0.00000	16,650		200.00
201.00		line 61)		10,030		201.00
202.00				16,650		202.00
202.00		ı		10,000	I	1-32.00

MAT. B - MEDICAL MAD CHIEN MEATIN SERVICES			Title XVIII	Hospital	11/20/2023 2:1 PPS	34 pm_
MART 8 - MEDICAL AND OTHER MEANTHS SERVICES 1,100 Seldical and other services (See instructions) 1,150 1,00 1						
1.00		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
4.00 Outlier payment (see instructions) 0 4.00		Medical and other services (see instructions)	<u> </u>			
Quality Qual						
## Sender the hospital specific payment to cost ratio (see instructions)						
Sum of fines 3, 4, and 4.01, divided by line 6 0.00 7.00			ıs)			
Transitional corridor payment (see instructions) 0 8.00	6.00	Line 2 times line 5			0	6.00
Ancillary service other pass through costs from wkst. D, Pt. IV, col. 13, line 200 0 0.00						
10.00 Organ acquisitions 1,080 11.00			ol 13 line 200		-	
1.10.0 Total cost (sum of lines 1 and 10) (see instructions) 1.00			.01. 13, Time 200		-	
Reasonable charges		,			1,508	
12.00 Ancillary service charges 7,838 12.00 13.00						
13.00 Organ acquisition charges (from wkst. D-4, Pt. III, col. 4, line 69) 7,818 14.00 Total reasonable charges (sum of lines 12 and 13) 7,818 14.00 Total reasonable charges (sum of lines 12 and 13) 15.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 15.00 15.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 15.00 15.	12 00				7 939	12 00
14.00 Cotal reasonable charges (sum of lines 12 and 13) 14.00 Cotal reasonable charges (sum of lines 12 and 13) 15.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 15.00 15.			59)		-	
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00					-	
16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 0 16.00 Natio of Jine 15 to Jine 16 (not to exceed 1.000000) 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.00000000						
17.00		Amounts that would have been realized from patients liable for pay			-	
13.00 Total customary charges (see instructions) 7,838 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 19.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0.00 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0.00 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0.00 20.00	17 00				0.000000	17 00
instructions) 20.00						
instructions	19.00	Excess of customary charges over reasonable cost (complete only if	¹ line 18 exceeds lin	ne 11) (see		
		instructions)	² line 11 exceeds lin	ne 18) (see		
23.00 cost of physicians' services in a teaching hospital (see instructions) 1,039,202 24.00 computation by payment (sum of lines 3, 4, 4.0.1, 8 and 9) 1,039,202 24.00 computation by payment (sum of lines 3, 4, 4.0.1, 8 and 9) 1,039,202 24.00 25.00					-	
1,039,202 24.00		· · · · · · · · · · · · · · · · · · ·	ions)		_	
COMPUTATION OF REIMBURSEMENT SETTLEMENT 2.5.00 Deductibles and coinsurance amounts (for CAH, see instructions) 2.5.00 Deductibles and coinsurance amounts (for CAH, see instructions) 2.5.00 Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2.7.00 2			0113)		-	
Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 222,636 26,000 1		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
27.00 subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see structions)			(for CAU instru			
Instructions					-	
REH facility payment amount	27.00		the sum of times 22	unu 25] (500	010,074	27.00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 31.00 31.00 51.00 61.00 52.7, 28, 28.50 and 29) 7.00 7.			50)		0	
30.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 818,074 30.00 31.00 7 799,85 31.00 31.00 7 8 8 8.00 31.00 8 8 8.00 8 8 8.00 8 8 8.00 8 8 8 8 8 8 8 8 8					0	
1.00					-	
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 0 0 33.00 0 0 0 0 0 0 0 0 0						
33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 0 Allowable bad debts (see instructions) 9,598 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 6,239 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 6,676 36.00 37.00 38.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 6,676 36.00 38.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 822,267 37.00 38.00 MSP-LCC reconciliation amount from PS&R -6 88.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 0 39.00 39.50 70.00	32.00				816,028	32.00
34.00 Allowable bad debts (see instructions) 9,998 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 6,673 35.00 35.00 Allowable bad debts (see instructions) 6,676 36.00 37.00 Subtotal (see instructions) 822,267 37.00 39.00 39.00 MSP-LCC reconciliation amount from PS&R -6 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 3	33 00				0	33 00
35.00 Adjusted reimbursable bad debts (see instructions) 6,239 35.00 Adjusted reimbursable bad debts for dual eligible beneficiaries (see instructions) 822,267 37.00 38.00 MSP-LCC reconciliation amount from PS&R -6 38.00 MSP-LCC reconciliation amount (see instructions) 39.50 39.50 39.50 39.50 MSP-LCC demonstration payment adjustment (see instructions) 0 39.50 39.50 MSP respirator payment adjustment amount before sequestration 0 39.97 MSP respirator payment adjustment amount before sequestration 0 39.97 MSP MSP respirator payment adjustment amount before sequestration 0 39.98 MSP MSP respirator payment adjustment amount febror sequestration 0 39.98 MSP MSP respirator payment adjustment amount febror sequestration 0 39.98 MSP respirator payment adjustment (see instructions) 0 40.01 MSP respirator payment adjustment (see instructions) 0 40.01 MSP respirator payment adjustment amount after sequestration 0 40.02 40.03 MSP respirator payment adjustment amount after sequestration 0 40.03 40.03 MSP respirator payment adjustment amount after sequestration 0 40.03 40.						
37.00 Subtotal (see instructions) 822,267 37.00 38.00 MSP-LCC reconcilitation amount from PS&R -6 38.00 39.00 70 70 70 70 70 70 70		Adjusted reimbursable bad debts (see instructions)			6,239	35.00
38.00 MSP-LCC reconciliation amount from PS&R -6 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 39.50 39.50 39.50 39.55 39.95			ons)			
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 39.00 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.57 39.57 39.57 39.57 39.57 39.57 39.57 39.57 39.58 39.58 39.59 39.59 39.50 39.						
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.75 39.75 39.75 39.75 39.75 39.75 39.75 39.97 39.97 39.98 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 39.90 3						
39.97 Demonstration payment adjustment amount before sequestration 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 RECOVERY OF ACCELERATED 39.	39.50	Pioneer ACO demonstration payment adjustment (see instructions)				
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments 41.01 Interim payments 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.02 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions)					-	
39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 50 50 50 50 50 50 50			dovices (see instruct	-ions)		
40.00 Subtotal (see instructions) 822,273 40.00 40.01 Sequestration adjustment (see instructions) 16,445 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 0 40.03 41.00 Interim payments 799,836 41.00 41.01 Tentative settlement (for contractors use only) 0 42.00 42.01 Tentative settlement -PARHM (for contractor use only) 42.01 43.01 Balance due provider/program (see instructions) 5,992 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 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 (see instructions) 0 93.00		· ·	levices (see ilistruct	.10115)	-	
40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 Protested amount (see instructions) 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00					-	
40.03 Sequestration adjustment-PARHM pass-throughs 40.03 41.00 41.01 Interim payments 799,836 41.00 41.01 1.01 Tentative settlement (for contractors use only) 42.00 42.01 42.01 43.00 Balance due provider/program (see instructions) 43.01 8alance due provider/program-PARHM (see instructions) 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 44.					-	
41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 97.00 Time Value of Money (see instructions) 98.00 Time Value of Money (see instructions) 99.00 Time Value of Money (see instructions) 99.00 Time Value of Money (see instructions) 90.00 Time Value of Money (see instructions)					0	
41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 **TO BE COMPLETED BY CONTRACTOR** 90.00 Outlier amount (see instructions) 0 outlier reconciliation adjustment amount (see instructions) 10 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 11 outlier amount (see instructions) 12 outlier amount (see instructions) 13 outlier reconciliation adjustment amount (see instructions) 14 outlier reconciliation adjustment amount (see instructions) 15 outlier reconciliation adjustment amount (see instructions) 16 outlier reconciliation adjustment amount (see instructions) 17 outlier value of Money (see instructions) 18 outlier reconciliation adjustment amount (see instructions) 19 outlier reconciliation adjustment amount (see instructions) 20 outlier value of Money (see instructions) 30 outlier value of Money (see instructions)		, , , , , , , , , , , , , , , , , , , ,			799 836	
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 5,992 43.00 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5,115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 1 O 00 Outlier reconciliation adjustment amount (see instructions) 1 O 91.00 1 The rate used to calculate the Time Value of Money 1 Time Value of Money (see instructions) 0 O 93.00					755,050	
43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions)					0	
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{1}{5}115.2} TO BE COMPLETED BY CONTRACTOR 90.00 Outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 1.00 The rate used to calculate the Time Value of Money 1.00 Time Value of Money (see instructions) 1.00 92.00 Time Value of Money (see instructions) 1.00 93.00					F 003	
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00					5,992	
90.00 Original outlier amount (see instructions) 0 90.00 01.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money 0.00 92.00 Time Value of Money (see instructions) 0 93.00		Protested amounts (nonallowable cost report items) in accordance w	vith CMS Pub. 15-2, c	chapter 1,	0	
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00		TO BE COMPLETED BY CONTRACTOR				
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00						
93.00 Time Value of Money (see instructions) 0 93.00						
94.00 Total (sum of lines 91 and 93) 0 94.00	94.00				0	94.00

Health Financial Systems	COMMUNITY	STROKE A	AND R	EHABILITATION	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT				Provider CCN: 15-3045	Period: From 07/01/2022 To 06/30/2023	Worksheet E Part B Date/Time Pro 11/20/2023 2	
				Title XVIII	Hospital	PPS	
						1.00	
MEDICARE PART B ANCILLARY COSTS							
200.00 Part B Combined Billed Days						C	200.00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY STROKE AND REHABILITATION ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-3045 Period: Worksheet E-1 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 11/20/2023 2:34 pm Title XVIII Hospital PPS Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 11,941,443 799,836 1.00 Interim payments payable on individual bills, either 2.00 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 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 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 3.02 0 3.02 0 3.03 0 0 3.03 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 0 3.51 0 0 3.52 3.52 0 3.53 3.53 0 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.99 3.50 - 3.98)4.00 11,941,443 799,836 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATIVE TO PROGRAM 0 0 5.50 0 0 5.51 5.51 0 5.52 0 5.52 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 0 5.99

6.00

6.01

6.02

7.00

8.00

5,992

805,828

NPR Date (Mo/Day/Yr)

2.00

0

44,956

Contractor

Number

1.00

11,986,399

0

5.50 - 5.98)

8.00 Name of Contractor

the cost report. (1)

SETTLEMENT TO PROVIDER

SETTLEMENT TO PROGRAM

Determined net settlement amount (balance due) based on

Total Medicare program liability (see instructions)

6.00

6.01

6.02

7.00

Health	Financial Systems COMMUNITY STROKE AND	REHABILITATION	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-3045	Period: From 07/01/2022 To 06/30/2023	Worksheet E-1 Part II Date/Time Pre 11/20/2023 2:	pared:
		Title XVIII	Hospital	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					1.00
2.00	Medicare days (see instructions)				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (see instructions)				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, col. 3 l	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of cline 168	ertified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00

9.00

10.00

30.00 31.00

32.00

9.00

31.00 Other Adjustment (specify)

Sequestration adjustment amount (see instructions)

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30.00 Initial/interim HIT payment adjustment (see instructions)

10.00 Calculation of the HIT incentive payment after sequestration (see instructions)

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

Health Financial Systems	COMMUNITY STROKE AND	REHABILITATION	In Lieu of Form CMS-2552-		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3045	Period: From 07/01/2022 To 06/30/2023	Worksheet E-3 Part III Date/Time Prepared: 11/20/2023 2:34 pm	

		T:+10 VV/TTT	unani tal	11/20/2023 2.	34 piii
		Title XVIII	Hospital	PPS	
				4 00	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			11,909,853	
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0167	ı
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			310,847	1
4.00	Outlier Payments			88,876	
5.00	Unweighted intern and resident FTE count in the most recent count to November 15, 2004 (see instructions)	ost reporting period end	ding on or prior	0.00	5.00
5.01	cap increases for the unweighted intern and resident FTE coun program or hospital closure, that would not be counted withou			0.00	5.01
6.00	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) New Teaching program adjustment. (see instructions)			0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth pe	eriod of a "new	0.00	ı
	teaching program" (see instructions)				
8.00	Current year's unweighted I&R FTE count for residents within teaching program" (see instructions)	eriod of a "new	0.00	8.00	
9.00	Intern and resident count for IRF PPS medical education adjus	tment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)			26.504110	10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000	11.00
12.00	Teaching Adjustment (see instructions)			0	12.00
13.00	Total PPS Payment (see instructions)			12,309,576	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruct	ion)		0	1
15.00	Organ acquisition (DO NOT USE THIS LINE)				15.00
16.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	1
17.00	Subtotal (see instructions)			12,309,576	1
18.00	Primary payer payments			0	1
19.00	Subtotal (line 17 less line 18).			12,309,576	ı
20.00				, ,	20.00
21.00	Subtotal (line 19 minus line 20)			12,248,188	1
22.00	Coinsurance				1
23.00					22.00
	Subtotal (line 21 minus line 22)	> (:+:>		12,216,595	
24.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		22,190	ł
25.00	Adjusted reimbursable bad debts (see instructions)			14,424	ı
26.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		19,226	
27.00	Subtotal (sum of lines 23 and 25)			12,231,019	
28.00	Direct graduate medical education payments (from Wkst. E-4, 1	ine 49)		0	
29.00	Other pass through costs (see instructions)			0	29.00
30.00	Outlier payments reconciliation			0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	31.50
31.98	Recovery of accelerated depreciation.			0	31.98
31.99	Demonstration payment adjustment amount before sequestration			0	31.99
32.00	Total amount payable to the provider (see instructions)			12,231,019	32.00
32.01	Sequestration adjustment (see instructions)			244,620	32.01
32.02	Demonstration payment adjustment amount after sequestration			0	1
33.00	Interim payments			11,941,443	•
34.00	Tentative settlement (for contractor use only)			0	1
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.0	2 33 and 34)		44,956	1
36.00	Protested amounts (nonallowable cost report items) in accorda		chantor 1	0	36.00
30.00	§115.2	ince with this rub. 13-2, t	enapter 1,	·	30.00
F0 55	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount from Wkst. E-3, Pt. III, line 4			88,876	1
	Outlier reconciliation adjustment amount (see instructions)			0	51.00
52.00					52.00
53.00	Time Value of Money (see instructions)			0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND THE COVID-19 PHE)	BEGINNING ON OR BEFORE	MAY 11, 2023 (THE	END OF	
99.00	Teaching Adjustment Factor for the cost reporting period imme	diately preceding Februa	ry 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)		0.000000	99.01

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

Provider CCN: 15-3045

Period: Worksheet G From 07/01/2022 To 06/30/2023 Date/Time Prepared:

11/20/2023 2:34 pm General Fund Specific Endowment Fund Plant Fund Purpose Fund 1.00 3.00 4.00 2.00 CURRENT ASSETS 1.00 Cash on hand in banks 995 0 0 0 1.00 0 0 2.00 2.00 Temporary investments 0 0 3.00 Notes receivable 0 0 3.00 4.00 4,349,929 0 0 Accounts receivable 0 4.00 0 5.00 Other receivable 20,466 0 0 5.00 0 6.00 Allowances for uncollectible notes and accounts receivable 6.00 0 7.00 Inventory 56,932 0 0 7.00 0 0 8.00 Prepaid expenses 0 8.00 9.00 Other current assets 133,975 0 0 0 9.00 10.00 Due from other funds 0 0 0 10.00 Total current assets (sum of lines 1-10) 4,562,297 0 11.00 11.00 0 0 FIXED ASSETS 12.00 Land 0 0 0 12.00 Land improvements 0 0 13.00 0 13.00 Ó 0 14.00 Accumulated depreciation 0 14.00 15.00 Buildings 46,378,727 0 0 0 15.00 0 16.00 16.00 Accumulated depreciation 0 0 17.00 Leasehold improvements 0 17.00 0 0 18.00 Accumulated depreciation 0 Λ 18.00 Fixed equipment 0 19.00 19.00 0 0 20.00 Accumulated depreciation 0 20.00 0 0 21.00 Automobiles and trucks 0 21.00 22.00 Accumulated depreciation 0 22.00 23.00 Major movable equipment 0 0 23.00 0 Accumulated depreciation 24.00 24.00 0 0 25.00 Minor equipment depreciable 0 25.00 26.00 Accumulated depreciation 0 0 0 26.00 0 27.00 HIT designated Assets 27.00 0 ol 28.00 Accumulated depreciation 0 0 28.00 0 0 29.00 Minor equipment-nondepreciable 0 29.00 30.00 Total fixed assets (sum of lines 12-29) 46,378,727 0 0 30.00 OTHER ASSETS 31.00 0 0 31.00 Investments 0 32.00 Deposits on leases 0 0 0 32.00 Due from owners/officers 0 0 0 33.00 33.00 34.00 Other assets 70.373 0 ol 34.00 0 Total other assets (sum of lines 31-34) 0 0 35.00 70,373 0 35.00 36.00 Total assets (sum of lines 11, 30, and 35) 51,011,397 0 0 0 36.00 CURRENT LIABILITIES 37.00 30.479 0 0 0 37.00 Accounts payable 0 38.00 Salaries, wages, and fees payable 712,642 0 0 38.00 0 0 0 39.00 39.00 Payroll taxes payable 40.00 Notes and loans payable (short term) 0 0 0 40.00 0 0 0 Deferred income 41.00 41.00 0 0 42.00 Accelerated payments 0 42.00 43.00 Due to other funds C 0 0 0 43.00 Other current liabilities 18,387 0 0 44.00 0 44.00 Total current liabilities (sum of lines 37 thru 44) 0 45.00 45.00 761,508 0 O l LONG TERM LIABILITIES 46.00 Mortgage payable 0 0 46.00 Notes payable 0 0 47.00 0 0 47.00 48.00 Unsecured loans 0 0 0 48.00 Other long term liabilities 137,631 0 0 49.00 49.00 0 50.00 Total long term liabilities (sum of lines 46 thru 49) 137,631 0 0 0 50.00 Total liabilities (sum of lines 45 and 50) 51.00 899,139 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 50,112,258 52.00 General fund balance 53.00 Specific purpose fund 0 53.00 54.00 Donor created - endowment fund balance - restricted 0 54.00 Donor created - endowment fund balance - unrestricted 55.00 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 0 57.00 58.00 0 58.00 replacement, and expansion Total fund balances (sum of lines 52 thru 58) 50,112,258 0 59.00 59.00 0 0 60.00 Total liabilities and fund balances (sum of lines 51 and 51,011,397 0 0 0 60.00 Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-3045

Period: worksheet G-1 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

					10 06/30/202	11/20/2023 2:	
		General	Fund	Special P	Purpose Fund	Endowment Fund	<i>y</i>
		1.00	2.00	3.00	4.00	F 00	
1 00	Fund balances at beginning of period	1.00	2.00 51,963,462	3.00	4.00	5.00	1.00
1.00	Net income (loss) (from Wkst. G-3, line 29)		2,200,640		'	١	2.00
3.00	Total (sum of line 1 and line 2)		54,164,102				3.00
4.00	Additions (credit adjustments) (specify)	0	34,104,102		0	٥	4.00
5.00	Additions (credit adjustments) (specify)	0			0	0	5.00
6.00		0			0	0	6.00
7.00		0			0	0	7.00
8.00					0		8.00
9.00					0	0	9.00
10.00	Total additions (sum of line 4-9)		0			ol	10.00
11.00	Subtotal (line 3 plus line 10)		54,164,102				11.00
12.00	Deductions (debit adjustments) (specify)	0	31,101,102		0	0	12.00
13.00	FUND TRANSFER	106			0	0	13.00
14.00	TRANSFERRED TO/FROM AFFILIATES	4,051,738			0	0	14.00
15.00		0			0	0	15.00
16.00		0			0	0	16.00
17.00		0			0	0	17.00
18.00	Total deductions (sum of lines 12-17)		4,051,844			o	18.00
19.00	Fund balance at end of period per balance		50,112,258			0	19.00
	sheet (line 11 minus line 18)						
		Endowment Fund	Plant	Fund	_		
		6.00	7.00	8.00	-		
1.00	Fund balances at beginning of period	0	7100		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0			0		3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11.00	Subtotal (line 3 plus line 10)	0			0		11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	FUND TRANSFER		0				13.00
14.00	TRANSFERRED TO/FROM AFFILIATES		0				14.00
15.00			0				15.00
16.00			0				16.00
17.00	Tatal deductions (sum of lines 12 17)		0				17.00
18.00	Total deductions (sum of lines 12-17)	0			0		18.00 19.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			U		19.00
	I sueer (Time II minus (The IO)	1		I	1	l	

Health Financial Systems COMMUN STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-3045 Period: worksheet G-2 From 07/01/2022 Parts I & II To 06/30/2023 Date/Time Prepared:

		'	0 00/30/2023	11/20/2023 2:	
	Cost Center Description	Inpatient	Outpatient	Total	
	·	1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	16,318,770		16,318,770	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	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)	16,318,770		16,318,770	10.00
	Intensive Care Type Inpatient Hospital Services	, , ,		, ,	
11.00	INTENSIVE CARE UNIT	0		0	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 line	es 0		0	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16,318,770		16,318,770	17.00
18.00	Ancillary services	20,385,466	0	20,385,466	18.00
19.00	Outpatient services	0	49,563,417	49,563,417	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	TAXABLE LAB	0	1,954	1,954	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to V	wkst. 36,704,236	49,565,371	86,269,607	28.00
	G-3, line 1)				
	PART II - OPERATING EXPENSES	·			
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,091,501		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 (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(t	ransfer	27,091,501		43.00
	to Wkst. G-3, line 4)				

Health Financial Systems		COMMUNITY STROKE AND REHABILITATION		In Lieu of Form CMS-2552-10		
STATEMENT OF REVENUES AND EXPENSES			Provider CCN: 15-3045	Period: From 07/01/2022	Worksheet G-3	
					Date/Time Prep 11/20/2023 2:	
					1.00	
1.00	0 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			86,269,607	1.00	
2.00	2.00 Less contractual allowances and discounts on patients' accounts				57,221,420	2.00
3.00 Net patient revenues (line 1 minus line 2)					29,048,187	3.00
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)					27,091,501	4.00
5.00 Net income from service to patients (line 3 minus line 4)					1.956.686	5 00

		11/20/2023 2:	34 pm_		
		1.00			
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	86,269,607	1.00		
2.00	Less contractual allowances and discounts on patients' accounts		2.00		
3.00	Net patient revenues (line 1 minus line 2)		3.00		
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		4.00		
5.00	Net income from service to patients (line 3 minus line 4)		5.00		
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc	8,460	6.00		
7.00	Income from investments	1,006	7.00		
8.00	Revenues from telephone and other miscellaneous communication services		8.00		
9.00	Revenue from television and radio service	0	9.00		
10.00	Purchase discounts	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	122,528	14.00		
15.00	Revenue from rental of living quarters	0	15.00		
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00		
17.00	Revenue from sale of drugs to other than patients	0	17.00		
18.00	Revenue from sale of medical records and abstracts	0	18.00		
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00		
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00		
21.00	Rental of vending machines	2,621	21.00		
22.00	Rental of hospital space	100,425	22.00		
23.00	Governmental appropriations	0	23.00		
24.00	OTHER INCOME	169	24.00		
24.01	GRANT INCOME	2,114	24.01		
24.02	CLASSES	-104	24.02		
24.50	COVID-19 PHE Funding	6,735	24.50		
25.00	Total other income (sum of lines 6-24)	243,954	25.00		
26.00	Total (line 5 plus line 25)	2,200,640	26.00		
27.00	OTHER EXPENSES (SPECIFY)	0	27.00		
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00		
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,200,640	29.00		