Community Health Rehab Hospital South Health Financial Systems In Lieu of Form CMS-2552-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-3044 Worksheet S Peri od. From 09/18/2018 Parts I-III AND SETTLEMENT SUMMARY 12/31/2018 Date/Time Prepared: То 5/20/2019 12:19 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 5/20/2019 Time: 12:19 pm use only]Manually submitted cost report 2 []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 0 Ē 4

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

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

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

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Community Health Rehab Hospital South (15-3044) for the cost reporting period beginning 09/18/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. (Si aned)

Officer or Administrator of Provider(s) CEO

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY				_	_	
1.00	Hospi tal	0	21, 985	0	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	21, 985	0	0	0	200.00

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

Title

PI TA	L AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provio	ler CCN:	15-3044	Period: From 09/18/2		orksheet art I	S-2
						To 12/31/2	2018 Da	te/Time 20/2019	
	1.00	2.00		3.00		4.	. 00	207 2017	
	lospital and Hospital Health Care Co Street: 607 Greenwood Springs Drive	PO Box:							
	City: Greenwood	State: IN	Zip Cod	e: 46143	Coun	ty: JOHNSON			
	2	Component Name	CCN	CBSA	Provi dei	Date I		System	
			Number	Number	- Туре	Certified		D, or N) KVIII XI	
		1.00	2.00	3.00	4.00	5.00		(VIII XI 7.00 8.	
	lospital and Hospital-Based Componen	t Identification:	I.						
) H	lospi tal	Community Health Reha	b 153044	26900	5	09/18/2018	N	P (
s	Subprovider - IPF	Hospital South							
	Subprovider - IRF								
	Subprovider - (Other)								
	Swing Beds – SNF Swing Beds – NF								
	lospital-Based SNF								
	lospi tal -Based NF								1
	lospi tal -Based OLTC								1
	lospi tal -Based HHA								1
	Separately Certified ASC Hospital-Based Hospice								1
	lospital-Based Health Clinic - RHC								1
	lospital-Based Health Clinic - FQHC								1
	Hospital-Based (CMHC) I Renal Dialysis								1
	ther								1
					-	From:		To:	
	Cost Departing Depied (mm/dd/unuu)					1.00	10 1	2.00 12/31/201	0 2
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					5	18	12/31/201	8 2
	<u>, , , , , , , , , , , , , , , , , , , </u>								
1	npatient PPS Information				1.00	2.00		3.00	
d § f h 01 D c	Does this facility qualify and is it disproportionate share hospital adjust (412.106? In column 1, enter "Y" for facility subject to 42 CFR Section §- nospital?) In column 2, enter "Y" for Did this hospital receive interim un- cost reporting period? Enter in colu- the portion of the cost reporting per-	stment, in accordance r yes or "N" for no. 412.106(c)(2)(Pickles r yes or "N" for no. compensated care paym mn 1, "Y" for yes or	with 42 CFA Is this amendment ents for thi "N" for no t	s for	N	N			2
E r)2 E c a	nter in column 2, "Y" for yes or "N reporting period occurring on or after s this a newly merged hospital that payments to be determined at cost reported at cost reported at cost reported prior to 0ctobe cost reporting period prior to 0ctobe or "N" for no, for the portion of the actober 1.	" for no for the port er October 1. (see in requires final uncom port settlement? (see " for no, for the por er 1. Enter in column	ion of the o structions) pensated can instruction tion of the 2, "Y" for	xost re ns) yes	Ν	N			2
03 D r a f i r D c	bid this hospital receive a geographi- ural as a result of the OMB standard adopted by CMS in FY2015? Enter in co for the portion of the cost reporting n column 2, "Y" for yes or "N" for in reporting period occurring on or afte boes this hospital contain at least counted in accordance with 42 CFR 41: yes or "N" for no.	ds for delineating sta olumn 1, "Y" for yes g period prior to Octa no for the portion of er October 1. (see in: 100 but not more than	atistical an or "N" for n ober 1. Ente the cost structions) 499 beds (a	reas no er	Ν	N		Ν	2
)0 Ŵ b i r	Which method is used to determine Mer below? In column 1, enter 1 if date of f date of discharge. Is the method of reporting period different from the reporting period? In column 2, enter	of admission, 2 if ce of identifying the da method used in the pr r "Y" for yes or "N"	nsus days, o ys in this o ior cost <u>for no</u> ,	or 3 cost		2 N		_	2
		In- Medi pai d	State In-S caid Medi days elig unp da	caid ible M aid pa ys	aid days	State HN Medicaid eligible unpaid	di cai d 10 days	Other Medi ca days	id
0 1	f this provider is an IPPS hospital		00 2.	00	3.00	4.00	5.00	6.00	0 2
i N C	n-state Medicaid paid days in colum Medicaid eligible unpaid days in colum put-of-state Medicaid paid days in co put-of-state Medicaid eligible unpaid Medicaid HMO paid and eligible bu	n 1, in-state umn 2, olumn 3, d days in column			0			_	

	Financial Systems Community Hea TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	N: 15-3044		18/2018 31/2018	Worksh Part I Date/1 5/20/2	Time Pre 2019 12:	2 epared:
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medi ca HMO da	ays Me	Other edi cai d days	
5 00	If this provider is an LDE optor the in state	1.00	2.00	3.00	4.00	5.00) 22	6.00	25.00
5.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	27	0				of Geogr	
					1.			. 00	1
6. 00 7. 00 5. 00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	rural. age) status "2" for r cation in d	at the end ural. If ap column 2.	of the cos plicable,	it	1 1 0			26.0 27.0 35.0
	effect in the cost reporting period.								
					Begin	ni ng: 00		li ng: . 00	-
6. 00 7. 00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	es.			er	0			36.0
7. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo	ne MDH tran:	sitional pa	yment in					37. (
3. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of								38.
	enter subsequent dates.				\/	(1)		(/)]	
					Y/			<u>//N</u> . 00	-
9.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	, (ii), or the mileage	(iii)? Ent requiremen	er in colum ts in	ime N in	N		N	39. (
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r "Y" for y					N	40. (
						V 1.00	XVIII 2.00		-
	Prospective Payment System (PPS)-Capital					1.00		0.00	
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce	·	•			N	N	N	45. (
	pursuant to 42 CFR §412.348(f)? If yes, complete Wks1 Pt. III.	. L, Pt. I	II and Wkst	. L-1, Pt.	I through				47.
7.00 3.00	Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals	:? Enter "	Y" for yes	or "N" for	no.	N N	N N	N	48.
6.00 7.00	Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting p				5	N			56.
	GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "\ "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or "N th of this (", complete	" for no in cost report e Worksheet	column 1. ing period?	lf column P Enter "Y				
3. 00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. D-5.		es as	N			58.
0.00	Are costs claimed on line 100 of Worksheet A? If yes	s, comprete	wkst. D-2,	Pt. I. NAHE 413.8 Y/N		neet A e #	Qualif	Through ication	
9.00							criter.		-
9.00				1.00	2	00		. 00	-

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ТА	Provider C	F	Period: From 09/18/2018 Fo 12/31/2018		pared
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N			0.00	. 0. 00	61. (
I. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. (
1.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. (
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61. (
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
1. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.
	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61.
						1.00	1
	ACA Provisions Affecting the Health Resources and Ser			. ,			
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ctions) a Teachi gram. (s	ng Health Cen see instruction	ter (THC) into			62. 62.
3. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c	67. (see instri	uctions)	N	63.
				Unwei ghted FTEs Nonprovi der Si te	FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No	onprovid	der Settinas	1.00 This base vear	2.00 is vour cost r	<u> </u>	
4. 00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	<u>re June</u> ty trair a-primar all nor d non-pr n columr	30, 2010. med residents y care provider imary care 3 the ratio	0.00	-		64.

				om 09/18/2018	Worksheet S-2 Part I	
			To	12/31/2018	Date/Time Pre 5/20/2019 12:	epared 19 pm
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	1
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	10301 181	4))	
	1.00	2.00	3.00	4.00	5.00	
.00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)						
		·	Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTES	FTEs in	$(\operatorname{col} \cdot 1 + \operatorname{col} \cdot$	
			Nonprovider Site	Hospi tal	2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Current Y beginning on or after July 1, 201		n Nonprovider Settir				
FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	nweighted non-prima N. Enter in column	ry care resident 3 the ratio of				
	Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
	J. J	Program Code	FTËs Nonprovider Site	FTES in Hospital	(col. 3 + col. 4))	
.00 Enter in column 1, the program	Program Name		FTĔs Nonprovider	FTEsin	(col. 3 + col. 4)) 5.00	_
.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)	J. J	Program Code	FTĔs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
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	J. J	Program Code	FTĔs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00 0.000000	_
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00 25	Program Code 2.00	FTĔs Nonprovi der Si te 3.00 0.00	FTES in Hospital 4.00 0.00	(col . 3 + col . 4)) 5.00 0.000000 0.0000000	
<pre>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)</pre>	1.00 1.00 2S rchiatric Facility (the facility have a efore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii) rate which program y	Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m	FTES in Hospital 4.00 0.00 1.0 rovider? N he most o. (see ing o.	(col . 3 + col . 4)) 5.00 0.000000 0.0000000	
<pre>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)</pre>	1.00 1.00 2S vchiatric Facility (the facility have a fore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii ate which program y / PPS nabilitation Facilit	Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m	FTES in Hospital 4.00 0.00 1.0 rovider? N he most o. (see ing o.	(col . 3 + col . 4)) 5.00 0.000000 0.0000000 0.0000000 0.000000	_

Health Financial Systems Community Healt	h Reh	ab Hospital Sc	buth	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	١	Provider C		Period: From 09/18/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Pre	
				10 12/31/2010	5/20/2019 12:	
					1.00	
Long Term Care Hospital PPS 80.00 s this a long term care hospital (LTCH)? Enter "Y" fo		and "N" for	20		N	80.00
81.00 Is this a LTCH co-located within another hospital for p				period? Enter	N	81.00
"Y" for yes and "N" for no.						
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)((1)(i)	TEEDA2 Ento	r "V" for ves	or "N" for po	N	85.00
86.00 Did this facility establish a new Other subprovider (ex						86.00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						
87.00 Is this hospital an extended neoplastic disease care ho 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ospi ta	al classified	under section		N	87.00
				V	XI X	
Title V and XIX Services				1.00	2.00	
90.00 Does this facility have title V and/or XIX inpatient ho	ospi ta	al services? E	nter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column.	•					
91.00 Is this hospital reimbursed for title V and/or XIX thro full or in part? Enter "Y" for yes or "N" for no in the				N	N	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF bec					N	92.00
instructions) Enter "Y" for yes or "N" for no in the ap				N	Ν	
93.00 Does this facility operate an ICF/IID facility for purp "Y" for yes or "N" for no in the applicable column.	oses	or title v an	a XIX? Enter	N	N	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for	yes,	and "N" for n	o in the	N	N	94.00
applicable column. 95.00 fline 94 is "Y", enter the reduction percentage in th	ne ann	licable colum	n	0.00	0.00	95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for				N N	N 0.00	96.00
applicable column.				0.00	0.00	07.00
97.00 f line 96 is "Y", enter the reduction percentage in th 98.00 Does title V or XIX follow Medicare (title XVIII) for t				0.00 Y	0.00 Y	97.00 98.00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter						
column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for t	the re	porting of ch	argos on Wkst	Y	Y	98.01
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 f				1	I	70.01
title XIX.					X	00.00
98.02 Does title V or XIX follow Medicare (title XVIII) for t bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for				Y	Y	98.02
for title V, and in column 2 for title XIX.	5					
98.03 Does title V or XIX follow Medicare (title XVIII) for a reimbursed 101% of inpatient services cost? Enter "Y" f				N	N	98.03
for title V, and in column 2 for title XIX.	i Ui ye					
98.04 Does title V or XIX follow Medicare (title XVIII) for a	a CAH	reimbursed 10	1% of	N	Ν	98.04
outpatient services cost? Enter "Y" for yes or "N" for in column 2 for title XIX.	noin	COLUMN I TOP	title v, and			
98.05 Does title V or XIX follow Medicare (title XVIII) and a				Y	Y	98.05
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no column 2 for title XIX.	o in c	column 1 for t	itle V, and ii	ו		
98.06 Does title V or XIX follow Medicare (title XVIII) when				Y	Y	98.06
Pts. I through IV? Enter "Y" for yes or "N" for no in c column 2 for title XIX.	col umn	1 for title	V, and in			
Rural Providers					L	
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 for outpatient services? (see instructions)	e all-	Inclusive met	hod of paymen			106.00
107.00 If this facility qualifies as a CAH, is it eligible for						107.00
training programs? Enter "Y" for yes or "N" for no in c yes, the GME elimination is not made on Wkst. B, Pt. I,				+		
reimbursed. If yes complete Wkst. D-2, Pt. II.	CUI.	25 and the p	rogram rs cos			
108.00 Is this a rural hospital qualifying for an exception to		CRNA fee sche	dul e? See 42	Ν		108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for r	<u>10.</u>	Physi cal	Occupati ona	Speech	Respi ratory	
		1.00	2.00	3.00	4.00	
109.00 If this hospital qualifies as a CAH or a cost provider, therapy services provided by outside supplier? Enter "Y		Ν	N	N	N	109.00
for yes or "N" for no for each therapy.						
					1.00	_
110.00 Did this hospital participate in the Rural Community Ho	ospi ta	al Demonstrati	on project (§	110A	1.00 N	110.00
Demonstration) for the current cost reporting period? Er	nter "	Y" for yes or	"N" for no.	f yes,		
complete Worksheet E, Part A, lines 200 through 218, ar applicable.	iu wor	NONCEL E-2, 1	THES ZOU LITEOU	agii ∠10, dS		

ealth Financial Systems Community Health Rehab Hospital So HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC	CN: 15-3044	Period: From 09/18/ To 12/31/	2018		et S-2	2
		10 12/01/		5/20/20		
		1.00		2.0	00	-
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Co Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	period? Enter enter the column 2.	N				111.00
			1.00	2.00	3.00	
 Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in is yes, enter the method used (A, B, or E only) in column 2. If column 2 i 3 either "93" percent for short term hospital or "98" percent for long ter psychiatric, rehabilitation and long term hospitals providers) based on th Pub. 15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" 	s "E", enter m care (inclu ne definition	in column udes	N		0	115.00
17.00 Is this facility legally-required to carry malpractice insurance? Enter "Y no.		"N" for	Y			117.00
18.00 is the malpractice insurance a claims-made or occurrence policy? Enter 1 i claim-made. Enter 2 if the policy is occurrence.	f the policy	is	1			118.00
	Premi ums	Losses	S	Insur	ance	
	1.00	2.00		3.0	00	-
18.01 List amounts of malpractice premiums and paid losses:	12, 6		0			0 118. 0 [.]
		1.00		2.0	00	-
18.02 Are malpractice premiums and paid losses reported in a cost center other t Administrative and General? If yes, submit supporting schedule listing co and amounts contained therein. 19.00 D0 NOT USE THIS LINE		N				118.0
20.001s this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no.	for yes or ne Outpatient	N		N		120. 0
21.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.	s charged to	N				121.0
22.00 Does the cost report contain heal thcare related taxes as defined in §1903(Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.		N				122. 0
Transplant Center Information 25.00Does this facility operate a transplant center? Enter "Y" for yes and "N"	for no. If	N				125.0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter the certif	ication date					126. 0
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certificity of the column 2 and termination date if applicable, in column 2	cation date					127. C
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.	cation date					128. 0
29.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.	cation date in	ר				129. C
30.00 If this is a Medicare certified pancreas transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2.	i fi cati on					130. 0
31.00 If this is a Medicare certified intestinal transplant center, enter the ce date in column 1 and termination date, if applicable, in column 2.						131. 0
32.00 If this is a Medicare certified islet transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.						132.0
 33.00 If this is a Medicare certified other transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 34.00 If this is an organ procurement organization (OPO), enter the OPO number i 						133. 0
and termination date, if applicable, in column 2. All Providers						
40.00 Are there any related organization or home office costs as defined in CMS chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home		Y		1890	003	140. C

Health Financial Systems	Community Health	n Rehab Hospital So	outh	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider C	CN: 15-3044	Period: From 09/18/2018	Worksheet S-2 Part I	2
					Date/Time Pre	
1.00		2.00		3.00	5/20/2019 12:	19 pm
If this facility is part of a cha	in organization, enter		ugh 143 the na		of the	
home office and enter the home of	<u>fice contractor name a</u>	nd contractor numb	er.			
141.00 Name: KINDRED HEALTHCARE OPERATI LLC.	NG Contractor's Nam	e: WI SCONSI N PHYSI C SERVI CES	CI ANS Contracto	r's Number: 0590)1	141.00
142.00 Street: 680 SOUTH FOURTH STREET	PO Box:	SERVICES				142.00
143.00 Ci ty: LOUI SVI LLE	State:	КҮ	Zip Code:	4020	2	143.00
					1.00	-
144.00 Are provider based physicians' cos	sts included in Worksh	eet A?			N N	144.00
				1.00		-
145.00 If costs for renal services are c	aimed on Wkst A lin	e 74 are the cost	s for	1.00	2.00	145.00
inpatient services only? Enter "Y	' for yes or "N" for n	o in column 1. If	column 1 is			
no, does the dialysis facility in		tion for this cost	reporting			
period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodolog		eviouslv filed cos	t report?	N		146.00
Enter "Y" for yes or "N" for no i	n column 1. (See CMS P					
yes, enter the approval date (mm/	dd/yyyy) in column 2.					
					1.00	1
147.00 Was there a change in the statist					N	147.00
148.00 Was there a change in the order of					N	148.00
149.00 Was there a change to the simplif	red cost finding metho	Part A	Part B	Title V	N Title XIX	149.00
		1.00	2.00	3.00	4.00	
Does this facility contain a prov						
or charges? Enter "Y" for yes or 155.00Hospi tal	N TOF NO FOR EACH CO	N	N N	N	N	155.00
156.00 Subprovi der – IPF		N	N	N	N	156.00
157.00 Subprovider - IRF		N	N	N	N	157.00
158. 00 SUBPROVI DER 159. 00 SNF		N	N	N	N	158.00 159.00
160.00HOME HEALTH AGENCY		N	N	N	N	160.00
161.00 CMHC			N	N	N	161.00
					1.00	-
Multicampus					1.00	
165.00 Is this hospital part of a Multic	ampus hospital that ha	s one or more camp	uses in differ	ent CBSAs?	N	165.00
Enter "Y" for yes or "N" for no.	Name	County	State Zip	Code CBSA	FTE/Campus	
	0	1.00		6.00 4.00	5.00	-
166.00 If line 165 is yes, for each					0.00	166.00
campus enter the name in column O, county in column 1, state in						
column 2, zip code in column 3,						
CBSA in column 4, FTE/Campus in						
column 5 (see instructions) 166.01					0.00	166.01
166.02						166. 02
166.03					0.00	166. 03
					1.00	-
Health Information Technology (HI				t Act		
167.00 Is this provider a meaningful use					N	167.00
168.00 If this provider is a CAH (line 1) reasonable cost incurred for the l			e 16/ is "Y"),	enter the	(0168.00
168.01 If this provider is a CAH and is	not a meaningful user,	does this provide		a hardship		168. 01
exception under §413.70(a)(6)(ii)				NULX 1 11		
169.00 If this provider is a meaningful transition factor. (see instruction		and is not a CAH	(TINE TUS IS	N), enter the	0.00	0169.00
				Begi nni ng	Endi ng	
170 00 Entor in columns 1 and 2 the FUD	oginning data and and	ing data for the -	oporting	1.00	2.00	170.00
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	segrinning date and end	ing uate for the r	epor tring			170.00
171.00 fline 167 is "Y", does this pro	lidor have any dave fo		llodin	1.00 N	2.00	0 171.00
section 1876 Medicare cost plans	reported on Wkst. S-3.	Pt. I, line 2, co	I. 6? Enter	IN IN		00
"Y" for yes and "N" for no in col	umn 1. If column 1 is			1		
1876 Medicare days in column 2. (s	see instructions)					

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-3044	Peri od: From 09/18/2018 To 12/31/2018 Y/N	Worksheet S-2 Part II Date/Time Pro 5/20/2019 12: Date	epared:
				1.00	2.00	-
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ente			
	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		1.00
	reporting period. In yes, enter the date of the onlinge in e	01 unit 2. (300	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.		N			2.00
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe relationships? (see instructions)	offices, drug ler or its of the board	Y			3.00
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A	03/31/2019	4.00
. 00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reconcisional statements of the statement of the stateme		N			5.00
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	-
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	5 N		6. 00
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		during the	N N		7.00 8.00
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	Ν		9.00
0. 00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.		he current	Ν		10.00
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11.00
					Y/N 1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes		long		N	12.00
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	N	13. 0
4.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement				N	14.0
5.00	Did total beds available change from the prior cost reporti	Par	yes, see inst t A		N t B	15.0
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2.00	3.00	4.00	
6. 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	Y	03/31/2019	Y	03/31/2019	16. 0
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		Ν		17.0
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.0
9.00	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		Ν		19. 0

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	CN: 15-3044	Period: From 09/18/2018 To 12/31/2018	Worksheet S Part II Date/Time F 5/20/2019 1	repare
		Descri	ption	Y/N	Y/N	
		C		1.00	3.00	
00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20.
		Y/N	Date	Y/N	Date	
00		1.00	2.00	3.00	4.00	01
00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.
				-	1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP Capital Related Cost	T CHILDRENS H	OSPI TALS)			
00	Have assets been relifed for Medicare purposes? If yes, see	instructions				22.
00	Have changes occurred in the Medicare depreciation expense of reporting period? If yes, see instructions.		als made dur	ing the cost		23
00		d into during	this cost re	porting period?		24
00	Have there been new capitalized leases entered into during t instructions.	the cost repor	ting period?	lfyes, see		25
00		e cost reporti	ng period? I	f yes, see		26
00	Has the provider's capitalization policy changed during the copy.	cost reportin	g period? If	yes, submit		27
00		tered into dur	ing the cost	reporting		28
00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or b		bt Service R	eserve Fund)		29
00			debt? If yes	, see		30
00	instructions. Has debt been recalled before scheduled maturity without iss instructions.	suance of new	debt? If yes	, see		31
00			d through co	ntractual		32
00	arrangements with suppliers of services? If yes, see instruct If line 32 is yes, were the requirements of Sec. 2135.2 appl no, see instructions.		g to competi	tive bidding? If		33
	Provi der-Based Physi ci ans					
00	Are services furnished at the provider facility under an arr If yes, see instructions.	angement with	provi der-ba	sed physi ci ans?		34
00	If line 34 is yes, were there new agreements or amended exis physicians during the cost reporting period? If yes, see ins		ts with the	provi der-based		35
				Y/N 1.00	Date 2.00	
	Home Office Costs					
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pre-	epared by the	home office?	Y Y		36 37
00				N		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 other			, N		39
00	see instructions. If line 36 is yes, did the provider render services to the h	nome office?	lfyes, see	Ν		40
	instructions.					
	Cost Report Preparer Contact Information	1.	00	2.	00	
00	Enter the first name, last name and the title/position N held by the cost report preparer in columns 1, 2, and 3,	II COLE		WI CK		41
	respectively. Enter the employer/company name of the cost report K	INDRED HEALTH	CARE OPERATI	٧G		42
00	preparer.	LC				

Health Fin	ancial Systems	Community Health	Rehab	Hospi tal	South		In Lieu	u of Form CMS-	2552-10
HOSPI TAL A	AND HOSPITAL HEALTH CARE REIMBURSEMEN	IT QUESTI ONNAI RE		Provi der	CCN: 15-3044		riod: om 09/18/2018	Worksheet S-2 Part II	
						То		Date/Time Pre 5/20/2019 12:	pared: 19 pm
					3.00				
Cost	t Report Preparer Contact Informatio	n							
41.00 Ent	er the first name, last name and the	ti tl e/posi ti on	REI	MBURSEMEN	IT MANAGER				41.00
hel	d by the cost report preparer in col	umns 1, 2, and 3,							
res	specti vel y.								
42.00 Ent	er the employer/company name of the	cost report							42.00
pre	eparer.								
43.00 Ent	er the telephone number and email ac	dress of the cost	:						43.00
rep	port preparer in columns 1 and 2, res	pecti vel y.							

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-3044	Period: From 09/18/2018 To 12/31/2018	Worksheet S-3 Part I Date/Time Pre	pared:
	Component	Worksheet A	No. of Beds	Bed Days		5/20/2019 12: I/P Days / O/P Visits / Trips Title V	19 pm
		Line Number	0.00	Avai I abl e	4.00	5 00	
1 00		1.00	2.00	3.00	4.00	5.00	1.00
1.00 2.00 3.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider	30.00	44	4,62	20 0.00	0	1.00 2.00 3.00
4.00	HMO I RF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
5.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation bade) (cost instruction)		44	4,62	0.00	0 0	6.00 7.00
8.00	beds) (see instructions) INTENSIVE CARE UNIT	31.00	0		0 0.00	0	8.00
9.00	CORONARY CARE UNIT	51.00	0		0.00	0	9.00
10.00	BURN I NTENSI VE CARE UNI T						10.0
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		44	4,62	0.00	0	14.00
15.00	CAH visits			.,		0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.0
18.00	SUBPROVI DER						18.0
19.00	SKILLED NURSING FACILITY	44.00	0		0	0	19.0
20.00	NURSING FACILITY						20.0
21.00	OTHER LONG TERM CARE						21.0
22.00	HOME HEALTH AGENCY						22.0
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
24.00	HOSPI CE						24.0
4. 10	HOSPICE (non-distinct part)	30.00					24.1
5.00	CMHC - CMHC						25. C
6. 00	RURAL HEALTH CLINIC						26. C
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.2
27.00	Total (sum of lines 14-26)		44				27.0
8.00	Observation Bed Days					0	28.0
9.00	Ambul ance Trips						29.0
30.00	Employee discount days (see instruction)						30.0
1.00	Employee discount days - IRF						31.0
32.00	Labor & delivery days (see instructions)		0		0		32.0
32.01	Total ancillary labor & delivery room						32.0
33 AA	outpatient days (see instructions)						22 0
33.00	LTCH non-covered days						33.0

	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	N: 15-3044	Period: From 09/18/2018 To 12/31/2018		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
2.00 2.00 3.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider	895 0 0	0 49 0		22		1.00 2.00 3.00
1.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
5.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	895	0	1, 32	0 22		6.00 7.00
	beds) (see instructions)						
3.00	INTENSIVE CARE UNIT	0	0		0		8.00
9.00	CORONARY CARE UNIT						9.00
0.00	BURN INTENSIVE CARE UNIT						10.00
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
2.00	OTHER SPECIAL CARE (SPECIFY)						12.00
3.00	NURSERY						13.00
4.00	Total (see instructions)	895	0	1, 32	0.00	63.90	14.00
5.00	CAH visits	0	0		0		15.00
6.00	SUBPROVIDER - IPF						16.00
7.00	SUBPROVI DER – I RF						17.00
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY	0	0		0 0.00	0.00	19.0
20.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00	HOSPICE						24.0
4.10	HOSPICE (non-distinct part)				0		24.1
5.00	CMHC - CMHC						25.0
6.00	RURAL HEALTH CLINIC						26. C
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
7.00	Total (sum of lines 14-26)				0.00	63.90	
8.00	Observation Bed Days		0		0		28. C
9.00	Ambul ance Trips	0					29.0
0.00	Employee discount days (see instruction)				0		30.0
1.00	Employee discount days - IRF	_	_		0		31.0
2.00	Labor & delivery days (see instructions)	0	0		0		32.0
2. 01	Total ancillary labor & delivery room				U		32.0
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0			1	1	33.0

	Financial Systems Commu AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	nity Health Reha AL DATA	Provider C		Period: From 09/18/2018 To 12/31/2018		pared:
		Full Time Equivalents		Di s	scharges		
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 20.00 21.00 23.00 24.00 24.00 24.00 24.00 24.00 25.00 23.00 24.00 25.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instructions) Total ancillary labor & delivery room	0. 00 0. 00 0. 00 0. 00	0		71 O	107	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 24. 00 24. 00 24. 00 25. 00 26. 02 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 33. 00 33. 00 34. 00 35. 00
33. 00	Courpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0 0		33. 00 33. 01

	Financial Systems		<u></u>	hab Hospital So Provider C	CN: 15-3044 F	Period: From 09/18/2018 Fo 12/31/2018		pare
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adj usted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
Ī	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARIES							1
	Total salaries (see	200. 00	1, 315, 021	C	1, 315, 021	1 44, 461. 00	29. 58	1.
	instructions) Non-physician anesthetist Part		0	C		0.00	0.00	2.
0	A Non-physician anesthetist Part		0	0		0.00	0.00	3.
	B		0			0.00	0.00	
	Physician-Part A - Administrative		0	C	(0.00	0.00	4
	Physicians - Part A - Teaching		0	C		0.00	0.00	4
	Physician and Non		0	C	(0.00	0.00	5
	Physician-Part B Non-physician-Part B for		O	c		0.00	0.00	6
	hospital-based RHC and FQHC							
	services Interns & residents (in an	21.00	0	0		0.00	0.00	7
	approved program)	21.00	Ū			0.00		
	Contracted interns and		0	C	(0.00	0.00	7
	residents (in an approved programs)							
	Home office and/or related		0	C	(0.00	0.00	8
	organization personnel SNF	44.00	O	c		0.00	0.00	Ģ
00	Excluded area salaries (see		0	84, 959	84, 959			
	instructions) DTHER WAGES & RELATED COSTS							
	Contract Labor: Direct Patient		64, 407	C	64, 40	7 1, 176. 00	54. 77	11
	Care Contract Labor: Top Level		0	0		0.00	0.00	1.
	management and other		0			0.00	0.00	¹ ∠
	management and administrative							
	services Contract Labor: Physician-Part		39, 060	c	39,060	217.00	180.00	13
	A - Administrative							
	Home office and/or related organization salaries and		0	C	(0.00	0.00	14
	wage-related costs							
	Home office salaries		223, 303		223, 303			
	Related organization salaries Home office: Physician Part A		0					
	- Administrative							
	Home office and Contract Physicians Part A - Teaching		0	C		0.00	0.00	
N	NAGE-RELATED COSTS	L		1		1	1	
	Wage-related costs (core) (see instructions)		209, 276	C	209, 276	5		17
00	Wage-related costs (other)		0	C		D		18
	(see instructions) Excluded areas		14, 454		14, 454	1		19
	Non-physician anesthetist Part		14, 454		(D		20
00	A Non-physician anesthetist Part		0					21
	B		U					
	Physician Part A -		0	C	(ס		22
	Administrative Physician Part A - Teaching		0	a		D		22
00	Physician Part B		O	C	(-		23
	Wage-related costs (RHC/FQHC) Interns & residents (in an		0			-		24
	approved program)		0					
	Home office wage-related (core)		0	C	(25
	Related organization		0	C	0	D		25
	wage-related (core)		~	_				
	Home office: Physician Part A - Administrative -		0	0				25
	wage-related (core)							
	Home office & Contract Physicians Part A - Teaching -		0	C	(נ		25
	wage-related (core)							
	DVERHEAD COSTS - DIRECT SALARIE						0.00	1 ~
	Employee Benefits Department Administrative & General	4.00 5.00	0 245, 324			0 0.00 4 7,311.00		

Heal th	Financial Systems	Commur	nity Health Re	ehab Hospital S	outh	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		eri od:	Worksheet S-3	
						rom 09/18/2018		norod.
					1	o 12/31/2018	Date/Time Pre 5/20/2019 12:	pared: 19 pm
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under			0 0) C	0.00	0.00	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00		0 0	C	0.00		29.00
30.00	Operation of Plant	7.00	21, 17	0 0	21, 170			
31.00	Laundry & Linen Service	8.00		0 0) C	0.00	0.00	31.00
32.00	Housekeepi ng	9.00	33, 84	1 (33, 841	2, 107.00	16.06	32.00
33.00	Housekeeping under contract			0 0) C	0.00	0.00	33.00
	(see instructions)							
34.00	Dietary	10.00	95, 10	8 0	95, 108	5, 287. 00	17.99	34.00
35.00	Dietary under contract (see			0 0) C	0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11.00		0 0) C	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00		0 0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	99, 76	2 0	99, 762	3, 142. 00	31.75	38.00
39.00	Central Services and Supply	14.00		0 0) C	0.00	0.00	39.00
40.00	Pharmacy	15.00	55, 37	0 0	55, 370	1, 393. 00	39. 75	40.00
41.00	Medical Records & Medical	16.00	42, 36	9 (42, 369	1, 399. 00	30. 29	41.00
	Records Library							
42.00	Soci al Servi ce	17.00	84, 95	9 -84, 959) C	0.00	0.00	42.00
43.00	Other General Service	18.00		0 0) C	0.00	0.00	43.00

Heal th	Financial Systems	Commu	nity Health Rel	hab Hospital Sc	outh	In Lie	eu of Form CMS-2	2552-10
HOSPI 1	TAL WAGE INDEX INFORMATION			Provider CO		Period: From 09/18/2018	Worksheet S-3 Part III	
						To 12/31/2018		
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		1, 315, 021	0	1, 315, 02	1 44, 461. 00	29. 58	1.00
	instructions)							
2.00	Excluded area salaries (see		0	84, 959	84, 95	9 2, 650. 00	32.06	2.00
	instructions)							
3.00	Subtotal salaries (line 1		1, 315, 021	-84, 959	1, 230, 06	2 41, 811. 00	29.42	3.00
	minus line 2)							
4.00	Subtotal other wages & related		326, 770	0	326, 77	5, 730. 93	57.02	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		209, 276	0	209, 27	6 0.00	17.01	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		1, 851, 067	-84, 959	1, 766, 10	8 47, 541. 93	37.15	6.00
7.00	Total overhead cost (see		677, 903	-84, 959	592, 94	4 21, 327.00	27.80	7.00
	instructions)							
				•				

Heal th	Financial Systems Community Health Reha	b Hospital South	In Lie	u of Form CMS-2	2552-10
	AL WAGE RELATED COSTS	Provi der CCN: 15-3044	Period: From 09/18/2018 To 12/31/2018	Worksheet S-3 Part IV Date/Time Pre 5/20/2019 12:	pared:
				Amount Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETIREMENT COST				
1.00	401K Employer Contributions			406	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0	
6.00	Legal /Accounting/Management Fees-Pension Plan			0	
7.00	Employee Managed Care Program Administration Fees			0	7.00
	HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administr			0	
8.02	Health Insurance (Self Funded with a Third Party Administrate	or)		93, 638	8. 02
8.03	Health Insurance (Purchased)			0	8.03
9.00	Prescription Drug Plan			0	9.00
10.00	Dental, Hearing and Vision Plan			7	10.00
11.00	Life Insurance (If employee is owner or beneficiary)			684	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			1, 324	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary	y)		0	14.00
15.00	'Workers' Compensation Insurance			12, 886	15.00
16.00	Retirement Health Care Cost (Only current year, not the extra	aordinary accrual require	ed by FASB 106.	0	16.00
	Non cumulative portion)		-		
	TAXES				
17.00	FICA-Employers Portion Only			86, 486	
18.00	Medicare Taxes - Employers Portion Only			0	18.00
19.00	Unemployment Insurance			0	19.00
20.00	State or Federal Unemployment Taxes			13, 846	20.00
	OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Finstructions))	Reported on lines 1 throu	igh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances			0	22.00
23.00	Tuition Reimbursement			0	23.00
24.00	Total Wage Related cost (Sum of lines 1 –23)			209, 277	24.00
	Part B - Other than Core Related Cost				1
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25.00

Health Financial Systems	Community Health Rehal	o Hospital South	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COS	Т	Provider CCN: 15-3044	Peri od:	Worksheet S-3	
			From 09/18/2018	Part V	
			To 12/31/2018		
Cast Contar Description			Contract Labor	5/20/2019 12: Benefit Cost	19 pili
Cost Center Description			1. 00	2.00	
PART V - Contract Labor and Benet	Fit Cost		1.00	2.00	
Hospital and Hospital-Based Compo 1.00 Total facility's contract labor			64, 407	209, 276	1.00
· · · · · · · · · · · · · · · · · · ·					
2.00 Hospital			64, 407	209, 276	
3.00 Subprovi der – I PF					3.00
4.00 Subprovider - IRF			0	0	4.00
5.00 Subprovi der - (Other)			0	0	5.00
6.00 Swing Beds - SNF			0	0	6.00
7.00 Swing Beds - NF			0	0	7.00
8.00 Hospital-Based SNF			0	0	8.00
9.00 Hospital-Based NF					9.00
10.00 Hospital-Based OLTC					10.00
11.00 Hospital-Based HHA					11.00
12.00 Separately Certified ASC					12.00
13.00 Hospital-Based Hospice					13.00
14.00 Hospital-Based Health Clinic RHC					14.00
15.00 Hospital-Based Health Clinic FQH	3				15.00
16.00 Hospital-Based-CMHC					16.00
17.00 Renal Dialysis			0	0	17.00
18.00 Other			0	0	18.00

	Financial Systems Commu SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	nity Health Reha F EXPENSES	Provider C		Peri od:	u of Form CMS- Worksheet A	
					From 09/18/2018 To 12/31/2018	Date/Time Pre 5/20/2019 12:	
	Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	1 Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
. 00	00100 CAP REL COSTS-BLDG & FIXT		597, 223			607, 605	
. 00	00200 CAP REL COSTS-MVBLE EQUIP		84, 028			121, 953	
. 00	00300 OTHER CAP REL COSTS		48, 307			0	
. 00	00400 EMPLOYEE BENEFI TS DEPARTMENT	0	269, 122			269, 122	
. 00	00500 ADMINI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT	245, 324	395, 197			633, 368	
. 00 . 00	00800 LAUNDRY & LINEN SERVICE	21, 170 0	98, 384 873		54 0 73 -873	119, 554 0	
. 00	00900 HOUSEKEEPING	33, 841	13, 038			47, 752	
0.00	01000 DI ETARY	95, 108	26, 557			121, 665	
1.00	01100 CAFETERIA	\$3, 100 0	20, 337		0 0	121,003	1
3.00	01300 NURSING ADMINISTRATION	99, 762	4, 288				
4.00	01400 CENTRAL SERVICES & SUPPLY	0	25		25 -25	0	1
5.00	01500 PHARMACY	55, 370	19, 956			82, 426	
6.00	01600 MEDI CAL RECORDS & LI BRARY	42, 369	0	42, 3	69 0	42, 369	16.00
7.00	01700 SOCIAL SERVICE	84, 959	781	85, 7	40 -85, 740	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
0.00	03000 ADULTS & PEDI ATRI CS	381, 088	62, 186	443, 2	74 -225	443, 049	30.00
1.00	03100 INTENSIVE CARE UNIT	0	0		0 0	0	
4.00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	44.00
	ANCI LLARY SERVICE COST CENTERS			1		-	1
0.00	05000 OPERATING ROOM	0	0		0 0	0	
4.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
0.00	06000 LABORATORY	0	5, 709			5, 709	
5.00 6.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	15, 809 82, 930	0			15, 809 85, 442	
7.00	06700 OCCUPATIONAL THERAPY	95, 233	2, 512 157			95, 390	
8.00	06800 SPEECH PATHOLOGY	62,058	107			62, 169	
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	02,000	18, 364			18, 364	
	07300 DRUGS CHARGED TO PATIENTS	0	43, 964			44, 653	
	07400 RENAL DI ALYSI S	0	0		0 0	0	
	OUTPATIENT SERVICE COST CENTERS						
0.00	09000 CLI NI C	0	0		0 647	647	90.00
1.00	09100 EMERGENCY	0	0		0 0	0	91.00
	OTHER REIMBURSABLE COST CENTERS			-			
	09500 AMBULANCE SERVICES	0	11, 786			11, 786	
8.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
	SPECIAL PURPOSE COST CENTERS						1
18.00		1, 315, 021	1, 702, 568	3, 017, 5	89 -85, 740	2, 931, 849	1118.00
00.00	NONREI MBURSABLE COST CENTERS	0	0		0 0	0	1100.00
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		190. 00 192. 00
92.00	07950 NONALLOWABLE CLINICAL LIAISON	0	0		0 85, 740		192.00
	07950 NONALLOWABLE CENTICAL LIAISON	0	0		0 0		194.00
94.01	07952 REGIONAL OFFICE	0	0			0	194.02
	07953 DI STRI CT OFFI CE	0	0		0 0	0	194.03
	07954 NON MCR CERTIFIED UNIT	0	0		0 0		194.04
94.05	07955 REG NURSG OFFICE	0	0		0 0		194. 05
94.06	07956 CONTACT CENTER	0	0		0 0		194.0
	07957 CENTRALI ZED ADMI SSI ONS DEPT	0	0		0 0		194.0
	07959 OTHER NONREIMBURSABLE - OPEN	0	0		0 0	0	194.0
	07958 VISITOR MEALS	0	0		0 0		194.0
	07962 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.10
74.10							
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION TOTAL (SUM OF LINES 118 through 199)	0 1, 315, 021	0 1, 702, 568	3, 017, 5	0 0	0 3, 017, 589	194. 1

RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-3044	From 09/18/2018	heet A
						Time Prepared 2019 12:19 pm
	Cost Center Description	Adjustments	Net Expenses			
		(See A-8) 6.00	For Allocation 7.00			
	GENERAL SERVICE COST CENTERS	0.00	7.00	1		
1.00	00100 CAP REL COSTS-BLDG & FIXT	-88, 548	519, 057			1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP	20, 474	142, 427	1		2.0
3.00	00300 OTHER CAP REL COSTS	0	Ċ	1		3. C
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-37,690	231, 432			4. C
5.00	00500 ADMINISTRATIVE & GENERAL	151, 888	785, 256	,		5. C
7.00	00700 OPERATION OF PLANT	-24, 084	95, 470			7.0
8.00	00800 LAUNDRY & LINEN SERVICE	0	C			8.0
9.00	00900 HOUSEKEEPI NG	-6, 189	41, 563			9. C
10. 00	01000 DI ETARY	-18, 935	102, 730			10. C
11. 00	01100 CAFETERI A	0	C			11. C
13.00	01300 NURSI NG ADMI NI STRATI ON	-14, 366	88, 651			13.0
14.00	01400 CENTRAL SERVICES & SUPPLY	0	C			14. C
15.00	01500 PHARMACY	-12, 227	70, 199			15. C
16.00	01600 MEDICAL RECORDS & LIBRARY	-6, 342	36, 027			16. C
17.00	01700 SOCIAL SERVICE	0	(17. C
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS	-3, 760	439, 289	1		30.0
	03100 I NTENSI VE CARE UNI T	0	C			31.0
44.00	04400 SKI LLED NURSI NG FACI LI TY	0				44. C
	ANCI LLARY SERVI CE COST CENTERS	<u>г</u>				
	05000 OPERATING ROOM	0	C			50. C
	05400 RADI OLOGY-DI AGNOSTI C	0	0			54. C
	06000 LABORATORY	0	5, 709	1		60. C
65.00		-2, 426	13, 383	1		65. C
	06600 PHYSI CAL THERAPY	-9, 595	75, 847	1		66. C
	06700 OCCUPATIONAL THERAPY	-12, 787	82,603	1		67.0
	06800 SPEECH PATHOLOGY	-5, 518	56, 651	1		68.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	-1, 485	16, 879	1		71. C
		-8, 012	36, 641 (74.0
74.00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	L. L	1		/4.0
00 00	09000 CLINIC	ol	647			90.0
	09100 EMERGENCY	0	047			90.0
91.00	OTHER REIMBURSABLE COST CENTERS	0		1		
95 00	09500 AMBULANCE SERVICES	-11, 786		1		95. 0
	09850 OTHER REIMBURSABLE COST CENTERS	0	C			98.0
70.00	SPECIAL PURPOSE COST CENTERS	U 0		1		/0.0
118. OC		-91, 388	2, 840, 461			118.0
110.00	NONREI MBURSABLE COST CENTERS	71,000	2,010,101	1		
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	o	(190. 0
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	(1		192.0
	07950 NONALLOWABLE CLINICAL LIAISON	0 0	85, 740	1		194.0
	07951 I DLE SPACE	0	(194. 0
	07952 REGIONAL OFFICE	0	C			194. 0
	07953 DI STRI CT OFFI CE	0	C			194.0
	07954 NON MCR CERTIFIED UNIT	0	C	•		194.0
	07955 REG NURSG OFFICE	0	C	•		194. C
	07956 CONTACT CENTER	0	C			194. C
	07957 CENTRALIZED ADMISSIONS DEPT	0	C			194. 0
	07959 OTHER NONREI MBURSABLE - OPEN	0	C			194. 0
	07958 VI SI TOR MEALS	0	C			194. C
	07962 OTHER NONREIMBURSABLE COST CENTERS	0	C			194. 1
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	C			194. 1
200.00		-91, 388	2, 926, 201	1		200. 0

Heal th	Financial Systems	Commu	unity Health Ref	nab Hospital S	outh	In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider C	CN: 15-3044	Peri od:	Worksheet A-	6
						From 09/18/2018 To 12/31/2018	Date/Time Pr 5/20/2019 12	epared: 19 pm
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	A - RECLASS NON ALLOWABLE CAS	SE MANAGER						
1.00	NONALLOWABLE CLINICAL	194.00	84, 959	781				1.00
	LI AI SON							
	TOTALS		84, 959	781				
	B - RECLASS LINEN ACCRUAL							
1.00	HOUSEKEEPI NG	9.00	0	873				1.00
	TOTALS			873				
	C - RECLASS TRAVEL EXPENSE							
1.00	NURSING ADMINISTRATION	13.00	0	25				1.00
	TOTALS			25				
	D - RELATED PARTY EXP RECLASS	5						
1.00	PHARMACY	15.00	0	7, 100				1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	689				2.00
3.00	CLINIC	90.00	0	647				3.00
	TOTALS			8, 436				
500.00	Grand Total: Increases		84, 959	10, 115				500.00

Heal th	Financial Systems	Commu	unity Health Reh	ab Hospital S	South	In Lie	u of Form CMS-	-2552-10
RECLAS	SIFICATIONS			Provi der (CCN: 15-3044	Peri od:	Worksheet A-	6
						From 09/18/2018 To 12/31/2018	Date/Time Pr 5/20/2019 12	epared: :19 pm
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	· .		
	6.00	7.00	8.00	9.00	10.00			
	A - RECLASS NON ALLOWABLE CAS	SE MANAGER	· · · ·					
1.00	SOCI AL SERVI CE	17.00	84, 959	781		0		1.00
	TOTALS		84, 959	781		7		
	B - RECLASS LINEN ACCRUAL							1
1.00	LAUNDRY & LINEN SERVICE	8.00	0	873	8	0		1.00
	TOTALS		0	873				
	C - RECLASS TRAVEL EXPENSE							1
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	25	5	0		1.00
	TOTALS		0	25	; ;	7		1
	D - RELATED PARTY EXP RECLASS	5						1
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	7, 153	5	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	1, 058	3	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	225	5	0		3.00
	TOTALS		0	8,436	,	1		1
500.00	Grand Total: Decreases		84, 959	10, 115				500.00

		nity Health Reh	nab Hospital Sc	outh		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-3044		iod: m 09/18/2018 12/31/2018	Worksheet A-7 Part I Date/Time Pre 5/20/2019 12:	pared:
				Acqui si ti on	IS			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES		_				
1.00	Land	0	0		0	0	0	1.00
2.00	Land Improvements	0	0		0	0	0	2.00
3.00	Buildings and Fixtures	0	0		0	0	0	3.00
4.00	Building Improvements	0	493, 977		0	493, 977	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	0	1, 804, 438		0	1, 804, 438	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	0	2, 298, 415		0	2, 298, 415	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	0	2, 298, 415		0	2, 298, 415	0	10.00
		Ending Balance	Fully					
		Ŭ	Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	0	0					1.00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	0	0					3.00
4.00	Building Improvements	493, 977	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	1, 804, 438	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	2, 298, 415	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	2, 298, 415	0					10.00

Heal th	Financial Systems Commu	nity Health Ref	nab Hospital Sc	buth	In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-3044	Peri od:	Worksheet A-7	
					From 09/18/2018 To 12/31/2018		narod
					10 12/31/2010	5/20/2019 12:	
			SL	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
						instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK						
1.00	CAP REL COSTS-BLDG & FIXT	18, 369			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	74, 918			0 0	0	2.00
3.00	Total (sum of lines 1-2)	93, 287			0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEEL A, COLUM		nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	597, 223				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	84, 028				2.00
3.00	Total (sum of lines 1-2)	0	681, 251				3.00

Heal th	Financial Systems Comm	unity Health Rel	hab Hospital So	outh	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 09/18/2018 Fo 12/31/2018		pared: 19 pm
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPI TAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
		1.00	2.00	3.00	4.00	5.00	
1.00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT	493, 977		493, 97	0. 214921	1, 268	1.00
2.00	CAP REL COSTS-BEDG & FIXT	1, 804, 438		1, 804, 438			2.00
3.00	Total (sum of lines 1-2)	2, 298, 415		2, 298, 415			3.00
0.00			TION OF OTHER (F CAPITAL	0.00
				1			
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capital-Relate d Costs	cols.5 through 7)			
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	9, 114		10, 382		578, 854	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	33, 293		37, 925			2.00
3.00	Total (sum of lines 1-2)	42, 407		48, 30		587, 964	3.00
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
					Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13.00	14.00	15.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS OF			0.11	4	540.053	1 00
1.00	CAP REL COSTS-BLDG & FIXT	0				017/007	1.00
2.00 3.00	CAP REL COSTS-MVBLE EQUIP	0	.,			142, 427	2.00 3.00
3.00	Total (sum of lines 1-2)	0	3, 658	42, 40	0	661, 484	3.00

Community Health Rehab Hospital South In Lieu of Form CMS-2552-10

Health Financial Systems

				1	rom 09/18/2018 To 12/31/2018		pared 19 pm
				Expense Classification on To/From Which the Amount is			
	Cost Center Description		Amount	Cost Center	-	Wkst. A-7 Ref.	
. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00 0	1. (
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.0
	COSTS-MVBLE EQUIP (chapter 2)			NI KEE COSTS MUDEL EQUIT			
. 00	Investment income - other (chapter 2)		0		0.00	0	3. (
. 00	Trade, quantity, and time	В	-23	ADMINISTRATIVE & GENERAL	5.00	0	4. (
i. 00	discounts (chapter 8) Refunds and rebates of		о		0.00	0	5. (
. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. (
	suppliers (chapter 8)		0				
. 00	Telephone services (pay stations excluded) (chapter 21)	A	-1, 210,	ADMI NI STRATI VE & GENERAL	5.00	0	7.(
8. 00	Television and radio service	A	-109	OPERATION OF PLANT	7.00	0	8. (
. 00	(chapter 21) Parking lot (chapter 21)		о		0.00	0	9. (
0.00	Provider-based physician adjustment	A-8-2	0			0	10. (
1.00	Sale of scrap, waste, etc.		О		0.00	0	11. (
2. 00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	170, 465			0	12.
3.00	Laundry and linen service		0		0.00		
4.00 5.00	Cafeteria-employees and guests Rental of quarters to employee and others		-3, 768 0	JIEIARY	10. 00 0. 00		14. 15.
6. 00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.
7.00	Sale of drugs to other than		о		0.00	0	17.
8. 00	patients Sale of medical records and		О		0.00	0	18.
9.00	abstracts Nursing and allied health		0		0.00	0	19.
	education (tuition, fees, books, etc.)		0				
0. 00 1. 00	Vending machines Income from imposition of interest, finance or penalty		0 0		0.00 0.00	0	20. 21.
2. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.
3. 00	repay Medicare overpayments	A-8-3		RESPI RATORY THERAPY	65.00		23.
3.00	therapy costs in excess of	A-0-3	01	LISTINATURI IIILRAFT	05.00		23.
4.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	01	PHYSI CAL THERAPY	66.00		24.
5.00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.
6. 00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.
7.00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.
8. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.
9.00 0.00	Physicians' assistant Adjustment for occupational	A-8-3	0	DCCUPATI ONAL THERAPY	0.00 67.00	0	
0. 99	therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.
	instructions)						
1. 00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.
2 00	CAH HIT Adjustment for		0		0.00	0	32.

DJUSTMEN	ITS TO EXPENSES			Provider CCN: 15-3044	Period: From 09/18/2018 To 12/31/2018		pare
				Expense Classification To/From Which the Amount		5/20/2019 12:	<u>19 p</u>
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
3. 00 OT	HER ADJUSTMENTS (SPECIFY)	1.00	2.00	3.00	4.00	5.00	33.
(3		В	-500	ADMI NI STRATI VE & GENERAL	5.00	0	
3. 02 OT	HER ADJUSTMENTS (SPECIFY)	D	-500	ADMINISTRATIVE & GENERAL	0.00	0	
	HER ADJUSTMENTS (SPECIFY)		0		0.00	0	33
	HER ADJUSTMENTS (SPECIFY)		C		0.00	0	33
	HER ADJUSTMENTS (SPECIFY)		0		0.00	0	33
	HER ADJUSTMENTS (SPECIFY)		0		0.00	0	33
	HER ADJUSTMENTS (SPECIFY)		0		0.00	0	33
	HER ADJUSTMENTS (SPECIFY)		0		0.00	0	33
	HER ADJUSTMENTS (SPECIFY)		0		0.00	0	33
. 10 0T) HER ADJUSTMENTS (SPECIFY)		0		0.00	0	33
(3) . 11 0T) HER ADJUSTMENTS (SPECIFY)		C		0.00	0	33
	HER OPERATING - PUBLIC	А	-214	ADMI NI STRATI VE & GENERAL	5.00	0	33
	LATI ONS HER OPERATI NG – MARKETI NG	А	-8	ADMI NI STRATI VE & GENERAL	5.00	0	33
	HER OPERATING - INTEREST HER ADJUSTMENTS (SPECIFY)	A	-10, 209 0	ADMI NI STRATI VE & GENERAL	5.00 0.00	0	
(3 16 OT) HER ADJUSTMENTS (SPECIFY)		0		0.00	0	33
(3 17 OT) HER ADJUSTMENTS (SPECIFY)		0		0.00	0	3:
(3 18 OT) HER ADJUSTMENTS (SPECIFY)		0		0.00	0	33
(3 19 OT) HER ADJUSTMENTS (SPECIFY)		0		0.00	0	33
(3			C		0.00	0	33
(3			C		0.00	0	3:
(3			0		0.00	0	
(3			0		0.00		33
(3			0		0.00	0	
(3			0 0		0.00		33
(3			0		0.00	0	
(3			0		0.00	0	
(3			0		0.00	0	
(3		А	_5 //4	ADMI NI STRATI VE & GENERAL	5.00	0	
30 OT	HER ADJUSTMENTS (SPECIFY)		-5, 440	CONTROLINATIVE & GENERAL	0.00	0	
	HER ADJUSTMENTS (SPECIFY)		C		0.00	0	33
	HER ADJUSTMENTS (SPECIFY)		C		0.00	0	33
	HER ADJUSTMENTS (SPECIFY)		C		0.00	0	33
	HER ADJUSTMENTS (SPECIFY)		0		0.00	0	33
	HER ADJUSTMENTS (SPECIFY)		0		0.00	0	33
. 36 OT) HER ADJUSTMENTS (SPECIFY)		O		0.00	0	33

Health Financial Systems ADJUSTMENTS TO EXPENSES	Commur	nity Health Rel	hab Hospital South Provider CCN: 15-3044 F	In Lie	u of Form CMS-2 Worksheet A-8	2552-10
			F	rom 09/18/2018 o 12/31/2018		
			Expense Classification on To/From Which the Amount is		572072019 12.	<u>19 piii</u>
Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
33. 37 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33. 37
33. 38 OTHER ADJUSTMENTS (SPECI FY) (3)		0		0.00	0	33. 38
33. 39 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 39
(3) 33. 40 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.40
33. 41 NON ALLOW AMBULANCE COSTS 33. 42 OTHER ADJUSTMENTS (SPECIFY)	А	-11, 786 0	AMBULANCE SERVICES	95.00 0.00	0 0	33. 41 33. 42
(3) 33. 43 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 43
(3) 33. 44 OTHER ADJUSTMENTS (SPECI FY)		0		0.00	0	33. 44
(3) 33. 45 BUSI NESS I NTERRUPTI ONS I NS	А	-2, 242	CAP REL COSTS-BLDG & FIXT	1.00	12	33. 45
34. 00 MEDI CARE VS BOOK BLDG	А		CAP REL COSTS-BLDG & FIXT	1.00	9	
34. 01 MEDI CARE VS BOOK MOV EQUI P 34. 02 OTHER ADJUSTMENTS (SPECI FY) (3)	A	-17, 250 0	CAP REL COSTS-MVBLE EQUIP	2.00 0.00	9 0	34. 01 34. 02
34. 03 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34. 03
34. 04 ASSET ADD-ON MOV EQUIP 34. 05 OTHER ADJUSTMENTS (SPECIFY)	A	50, 045 0	CAP REL COSTS-MVBLE EQUIP	2.00 0.00	9 0	34. 04 34. 05
(3) 34. 06 OTHER ADJUSTMENTS (SPECI FY)		0		0.00	0	34.06
(3) 34. 07 OTHER ADJUSTMENTS (SPECI FY)		0		0.00	0	34.07
(3) 34. 08 OTHER ADJUSTMENTS (SPECI FY)		0		0.00	0	34.08
(3) 34. 09 OTHER ADJUSTMENTS (SPECI FY)		0		0.00	0	34.09
(3) 34. 10 OTHER ADJUSTMENTS (SPECI FY)		0		0.00	0	34. 10
(3) 34. 11 OTHER ADJUSTMENTS (SPECI FY)		0		0.00	0	34. 11
(3) 34. 12 OTHER ADJUSTMENTS (SPECI FY)		0		0.00	0	34. 12
(3) 34. 13 PATIENT PHONE - DEPREC EQUIP 34. 14 OTHER ADJUSTMENTS (SPECIFY)	А	-1, 458 0	CAP REL COSTS-MVBLE EQUIP	2.00 0.00		34. 13 34. 14
(3) 34. 15 DEFERRED PRE OPENING COSTS	А		ADMI NI STRATI VE & GENERAL	5.00	0	34. 15
34. 16REMOVEPRECERTEXPENSE34. 17REMOVEPRECERTEXPENSE	A A		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1.00 2.00	9 9	34. 16 34. 17
34.18 REMOVE PRE CERT EXPENSE 34.19 REMOVE PRE CERT EXPENSE	A		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	2.00 4.00		34. 18 34. 19
34.20 REMOVE PRE CERT EXPENSE	A	-68, 117	ADMI NI STRATI VE & GENERAL	5.00	0	34.20
34. 21REMOVEPRECERTEXPENSE34. 22OTHERADJUSTMENTS(SPECIFY)	A	-23, 975 0	OPERATION OF PLANT	7.00 0.00	0	34. 21 34. 22
(3) 34.23 REMOVE PRE CERT EXPENSE	А	-6, 189	HOUSEKEEPI NG	9.00	0	34. 23
34.24 REMOVE PRE CERT EXPENSE 34.25 REMOVE PRE CERT EXPENSE	A A		DI ETARY NURSI NG ADMI NI STRATI ON	10.00 13.00		34. 24 34. 25
34.26 REMOVE PRE CERT EXPENSE	A	-12, 227	PHARMACY	15.00	0	34.26
34.27 REMOVE PRE CERT EXPENSE 34.28 REMOVE PRE CERT EXPENSE	A A		MEDICAL RECORDS & LIBRARY ADULTS & PEDIATRICS	16.00 30.00	0	34. 27 34. 28
35.00 REMOVE PRE CERT EXPENSE	A	-2, 426	RESPI RATORY THERAPY	65.00	0	35.00
35.01 REMOVE PRE CERT EXPENSE 35.02 REMOVE PRE CERT EXPENSE	A A		PHYSICAL THERAPY OCCUPATIONAL THERAPY	66.00 67.00	0	35. 01 35. 02
35.03 REMOVE PRE CERT EXPENSE 35.04 REMOVE PRE CERT EXPENSE	A A	-5, 518	SPEECH PATHOLOGY MEDICAL SUPPLIES CHARGED TO	68.00 71.00	0	35. 03 35. 04
35. 05 REMOVE PRE CERT EXPENSE 35. 06 OTHER ADJUSTMENTS (SPECI FY)	А		PATIENTS DRUGS CHARGED TO PATIENTS	73.00 0.00	0	35. 05 35. 06
35. 06 OTHER ADJUSTMENTS (SPECIFY) (3) 35. 07 OTHER ADJUSTMENTS (SPECIFY)		0		0.00		
(3)		0		0.00	0	55.07

ADJUSTN	MENTS TO EXPENSES			Provider CCN: 15-3044	Peri od: From 09/18/2018 To 12/31/2018	Worksheet A-8 Date/Time Pre 5/20/2019 12:	pared:
				Expense Classification To/From Which the Amount i			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
35.08	OTHER ADJUSTMENTS (SPECIFY)	1.00	2.00	3.00	4.00	5.00	35.08
	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 09
35. 10	(3) PHYSICIAN FEE ADJUSTMENT	А	-39,060	ADMI NI STRATI VE & GENERAL	5.00	0	35.10
35. 11	PHYSICIAN FEE ADJUSTMENT	A	39, 060	ADULTS & PEDIATRICS	30.00		35. 11
35. 12	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35.12
35. 13	(3)OTHER ADJUSTMENTS (SPECIFY)(3)		0		0.00	0	35. 13
35. 14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35. 14
35. 15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35. 15
35. 16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.16
35. 17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35. 17
35. 18	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35. 18
35. 19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35. 19
35. 20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35. 20
35. 21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35. 21
35. 22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35. 22
35. 23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35. 23
35. 24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35. 24
35. 25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35. 25
	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-91, 388				50. OC

(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.
(2) Additional environment of the set of the set

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	Community Health Re	ehab Hospital South	In Lie	eu of Form CMS-:	2552-10
STATEME	NT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-3044	Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 09/18/2018		
				To 12/31/2018	Date/Time Pre 5/20/2019 12:	
	Line No.	Cost Center	Expense Items	Amount of	Amount	i i più
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs	358, 441	187, 976	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
4.06	5.00	ADMINISTRATIVE & GENERAL	Hospital Related services	344	344	4.06
4.14	15.00	PHARMACY	Hospital Related services	22, 700	22, 700	4.14
4.28	73.00	DRUGS CHARGED TO PATIENTS	Hospital Related services	1, 191	1, 191	4. 28
4.30	90.00	CLINIC	Hospital Related services	646	646	4.30
5.00	0		0	383, 322	212, 857	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.

1140 11	been poored to normoneour na				or this parti					
				Related Organization(s) and/	or Home Office					
						1				
						i i				
	Symbol (1)	Name	Percentage of	Name	Percentage of					
	- · · · ·		Ownershi p		Ownershi p					
	1.00	2.00	3.00	4.00	5.00					
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:									

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

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

rerinbur	Sement under title Aviii.		
6.00	В	49.00 KH0LLC 100.00	6.00
7.00		0.00 0.00	7.00
8.00		0.00 0.00	8.00
9.00		0.00 0.00	9.00
10.00	В	51.00 Comm HI th Ntwrk 100.00	10.00
10.01		0.00 0.00	10.01
10. 02		0.00 0.00	10.02
10.03		0.00 0.00	10.03
10.04		0.00 0.00	10.04
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 organi zati on.

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

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

Heal th Fi	nancial Syste	ems		Community H	ealth Reha	b Hospital	South	 In Lie	u of Form CMS	-2552-10
STATEMEN	T OF COSTS OF	SERVICES FROM	1 RELATED	ORGANI ZATI ONS	AND HOME	Provi der	CCN: 15-3	Peri od:	Worksheet A	-8-1
OFFICE CO	OSTS							From 09/18/2018		
UTTOE O	0010							To 12/31/2018	Date/Time P	repared:
									5/20/2019 12	2:19 pm
	Net	Wkst. A-7 Ref								
	Adjustments									
	col. 4 minus									

	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	170, 465	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.06	0	0		4.06
4.14	0	0		4.14
4.28	0	0		4. 28
4.30	0	0		4.30
5.00	170, 465			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.

cen posteu to norkaneet A,	cordinas r and/or 2, the amount arrowable should be that eated th cordinar 4 or this part.	-
Related Organization(s)		
and/or Home Office		
Type of Business		1
6.00		
INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HOME OFFICE:	
	Related Organization(s) and/or Home Office Type of Business 6.00	Type of Busi ness

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	HomeOffice Cost	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00	Hospital Svcs	10.00
10. 01		10.01
10. 02		10.02
10. 03		10.03
10.04		10.04
100.00		100.00

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

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

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

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

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

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

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CO	CN: 15-3044	Period: From 09/18/2018	eu of Form CMS-2552 Worksheet B Part I	
					To 12/31/2018	Date/Time Pre	pared
			CAPI TAL REL	ATED COSTS		5/20/2019 12:	19 pr
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP		Subtotal	
		for Cost Allocation			BENEFI TS DEPARTMENT		
		(from Wkst A			DEFARTIVIENT		
		col. 7)					
		0	1.00	2.00	4.00	4A	
	AL SERVICE COST CENTERS	E10 0E7	519, 057				1 1.
	CAP REL COSTS-BEDG & FIXT	519, 057 142, 427	519,057	142, 42	7		2.
	EMPLOYEE BENEFITS DEPARTMENT	231, 432	0	142, 42	0 231, 432		4.
	ADMINI STRATI VE & GENERAL	785, 256	48, 108	13, 20		889, 740	
	OPERATION OF PLANT	95, 470	26, 415	7, 24		132, 859	
00800 00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	8.
	HOUSEKEEPING	41, 563	1, 492	40		49, 420	
	DIETARY	102, 730	37, 310	10, 23		167, 016	
	CAFETERIA NURSI NG ADMI NI STRATI ON	00 451	0	20		0	
	CENTRAL SERVICES & SUPPLY	88, 651	1, 178 8, 579	32 2, 35		107, 709 10, 933	
	PHARMACY	70, 199	3, 828	1, 05		84, 822	
	MEDICAL RECORDS & LIBRARY	36, 027	1, 728	47		45, 686	
	SOCIAL SERVICE	0	1, 492	40		1, 901	
	I ENT ROUTI NE SERVI CE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
	ADULTS & PEDIATRICS	439, 289	311, 185	85, 38		902, 930	
		0	0		0 0	0	
	SKILLED NURSING FACILITY	U	0		0 0	0	44.
	OPERATING ROOM	0	0		0 0	0	50.
	RADI OLOGY-DI AGNOSTI C	Ő	0		0 0	0	
	LABORATORY	5, 709	942	25	59 0	6, 910	
00 06500	RESPI RATORY THERAPY	13, 383	1, 816	49	2, 782	18, 479	65.
	PHYSI CAL THERAPY	75, 847	31, 666	8, 68		130, 797	
	OCCUPATIONAL THERAPY	82,603	22, 410	6, 14		127, 922	
	SPEECH PATHOLOGY	56, 651	18, 199	4, 99		90, 766	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 879 36, 641	0		0 0	16, 879 36, 641	
	RENAL DIALYSIS	30, 041	0		0 0	30, 041	
	TIENT SERVICE COST CENTERS	<u> </u>				0	1
00 09000	CLINIC	647	0		0 0	647	90.
	EMERGENCY	0	0		0 0	0	91.
	REIMBURSABLE COST CENTERS						1
	AMBULANCE SERVICES	0	0		0 0	0	95. 98.
	OTHER REIMBURSABLE COST CENTERS	U	0		0 0	0	90.
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	2, 840, 461	516, 348	141, 68	216, 480	2, 822, 057	1118.
	MBURSABLE COST CENTERS		-				
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.
	PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.
	NONALLOWABLE CLINICAL LIAISON	85, 740	2, 709	74	14, 952	104, 144	
	I DLE SPACE REGIONAL OFFICE	0	0				194.
	DISTRICT OFFICE	0	0		0 0		194. 194.
	NON MCR CERTIFIED UNIT	0	0		0 0		194.
	REG NURSG OFFICE	0	0		0 0		194.
	CONTACT CENTER	0	0		0 0		194.
4. 07 07957	CENTRALIZED ADMISSIONS DEPT	0	0		0 0	0	194.
	OTHER NONREIMBURSABLE - OPEN	0	0		0 0		194.
	VISITOR MEALS	0	0		0 0		194.
	OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194.
	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0		0		194.
0.00	Cross Foot Adjustments Negative Cost Centers		0				200. 201.
1.00							

OST ALI	OCATION - GENERAL SERVICE COSTS		Provider C		Period: From 09/18/2018 To 12/31/2018	5/20/2019 12:	epared: 19 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPING	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
G	ENERAL SERVICE COST CENTERS						
	0100 CAP REL COSTS-BLDG & FIXT						1.00
. 00 0	0200 CAP REL COSTS-MVBLE EQUIP						2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	0500 ADMINISTRATIVE & GENERAL	889, 740					5.0
	0700 OPERATION OF PLANT	58, 047	190, 906				7.0
	0800 LAUNDRY & LINEN SERVICE	0	C		0		8.0
	0900 HOUSEKEEPI NG	21, 592	641		0 71,653		9.0
	1000 DI ETARY	72, 970	16, 023		6, 034	262, 043	
		0	0		0 0	0	
	1300 NURSING ADMINISTRATION	47,059	506		0 191	0	
	1400 CENTRAL SERVICES & SUPPLY	4,777	3, 684		1, 387	0	
	1500 PHARMACY	37,059	1, 644		0 619	0	
	1600 MEDI CAL RECORDS & LI BRARY	19, 960	742		279	0	
	1700 SOCIAL SERVICE	831	641		241	0	17.0
	NPATIENT ROUTINE SERVICE COST CENTERS	204 402	122 (20		50.220	262.042	200
	3000 ADULTS & PEDIATRICS 3100 INTENSIVE CARE UNIT	394, 492	133, 639		0 50, 330 0 0	262, 043 0	
	4400 SKILLED NURSING FACILITY	0	0			0	
	NCI LLARY SERVICE COST CENTERS	0	0		<u> </u>	0	44.0
	5000 OPERATI NG ROOM	0	C		0 0	0	50.0
	5400 RADI OLOGY-DI AGNOSTI C	0	0			0	
	6000 LABORATORY	3, 019	405		0 152	0	
	6500 RESPI RATORY THERAPY	8,074	780		294	0	
	6600 PHYSI CAL THERAPY	57, 146	13, 599		5, 121	0	66.0
	6700 OCCUPATI ONAL THERAPY	55, 890	9, 624		3, 624	0	67.00
	6800 SPEECH PATHOLOGY	39,656	7, 815		2, 943	0	68.0
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7,375	0		0 0	0	
	7300 DRUGS CHARGED TO PATIENTS	16,009	C		0 0	0	
	7400 RENAL DIALYSIS	0	C		o c	0	74.0
0	UTPATIENT SERVICE COST CENTERS						
0.00 0	9000 CLI NI C	283	C		0 0	0	90.0
	9100 EMERGENCY	0	C		0 0	0	91.0
	THER REIMBURSABLE COST CENTERS	-		1	_		
	9500 AMBULANCE SERVICES	0	C		0 0	0	
	9850 OTHER REIMBURSABLE COST CENTERS	0	C		0 0	0	98.0
	PECIAL PURPOSE COST CENTERS	1		1	1		
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	844, 239	189, 743		0 71, 215	262, 043	118. 0
	ONREI MBURSABLE COST CENTERS						100 0
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.0
	9200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		192.0
	7950 NONALLOWABLE CLINICAL LIAISON	45, 501	1, 163		438		194.0
	7951 I DLE SPACE	0	0		0 0		194.0
	7952 REGIONAL OFFICE	0	0				194.0
		0	0		0 0		194.0
	7954 NON MCR CERTIFIED UNIT 7955 REG NURSG OFFICE	0	0		0 0		194.0
	7955 REG NURSG OFFICE 7956 CONTACT CENTER	0	0				194. 0 194. 0
		0	0				
	7957 CENTRALIZED ADMISSIONS DEPT 7959 OTHER NONREIMBURSABLE – OPEN						194. 0 194. 0
	7959 VISITOR MEALS						194. C
	7958 VISITOR MEALS 7962 OTHER NONREIMBURSABLE COST CENTERS						194.0
	7962 OTHER NORRET MBORSABLE COST CENTERS 7961 NONRET MB NEW BUSINESS IMPLEMENTATION						194.1
94. 110 00. 00	Cross Foot Adjustments		U			0	200. 0
00.00	Negative Cost Centers	0	0		o o	0	200.0
01.00							

	2	nity Health Reh				u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 09/18/2018	Worksheet B Part I	
					To 12/31/2018	Date/Time Pre	
	Cost Center Description	CAFETERIA	NURSI NG	CENTRAL	PHARMACY	5/20/2019 12: MEDI CAL	19 pm
			DMI NI STRATI ON			RECORDS &	
		11.00	12.00	SUPPLY	15.00	LIBRARY	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	16.00	
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
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00		0					10.00
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	166 146				11.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	155, 465 0	20, 78	21		14.00
	01500 PHARMACY	0	0	10, 14			15.00
	01600 MEDICAL RECORDS & LIBRARY	0	0	10, 1	0 0	66, 667	
	01700 SOCIAL SERVICE	Ő	0	61	-	00,007	
	INPATIENT ROUTINE SERVICE COST CENTERS		-		-1 -1		
30.00	03000 ADULTS & PEDI ATRI CS	0	155, 465	25	54 0	31, 202	2 30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0		0 0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	0 44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
60.00		0	0		0 0	257	
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0	4.00	0 0	763	
66.00 67.00	06700 OCCUPATIONAL THERAPY	0	0	4, 83 63		10, 620 11, 379	
	06800 SPEECH PATHOLOGY	0	0	03	0 0	8, 145	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4, 30		74	
	07300 DRUGS CHARGED TO PATIENTS	Ő	0	1,00	0 134, 285	4, 105	
	07400 RENAL DIALYSIS	0	0		0 0	0	
	OUTPATIENT SERVICE COST CENTERS	· · · · · ·			-1		
90.00	09000 CLI NI C	0	0		0 0	122	2 90.00
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	0	0		0 0	0	
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
110 00	SPECIAL PURPOSE COST CENTERS	0	166 446	20.70	124 205	// //7	7110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	UU	155, 465	20, 78	31 134, 285	00, 007	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	0	0		0 0		192.00
	07950 NONALLOWABLE CLINICAL LIAISON	0	0		0 0		194.00
194.01	07951 I DLE SPACE	0	0		0 0	0	194.01
194.02	07952 REGIONAL OFFICE	0	0		0 0	0	194.02
	07953 DISTRICT OFFICE	0	0		0 0		194.03
194.04	07954 NON MCR CERTIFIED UNIT	0	0		0 0		0 194. 04
	07955 REG NURSG OFFICE	0	0		0 0		0 194.05
	07956 CONTACT CENTER	0	0		0 0		194.06
194.06	ATACT CENTRAL LTER ADMICCLONG REPT		0		0) 194.07) 194.08
194.06 194.07	07957 CENTRALIZED ADMISSIONS DEPT		~			()	1194 08
194. 06 194. 07 194. 08	07959 OTHER NONREIMBURSABLE - OPEN	0	0				
194.06 194.07 194.08 194.09	07959 OTHER NONREIMBURSABLE - OPEN 07958 VISITOR MEALS	0	0			0	194.09
194.06 194.07 194.08 194.09 194.10	07959 OTHER NONREIMBURSABLE – OPEN 07958 VISITOR MEALS 07962 OTHER NONREIMBURSABLE COST CENTERS	0	0 0 0			0 0) 194. 09) 194. 10
194.06 194.07 194.08 194.09 194.10 194.11	07959 OTHER NONREIMBURSABLE - OPEN 07958 VISITOR MEALS 07962 OTHER NONREIMBURSABLE COST CENTERS 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0 0 0 0	0 0 0 0		0 0 0 0 0 0	0 0) 194.09) 194.10) 194.11
194.06 194.07 194.08 194.09 194.10	07959 OTHER NONREIMBURSABLE - OPEN 07958 VISITOR MEALS 07962 OTHER NONREIMBURSABLE COST CENTERS 07961 NONREIMB NEW BUSINESS IMPLEMENTATION Cross Foot Adjustments		0 0 0 0			0 0 0) 194.09) 194.10

COST A	Financial Systems Commu LLOCATION - GENERAL SERVICE COSTS	unity Health Reha			Peri od:	u of Form CMS-2552-10 Worksheet B
					From 09/18/2018 To 12/31/2018	Part I
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Total t	
		17.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS			1		
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMINISTRATIVE & GENERAL					5.00
7.00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					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	4, 227				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	4, 227	1, 934, 582	2	0 1, 934, 582	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	C		0 0	31.00
44.00	04400 SKILLED NURSING FACILITY	0	C		0 0	44.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	C		0 0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	54.00
60.00	06000 LABORATORY	0	10, 743	3	0 10, 743	60.00
65.00	06500 RESPI RATORY THERAPY	0	28, 390		0 28, 390	65.00
66.00	06600 PHYSI CAL THERAPY	0	222, 119	2	0 222, 119	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	209, 074	ł	0 209, 074	67.00
68.00	06800 SPEECH PATHOLOGY	0	149, 325	5	0 149, 325	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	28, 630		0 28, 630	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	191, 040		0 191, 040	73.00
74.00	07400 RENAL DI ALYSI S	0	C)	0 0	74.00
	OUTPATIENT SERVICE COST CENTERS			1	-	
90.00	09000 CLI NI C	0	1, 052		0 1,052	90.00
91.00	09100 EMERGENCY	0	C		0 0	91.00
	OTHER REIMBURSABLE COST CENTERS	-		.1	-	
95.00	09500 AMBULANCE SERVICES	0	C		0 0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	C	<u> </u>	0 0	98.00
110 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	4 227	2 774 055		0 2 774 055	110.00
118.00	NONREI MBURSABLE COST CENTERS	4, 227	2, 774, 955		0 2, 774, 955	118.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	1	0 0	190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	0				190.00
		0		'	0	
	07950 NONALLOWABLE CLINICAL LIAISON 07951 IDLE SPACE	0	151, 246		0 151, 246	194. 00 194. 01
	07951 TDLE SPACE 07952 REGIONAL OFFICE	0			0 0	194.01
		0			0 0	
	07953 DISTRICT OFFICE 07954 NON MCR CERTIFIED UNIT	0			0 0	194.03
		0			0 0	194.04
	07955 REG NURSG OFFICE			Ś		194.05 194.06
	07956 CONTACT CENTER 07957 CENTRALIZED ADMISSIONS DEPT			Ś		
				()		194.07
	07959 OTHER NONREI MBURSABLE - OPEN			Ś		194.08
	07958 VISITOR MEALS	0			0	194.09
	07962 OTHER NONREI MBURSABLE COST CENTERS				0	194. 10 194. 11
194.10			(Л	0 0	1194.
194.10 194.11	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	~			
194.10 194.11 200.00	Cross Foot Adjustments	0	C		0 0	200.00
194.10 194.11	Cross Foot Adjustments Negative Cost Centers	0 4, 227	C C 2, 926, 201		0 0 0 0 0 2, 926, 201	

	ancial Systems Commu I OF CAPITAL RELATED COSTS	unity Health Ref	Provider C		eriod:	u of Form CMS-: Worksheet B	2552-10
				F	rom 09/18/2018 o 12/31/2018	Part II Date/Time Pre 5/20/2019 12:	pared: 19 pm
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	ERAL SERVICE COST CENTERS						1
2.00 0020 4.00 0040	00 CAP REL COSTS-BLDG & FIXT 00 CAP REL COSTS-MVBLE EQUIP 00 EMPLOYEE BENEFITS DEPARTMENT 00 ADMINISTRATIVE & GENERAL	0 41, 857	0 48, 108	C 13, 201	0 103, 166	0	
7.00 0070 8.00 0080	00 OPERATION OF PLANT 00 LAUNDRY & LINEN SERVICE 00 HOUSEKEEPING	0	26, 415 0 1, 492	7, 248 C 409	33, 663 0	0 0 0	7.00 8.00
11.00 0110	00 DI ETARY 00 CAFETERIA 00 NURSI NG ADMINI STRATI ON	0 0 0	37, 310 0 1, 178	10, 238 C 323	0	0 0 0	
15.00 0150 16.00 0160	00 CENTRAL SERVICES & SUPPLY 00 PHARMACY 00 MEDICAL RECORDS & LI BRARY	000000000000000000000000000000000000000	8, 579 3, 828 1, 728	2, 354 1, 050 474	4, 878 2, 202	0 0 0	15.00 16.00
	00 SOCIAL SERVICE ATIENT ROUTINE SERVICE COST CENTERS	0	1, 492	409	1, 901	0	17.00
30.00 0300 31.00 0310	00 ADULTS & PEDIATRICS 00 INTENSIVE CARE UNIT 00 SKILLED NURSING FACILITY	000000000000000000000000000000000000000	311, 185 0 0	85, 389 C C	0	000000000000000000000000000000000000000	31.00
ANCI	ILLARY SERVICE COST CENTERS						
54.00 0540	00 OPERATI NG ROOM 00 RADI OLOGY-DI AGNOSTI C 00 LABORATORY	000000000000000000000000000000000000000	0 0 942	C C 259	0	0 0 0	50.00 54.00 60.00
66.00 0660 67.00 0670	00 RESPIRATORY THERAPY 00 PHYSICAL THERAPY 00 OCCUPATIONAL THERAPY	0	1, 816 31, 666 22, 410	498 8, 689 6, 149	40, 355 28, 559	0 0 0	67.00
71.00 0710 73.00 0730	00 SPEECH PATHOLOGY 00 MEDICAL SUPPLIES CHARGED TO PATIENTS 00 DRUGS CHARGED TO PATIENTS 00 DRUGS DIALYSIS		18, 199 0 0 0	4, 994 C C	0	0 0 0	73.00
	00 RENAL DIALYSES PATEENT SERVICE COST CENTERS	0	0	C	0	0	74.00
90.00 0900 91.00 0910	00 CLINIC 00 EMERGENCY	0	0	C		0	
95.00 0950 98.00 0985	ER REI MBURSABLE COST CENTERS 00 AMBULANCE SERVI CES 50 OTHER REI MBURSABLE COST CENTERS	0000				0	
118.00	CIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	41, 857	516, 348	141, 684	699, 889		118.00
192.00 1920 194.00 0795	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 00 PHYSICIANS' PRIVATE OFFICES 50 NONALLOWABLE CLINICAL LIAISON	000000000000000000000000000000000000000	0 2, 709	C 743	0 3, 452	0 0	190.00 192.00 194.00
194. 02 0795 194. 03 0795	51 IDLE SPACE 52 REGIONAL OFFICE 53 DISTRICT OFFICE 54 NON MCR CERTIFIED UNIT		000000000000000000000000000000000000000	0 0 0 0	0	0 0	194. 01 194. 02 194. 03 194. 04
194. 05 0795 194. 06 0795	54 NON MCR CERTIFIED UNIT 55 REG NURSG OFFICE 56 CONTACT CENTER 57 CENTRALIZED ADMISSIONS DEPT				0	0 0	194. 02 194. 05 194. 06 194. 07
194. 08 0795 194. 09 0795 194. 10 0796	59 OTHER NONREIMBURSABLE – OPEN 58 VISITOR MEALS 62 OTHER NONREIMBURSABLE COST CENTERS		0	C C C	0	0 0 0	194. 08 194. 09 194. 10
200. 00 201. 00	61 NONREIMB NEW BUSINESS IMPLEMENTATION Cross Foot Adjustments Negative Cost Centers	0	0	c	0 0 0	0	194. 11 200. 00 201. 00
202.00	TOTAL (sum lines 118 through 201)	41, 857	519, 057	142, 427	703, 341	0	202.00

Cost Center Description ADMINISTRATIVE OPERATION OF (LINEN STRAT) LAUNDRY & (LINEN STRAT) HOUSEKEEPING DETRATY 01:00 COST CENTERS 5:00 7:00 8:00 9:00 10:00 1:00 COST CENTERS 5:00 7:00 8:00 0:00 <t< th=""><th>ALLOC</th><th>ATION OF CAPITAL RELATED COSTS</th><th>-</th><th>Provider C</th><th></th><th>Period: From 09/18/2018 To 12/31/2018</th><th>Worksheet B Part II Date/Time Pre</th><th>narod:</th></t<>	ALLOC	ATION OF CAPITAL RELATED COSTS	-	Provider C		Period: From 09/18/2018 To 12/31/2018	Worksheet B Part II Date/Time Pre	narod:
Image: Service of the control of the provide of the service of the servic						10 12/31/2010		
EINERAL SERVICE COST CENTERS 5.00 7.00 8.00 9.00 10.00 00100 CAP REL COST-SELUG & FLXT 0 00200 CAP REL COST-SELUG & FLXT 0 00200 CAP REL COST-SELUG & FLXT 0.00 0020 CAP REL COST-SELUG & FLXT 0 0.00 0000 CAP REL COST-SELUG & FLXT 0 0 0 0.00 0020 CAP REL COST-SELUG & FLXT 0 0 0 0 0 0.00 0020 CAP REL COST-SELUG & FLXT 0 0 0 0 0 0.00 0020 CAPRETON OF PA ATHAL 0.710 012 0 0 0 0 10.00 01000 CAPRETON OF PA ATHAL 0.750 0100 122 0 1 0 11.00 01100 CAPRETAL SAMIN STRATION 5.450 107 0 12 0 1 11.00 01300 CAPRETAL SAMIN STRATION 5.454 743 282 0 0 0 1 1 0 0 0 1 0 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0		Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		
DENERAL SERVICE COST CENTERS 1.00 ODTOG CAP REL COSTS-ANDEA E LUT 2.00 DOZOD CAP REL COSTS-ANDEA E LUDI P 2.00 DOZOD CAP REL COSTS-ANDEA E LUDI P 3.00 DOZOD CAP REL COSTS-ANDEA E LUDI P 4.00 DOZOD CAP REL COSTS-ANDEA E LUDI P 5.00 DOZOD CAP REL COSTS-ANDEA E LUDI P 6.01 DOZAD CAP REL COSTS-ANDEA E LUDI P 6.01 DORADI DEPARTI WO REPLAYT 6.01 DORADI DEPARTI WO REPLAYT 6.01 DORADI DEPART 0.01100 CAFETENI A 8.4651 1.00 DITADO TARANANI STRATI N 1.00 DITADO TARANANI STRATION 1.00 DITADO TARANANI STRATION 1.00 DITADO TARANANI STRATION 1.00 DITADO TARANANI STRATIVE & SUPPLY 1.00 DITADO TARANANI STRATIVE & SUPPLY 1.00 DITADO TARANANI STRATIVE & COST CENTERS 1.00 DITADO TARANANI STRATIVE & COST CENTERS <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
1.00 ORTOO CAP FEL COSTS-FUDG & FLXT 2.00 ORZOO CAP FEL COSTS-FUDG & FLXT 2.00 ORZOO CAP FEL COSTS-FUDG & FLXT 2.00 ORZOO CAP FEL COSTS-FUDG & FLXT 3.00 ORZOO CAP FEL COSTS & FLXT 3.00 ORZOO CAP FEL COSTS 3.00 OTSOO PHARMACY 4.00 OTAGO CAPTA 3.00 OTSOO PHARMACY 4.00 OTAGO CAPTA 3.00 OT			5.00	7.00	8.00	9.00	10.00	
2.00 00200 CAP REL COSTS-MVBLE BOUI P 4.00 00400 CHUYCE EDERTEN TS DEPARTMENT 5.00 00500 OPERATION OF PLANT 6.00 00600 LAUNDRY & LINN SERVICE 0.00000 DIFLARY 0.00000 DIFLARY 10.00 10000 DIFLARY 10.00 10000 DIFLARY 10.00 10000 CAFTERIA AND INSTRATION 13.00 10000 CAFTERIA AND INSTRATION 13.00 10000 CAFTERIA AND INSTRATION 13.00 10000 CAFTERIA SERVICE 0.00000 CAFTERIA SERVICES & SUPPLY 5.466 107 0.00000 CAFTERIA SERVICES & SUPPLY 5.456 107 0.00000 OPERATION SERVICES & SUPPLY 5.456 107 0.00000 OPERATION SERVICE 0.00000 OPERATION SERVICE 0.0000000 OPERATION SERVICE 0.00000 OPERATION SERVICE 0.0000000 OPERATION SERVICE 0.0000000 OPERATION SERVICE 0.00000 OPERATION SERVICE 0.0000000 OPERATION SERVICE 0.00000000 OPERATION SERVICE 0.000000000 OPERATION SERVICE 0.000000000 OPERATION SERVICE 0.000000000 OPERATION SERVICE 0.000000000 OPERATION SERVICE 0.000000000000 OPERATION SERVICE 0.0000000000000 OPERATION SERVICE 0.00000000000000000000000000000000000			Т		1			
4.00 Oddo0_EMPLOYEE RENEFITS DEPARTMENT 0 0 0.00 00000_MMI STRATUR & GENERAL 103, 166 0, 394 7.00 00700_OPERATION OF PLANT 6, 731 40, 394 0.00 00000_MUSERKEPING 2, 504 136 0 4, 551 0.00 00000_HOJSERKEPING 2, 504 136 0 4, 551 11.00 01100_CAFETERIA 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1.00</td>								1.00
5.00 00500 ADMINISTRATIVE & GENERAL 103, 166 0 7.00 00700 DEPENTION OF PLANT 6, 731 40, 394 8.00 00800 LAUNDRY & LINEN SERVICE 0 0 0 9.00 00000 DEFARTION OF PLANT 6, 731 40, 394 0 10.00 10000 DEFARTION SERVICES & SUPPLY 544 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>2.00</td></t<>								2.00
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9.00 00000 HUSEKEEPING 2.504 136 0 4.541 10.00 01000 LETARY 8.461 3.390 0 382 59,781 1 11.00 01100 CAFETRIA 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			6, 731	40, 394		0		7.00
10.00 01000 DICAPTERAY 8, 401 3, 390 382 59, 781 11.00 01100 CAFTERIA ISK ADMINISTRATION 5, 456 107 0 12 0 1 13.00 01300 NURSING ADMINISTRATION 5, 456 107 0 12 0 1 14.00 01400 CENTRAL SERVICES & SUPPLY 5, 54 780 0 88 0 1 15.00 01500 FRADRIN ICES & SUPPLY 4, 297 348 0 15 0 1 10.00 01000 SCIAL SERVICE 96 136 0 15 0 1 11.00 01000 SCIAL SERVICE 96 0 </td <td></td> <td></td> <td>2 504</td> <td>124</td> <td></td> <td></td> <td></td> <td>8.00</td>			2 504	124				8.00
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INPATIENT ROUTINE SERVICE COST CENTERS Image Stress 0.00 02000 ADULTS & PEDIATRICS 45, 743 28, 276 0 3, 188 59, 781 3 0.00 030100 INTERSIVE CARE UNIT 0 <								1
30.00 03000 ADULTS & PEDIATRICS 45,743 28,276 0 3,188 59,781 31.00 03100 NTENSI VE CARE LUNT 0	17.00		70	130		15	0	17.00
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44.00 Odd200 SKILLED NURSING FACILITY O <								1
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50. 00 OSCOOL OPERATING ROOM O <td></td> <td></td> <td></td> <td><u> </u></td> <td></td> <td><u> </u></td> <td></td> <td></td>				<u> </u>		<u> </u>		
54.00 Color Option (Laboratory) Color option (Laboratory) <thcolor (laboratory)<="" optioptioption="" th=""> Color option (L</thcolor>	50.00		0	0		0 0	0	50.00
60:00 IABORATORY 350 66 0 10 0 6 60:00 IABORATORY 936 165 0 19 0 6 66:00 06500 PHYSI CAL THERAPY 6,626 2,877 0 325 0 6 67:00 0CCUPATI ONAL THERAPY 6,480 2,036 0 230 0 6 68:00 0600 SPECL PATHOLOCY 4,598 1,654 0 187 0 6 71:00 07300 PRUSO CARACED TO PATI ENTS 1,856 0	54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
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71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 1,855 0 0 0 0 7 73.00 DRUGS CHARGED TO PATIENTS 1,856 0	67.00	06700 OCCUPATI ONAL THERAPY	6, 480	2, 036		0 230	0	67.00
73.00 07300 DRUGS CHARGED TO PATIENTS 1,856 0	68.00	06800 SPEECH PATHOLOGY	4, 598	1, 654		0 187	0	68.00
74.00 OT400 RENAL DI ALYSI S 0 0 0 0 0 7 00.00 PODOC CLINI C 33 0 0 0 0 9 91.00 O9100 EMERGENCY 0 0 0 0 9 9 00 09500 AMBURSABLE COST CENTERS 0 0 0 0 9 9 9 0 0 0 0 0 9 9 9 0 0 0 0 0 9 9 0 0 0 0 0 0 9 9 0 09500 AMBURSABLE COST CENTERS 0 0 0 0 0 9 9 0 0 9 0 11 <td< td=""><td>71.00</td><td>07100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td><td>855</td><td>0</td><td></td><td>0 0</td><td>0</td><td>71.00</td></td<>	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	855	0		0 0	0	71.00
OUTPATI ENT SERVICE COST CENTERS Image: Cost of Centers Image: Cost o	73.00	07300 DRUGS CHARGED TO PATIENTS	1,856	0		0 0	0	73.00
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194.09 07958 VI SI TOR MEALS 0 0 0 19 194.10 07962 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 19 194.10 07962 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 19 194.11 07961 NONREI MB NEW BUSI NESS I MPLEMENTATI ON 0 0 0 0 19 200.00 Cross Foot Adjustments 0 0 0 0 20 201.00 Negative Cost Centers 0 0 0 0 0 20						-		194.07
194.10 07962 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 19 194.11 07961 NONREI MB NEW BUSI NESS I MPLEMENTATI ON 0 0 0 0 19 200.00 Cross Foot Adjustments 0 0 0 0 20 201.00 Negative Cost Centers 0 <								194.08
194.11 07961 NONREI MB_NEW_BUSINESS_IMPLEMENTATION 0 0 0 19 200.00 Cross_Foot_Adjustments 20 0 0 0 20 201.00 Negative Cost_Centers 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>194.09</td>								194.09
200.00 Cross Foot Adjustments 20 201.00 Negative Cost Centers 0								194.10
201.00 Negative Cost Centers 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>200.00</td>							0	200.00
			0	n –		0 0	n	200.00
202.00 TOTAL (sum lines 118 through 201) 103,166 40,394 0 4,541 59,781 20			103 166	40.394				

	Financial Systems Commu	nity Health Rel	Provi der CC		Period:	u of Form CMS- Worksheet B	2002-10
ALLUU	ATTON OF CAPITAL RELATED COSTS		Provider Co		From 09/18/2018	Part II	
				1	To 12/31/2018	Date/Time Pre 5/20/2019 12:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON			RECORDS &	
		11.00	10.00	SUPPLY	15.00	LIBRARY	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	16.00	
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
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	_					10.00
11.00		0	7 7 /				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	7,076	40.055	_		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	12, 355			14.00
15.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0	6, 030		4 (01	15.00
16.00 17.00	01700 SOCIAL SERVICE	0	-	364	-	4, 691 0	
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		+ <u> </u>	0	17.00
30.00	03000 ADULTS & PEDIATRICS	0	7, 076	151	0	2, 196	30.00
31.00	03100 I NTENSI VE CARE UNI T	0		(2, 1,0	
44.00	04400 SKI LLED NURSI NG FACI LI TY	0		(Ő	
	ANCI LLARY SERVICE COST CENTERS	-			-1 -1	-	
50.00	05000 OPERATI NG ROOM	0	0	(0 0	C	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0 0	C	54.00
60.00	06000 LABORATORY	0	0	(0 0	18	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	(0 0	54	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	2, 875	5 0	747	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	377	7 0	800	
68.00	06800 SPEECH PATHOLOGY	0	0	(573	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	2, 558		5	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(289	
74.00	07400 RENAL DIALYSIS	0	0	(0 0	0	74.00
00.00	OUTPATIENT SERVICE COST CENTERS		0			0	
90.00 91.00	09000 CLINIC 09100 EMERGENCY	0		(9	
91.00	OTHER REIMBURSABLE COST CENTERS	0	0	L(<u> </u>	0	91.00
95.00	09500 AMBULANCE SERVICES	0	0	(0	0	95.00
98.00		0		(C	
70.00	SPECIAL PURPOSE COST CENTERS				<u> </u>		, ,0.00
118.00		0	7,076	12, 355	5 15, 592	4, 691	118.00
	NONREI MBURSABLE COST CENTERS				· · · · ·		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	(0 0	C	192.00
	07950 NONALLOWABLE CLINICAL LIAISON	0	0	(0 0		194.00
	07951 I DLE SPACE	0	0	(0 0		194.01
	207952 REGIONAL OFFICE	0	0	(0 0		194. 02
	3 07953 DI STRI CT OFFI CE	0	0	(0 0		194.03
194.04	4 07954 NON MCR CERTIFIED UNIT	0	0	(0		194.04
	07955 REG NURSG OFFICE	0	0	(194.05
	07956 CONTACT CENTER 707957 CENTRALIZED ADMISSIONS DEPT	0	0	() 194.06) 194.07
	307959 OTHER NONREIMBURSABLE - OPEN		0				194.07
	07959 VISITOR MEALS						194.08
	07958 VISITOR MEALS						194.09
	107962 OTHER NORREIMBORSABLE COST CENTERS			r () 194. 10
200.00			0			0	200.00
200.00		0	0	r		0	200.00
202.00		0		12, 355	5 15, 592		202.00
			., 570	,		., 571	,00

LLOCA	Financial Systems Commu TION OF CAPITAL RELATED COSTS	unity Health Reha			Peri od:	u of Form CMS-2552 Worksheet B
					From 09/18/2018 To 12/31/2018	Part II
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Total t	
	T	17.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS	1 1		1		
. 00	00100 CAP REL COSTS-BLDG & FIXT					1.
. 00	00200 CAP REL COSTS-MVBLE EQUIP					2.
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.
. 00	00500 ADMI NI STRATI VE & GENERAL					5.
. 00	00700 OPERATION OF PLANT					7.
. 00	00800 LAUNDRY & LINEN SERVICE					8.
. 00	00900 HOUSEKEEPI NG					9.
0.00	01000 DI ETARY					10.
1.00						11.
3.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY					13.
4.00 5.00	01500 PHARMACY					14.
5.00 6.00	01600 MEDICAL RECORDS & LIBRARY					15.
7.00	01700 SOCIAL SERVICE	2, 512				17.
7.00	INPATIENT ROUTINE SERVICE COST CENTERS	2, 512				17.
0.00	03000 ADULTS & PEDIATRICS	2, 512	545, 497	7	0 545, 497	30.
1.00	03100 I NTENSI VE CARE UNI T	2, 512	545, 477		0 0	31.
4.00	04400 SKILLED NURSING FACILITY	0	(0 0	44.
4.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>		7	0 0	
0.00	05000 OPERATI NG ROOM	0	(b	0 0	50.
4.00	05400 RADI OLOGY-DI AGNOSTI C	0	(0 0	54.
0.00	06000 LABORATORY	0	1, 665		0 1,665	60.
5.00	06500 RESPI RATORY THERAPY	0	3, 488		0 3, 488	65.
6.00	06600 PHYSI CAL THERAPY	0	53, 805		0 53, 805	66.
7.00	06700 OCCUPATI ONAL THERAPY	0	38, 482		0 38, 482	67.
8.00	06800 SPEECH PATHOLOGY	0	30, 205		0 30, 205	68.
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 418	3	0 3, 418	71.
3.00	07300 DRUGS CHARGED TO PATIENTS	0	17, 737	7	0 17,737	73.
4.00	07400 RENAL DI ALYSI S	0	(0 0	74.
	OUTPATIENT SERVICE COST CENTERS			1		
0.00	09000 CLI NI C	0	42		0 42	90.
1.00	09100 EMERGENCY	0	(0 0	91.
	OTHER REIMBURSABLE COST CENTERS					
5.00	09500 AMBULANCE SERVICES	0	(0 0	95.
8.00	09850 OTHER REIMBURSABLE COST CENTERS	0	(<u>ן</u>	0 0	98.
18.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	2, 512	694, 339		0 694, 339	118.
10.00	NONREIMBURSABLE COST CENTERS	2, 512	094, 335	/	0 094, 339	
00 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	(0 0	190.
	19000 BIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	(190.
	07950 NONALLOWABLE CLINICAL LIAISON	0	9, 002	1	0 9,002	192.
	07951 I DLE SPACE	0	7,002		0 9,002	194.
	07951 TELE SPACE		ſ	5		194.
	07953 DI STRI CT OFFI CE	0	(0 0	194.
	07954 NON MCR CERTIFIED UNIT		ſ	ő	0 0	194.
	07955 REG NURSG OFFICE		(0 0	194.
	07956 CONTACT CENTER	0	(0 0	194.
	07957 CENTRALIZED ADMISSIONS DEPT	0	(0 0	194.
	07959 OTHER NONREI MBURSABLE - OPEN	0	(0 0	194.
	07958 VI SI TOR MEALS	0	(0 0	194.
	07962 OTHER NONREIMBURSABLE COST CENTERS	0	(0 0	194.
	07961 NONREI MB NEW BUSI NESS I MPLEMENTATI ON	0	(0 0	194.
00.00			(0 0	200.
01.00		0	(0 0	201.
01. UC						

Community Health Rehab Hospital South

In Lieu of Form CMS-2552-10

				F	rom 09/18/2018 o 12/31/2018		
		CAPI TAL REL	ATED COSTS			5/20/2019 12:	<u>19 p</u>
	Cost Center Description	BLDG & FIXT (SQUARE FEET #1)	MVBLE EQUIP (SQUARE FEET #2)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	52, 879					1 1.
00 00	00200 CAP REL COSTS-BEDG & FIXT	52,079	52, 879				2.
00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	02,077	1, 315, 021			4.
00	00500 ADMI NI STRATI VE & GENERAL	4, 901	4, 901	245, 324	-889, 740	2, 036, 461	5
00	00700 OPERATION OF PLANT	2, 691	2, 691	21, 170		132, 859	
)0)0	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0 152	0 152	0 33, 841	0	0 49, 420	
	01000 DI ETARY	3, 801	3, 801	95, 108	0	167, 016	
	01100 CAFETERI A	0	0	0	0	0	
	01300 NURSING ADMINISTRATION	120	120	99, 762	0	107, 709	
	01400 CENTRAL SERVICES & SUPPLY	874	874	0	0	10, 933	
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	390 176	390 176	55, 370		84, 822 45, 686	
	01700 SOCIAL SERVICE	178	170	42, 369 0		43, 888	
00	INPATIENT ROUTINE SERVICE COST CENTERS	102	102	0		1, 701	1 ''
	03000 ADULTS & PEDIATRICS	31, 702	31, 702	381, 088	0	902, 930	30
	03100 I NTENSI VE CARE UNI T	0	0	0		0	
00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	44
00	05000 OPERATING ROOM	0	0	0	0	0	50
	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	-	0	
00	06000 LABORATORY	96	96	0	0	6, 910	60
	06500 RESPI RATORY THERAPY	185	185	15, 809		18, 479	
	06600 PHYSI CAL THERAPY	3, 226	3, 226	82, 930		130, 797	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	2, 283 1, 854	2, 283 1, 854	95, 233 62, 058		127, 922 90, 766	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	02,000	0	16, 879	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	36, 641	
00	07400 RENAL DI ALYSI S	0	0	0	0	0	74
00	OUTPATI ENT SERVICE COST CENTERS	0		0	0	647	90
	09100 EMERGENCY	0		0		047	
00	OTHER REIMBURSABLE COST CENTERS		<u> </u>				
	09500 AMBULANCE SERVI CES	0	0	0		0	
00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98
3. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	52, 603	52, 603	1, 230, 062	-889, 740	1, 932, 317	1110
3. 00	NONREIMBURSABLE COST CENTERS	52,003	52,003	1, 230, 002	-007, 740	1, 732, 317	
0. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192
	07950 NONALLOWABLE CLINICAL LIAISON 07951 IDLE SPACE	276 0	276	84, 959	0	104, 144	194
	07951 TDLE SPACE 07952 REGIONAL OFFICE	0	0	0	0		194
	07953 DI STRI CT OFFI CE	0	0	0	0		194
1.04	07954 NON MCR CERTIFIED UNIT	0	0	0	0		194
	07955 REG NURSG OFFICE	0	0	0	0		194
	07956 CONTACT CENTER 07957 CENTRALIZED ADMISSIONS DEPT	0	0	0	0		194 194
	07959 OTHER NONREIMBURSABLE - OPEN	0	0	0	0		194
	07958 VISITOR MEALS	0	0	0	0		194
I. 10	07962 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194
0. 00	Cross Foot Adjustments Negative Cost Centers						200 201
. 00 2. 00	Cost to be allocated (per Wkst. B, Part I)	519, 057	142, 427	231, 432		889, 740	
8. 00 9. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	9. 815938	2. 693451	0. 175991 0		0. 436905 103, 166	
5. 00	Part II) Unit cost multiplier (Wkst. B, Part II)			0.000000		0. 050659	205
	NAHE adjustment amount to be allocated						206
5.00	(per Wkst. B-2)		I				

		cial Systems Commu FION - STATISTICAL BASIS	nity Health Rel	Provider CO	CN: 15-3044 P F	eriod: rom 09/18/2018 o 12/31/2018	u of Form CMS- Worksheet B-1 Date/Time Pre 5/20/2019 12:	epare
		Cost Center Description	OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPI NG (SQUARE FEET #4)	DI ETARY (MEALS SERVED)	CAFETERI A (CAFETERI A FTES)	
			7.00	8.00	9.00	10.00	11.00	
00 00	00100	AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1
00 00 00 00 00 00 00 0.00 1.00	00400 00500 00700 00800 00900 01000	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA	45, 287 0 152 3, 801 0	1, 322 0 0 0	45, 135 3, 801 0	100	42	4 5 7 8 9
3.00	1	NURSI NG ADMI NI STRATI ON	120	0	120	-	5	
4.00		CENTRAL SERVICES & SUPPLY	874	0	874		0	
5.00		PHARMACY	390		390		2	
5.00 7.00		MEDICAL RECORDS & LIBRARY	176		176		2	16
1.00		SOCIAL SERVICE	152	0	102	0	4	17
	03000	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	31, 702 0		31, 702 0		19 0	
1.00		SKILLED NURSING FACILITY	0	0	0	0	0	44
0. 00		LARY SERVICE COST CENTERS	0	0	0	0	0	50
. 00		RADI OLOGY-DI AGNOSTI C	0		0		0	
. 00		LABORATORY	96		96	-	0	
. 00		RESPI RATORY THERAPY	185	0	185	0	1	
. 00	06600	PHYSI CAL THERAPY	3, 226	0	3, 226	0	3	66
. 00	06700	OCCUPATIONAL THERAPY	2, 283	0	2, 283	0	4	67
. 00		SPEECH PATHOLOGY	1, 854	0	1, 854	0	2	68
		MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		0	
		DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
. 00		RENAL DIALYSIS TIENT SERVICE COST CENTERS	0	0	0	0	0	74
. 00			0	0	0	0	0	90
. 00		EMERGENCY	0		0		0	
		REIMBURSABLE COST CENTERS						
		AMBULANCE SERVICES	0					
. 00		OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98
		AL PURPOSE COST CENTERS	45.014	4 000	44.050	100	10	1110
3. OC	-	SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	45, 011	1, 322	44, 859	100	42	118
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190
		PHYSICIANS' PRIVATE OFFICES	0		0	-		192
4. OC	07950	NONALLOWABLE CLINICAL LIAISON	276	0	276	0		194
4.01	07951	I DLE SPACE	0	0	0	0	0	194
		REGIONAL OFFICE	0	0	0	0		194
		DI STRI CT OFFI CE	0	0	0	0		194
		NON MCR CERTIFIED UNIT	0	0	0	-		194
		REG NURSG OFFICE CONTACT CENTER	0	0	0	0		194 194
		CENTRALIZED ADMISSIONS DEPT	0	0		0		194
		OTHER NONREIMBURSABLE - OPEN	0			0		194
		VISITOR MEALS	0	0	0	0		194
	1	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194
		NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194
D. OC		Cross Foot Adjustments						200
1.00 2.00		Negative Cost Centers Cost to be allocated (per Wkst. B, Doct L)	190, 906	0	71, 653	262, 043	0	201 202
3.00 4.00		Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	4. 215470 40, 394		1. 587526 4, 541	2, 620. 430000 59, 781	0. 000000 0	203 204
5. OC	þ	Part II) Unit cost multiplier (Wkst. B, Part II)	0. 891956	0. 000000	0. 100609	597. 810000	0. 000000	205
6. OC	D	NAHE adjustment amount to be allocated						206
	1	(per Wkst. B-2)						
7. OC		NAHE unit cost multiplier (Wkst. D,						207

Cost Center Description NURSING DUM INSTRATION (NURSING FTES) CENTRAL SUPPLY (COSTED REQUIS.) PHARAVER (COSTED RECORDS a LIBRARY (COSTED RECORDS A LIBRA	/Time Prepar /2019 12:19	Worksheet B	Worksheet B	l W		:N:15-3044 ∣P	Drovider ((
Cost Center Description NURSING ADMINISTRATION (NRSING FTES) CENTRAL SERVICES & SUPPLY (COSTED) PHARMACY RECORDS & (CATI (CATI (CATI) ISENERAL SERVICE COST CENTERS 13.00 14.00 15.00 16.00 1 ISENERAL SERVICE COST CENTERS 13.00 14.00 15.00 16.00 1 100 00200 (CAP REL COSTS-INDER E FUXT 2.00 00200 (CAP REL COSTS-INTRET E GUILP 2.00 1 0 1 0 1 0 1 0 0 1 0 0 0 0 0 1 0 0 0 0 0 1 0<	/2019 12:19			3		F			LOCATION - STATISTICAL BASIS				
ADMI IN STRATI ON SUPPLY SERVICES & SUPPLY COSTED (COSTED RECURDS.) RECORDS S (FOULS.) (CPATH (GROSS 1.00 CENERAL SERVICE COST CENTERS 13.00 14.00 15.00 16.00 1 1.00 COSTED (COSTED RECURDS.) RECORDS S (COSTED RECURDS.) 15.00 16.00 1 1.00 COSDE CAP RECCOSTS BLOG E TIT (COSTED RECORDS VERSION CONTRACTOR SERVICE SCORD CAP RECORDS PLANT SCORD CAP RECORDS PLANT SCORD CAP RECORDS PLANT SCORD CAP RECORDS PLANT SCORD CAP RECORDS SERVICE SCORD CAP RECORDS SERVICE SCORD SERVICE SCORD SCORD		Date/Time Pi 5/20/2019 12			To 12/31/2018	Т							
ENDERING FTES SUPPLY (CONST) RÉQUIS.) EQUIS.) CONSTO (FRVENUE) CATIL (GROSS) 0 00100 (CAP REL COST CENTERS 13.00 15.00 16.00 1 1.00 00100 (CAP REL COSTS-MUBLE EQUIP (GROSS) 14.00 15.00 16.00 1 0.00 00200 (CAP REL COSTS-MUBLE EQUIP (GROSS) 14.00 15.00 16.00 1 0.00 00200 (CAP REL COSTS-MUBLE EQUIP (GROSS) 16.00 1 <	SERVICE	SOCIAL SERVIO	SOCIAL SERVI	S0					Cost Center Description				
ENERGI SERVICE COST CENTERS 13.00 14.00 15.00 16.00 1 10 000100 CAP REL COSTS-MUDE & FIXT	ENT DAYS)	(PATIENT DAYS	(PATIENT DAY	(P.									
CENERAL SERVICE COST CENTERS 13.00 14.00 15.00 16.00 1 00100 CAP REL COSTS-BLOG & FLXT 0								(NURSING FTES)					
1. 00 00100 CAP REL COSTS -BUDG & FLXT 2. 00 00200 CAP REL COSTS -WELE COULP 4. 00 00400 EMPLOYEE BENEFLTS DEPARTMENT 5. 00 00500 OPERATION OF PLANT 8. 00 00000 ODERATION OF PLANT 8. 00 00000 ODERATION OF PLANT 10. 00 1000 CAPETERIA 11. 00 01100 CAPETERIA 13. 00 01100 CAPETERIA 14. 00 01400 CENTRAL SERVICE A SUPPLY 0 14. 00 01400 CENTRAL SERVICE COST CENTERS 19 00 10. 00 10. 00	7.00	17.00	17.00		· · · ·	15.00		13.00					
2.00 00200 CAP. REL COSTS-MUBLE EQUIP 4.00 00400 DENLOYE BENET IS DEPARTIMENT 5.00 00500 ADM INI STRATI VE & GENERAL 7.00 00700 DOPERATI, ON OF PLANT 8.00 00500 HUBING PLANT 1.00 01100 DIE TARY 1.00 01100 DIE TARY 1.00 01100 CENTRAL SERVI CES SUPPLY 0 1.20 01400 CENTRAL SERVI CES SUPPLY 0 2, 317 43, 964 1.00 0100 DIE DIAL SERVI CES SUPPLY 0 2, 317 43, 964 1.00 0100 DIE DIAL SERVI CES SUPPLY 0 120 3001AL SERVI CES SUPPLY 0 120 3001AL SERVI CES SUPPLY 0 120 3001AL SERVI CES SUPPLY 0 120 3001A DIE ICAL SERVI CES COST CENTERS 0 00 0000 PENATING ROUTE 1.00 0100 DIE ICAL SERVI CES COST CENTERS 5.0 00 55000 PENATING ROUTE 5.0 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1	1								
5. 00 000500 ADMINI STRATI VE & GENERAL.													
7. 00 00720 OPERATION OF PLANT									00400 EMPLOYEE BENEFITS DEPARTMENT				
B. 00 000800 LANDRY & LINEN SERVICE	-												
10.00 01000 DITARY Image: Constraint of the c	8												
11.00 01100 CAPTERIA Image: Control of Contro													
13.00 01300 NURSING ADMINISTRATION 19 14.00 01400 CNTARL 0 15.00 01500 PHARMACY 0 2, 317 16.00 01600 REDICAL RECORDS & LIBRARY 0 0 00 000 SOCI ALL SERVICE 0 140 0 0 IMPATIENT ROUTINE SERVICE COST CENTERS 9 5.8 0 2, 293, 128 31.00 03000 ANCIO LLAR PEDIATRICS 19 5.8 0 2, 293, 128 31.00 03000 INTESSIVE CARE UNIT 0 0 0 0 0 44.00 04000 SKILLED NUBSING FACILLTY 0 0 0 0 0 50.00 055000 OPERATING ROOM 0 <td< td=""><td>1(</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>	1(
15.00 01500 PHARMACY 0 2, 317 43, 964 16.00 01600 MEDI CAL, RECORDS & LIBRARY 0 0 0 4, 899, 257 17.00 001700 SOCI AL SERVI CE 0 140 0 0 0 IMPATI ENT ROUTI NE SERVI CE COST CENTERS 0 0 0 0 0 0 13.00 03100 NTENSI VE CABE UNI T 0 0 0 0 0 0 44.00 04400 SKI LLED NURSING FACILI TY 0 0 0 0 0 0 0 55.00 065000 (PERATING ROM 0	1:							19					
16.00 01600 MEDICAL RECORDS & LI BRARY 0 0 0 0 0 17.00 01700 SOCIAL SERVICE 0 140 0 0 0 17.00 03000 SOCIAL SERVICE 0STOCIAL SERVICE 0 140 0 0 0 30.00 03000 ADULTS & PEDIATRICS 19 58 0 2,293,128 31.00 03100 ILERY SERVICE COST CENTERS 0 0 0 0 50.00 OSDOO OPERATING ROOM 0 0 0 0 0 0 64.00 05400 RAID LOGY CE COST CENTERS 0 0 0 0 0 0 50.00 OSDOO DERATING ROOM 0	14								01400 CENTRAL SERVICES & SUPPLY				
17.00 0 0 140 0 0 1NPAT LENT ROUTINE SERVICE COST CENTERS	1!							0					
INPATI ENT ROUTINE SERVICE COST CENTERS Image: Cost Centers 30.00 03000 AULTS & PEDIATRICS 19 58 0 2,293,128 31.00 03100 INTENSIVE CARE UNIT 0 0 0 0 44.00 04400 SKI LED NURSING FACILITY 0 0 0 0 ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 50.00 05000 (PENTI NG ROOM 0 0 0 0 0 64.00 06000 (LABORATORY 0 0 0 0 0 0 0 0 65.00 06000 PHYSICAL THERAPY 0 1,105 0 780,410 67.00 06000 SPECEL PATHOLOCY 0 0 145 0 836,183 68.00 06000 SPECE ATARGED TO PATI ENTS 0 983 0 5,410 73.00 07300 REVACE MARGED TO PATI ENTS 0 0 0 0 0 74.00 07400 RENAL DI ALYSIS 0 0 0 0	1, 322 1	1. 32	1.3				-	-					
31.00 O3100 INTENSI VE CARE UNIT 0 0 0 0 ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 50.00 OSCOOL OPERATI NG ROOM 0 0 0 0 0 64.00 GAOOR PADI OLOCY-DI AGNOSTI C 0 0 0 0 0 0 65.00 OBCOOL ABORATORY 0 0 0 0 56, 054 66.00 OBCOOL PHYSICAL THERAPY 0 1,105 0 780, 410 67.00 OSTOOL OCUPATI ONAL THERAPY 0 1,415 0 836, 183 68.00 OBGOOR SPECH PATHOLOCY 0 0 598, 546 71.00 70100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 546 71.00 OTAOO RENAL DI ALYSIS 0	11022	., 0.	.,,,	-1									
44.00 04400 SkillED NURSING FACILITY 0 0 0 ANCILLARY SERVICE COST CENTERS 0	1, 322 30	1, 32	1, 3										
ANCILLARY SERVICE COST CENTERS 0 50.00 05000 DEPRATI NG ROOM 0 0 0 0 50.00 05000 PERATI NG ROOM 0	0 3												
54.00 05400 ABD IOLOGY-DIAGNOSTI C 0 0 0 0 60.00 06000 LABORATORY 0 0 0 18,916 65.00 06500 RESPIRATORY THERAPY 0 1,105 0 780,410 66.00 06600 PHYSI CAL THERAPY 0 1,105 0 780,410 67.00 06700 OCCUPATI ONAL THERAPY 0 1,105 0 780,410 67.00 066800 SPEECH PATHOLOGY 0 145 0 836,183 68.01 06800 SPEECH PATHOLOGY 0 0 0 58,546 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 983 0 5,410 73.00 07300 RUGS CHARGED TO PATI ENTS 0 0 0 0 0 00.00 09000 CLINIC 0 0 0 0 0 0 01.00 09100 EMERGENCY 0 0 0 0 0 0 02.01				<u> </u>		0							
60.00 06000 LABORATORY 0 0 0 18,916 65.00 06500 RESPI RATORY THERAPY 0 0 0 56,054 66.00 06600 PHYSI CAL THERAPY 0 1,105 0 780,410 67.00 06600 PHYSI CAL THERAPY 0 145 0 836,183 68.00 06800 SPECH PATHOLOGY 0 0 0 586,183 68.00 07300 DRUGS CHARGED TO PATIENTS 0 983 0 5,410 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 01.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 01.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 01.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 091000 EMERGENCY 0 0 0 0 0 0 09500	0 50				-	-		0					
65:00 06500 RESPIRATORY THERAPY 0 0 0 56,054 66:00 06600 PHYSI CAL THERAPY 0 1,105 0 780,410 67:00 0COTOD 0CUPTIONAL THERAPY 0 145 0 836,183 68:00 06800 SPEECH PATHOLOGY 0 0 0 598,546 71:00 DOTOO PATHORNOR 0 0 0 5410 73:00 OT300 RUGS CHARGED TO PATIENTS 0 0 43,964 301,667 74:00 O7400 RENAL DI ALYSI S 0 0 0 0 0 00:00 OPIONO ELINES 0 0 0 0 0 0 0 00:00 00000 CLINI RC CENTERS 0	0 54			1	, v	0	0	0					
66.00 06600 PHYSI CAL THERAPY 0 1, 105 0 780, 410 67.00 0CCUPATI ONAL THERAPY 0 145 0 836, 183 68.00 0SECEN PATHOLOGY 0 0 0 598, 546 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 983 0 5, 410 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 43, 964 301, 667 74.00 07400 RENAL DI ALYSIS 0 0 0 0 00 07000 CLINIC 0 0 0 0 0 00 09000 CLINIC 0 0 0 0 0 0100 EMERGENCY 0 0 0 0 0 0 09500 AMBULANCE SERVICES 0 0 0 0 0 0 98.00 09850 OTHER REI MBURSABLE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 19 4,	0 6					0	0	0					
68.00 06800 SPEECH PATHOLOGY 0 0 0 598, 546 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 983 0 5, 410 73.00 07400 RENAL DI ALYSIS 0 0 43, 964 301, 667 74.00 07400 RENAL DI ALYSIS 0 0 0 0 0 0000 CLINIC 0 0 0 0 0 0 0 90.00 09000 CLINIC 0 </td <td>0 60</td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>1, 105</td> <td>0</td> <td>06600 PHYSI CAL THERAPY</td>	0 60					0	1, 105	0	06600 PHYSI CAL THERAPY				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 983 0 5,410 73.00 07300 DRUGS CHARGED TO PATIENTS 0 <td>0 6</td> <td></td> <td></td> <td></td> <td>000, 100</td> <td>0</td> <td></td> <td>0</td> <td></td>	0 6				000, 100	0		0					
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 43,964 301,667 74.00 O7400 RENAL DIALYSIS 0	0 68					0		0					
OUTPATI ENT SERVICE COST CENTERS O O O State State </td <td>0 7:</td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td></td> <td>0</td> <td></td>	0 7:					0		0					
90.00 09000 CLINIC 0 0 0 8,943 91.00 EMERGENCY 0 <td< td=""><td>0 74</td><td></td><td></td><td></td><td>0 0</td><td>0</td><td>0</td><td>0</td><td></td></td<>	0 74				0 0	0	0	0					
91.00 O9100 EMERGENCY O O O 07HER REI MBURSABLE COST CENTERS 0	0 90			3	8 943	0	0	0					
95.00 09500 AMBULANCE SERVICES 0 0 0 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 19 4,748 43,964 4,899,257 NONREI MBURSABLE COST CENTERS VONREI MBURSABLE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 19 4,748 43,964 4,899,257 NONREI MBURSABLE COST CENTERS VENTOTALS (SUM OF LINES 1 through 117) 19 4,748 43,964 4,899,257 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 10 07951 IDLE SPACE 0 0 0 0 194.02 07952 REGI ONAL OFFICE 0 0 0 0 <td <="" colspan="4" td=""><td>0 9</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td>	<td>0 9</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>				0 9								
98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 19 4,748 43,964 4,899,257 NONRE IMBURSABLE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 19 4,748 43,964 4,899,257 NONRE IMBURSABLE COST CENTERS 190.00 19200 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192.00 07950 NONALLOWABLE CLINI CAL LI AI SON 0 0 0 0 0 10 07951 I DE SPACE 0 0 0 0 0 194.02 07952 REGI ONAL OFFICE 0 0 0 0 0 194.04 07954 NON MCR CERTI FI ED UNI T 0 0 0				_									
SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 19 4,748 43,964 4,899,257 NONREI MBURSABLE COST CENTERS 190.00 190.00 197.00 0 0 0 190.00 190.00 190.00 190.00 190.00 190.00 190.00 0 0 0 0 0 192.00 192.00 192.00 192.00 192.00 0 0 0 0 0 192.00 192.00 192.00 192.00 0 0 0 0 0 0 0 0 0 0 0 0													

Health Financial Systems Commu	nity Health Reh	ab Hospital Sc	outh	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 09/18/2018 To 12/31/2018	5/20/2019 12:	
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description		Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)			1.00		
	1.00	2.00	3.00	4.00	5.00	
30.00 O3000 ADULTS & PEDIATRICS	1, 934, 582		1, 934, 58		1 024 502	30.00
31. 00 03100 INTENSIVE CARE UNIT	1, 934, 582		1, 934, 56	0 0	1, 934, 582	30.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0			0 0	0	44.00
ANCI LLARY SERVICE COST CENTERS	0			0 0	0	44.00
50. 00 05000 OPERATI NG ROOM	0			0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 0	0	54.00
60, 00 06000 LABORATORY	10, 743		10, 74	3 0	10, 743	60.00
65. 00 06500 RESPIRATORY THERAPY	28, 390	0	28, 39		28, 390	65.00
66. 00 06600 PHYSI CAL THERAPY	222, 119	0	222, 11		222, 119	66.00
67.00 06700 OCCUPATIONAL THERAPY	209,074	0	209, 07		209, 074	67.00
68.00 06800 SPEECH PATHOLOGY	149, 325	0	149, 32		149, 325	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	28,630		28, 63	0 0	28, 630	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	191,040		191, 04	0 0	191, 040	73.00
74.00 07400 RENAL DI ALYSI S	0			0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS	· · ·					1
90. 00 09000 CLI NI C	1, 052		1, 05	0	1, 052	90.00
91. 00 09100 EMERGENCY	0			0 0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0			0 0	0	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	98.00
200.00 Subtotal (see instructions)	2, 774, 955	0	2, 774, 95	5 0	2, 774, 955	
201.00 Less Observation Beds	0			0		201.00
202.00 Total (see instructions)	2, 774, 955	0	2, 774, 95	0	2, 774, 955	202.00

Health Financial Systems Commu	nity Health Reh	ab Hospital So	outh	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Peri od:	Worksheet C	
				From 09/18/2018		
				To 12/31/2018	Date/Time Pre 5/20/2019 12:	
·		Title	XVIII	Hospi tal	PPS	17 pm
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
			+ col. 7)	Rati o	I npati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 293, 128		2, 293, 12	8		30.00
31.00 03100 INTENSIVE CARE UNIT	0			0		31.00
44.00 04400 SKILLED NURSING FACILITY	0			0		44.00
ANCI LLARY SERVI CE COST CENTERS	,		1			-
50. 00 05000 OPERATI NG ROOM	0	0		0 0. 000000		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0. 000000		
60. 00 06000 LABORATORY	18, 916	0	18, 91			
65. 00 06500 RESPI RATORY THERAPY	56, 054	0	56, 05		0.00000	
66.00 06600 PHYSI CAL THERAPY	780, 410	0	780, 41			
67.00 06700 OCCUPATI ONAL THERAPY	836, 183	0	836, 18			
68.00 06800 SPEECH PATHOLOGY	598, 546	0	598, 54			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 410	0	5, 41			
73.00 07300 DRUGS CHARGED TO PATIENTS	301, 667	0	301, 66		0.00000	
74.00 07400 RENAL DIALYSIS	0	0		0 0.000000	0.00000	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	8, 943	0				
91. 00 09100 EMERGENCY	0	0		0 0.000000	0.00000	91.00
OTHER REI MBURSABLE COST CENTERS			1			1 05 00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0.00000		
98.00 09850 OTHER REI MBURSABLE COST CENTERS	0	0	1 000 07	0 0.000000	0. 000000	
200.00 Subtotal (see instructions)	4, 899, 257	0	4, 899, 25	/		200.00
201.00 Less Observation Beds	4 000 055	-	1 000 07	-		201.00
202.00 Total (see instructions)	4, 899, 257	0	4, 899, 25	/		202.00

	nunity Health Reha			u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3044	Period: From 09/18/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre	parad
			10 12/31/2016	5/20/2019 12:	19 pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient	· ·			
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
44. 00 04400 SKI LLED NURSING FACILITY					44.00
ANCI LLARY SERVI CE COST CENTERS					_
50. 00 05000 OPERATI NG ROOM	0. 000000				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.00000				54.00
60. 00 06000 LABORATORY	0. 567932				60.00
65.00 06500 RESPI RATORY THERAPY	0. 506476				65.00
66.00 06600 PHYSI CAL THERAPY	0. 284618				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 250034				67.00
68.00 06800 SPEECH PATHOLOGY	0. 249480				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5. 292052				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 633281				73.00
74.00 07400 RENAL DI ALYSI S	0.000000				74.00
OUTPATIENT SERVICE COST CENTERS					1
90. 00 09000 CLINIC	0. 117634				90.00
91.00 09100 EMERGENCY	0. 000000				91.00
OTHER REI MBURSABLE COST CENTERS	0.000000				
95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000				98.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems Comm	unity Health Reh	ab_Hospital_Sc	outh	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 09/18/2018 To 12/31/2018	5/20/2019 12:	pared: 19 pm
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description		Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 1 001 500		1 001 5		1 001 500	
30. 00 03000 ADULTS & PEDI ATRI CS	1, 934, 582		1, 934, 58		1, 934, 582	
31. 00 03100 I NTENSI VE CARE UNI T	0			0 0	0	
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0			0 0	0	44.00
ANCI LLARY SERVI CE COST CENTERS			[0	50.00
50. 00 05000 OPERATING ROOM	0			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		10 7	0 0	0	
	10, 743		10, 74		10, 743	•
65. 00 06500 RESPI RATORY THERAPY	28, 390	0	28, 39		28, 390	•
66. 00 06600 PHYSI CAL THERAPY	222, 119	0	222, 1		222, 119	•
67.00 06700 OCCUPATIONAL THERAPY	209,074	0	209, 07		209, 074	•
68. 00 06800 SPEECH PATHOLOGY	149, 325	0	149, 32		149, 325	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	28, 630		28, 63		28, 630	•
73. 00 07300 DRUGS CHARGED TO PATIENTS	191, 040		191, 04		191, 040	•
74. 00 07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	0			0 0	0	74.00
90. 00 09000 CLINIC	1,052		1, 05	·	1, 052	90.00
91. 00 09100 EMERGENCY	1,052		1, 00	52 0 0 0	1,052	•
OTHER REIMBURSABLE COST CENTERS	U			0 0	0	91.00
95. 00 09500 AMBULANCE SERVICES	0			0 0	0	95.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	
200.00 Subtotal (see instructions)	2, 774, 955	0	2, 774, 95	5 0	2, 774, 955	
201.00 Less Observation Beds	2, 114, 955	0	2, 114, 93	0		200.00
202.00 Total (see instructions)	2, 774, 955	0	2, 774, 95	U	2, 774, 955	
	2,114,900	0	2,114,90	0	2, 114, 900	202.00

Health Financial Systems	Community Health Reha	ab Hospital So	outh	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 09/18/2018 To 12/31/2018		pared:
		T; +1	e XIX	Hospi tal	5/20/2019 12: Cost	19 pm
		Charges	e XIX	HOSPITAL	COST	
Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 293, 128		2, 293, 12	8		30.00
31.00 03100 INTENSIVE CARE UNIT	0			0		31.00
44.00 04400 SKILLED NURSING FACILITY	0			0		44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 0. 000000	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0. 000000	0. 000000	
60. 00 06000 LABORATORY	18, 916	0	18, 91		0. 000000	
65. 00 06500 RESPI RATORY THERAPY	56, 054	0	56, 05		0. 000000	
66. 00 06600 PHYSI CAL THERAPY	780, 410	0	780, 41		0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	836, 183	0	836, 18		0. 000000	
68.00 06800 SPEECH PATHOLOGY	598, 546	0	598, 54	6 0. 249480	0.00000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	NTS 5, 410	0	5, 41	0 5. 292052	0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	301, 667	0	301, 66		0. 000000	
74.00 07400 RENAL DIALYSIS	0	0		0 0. 000000	0. 000000	74.00
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	8, 943	0	8, 94		0. 000000	•
91.00 09100 EMERGENCY	0	0		0 0. 000000	0. 000000	91.00
OTHER REIMBURSABLE COST CENTERS			1			
95. 00 09500 AMBULANCE SERVICES	0	0		0 0. 000000	0. 000000	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0. 000000	0. 000000	•
200.00 Subtotal (see instructions)	4, 899, 257	0	4, 899, 25	7		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	4, 899, 257	0	4, 899, 25	7		202.00

Health Financial Systems Comm	unity Health Reha	b Hospital South	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3044	Period: From 09/18/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/20/2019 12:	pared: 19 pm
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	_				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
44.00 04400 SKILLED NURSING FACILITY					44.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
74.00 07400 RENAL DIALYSIS	0. 000000				74.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 000000				90.00
91.00 09100 EMERGENCY	0. 000000				91.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES	0. 000000				95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000				98.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CA	APITAL COSTS	Provider CC		Period: From 09/18/2018	Worksheet D	
					Date/Time Pre	anared:
					5/20/2019 12:	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost		1	
	Part II, col.		(col. 1 - col.		1	
	26)	/	2)	//		
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00 ADULTS & PEDIATRICS	545, 497	. 0'	545, 497	7 1, 322		
1.00 INTENSIVE CARE UNIT	0	, i	((ט ^ט	0.00	31.00
4.00 SKILLED NURSING FACILITY	0	, i	(ט ^ו ס	0.00	44.00
00.00 Total (lines 30 through 199)	545, 497	·'	545, 497	7 1, 322		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						4
30. 00 ADULTS & PEDIATRICS	895	369, 304	1		,	30.00
1.00 INTENSIVE CARE UNIT	0	, 0'	J.		,	31.00
4.00 SKILLED NURSING FACILITY	0	, O')		,	44.00
200.00 Total (lines 30 through 199)	895	369, 304	4		,	200.00

Health Financial Systems Commu	In Lie	u of Form CMS-2	2552-10			
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-3044	Peri od:	Worksheet D	
				From 09/18/2018		
				To 12/31/2018	Date/Time Pre 5/20/2019 12:	
		Title	xvi i	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,			(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	ů l		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0.0000	0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0.0000	0 0	0	54.00
60. 00 06000 LABORATORY	1,665	18, 916	0. 08802	13, 348	1, 175	60.00
65. 00 06500 RESPI RATORY THERAPY	3, 488	56, 054	0.06222	26 23, 964	1, 491	65.00
66. 00 06600 PHYSI CAL THERAPY	53, 805	780, 410	0. 06894	486, 286	33, 527	66.00
67.00 06700 OCCUPATI ONAL THERAPY	38, 482	836, 183	0. 04602	517, 091	23, 797	67.00
68.00 06800 SPEECH PATHOLOGY	30, 205	598, 546	0. 05040	415, 212	20, 953	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 418	5, 410	0. 63179	2, 546	1, 609	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	17, 737	301, 667	0. 05879	97 154, 835	9, 104	73.00
74.00 07400 RENAL DIALYSIS	0	0	0.0000	0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	42	8, 943	0.0046	8, 943	42	90.00
91.00 09100 EMERGENCY	0	0	0.0000	0 0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.0000	0 0	0	98.00
200.00 Total (lines 50 through 199)	148, 842	2, 606, 129		1, 622, 225	91, 698	200. 00

Health Financial Systems	Community Health Rehab	Hospital Sc	outh	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE C	THER PASS THROUGH COSTS	Provider CC		Period: From 09/18/2018 Fo 12/31/2018	Date/Time Pre 5/20/2019 12:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Nur	sing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTER	S					
30.00 03000 ADULTS & PEDIATRICS	0	0	(0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	(0 0	0	31.00
44.00 04400 SKILLED NURSING FACILITY	0	0	(0 0		44.00
200.00 Total (lines 30 through 199)	0	0	(0 0	0	200.00
Cost Center Description	Swing-Bed T	otal Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment (s	um of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see 1	through 3,	-			
	instructions) mi	nus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTER	S					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1, 32	0.00	895	30.00
31.00 03100 INTENSIVE CARE UNIT		0	(0.00	0	31.00
44.00 04400 SKILLED NURSING FACILITY		0	(0.00	0	44.00
200.00 Total (lines 30 through 199)		0	1, 32	2	895	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTER	S					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199)						200.00

Health Financial Systems Community Health Rehab Hospital South In Lieu of Form CMS-2552-10								
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Peri od:	Worksheet D			
THROUGH COSTS				From 09/18/2018				
				To 12/31/2018	Date/Time Pre 5/20/2019 12:			
		Ti +L c	2 XVIII	Hospi tal	PPS	19 pili		
Cost Center Description	Non Physician			Allied Health				
cost center bescription		Post-Stepdown		Post-Stepdown				
	Cost	Adjustments		Adjustments				
	1.00	2A	2.00	3A	3, 00			
ANCI LLARY SERVI CE COST CENTERS	1.00	20	2.00	5/1	5.00			
50. 00 05000 OPERATING ROOM	0	0		0	0	50.00		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 0	0	54.00		
60, 00 06000 LABORATORY	0	0		0	0	60.00		
65. 00 06500 RESPI RATORY THERAPY	0			0 0	0	65.00		
66. 00 06600 PHYSI CAL THERAPY	0			0 0	0	66.00		
67. 00 06700 OCCUPATI ONAL THERAPY	0			0 0	0	67.00		
68. 00 06800 SPEECH PATHOLOGY	0	l d		0 0	0	68,00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	c c		0 0	0	71.00		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	c c		0 0	0	73.00		
74.00 07400 RENAL DIALYSIS	0	c		0 0	0	74.00		
OUTPATIENT SERVICE COST CENTERS								
90. 00 09000 CLINIC	0	0)	0 C	0	90.00		
91.00 09100 EMERGENCY	0	0		0 0	0	91.00		
OTHER REIMBURSABLE COST CENTERS								
95. 00 09500 AMBULANCE SERVICES						95.00		
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0)	0 0	0	98.00		
200.00 Total (lines 50 through 199)	0	C		0 0	0	200. 00		

Heal th	Financial Systems Commu	munity Health Rehab Hospital South			In Lieu of Form CMS-2552-10			
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provider C		Period:	Worksheet D		
THROUG	H COSTS				From 09/18/2018 To 12/31/2018		narad	
					10 12/31/2016	Date/Time Pre 5/20/2019 12:	19 pm	
			Title	XVIII	Hospi tal	PPS	<u>, bur</u>	
	Cost Center Description		Total Cost	Total	Total Charges	Ratio of Cost		
		Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges		
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.		
			4)	col s. 2, 3,	8)	7)		
				and 4)				
		4.00	5.00	6.00	7.00	8.00		
	ANCI LLARY SERVI CE COST CENTERS	1		1				
50.00	05000 OPERATING ROOM	0	C		0 0	0.000000		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0.00000		
60.00	06000 LABORATORY	0	C		0 18, 916			
65.00	06500 RESPI RATORY THERAPY	0	C		0 56, 054			
66.00	06600 PHYSI CAL THERAPY	0	C		0 780, 410			
67.00	06700 OCCUPATI ONAL THERAPY	0	C		0 836, 183			
	06800 SPEECH PATHOLOGY	0	C		0 598, 546			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 5, 410			
	07300 DRUGS CHARGED TO PATIENTS	0	C		0 301, 667	0.00000		
74.00	07400 RENAL DIALYSIS	0	0		0 0	0.00000	74.00	
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLI NI C	0	C		0 8, 943			
91.00	09100 EMERGENCY	0	0		0 0	0.00000	91.00	
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00	
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0.00000		
200.00	Total (lines 50 through 199)	0	C	1	0 2, 606, 129		200.00	

Health Financial Systems Commu	unity Health Reh	ab Hospital Sc	outh	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider CO		Period: From 09/18/2018	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2018		nared
				10 12/01/2010	5/20/2019 12:	19 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	1 1					
50.00 05000 OPERATI NG ROOM	0. 000000	0		0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	13, 348		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	23, 964		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	486, 286		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	517, 091		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	415, 212		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	2, 546		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	154, 835		0 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0. 000000	0		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	8, 943		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	
200.00 Total (lines 50 through 199)		1, 622, 225		0 0	0	200. 00

Community	Heal th	Rehab	Hospi tal	South		
			Drovi dor	CCNI 1E	2011	Dori

In Lieu of Form CMS-2552-10

	Financial Systems Community Health Rehal		In Lie	u of Form CMS-2	
	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-3044	Period: From 09/18/2018 To 12/31/2018	Worksheet D-1	
				5/20/2019 12:	19 pm
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	cost center bescription			1.00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	(c. oveluding nowhern)		1, 322	1.00
2.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			1, 322	2.00
3.00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
	do not complete this line.		-	4 999	
4.00 5.00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	1, 322 0	4.00 5.00
5.00	reporting period	Solin days) thi bagin becchib		0	0.00
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.00
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m dave) through Docombo	r 21 of the cost	0	7.00
7.00	reporting period	Jill days) thi ough becembe	I SI UI LIIE CUSL	0	7.00
8.00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)			005	0.00
9.00	Total inpatient days including private room days applicable t newborn days)	to the program (excluding	y swing-bed and	895	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.00
	through December 31 of the cost reporting period (see instruc				
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		room days) atter	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.00
	through December 31 of the cost reporting period				10.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.00
14.00	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)		•	0	
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 servic	ces through December 31	of the cost	0.00	17.00
	reporting period	Ũ			
18.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost	0.00	18.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19.00
20.00	reporting period	a often December 21 of	the east	0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es aiter December 31 01	the cost	0.00	20.00
21.00	Total general inpatient routine service cost (see instruction			1, 934, 582	21.00
22.00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost repor	ting period (line	0	22.00
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	- 31 of the cost reporti	ng period (line 6	0	23.00
	x line 18)				
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost report	ing period (line	0	24.00
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25.00
26.00	x line 20) Total aming had aget (age instructions)			0	24.00
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 1, 934, 582	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			.,	
28.00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	1
29.00 30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	1
32.00	Average private room per diem charge (line 29 ÷ line 3)				32.00
33.00 34.00	Average semi-private room per diem charge (line 30 ÷ line 4)	nuc line 22)(coo instru	ations)	0.00	33.00 34.00
35.00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		ctrons)		35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	1, 934, 582	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JUSTMENTS			1
38.00	Adjusted general inpatient routine service cost per diem (see	-		1, 463. 38	1
39.00 40.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			1, 309, 725 0	1
	Total Program general inpatient routine service cost (line 39			1, 309, 725	
				, , . =0	

		nity Health Rel				u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		Period: From 09/18/2018	Worksheet D-1	
					To 12/31/2018		
			Title	• XVIII	Hospi tal	5/20/2019 12: PPS	19 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 -	+	(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
42.00	NURSERY (title V & XIX only)						42.00
42.00	Intensive Care Type Inpatient Hospital Units			0.00		0	42.00
	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0.00	0	0	43.00 44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
						1.00	
	Program inpatient ancillary service cost (Wk			``		503, 581	48.00
49.00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ns)		1, 813, 306	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sum	of Parts I and	369, 304	50.00
51.00	III) Pass through costs applicable to Program inpa	atient ancillar	ry services (fr	rom Wkst. D, su	um of Parts II	91, 698	51.00
52.00	and IV) Total Program excludable cost (sum of lines !	E0 and $E1$)				461, 002	52.00
	Total Program inpatient operating cost exclusion	,	elated, non-phy	sician anesthe	etist, and	1, 352, 304	52.00
	medical education costs (line 49 minus line						
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	55.00
	Target amount (line 54 x line 55)					0	56.00
	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (I	ine 56 minus l	ine 53)	0	57.00 58.00
	Lesser of lines 53/54 or 55 from the cost re	pounded by the	0.00	59.00			
	market basket	0.1	C I				
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line:				he amount by	0.00	60.00 61.00
01.00	which operating costs (line 53) are less than						01.00
(0.00	amount (line 56), otherwise enter zero (see	instructions)					10.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paymu		0	62.00 63.00			
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST			00.00			
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reportir	ng period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65.00
	instructions)(title XVIII only)			1 3			
66.00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	n December 31 d	of the cost rep	oorting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repor	ting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	routine costs (line 67 + line	. 68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND ICF/IID	ONLY			
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	5		. ,			70.00 71.00
72.00	Program routine service cost (line 9 x line)		The 70 ÷ The	2)			72.00
73.00	Medically necessary private room cost applic						73.00
74.00 75.00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient	•			ort II column		74.00 75.00
75.00	26, line 45)	foutifie service	COSTS (ITOM W	UIKSHEEL D, FO			75.00
	Per diem capital-related costs (line 75 ÷ li						76.00
77.00 78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu:						77.00 78.00
79.00	Aggregate charges to beneficiaries for excess	,	orovider record	ls)			79.00
80.00	Total Program routine service costs for compa		cost limitation	ı (line 78 minu	ıs line 79)		80.00
81.00 82.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81.00 82.00
	Reasonable inpatient routine service costs (83.00
84.00	Program inpatient ancillary services (see in:						84.00
	Utilization review - physician compensation Total Program inpatient operating costs (sum			85.00 86.00			
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			0.00	87.00 88.00
88.00 89.00	Observation bed cost (line 87 x line 88) (see						88.00 89.00

Health Financial Systems	Community	Heal th	Rehat	o Hospital S	outh	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST				Provider C	CN: 15-3044	Period:	Worksheet D-1	
						From 09/18/2018 To 12/31/2018		
				Title	e XVIII	Hospi tal	PPS	
Cost Center Description		Cost	R	outine Cost	column 1 ÷	Total	Observati on	
			(f	rom line 21)	column 2	Observati on	Bed Pass	
						Bed Cost (from	Through Cost	
						line 89)	(col. 3 x col.	
							4) (see	
							instructions)	
		1.00		2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THRC	UGH COST							
90.00 Capital-related cost		545,	497	1, 934, 582	0. 2819	72 0	0	90.00
91.00 Nursing School cost			0	1, 934, 582	0.0000	0 0	0	91.00
92.00 Allied health cost	1		0	1, 934, 582	0. 0000	0 0	0	92.00
93.00 All other Medical Education			0	1, 934, 582	0. 0000	00 0	0	93.00

Community	Heal th	Rehab	Hospi tal	South			
			Dreavel dore	CCNL 1	E '	2044	De

)MPUT/	Financial Systems Community Health Rehat	Provider CCN: 15-3044	Period: From 09/18/2018 To 12/31/2018	u of Form CMS-2 Worksheet D-1 Date/Time Pre 5/20/2019 12:	pare
	Cost Contor Description	Title XIX	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I – ALL PROVIDER COMPONENTS				
00	Inpatient days (including private room days and swing-bed day			1, 322	1.
	Inpatient days (including private room days, excluding swing-	ivata naam dava	1, 322	2.	
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). If you have only pr	Tvate room days,	0	3.
00	Semi-private room days (excluding swing-bed and observation b			1, 322	4
00	Total swing-bed SNF type inpatient days (including private ro reporting period	om days) through Decembe	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				_
00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	- 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable t newborn days)	o the Program (excluding	g swing-bed and	0	9
00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private n	oom days)	0	10
	through December 31 of the cost reporting period (see instruc				
00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		room days) arter	0	11
00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
00	through December 31 of the cost reporting period				
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
00	Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 (of the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to servic	os aftar Docombor 21 of	the cost	0.00	10
	reporting period			0.00	
00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of	f the cost	0.00	19
00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20
00	reporting period Total general inpatient routine service cost (see instruction	c)		1, 934, 582	21
	Swing-bed cost applicable to SNF type services through Decemb		ina period (line	1, 934, 382	
	5 x line 17)				
00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23
00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24
00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20)		, point de (initia de la compañía de	-	
	Total swing-bed cost (see instructions)	(1) 01 1 11 0()		0	
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 26)		1, 934, 582	21
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	· Lipo 28)		0 0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)	÷ ITTIE 28)		0.000000	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instrud	ctions)	0.00	
	Average per diem private room cost differential (line 34 x li			0.00	
	Private room cost differential adjustment (line 3 x line 35)			0	
00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	tterential (line	1, 934, 582	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see			1, 463. 38	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			0	
50	Total Program general inpatient routine service cost (line 39				40

Heal th	Financial Systems Comm	unity Health Reh	nab Hospital S	South	In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der (CCN: 15-3044	Period: From 09/18/2018	Worksheet D-1	
					To 12/31/2018	Date/Time Pre	
			Ti t	le XIX	Hospi tal	5/20/2019 12: Cost	19 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Day		÷	(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4.00	4)	
42.00	NURSERY (title V & XIX only)		2100	0100		01.00	42.00
42.00	Intensive Care Type Inpatient Hospital Units					0	42.00
	INTENSIVE CARE UNIT CORONARY CARE UNIT	0		0 0.0	0 0	0	43.00 44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
						1.00	
	Program inpatient ancillary service cost (Wk					0	48.00
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see Instructi	ons)		0	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
51.00) Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D, s	um of Parts II	0	51.00
52.00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
	Total Program inpatient operating cost exclu		lated, non-ph	ysician anesth	etist, and	0	53.00
	medical education costs (line 49 minus line		•				
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	55.00
	Target amount (line 54 x line 55)					0	56.00
	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (line 56 minus	line 53)	0	57.00 58.00
	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	mpounded by the		59.00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost conort up	dated by the	markat backat		0.00	60.00
	If line 53/54 is less than the lower of line				the amount by	0.00	61.00
	which operating costs (line 53) are less that		s (lines 54 x	60), or 1% of	the target		
62.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive paym	nent (see instru	ctions)			0	63.00
(1 . 0.0	PROGRAM INPATIENT ROUTINE SWING BED COST		- 04 C H		1 1 (0		
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts through Dece	mber 31 of th	e cost reporti	ng period (See	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the	cost reporting	period (See	0	65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 nlus line	65)(title XVII	Lonly) For	0	66.00
	CAH (see instructions)					0	67.00
	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	-					
	Title V or XIX swing-bed NF inpatient routir (line 13 x line 20)				rting period	0	
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70.00	Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.00
72.00 73.00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	(line 14 v l	ine 35)			72.00 73.00
74.00	Total Program general inpatient routine serv						74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	Worksheet B, F	art II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
	Program capital-related costs (line 9 x line	,					77.00
78.00 79.00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi der recor	ds)			78.00 79.00
80.00	Total Program routine service costs for comp	• •		· · · · · · · · · · · · · · · · · · ·	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi		`				81.00
82.00 83.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82.00 83.00
84.00	Program inpatient ancillary services (see in		- /				84.00
	Utilization review - physician compensation	•					85.00
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		rougn 85)				86.00
	Total observation bed days (see instructions	5)				0	87.00
88.00 89.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se					0.00	88. 00 89. 00
J7. UU	Observation bed cost (THE OF A THE OD) (SE					1 0	07.00

Health Financial Systems Co	nmunity He	ealth R	ehab	Hospital S	outh		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST				Provider (CCN: 15-30		Period:	Worksheet D-1	
							rom 09/18/2018 o 12/31/2018		
				Ti t	le XIX		Hospi tal	Cost	
Cost Center Description	Co	ost	Ro	outine Cost	col umn	1 ÷	Total	Observati on	
			(fr	om line 21) colum	ın 2	Observati on	Bed Pass	
							Bed Cost (from	Through Cost	
							line 89)	(col. 3 x col.	
								4) (see	
								instructions)	
	1.	. 00		2.00	3.0	0	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUG	H COST								
90.00 Capital-related cost		545, 49	7	1, 934, 58	2 0.	281972	2 0	0	90.00
91.00 Nursing School cost			0	1, 934, 58	2 0.	000000	0	0	91.00
92.00 Allied health cost			0	1, 934, 58	2 0.	000000	0	0	92.00
93.00 All other Medical Education			0	1, 934, 58	2 0.	000000	0	0	93.00

	I Financial Systems Comm FIONMENT OF COST OF SERVICES RENDERED BY INTE	INNI TY Heal th Reh		CN: 15-3044 Pe	eriod: rom 09/18/2018	Date/Time Pre 5/20/2019 12:	pare
	Cost Center Description	Percent of Assigned Time	Expense Allocation	Total Inpatient Day All Patients	Average Cost Per Day	Health Care Program <u>Inpatient Days</u> Title V	
		1.00	2.00	3.00	4.00	5.00	
00	PART I - NOT IN APPROVED TEACHING PROGRAM Total cost of services rendered	0.00	C	J		1	1 1.
00	Hospital Inpatient Routine Services:	0.00		1		1	1 ''
00 00 00 00 00 00 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY	0.00 0.00		.,	0. 00 0. 00		
00 00 00 00 00	Subtotal (sum of lines 2 through 8) SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY	0.00	c		0. 00	0	9 10 11 12 13
00 00 00 00 00 00 00	NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY CMHC AMBULATORY SURGICAL CENTER (D.P.) HOSPICE Subtotal (sum of lines 9 through 19)	0.00	C	2		Titles V and	14 15 16 17 18 19 20
	Cast Captor Description			Total Charges		XIX Outpatient and Title XVIII Part B Charges Title V	
	Cost Center Description			Total Charges (from Worksheet C. Part I, column 8, lines 88 through 93)	to Charges (col. 2 ÷ col.	nnev	
	Hospital Outpatient Services:	1.00	2.00	3.00	4.00	5.00	-
00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER CLINIC	0.00	C	8, 943	0.00000	0	21 22 23
00 00 00 00	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) OTHER OUTPATIENT SERVICE COST CENTER Subtotal (sum of lines 21 through 26) Total (sum of lines 20 and 27)	0.00	c		0. 000000	0	25 26 27
00 00 00 00	OBSERVATION BEDS (NON-DISTINCT PART) OTHER OUTPATIENT SERVICE COST CENTER Subtotal (sum of lines 21 through 26)	0.00 0.00 Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	C Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)	24 25 26 27 28
00 00 00 00	OBSERVATION BEDS (NON-DISTINCT PART) OTHER OUTPATIENT SERVICE COST CENTER Subtotal (sum of lines 21 through 26) Total (sum of lines 20 and 27)	0.00 0.00 Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22 1.00	C Swing bed Amount 2.00	Net cost (column 1 plus column 2) 3.00	Total Inpatient Days - All Patients 4.00	Average Cost Per Day (col.	25 26 27
00 00 00 00	OBSERVATION BEDS (NON-DISTINCT PART) OTHER OUTPATIENT SERVICE COST CENTER Subtotal (sum of lines 21 through 26) Total (sum of lines 20 and 27) Cost Center Description	0.00 0.00 Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22 1.00	C Swing bed Amount 2.00	Net cost (column 1 plus column 2) 3.00	Total Inpatient Days - All Patients 4.00	Average Cost Per Day (col. 3 ÷ col. 4)	25 26 27
00 00 00 00 00 00 00 00 00 00 00 00 00	OBSERVATION BEDS (NON-DISTINCT PART) OTHER OUTPATIENT SERVICE COST CENTER Subtotal (sum of lines 21 through 26) Total (sum of lines 20 and 27) Cost Center Description PART II - IN AN APPROVED TEACHING PROGRAM (Hospital Inpatient Routine Services: ADULTS & PEDIATRICS Swing Bed - SNF Swing Bed - NF INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0.00 0.00 Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22 1.00	C Swing bed Amount 2.00 T B INPATIENT	Net cost (col umn 1 pl us col umn 2) 3.00 ROUTI NE COSTS (0 0	Total Inpatient Days - All Patients 4.00	Average Cost Per Day (col. 3 ÷ col. 4) 5.00	25 26 27 28 29 30 31 32 33 34 35
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	OBSERVATION BEDS (NON-DISTINCT PART) OTHER OUTPATIENT SERVICE COST CENTER Subtotal (sum of lines 21 through 26) Total (sum of lines 20 and 27) Cost Center Description PART 11 - IN AN APPROVED TEACHING PROGRAM (Hospital Inpatient Routine Services: ADULTS & PEDIATRICS Swing Bed - SNF Swing Bed - NF INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0.00 0.00 Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22 1.00 TITLE XVIII, PAR	C Swing bed Amount 2.00 T B INPATIENT C C C C	Net cost (col umn 1 pl us col umn 2) 3.00 ROUTI NE COSTS (0 0 0 0	Total Inpatient Days - All Patients 4.00 DNLY) 1,322 0	Average Cost Per Day (col. 3 ÷ col. 4) 5.00 0.00 0.00 0.00	25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40

Health Financial Systems Commu	nity Health Rehab Hospital So	buth	In Lieu of Form CMS	-2552-10
APPORTIONMENT OF COST OF SERVICES RENDERED BY INTER	NS AND RESIDENTS Provider C		Period: Worksheet D-	2
			From 09/18/2018 To 12/31/2018 Date/Time Pr 5/20/2019 12	
	Not In Approved Teachin	g Program	In Approved Teaching Progra	m
Cost Center Description	(from Part I:)	Amount	(from Part II, col. 7, -)	
	1.00	2.00	3.00	_
PART III - SUMMARY FOR TITLE XVIII (TO BE COM	IPLETED ONLY IF BOTH PARTS I	AND II ARE USE	ED)	
Hospi tal		1		
43.00 Inpatient	col. 9, line 9.00	(Oline 37.00	43.00
44.00 Outpatient	col. 9, line 27.00	(44.00
45.00 Total Hospital (sum of lines 43 and 44)		(45.00
46.00 SUBPROVIDER - IPF				46.00
47.00 SUBPROVIDER - IRF				47.00
48.00 SUBPROVI DER				48.00
49.00 SKILLED NURSING FACILITY	col. 9, line 13.00	(Dcol. 9, line 41.00	₿ 49.00

	unity Health Ref				u of Form CMS-	
APPORTIONMENT OF COST OF SERVICES RENDERED BY INTER	RNS AND RESIDENT	S Provider C		Period: From 09/18/2018 To 12/31/2018		pared:
	Heal th Car	re Program			5/20/2019 12:	19 pm
	Inpatie					
Cost Center Description	Title XVIII, Part B Only less Part A Coverage but no Part B Coverage	Title XIX	Title V (col. 4 x col. 5)	(col. 4 x col. 6)	7)	
PART I - NOT IN APPROVED TEACHING PROGRAM	6.00	7.00	8.00	9.00	10.00	
1.00 Total cost of services rendered						1.00
Hospital Inpatient Routine Services:			1			
2.00 ADULTS & PEDIATRICS	895	0		0 0	0	
B. 00 I NTENSI VE CARE UNI T I. 00 CORONARY CARE UNI T 5. 00 BURN I NTENSI VE CARE UNI T 5. 00 SURGI CAL I NTENSI VE CARE UNI T 7. 00 OTHER SPECI AL CARE (SPECI FY)	0	C		0 0	0	4. 00 5. 00 6. 00 7. 00
 NURSERY Subtotal (sum of lines 2 through 8) SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER 				o o	0	8.00 9.00 10.00 11.00 12.00
13.00 SKILLED NURSING FACILITY 14.00 NURSING FACILITY 15.00 OTHER LONG TERM CARE 16.00 HOME HEALTH AGENCY 17.00 CMHC 18.00 AMBULATORY SURGICAL CENTER (D.P.)	0	С		0 0	0	
19. 00 HOSPICE						19.00
20.00 Subtotal (sum of lines 9 through 19)	Titles V and >			nd XIX Outpatier		20.00
Cost Center Description	and Title X Char		Title V	XVIII Part B Cos	Title XIX	
	Part B	7.00	0.00	Part B	10.00	
Hospital Outpatient Services:	6.00	7.00	8.00	9.00	10.00	
21.00 RURAL HEALTH CLINIC 22.00 FEDERALLY QUALIFIED HEALTH CENTER 23.00 CLINIC 24.00 EMERGENCY 25.00 OBSERVATION BEDS (NON-DISTINCT PART) 26.00 OTHER OUTPATIENT SERVICE COST CENTER 27.00 Subtotal (sum of lines 21 through 26) 28.00 Total (sum of lines 20 and 27)	8, 943 0	C C			0 0 0	24.00 25.00 26.00
Cost Center Description	Inpatient Days	(col. 5 x col. 6)	Resi dents			
PART II - IN AN APPROVED TEACHING PROGRAM (T	6.00	7.00 T B INPATIENT	11.00 ROUTINE COSTS	ONLY)		
Hospital Inpatient Routine Services:	,			· · · · · · · · · · · · · · · · · · ·		1
29.00 ADULTS & PEDIATRICS 30.00 Swing Bed - SNF 31.00 Swing Bed - NF 32.00 INTENSIVE CARE UNIT 33.00 CORONARY CARE UNIT 54.00 BURN INTENSIVE CARE UNIT 55.00 SURGICAL INTENSIVE CARE UNIT 36.00 OTHER SPECIAL CARE (SPECIFY) 37.00 Subtotal (sum of lines 29, and 32 through	000000000000000000000000000000000000000	c c c		0		29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00
36) 88.00 SUBPROVIDER - IPF 99.00 SUBPROVIDER - IRF 10.00 SUBPROVIDER 11.00 SKILLED NURSING FACILITY	0	C		0		38.00 39.00 40.00 41.00

Health Financial Systems Commu	nity Health Ref	hab Hospital South	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF COST OF SERVICES RENDERED BY INTER	NS AND RESIDEN	TS Provider CCN: 15-3044	Peri od:	Worksheet D-2	
			From 09/18/2018 To 12/31/2018	Date/Time Pre 5/20/2019 12:	
	In Approved	Total Title XVIII	Costs		
	Teachi ng				
	Program				
Cost Center Description	Amount	(to Wkst. E, Part B -)	(col. 2 + col.		
			4)		
	4.00	5.00	6.00		
PART III - SUMMARY FOR TITLE XVIII (TO BE COM	IPLETED ONLY IF	BOTH PARTS I AND II ARE U	SED)		
Hospi tal					
43.00 Inpatient	0		0		43.00
44.00 Outpatient					44.00
45.00 Total Hospital (sum of lines 43 and 44)	0	line 22	0		45.00
46.00 SUBPROVIDER - IPF					46.00
47.00 SUBPROVIDER - IRF					47.00
48.00 SUBPROVI DER					48.00
49.00 SKILLED NURSING FACILITY	0	line 22	0		49.00
	1		'		

Health Financial Systems	Community Health Rehab Hospital S			u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMEN	IT Provider (Peri od:	Worksheet D-3	
			From 09/18/2018 To 12/31/2018	Date/Time Pre	nared
			10 12/31/2010	5/20/2019 12:	
	Titl	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00 03000 ADULTS & PEDI ATRI CS			1, 448, 879		30.00
31.00 03100 I NTENSI VE CARE UNI T			0		31.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATING ROOM		0.00000		0	
54.00 05400 RADI OLOGY-DI AGNOSTI C		0.00000		0	
		0.56793			60.00
65. 00 06500 RESPIRATORY THERAPY		0.50647			
66. 00 06600 PHYSI CAL THERAPY		0. 28461			
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY		0. 25003		129, 290	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIL	NTC	5. 29205			
73. 00 07300 DRUGS CHARGED TO PATIENTS	1115	0. 63328			
74. 00 07400 RENAL DIALYSIS		0.00000		90,054	
OUTPATIENT SERVICE COST CENTERS		0.0000	0 0	0	74.00
90. 00 09000 CLINIC		0. 11763	8, 943	1,052	90.00
91. 00 09100 EMERGENCY		0. 00000		1,032	
OTHER REIMBURSABLE COST CENTERS		0.00000	0	Ŭ	1 71.00
95. 00 09500 AMBULANCE SERVICES					95.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0. 00000	0 0	0	
200.00 Total (sum of lines 50 through 9-	and 96 through 98)		1, 622, 225	-	
	ces-Program only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line			1, 622, 225		202.00

Health Financial Systems	Community Health Rehab	Hospital So	outh	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMEN	IT	Provider C		Period:	Worksheet D-3	
				From 09/18/2018 To 12/31/2018	Date/Time Pre	narod
				10 12/31/2010	5/20/2019 12:	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						0.0.00
30. 00 03000 ADULTS & PEDI ATRI CS				0		30.00
31. 00 03100 I NTENSI VE CARE UNI T				0		31.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM			0.00000	0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0.00000	-	0	54.00
60. 00 06000 LABORATORY			0. 56793	-	0	60.00
65. 00 06500 RESPI RATORY THERAPY			0. 50647	-	0	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 28461		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY			0. 25003		0	67.00
68.00 06800 SPEECH PATHOLOGY			0. 24948		0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	ENTS		5. 29205	2 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 63328	1 0	0	73.00
74.00 07400 RENAL DIALYSIS			0.00000	0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C			0. 11763		0	
91.00 09100 EMERGENCY			0.00000	0 0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES					_	95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS			0.00000	0 0	0	
200.00 Total (sum of lines 50 through 94	5,	() ()		0	0	200.00
201.00 Less PBP Clinic Laboratory Servic		(line 61)		0		201.00
202.00 Net charges (line 200 minus line	201)		I	0		202.00

VALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 09/18/2018 To 12/31/2018		pared
			XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	-
00	Total interim payments paid to provider		1, 553, 00		0	1.0
00	Interim payments payable on individual bills, either			0	0	
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3. (
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER			0	0	3. (
02				0	0	3.
03				0	0	3.
04				0	0	3.
05				0	0	3.
	Provider to Program					4
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	
52				0	0	
53 54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	
//	3. 50-3. 98)			0	0	J. J.
00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 553, 00	9	0	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					1
01	TENTATI VE TO PROVIDER			0	0	5.
02				0	0	
03				0	0	
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	
51				0	0	
52				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.
00	5.50-5.98)					
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER		21, 98	5	0	6.
02	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		1, 574, 99	0	0	
			.,, , , , ,	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
)	1.00	2.00	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3044	Period: From 09/18/2018 To 12/31/2018	Worksheet E-3 Part III Date/Time Pre 5/20/2019 12:	pare
		Title XVIII	Hospi tal	PPS	
				1.00	
. 00	PART III - MEDICARE PART A SERVICES - IRF PPS Net Federal PPS Payment (see instructions)			1, 602, 458	1.
. 00				0.0077	2.
00	Medicare SSI ratio (IRF PPS only) (see instructions)				2
00	Inpatient Rehabilitation LIP Payments (see instructions	5)		22, 434 0	
00	Outlier Payments Unweighted intern and resident FTE count in the most re to November 15, 2004 (see instructions)	ecent cost reporting period e	nding on or prior	0.00	4 5
01	Cap increases for the unweighted intern and resident FT	F count for residents that we	re displaced by	0.00	5
	program or hospital closure, that would not be counted CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions	without a temporary cap adjust		0.00	
00	New Teaching program adjustment. (see instructions)			0.00	6
00	Current year's unweighted FTE count of I&R excluding FT	Es in the new program growth	period of a "new	0.00	
	teaching program" (see instructions)				
00	Current year's unweighted I&R FTE count for residents w	vithin the new program growth	period of a "new	0.00	8
	teaching program" (see instructions)				
00	Intern and resident count for IRF PPS medical education	n adjustment (see instructions)	0.00	
	Average Daily Census (see instructions)			12.590476	
	Teaching Adjustment Factor (see instructions)			0.00000	
. 00	Teaching Adjustment (see instructions)			0	1:
. 00	Total PPS Payment (see instructions)			1, 624, 892	13
. 00	Nursing and Allied Health Managed Care payments (see in	nstruction)		0	14
	Organ acquisition (DO NOT USE THIS LINE)				1!
	Cost of physicians' services in a teaching hospital (se	e instructions)		0	10
	Subtotal (see instructions)			1, 624, 892	
	Primary payer payments			0	18
	Subtotal (line 17 less line 18).			1, 624, 892	
	Deducti bl es			9, 380	
	Subtotal (line 19 minus line 20)			1, 615, 512	
	Coinsurance			8, 375	
	Subtotal (line 21 minus line 22)			1, 607, 137	
	Allowable bad debts (exclude bad debts for professional	services) (see instructions)		0	2
	Adjusted reimbursable bad debts (see instructions)			0	2
	Allowable bad debts for dual eligible beneficiaries (se	e instructions)		0	2
	Subtotal (sum of lines 23 and 25)			1, 607, 137	
	Direct graduate medical education payments (from Wkst.	E-4, line 49)		0	2
	Other pass through costs (see instructions)			0	2
	Outlier payments reconciliation			0	30
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	3
	Pioneer ACO demonstration payment adjustment (see instr			0	3
	Demonstration payment adjustment amount before sequestr			0	31
	Total amount payable to the provider (see instructions)			1, 607, 137	
	Sequestration adjustment (see instructions)			32, 143	
	Demonstration payment adjustment amount after sequestra	ation		0	
	Interim payments			1, 553, 009	
	Tentative settlement (for contractor use only)			0	34
. 00	Balance due provider/program (line 32 minus lines 32.01			21, 985	
. 00	Protested amounts (nonallowable cost report items) in a §115.2	accordance with CMS Pub. 15-2,	chapter 1,	0	36
00	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount from Wkst. E-3, Pt. III, line 4			0	50
	Outlier reconciliation adjustment amount (see instructi	ons)		0	51
	The rate used to calculate the Time Value of Money			0.00	152

CULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3044	Period: From 09/18/2018 To 12/31/2018	Worksheet E-3 Part IV Date/Time Pre 5/20/2019 12:	pare
	Title XVIII	Hospi tal	PPS	
			1.00	
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
00 Net Federal PPS Payments (see instructions)			0	
01 Full standard payment amount			0	
D2 Short stay outlier standard payment amount			0	
03 Site neutral payment amount - Cost			0	
04 Site neutral payment amount - IPPS comparable			0	
00 Outlier Payments			0	
DO Total PPS Payments (sum of lines 1 and 2)			0	-
Nursing and Allied Health Managed Care payments (see) Instructions)		0	
00 Organ acquisition (DO NOT USE THIS LINE)			0	5
Cost of physicians' services in a teaching hospital	(see instructions)		0	
00 Subtotal (see instructions)			0	
00 Primary payer payments			-	-
00 Subtotal (line 7 less line 8).			0	
00 Deductibles			0	
00 Subtotal (line 9 minus line 10) 00 Coinsurance			0	
00 Coinsurance 00 Subtotal (line 11 minus line 12)			0	
00 Allowable bad debts (exclude bad debts for profession	anal convisor) (coo instructions)		0	
	mai services) (see instructions)		0	
5	(coo instructions)		0	
00 Allowable bad debts for dual eligible beneficiaries 00 Subtotal (sum of lines 13 and 15)	(see Thisti dettons)		0	
00 Direct graduate medical education payments (from Wks	= 1 $(1 - 1)$		0	
00 Other pass through costs (see instructions)	st. E-4, 1111e 49)		0	
00 Outlier payments reconciliation			0	
00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
50 Pioneer ACO demonstration payment adjustment (see ir	estructions)		0	
99 Demonstration payment adjustment amount before seque	-		0	
00 Total amount payable to the provider (see instruction			0	
01 Sequestration adjustment (see instructions)	(13)		0	
02 Demonstration payment adjustment amount after seques	stration		0	
00 Interim payments			0	
00 Tentative settlement (for contractor use only)			0	
00 Balance due provider/program (line 22 minus lines 22	2.01, 22.02, 23 and 24)		0	
00 Protested amounts (nonallowable cost report items) i		chapter 1.	0	
§115. 2			Ũ	
TO BE COMPLETED BY CONTRACTOR				
00 Original outlier amount from Wkst. E-3, Pt IV, line	2 (see instructions)		0	50
00 Outlier reconciliation adjustment amount (see instru			0	
00 The rate used to calculate the Time Value of Money (0.00	
00 Time Value of Money (see instructions)	· · · · · · · · · · · · · · · · · · ·		0	

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3044	Peri od: From 09/18/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Pre 5/20/2019 12:	pare
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	<u> </u>
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	DVICES FOR TITLES V OR Y		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	RVICES FOR TITLES V OR 7	ATA SERVICES		1
00	Inpatient hospital/SNF/NF services		0		1 1
00	Medical and other services		Ŭ	0	
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		0	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments		_	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable Charges Routine service charges		0		8
00	Ancillary service charges		0	0	
00	Organ acquisition charges, net of revenue		0	0	10
00	Incentive from target amount computation		0		11
00	Total reasonable charges (sum of lines 8 through 11)		0	0	12
	CUSTOMARY CHARGES				
00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13
	basi s				
00	Amounts that would have been realized from patients liable fo		on 0	0	14
00	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)	0. 000000	0. 000000	15
00	Ratio of line 13 to line 14 (not to exceed 1.000000) Total customary charges (see instructions)	0.000000	0.000000	16	
00				0	
00	line 4) (see instructions)		0	0	
. 00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds lir	ne O	0	18
	16) (see instructions)				
00	Interns and Residents (see instructions)		0	0	
. 00	Cost of physicians' services in a teaching hospital (see instructions)			0	
00	Cost of covered services (enter the lesser of line 4 or line		0	0	21
00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be Other than outlier payments	completed for PPS provi	ders.	0	22
00	Outlier payments		0	0	
00	Program capital payments		0	0	24
00	Capital exception payments (see instructions)		0		25
00	Routine and Ancillary service other pass through costs		0	0	
00	Subtotal (sum of lines 22 through 26)	0	0	27	
00	Customary charges (title V or XIX PPS covered services only)	0	0	28	
00	Titles V or XIX (sum of lines 21 and 27)		0	0	29
~ ~	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
00	Excess of reasonable cost (from line 18)	、 、	0	0	
00 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6 Deductibles)	0	0	
00			0	0	
00	Allowable bad debts (see instructions)	0	0		
00	Utilization review	0	0	35	
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			0	
00	OTHER ADJUSTMENTS			0	
01	OTHER ADJUSTMENTS			0	
00	Subtotal (line 36 ± line 37)	0	0		
00	Direct graduate medical education payments (from Wkst. E-4)	0		39	
00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
. 00					
. 00					42
00	Protested amounts (nonallowable cost report items) in accorda chapter 1, §115.2	TICE WI LIT CWS PUD 15-2,	0	0	43

	E SHEET (If you are nonproprietary and do not maintain pe accounting records, complete the General Fund column	Provider C		Period: From 09/18/2018	Worksheet G	
niu-ty niy)	pe accounting records, comprete the General Fund cordinin			To 12/31/2018	Date/Time Pre 5/20/2019 12:	epare 19 p
		General Fund	Specific Purpose Fund	Endowment Fund		
	CURRENT ASSETS	1.00	2.00	3.00	4.00	-
	Cash on hand in banks	222, 450		0 0	0	1 1
	Temporary investments	0		0 0	0	
	Notes receivable	0		0 0	0	3
00	Accounts receivable	2, 200, 767		0 0	0	4
00	Other recei vabl e	-1, 159, 838		0 0	0	5
	Allowances for uncollectible notes and accounts receivable	-35, 982		0 0	0	
	Inventory	93, 951		0 0	0	
	Prepaid expenses	49, 193			0	
	Other current assets Due from other funds	0		0 0	0	
	Total current assets (sum of lines 1-10)	1, 370, 541			0	
-	FIXED ASSETS	1, 370, 341		5 0	0	1''
	Land	0		0 0	0	1 12
	Land improvements	0		0 0	0	
	Accumulated depreciation	0		0 0	0	14
00	Bui I di ngs	0		0 0	0	15
	Accumulated depreciation	0		0 0	0	
-	Leasehold improvements	493, 977		0 0	0	
	Accumulated depreciation	-18, 369		0 0	0	
	Fixed equipment	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Automobiles and trucks	0		0 0	0	
	Accumulated depreciation Major movable equipment	1, 804, 438			0	
	Accumul ated depreciation	-74, 918			0	
	Mi nor equipment depreciable	-74, 910			0	
	Accumulated depreciation	0		0 0	0	
	HIT designated Assets	0		0 0	0	
	Accumul ated depreciation	0		0 0	0	
. 00	Mi nor equi pment-nondepreci abl e	0		0 0	0	29
. 00	Total fixed assets (sum of lines 12-29)	2, 205, 128		0 0	0	30
-	OTHER ASSETS					
	Investments	0		0 0	0	31
	Deposits on Leases	0		0 0	0	
	Due from owners/officers	0		0 0	0	
	Other assets	10, 790			0	
	Total other assets (sum of lines 31-34)	10, 790 3, 586, 459			0	
-	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	5, 000, 409		<u> </u>	0	30
	Accounts payable	1, 164, 579		0 0	0	37
-	Salaries, wages, and fees payable	259, 294		0 0	0	
	Payroll taxes payable	72, 945		0 0	0	
	Notes and Loans payable (short term)	0		0 0	0	
	Deferred income	0		0 0	0	41
. 00	Accelerated payments	0				42
	Due to other funds	0		0 0	0	
	Other current liabilities	52, 407		0 0	0	
	Total current liabilities (sum of lines 37 thru 44)	1, 549, 225		0 0	0	45
	LONG TERM LIABILITIES	0				1
	Mortgage payable	0			0	
	Notes payable Unsecured Loans	0		0 0	0	
	Other long term liabilities	335, 449		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	335, 449		0 0	0	
	Total liabilities (sum of lines 45 and 50)	1, 884, 674		0 0	0	
	CAPITAL ACCOUNTS	.,	1			
	General fund balance	1, 701, 785				1 52
00	Specific purpose fund			D		53
00	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion Total fund balances (sum of Lines 52 thru 58)	1 701 705		-	_	F
	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	1, 701, 785			0	
	Total liabilities and fund balances (sum of lines 51 and	3, 586, 459		J 0	. 0	60

		nity Health Reha				u of Form CMS-2	2552-10
STATEMENT OF CHANGES IN FUND BALANCES			Provider CC		Period: From 09/18/2018 To 12/31/2018	5/20/2019 12:	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 18.00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY TRANSFERS\ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) INTERCOMPANY TRANSFERS\ROUNDING	0 2, 434, 298 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 -732, 513 -732, 513 2, 434, 298 1, 701, 785 0			0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	Endowment Fund	1, 701, 785 Pl ant		0		19.00
					_		
1.00	Fund balances at beginning of period	6.00	7.00	8.00	0		1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) INTERCOMPANY TRANSFERS\ROUNDING	0	0 0 0 0 0 0		0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) INTERCOMPANY TRANSFERS\ROUNDING	0	0 0 0 0 0 0		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0			0 0		18. 00 19. 00

STATE	Financial Systems Community Health Rehab NENT OF PATIENT REVENUES AND OPERATING EXPENSES			15-3044	Peri od:	worksheet G-2	
					From 09/18/2018 To 12/31/2018		
	Cost Center Description			Inpati ent	Outpati ent	Total	
				1.00	2.00	3.00	
	PART I – PATIENT REVENUES						
	General Inpatient Routine Services				-		
1.00	Hospi tal			2, 293, 12	28	2, 293, 128	
2.00	SUBPROVIDER - IPF						2.0
3.00	SUBPROVIDER - IRF						3.0
4.00	SUBPROVIDER						4.0
5.00	Swing bed - SNF				0	0	
6.00	Swing bed - NF				0	0	
7.00	SKILLED NURSING FACILITY				0	C	
8.00	NURSING FACILITY						8.0
9.00	OTHER LONG TERM CARE			2 202 1/	20	2 202 120	9.0
10.00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services			2, 293, 12	28	2, 293, 128	3 10.0
11.00	INTENSIVE CARE UNIT				0	0) 11.0
12.00	CORONARY CARE UNIT				0		12.0
13.00	BURN INTENSIVE CARE UNIT						12.0
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.0
15.00	OTHER SPECIAL CARE (SPECIFY)						15.0
16.00	Total intensive care type inpatient hospital services (sum of I	ines			0		
10.00	11-15)	11105			0		10.0
17.00	Total inpatient routine care services (sum of lines 10 and 16)			2, 293, 12	28	2, 293, 128	3 17.0
18.00	Ancillary services			2, 606, 12			
19.00	Outpatient services			, ,	0 0		
20.00	RURAL HEALTH CLINIC				0 0	0	20.0
21.00	FEDERALLY QUALIFIED HEALTH CENTER				0 0	0	21.0
22.00	HOME HEALTH AGENCY						22.0
23.00	AMBULANCE SERVICES				0 0	(c	23.0
24.00	СМНС						24.0
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.0
26.00	HOSPICE						26.0
27.00	OTHER (SPECIFY)				0 0	0	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst.		4, 899, 25	57 0	4, 899, 257	7 28.0
	G-3, line 1)						
	PART II - OPERATING EXPENSES					1	1
29.00	Operating expenses (per Wkst. A, column 3, line 200)				3, 017, 589		29.0
30.00	ADD (SPECIFY)				0		30.0
31.00					0		31.0
32.00					0		32.0
33.00					0		33.0
34.00 35.00					0		34.0
35.00	Total additions (sum of lines 30-35)				0		35.0
37.00	DEDUCT (SPECIFY)				0		37.0
38.00					0		37.0
38.00					0		38.0
40.00					0		40.0
40.00					0		40.0
41.00	Total deductions (sum of lines 37-41)				0		41.0
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfe	-r		3, 017, 589		42.0
-5.00	to Wkst. G-3, line 4)	(ci ansi e	~		5,017,307		45.0

Heal th	Financial Systems Community Health Rehab) Hospital South	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-3044	Peri od:	Worksheet G-3	
	From 09/18/2018 To 12/31/2018				oared:
	10 12/31/2018				
				5/20/2019 12:	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	e 28)		4, 899, 257	1.00
2.00	Less contractual allowances and discounts on patients' accoun	2, 618, 472	2.00		
3.00	Net patient revenues (line 1 minus line 2)			2, 280, 785	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line		3, 017, 589	4.00	
5.00	Net income from service to patients (line 3 minus line 4)			-736, 804	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			23	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			3, 768	14.00
15.00				0	15.00
16.00		han patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
18.00				0	18.00
19.00				0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	5			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	MI SCELLANEOUS I NCOME			500	
25.00	Total other income (sum of lines 6-24)			4, 291	25.00
26.00	Total (line 5 plus line 25) OTHER EXPENSES			-732, 513	
27.00 28.00	Total other expenses (sum of line 27 and subscripts)			0	27.00 28.00
	Net income (or loss) for the period (line 26 minus line 28)			-732, 513	
27.00			I	-752, 515	27.00