Health Financial Systems COMMUNITY STROKE AND REHABILITATION In Lieu of Form CMS-2552-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-3045 Worksheet S Peri od. From 08/30/2019 Parts I-III AND SETTLEMENT SUMMARY 06/30/2020 Date/Time Prepared: То 11/25/2020 11:50 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 11/25/2020 Time: 11:50 am use only] Manually prepared 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 OF 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 STROKE AND REHABILITATION (15-3045) for the cost reporting period beginning 08/30/2019 and ending 06/30/2020 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.

[X] 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.

(Signed) DANI EL O' BRI EN
Officer or Administrator of Provider(s)
CFO
Ti tl e
(Dated when report is electronically signed.) Date

	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY					_	
1.00	Hospi tal	0	18, 008	2, 234	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00) Total	0	18, 008	2, 234	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.

114	AL AND HOSPITAL HEALTH CARE COMPLEX	DENIIFICATION DATA	F	Provi der	CCN: T	5-3045	Period: From 08/3		Workshe Part I		
							To 06/3	0/2020	Date/Ti 11/25/2		
	1.00	2.00)	3. (00			4.00			
	Hospital and Hospital Health Care Co Street: 10215 BROADWAY	PO Box:									1
	City: CROWN POINT	State: IN	Zi	p Code: 4	6307	Count	ty: LAKE				2
		Component Name			CBSA	Provi der			ent Syst		
			Nu	mber Nu	umber	Туре	Certifie		, 0, or	<u> </u>	-
		1.00	2	. 00 3	3. 00	4.00	5.00	0. OC	XVIII) 7.00	XI X 8.00	1
	Hospital and Hospital-Based Componer		2			1.00	0.00	0.00	/ /.00	0.00	
Ī	Hospi tal	COMMUNITY STROKE AN	ND 15	3045 2	3844	5	08/30/20	19 N	Р	Р	3
	Subprovider - IPF	REHABI LI TATI ON									4
	Subprovider - IRF										5
	Subprovider - (Other)										6
	Swing Beds - SNF										7
	Swing Beds – NF Hospital-Based SNF										8
	Hospi tal -Based NF										10
	Hospital-Based OLTC										11
	Hospital-Based HHA										12
	Separatel y Certified ASC Hospital-Based Hospice										13
	Hospital-Based Health Clinic - RHC										15
	Hospital-Based Health Clinic - FQHC										16
	Hospital-Based (CMHC) I										17
	Renal Dialysis Other										18
-		<u> </u>		1		1	Fro	m:	То	:	
							1. (2.0		
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						08/30/		06/30/	2020	20
											21
						1.00	2. (00	3. 0	00	
	Inpatient PPS Information Does this facility qualify and is it	currently receivin		s for		N	N				22
	disproportionate share hospital adju										
	§412.106? In column 1, enter "Y" fo	r yes or "N" for no	o. Is this	5							
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo			ent							
	Did this hospital receive interim un			or this		Ν	N				22
	cost reporting period? Enter in colu	mn 1, "Y" for yes o	or "N" for	no for							
	the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N										
	reporting period occurring on or aft										
	Is this a newly merged hospital that					Ν	N				22
	payments to be determined at cost re										
	Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob										
	or "N" for no, for the portion of th										
	October 1.										
	Did this hospital receive a geograph					Ν	N		N		22
	rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c										
	for the portion of the cost reportin	g period prior to 0	october 1.	Enter							
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft										
	Does this hospital contain at least										
	counted in accordance with 42 CFR 41										
	yes or "N" for no. Which mothed is used to determine Me	dicaid dave on line	x 21 and	(or 25			3 N				
	Which method is used to determine Me below? In column 1, enter 1 if date						3 N				23
	if date of discharge. Is the method	of identifying the	days in t	his cost							
	reporting period different from the			st							
	reporting period? In column 2, ente		n-State	In-State	e 01	ut-of	Out-of	Medi ca	nid 0.	ther	
		M	ledi cai d	Medi cai d	a s	State	State	HMO da		li cai d	
		pa	aid days	eligible			Medicaid		d	lays	
				unpai d days	par	d days	el i gi bl e unpai d				
			1.00	2.00		3. 00	4. 00	5.00) 6	. 00	1
	If this provider is an IPPS hospital		0		0	0	0		0	0	24
	in-state Medicaid paid days in colum										
					1		I		1		1
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c										
	Medicald eigible unpaid days in co out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu	olumn 3, d days in column									

SPITAL AND HOSPITAL HEALTH C	ARE CONFLEX IDENTIFICATION		Provider CC	n. 10-3040	Period: From 08/3 To 06/3	0/2019 0/2020	Part I Date/Ti 11/25/2		epare
		In-State Medicaid paid days	In-State Medi cai d el i gi bl e unpai d days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	id 0 ys Meo	ther di cai d days	
		1.00	2.00	3.00	4.00	5.00		5.00	
Medicaid eligible unpaid	olumn 1, the in-state		0	0	8		38		25
					1.		Date of 2.		-
	graphic classification (not		at the beg	jinning of t		1			26
00 Enter your standard geog	Enter "1" for urban or "2" graphic classification (not in column 1, "1" for urban	wage) status			t	1			27
	e of the geographic reclass hity hospital (SCH), enter cting period			CH status in	1	0			35
					Begi n		Endi		
00 Enter applicable beginni	ng and ending dates of SCH	status Subs	crint line	36 for numb	1. Per	00	2.	00	36
of periods in excess of 00 If this is a Medicare de	one and enter subsequent dependent hospital (MDH), en	ates.	·			0			30
accordance with FY 2016	t reporting period. er MDH that is eligible for OPPS final rule? Enter "Y"								37
	the beginning and ending da ot this line for the number								38
onter subsequent dates.					Y/		Y/		
00 Does this facility quali	fy for the inpatient hospi		-1: .	Saul 1 and 1 and 1	1. Ime N		2.		39
hospitals in accordance 1 "Y" for yes or "N" for accordance with 42 CFR 4 or "N" for no. (see inst 00 Is this hospital subject "N" for no in column 1,	with 42 CFR §412.101(b)(2) ro. Does the facility mee 412.101(b)(2)(i), (ii), or tructions) t to the HAC program reduct for discharges prior to Oc	(i), (ii), or t the mileage (iii)? Enter ion adjustmen tober 1. Ente	(iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y	ter in colum nts in 2 "Y" for ye (" for yes o	in is ir N		Ν		40
	charges on or after October	T. (See Thst	ructions)			V	XVIII	XIX	
						1.00		3.00	
00 Does this facility quali	tem (PPS)-Capital	mont for disp	roporti opat	o sharo in	accordanco	N	N	N	45
with 42 CFR Section §412 00 Is this facility eligibl	2.320? (see instructions) e for additional payment e 348(f)? If yes, complete W	xception for	extraordi na	ary circumst	ances	N	N	N	45
Pt. III. 00 Is this a new hospital u	under 42 CFR §412.300(b) PP	S capital? E	nter "Y for	yes or "N"	for no.	N	N	N	47
00 Is the facility electing Teaching Hospitals	g full federal capital paym	ent? Enter "	Y" for yes	or "N" for	no.	N	N	N	48
00 Is this a hospital invol "N" for no in column 1.	ved in training residents If column 1 is "Y", are yo Enter "Y" for yes or "N" fo	u impacted by	CR 11642 (N		56
00 If line 56 is yes, is th GME programs trained at is "Y" did residents sta for yes or "N" for no ir	this the first cost reportin this facility? Enter "Y" art training in the first m n column 2. If column 2 is Parts III & IV and D-2, Pt.	g period duri for yes or "N onth of this "Y", complet	ng which re " for no ir cost report e Worksheet	n column 1. ing period?	lf column P Enter "Y				57
00 If line 56 is yes, did t	this facility elect cost re 1, chapter 21, §2148? If ye	imbursement f	or physicia	ans' service	es as	N			58
00 Are costs claimed on lir	ne 100 of Worksheet A? If :	yes, complete	Wkst. D-2,	Pt. I. NAHE 413.8 Y/N	35 Worksh Lin	e #	Pass-T Qualifi Criteri	cation	
				1.00	2.	00	3.	00	
00 Are you claiming nursing			to for	1.00	2.		э.		60

IOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CO	F	eriod: rom 08/30/2019 o 06/30/2020	Worksheet S-2 Part I Date/Time Pre 11/25/2020 11	pared
		Y/N	IME	Direct GME	IME	Direct GME	
1 00	Did your been tel mercius FTF elete yeden ACA	1.00	2.00	3.00	4.00	5.00	11.0
1. 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	N			0.00	0.00	61.0
. 02	ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care						61.0
	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						
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)						61.0
1.04							61.
1. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. (
1. 06	, . ,						61. (
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	1
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 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						
2.00 2.01	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 [.] ee instructio	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, complete	ettings	during this co			N	63.
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Contion EEOA of the AGA Barry Mary ETE D. 1.1. 1.		lon Cott:	1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor			nnis base year	is your cost r	eporting	
4. 00	Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor 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	ty train -primar all non d non-pr n column	ed residents y care provider imary care 3 the ratio	0.00	0.00	0. 000000	64.

SPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Provider C	Fr	eriod: om 08/30/2019	Worksheet S-2 Part I	
			To	06/30/2020	Date/Time Pre 11/25/2020 11	parec
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	1
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
	1.00	2.00	Si te 3. 00	4.00	5.00	-
.00 Enter in column 1, if line 63 is yes, or your facility	1.00	2.00	0.00	0.00) 65.
trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)			Unweighted		Ratio (col. 1/	
			FTEs Nonprovi der	Unweighted FTEs in Hospital	(col. 1 + col. 2))	
			Si te			4
Section 5504 of the ACA Current	Vear ETE Residents i	n Nonnrovider Settin	1.00	2.00	3.00	
beginning on or after July 1, 20 00 Enter in column 1 the number of	010	·	0.00	•		
FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima al. Enter in column 3	ry care resident 3 the ratio of	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
00 Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00 0.000000	1
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						
				1.0	0 2.00 3.00	
Inpatient Psychiatric Facility F						
00 Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no		IPF), or does it cont	tain an IP⊦ subp	rovider? N		70.
00 If line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)	the facility have an before November 15, 20 blumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	004? Enter "Y" for y ility train residents)(D)? Enter "Y" for y	yes or "N" for n s in a new teach yes or "N" for n	o. (see i ng o.	0	71.
Inpatient Rehabilitation Facilit		y (IRF), or does it o	contain an IRF	Y		75.
.00 Is this facility an Inpatient Re subprovider? Enter "Y" for yes						1

Heal th	Financial Systems COMMUNITY STROKE AND REH	ABI LI TATI ON	In	Lieu of Form CMS	8-2552-10
		ovider CCN: 15-304	5 Peri od:	Worksheet S	
			From 08/30/20 To 06/30/20		renared
			10 00/30/20	11/25/2020	<u>11:50 am</u>
				1.00	_
	Long Term Care Hospital PPS				
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all	of the cost repo	rting period? Ent	er N	81.00
	"Y" for yes and "N" for no. TEFRA Provi ders				_
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFF	A? Enter "Y" for	ves or "N" for n	o. N	85.00
	Did this facility establish a new Other subprovider (excluded uni		2		86.00
	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				
	Is this hospital an extended neoplastic disease care hospital cla	assified under sec	tion	N	87.00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		V	XIX	
			1.00	2.00	
	Title V and XIX Services				
	Does this facility have title V and/or XIX inpatient hospital ser	rvices? Enter "Y"	for N	Y	90.00
	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the co	ost report either	in N	N	91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicabl				
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual ce		e	N	92.00
93.00	instructions) Enter "Y" for yes or "N" for no in the applicable of Does this facility operate an ICF/IID facility for purposes of ti		ter N	N	93.00
75.00	"Y" for yes or "N" for no in the applicable column.			IN IN	75.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and '	'N" for no in the	N	N	94.00
	applicable column.		0.00	0.00	05.00
	If line 94 is "Y", enter the reduction percentage in the applicat Does title V or XIX reduce operating cost? Enter "Y" for yes or '		0. 00 N	0.00 N	95.00 96.00
70.00	applicable column.				70.00
	If line 96 is "Y", enter the reduction percentage in the applicat		0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns			N	98.00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for ye column 1 for title V, and in column 2 for title XIX.	es or in for no i	n		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporti	ng of charges on	Wkst. N	Y	98.01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title $\$	/, and in column 2	for		
	title XIX. Does title V or XIX follow Medicare (title XVIII) for the calcula	tion of obsorvati	on N	Y	98.02
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N"				90.02
	for title V, and in column 2 for title XIX.				
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical			N	98.03
	reimbursed 101% of inpatient services cost? Enter "Y" for yes or for title V, and in column 2 for title XIX.	N FOF NO IN COL	umnı		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimk	oursed 101% of	N	N	98.04
	outpatient services cost? Enter "Y" for yes or "N" for no in colu	umn 1 for title V,	and		
08 05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back th	PCE disallowanc	e on N	Y	98.05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column				70.00
	column 2 for title XIX.				
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimk			N	98.06
	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 fo column 2 for title XIX.	bi ti ti e v, anu i n			
	Rural Providers				
	Does this hospital qualify as a CAH?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclu for outpatient services? (see instructions)	isive method of pa	yment		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost re	eimbursement for I	&R		107.00
	training programs? Enter "Y" for yes or "N" for no in column 1.	(see instructions)		
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you 1				
	approved medical education program in the CAH's excluded IPF and Enter "Y" for yes or "N" for no in column 2. (see instructions)				
108.00	Is this a rural hospital qualifying for an exception to the CRNA	fee schedul e? Se	e 42 N		108.00
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.				_
		ysical Occupat 1.00 2.0		Respirator 4.00	4
109.00	If this hospital qualifies as a CAH or a cost provider, are	2.0	0.00	1.00	109.00
	therapy services provided by outside supplier? Enter "Y"				
	for yes or "N" for no for each therapy.				
				1.00	-
	Did this hospital participate in the Rural Community Hospital Dem			N	110.00
	Demonstration) for the current cost reporting period? Enter "Y" for				
	complete Worksheet E, Part A, lines 200 through 218, and Workshee applicable.	et E-Z, TINES 200	unrougn 215, as		
	12Fb			I	I.

Health Financial Systems COMMUNITY STROKE AND REHABILITAT	TI ON	In Lie	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider (CCN: 15-3045	Period: From 08/30/2019		
		To 06/30/2020	Date/Time Pr 11/25/2020 1	repared: 1:50 am
		1.00	2.00	_
111.00 If this facility qualifies as a CAH, did it participate in the Frontier of Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, 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 n column 2.	N		111.00
	1.00	2.00	3.00	_
112. 00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N			112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00
	Premi ums	2.00	I nsurance	_
118.01 List amounts of malpractice premiums and paid losses:		1 (0118.01
118.02 Are malpractice premiums and paid losses reported in a cost center other	than the	1.00 N	2.00	118.02
 Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless profisal and applicable amendments? (see instructions) Enter in column 1, ""N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) 	cost centers ovision in ACA Y" for yes or the Outpatient	N	N	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable device	es charged to	N		121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §190. 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.				122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N"	" for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certi	ification date			126.00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certi	fication date			127.00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certi	fication date			128.00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certifi		n		129.00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the center of the center				130.00
date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the o				131.00
date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified islet transplant center, enter the certified islet transplant center.				131.00
in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved				133.00
134.00 f this is an organ procurement organization (OPO), enter the OPO number and termination date, if applicable, in column 2. All Providers				134.00
140.00 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 are claimed, enter in column 2 the home office chain number. (see instruct	e office costs	Y	15H054	140.00

	X IDENTIFICATION DATA	E AND REHABILITAT		Peri od:		u of Form CMS Worksheet S-	
					8/30/2019		conarad
				10 0	5/30/2020	11/25/2020 1	
1.00		2.00			3.00		
If this facility is part of a chai				e name and	address	of the	
home office and enter the home off				ator'o Nu	mborn. 0000	1	141.
41.00 Name: COMMUNITY FOUNDATION OF NW 42.00 Street: 10010 DON POWERS DRIVE	IN Contractor's Name PO Box:	e: WPS	Contra	ictor's Nu			141.
43. 00 City: MUNSTER	State:	IN	Zip Co	ide:	4632	21	143. (
			I _ I				
						1.00	
44.00 Are provider based physicians' cos	sts included in Workshe	et A?				Y	144. (
					1.00	2.00	-
45.00 f costs for renal services are cl	aimed on Wkst. A. line	74, are the cost	s for		Y	2.00	145. (
inpatient services only? Enter "Y"				5			
no, does the dialysis facility inc		ion for this cost	reporting				
period? Enter "Y" for yes or "N"		wiewely filed and	++2		N		144
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir				lf	Ν		146. (
yes, enter the approval date (mm/c			40, 34020)				
47.00 Was there a she in the initial						1.00	1.47
47.00Was there a change in the statisti 48.00Was there a change in the order of						N N	147.0
49.00Was there a change to the simplifi				or no		N	148.0
The option of the option of the option of the option		Part A	Part E		itle V	Title XIX	117.
		1.00	2.00		3.00	4.00	
Does this facility contain a provi							
or charges? Enter "Y" for yes or '	'N" for no for each com			<u>3. (See 42</u>			
55.00 Hospital 56.00 Subprovider - IPF		N N	N N		N N	N N	155.
57.00 Subprovider - IRF		N	N		N	N	157.
58. 00 SUBPROVI DER							158. (
59. 00 SNF		Ν	N		Ν	N	159. (
60.00 HOME HEALTH AGENCY		N	N		Ν	Ν	160. (
61.00 CMHC			N		N	N	161.0
						1.00	_
Multicampus						1.00	
65.00 Is this hospital part of a Multica	ampus hospital that has	one or more camp	uses in dif	ferent CB	SAs?	N	165. 0
Enter "Y" for yes or "N" for no.		<u> </u>		71 0 1	0004	575 (0	_
	Name O	<u>County</u> 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00	_
66.00 fline 165 is yes, for each	0	1.00	2.00	3.00	4.00		00 166. 0
						0.0	
campus enter the name in column							
campus enter the name in column O, county in column 1, state in							
0, county in column 1, state in column 2, zip code in column 3,							
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
0, county in column 1, state in column 2, zip code in column 3,							_
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in						1.00	
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI						1	
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user	under §1886(n)? Ente	er "Y" for yes or	"N" for no.			1.00 Y	
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10	under §1886(n)? Ente D5 is "Y") and is a mea	er "Y" for yes or ningful user (lin	"N" for no.		the	1	
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	under §1886(n)? Ente 05 is "Y") and is a mea HT assets (see instruc	er "Y" for yes or ningful user (lin stions)	"N" for no. e 167 is "\	"), enter		1	168. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)?	under §1886(n)? Ente 5 is "Y") and is a mea HT assets (see instruc not a meaningful user, 2 Enter "Y" for yes or	r "Y" for yes or ningful user (lin tions) does this provide "N" for no. (see	"N" for no. e 167 is "א r qualify f instructior	("), enter For a hard hs)	shi p	Y	168. (168. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is r exception under §413.70(a)(6)(i)) 69.00 If this provider is a meaningful u	under §1886(n)? Ente 5 is "Y") and is a mea 41T assets (see instruc hot a meaningful user, 2 Enter "Y" for yes or user (line 167 is "Y")	r "Y" for yes or ningful user (lin tions) does this provide "N" for no. (see	"N" for no. e 167 is "א r qualify f instructior	("), enter For a hard hs)	shi p	Y	168. (168. (
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0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii) ? 69.00 If this provider is a meaningful u transition factor. (see instruction	under §1886(n)? Ente 5 is "Y") and is a mea HIT assets (see instruc not a meaningful user, 2 Enter "Y" for yes or user (line 167 is "Y") nns)	er "Y" for yes or ningful user (lin tions) does this provide "N" for no. (see and is not a CAH	"N" for no. e 167 is "\ r qualify f instructior (line 105 i	("), enter For a hard hs) s "N"), e Be	ship nter the	Y 0. (168. (168. (00169. (
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0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the F 68.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)? 69.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR th period respectively (mm/dd/yyyy)	- under §1886(n)? Ente 5 is "Y") and is a mea HIT assets (see instruc- not a meaningful user, P Enter "Y" for yes or ser (line 167 is "Y") ons) peginning date and endi	r "Y" for yes or ningful user (lin tions) does this provide "N" for no. (see and is not a CAH ng date for the r	"N" for no. e 167 is "\ r qualify f instructior (line 105 i eporting	/"), enter for a hard is) s "N"), e Be	ship nter the ginning 1.00	Y O. (Endi ng	168. (168. (00 169. (170. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the F 68.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)? 69.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR th period respectively (mm/dd/yyyy) 71.00 If line 167 is "Y", does this provider	- under §1886(n)? Ente 5 is "Y") and is a mea 11 assets (see instruc- not a meaningful user, 2 Enter "Y" for yes or iser (line 167 is "Y") pons) peginning date and endi vider have any days for	r "Y" for yes or ningful user (lin tions) does this provide "N" for no. (see and is not a CAH ng date for the r	"N" for no. e 167 is "\ r qualify f instructior (line 105 i eporting lled in	/"), enter for a hard is) s "N"), e Be	ship nter the ginning 1.00	Y 0.1 Endi ng 2.00	168. (168. (00169. (
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the H exception under §413.70(a) (6) (ii) (5 59.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR to period respectively (mm/dd/yyyy)	- under §1886(n)? Ente 5 is "Y") and is a mea 11 assets (see instruc- not a meaningful user, 2 Enter "Y" for yes or user (line 167 is "Y") peginning date and endi vider have any days for reported on Wkst. S-3,	r "Y" for yes or ningful user (lin tions) does this provide "N" for no. (see and is not a CAH ng date for the r individuals enro Pt. I, line 2, co	"N" for no. e 167 is ") r qualify 1 instructior (line 105 i eporting lled in 1. 6? Enter	/"), enter for a hard is) s "N"), e Be	ship nter the ginning 1.00	Y 0.1 Endi ng 2.00	168. 168. 00169. 170.

	Financial Systems COMMUNITY STROKE AN AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Provider C		Period: From 08/30/2019 To 06/30/2020	Date/Time Pr	epared:
				N/ /N	11/25/2020 1	1:50 an
				Y/N 1.00	Date 2.00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses. Ente			
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					_
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			N		1.0
	reporting period? If yes, enter the date of the change in c	Joi unin 2. (See	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum		N			2.0
. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, includir 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 other	offices, drug der or its of the board	N			3. 0
	relationships? (see instructions)		Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
1.00	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.	for Compiled,	Y	A		4.0
5.00	Are the cost report total expenses and total revenues different total expenses and total revenues different those on the filed financial statements? If yes, submit reconcisional statements are submit reconcisional statements and total statements are submit reconcisional statements are submit reconcisional statements are submit reconcisional statements.		N			5.0
				Y/N 1.00	Legal Oper.	
	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	N		6.0
7.00 3.00	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.	and/or renewed	0	N N		7.0 8.0
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education N program in the current cost report? If yes, see instructions.					9.0
0.00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		the current	N		10.0
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		11.0
					Y/N	_
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes	s, see instruct	tions.		Y	12.0
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			st reporting	Ν	13.0
4.00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	[≈] yes, see ins	tructions.	N	14.0
5 00	Bed Complement Did total beds available change from the prior cost reporti	ng poriod2 lf	vos soo inst	ructions	N	15.0
15.00	The total beds available change from the pirol cost report		-t A		t B	15.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	<u>PS&R Data</u> 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	N		N		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	Y	10/14/2020	Y	10/14/2020	17. C
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. C
	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 information? If yes, see instructions.	Ν		Ν		19. 0

Health Financial Systems

	Financial Systems COMMUNITY STROKE A	ND REHABILITAT	ION		u of Form CMS-2	2552-1
10SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-3045	Period: From 08/30/2019 To 06/30/2020		
					11/25/2020 11	
		Descr	iption	Y/N	Y/N	
			0	1.00	3.00	
0. 00	If line 16 or 17 is yes, were adjustments made to PS&R			N	Ν	20.00
	Report data for Other? Describe the other adjustments:					
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's	N		N		21.00
	records? If yes, see instructions.					
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	IOSPI TALS)			
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, see					22.00
3.00	Have changes occurred in the Medicare depreciation expense	due to apprais	sals made duri	ng the cost		23.0
	reporting period? If yes, see instructions.					
4.00	Were new leases and/or amendments to existing leases entere	ed into during	this cost rep	orting period?		24.0
	If yes, see instructions					
5.00	Have there been new capitalized leases entered into during	the cost repor	ting period?	lf yes, see		25.00
	instructions.					
6.00	Were assets subject to Sec.2314 of DEFRA acquired during th	he cost reporti	ng period? If	fyes, see		26.0
	instructions.					
7.00	Has the provider's capitalization policy changed during the	e cost reportir	ng period? If	yes, submit		27.0
	сору.					
	Interest Expense					
3.00	Were new loans, mortgage agreements or letters of credit en	ntered into dur	ing the cost	reporting		28.0
	period? If yes, see instructions.					
9.00	Did the provider have a funded depreciation account and/or		ebt Service Re	eserve Fund)		29.0
	treated as a funded depreciation account? If yes, see instr	ructions				
0. 00	Has existing debt been replaced prior to its scheduled matu	urity with new	debt? If yes,	see		30.0
	instructions.					
1.00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see		31.0
	instructions.					
- F	Purchased Services					
2.00	Have changes or new agreements occurred in patient care set		ed through cor	ntractual		32.0
	arrangements with suppliers of services? If yes, see instru					
3.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pertainir	ng to competit	ive bidding? If		33.0
	no, see instructions.					1
	Provi der-Based Physi ci ans					
4.00	Are services furnished at the provider facility under an an	rrangement with	n provider-bas	sed physicians?		34.0
	If yes, see instructions.					
5.00	If line 34 is yes, were there new agreements or amended exi		nts with the p	provi der-based		35.0
	physicians during the cost reporting period? If yes, see in	nstructions.	-) (/NI	D 1	
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					1 0 / 0
	Were home office costs claimed on the cost report?					36.0
7.00	If line 36 is yes, has a home office cost statement been p	repared by the	nome office?			37.0
	If yes, see instructions.					
3.00	If line 36 is yes, was the fiscal year end of the home of					38.0
	the provider? If yes, enter in column 2 the fiscal year end					0.0 -
	If line 36 is yes, did the provider render services to othe	er chain compor	nents? If yes,			39.0
9.00	see instructions.		1.6			
			If yes, see			
	If line 36 is yes, did the provider render services to the	nome office?	, j==, ===			40.0
		nome office?				40.0
	If line 36 is yes, did the provider render services to the					40.0
D. 00	If line 36 is yes, did the provider render services to the instructions.		00	2.	00	40. C
0. 00	If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information	1.			00	
0. 00	If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position			2. WOERNER	00	
0. 00	If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	1.			00	
0. 00	If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	1. CATHERI NE	00		00	41. (
0. 00	If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	1.	00		00	41. (
0.00	If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	1. CATHERI NE COMMUNI TY HOSF	00	WOERNER		41. C
0.00	If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	1. CATHERI NE	00	WOERNER	00 ERNER@COMHS. OR	41. 0

Health Financial Systems COMML	AND REHABILIT	ATION	In Lieu of Form CMS-2552-1			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			- CCN: 15-3045	Period: From 08/30/2019	Worksheet S-2 Part II	
		_			Date/Time Pre 11/25/2020 11	pared: :50 am
			3.00			
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the title	/position	DI RECTOR OF	REI MBURSEMENT			41.00
held by the cost report preparer in columns 1	, 2, and 3,					
respecti vel y.						
42.00 Enter the employer/company name of the cost r	eport					42.00
preparer.						
43.00 Enter the telephone number and email address	of the cost					43.00
report preparer in columns 1 and 2, respectiv	el y.					

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-3045	Period: From 08/30/2019 To 06/30/2020	Worksheet S-3 Part I Date/Time Pre	
						11/25/2020 11 I/P Days / O/P Visits / Trips	50 am
	Component	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	30	9, 18	30 0. 00	0	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider						2.00 3.00 4.00
5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation		30	9, 18	30 0.00	0 0 0	5.00 6.00 7.00
8.00 9.00 10.00 11.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	31. 00	0		0 0.00	0	8.00 9.00 10.00 11.00
12.00 13.00 14.00 15.00	OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits	43.00	30	9, 18	0.00	0 0 0	12.00 13.00 14.00 15.00
16.00 17.00 18.00 19.00	SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY	41. 00	0		0	0	16.00 17.00 18.00 19.00
20.00 21.00 22.00 23.00 24.00 24.10 25.00	NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	116. 00 30. 00	0		0		20.00 21.00 22.00 23.00 24.00 24.10 25.00
26.00 26.25 27.00 28.00 29.00 30.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction)	89.00	30			0	26.00 26.25 27.00 28.00 29.00 30.00
31. 00 32. 00 32. 01	Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)		0		0		31.00 32.00 32.01
33. 00 33. 01	LTCH non-covered days LTCH si te neutral days and discharges						33. 00 33. 01

	Financial Systems COMMM	AL DATA	Provider CO	CN: 15-3045		riod: om 08/30/2019 06/30/2020	Worksheet S-3 Part I Date/Time Pre 11/25/2020 11	pared
		I/P Days	/ O/P Visits / Trips		Full Time E		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	
	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)	2,876	15	4, 20	65			1.0
	HMO and other (see instructions)	375	46					2.0
	HMO IPF Subprovider	0	0					3.0
	HMO IRF Subprovider	0	0					4.0
	Hospital Adults & Peds. Swing Bed SNF	0	0		0			5.0
	Hospital Adults & Peds. Swing Bed NF		0		0			6.1
	Total Adults and Peds. (exclude observation beds) (see instructions)	2, 876	15	4, 20	65			7.
. 00	INTENSIVE CARE UNIT	0	0		0			8.
00	CORONARY CARE UNIT							9.
. 00	BURN INTENSIVE CARE UNIT							10.
. 00	SURGICAL INTENSIVE CARE UNIT							11.
2.00	OTHER SPECIAL CARE (SPECIFY)							12.
	NURSERY		0		0			13.
1.00	Total (see instructions)	2, 876	15	4, 2	65	0.00	77.14	14.
1	CAH visits	0	0		0			15.
. 00	SUBPROVIDER - IPF							16.
. 00	SUBPROVIDER – IRF	0	0		0	0.00	0.00	17.
. 00	SUBPROVI DER							18
.00	SKILLED NURSING FACILITY							19
. 00	NURSING FACILITY							20
. 00	OTHER LONG TERM CARE							21.
. 00	HOME HEALTH AGENCY							22.
. 00	AMBULATORY SURGICAL CENTER (D. P.)							23.
. 00	HOSPI CE	0	0	1	0	0.00	0.00	24.
10	HOSPICE (non-distinct part)				0			24
. 00	CMHC – CMHC							25.
. 00	RURAL HEALTH CLINIC							26.
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00	0.00	26.
. 00	Total (sum of lines 14-26)					0.00	77.14	27.
. 00	Observation Bed Days		0		0			28.
. 00	Ambul ance Trips	0						29.
. 00	Employee discount days (see instruction)				0			30.
. 00	Employee discount days - IRF				0			31.
. 00	Labor & delivery days (see instructions)	0	0		0			32.
. 01	Total ancillary labor & delivery room				0			32.
	outpatient days (see instructions)							
3.00	LTCH non-covered days	0						33.
01	LTCH site neutral days and discharges	0						33

IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICA	AL DATA	Provider CC	CN: 15-3045	Period: From 08/30/2019 To 06/30/2020	Worksheet S-3 Part I Date/Time Pre 11/25/2020 11	pared:
	Full Time Equivalents		Di s	charges		
Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	Workers				Patients	
	11.00	12.00	13.00	14.00	15.00	
 .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) 2.00 HMO and other (see instructions) 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 5.00 CORONARY CARE UNIT 		0		45 1 31 4 0 0	347	1.0 2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0
0.00 BURN INTENSIVE CARE UNIT 1.00 SURGICAL INTENSIVE CARE UNIT 2.00 OTHER SPECIAL CARE (SPECIFY) 3.00 NURSERY 4.00 Total (see instructions) 5.00 [CAH visits	0. 00	0	2.	45 1	347	10. (11. (12. (13. (14. (15. (
6.00 SUBPROVIDER - IPF 7.00 SUBPROVIDER - IRF 8.00 SUBPROVIDER 9.00 SKILLED NURSING FACILITY 0.00 NURSING FACILITY 1.00 OTHER LONG TERM CARE 2.00 HOME HEALTH AGENCY 3.00 AMBULATORY SURGICAL CENTER (D.P.)	0. 00	0		0 0	0	16. (17. (18. (19. (20. (21. (22. (23. (
4.00 HOSPICE 4.10 HOSPICE (non-distinct part) 5.00 CMHC - CMHC 6.00 RURAL HEALTH CLINIC 6.25 FEDERALLY QUALIFIED HEALTH CENTER 7.00 Total (sum of lines 14-26)	0.00 0.00 0.00					24.0 24. 25.0 26.0 26.2
 8.00 Observation Bed Days 9.00 Ambulance Trips 0.00 Employee discount days (see instruction) 1.00 Employee discount days - IRF 2.00 Labor & delivery days (see instructions) 2.01 Total ancillary labor & delivery room 	0.00					27. 28. 29. 30. 31. 32. 32.
outpatient days (see instructions) 3.00 LTCH non-covered days 3.01 LTCH site neutral days and discharges				0		33. 33.

Health Financial Systems COMM RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	UNITY STROKE AND F EXPENSES	REHABILITATI		In Lie eriod:	u of Form CMS-2 Worksheet A	2552-10
			F Te	rom 08/30/2019 0 06/30/2020	Date/Time Pre 11/25/2020 11	
Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	<u></u>
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS		2, 514, 491	2, 514, 491	20, 719	2, 535, 210	1.00
2.00 00200 CAP REL COSTS MVBLE EQUIP		888, 646		20, 717	888, 646	2.00
3.00 00300 OTHER CAP REL COSTS		0	0	0	0	3.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00540 NONPATI ENT TELEPHONES	54, 135 0	658, 279 0	712, 414 0	0	712, 414 0	4. 00 5. 01
5. 02 00550 PURCHASI NG & RECEI VI NG STORES	48, 321	39, 529		0	87, 850	5.02
5. 03 00560 ADMI TTI NG	264, 079	29, 548		0	293, 627	5.03
5. 04 00590 CASHI ERING ACCOUNTS RECEI VABLE 5. 05 00592 OTHER ADMINI STRATI VE & GENERAL COSTS	0 345, 594	0 3, 107, 529	-	0 -93, 229	0 3, 359, 894	5.04 5.05
7.00 00700 OPERATION OF PLANT	439, 645	1, 216, 649		0	1, 656, 294	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	33, 199		0	33, 199	8.00
9.00 00900 HOUSEKEEPING	131, 459	204, 948		0	336, 407	9.00
10. 00 01000 DI ETARY	270, 228	129, 710 0		-90, 642	309, 296	10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	2, 880	1, 425	-	90, 642 72, 510	90, 642 76, 815	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	2,000	0	0	0	0,0,010	14.00
15. 00 01500 PHARMACY	111, 643	242, 907	354, 550	0	354, 550	15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	0		0	0	16.00
17. 00 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	17.00
30. 00 03000 ADULTS & PEDIATRICS	1, 868, 454	779, 742	2, 648, 196	0	2, 648, 196	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0		0	0	31.00
41. 00 04100 SUBPROVI DER – I RF	0	0		0	0	41.00
43. 00 04300 NURSERY	0	0	0	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	50.00
51. 00 05100 RECOVERY ROOM	0	0		0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	189, 800	56, 418		0	246, 218	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0 44 194	0 20 E7E	0	0	0	55.00 56.00
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN	46, 186 136, 542	38, 575 34, 804		0	84, 761 171, 346	56.00 57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	51, 240	23, 167		0	74, 407	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	-	0	0	59.00
	258, 228	243, 609		-1, 864	499, 973	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 65. 00 06500 RESPI RATORY THERAPY	0 180, 506	0 32, 438	0 212, 944	1, 864 0	1, 864 212, 944	62.00 65.00
66. 00 06600 PHYSI CAL THERAPY	162, 479	513, 973		0	676, 452	66.00
67.00 06700 OCCUPATI ONAL THERAPY	72, 279	460, 181		0	532, 460	67.00
68.00 06800 SPEECH PATHOLOGY	17, 060	109, 261		0	126, 321	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	54, 097 2, 000	18, 563 1, 325		0	72, 660 3, 325	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,000	22, 132		0	22, 132	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DI ALYSI S	0	32, 584		0	32, 584	74.00
75.00 07500 ASC (NON-DISTINCT PART) 76.00 03020 OTHER ANCILLARY	0 36, 262	0 14, 305	0 50, 567	0	0 50, 567	75.00 76.00
OUTPATIENT SERVICE COST CENTERS	30, 202	14, 303	50, 507	0	30, 307	70.00
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) SPECI AL PURPOSE COST CENTERS						92.00
113. 00 11300 I NTEREST EXPENSE		0	0	0	0	113.00
116.00 11600 HOSPI CE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	4, 743, 117	11, 447, 937	16, 191, 054	0	16, 191, 054	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
190.0019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00 191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
194.00 07950 OTHER NONRELMBURSABLE DEPARTMENTS	0	1, 173				194.00 104.01
194.01 07951 ADVERTISING 200.00 TOTAL (SUM OF LINES 118 through 199)	0 4, 743, 117	29, 144 11, 478, 254			29, 144 16, 221, 371	
	4,743,117	11, 470, 204	10,221,371	U U	10, 221, 371	200.00

In Lieu of Form CMS-2552-10 Worksheet A

	Cret Creter Description	A		1.1.207	<u>2020 11:50 ar</u>
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS		1		
00	00100 CAP REL COSTS-BLDG & FIXT	6, 612			1.0
00 00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS	63,004			2.0 3.0
00	00400 EMPLOYEE BENEFITS DEPARTMENT	92, 563			4.0
01	00540 NONPATI ENT TELEPHONES	41, 675			5.0
02	00550 PURCHASI NG & RECEI VI NG STORES	0			5.0
03	00560 ADMI TTI NG	0			5.0
04	00590 CASHI ERING ACCOUNTS RECEIVABLE	220, 865			5.0
05	00592 OTHER ADMINISTRATIVE & GENERAL COSTS	-1, 597, 600	1, 762, 294		5.0
00	00700 OPERATION OF PLANT	0	1, 656, 294		7.0
00	00800 LAUNDRY & LINEN SERVICE	0			8.0
00	00900 HOUSEKEEPI NG	0	000, 107		9.0
). 00	01000 DI ETARY	-20			10.0
1.00		-14, 578			11.0
3.00	01300 NURSI NG ADMI NI STRATI ON	0			13.0
4.00 5.00	01400 CENTRAL SERVICES & SUPPLY	0	-		14. 0 15. 0
5.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	172, 348			16.0
7.00	01700 SOCIAL SERVICE	0			17.0
. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	/j 0j		17.0
0. 00	03000 ADULTS & PEDIATRICS	0	2, 648, 196		30. 0
1.00	03100 I NTENSI VE CARE UNI T	0			31.0
1.00	04100 SUBPROVIDER - IRF	0			41.0
3.00	04300 NURSERY	0	0		43.0
	ANCI LLARY SERVICE COST CENTERS				
0. 00	05000 OPERATING ROOM	0			50.0
I. 00	05100 RECOVERY ROOM	0			51.0
3.00	05300 ANESTHESI OLOGY	0			53.0
1.00	05400 RADI OLOGY-DI AGNOSTI C	-1, 062			54.0
5.00	05500 RADI OLOGY-THERAPEUTI C	0			55.0
5.00 7.00	05600 RADI 0I SOTOPE 05700 CT SCAN	0	84, 761 171, 346		56. 0 57. 0
3.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			58.0
9.00	05900 CARDI AC CATHETERI ZATI ON	0			59.0
). 00	06000 LABORATORY	-3, 641	-		60.0
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			62.0
5.00	06500 RESPI RATORY THERAPY	0			65.0
5.00	06600 PHYSI CAL THERAPY	0	676, 452		66.0
7.00	06700 OCCUPATI ONAL THERAPY	0	532, 460		67.0
3.00	06800 SPEECH PATHOLOGY	0	126, 321		68.0
9.00	06900 ELECTROCARDI OLOGY	0	72, 660		69. C
0. 00	07000 ELECTROENCEPHALOGRAPHY	0	3, 325		70.0
1.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	22, 132		71.0
2.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		72.0
	07300 DRUGS CHARGED TO PATIENTS	0			73.0
	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0			74.0
	03020 OTHER ANCILLARY	0			76.0
5. 00	OUTPATIENT SERVICE COST CENTERS	0	<u> </u>		/0.0
0. 00	09000 CLINIC	0	0		90.0
	09100 EMERGENCY	0			91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.0
	SPECIAL PURPOSE COST CENTERS	1	· · · ·		
3.00	11300 INTEREST EXPENSE	0	0 0		113.0
16.00	11600 HOSPI CE	0	0		116. 0
18.00		-1, 019, 834	15, 171, 220		118. 0
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0 0		190. C
	19100 RESEARCH	0	0		191. (
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192. C
	19300 NONPAI D WORKERS	0	0		193. C
	07950 OTHER NONREI MBURSABLE DEPARTMENTS	0	1, 173		194. C
1/1 ()1	07951 ADVERTI SI NG	ı 0	29, 144		194. C

Heal th	Financial Systems	COMM	NUNITY STROKE AN	ID REHABILITAT	I ON	In Lie	u of Form CMS	-2552-10
RECLAS	SEFECATIONS			Provider (CCN: 15-3045	Peri od:	Worksheet A-	6
						From 08/30/2019 To 06/30/2020	Date/Time Pr 11/25/2020 1	epared: <u>1:50 am</u>
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A - RECLASS BUILDING INSURAN	CE	· · · · · ·					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	20, 719				1.00
	TOTALS		0	20, 719				1
	B - CAFETERIA RECLASS							
1.00	CAFETERI A	11.00	53, 431	37, 211				1.00
	TOTALS		53, 431	37, 211				
	C - CNO SALARY RECLASS							
1.00	NURSING ADMINISTRATION	13.00	72, 510	0				1.00
	TOTALS		72, 510	0				
	D - RECLASS BLOOD COSTS							
1.00	WHOLE BLOOD & PACKED RED	62.00	0	1, 864				1.00
	BLOOD_CELLS							
	TOTALS		0	1, 864]			
500.00	Grand Total: Increases		125, 941	59, 794				500.00

Heal th	Financial Systems	COM	IUNITY STROKE ANI	D REHABILITAT	-I ON	In Lie	u of Form CMS·	-2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-3045	Period: From 08/30/2019	Worksheet A-	6
						To 06/30/2020	Date/Time Pro 11/25/2020 1	epared: 1:50 am
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	A - RECLASS BUILDING INSURANC	ČE .						
1.00	OTHER ADMINI STRATI VE &	5.05	0	20, 719	1	2		1.00
	GENERAL COSTS							
	TOTALS			20, 719		7		
	B - CAFETERIA RECLASS							1
1.00	DI ETARY	10.00	53, 431	37, 211		0		1.00
	TOTALS		53, 431	37, 211		7		
	C - CNO SALARY RECLASS		· · · · · ·					1
1.00	OTHER ADMINI STRATI VE &	5.05	72, 510	0		0		1.00
	GENERAL COSTS							
	TOTALS		72, 510	0		7		
	D - RECLASS BLOOD COSTS							1
1.00	LABORATORY	60.00	0	1, 864		0		1.00
	TOTALS		0	1,864		7		1
500.00	Grand Total: Decreases		125, 941	59, 794		7		500.00

Heal th Financia	al Systems		
RECONCI LI ATI ON	OF CAPITAL	COSTS	CENTERS

In Lieu of Form CMS-2552-10 Worksheet A-7

				54. 10 0010	Fron	n 08/30/2019 06/30/2020	Part I Date/Time Pre 11/25/2020 11	
				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 ASSE							
1.00	Land	683, 805	34, 777		0	34, 777	0	1.00
2.00	Land Improvements	0	1, 094, 290		0	1, 094, 290		2.00
3.00	Buildings and Fixtures	0	49, 209, 895		0	49, 209, 895	0	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	771, 818	7, 838, 942		0	7, 838, 942	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1, 455, 623	58, 177, 904		0	58, 177, 904	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	1, 455, 623	58, 177, 904		0	58, 177, 904	0	10.00
		Endi ng Bal ance	Fully					
			Depreci ated					
			Assets					
	1	6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	718, 582	0					1.00
2.00	Land Improvements	1, 094, 290	0					2.00
3.00	Buildings and Fixtures	49, 209, 895	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	8, 610, 760	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	59, 633, 527	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	59, 633, 527	0					10.00

Heal th	Financial Systems COMM	UNITY STROKE AN	ID REHABILITATI	ON	In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-3045	Peri od:	Worksheet A-7	
					From 08/30/2019 To 06/30/2020		naradi
					10 00/30/2020	11/25/2020 11	:50 am
			SL	JMMARY OF CAF	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK		N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 514, 491	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	888, 646	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	3, 403, 137	0		0 0	0	3.00
		SUMMARY O	F CAPI TAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	45.00				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEEL A, COLUM		nd 2			1
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 514, 491				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	888, 646				2.00
3.00	Total (sum of lines 1-2)		3, 403, 137				3.00

······································	JNITY STROKE AN	D REHABILITATI			u of Form CMS-2	
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CC	F	Period: From 08/30/2019 Fo 06/30/2020		bared:
	COMF	PUTATION OF RAT	-1 OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	51, 022, 766 8, 610, 761 59, 633, 527	O O O TION OF OTHER C	51, 022, 766 8, 610, 76 59, 633, 52 CAPI TAL	0. 144395	0 0 F CAPITAL	1.00 2.00 3.00
Cost Center Description	Taxes	Other Capi tal -Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE .00 CAP REL COSTS-BLDG & FIXT		0		2 521 102		1 0
.00 CAP REL COSTS-BLDG & FIXT .00 CAP REL COSTS-MVBLE EQUIP .00 Total (sum of lines 1-2)	0 0	0		2, 521, 103 951, 650 3, 472, 753		1.0 2.0 3.0
		SL	IMMARY OF CAPI			010
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE .00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP	NTERS 0 0	20, 719			2, 541, 822 951, 650	1. 0 2. 0
3.00 Total (sum of lines 1-2)	0	20, 719			3, 493, 472	3.0

DJUSTME	NTS TO EXPENSES			Provider CCN: 15-3045	Period: From 08/30/2019	Worksheet A-8	
					To 06/30/2020	Date/Time Pre 11/25/2020 11	
				Expense Classification o To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
ıl 00.	nvestment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00) 1. (
C	OSTS-BLDG & FIXT (chapter 2)						
	nvestment income - CAP REL DSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.0
	nvestment income - other chapter 2)		0		0.00	0	3.0
. 00 Ti	rade, quantity, and time iscounts (chapter 8)		0		0.00	0	4. (
. 00 Re	efunds and rebates of		0		0.00	0	5.0
	xpenses (chapter 8) ental of provider space by		0		0.00	0	6.0
. 00 Te	uppliers (chapter 8) elephone services (pay tations excluded) (chapter	А	-1, 538	NONPATI ENT TELEPHONES	5. 01	0	7.0
. 00 Te	1) elevision and radio service	А	-1, 214	CAP REL COSTS-MVBLE EQUIP	2.00	9	8. (
	chapter 21) arking lot (chapter 21)		0		0.00	0	9. (
0. 00 Pi	rovider-based physician djustment	A-8-2	-5, 135			0	
1.00 Sa	ale of scrap, waste, etc.		0		0.00	0	11. (
2.00 Re	chapter 23) elated organization	A-8-1	-491, 681			0	12.
	ransactions (chapter 10) aundry and linen service		0		0.00	0	13.
	afeteria-employees and guests ental of quarters to employee	В	-14, 578	CAFETERI A	11.00 0.00	0	
ar	nd others ale of medical and surgical		0		0.00	0	
รเ	upplies to other than atients		0		0.00	0	10.
7.00 Sa	ale of drugs to other than atients		0		0.00	0	17.
8.00 Sa	ale of medical records and		0		0.00	0	18.
	ostracts ursing and allied health		0		0.00	0	19.
	ducation (tuition, fees, poks, etc.)						
0. 00 Ve	ending machines ncome from imposition of		0		0.00	0	
ii	nterest, finance or penalty		0		0.00	0	21.
	narges (chapter 21) nterest expense on Medicare		0		0.00	0	22.
	verpayments and borrowings to epay Medicare overpayments						
3.00 Ad	djustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.
Li	nerapy costs in excess of imitation (chapter 14)						
	djustment for physical nerapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.
Li	imitation (chapter 14) tilization review –		0	*** Cost Center Deleted ***	· 114.00		25.
pł	nysicians' compensation		0	cost center bereted	114.00		20.
6.00 De	chapter 21) epreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.
	OSTS-BLDG & FLXT epreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.
C	DSTS-MVBLE EQUIP Dn-physician Anesthetist			*** Cost Center Deleted ***		-	28.
9.00 Pł	nysi ci ans' assi stant		0		0.00	0	29.
	djustment for occupational herapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.
11	imitation (chapter 14) ospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.
ii	nstructions)						
pa	djustment for speech athology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.
	imitation (chapter 14) AH HIT Adjustment for		0		0.00	0	32.
	epreciation and Interest		Ŭ		0.00	0	02.

	Financial Systems	COMMU	JNI TY STROKE AI	ND REHABILITATION		u of Form CMS-2	
ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 08/30/2019 To 06/30/2020	Date/Time Pre 11/25/2020 11	
				Expense Classification or			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	OFFSET OTHER INCOME A&G	В		OTHER ADMINISTRATIVE &	5.05	0	33.00
				GENERAL COSTS			
	OFFSET OTHER INCOME DIETARY	В		DI ETARY	10.00		33.01
33. 02	OFFSET OTHER INCOME HR	В		EMPLOYEE BENEFITS DEPARTMEN			33.02
33.03	INCOME FROM RESTRICTED ASSETS	В		OTHER ADMINISTRATIVE &	5.05	0	33.03
				GENERAL COSTS			
33.04	OFFSET OTHER CONTRIBUTIONS	A		OTHER ADMINISTRATIVE &	5.05	0	33.04
				GENERAL COSTS			
33.05	OFFSET OTHER CONTRIBUTIONS	A		OTHER ADMINISTRATIVE &	5.05	0	33.05
22.04	OFFECT DUVELOLAN ALLOCATION	•		GENERAL COSTS	F 0F		22.00
33.06	OFFSET PHYSICIAN ALLOCATION	A		OTHER ADMINISTRATIVE &	5.05	0	33.06
33.07	OTHER ADJUSTMENTS (SPECIFY)		0	GENERAL COSTS	0.00	0	33.07
33.07	(3)		0		0.00	0	33.07
33.08	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.08
55.00	(3)		0		0.00	0	33.00
50.00	TOTAL (sum of lines 1 thru 49)		-1, 019, 834				50.00
50.00	(Transfer to Worksheet A,		1, 017, 034				00.00
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.

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

Heal th	Financial Systems	COMMUNITY STROKE	AND REHABILITATION	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Period: From 08/30/2019	Worksheet A-8	8-1
OFFICE				To 06/30/2019		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5. 05	OTHER ADMINISTRATIVE & GENER	CFNI NONCAPITAL COSTS ALLOCA	533, 388	2, 082, 920	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE CAPITAL COSTS	6, 612	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE CAPITAL COSTS	64, 218	0	3.00
3.01	5.05	OTHER ADMINISTRATIVE & GENER	CFNI SALARY ALLOCATION	458, 012	0	3.01
3.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	CFNI BENEFITS ALLOCATION	92, 583	0	3. 02
4.00	5. 01	NONPATIENT TELEPHONES	TELECOMMUNICATION ALLOCATION	43, 213	0	4.00
4.01	5.04	CASHIERING ACCOUNTS RECEIVAB	PATIENT ACCOUNTING ALLOCATIO	220, 865	0	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS ALLOCATION	172, 348	0	4.02
5.00	TOTALS (sum of lines 1-4).			1, 591, 239	2, 082, 920	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

nds not been posted to norkandet A, der and of 2, the amount arrowable anound be mareated in obtaining of this part.									
				Related Organization(s) and/	or Home Office				
				-		1			
						1			
						i i			
	Symbol (1)	Name	Percentage of	Name	Percentage of				
	Symbol (1)	Name		Name		í.			
			Ownership		Ownershi p				
	1.00	2.00	3.00	4.00	5.00				
	B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HO	ME OFFICE:						

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

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

rerinbur	Schone under trette Avirr.					
6.00	В	CFNI	100.00	CFNI	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			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

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

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

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

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

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

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

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

			11/25/2020 1	<u>1:50 am</u>
	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	-1, 549, 532	0		1.00
2.00	6, 612	9		2.00
3.00	64, 218	9		3.00
3.01	458, 012	0		3.01
3.02	92, 583	0		3. 02
4.00	43, 213	0		4.00
4.01	220, 865	0		4.01
4.02	172, 348	0		4.02
5.00	-491, 681			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

TIAS TIOL	been posted to worksheet A,	orunnis i anu/or z, t	The allount arrowable	shourd be fr	lui cateu TII coi u	111 4 OT LI	iis part.	
	Related Organization(s)							
	and/or Home Office							
	Type of Business							
	Type of busiliess							
	6. 00							
	B. INTERRELATIONSHIP TO RELA	D ORGANIZATION(S) AN	ND/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	HEALTHCARE	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10. 00 100. 00		10.00
100.00		100.00

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

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

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

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

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

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.

Health Financial Systems PROVIDER BASED PHYSICIAN ADJUSTMENT

COMMUNITY STROKE AND I			REHABI LI TATI ON				
			Provider CCN: 15-3045	De			

In Lieu of Form CMS-2552-10 Worksheet A-8-2

Wkst. A Line # Cost Center/Physician Identifier Total Remuneration Professional Component Professional Component RCE Amount Physician/Pro- ider Component RCE Amount Physician/Pro- ider Component Hours 1.00 5.05 AGGREGATE-OTHER ADMI NISTATI VE & GEN LI 4.703 0 4.00 5.00 6.00 7.00 2.00 54.00 AGGREGATE-ADDI OLOGY-DI AGNOST LC 2.500 0 4.703 0 4.703 211,500 4 3.00 60.00 AGGREGATE-LABORATORY 9,773 0 9,773 260,300 4 4.00 0.00 0 0 0 0 0 0 0 0 5.00 0.00 0	PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider (Peri od:	Worksheet A-8	3-2
West: A Line # Cost Center/Physician Identifier Total Remuneration Professional Component Provider Component RCE Amount Physician/Professional der Component 1.00 1.00 5.05 AGGREGATE-OTHER ADMINISTRATIVE & GEN 0 4.00 5.00 6.00 7.00 2.00 5.0.00 6.00 211.500 7.00 4.00 2.500 2.500 2.500 2.500 2.500 2.500 2.500 2.500 0 1.00 2.500 0 1.00 2.500 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>Date/Time Pre</td> <td></td>								Date/Time Pre	
Image: Instruction Identifier Remuneration Component Component Component Identifier 1.00 2.00 3.00 4.00 5.00 6.00 7.00 2.00 5.05 AGGRECATE-0THER ADMINISTRATIVE & GEN IC 4.703 0 4.703 211,500 .0 3.00 60.00 AGGREGATE-1ABORATORY 9,773 0 9,773 260,300 4 4.00 0.00 0 0 0 0 0 0 0 5.00 0.00 0 0 0 0 0 0 0 0 6.00 0.00 0		Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount		
Image: constraint of the section of the sec						Component		ider Component	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 5.05 AGGREGATE-OTHER ADMINISTRATIVE & GEN DIGGREGATE-ABJOLOGY-DIAGNOST IC 4.703 0 4.703 211,500 4 4.703 2.500 2.500 2.11,500 4 4.703 2.500 2.500 2.500 2.11,500 4 4.703 2.500 2.500 2.71,900 1 4.703 2.60,300 4 4.703 0 9,773 2.60,300 4 6 6 0									
1.00 5.05/AGGRECATE-OTHER 4.703 0 4.703 211,500 4 2.00 54.00/AGGRECATE-RADIOLOGY-DIAGNOST 2,500 0 2,500 271,900 1 3.00 60.00/AGGRECATE-LABORATORY 9,773 0 9,773 260,300 4 4.00 0		1.00	2.00	3.00	4.00	5.00	6.00		
ADMI NI STRATI VE & GEN In Component 3.00 ADMI NI STRATI VE & GEN In Component 0.00 2,500 0 2,500 2,500 2,500 2,500 100 3.00 6.00 0.00 0	1.00							42	1.00
2.00 54.00 ACCREGATE - RADI OLOGY - DI AGNOST IC 2,500 0 2,500 271,900 1 3.00 60.00 ACCREGATE - LABORATORY 9,773 0 9,773 260,300 4 4.00 0.00 0					-	.,			
3.00 60.00 ACGREGATE-LABORATORY 9,773 0 9,773 260,300 4 4.00 0.00 0	2.00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST	2, 500	0	2, 500	271, 900	11	2.00
4.00 0.00 0<	3 00	60.00		9 773	0	9 773	260,300	49	3.00
5.00 0.00 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td></td>								0	
6.00 0.00 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td>0</td> <td></td>							-	0	
7.00 0.00 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td>0</td> <td>6.00</td>							-	0	6.00
8.00 0.00 0.00 0				0	-			-	
9.00 0.00 0.00 0				0	U U		0	0	7.00
10.00 0.00 0<				0			0	0	
200.00 16,976 0 16,976 0 16,976 00 Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit 5 Percent of Unadjusted RCE Limit Cost of Cost of Limit Provider Component Share of col. Physician Cost Share of col. 1.00 2.00 8.00 9.00 12.00 13.00 14.00 1.00 5.05 AGGREGATE-OTHER AMINI STRATI VE & CEN IC 4.271 214 0 0 0 0 2.00 54.00 AGGREGATE-LABORATORY 6,132 307 0				0	0	0	0 0	0	9.00
Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit RCE Unadjusted RCE Limit Dercent of Unadjusted RCE Limit Cost of Memberships & Continuing Education Provider Component Share of col. Physician Cos of Malpractic Insurance 1.00 5.05 AGGREGATE-OTHER ADMINISTRATIVE & GEN IC 4.271 214 0 0 14.00 2.00 54.00 AGGREGATE-RADI OLOGY-DI AGNOST IC 1,438 72 0		0.00		0	0	0	0 0	0	
Identifier Limit Unadjusted RCE Memberships & Limit Component bare of col. of Mal practice insurance 1.00 2.00 8.00 9.00 12.00 13.00 14.00 1.00 5.05 AGGREGATE-OTHER ADMINISTRATIVE & GEN 4.271 214 0 0 14.00 2.00 54.00 AGGREGATE-CADIOLOGY-DI AGNOST IC 1,438 72 0 0 0 3.00 60.00 AGGREGATE-LABORATORY 6,132 307 0	200.00			16, 976	0	16, 976		102	200.00
Image: Continuing Education Share of col. Insurance Education 1.00 2.00 8.00 9.00 12.00 13.00 14.00 2.00 54.05 AGGREGATE-OTHER ADMINISTRATIVE & GEN 4.271 214 0 0 0 0 2.00 54.00 AGGREGATE-ADIOLOGY-DI AGNOST 1,438 72 0		Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
Image: Non-Section Education 12 1.00 2.00 8.00 9.00 12.00 13.00 14.00 1.00 5.05 AGGREGATE-OTHER ADMINISTRATIVE & GEN DO AGGREGATE-RADIOLOGY-DIAGNOST IC 4.271 214 0 0 0 2.00 54.00 AGGREGATE-RADIOLOGY-DIAGNOST IC 1,438 72 0 0 0 3.00 60.00 AGGREGATE-LABORATORY 6,132 307 0 0 0 4.00 0.00 0 0 0 0 0 0 5.00 0.00 0 0 0 0 0 0 0 6.00 0.00 0 0 0 0 0 0 0 0 9.00 0.00 0			Identifier	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$					Limit	Conti nui ng	Share of col.	Insurance	
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$						Education	12		
1.00 5.05 AGGREGATE-OTHER ADMINISTRATIVE & GEN IC 4.271 214 0 0 3.00 64.00 AGGREGATE-LABORATORY 6,132 307 0 0 0 3.00 60.00 AGGREGATE-LABORATORY 6,132 307 0 0 0 4.00 0.00 0 </td <td></td> <td>1,00</td> <td>2.00</td> <td>8,00</td> <td>9,00</td> <td>12.00</td> <td></td> <td>14,00</td> <td></td>		1,00	2.00	8,00	9,00	12.00		14,00	
2.00 54.00 AGGREGATE-RADIOLOGY-DIAGNOST IC 1,438 72 0 0 3.00 60.00 AGGREGATE-LABORATORY 6,132 307 0 0 4.00 0.00 0 0 0 0 0 0 5.00 0.00 0 0 0 0 0 0 6.00 0.00 0 0 0 0 0 0 6.00 0.00 0 0 0 0 0 0 7.00 0.00 0 0 0 0 0 0 9.00 0.00 0 0 0 0 0 0 0 200.00 0.00 0 0 0 0 0 0 0 1.00 2.00 11.841 593 0 0 0 0 1.00 2.00 14 0 17.00 18.00 14 1.00 1.062	1.00								1.00
2.00 54.00 AGGREGATE - RADI OLOGY - DI AGNOST I C 1, 438 72 0 0 3.00 60.00 AGGREGATE - LABORATORY 6, 132 307 0 0 0 4.00 0.00 0 0 0 0 0 0 0 0 5.00 0.00 0				.,			-	-	
3.00 60.00 AGGREGATE - LABORATORY 6, 132 307 0 0 4.00 0.00 0	2.00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST	1, 438	72	C	0	0	2.00
4.00 0.00 0.00 0	3 00	60.00		6 132	307			0	3.00
5.00 0.00 0.00 0							-	0	
6.00 0.00 0.00 0				-	-	-	-	0	
7.00 0.00 0.00 0				0	-	-		-	
8.00 0.00 0.00 0				0	-		0	0	6.00
9.00 0.00 0.00 0				0	-	-	0	0	
10.00 0.00 0<				0	-	-	0 0	0	8.00
200.00 11,841 593 0 0 Wkst. A Line # Cost Center/Physician Identifier Provider Component Share of col. Adj usted RCE Limit RCE Disal Iowance Adj ustment 1.00 2.00 16.00 17.00 18.00 1.00 5.05 AGGREGATE-OTHER ADMI NI STRATI VE & GEN 0 4,271 432 432 2.00 54.00 AGGREGATE-RADI OLOGY-DI AGNOST IC 0 1,438 1,062 1,062 3.00 60.00 AGGREGATE-LABORATORY 0 6,132 3,641 3,641 4.00 0.00 0 0 0 0 0 0 5.00 0.00 0 0 0 0 0 0 6.00 0.00 0 0 0 0 0 0 0 7.00 0.00 0 0 0 0 0 0 8.00 0.00 0 0 0 0 0 0				0	-		0 0	0	9.00
Wkst. A Line # Cost Center/Physician Identifier Provider Component Share of col. 14 Adjusted RCE Limit RCE Disal Iowance Adjustment 1.00 2.00 16.00 17.00 18.00 1.00 5.05 AGGREGATE-OTHER ADMINISTRATIVE & GEN 0 4,271 432 432 2.00 54.00 AGGREGATE-RADIOLOGY-DI AGNOST IC 0 1,438 1,062 1,062 3.00 60.00 AGGREGATE-LABORATORY 0 6,132 3,641 3,641 4.00 0.00 0 0 0 0 0 0 5.00 0.00 0 0 0 0 0 0 6.00 0.00 0 0 0 0 0 0 7.00 0.00 0 0 0 0 0 0 8.00 0.00 0 0 0 0 0 0	10.00	0.00		0	0	0	0 0	0	10.00
Wkst. A Line # Cost Center/Physician Identifier Provider Component Share of col. 14 Adjusted RCE Limit RCE Disal Iowance Adjustment 1.00 2.00 16.00 17.00 18.00 1.00 5.05 AGGREGATE-OTHER ADMI NI STRATI VE & GEN 0 4,271 432 432 2.00 54.00 AGGREGATE-RADI OLOGY-DI AGNOST IC 0 1,438 1,062 1,062 3.00 60.00 AGGREGATE-LABORATORY 0 6,132 3,641 3,641 4.00 0.00 0 0 0 0 0 0 5.00 0.00 0 0 0 0 0 0 6.00 0.00 0 0 0 0 0 0 7.00 0.00 0 0 0 0 0 0 8.00 0.00 0 0 0 0 0 0	200.00			11, 841	593	0	0 0	0	200.00
Identifier Component Share of col. 14 Limit Disal Iowance Identifier 1.00 2.00 15.00 16.00 17.00 18.00 1.00 5.05 AGGREGATE-OTHER ADMINISTRATIVE & GEN 0 4,271 432 432 2.00 54.00 AGGREGATE-RADIOLOGY-DIAGNOST IC 0 1,438 1,062 1,062 3.00 60.00 AGGREGATE-LABORATORY 0 6,132 3,641 3,641 4.00 0.00 0 0 0 0 0 0 5.00 0.00 0 0 0 0 0 0 0 6.00 0.00 0 0 0 0 0 0 7.00 0.00 0 0 0 0 0 0 8.00 0.00 0 0 0 0 0 0		Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adiustment		
Image: Normal Share of col. Share of col. 14 Image: Normal Share of col. 14 1.00 2.00 15.00 16.00 17.00 18.00 1.00 5.05 AGGREGATE-OTHER ADMI NI STRATI VE & GEN 0 4,271 432 432 2.00 54.00 AGGREGATE-RADI OLOGY-DI AGNOST I C 0 1,438 1,062 1,062 3.00 60.00 AGGREGATE-LABORATORY 0 6,132 3,641 3,641 4.00 0.00 0 0 0 0 0 0 5.00 0.00 0 0 0 0 0 0 6.00 0.00 0 0 0 0 0 0 5.00 0.00 0 0 0 0 0 0 6.00 0.00 0 0 0 0 0 0 7.00 0.00 0 0 0 0 0 0 8.00 0.00 </td <td></td> <td></td> <td></td> <td>Component</td> <td></td> <td>Di sal I owance</td> <td></td> <td></td> <td></td>				Component		Di sal I owance			
Image: Non-Strain of the strain of									
1.00 2.00 15.00 16.00 17.00 18.00 1.00 5.05 AGGREGATE-OTHER ADMI NI STRATI VE & GEN 0 4,271 432 432 2.00 54.00 AGGREGATE-RADI OLOGY-DI AGNOST I C 0 1,438 1,062 1,062 3.00 60.00 AGGREGATE-LABORATORY 0 6,132 3,641 3,641 4.00 0.00 0 0 0 0 0 0 5.00 0.00 0 0 0 0 0 0 6.00 0.00 0 0 0 0 0 0 7.00 0.00 0 0 0 0 0 0 8.00 0.00 0 0 0 0 0 0									
ADMI NI STRATI VE & GEN Addit NI		1.00	2.00	15.00	16.00	17.00	18.00		
2.00 54.00 AGGREGATE-RADI OLOGY-DI AGNOST 0 1,438 1,062 1,062 3.00 60.00 AGGREGATE-LABORATORY 0 6,132 3,641 3,641 4.00 0.00 0 0 0 0 0 5.00 0.00 0 0 0 0 0 6.00 0.00 0 0 0 0 0 7.00 0.00 0 0 0 0 0 8.00 0.00 0 0 0 0 0	1.00	5. 05		0	4, 271	432	432		1.00
I C 0 60.00 AGGREGATE-LABORATORY 0 6,132 3,641 3,641 4.00 0.00 0 0 0 0 0 5.00 0.00 0 0 0 0 0 6.00 0.00 0 0 0 0 0 7.00 0.00 0 0 0 0 0 8.00 0.00 0 0 0 0 0									
3.00 60.00 AGGREGATE-LABORATORY 0 6,132 3,641 3,641 4.00 0.00 0 0 0 0 5.00 0.00 0 0 0 0 6.00 0.00 0 0 0 0 6.00 0.00 0 0 0 0 7.00 0.00 0 0 0 0 8.00 0.00 0 0 0 0	2.00	54.00		0	1, 438	1, 062	1,062		2.00
4.00 0.00 0 0 0 0 5.00 0.00 0 0 0 0 0 6.00 0.00 0 0 0 0 0 7.00 0.00 0 0 0 0 0 8.00 0.00 0 0 0 0 0	3 00	60.00		0	6 122	3 6/1	3 6/1		3.00
5.00 0.00 0 0 0 6.00 0.00 0 0 0 0 7.00 0.00 0 0 0 0 8.00 0.00 0 0 0 0									3.00 4.00
6.00 0.00 0 0 0 7.00 0.00 0 0 0 8.00 0.00 0 0 0					-		-		
7.00 0.00 0 </td <td></td> <td></td> <td></td> <td>0</td> <td>-</td> <td></td> <td>-</td> <td></td> <td>5.00</td>				0	-		-		5.00
8.00 0.00 0 0 0				-	-		-		6.00
				, v	-	-	0 0		7.00
9.00 0.00 0 0 0	8.00			-	0	0	0 0		8.00
	9.00	0.00		0	0	0	0 0		9.00
	10.00	0.00		0	0	0	0 0		10.00
200.00 0 11,841 5,135 5,135	200.00			0	11, 841	5, 135	5, 135		200.00
	,							• 1	

In Lieu of Form CMS-2552-10 Worksheet B

COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 08/30/2019 To 06/30/2020		pared: :50 am
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		col. 7) 0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	2, 541, 822	2, 541, 822				1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	951, 650 804, 977	4, 010	951, 65 93			2.00 4.00
4.00 5.01	00540 NONPATIENT TELEPHONES	41, 675	4,010		0 009,918	41, 675	4.00 5.01
5.02	00550 PURCHASING & RECEIVING STORES	87, 850	38, 842				5. 02
5.03	00560 ADMI TTI NG	293, 627	22, 459	3, 17	0 45, 614		
5.04	00590 CASHI ERI NG ACCOUNTS RECEI VABLE	220, 865	0		0 0	220, 865	5.04
5.05 7.00	00592 OTHER ADMINISTRATIVE & GENERAL COSTS 00700 OPERATION OF PLANT	1, 762, 294 1, 656, 294	38, 227 352, 796				5.05 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	33, 199	0	33, 77	0 73, 737	33, 199	8.00
9.00	00900 HOUSEKEEPI NG	336, 407	47, 796	3, 43	2 22, 707	410, 342	9.00
10.00	01000 DI ETARY	309, 276	81, 299			471, 549	
11.00	01100 CAFETERIA	76, 064	43, 589		0 9, 229	128, 882	
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	76, 815 0	4, 182		0 13,022	94,019	
15.00	01500 PHARMACY	354, 550	2, 903	10, 79	7 19, 284	387, 534	
16.00	01600 MEDICAL RECORDS & LIBRARY	172, 348	2, 509		0 0	174, 857	16.00
17.00	01700 SOCIAL SERVICE	0	0		0 0	0	17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 648, 196	865, 237	67, 21	3 322, 733	3, 903, 379	30.00
30.00	03100 I NTENSI VE CARE UNI T	2, 048, 190	005, 237	07,21	0 0	0	31.00
41.00	04100 SUBPROVIDER - IRF	0	0		0 0	0	41.00
43.00	04300 NURSERY	0	0		0 0	0	43.00
F0 00	ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	0	50.00
50.00 51.00	05100 RECOVERY ROOM	0	0			0	50.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	245, 156	102, 799	197, 21	5 32, 784	577, 954	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56.00 57.00	05600 RADI 0I SOTOPE 05700 CT SCAN	84, 761 171, 346	7, 773 17, 047				
58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	74, 407	42, 187			326, 289 324, 176	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00	06000 LABORATORY	496, 332	55, 052	28, 48	3 44, 603		
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 864	0		0 0	1, 864	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	212, 944 676, 452	123, 708	55 37, 34			
67.00	06700 OCCUPATI ONAL THERAPY	532, 460	4, 649				
68.00	06800 SPEECH PATHOLOGY	126, 321	3, 345			133, 203	68.00
69.00	06900 ELECTROCARDI OLOGY	72, 660	10, 332				
70.00 71.00		3, 325 22, 132	0	72	8 345 0 0	4, 398	70.00 71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
74.00	07400 RENAL DI ALYSI S	32, 584	13, 874			46, 525	
75.00 76.00		0 50, 567	0		0 0 0 6,263	0 56, 830	75.00 76.00
70.00	OUTPATIENT SERVICE COST CENTERS	50, 507	0		0,203		70.00
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00		0	0		0 0	0	91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)					0	92.00
113 0	SPECIAL PURPOSE COST CENTERS			1			113.00
	11600 HOSPI CE	0	0		0 0	0	116.00
118.00		15, 171, 220	1, 884, 615	951, 65	0 809, 918	14, 514, 013	118.00
100.0	NONREI MBURSABLE COST CENTERS			1		-	100.00
	D 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00 191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	657, 207		0 0	657, 207	
	19300 NONPALD WORKERS	0	0		0 0		193.00
	07950 OTHER NONREI MBURSABLE DEPARTMENTS	1, 173	0		0 0		194.00
	107951 ADVERTI SI NG	29, 144	0		0 0	29, 144	
200.00 201.00			Ω		0 0		200. 00 201. 00
201.00	5	15, 201, 537	2, 541, 822	951, 65	0 809, 918		
		. · · ·				- · · · · · · · · · · · · · · · · · · ·	-

	nancial Systems COMMU DCATION - GENERAL SERVICE COSTS	UNITY STROKE ANI	Provi der CO	CN: 15-3045 Pe	eriod: rom 08/30/2019	u of Form CMS-2 Worksheet B Part I	
				Te		Date/Time Pre 11/25/2020 11	pared
	Cost Center Description	NONPATI ENT TELEPHONES	Subtotal	PURCHASI NG & RECEI VI NG STORES	ADMI TTI NG	CASHI ERI NG ACCOUNTS RECEI VABLE	
0.51		5.01	5A. 01	5.02	5.03	5.04	
	NERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT						1.0
	200 CAP REL COSTS-BEDG & TTXT						2.0
	400 EMPLOYEE BENEFITS DEPARTMENT						4. (
	540 NONPATIENT TELEPHONES	41, 675					5.0
02 005	550 PURCHASING & RECEIVING STORES	372	135, 809	135, 809			5.0
	560 ADMI TTI NG	1,003	365, 873	3, 298	369, 171		5.0
1	590 CASHI ERI NG ACCOUNTS RECEI VABLE	607 5 412	221, 472	1, 996	0	223, 468	5.0
1	592 OTHER ADMINISTRATIVE & GENERAL COSTS 700 OPERATION OF PLANT	5, 413 5, 831	1, 974, 314 2, 126, 836	17, 796 19, 171	0	0	5. (7. (
	800 LAUNDRY & LINEN SERVICE	91	33, 290	300	0	0	8.0
	900 HOUSEKEEPING	1, 128	411, 470	3, 709	0	0	9. (
	DOO DI ETARY	1, 296	472, 845	4, 262	0	0	10. (
	100 CAFETERI A	354	129, 236	1, 165	0	0	11.0
	300 NURSI NG ADMI NI STRATI ON	258 0	94, 277	850 0	0	0	13. 14.
	400 CENTRAL SERVI CES & SUPPLY 500 PHARMACY	1, 065	388, 599	3, 503	0	0	14.
	600 MEDICAL RECORDS & LIBRARY	481	175, 338	1, 580	0	0	16.
	700 SOCI AL SERVI CE	0	0	0	0	0	17.
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	10, 732	3, 914, 111	35, 289	83, 383	50, 474	
	100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.
	100 SUBPROVI DER – I RF 300 NURSERY	0	0	0	0	0	41. 43.
	CILLARY SERVICE COST CENTERS	U	0	0	0	0	43.
	DOO OPERATI NG ROOM	0	0	0	0	0	50.
. 00 051	100 RECOVERY ROOM	0	0	0	0	0	51.
	300 ANESTHESI OLOGY	0	0	0	0	0	53.
	400 RADI OLOGY-DI AGNOSTI C	1, 589	579, 543	5, 224	27, 351	16, 556	
	500 RADI OLOGY-THERAPEUTI C	0	151 410	0	17.070	0	55.
	600 RADI 0I SOTOPE 700 CT SCAN	415 897	151, 418 327, 186	1, 365 2, 949	17, 972 24, 952	10, 879 15, 104	
	BOO MAGNETIC RESONANCE IMAGING (MRI)	891	325, 067	2, 949	24, 932	13, 878	
	900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.
. 00 060	DOO LABORATORY	1, 717	626, 187	5, 644	35, 675	21, 595	60.
1	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	5	1, 869	17	663	401	62.
	500 RESPI RATORY THERAPY	673	245, 350	2, 212	8, 090	4, 897	65.
	600 PHYSI CAL THERAPY 700 OCCUPATI ONAL THERAPY	2, 379 1, 515	867, 953 552, 477	7, 824 4, 980	43, 373 35, 267	26, 255 21, 348	
	800 SPEECH PATHOLOGY	366	133, 569	1, 204	7, 385	4, 470	
	900 ELECTROCARDI OLOGY	350	127, 792	1, 152	24, 199	14, 648	
	000 ELECTROENCEPHALOGRAPHY	12	4, 410	40	3, 541	2, 143	70.
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	61	22, 193	200	289	175	
	200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72
	300 DRUGS CHARGED TO PATIENTS 400 RENAL DIALYSIS	128	U 46 653	421	30, 847 3, 174	18, 673 1, 921	
	500 ASC (NON-DI STINCT PART)	128	46, 653 0	421	3, 174 N	1, 921	
	020 OTHER ANCI LLARY	156	56, 986	514	84		76.
	TPATIENT SERVICE COST CENTERS						
	DOO CLINIC	0	0	0	0	0	
	100 EMERGENCY	0	0	0	0	0	
	200 OBSERVATION BEDS (NON-DISTINCT PART)		0				92.
	300 INTEREST EXPENSE						113.
	600 HOSPI CE	О	0	0	0	0	116.
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	39, 785	14, 512, 123	129, 595	369, 171	223, 468	
NOM	NREI MBURSABLE COST CENTERS				· · ·		
0. 00 190	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	-	190.
	100 RESEARCH	0	0	0	0		191.
	200 PHYSI CI ANS' PRI VATE OFFI CES	1, 807	659, 014	5, 940	0		192.
	300 NONPALD WORKERS 950 OTHER NONREIMBURSABLE DEPARTMENTS	0	0 1 17/	0	0		193. 194.
	950 OTHER NUNREIMBURSABLE DEPARTMENTS 951 ADVERTISING	3 80	1, 176 29, 224	11 263	0		194. 194.
4.01079 0.00	Cross Foot Adjustments	80	∠∍, ∠24 ∩	203	0	0	200.
1.00	Negative Cost Centers	О	0	0	0	0	201.
	TOTAL (sum lines 118 through 201)		-		-	223, 468	

0001 //	LLOCATION - GENERAL SERVICE COSTS		Provider C	F	eriod: rom 08/30/2019 o 06/30/2020	Worksheet B Part I Date/Time Pre 11/25/2020 11	2552-10 epared: :50 am
	Cost Center Description	Subtotal	OTHER ADMI NI STRATI VE & GENERAL COSTS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5A. 04	5.05	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS			1			
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00 \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATI ENT TELEPHONES 00550 PURCHASING & RECEIVING STORES 00560 ADMITTING 00590 CASHIERING ACCOUNTS RECEIVABLE 00592 OTHER ADMINISTRATIVE & GENERAL COSTS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY	1, 992, 110 2, 146, 007 33, 590 415, 179 477, 107	323, 639 5, 066 62, 613	2, 469, 646 0 56, 600	38, 656 0	534, 392 21, 321	
	01100 CAFETERI A	130, 401				11, 431	
13.00	01300 NURSING ADMINISTRATION	95, 127		4, 952	0	1, 097	
	01400 CENTRAL SERVI CES & SUPPLY	C	-	-	0	0	
		392, 102			0	761	
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	176, 918 C		2, 971 0	0	658 0	
	INPATIENT ROUTINE SERVICE COST CENTERS		<u>, </u>				
	03000 ADULTS & PEDIATRICS	4, 083, 257		1, 024, 621	38, 656	226, 912	
	03100 I NTENSI VE CARE UNI T	C			0	0	
	04100 SUBPROVI DER – I RF 04300 NURSERY	C		0	0	0	
45.00	ANCI LLARY SERVICE COST CENTERS		<u>л</u> 0	0	0	0	43.00
	05000 OPERATI NG ROOM	C	0 0			0	50.00
	05100 RECOVERY ROOM	C			-	0	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	C 628, 674		0 121, 734	0	0 26, 959	
	05500 RADI OLOGY-THERAPEUTI C	020, 074		0	0	20, 939	55.00
	05600 RADI OI SOTOPE	181, 634	27, 392	9, 205	0	2, 039	
57.00	05700 CT SCAN	370, 191			0	4, 471	
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	364, 801		49, 958 0	0	11, 064 0	1
	06000 LABORATORY	689, 101		-	-	14, 438	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 950			0	0	1
	06500 RESPI RATORY THERAPY	260, 549			0	0	
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	945, 405				32, 443	
	06800 SPEECH PATHOLOGY	614, 072 146, 628			0	1, 219 877	
	06900 ELECTROCARDI OLOGY	167, 791			-	2, 709	
	07000 ELECTROENCEPHALOGRAPHY	10, 134	1, 528	0	0	0	70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	22, 857			0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	C 49, 520	-	-	0	0	
	07400 RENAL DI ALYSI S	52, 169			0	3, 638	
	07500 ASC (NON-DI STI NCT PART)	C			0	0	
76.00	03020 OTHER ANCI LLARY	57,635	8, 692	0	0	0	76.00
90.00	OUTPATI ENT SERVICE COST CENTERS	C	0	0	0	0	90.00
	09100 EMERGENCY	C				0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	C					92.00
112 00	SPECIAL PURPOSE COST CENTERS		1				1112 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	C		0	0	0	113.00 116.00
118.00		14, 505, 909	1, 887, 202	1, 691, 378	38, 656		
	NONREI MBURSABLE COST CENTERS	•		1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	0	0		190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	C 664, 954	0 100, 282	0 778, 268	0	0 172, 355	191.00
	19300 NONPAID WORKERS	004, 954) 100, 282) N	//0,208 0	0 0		192.00
	07950 OTHER NONREI MBURSABLE DEPARTMENTS	1, 187			0		194.00
	07951 ADVERTI SI NG	29, 487		0	0		194.01
		0	1	1	1		200.00
200.00 201.00			-	-	-	~	200.00

	Financial Systems COMM	UNI TY STROKE AND	Provider C	CN: 15-3045 Pe	eriod: com 08/30/2019	u of Form CMS- Worksheet B Part I Date/Time Pre 11/25/2020 11	epared:
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
00	GENERAL SERVICE COST CENTERS						1 1 00
. 00 . 00 . 01 . 02 . 03 . 04 . 05 . 00 . 00 . 00 0. 00 1. 00 3. 00 4. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATI ENT TELEPHONES 00550 PURCHASING & RECEIVING STORES 00560 ADMITTING 00590 CASHI ERING ACCOUNTS RECEIVABLE 00592 OTHER ADMINISTRATIVE & GENERAL COSTS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	666, 656 0 0	213, 116 4, 925		0		1.00 2.00 4.00 5.01 5.02 5.03 5.04 5.05 7.00 8.00 9.00 10.00 11.00 13.00 14.00
5.00	01500 PHARMACY	0	7, 294		0	462, 727	
6.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	02,727	1
7.00	01700 SOCIAL SERVICE	0	C	0	0	0	17.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
0.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	666, 656 0	122, 064 0		0	0	1
1.00	04100 SUBPROVIDER - IRF	0	0		0	0	
3.00	04300 NURSERY	0	C		0	0	
	ANCILLARY SERVICE COST CENTERS						
0.00	05000 OPERATING ROOM	0	0		0	0	
1.00	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	0	0	0	0	0	
3.00 4.00	05300 ANESTHESTOLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	12, 400	-	0	0	
5.00	05500 RADI OLOGY-THERAPEUTI C	0	12, 100		0	0	
6.00	05600 RADI OI SOTOPE	0	3, 017	0	0	0	56.00
7.00	05700 CT SCAN	0	8, 920		0	0	
8.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	3, 348	0	0	0	58.0
9.00 0.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0 16, 870	0	0	0	59.0 60.0
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	10, 0, 0	0	0	0	
5.00	06500 RESPI RATORY THERAPY	0	11, 792	6, 901	0	0	
6. 00	06600 PHYSI CAL THERAPY	0	10, 615		0	0	
7.00	06700 OCCUPATIONAL THERAPY	0	4, 722		0	0	
8.00 9.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	1, 115 3, 534		0	0	68.0 69.0
0.00	07000 ELECTROENCEPHALOGRAPHY	0	131		0	0	
1.00		0	C		0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
3.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	462, 727	
4.00 5.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	
	03020 OTHER ANCI LLARY	0	2, 369	5	0	0	
	OUTPATIENT SERVICE COST CENTERS	-					1
	09000 CLINIC	0	C	0	0	0	
1.00	09100 EMERGENCY	0	C	0	0	0	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						92.0
13 00	11300 I NTEREST EXPENSE						113.0
	11600 HOSPI CE	0	C	0	0	0	116.00
18.00		666, 656	213, 116	120, 447	0	462, 727	118.00
90 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19100 RESEARCH	0	0	0	0		190.0
	19200 PHYSI CLANS' PRI VATE OFFI CES	o	0	0	Ő		192.00
93.00	19300 NONPALD WORKERS	0	C	0	0	0	193. 0
	07950 OTHER NONREIMBURSABLE DEPARTMENTS	0	C	0	0		194. 0
	07951 ADVERTI SI NG	0	0	0	0	0	194.0
00.00							200. 0
01.00	Negative Cost Centers		<u>^</u>			∩	201. 0

Health Fir	nancial Systems COMM	UNITY STROKE AN	D REHABILITATI	ON	In Lie	u of Form CMS-2	2552-10
COST ALLO	CATION - GENERAL SERVICE COSTS		Provider CC	N: 15-3045 P	eriod: rom 08/30/2019	Worksheet B Part I	
				Ť			pared: 50 am
	Cost Center Description	MEDI CAL S RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
	NERAL SERVICE COST CENTERS						1 00
	100 CAP REL COSTS-BLDG & FIXT 200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
	400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 005	540 NONPATIENT TELEPHONES						5.01
	550 PURCHASING & RECEIVING STORES						5.02
	560 ADMITTING 590 CASHIERING ACCOUNTS RECEIVABLE						5.03 5.04
	592 OTHER ADMINISTRATIVE & GENERAL COSTS						5.05
	700 OPERATION OF PLANT						7.00
	BOO LAUNDRY & LINEN SERVICE						8.00
	900 HOUSEKEEPING DOO DI ETARY						9.00 10.00
	100 CAFETERI A						11.00
	300 NURSI NG ADMI NI STRATI ON						13.00
	400 CENTRAL SERVICES & SUPPLY						14.00
1	500 PHARMACY 600 MEDICAL RECORDS & LIBRARY	207, 228					15.00 16.00
1	700 SOCIAL SERVICE	207,228	0				17.00
	PATIENT ROUTINE SERVICE COST CENTERS		-1		I		
	DOO ADULTS & PEDIATRICS	46, 804	0	6, 936, 378	0	6, 936, 378	1
		0	0	0	0	0	31.00
	100 SUBPROVI DER – I RF 300 NURSERY	0	0	0	0	0	41.00 43.00
	CILLARY SERVICE COST CENTERS	<u> </u>	0	0	0	0	43.00
1	DOO OPERATING ROOM	0	0	0	0	0	50.00
1	100 RECOVERY ROOM	0	0	0	0	0	51.00
1	300 ANESTHESI OLOGY 400 RADI OLOGY-DI AGNOSTI C	15, 353	0	0 899, 930	0	0 899, 930	
	500 RADI OLOGY-THERAPEUTI C	0	0	077,730	0	0,7,750	55.00
56.00 056	600 RADI OI SOTOPE	10, 088	0	233, 375	0	233, 375	56.00
	700 CT SCAN	14,006	0	473, 604	0	473, 604	
	BOO MAGNETIC RESONANCE IMAGING (MRI) 900 CARDIAC CATHETERIZATION	12, 869	0	497, 056 0	0	497, 056 0	58.00 59.00
	DOO LABORATORY	20, 026	0	909, 551	0	909, 551	60.00
62.00 062	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	372	0	3, 767	0	3, 767	62.00
	500 RESPIRATORY THERAPY	4, 541	0	323, 076	0	323, 076	
	600 PHYSI CAL THERAPY 700 OCCUPATI ONAL THERAPY	24, 347 19, 797	0	1, 301, 882 737, 924	0	1, 301, 882 737, 924	
	BOO SPEECH PATHOLOGY	4, 146	0	178, 841	0	178, 841	
	900 ELECTROCARDI OLOGY	13, 584	0	225, 158	0	225, 158	
70.00 070	DOO ELECTROENCEPHALOGRAPHY	1, 988	0	13, 906	0	13, 906	1
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	162	0	26, 466	0	26, 466	
	200 IMPL. DEV. CHARGED TO PATIENTS 300 DRUGS CHARGED TO PATIENTS	17, 316	0	537, 031	0	0 537, 031	72.00 73.00
	400 RENAL DIALYSIS	1, 782	0	81, 886	0	81, 886	1
	500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
	D20 OTHER ANCI LLARY	47	0	70, 547	0	70, 547	76.00
	TPATIENT SERVICE COST CENTERS	0	0	0	0	0	90.00
1	100 EMERGENCY	0	0	0	0	0	91.00
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	ECIAL PURPOSE COST CENTERS						
	300 I NTEREST EXPENSE 600 HOSPI CE	0	0	0	0	0	113.00 116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	207, 228	0	13, 450, 378	0	13, 450, 378	
	NREIMBURSABLE COST CENTERS						
	DOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	100 RESEARCH	0	0	1 715 050	0		191.00
	200 PHYSICIANS' PRIVATE OFFICES 300 NONPAID WORKERS	0	0	1, 715, 859 0	0	1, 715, 859 0	192.00 193.00
	950 OTHER NONREI MBURSABLE DEPARTMENTS	0	0	1, 366	0		194.00
194.01079	951 ADVERTI SI NG	0	0	33, 934	0	33, 934	194. 01
200.00	Cross Foot Adjustments		~	0	0		200.00
201.00 202.00	Negative Cost Centers TOTAL (sum lines 118 through 201)	0 207, 228	0	0 15, 201, 537	0	0 15, 201, 537	201.00
202.00	TRACE (Sum Tries The thiough 201)	201,220	ų	15, 201, 337	u u	10,201,007	202.00

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COMMUNITY STROKE AND REHABILITATION

Heal th	Financial Systems COMM	UNITY STROKE AN	ID REHABILITATI	ON	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CO	Fr	eriod: com 08/30/2019 o 06/30/2020	Worksheet B Part II Date/Time Pre 11/25/2020 11	pared: :50 am
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL REI	ATED COSTS	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	1	0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						1
1.00 2.00 4.00 5.01	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES	0	4, 010 0	931 0	4, 941 0	4, 941 0	1.00 2.00 4.00 5.01
5.02 5.03 5.04	00550 PURCHASING & RECEIVING STORES 00560 ADMITTING 00590 CASHIERING ACCOUNTS RECEIVABLE	0 0 0	38, 842 22, 459 0	399 3, 170 0	39, 241 25, 629 0	51 278 0	•
5.05 7.00 8.00	00592 OTHER ADMINISTRATIVE & GENERAL COSTS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0 0 0	38, 227 352, 796 0	121, 211 35, 976 0	159, 438 388, 772 0	288 463 0	7.00
9.00 10.00 11.00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A	0 0 0	47, 796 81, 299 43, 589	3, 432 43, 527 0	51, 228 124, 826 43, 589	139 229 56	10.00
13.00 14.00 15.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0 0 0	4, 182 0 2, 903	0 0 10, 797	4, 182 0 13, 700	79 0 118	14.00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	2, 509 0	0	2, 509 0	0	
30.00 31.00 41.00 43.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04300 NURSERY	0 0 0	865, 237 0 0 0	67, 213 0 0 0	932, 450 0 0 0	1, 969 0 0 0	31.00 41.00
	ANCILLARY SERVICE COST CENTERS				- 1	-	
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	0 0	0	0 0	0 0	50.00 51.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0 102, 799	0 197, 215	0 300, 014	0 200	
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	7, 773	0 50, 491	0 58, 264	0	55.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0	17, 047 42, 187	114, 311 198, 731	131, 358 240, 918	47 144 54	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	42, 107 0 55, 052	0 28, 483	0 83, 535	0 272	59.00
62.00 65.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0 0 122 709	0 555 27 240	0 555 171 057	0 190	
66.00 67.00 68.00	06700 OCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	123, 708 4, 649 3, 345	37, 349 1, 368 590	161, 057 6, 017 3, 935	171 76 18	67.00
69.00	06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY	0	10, 332		45, 438 728	57	•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 0	71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0 13, 874	0 67	0 13, 941	0 0	
	07500 ASC (NON-DI STI NCT PART) 03020 OTHER ANCI LLARY	0	0 0	0 0	0 0	0 38	
	OUTPATIENT SERVICE COST CENTERS			[]			
91.00	09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0 0	0 0	0 0 0	0 0	
	SPECIAL PURPOSE COST CENTERS				0		113.00
	11600 HOSPI CE	0	0 1, 884, 615	0 951, 650	0 2, 836, 265		116. 00 118. 00
191.00	19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES	000000000000000000000000000000000000000	0 0 657, 207	0 0 0	0 0 657, 207	0	190. 00 191. 00 192. 00
193.00 194.00	19300 NONPALD WORKERS 07950 OTHER NONREI MBURSABLE DEPARTMENTS 07951 ADVERTI SI NG	0	0 0 0	0 0 0	0 0 0	0 0	193.00 194.00 194.01
200. 00 201. 00 202. 00	Cross Foot Adjustments Negative Cost Centers	0	0 2, 541, 822	0 951, 650	0 0 3, 493, 472	0	200. 00 201. 00 202. 00

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COMMUNITY STROKE AND REHABILITATION

Heal th	Financial Systems COMM	UNITY STROKE A	ND REHABILITATI	ON	In Lie	u of Form CMS-	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CC	N: 15-3045 P	eriod: rom 08/30/2019 o 06/30/2020	Worksheet B Part II Date/Time Pre 11/25/2020 11	pared:
	Cost Center Description	NONPATI ENT TELEPHONES	PURCHASI NG & RECEI VI NG STORES	ADMI TTI NG	CASHI ERI NG ACCOUNTS RECEI VABLE	OTHER ADMI NI STRATI VE & GENERAL COSTS	
		5.01	5.02	5.03	5.04	5.05	
	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
5.01	00540 NONPATI ENT TELEPHONES	0					5.01
5.02	00550 PURCHASING & RECEIVING STORES	0	39, 292	24 041			5.02
5.03 5.04	00560 ADMITTING 00590 CASHIERING ACCOUNTS RECEIVABLE	0	954 578	26, 861 0	578		5.03 5.04
5.04	00592 OTHER ADMINISTRATIVE & GENERAL COSTS		5, 149	0	0	164, 875	1
7.00	00700 OPERATION OF PLANT	0	5, 547	0	0	26, 786	
8.00	00800 LAUNDRY & LINEN SERVICE	0	87	0	0	419	
9.00	00900 HOUSEKEEPI NG	0	1, 073	0	0	5, 182	1
10.00	01000 DI ETARY	0	1, 233	0	0	5, 955	10.00
11.00	01100 CAFETERI A	0	337	0	0	1, 628	11.00
13.00	01300 NURSING ADMINISTRATION	0	246	0	0	1, 187	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	
15.00		0	.,	0	0	4, 894	1
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0		0	0	2, 208 0	1
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	<u> </u>	0	0	0	17.00
30.00	03000 ADULTS & PEDI ATRI CS	0	10, 208	6, 065	129	50, 966	30.00
31.00	03100 I NTENSI VE CARE UNI T	0		0,000	0	00,700	
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	1
43.00	04300 NURSERY	0	0	0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS		,		1		
50.00	05000 OPERATING ROOM	0		0	0	0	
51.00	05100 RECOVERY ROOM	0	0	0	0	0	
53.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	1 511	0	0	0 7, 847	
54.00 55.00	05500 RADI OLOGY-THERAPEUTI C	0	1, 511 0	1, 990 0	43	0 /, 84	1
56.00	05600 RADI OL SOTOPE	0	395	1, 308	28	2, 267	1
57.00	05700 CT SCAN	0	853	1, 816		4, 621	1
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	848	1, 668	36	4, 553	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	1, 633	2, 596	56	8, 601	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	5	48	1	37	1
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	640	589		3, 252	
66.00 67.00	06700 OCCUPATIONAL THERAPY	0	2, 264 1, 441	3, 156 2, 566		11, 801 7, 665	
68.00	06800 SPEECH PATHOLOGY	0	348	537	12	1, 830	
69.00	06900 ELECTROCARDI OLOGY	0	333	1, 761	38	2,094	
	07000 ELECTROENCEPHALOGRAPHY	0		258	6		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	58	21	0	285	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	2, 245	49		73.00
	07400 RENAL DI ALYSI S	0	122	231	5		74.00
	07500 ASC (NON-DISTINCT PART) 03020 OTHER ANCILLARY	0	149	0	0	0	75.00 76.00
76.00	OUTPATIENT SERVICE COST CENTERS	0	149	6	0	/19	76.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE			0		0	113.00
116.00	11600 HOSPICE	0		0 26, 861	0 578	0 156, 192	116.00
110.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	57,494	20, 001	576	150, 192	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19100 RESEARCH	0	0	0	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	1, 719	0	0		192.00
	19300 NONPAI D WORKERS	0	0	0	0	0	193.00
	07950 OTHER NONREIMBURSABLE DEPARTMENTS	0	3	0	0		194.00
	07951 ADVERTI SI NG	0	76	0	0	368	194.01
200.00		_		-	_	_	200.00
201.00			0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	39, 292	26, 861	578	164, 875	1202. UU

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Heal th	Financial Systems COMM	UNITY STROKE AN	ID REHABILITATI	ON	In Lie	u of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C	F	veriod: rom 08/30/2019 o 06/30/2020		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATIENT TELEPHONES						5. 01
5.02 5.03	00550 PURCHASI NG & RECEI VI NG STORES 00560 ADMI TTI NG						5.02 5.03
5.03 5.04	00590 CASHI ERING ACCOUNTS RECEIVABLE						5.03
5.05	00592 OTHER ADMINISTRATIVE & GENERAL COSTS						5.05
7.00	00700 OPERATION OF PLANT	421, 568	50/				7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0 9, 662	506 0				8.00 9.00
10.00	01000 DI ETARY	16, 434	0				10.00
11.00	01100 CAFETERI A	8, 811	0	.,		,	
13.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	845	0			1, 291	
14.00 15.00	01500 PHARMACY	0 587	0	96		0 1, 912	
16.00	01600 MEDICAL RECORDS & LI BRARY	507	0				
17.00	01700 SOCIAL SERVICE	0	0	C	0	0	17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	174, 904	506	28, 570	151, 361	31, 995	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0				
41.00	04100 SUBPROVI DER – I RF	0	0				
43.00	04300 NURSERY	0	0	C	0	C	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	0	0	C	0	C	50.00
51.00	05100 RECOVERY ROOM	0	0		-		
53.00	05300 ANESTHESI OLOGY	0	0		-		
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	20, 780	0	3, 394		3, 250 0	
56.00	05600 RADI OLOGI THERA LUTTO	1, 571	0	257	-		
57.00	05700 CT SCAN	3, 446	0	563		2, 338	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	8, 528	0				
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 11, 128	0	C 1, 818	-	0 4, 422	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				
65.00	06500 RESPI RATORY THERAPY	0	0		-		
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	25, 007 940	0	4, 085 154		2, 782 1, 238	
68.00	06800 SPEECH PATHOLOGY	676	0				
69.00	06900 ELECTROCARDI OLOGY	2, 088	0	341		926	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	-	-	34	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		-		
	07300 DRUGS CHARGED TO PATIENTS	0	0				
74.00	07400 RENAL DI ALYSI S	2, 804	0	458		C	•
75.00 76.00	07500 ASC (NON-DI STI NCT PART) 03020 OTHER ANCI LLARY	0	0		-		
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		0	021	70.00
90.00		0	0				
91.00	09100 EMERGENCY	0	0	C	0	C	
92.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) SPECIAL PURPOSE COST CENTERS						92.00
	11300 INTEREST EXPENSE						113.00
		0	0		-		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	288, 718	506	45, 583	151, 361	55,860	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190.00
191.00	19100 RESEARCH	0	0		-	C	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	132, 850	0	21, 701			192.00
) 19300 NONPAI D WORKERS) 07950 OTHER NONREI MBURSABLE DEPARTMENTS	0	0		-		193.00 194.00
	07951 ADVERTI SI NG	0	0	0	-		194.00
200.00	Cross Foot Adjustments						200.00
201.00 202.00	0	0 421, 568	0 506	C 67, 284	0 151, 361		201.00
202.00	I TOTAL (Sum TITIES TTO THEOUGH 201)	421,000	500	1 07,204	101, 301	1 55,800	1202.00

Heal th	Financial Systems COMM	NUNITY STROKE AN	D REHABILITATI	ON	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	1	Period: From 08/30/2019 To 06/30/2020	Worksheet B Part II Date/Time Pre 11/25/2020 11	pared: 50 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		13.00	14.00	15.00	16.00	17.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATI ENT TELEPHONES						5.01
5.02	00550 PURCHASING & RECEIVING STORES						5.02
5.03	00560 ADMI TTI NG						5.03
5.04	00590 CASHI ERI NG ACCOUNTS RECEI VABLE						5.04
5.05 7.00	00592 OTHER ADMINISTRATIVE & GENERAL COSTS						5.05
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSING ADMINISTRATION	7, 968					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0	22, 32			15.00
16. 00 17. 00	01700 SOCIAL SERVICE	0	0		0 5,764 0 0	0	16.00 17.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	· · · · · · · · · · · · · · · · · · ·	5 0	0	17.00
30.00	03000 ADULTS & PEDIATRICS	7, 384	0		0 1, 305	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0		0 0	0	31.00
41.00	04100 SUBPROVI DER – I RF	0	0		0 0	0	41.00
43.00	04300 NURSERY	0	0		0 0	0	43.00
		0	0			0	
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	0 0			0	50.00 51.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 427	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0		280	0	56.00
57.00	05700 CT SCAN	0	0		389	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		358	0	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0		0 0 0 557	0	59.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 10	0	60.00 62.00
65.00	06500 RESPI RATORY THERAPY	457	0		126	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 677	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 550	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 115	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		378	0	69.00
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8	0		D 55	0	70.00 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	22, 32		0	73.00
74.00	07400 RENAL DIALYSIS	0	0		50	0	74.00
	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
76.00	03020 OTHER ANCI LLARY	119	0		D1	0	76.00
00.00			0			0	00.00
90.00 91.00	09000 CLINIC 09100 EMERGENCY	0	0			0	90.00 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	92.00
	SPECIAL PURPOSE COST CENTERS	I					
113.00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	0	0		0 0		116.00
118.00		7, 968	0	22, 32	5, 764	0	118.00
100 00	NONREI MBURSABLE COST CENTERS		-			2	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	0				190. 00 191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				191.00
	19300 NONPAI D WORKERS	0	0		0 0		193.00
	07950 OTHER NONREI MBURSABLE DEPARTMENTS	0	0		o o		194.00
	07951 ADVERTI SI NG	0	0		0 0	0	194.01
200.00							200.00
201.00		0	0	22.00		0	201.00
202.00	TOTAL (sum lines 118 through 201)	7, 968	0	22, 32	5, 764	0	202.00

Health Financial Systems COMM	IUNITY STROKE A	ND REHABILITATI	ON	In Lieu	of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-3045		Worksheet B Part II
				To 06/30/2020	Date/Time Prepared:
Cost Center Description	Subtotal	Intern &	Total		11/25/2020 11:50 am
		Residents Cost & Post			
		Stepdown			
	24.00	Adjustments	24.00	_	
GENERAL SERVICE COST CENTERS	24.00	25.00	26.00		
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					2.00
5. 01 00540 NONPATIENT TELEPHONES					5. 01
5. 02 00550 PURCHASI NG & RECEI VI NG STORES					5. 02
					5.03
5. 04 00590 CASHI ERING ACCOUNTS RECEIVABLE 5. 05 00592 OTHER ADMINISTRATIVE & GENERAL COSTS					5.04
7. 00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY					9.00 10.00
11. 00 01100 CAFETERIA					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY					14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY					15.00 16.00
17. 00 01700 SOCIAL SERVICE					17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	T	-		1	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	1, 397, 812		1, 397, 81	0	30.00 31.00
41. 00 04100 SUBPROVI DER – I RF	0			0	41.00
43. 00 04300 NURSERY	0	0		0	43.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	C	0		0	50.00
51. 00 05100 RECOVERY ROOM	0			0	51.00
53.00 05300 ANESTHESI OLOGY	0			0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	339, 456		339, 45	56	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	65, 210	-	65, 21	0	55.00 56.00
57. 00 05700 CT SCAN	145, 567	1 1	145, 56		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	259, 233	1 1	259, 23		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0 114, 618		114, 61	0	59.00 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	101	1	10		62.00
65. 00 06500 RESPI RATORY THERAPY	8, 913	1	8, 91		65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	211,068		211, 06		66. 00 67. 00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	7,873		20, 70 7, 87		68.00
69.00 06900 ELECTROCARDI OLOGY	53, 454		53, 45		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 229	1 1	1, 22		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	369		36	0	71.00 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	25, 713	-	25, 71	13	73.00
74.00 07400 RENAL DIALYSIS	18, 262		18, 26		74.00
75. 00 07500 ASC (NON-DI STINCT PART) 76. 00 03020 OTHER ANCI LLARY	1 452		1 4 5	0	75.00
OUTPATIENT SERVICE COST CENTERS	1, 653	<u> </u>	1, 65		76.00
90. 00 09000 CLI NI C	0			0	90.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	I				92.00
113.00 11300 I NTEREST EXPENSE					113.00
116.00 11600 HOSPI CE	0	0	0 / 74 07	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	2, 671, 233	0	2, 671, 23	33	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190. 00
191. 00 19100 RESEARCH	0	-		0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 193.00 19300 NONPAID WORKERS	821, 777		821, 77		192. 00 193. 00
193. 00 19300 NONPALD WORKERS 194. 00 07950 OTHER NONREIMBURSABLE DEPARTMENTS	18	-	1	18	193.00
194. 01 07951 ADVERTI SI NG	444	0	44		194.01
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0		0	200. 00 201. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	3, 493, 472	0	3, 493, 47	12	201.00
	1 0, 1, 0, 1, 2	, v	5, ., 5, 4,	1	1202.00

In Lieu of Form CMS-2552-10

	OMMUNITY STROKE A				u of Form CMS-	
ST ALLOCATION - STATISTICAL BASIS		Provider CC	N: 15-3045	Period: From 08/30/2019	Worksheet B-1	
				o 06/30/2020		
		LATED COSTS			11/25/2020 11	:50 a
	CAPITAL RE	LATED CUSTS				
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	NONPATI ENT	
•	(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS		TELEPHONES	
			DEPARTMENT		(ACCUM. COS)	
			(GROSS			
	1.00	0.00	SALARI ES)	54.04	F 01	
GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	5A. 01	5. 01	
00 00100 CAP REL COSTS-BLDG & FIXT	103, 331	1				1 1.0
00 00200 CAP REL COSTS-MVBLE EQUI P	100,001	865, 444				2.0
00 00400 EMPLOYEE BENEFITS DEPARTMENT	163		4, 688, 982			4.
01 00540 NONPATI ENT TELEPHONES	C		C		15, 159, 862	
02 00550 PURCHASING & RECEIVING STORES	1, 579	363	48, 321	0	135, 437	5.0
03 00560 ADMI TTI NG	913	2, 883	264, 079	0	364, 870	5.
04 00590 CASHI ERI NG ACCOUNTS RECEI VABLE	C	0 0	C		220, 865	
05 00592 OTHER ADMINI STRATI VE & GENERAL COSTS	1, 554		273, 084		1, 968, 901	
00 00700 OPERATION OF PLANT	14, 342		439, 645		2, 121, 005	
00 00800 LAUNDRY & LINEN SERVICE	0	, v	0	-	33, 199	
	1, 943		131, 459		410, 342	
	3, 305		216, 797		471, 549 128, 882	
. 00 01100 CAFETERIA . 00 01300 NURSI NG ADMI NI STRATI ON	1, 772	1	53, 431 75, 390		94, 019	
. 00 01400 CENTRAL SERVICES & SUPPLY	170		75, 570		94,019	
. 00 01500 PHARMACY	118	-	111, 643	0	387, 534	
. 00 01600 MEDICAL RECORDS & LIBRARY	102			0 0	174, 857	
. 00 01700 SOCIAL SERVICE	02		C		0	
INPATIENT ROUTINE SERVICE COST CENTERS		<u>, </u>				1
. 00 03000 ADULTS & PEDIATRICS	35, 174	61, 124	1, 868, 454	0	3, 903, 379	30.
. 00 03100 INTENSIVE CARE UNIT	C		C		0	
. 00 04100 SUBPROVIDER - IRF	C	0 0	C	0 0	0	41.
. 00 04300 NURSERY	C	0 0	C	0 0	0	43.
ANCI LLARY SERVICE COST CENTERS						
. 00 05000 OPERATI NG ROOM	C	0 0	C		0	
. 00 05100 RECOVERY ROOM	C	0 0	C	0 0	0	
. 00 05300 ANESTHESI OLOGY	C	0 0	C	0 0	0	
. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 179		189, 800		577, 954	
. 00 05500 RADI OLOGY-THERAPEUTI C	0	-	C	-	0	
. 00 05600 RADI 0I SOTOPE . 00 05700 CT_SCAN	316 693		46, 186		151,003	
.00 05700 CT SCAN .00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 715		136, 542 51, 240		326, 289 324, 176	
. 00 05900 CARDI AC CATHETERI ZATI ON	1, / 13	0 100,720	51, 240		0	
. 00 06000 LABORATORY	2, 238	25, 903	258, 228	-	624, 470	
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2,200	0	200, 220		1, 864	
. 00 06500 RESPI RATORY THERAPY	0	505	180, 506	0	244, 677	
00 06600 PHYSI CAL THERAPY	5,029		162, 479		865, 574	
. 00 06700 OCCUPATI ONAL THERAPY	189	1, 244	72, 279	0 0	550, 962	67.
. 00 06800 SPEECH PATHOLOGY	136	537	17,060	0 0	133, 203	68.
. 00 06900 ELECTROCARDI OLOGY	420	31, 926	54, 097	0	127, 442	69.
. 00 07000 ELECTROENCEPHALOGRAPHY	C	662	2,000	0 0	4, 398	70
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0 0	C	0 0	22, 132	
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	0 0	C	0 0	0	
. 00 07300 DRUGS CHARGED TO PATIENTS	C		C	0	0	
. 00 07400 RENAL DI ALYSI S	564	61	C	0 0	46, 525	
. 00 07500 ASC (NON-DI STI NCT PART)		0	0	, s	0	1 . 0.
00 03020 OTHER ANCI LLARY		ט ט	36, 262	0	56, 830	76.
OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	90.
. 00 09100 EMERGENCY			C		0	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	0	92.
SPECIAL PURPOSE COST CENTERS						/2.
3. 00 11300 I NTEREST EXPENSE						113.
5. 00 11600 HOSPI CE	0	o	C	0	0	116.
3.00 SUBTOTALS (SUM OF LINES 1 through 11)	-	-	4, 688, 982	-		
NONREI MBURSABLE COST CENTERS						
D. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	C	0 0	0	190.
1. 00 19100 RESEARCH	C	0 0	C	0	0	191.
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	26, 717	0 0	C	0 0	657, 207	
3. 00 19300 NONPALD WORKERS	0	0 0	C	0 0		193.
4.00079500THER NONREIMBURSABLE DEPARTMENTS	C	0 0	C	0 0	1, 173	
4. 01 07951 ADVERTI SI NG	C	0 0	C	0	29, 144	
0.00 Cross Foot Adjustments						200.
1.00 Negative Cost Centers						201.
2.00 Cost to be allocated (per Wkst. B,	2, 541, 822	951,650	809, 918	3	41, 675	202.
	2,011,022					
Part I) 3.00 Unit cost multiplier (Wkst. B, Part I			0. 172728		0.002749	

Health Financial Systems	COMMUNITY STROKE A	ND REHABILITATI	ON	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 08/30/2019	Worksheet B-1	
				Fo 06/30/2019	Date/Time Pre 11/25/2020 11	
	CAPI TAL REI	LATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFI TS	Reconci I i ati on	NONPATI ENT TELEPHONES	
			DEPARTMENT (GROSS		(ACCUM. COS)	
	1.00	2.00	SALARI ES) 4. 00	5A. 01	5.01	
204.00 Cost to be allocated (per Wkst. B, Part II)			4, 94	1	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part			0. 001054	4	0. 000000	205.00
206.00 NAHE adjustment amount to be alloca (per Wkst. B-2)	ted					206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

ST ALLOCATION - STATISTICAL BASIS		Provider CC	N: 15-3045 P	veriod: rom 08/30/2019	u of Form CMS-25 Worksheet B-1
				o 06/30/2020	Date/Time Prepa 11/25/2020 11:5
Cost Center Description	Reconciliation	PURCHASING & RECEIVING STORES (ACCUM. COS)	ADMI TTI NG (GROSS CHARGES)	ACCOUNTS RECEI VABLE (GROSS	Reconciliation
	5A. 02	5.02	5.03	CHARGES) 5.04	5A. 05
GENERAL SERVICE COST CENTERS				1	
00 00100 CAP REL COSTS-BLDG & FIXT 00 00200 CAP REL COSTS-MVBLE EQUIP 00 00400 EMPLOYEE BENEFITS DEPARTMENT 01 00540 NONPATIENT TELEPHONES 02 00550 PURCHASING & RECEIVING STORES 03 00560 ADMITTING 04 00590 CASHIERING ACCOUNTS 05 00592 OTHER ADMINISTRATIVE & GENERAL 05 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE	-135, 809 0 0 0 0 0	365, 873 221, 472 1, 974, 314 2, 126, 836 33, 290	24, 203, 473 0 0 0 0 0 0	24, 203, 473 0	-1, 992, 110 0 0
00 00900 HOUSEKEEPING .00 01000 DIETARY .00 01000 DIETARY	0	411, 470 472, 845	0	0	0
. 00 01100 CAFETERIA 3. 00 01300 NURSING ADMINISTRATION	0	129, 236 94, 277	0	0	0
. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0
0. 00 01500 PHARMACY 0. 00 01600 MEDICAL_RECORDS_&_LIBRARY	0	388, 599 175, 338	0	0	0
00 01700 SOCIAL SERVICE	0		0	-	0
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	3, 914, 111	5, 467, 008	5, 467, 008	0
. 00 03100 INTENSIVE CARE UNIT	0	3, 914, 111	5, 467, 008 0		0
. 00 04100 SUBPROVIDER - IRF	0	0	0		0
ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0
. 00 05000 OPERATI NG ROOM	0		0		0
. 00 05100 RECOVERY ROOM . 00 05300 ANESTHESI 0LOGY	0	0	0	0	0
. 00 05400 RADI OLOGY-DI AGNOSTI C	0	579, 543	1, 793, 152	1, 793, 152	0
0. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0
0. 00 05600 RADI 0I SOTOPE 2. 00 05700 CT_SCAN	0	151, 418 327, 186	1, 178, 228 1, 635, 868		0
. OO 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	325, 067	1, 503, 057	1, 503, 057	0
2. 00 05900 CARDI AC_CATHETERI ZATI ON 2. 00 06000 LABORATORY	0	0 626, 187	0 2, 338, 913	0 2, 338, 913	0
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1, 869	43, 443	43, 443	0
00 06500 RESPI RATORY THERAPY 00 06600 PHYSI CAL THERAPY	0	245, 350 867, 953	530, 361 2, 843, 557		0
00 06700 OCCUPATI ONAL THERAPY	0	552, 477	2, 312, 142		0
00 06800 SPEECH PATHOLOGY	0		484, 180		0
00 06900 ELECTROCARDI OLOGY 00 07000 ELECTROENCEPHALOGRAPHY	0	127, 792 4, 410	1, 586, 489 232, 135		0
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22, 193	18, 940		0
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 3. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0 2, 022, 380	0 2, 022, 380	0
. 00 07400 RENAL DIALYSIS	0	46, 653	208, 100		0
0. 00 07500 ASC (NON-DI STINCT PART) 0. 00 03020 OTHER ANCI LLARY	0	0 56, 986	0 5, 520	0 5, 520	0
OUTPATIENT SERVICE COST CENTERS	0	50, 900	5, 520	5, 520	0
0. 00 09000 CLINIC	0	0	0	0	0
. 00 09100 EMERGENCY 2. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS		Г — Т		1	
3. 00 11300 I NTEREST EXPENSE 6. 00 11600 HOSPI CE		0	0	0	01
8.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	-135, 809	14, 376, 314	24, 203, 473	24, 203, 473	
0.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 1.00 19100 RESEARCH	0	0	0	0	0 1
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	659, 014	0	0	01
3. 00 19300 NONPAI D WORKERS	0	0	0	0	0 1
4. 00 07950 OTHER NONREIMBURSABLE DEPARTMENTS 4. 01 07951 ADVERTI SI NG	0	1, 176 29, 224	0		0 1
0.00 Cross Foot Adjustments		27,224	0		2
11.00 Negative Cost Centers		125 000	2/0 171	222 442	2
2.00 Cost to be allocated (per Wkst. B, Part I)		135, 809	369, 171	223, 468	2
3.00 Unit cost multiplier (Wkst. B, Part I)		0. 009014	0. 015253		20
4.00 Cost to be allocated (per Wkst. B, Part II)		39, 292	26, 861	578	2

Health Financial Systems COMM	IUNI TY STROKE AN	ND REHABILITATI	ON	In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 08/30/2019	Worksheet B-1	
				To 06/30/2020		pared: :50 am_
Cost Center Description	Reconciliation	PURCHASING & RECEIVING STORES (ACCUM. COS)	ADMI TTI NG (GROSS CHARGES)	CASHI ERI NG ACCOUNTS RECEI VABLE (GROSS	Reconciliation	
	5A. 02	5.02	5.03	CHARGES) 5. 04	5A. 05	
205.00 Unit cost multiplier (Wkst. B, Part	0111 02	0. 002608				205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	LLOCAT	ION - STATISTICAL BASIS		Provider C		eriod: rom 08/30/2019	Worksheet B-1	
					T,		Date/Time Pre 11/25/2020 11	
		Cost Center Description	OTHER ADMI NI STRATI VE & GENERAL COSTS (ACCUM. COS)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	
	OFNED		5.05	7.00	8.00	9.00	10.00	
		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1 1
00 00 01 02 03 04 05 00 00 00 00 00 00 00 00 00 00 00 00	00200 00400 00540 00550 00590 00700 00800 00900 01000 01100 01300 01400 01500 01600	CAP REL COSTS-MVBLE EQUI P EMPLOYEE BENEFITS DEPARTMENT NONPATI ENT TELEPHONES PURCHASI NG & RECEI VI NG STORES ADMI TTI NG CASHI ERI NG ACCOUNTS RECEI VABLE OTHER ADMI NI STRATI VE & GENERAL COSTS OPERATI ON OF PLANT LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG ADMI NI STRATI ON CENTRAL SERVI CES & SUPPLY PHARMACY MEDI CAL RECORDS & LI BRARY	13, 209, 427 2, 146, 007 33, 590 415, 179 477, 107 130, 401 95, 127 0 392, 102 176, 918	84, 780 0 1, 943 3, 305 1, 772 170 0 118 102	4, 265 0 0 0 0 0 0 0 0 0 0 0	82, 837 3, 305 1, 772 170 0 118 102	13, 642 0 0 0 0 0 0 0 0	22 44 55 55 55 55 57 77 85 59 77 85 59 10 111 113 144 155 16 16
00		SOCIAL SERVICE	0	0	0	0	0	17
00		ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	4,083,257	35, 174	4, 265	35, 174	13, 642	30
		INTENSIVE CARE UNIT	4,083,257	35, 174		35, 174 0	13, 642	
00	04100	SUBPROVIDER - IRF	0	0	0	0	0	
		NURSERY	0	0	0	0	0	43
		LARY SERVICE COST CENTERS	0	0	0	0	0	5
		RECOVERY ROOM	0	0		0	0	
00	05300	ANESTHESI OLOGY	0	0	-	0	0	5
	1 1	RADI OLOGY - DI AGNOSTI C	628, 674	4, 179		4, 179	0	
		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	181, 634	0 316		0 316	0	
		CT SCAN	370, 191	693		693	0	
	1 1	MAGNETIC RESONANCE I MAGING (MRI)	364, 801	1, 715		1, 715	0	
		CARDI AC CATHETERI ZATI ON LABORATORY	0 689, 101	0 2, 238	-	0 2, 238	0	
		WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 950	2, 230		2,238	0	
00	06500	RESPI RATORY THERAPY	260, 549	0		0	0	6
		PHYSI CAL THERAPY	945, 405	5, 029		5, 029	0	
		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	614, 072 146, 628	189 136		189 136	0	-
		ELECTROCARDI OLOGY	167, 791	420		420		
00	07000	ELECTROENCEPHALOGRAPHY	10, 134	0	0	0	0	7
		MEDICAL SUPPLIES CHARGED TO PATIENTS	22,857	0	0	0	0	
		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	49, 520		0	0	0	
00	07400	RENAL DI ALYSI S	52, 169	564	0	564	0	
		ASC (NON-DI STINCT PART)	0	0	-	0	0	
		OTHER ANCI LLARY TI ENT SERVI CE COST CENTERS	57,635	0	0	0	0	7
		CLINIC	0	0	0	0	0	9
		EMERGENCY	0	0	0	0	0	
00		OBSERVATION BEDS (NON-DISTINCT PART)						9
. 00		INTEREST EXPENSE						11
. 00	11600	HOSPI CE	0	0	0	0		11
8. 00		SUBTOTALS (SUM OF LINES 1 through 117)	12, 513, 799	58, 063	4, 265	56, 120	13, 642	111
		MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190
		RESEARCH	0	0	0	0		19
		PHYSICIANS' PRIVATE OFFICES	664, 954	26, 717	0	26, 717		19
		NONPAID WORKERS OTHER NONREIMBURSABLE DEPARTMENTS	0	0	0	0		193 194
		ADVERTISING	1, 187 29, 487		0 0	0		194
). 00		Cross Foot Adjustments	27,107			0		200
. 00		Negative Cost Centers						20
2. 00		Cost to be allocated (per Wkst. B,	1, 992, 110	2, 469, 646	38, 656	534, 392	666, 656	20
		Part I) Unit cost multiplier (Wkst. B, Part I)	0. 150810	29. 130054	9. 063540	6. 451127	48.867908	20:
3.00		Cost to be allocated (per Wkst. B,	164, 875			67, 284	151, 361	

Health Financial Systems COMM	IUNI TY STROKE AM	D REHABILITATI	ON	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 08/30/2019	Worksheet B-1	
				To 06/30/2020	Date/Time Pre 11/25/2020 11	
Cost Center Description	OTHER	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	ADMI NI STRATI VE	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
	& GENERAL	(SQUARE FEET)	(TOTAL PATIEN	Г		
	COSTS		DAYS)			
	(ACCUM. COS)					
	5.05	7.00	8.00	9.00	10.00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 012482	4. 972494	0. 11864	0. 812246	11.095221	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

SI ALLO	CATION - STATISTICAL BASIS		Provider CC		eriod: com 08/30/2019	Worksheet B-1	
				Fr Tc		Date/Time Pre	pare
	Cost Center Description	CAFETERI A (GROSS SALARI ES)	NURSI NG ADMI NI STRATI ON (NURSI NG	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	11/25/2020 11 MEDI CAL RECORDS & LI BRARY (GROSS	: 50
		11.00	SALARI ES)	REQUIS.)	15.00	CHARGES)	
GEN	IERAL SERVI CE COST CENTERS	11.00	13.00	14.00	15.00	16.00	-
	00 CAP REL COSTS-BLDG & FIXT						1
	200 CAP REL COSTS-MVBLE EQUIP						2
	OO EMPLOYEE BENEFITS DEPARTMENT						4
	40 NONPATI ENT TELEPHONES 50 PURCHASI NG & RECEI VI NG STORES						5
	660 ADMI TTI NG						5
	590 CASHI ERI NG ACCOUNTS RECEI VABLE						5
	92 OTHER ADMINISTRATIVE & GENERAL COSTS						5
	OO OPERATION OF PLANT						7
	300 LAUNDRY & LINEN SERVICE						8
	200 HOUSEKEEPI NG 200 DI ETARY						10
	00 CAFETERIA	3, 262, 166					10
	BOO NURSI NG ADMI NI STRATI ON	75, 390	1				13
	00 CENTRAL SERVICES & SUPPLY	0	0	0			14
	500 PHARMACY	111, 643	0	0	100		15
1	000 MEDI CAL RECORDS & LI BRARY	0	0	0	0	24, 203, 473	
	00 SOCIAL SERVICE	0	0	0	0	0	17
	ATIENT ROUTINE SERVICE COST CENTERS	1, 868, 454	58, 712	0	0	5, 467, 008	30
	00 INTENSIVE CARE UNIT	1, 000, 434	0	0	0	5,467,008	
	00 SUBPROVI DER – I RF	0	0	0	0	0	-
	BOO NURSERY	0	0	0	0	0	
	I LLARY SERVICE COST CENTERS	[
	DOO OPERATING ROOM	0		0	0	0	
	OO RECOVERY ROOM	0	0	0	0	0	
	300 ANESTHESI OLOGY	100.000	0	0	0	1 702 152	
	100 RADI OLOGY-DI AGNOSTI C 500 RADI OLOGY-THERAPEUTI C	189, 800	0	0	0	1, 793, 152 0	
	000 RADI OL SOTOPE	46, 186	0	0	0	1, 178, 228	
	YOO CT SCAN	136, 542	1	0	0	1, 635, 868	
00 058	BOO MAGNETIC RESONANCE IMAGING (MRI)	51, 240	0	0	0	1, 503, 057	58
	200 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
	DOO LABORATORY	258, 228	0	0	0	2, 338, 913	
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS 500 RESPI RATORY THERAPY	190 506	3, 630	0	0	43, 443 530, 361	
	00 PHYSICAL THERAPY	180, 506 162, 479		0	0	2, 843, 557	
	00 OCCUPATIONAL THERAPY	72, 279	1	0	0	2, 312, 142	
	BOO SPEECH PATHOLOGY	17,060	1	0	0	484, 180	
00 069	200 ELECTROCARDI OLOGY	54, 097	0	0	0	1, 586, 489	69
	000 ELECTROENCEPHALOGRAPHY	2,000	66	0	0	232, 135	
	00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	18, 940	
	200 I MPL. DEV. CHARGED TO PATIENTS 300 DRUGS CHARGED TO PATIENTS	0	0	0	100	0 2, 022, 380	
	100 RENAL DIALYSIS			0	100	2, 022, 380	
	00 ASC (NON-DI STI NCT PART)	0	0	0	0	200, 100	
	020 OTHER ANCI LLARY	36, 262	949	0	0	5, 520	
	PATIENT SERVICE COST CENTERS						
	DOO CLINIC	0	0	0	0	0	
	00 EMERGENCY	0	0	0	0	0	
	200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	BOO INTEREST EXPENSE						111
	00 HOSPI CE	o	0	0	0	0	110
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 262, 166	63, 357	0	100	24, 203, 473	
NON	REI MBURSABLE COST CENTERS						
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190
	00 RESEARCH	0	0	0	0		191
	200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192
	300 NONPALD WORKERS 250 OTHER NONREIMBURSABLE DEPARTMENTS		0	0	0) 193) 194
	250 OTHER NONRETMBURSABLE DEPARTMENTS			0	0		194
01077	Cross Foot Adjustments			0	0	0	200
. 00	Negative Cost Centers						201
2.00	Cost to be allocated (per Wkst. B,	213, 116	120, 447	0	462, 727	207, 228	
	Part I)						
3.00 1.00	Unit cost multiplier (Wkst. B, Part I)	0. 065330	1 1	0.00000	4,627.270000	0.008562	
	Cost to be allocated (per Wkst. B,	55, 860	7,968	0	22, 320	5, 764	1204

Heal th F	inancial Systems COMM	JNITY STROKE A	ND REHABILITATI	ON	In Lie	u of Form CMS-	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider CC		Period: From 08/30/2019	Worksheet B-1	l
					To 06/30/2020	Date/Time Pre 11/25/2020 11	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(GROSS	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
		SALARI ES)		SUPPLY	REQUIS.)	LI BRARY	
			(NURSI NG	(COSTED		(GROSS	
			SALARI ES)	REQUIS.)		CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 017124	0. 125764	0.00000	223. 200000	0. 000238	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

			From 08/30/2019 To 06/30/2020	
	Cost Center Description	SOCI AL SERVI CE		
		(TIME SPENT) 17.00		
-	GENERAL SERVICE COST CENTERS			
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP			1.
	00400 EMPLOYEE BENEFITS DEPARTMENT			4.
	00540 NONPATIENT TELEPHONES			5.
	00550 PURCHASING & RECEIVING STORES			5.
	00560 ADMI TTI NG			5.
	00590 CASHI ERI NG ACCOUNTS RECEI VABLE			5.
	00592 OTHER ADMINISTRATIVE & GENERAL COSTS			5.
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE			7.
	00900 HOUSEKEEPING			9.
	01000 DI ETARY			10.
. 00 0	01100 CAFETERI A			11.
	01300 NURSING ADMINISTRATION			13.
	01400 CENTRAL SERVICES & SUPPLY			14.
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY			15. 16.
	01700 SOCIAL SERVICE	o		10.
	INPATIENT ROUTINE SERVICE COST CENTERS			
. 00 0	03000 ADULTS & PEDI ATRI CS	0		30.
	03100 I NTENSI VE CARE UNI T	0		31.
	04100 SUBPROVIDER - IRF	0		41.
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0		43.
	05000 OPERATING ROOM	0		50.
	05100 RECOVERY ROOM	0		51.
. 00 0	05300 ANESTHESI OLOGY	0		53.
	05400 RADI OLOGY-DI AGNOSTI C	0		54.
	05500 RADI OLOGY-THERAPEUTI C	0		55.
	05600 RADI OI SOTOPE 05700 CT SCAN	0		56. 57.
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		58.
	05900 CARDI AC CATHETERI ZATI ON	Ő		59.
. 00 0	06000 LABORATORY	0		60.
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		62.
1	06500 RESPI RATORY THERAPY	0		65.
1	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0		66. 67.
	06800 SPEECH PATHOLOGY	0		68.
	06900 ELECTROCARDI OLOGY	0		69.
. 00 0	07000 ELECTROENCEPHALOGRAPHY	0		70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0		72. 73.
	07400 RENAL DIALYSIS	0		73.
	07500 ASC (NON-DISTINCT PART)	Ő		75.
. 00	03020 OTHER ANCI LLARY	0		76.
	OUTPATIENT SERVICE COST CENTERS			
		0		90.
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		91. 92.
	SPECIAL PURPOSE COST CENTERS			72.
	11300 INTEREST EXPENSE			113.
	11600 HOSPI CE	0		116.
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	 	118.
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.
	19000 RESEARCH	0		190.
	19200 PHYSI CLANS' PRI VATE OFFI CES	0		192.
3. 00 ⁻	19300 NONPAID WORKERS	O		193.
	07950 OTHER NONREI MBURSABLE DEPARTMENTS	0		194.
	07951 ADVERTI SI NG	0		194.
0. 00 1. 00	Cross Foot Adjustments Negative Cost Centers			200. 201.
2.00	Cost to be allocated (per Wkst. B,	0		201. 202.
	Part I)			202.
3.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000		203.
4.00	Cost to be allocated (per Wkst. B,	0		204.
E 00	Part II)	0.000000		0.05
5.00	Unit cost multiplier (Wkst. B, Part	0. 000000		205.

Health Financial Syste	ems COM	MUNITY STROKE AN	D REHABILITATION	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STA	TISTICAL BASIS		Provider CCN: 15-3045	Period: From 08/30/2019	Worksheet B-1	
					Date/Time Pre 11/25/2020 11	
Cost Cent	er Description	SOCI AL SERVI CE				
		(TIME SPENT)				
		17.00				
	stment amount to be allocated					206.00
207.00 (per Wkst NAHE unit Parts III	cost multiplier (Wkst. D,					207. 00

Hearth Frhancial Systems COM	MMUNITY STRUKE AN	ND REHABILITATI	UN	In Lie	U OT FORM CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 08/30/2019 To 06/30/2020		epared:
					11/25/2020 11	:50 am
		litle	XVIII	Hospi tal	PPS	
				Costs	-	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)				5.00	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(00(070		(00 (07		(00 (070	0.00
30. 00 03000 ADULTS & PEDI ATRI CS	6, 936, 378		6, 936, 37	8 0	6, 936, 378	
31. 00 03100 I NTENSI VE CARE UNI T	0			0 0	0	
41. 00 O4100 SUBPROVIDER - IRF	0			0 0	0	
43. 00 04300 NURSERY	0			0 0	0	43.00
ANCI LLARY SERVICE COST CENTERS	-		1	-1 -1	-	
50. 00 05000 OPERATI NG ROOM	0			0 0	0	
51.00 05100 RECOVERY ROOM	0			0 0	0	
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	899, 930		899, 93	0 1, 062	900, 992	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0 0	0	
56. 00 05600 RADI OI SOTOPE	233, 375		233, 37		233, 375	
57.00 05700 CT SCAN	473, 604		473, 60		473, 604	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	497,056		497, 05	6 0	497, 056	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
60. 00 06000 LABORATORY	909, 551		909, 55	1 3, 641	913, 192	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	3, 767		3, 76	7 0	3, 767	62.00
65. 00 06500 RESPI RATORY THERAPY	323, 076	0	323, 07	6 0	323, 076	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 301, 882	0	1, 301, 88	2 0	1, 301, 882	66.00
67.00 06700 OCCUPATI ONAL THERAPY	737, 924	0	737, 92		737, 924	67.00
68.00 06800 SPEECH PATHOLOGY	178, 841	0	178, 84	1 0	178, 841	68.00
69. 00 06900 ELECTROCARDI OLOGY	225, 158		225, 15	8 0	225, 158	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	13,906		13, 90	6 0	13, 906	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 466		26, 46		26, 466	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	537,031		537, 03	1 0	537, 031	73.00
74.00 07400 RENAL DIALYSIS	81, 886		81, 88	6 0	81, 886	
75.00 07500 ASC (NON-DI STINCT PART)	0			0 0	0	
76. 00 03020 OTHER ANCI LLARY	70, 547		70, 54	7 0	70, 547	
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0			0 0	0	90.00
91.00 09100 EMERGENCY	0			0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
SPECIAL PURPOSE COST CENTERS				<u> </u>		1
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	0			o	0	116.00
200.00 Subtotal (see instructions)	13, 450, 378	0	13, 450, 37	8 4, 703		
201.00 Less Observation Beds	0			0		201.00
202.00 Total (see instructions)	13, 450, 378	0	13, 450, 37	8 4, 703		
	1 10, 100, 070		1 10, 100, 07	-, ,,,,,,,,	1 10, 100, 001	1-02.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-3045	Peri od:	Worksheet C	
			. 10 0010	From 08/30/2019	Part I	
				To 06/30/2020	Date/Time Pre 11/25/2020 11	epared:
			XVIII	lloonitol	PPS	:50 an
		Charges	XVIII	Hospi tal	PP5	
Cost Center Description	Inpatient	Outpati ent	Total (col	6 Cost or Other	TEFRA	
cost center bescription	inpatient	outpatrent	+ col. 7	Ratio	Inpatient	
				hatro	Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS	5, 467, 008		5, 467, 00	08		30.0
31.00 03100 INTENSIVE CARE UNIT	0			0		31.0
1.00 04100 SUBPROVIDER – IRF	0			0		41.0
13. 00 04300 NURSERY	0			0		43.0
ANCI LLARY SERVI CE COST CENTERS	,					
50. 00 05000 OPERATI NG ROOM	0	0		0 0. 000000		
51.00 05100 RECOVERY ROOM	0	0		0 0. 000000		
53. 00 05300 ANESTHESI OLOGY	0	0		0 0. 000000		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	96, 615	1, 696, 537	1, 793, 1		0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0.00000	0.00000	
56. 00 05600 RADI OI SOTOPE	9, 305	1, 168, 923	1, 178, 2		0.000000	
57.00 05700 CT SCAN	122, 204	1, 513, 664	1, 635, 8		0.000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	15, 086	1, 487, 971	1, 503, 0		0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0 000 0	0 0.00000	0.000000	
50.00 06000 LABORATORY	608, 331	1, 730, 582	2, 338, 9		0. 000000	
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	21,771	21, 672	43, 4		0.000000	
55. 00 06500 RESPI RATORY THERAPY 56. 00 06600 PHYSI CAL THERAPY	490, 032 2, 081, 085	40, 329 762, 472	530, 30 2, 843, 5			
57. 00 06700 OCCUPATIONAL THERAPY	2, 081, 085	209, 455	2, 312, 1		0. 000000	
58. 00 06800 SPEECH PATHOLOGY	412,035	209, 435	484, 1			
59. 00 06900 ELECTROCARDI OLOGY	67, 154	1, 519, 335	1, 586, 48		0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	07,134	232, 135				
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 739	2, 201	18, 9		0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 737	2,201	10, 7	0 0. 000000	0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 871, 049	151, 331	2, 022, 3		0.000000	
74. 00 07400 RENAL DI ALYSI S	208, 100	01,001	208, 10		0. 000000	
75. 00 07500 ASC (NON-DI STINCT PART)	200,100	0	2007	0 0. 000000		
76.00 03020 OTHER ANCI LLARY	5, 520	0	5, 5			
OUTPATIENT SERVICE COST CENTERS	0,020		0,0.	121700201	0100000	
20. 00 09000 CLINIC	0	0		0 0.000000	0.00000	90. C
91. 00 09100 EMERGENCY	0	0		0 0.000000		
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0.000000	0.000000	
SPECIAL PURPOSE COST CENTERS						
13.00 11300 INTEREST EXPENSE						113.0
16.00 11600 HOSPI CE	0	0		0		116.0
200.00 Subtotal (see instructions)	13, 594, 721	10, 608, 752	24, 203, 4	73		200.0
201.00 Less Observation Beds						201.0
202.00 Total (see instructions)	13, 594, 721	10, 608, 752	24, 203, 4	73		202.0

Health Financial Systems	COMMUNITY STROKE AND	REHABILITATION	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGE	ES	Provider CCN: 15-3045	Period: From 08/30/2019 To 06/30/2020	Worksheet C Part I Date/Time Prepared: 11/25/2020 11:50 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient Ratio 11.00			
INPATIENT ROUTINE SERVICE COST C				
30. 00 03000 ADULTS & PEDIATRICS	ENTERS			30.00
31. 00 03100 I NTENSI VE CARE UNI T				31.00
41. 00 04100 SUBPROVIDER - IRF				
				41.00
43.00 04300 NURSERY				43.00
ANCI LLARY SERVI CE COST CENTERS	0,000000			
50.00 05000 OPERATING ROOM	0. 000000			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
53.00 05300 ANESTHESI OLOGY	0. 000000			53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 502463			54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000			55.00
56. 00 05600 RADI 0I SOTOPE	0. 198073			56.00
57.00 05700 CT SCAN	0. 289512			57.00
58.00 05800 MAGNETIC RESONANCE I MAGING	(MRI) 0. 330697			58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 390434			60.00
62. 00 06200 WHOLE BLOOD & PACKED RED B				62.00
65. 00 06500 RESPIRATORY THERAPY	0. 609162			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 457836			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 319152			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 369369			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 141922			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 059905			70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATI				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 265544			73.00
74.00 07400 RENAL DIALYSIS	0. 393494			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75.00
76.00 03020 OTHER ANCI LLARY	12. 780254			76.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
91.00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DIST	INCT PART) 0. 000000			92.00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE				113.00
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions				200.00
201.00 Less Observation Beds	,			200.00
202.00 Total (see instructions)				201.00
	I I			1202.00

Hearth Frhancial Systems COMM	UNITY STRUKE AN	ND REHABILITATI	UN	In Lie	U OT FORM CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 08/30/2019 To 06/30/2020	Worksheet C Part I Date/Time Pre 11/25/2020 11	epared:
		Ti +1	e XIX	Hospi tal	PPS	. 50 am
		1111		Costs	113	
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			r	-		
30. 00 03000 ADULTS & PEDIATRICS	6, 936, 378		6, 936, 37	8 0	6, 936, 378	
31.00 03100 INTENSIVE CARE UNIT	0			0 0	0	31.00
41. 00 04100 SUBPROVIDER - IRF	0			0 0	0	41.00
43. 00 04300 NURSERY	0			0 0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0			0 0	0	50.00
51.00 05100 RECOVERY ROOM	0			0 0	0	51.00
53.00 05300 ANESTHESI OLOGY	0		1	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	899, 930		899, 93	0 1, 062	900, 992	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	233, 375		233, 37	5 0	233, 375	56.00
57. 00 05700 CT SCAN	473, 604		473, 60		473, 604	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	497,056		497,05		497,056	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	
60. 00 06000 LABORATORY	909, 551		909, 55	1 3, 641	913, 192	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	3, 767		3, 76		3, 767	
65. 00 06500 RESPIRATORY THERAPY	323,076	0			323, 076	
66. 00 06600 PHYSI CAL THERAPY	1, 301, 882	0	1, 301, 88		1, 301, 882	
67. 00 06700 OCCUPATI ONAL THERAPY	737, 924	0	737, 92		737, 924	
68. 00 06800 SPEECH PATHOLOGY		0			178, 841	
	178, 841	0	178, 84			
	225, 158		225, 15		225, 158	
70. 00 07000 ELECTROENCEPHALOGRAPHY	13,906		13, 90		13, 906	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	26, 466		26, 46	6 U	26, 466	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0		507.00	0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	537,031		537, 03		537, 031	
74.00 07400 RENAL DI ALYSI S	81, 886		81, 88		81, 886	
75.00 07500 ASC (NON-DI STINCT PART)	0			0 0	0	
76. 00 03020 OTHER ANCI LLARY	70, 547		70, 54	/ 0	70, 547	76.00
OUTPATIENT SERVICE COST CENTERS	-		1	-1 -1	-	
90. 00 09000 CLINIC	0			0 0	0	
91.00 09100 EMERGENCY	0			0 0	0	
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0			0	0	92.00
SPECIAL PURPOSE COST CENTERS	T1		1	1		
113.00 11300 INTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	0			0		116.00
200.00 Subtotal (see instructions)	13, 450, 378	0	13, 450, 37	8 4, 703		
201.00 Less Observation Beds	0			0		201.00
202.00 Total (see instructions)	13, 450, 378	0	13, 450, 37	8 4, 703	13, 455, 081	202.00

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-3045	Period: From 08/30/2019 To 06/30/2020	Worksheet C Part I Date/Time Pre 11/25/2020 11	
		Ti tl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00 03000 ADULTS & PEDIATRICS	5, 467, 008		5, 467, 0	28		30.0
1.00 03100 I NTENSI VE CARE UNI T	0			0		31.0
1.00 04100 SUBPROVIDER - IRF	0			0		41. C
3. 00 04300 NURSERY	0			0		43.0
ANCI LLARY SERVI CE COST CENTERS	· · · · ·					
0.00 05000 OPERATING ROOM	0	0		0 0. 000000	0.00000	
1.00 05100 RECOVERY ROOM	0	0		0 0. 000000	0. 000000	51.
3. 00 05300 ANESTHESI OLOGY	0	0		0 0. 000000	0. 000000	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	96, 615	1, 696, 537	1, 793, 1		0. 000000	
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0.000000	0. 000000	55.0
6. 00 05600 RADI 0I SOTOPE	9, 305	1, 168, 923			0. 000000	
7.00 05700 CT SCAN	122, 204	1, 513, 664			0.00000	
8.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	15, 086	1, 487, 971	1, 503, 0		0.000000	58.
9.00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.00000	0.000000	
0.00 06000 LABORATORY	608, 331	1, 730, 582			0.000000	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	21, 771	21, 672			0.000000	62.
5. 00 06500 RESPI RATORY THERAPY	490, 032	40, 329			0.000000	
6.00 06600 PHYSI CAL THERAPY	2,081,085	762, 472			0.000000	66. 67.
7.00 06700 OCCUPATIONAL THERAPY	2, 102, 687	209, 455			0.000000	
8. 00 06800 SPEECH PATHOLOGY 9. 00 06900 ELECTROCARDI OLOGY	412,035	72, 145			0. 000000 0. 000000	68. 69.
0. 00 07000 ELECTROCARDI OLOGY	67, 154	1, 519, 335			0.000000	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 739	232, 135 2, 201	232, 1 18, 9		0.000000	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 739	2, 201	10, 9	0 0.000000	0.000000	
3. 00 07300 DRUGS CHARGED TO PATIENTS	1, 871, 049	151, 331	2, 022, 3		0.000000	
4. 00 07400 RENAL DIALYSIS	208, 100	151, 551	2, 022, 3		0.000000	
5. 00 07500 ASC (NON-DI STINCT PART)	200,100	0	200, 1	0 0. 000000	0.000000	
6.00 03020 OTHER ANCILLARY	5, 520	0	5, 5		0.000000	75. 76.
OUTPATIENT SERVICE COST CENTERS	5, 520	0	<u> </u>	20 12.760254	0.00000	/0.
0. 00 09000 CLINIC	0	0		0 0.000000	0. 000000	90.
1. 00 09100 EMERGENCY	0	0		0 0.000000	0.000000	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0.000000	0.000000	

			-	-	-			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.00000	0.000000	92.00
	SPECI	AL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPI CE	0	0	0			116.00
200.00		Subtotal (see instructions)	13, 594, 721	10, 608, 752	24, 203, 473			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13, 594, 721	10, 608, 752	24, 203, 473			202.00

Health Financial Systems COM	MUNITY STROKE AND	REHABI LI TATI ON	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3045	Peri od:	Worksheet C
			From 08/30/2019	Part I
			To 06/30/2020	Date/Time Prepared: 11/25/2020 11:50 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient		nooprea	
	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
41.00 04100 SUBPROVIDER - IRF				41.00
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 502463			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
56. 00 05600 RADI OI SOTOPE	0. 198073			56.00
57. 00 05700 CT SCAN	0. 289512			57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 330697			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 390434			60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 086711			62.00
65. 00 06500 RESPI RATORY THERAPY	0. 609162			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 457836			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 319152			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 369369			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 141922			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 059905			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 397360			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 265544			73.00
74. 00 07400 RENAL DIALYSIS	0. 393494			74.00
75. 00 07500 ASC (NON-DI STINCT PART)	0. 000000			75.00
76. 00 03020 OTHER ANCI LLARY	12. 780254			76.00
OUTPATIENT SERVICE COST CENTERS	12.700234			/0.00
90. 00 09000 CLINIC	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			91.00
SPECIAL PURPOSE COST CENTERS	0.000000			92.00
113. 00 11300 I NTEREST EXPENSE				113.00
116. 00 11600 HOSPI CE				115.00
				200.00
200.00Subtotal (see instructions)201.00Less Observation Beds				200.00
202.00 Total (see instructions)				201.00
	1			1202.00

Health Financial Systems COM	MUNITY STROKE AN	ND REHABILITATI	ON	In Lie	eu of Form CMS-2	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R. REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C	CN: 15-3045	Period: From 08/30/2019 To 06/30/2020		pared: :50 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating Cos	st Capital	Operating Cost	
	(Wkst. B, Part	(Wkst. B, Part	Net of Capita	al Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0 0	50.00
51.00 05100 RECOVERY ROOM	0	0)	0 0	0 0	51.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0 0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	899, 930	339, 456	560, 47	74 C	0 0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0 0	55.00
56. 00 05600 RADI OI SOTOPE	233, 375	65, 210	168, 16	55 C	o l	56.00
57. 00 05700 CT SCAN	473, 604	145, 567			0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	497,056	259, 233				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0		59.00
60. 00 06000 LABORATORY	909, 551	114, 618		33 0	o o	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	3, 767	101				62.00
65. 00 06500 RESPI RATORY THERAPY	323,076	8, 913			°	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 301, 882	211, 068				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	737, 924	20, 702			°	67.00
68. 00 06800 SPEECH PATHOLOGY	178, 841	7,873				68.00
69. 00 06900 ELECTROCARDI OLOGY	225, 158	53, 454				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	13, 906	1, 229			-	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		369				70.00
	26, 466	309				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	537, 031	25, 713			0	73.00
74.00 07400 RENAL DIALYSIS	81, 886	18, 262			0	74.00
75.00 07500 ASC (NON-DI STINCT PART)	0	0		0 0	-	75.00
76.00 03020 OTHER ANCI LLARY	70, 547	1, 653	68, 89	94 C	0 0	76.00
OUTPATIENT SERVICE COST CENTERS			1	-	1	
90. 00 09000 CLI NI C	0	0		0 0		90.00
91.00 09100 EMERGENCY	0	0		0 0		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
SPECIAL PURPOSE COST CENTERS			1	-	1	
113.00 11300 INTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
200.00 Subtotal (sum of lines 50 thru 199)	6, 514, 000	1, 273, 421	5, 240, 57	79 C		200.00
201.00 Less Observation Beds	0	0		0 0		201.00
202.00 Total (line 200 minus line 201)	6, 514, 000	1, 273, 421	5, 240, 57	79 C	0 0	202.00

	cial Systems COM OF OUTPATIENT SERVICE COST TO CHARGE R	MUNITY STROKE AN ATLOS NET OF	Provi der C		Peri od:	ieu of Form CM Worksheet C	
	FOR MEDICALD ONLY				From 08/30/20	19 Part II	
EDUCTIONS 1					To 06/30/20		repare
						11/25/2020	
				e XIX	Hospi tal	PPS	_
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
			(Worksheet C,				
		Operating Cost			6		
		Reduction	8)	/ col . 7)			
		6.00	7.00	8.00			
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	0	C				50.
	RECOVERY ROOM	0	C				51.
	ANESTHESI OLOGY	0	C	0. 0000			53.
	RADI OLOGY-DI AGNOSTI C	899, 930	1, 793, 152				54.
	RADI OLOGY-THERAPEUTI C	0	C	010000			55.
6.00 05600	RADI OI SOTOPE	233, 375	1, 178, 228	0. 1980	73		56.
7.00 05700	CT SCAN	473, 604	1, 635, 868	0. 2895	12		57.
3. 00 05800	MAGNETIC RESONANCE IMAGING (MRI)	497, 056	1, 503, 057	0. 3306	97		58.
9.00 05900	CARDI AC CATHETERI ZATI ON	0	C	0.0000	00		59
0.00 06000	LABORATORY	909, 551	2, 338, 913	0. 3888	78		60.
	WHOLE BLOOD & PACKED RED BLOOD CELLS	3, 767	43, 443				62.
	RESPI RATORY THERAPY	323,076	530, 361				65
	PHYSI CAL THERAPY	1, 301, 882	2, 843, 557				66.
	OCCUPATIONAL THERAPY	737, 924	2, 312, 142				67
	SPEECH PATHOLOGY	178, 841	484, 180				68.
	ELECTROCARDI OLOGY	225, 158	1, 586, 489				69.
	ELECTROENCEPHALOGRAPHY	13, 906	232, 135				70
	MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 466	18, 940				71
	IMPL. DEV. CHARGED TO PATIENTS	20, 400	10, 940				72
		-	0				
	DRUGS CHARGED TO PATIENTS	537,031	2,022,380				73
	RENAL DIALYSIS	81, 886	208, 100				74
	ASC (NON-DISTINCT PART)	0	C	010000			75
	OTHER ANCI LLARY	70, 547	5, 520	12. 7802	54		76
	TIENT SERVICE COST CENTERS	1					
	CLINIC	0	C				90
	EMERGENCY	0	C	0.0000	00		91
2.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	C	0.0000	00		92
	AL PURPOSE COST CENTERS						
3.0011300	INTEREST EXPENSE						113
6.00 11600	HOSPI CE	0	C	0. 0000	00		116
	Subtotal (sum of lines 50 thru 199)	6, 514, 000	18, 736, 465				200
	Less Observation Beds	0	C				201
	Total (line 200 minus line 201)	6, 514, 000	18, 736, 465				202

Health Financial Systems	COMMUNITY STROKE AN	ND REHABILITATI	ION	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAF	PITAL COSTS			Period: From 08/30/2019 To 06/30/2020	Date/Time Pre 11/25/2020 11	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 397, 812	C	1, 397, 81	2 4, 265	327.74	30.00
31.00 INTENSIVE CARE UNIT	0			0 0	0.00	31.00
41.00 SUBPROVIDER - IRF	0	0		0 0	0.00	41.00
43.00 NURSERY	0			0 0	0.00	43.00
200.00 Total (lines 30 through 199)	1, 397, 812		1, 397, 81	2 4, 265		200.00
Cost Center Description	Inpati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 876	942, 580)			30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
41.00 SUBPROVIDER - IRF	0	l o				41.00
43.00 NURSERY	0	l d				43.00
200.00 Total (lines 30 through 199)	2, 876	942, 580				200.00

Health Financial Systems COMM	IUNITY STROKE AN	ND REHABILITATI	ON	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-3045	Period: From 08/30/2019		
				To 06/30/2020	Date/Time Pre 11/25/2020 11	pared: :50 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	-	1			
50. 00 05000 OPERATI NG ROOM	0	0	0.0000		0	
51.00 05100 RECOVERY ROOM	0	0	0.0000		0	51.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	339, 456	1, 793, 152			13, 119	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.0000		0	55.00
56. 00 05600 RADI 0I SOTOPE	65, 210	1, 178, 228				
57.00 05700 CT SCAN	145, 567	1, 635, 868				
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	259, 233	1, 503, 057			565	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.0000	0 0	0	59.00
60. 00 06000 LABORATORY	114, 618	2, 338, 913	0.04900	420, 288	20, 596	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	101	43, 443	0.00232	9, 789	23	62.00
65. 00 06500 RESPI RATORY THERAPY	8, 913	530, 361	0. 01680	397, 004	6, 672	65.00
66. 00 06600 PHYSI CAL THERAPY	211,068	2, 843, 557	0.07422	1, 408, 364	104, 539	66.00
67.00 06700 OCCUPATI ONAL THERAPY	20, 702	2, 312, 142	0.00895	54 1, 423, 728	12, 748	67.00
68.00 06800 SPEECH PATHOLOGY	7,873	484, 180	0. 01620	275, 459	4, 479	68.00
69. 00 06900 ELECTROCARDI OLOGY	53, 454	1, 586, 489	0. 03369	47, 069	1, 586	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	1, 229	232, 135	0.00529	94 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	369	18, 940	0. 01948	33 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.0000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	25, 713	2, 022, 380	0.0127	1, 318, 405	16, 762	73.00
74.00 07400 RENAL DIALYSIS	18, 262	208, 100	0.08775	56 154, 930	13, 596	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.0000	0 0	0	75.00
76. 00 03020 OTHER ANCI LLARY	1,653	5, 520			709	76.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0	0.0000	0 00	0	90.00
91.00 09100 EMERGENCY	0	0	0.0000		0	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.0000	0 0	0	92.00
200.00 Total (lines 50 through 199)	1, 273, 421	18, 736, 465		5, 605, 758	202, 025	200. 00

Health Financial Systems	COMMUNI TY STROKE AI	ID REHABILITATI	ON	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE O	THER PASS THROUGH COS	S Provider C	F	veriod: rom 08/30/2019 o 06/30/2020		pared: :50 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown	0	Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	C	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	c	0	0	31.00
41. 00 04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
43. 00 04300 NURSERY	0	0		0	0	
200.00 Total (lines 30 through 199)	0	0		0	-	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	I npati ent	200.00
	Adjustment	(sum of cols.	Days	$5 \div col.$ (col.	Program Days	
	Amount (see	1 through 3,	buys	0 . 001. 0)	rrogram bays	
		minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS		0.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS		0	4, 265	0.00	2, 876	30.00
31. 00 03100 I NTENSI VE CARE UNI T		0	1,200	0.00		•
41. 00 04100 SUBPROVIDER - IRF	0	0		0.00		•
43. 00 04300 NURSERY	0	0		0.00		•
200.00 Total (lines 30 through 199)		0	4, 265			200.00
Cost Center Description	I npati ent	0	4,200		2,070	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7 x					
	cost (col. 7 x					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	,					30.00
31. 00 03100 I NTENSI VE CARE UNI T						31.00
41. 00 04100 SUBPROVIDER - IRF	0					41.00
	0					
43. 00 04300 NURSERY	0					43.00
						000 00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems COMM	IUNI TY STROKE AND	D REHABILITAT	ION	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS	Provi der C	CN: 15-3045	Period: From 08/30/2019 To 06/30/2020		pared: :50 am
		Titl€	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician N	lursi ng School	Nursing Schoo	Allied Health	Allied Health	
	Anesthetist I	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS			_			
50.00 05000 OPERATING ROOM	0	C)	0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	C		0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C		0 0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0	C		0 0	0	56.00
57.00 05700 CT SCAN	0	C		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	C		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	C		0 0	0	75.00
76.00 03020 OTHER ANCI LLARY	0	C		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	· · · ·				-	
90. 00 09000 CLINIC	0	C)	0 0	0	90.00
91. 00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	C		0 0	0	200. 00

Health Financial Systems COM	MUNITY STROKE A	ND REHABILITATI	ON	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 08/30/2019 To 06/30/2020		narod
				10 00/ 30/ 2020	11/25/2020 11	:50 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
		5.00			instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	0	0		0	0.00000	
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM	0	0		0 0	0.000000	
	0	0		0 0	0.000000	
	0	0		0 1 702 152		
	0	0		0 1, 793, 152		
55. 00 05500 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0	0		0 1 170 000	0.000000	1
	0	0		0 1, 178, 228		
57.00 05700 CT SCAN	0	0		0 1, 635, 868		1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 1, 503, 057		1
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	0		0 0 012	0.000000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 2, 338, 913 0 43, 443		1
65. 00 06500 RESPIRATORY THERAPY	0	0		0 43, 443 0 530, 361	0.000000	
66. 00 06600 PHYSI CAL THERAPY	0			0 2, 843, 557		1
67. 00 06700 OCCUPATIONAL THERAPY	0			0 2, 312, 142		
68. 00 06800 SPEECH PATHOLOGY	0			0 2, 312, 142		1
69. 00 06900 ELECTROCARDI OLOGY	0			0 1, 586, 489		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 1, 580, 489		1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 18, 940		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 10, 740		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			0 2,022,380		
74. 00 07400 RENAL DIALYSIS	0			0 208, 100		1
75. 00 07500 ASC (NON-DI STINCT PART)	0	0		0 0		
76. 00 03020 OTHER ANCI LLARY	0	-		0 5, 520		1
OUTPATIENT SERVICE COST CENTERS					0.00000	1 0.00
90. 00 09000 CLINIC	0	0		0 0	0.000000	90.00
91. 00 09100 EMERGENCY	0			0 0		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	-		0 0	0. 000000	
200.00 Total (lines 50 through 199)	0	0		0 18, 736, 465		200.00
		,				

Health Financial Systems COMM	IUNI TY STROKE AND	REHABI LI TATI	ON	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	VICE OTHER PASS	Provider C		Period: From 08/30/2019 To 06/30/2020		pared: :50 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 000000	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	69, 299		0 512, 648	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	3, 354		0 461, 366	0	56.00
57.00 05700 CT SCAN	0. 000000	72, 425		0 599, 845	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	3, 276		0 675, 204	0	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	420, 288		0 123, 728	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	9, 789		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	397, 004		0 27, 383	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 408, 364		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 423, 728		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	275, 459		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	47,069		0 584, 154	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 125, 808	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0, 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	1, 318, 405		0 75, 243	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	154, 930		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0		0 0	0	75.00
76.00 03020 OTHER ANCI LLARY	0.000000	2, 368		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS		_, 000	1			1
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		5, 605, 758		0 3, 185, 379	-	200.00

Health Financial Systems COM APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND Com	<u>/UNITY STROKE AI</u> D VACCINE COST	ND REHABILIIAII Provider C		Peri od:	u of Form CMS-2 Worksheet D	2552-10
				From 08/30/2019 To 06/30/2020	Part V Date/Time Pre	narodi
				10 00/30/2020	11/25/2020 11	:50 am
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00	2.00	(see inst.)	(see inst.)	F 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0. 000000	0		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000			0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 501870				257, 283	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			0 0	237,203	55.00
56. 00 05600 RADI 0I SOTOPE	0. 198073			0 0	91, 384	
57. 00 05700 CT SCAN	0. 289512			0 0	173, 662	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 330697			0 0	223, 288	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			0 0	223, 200	59.00
60. 00 06000 LABORATORY	0. 388878			0 0	48, 115	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 086711	0		0 0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 609162	27, 383		0 0	16, 681	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 457836			0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 319152			0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 369369			0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 141922	584, 154		0 0	82, 904	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 059905			0 0	7, 537	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 397360	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	1	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 265544	75, 243	1	0 7,682	19, 980	73.00
74.00 07400 RENAL DIALYSIS	0. 393494	0	1	0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
76.00 03020 OTHER ANCI LLARY	12. 780254	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	_		-			
90. 00 09000 CLINIC	0. 000000			0 0	0	90.00
91.00 09100 EMERGENCY	0. 000000			0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			0 0	0	
200.00 Subtotal (see instructions)		3, 185, 379		0 7,682	920, 834	•
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges		0 405 070			000 00.	000 00
202.00 Net Charges (line 200 - line 201)	I	3, 185, 379	l	0 7,682	920, 834	202.00

Health Financial Systems COM	UNITY STROKE A	ND REHABILITATI	I ON	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C		Peri od: From 08/30/2019 To 06/30/2020	Worksheet D Part V Date/Time Pre 11/25/2020 11	
		Title	e XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)	-			
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATING ROOM	0	C	1			50.00
51. 00 05100 RECOVERY ROOM	0		•			51.00
53. 00 05300 ANESTHESI OLOGY	0					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0					54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0					55.00
56. 00 05600 RADIOLOGI - THERAPEOTIC	0					56.00
57. 00 05700 CT SCAN	0					57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0					58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0					59.00
60. 00 06000 LABORATORY						60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0					62.00
65. 00 06500 RESPIRATORY THERAPY	0					65.00
66. 00 06600 PHYSI CAL THERAPY	0					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0					67.00
68. 00 06800 SPEECH PATHOLOGY	0					68.00
69. 00 06900 ELECTROCARDI OLOGY	0					69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	c c				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	c c				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 040				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0				75.00
76.00 03020 OTHER ANCI LLARY	0	C				76.00
OUTPATIENT SERVICE COST CENTERS	_					
90. 00 09000 CLINIC	0		•			90.00
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	2,040				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	_					
202.00 Net Charges (line 200 - line 201)	0	2,040	n l			202.00

Health Financial Systems	COMMUNITY STROKE AN	ID REHABILITATI	ON	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAN	PITAL COSTS	Provider C		Period: From 08/30/2019 To 06/30/2020	Date/Time Pre 11/25/2020 11	epared: :50 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 397, 812	0	1, 397, 81	2 4, 265	327.74	30.00
31.00 INTENSIVE CARE UNIT	0			0 0	0.00	31.00
41.00 SUBPROVIDER - IRF	0	C		0 0	0.00	41.00
43.00 NURSERY	0			0 0	0.00	43.00
200.00 Total (lines 30 through 199)	1, 397, 812		1, 397, 81	2 4, 265		200.00
Cost Center Description	Inpatient	Inpati ent				
	Program days	Program				
	Ū J	Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	15	4, 916				30.00
31.00 INTENSIVE CARE UNIT	0	C				31.00
41.00 SUBPROVIDER - IRF	0	C				41.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	15	4, 916				200.00

Health Financial Systems COMM	IUNI TY STROKE AI	ND REHABILITATI	ON	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-3045	Peri od:	Worksheet D	
				From 08/30/2019 To 06/30/2020	Part II Date/Time Pre	narod
				10 00/30/2020	11/25/2020 11	:50 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ co	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)				5.00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			0.0000		0	50.00
50. 00 05000 OPERATING ROOM	0	0	0.0000		0	50.00
51.00 05100 RECOVERY ROOM	0		0.0000		0	51.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	339, 456	1, 793, 152	0.0000		0	53.00 54.00
55. 00 05500 RADI OLOGY - DI AGNOSTI C	339,430	1, 793, 152			0	54.00
56. 00 05600 RADI OLOGI - THERAPEUTI C	65, 210	, s			0	56.00
57. 00 05700 CT SCAN	145, 567				0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	259, 233				0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	237, 233				0	59.00
60. 00 06000 LABORATORY	114, 618	-			37	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	101				0	62.00
65. 00 06500 RESPIRATORY THERAPY	8, 913				0	65.00
66. 00 06600 PHYSI CAL THERAPY	211,068					66.00
67.00 06700 OCCUPATI ONAL THERAPY	20, 702					67.00
68.00 06800 SPEECH PATHOLOGY	7,873				38	68.00
69. 00 06900 ELECTROCARDI OLOGY	53, 454				0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	1, 229	232, 135	0.0052	94 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	369	18, 940	0. 0194	33 221	4	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.0000	0 00	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	25, 713	2, 022, 380	0. 0127	14 2, 031	26	73.00
74.00 07400 RENAL DIALYSIS	18, 262	208, 100	0. 0877	56 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.0000	0 0	0	75.00
76.00 03020 OTHER ANCI LLARY	1, 653	5, 520	0. 2994	57 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	0.0000		0	90.00
91.00 09100 EMERGENCY	0	, s	0.0000		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	, s	0.0000		0	
200.00 Total (lines 50 through 199)	1, 273, 421	18, 736, 465	1	20, 852	761	200. 00

31.00 03100 INTENSIVE CARE UNIT 0 0 0 0 0 31.00 41.00 04100 SUBPROVIDER - IRF 0 0 0 0 0 0 41.00 43.00 04300 NURSERY 0 0 0 0 0 0 43.00 200.00 Total (Lines 30 through 199) 0 0 0 0 0 0 0 200.00 0	Health Financial Systems	COMMUNITY STROKE AN	ID REHABI LI TATI	ON	In Lie	eu of Form CMS-:	2552-10
Cost Center Description Nursing School Post-Stepdown Adjustments Allied Health Post-Stepdown Adjustments Allied Health Cost All Other Medical Education Cost 30.00 03000 ADULTS & PEDIATRICS 0 <td>APPORTIONMENT OF INPATIENT ROUTINE SERVICE C</td> <td>THER PASS THROUGH COST</td> <td>S Provider C</td> <td></td> <td>From 08/30/2019 To 06/30/2020</td> <td>Part III Date/Time Pre 11/25/2020 11</td> <td>pared: :50 am</td>	APPORTIONMENT OF INPATIENT ROUTINE SERVICE C	THER PASS THROUGH COST	S Provider C		From 08/30/2019 To 06/30/2020	Part III Date/Time Pre 11/25/2020 11	pared: :50 am
Impart ent rough Post - Stepdown Adj ustments Cost Adj ustments Medical Education Cost 0.00 03000 ADULTS & PEDIATRICS 0			Titl	e XIX	Hospi tal	PPS	
Adj ustments Adj ustments Education Cost 1A 1.00 2A 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 0.00 0 0 0.00 30.00 30.00 001UTES is PEDIATRICS 0 0 0 0 0 0 0 0 0 30.00 31.00 31.00 03100 INTENSI VE CARE UNI T 0	Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
INPATI ENT ROUTI NE SERVICE COST CENTERS 0 0 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 0 0 30.00 43.00 0 0 0 0 0 43.00 0 0 0 0 0 200.00 10 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 30.00 31.00		Post-Stepdown	-	Post-Stepdowr	Cost	Medi cal	
INPATI ENT ROUTI NE SERVICE COST CENTERS 0		Adjustments		Adjustments		Education Cost	
30.00 03000 ADULTS & PEDIATRICS 0 <th0< td=""><td></td><td>1A</td><td>1.00</td><td>2A</td><td>2.00</td><td>3.00</td><td></td></th0<>		1A	1.00	2A	2.00	3.00	
31.00 03100 INTENSIVE CARE UNIT 0	INPATIENT ROUTINE SERVICE COST CENTER	S					
41.00 04100 SUBPROVIDER - IRF 0 0 0 0 0 0 41.00 200.00 Total (lines 30 through 199) 0 0 0 0 0 0 43.00 200.00 Total (lines 30 through 199) 0 0 0 0 0 0 0 43.00 200.00 Total (lines 30 through 199) 0 0 0 0 0 0 0 0 0 0 200.00 0<	30. 00 03000 ADULTS & PEDI ATRI CS	0	C)	0 0	0	30.00
43.00 04300 NURSERY 0	31.00 03100 INTENSIVE CARE UNIT	0	C		0 0	0	31.00
43.00 04300 NURSERY 0		0	0		0	0	•
200.00 Total (lines 30 through 199) 0		0	0		0	0	
Cost Center Description Swing-Bed Adjustment Amount (see instructions) Total Costs (sum of cols. 1 through 3, instructions) Total Patient Days Per Diem (col. 5 + col. 6) Inpatient Program Days 30.00 03000 ADULTS & PEDIATRICS 0 6.00 7.00 8.00 30.00 03000 ADULTS & PEDIATRICS 0 0 0.00 0.00 30.00 31.00 03100 INTENSI VE CARE UNIT 0 0 0 0.00 0 31.00 30.00 Oddon NURSERY 0 0 0 0 0 4.265 0.00 0 43.00 200.00 Total (Lines 30 through 199) Inpatient Program Pass-Through Cost (col. 7 x col. 8) 1 1 1 1 20.00 30.00 30.00 30.00 03000 ADULTS & PEDIATRICS 0 0 4.265 0.00 15 30.00 200.00 Total Patient Program Program Pass-Through Cost (col. 7 x col. 8) 9.00 30.00 30.00 30.00 30.00 31.00 03000 ADULTS & PEDIATRICS <		0	0		0	-	
Adjustment Amount (see instructions) Days 5 + col. 6) Program Days INPATI ENT ROUTI NE SERVICE COST CENTERS instructions) instructions) 6.00 7.00 8.00 INPATI ENT ROUTI NE SERVICE COST CENTERS 0 0 4.265 0.00 15 30.00 30.00 03000 ADULTS & PEDIATRICS 0 0 4.265 0.00 15 30.00 1.00 03100 INTENSI VE CARE UNIT 0 0 0 0.41.00 41.00 0 0 0 0 41.00 41.00 43.00 0		Swing-Bed	Total Costs	Total Patient	Per Diem (col		200.00
Amount (see instructions) 1 through 3, minus col. 4) 0 0 0 4.00 5.00 6.00 7.00 8.00 30.00 03000 ADULTS & PEDIATRICS 0 0 4.00 5.00 6.00 7.00 8.00 31.00 03100 INTENSIVE CARE UNIT 0 0 0 0 0 0 31.00 31.00 0 <td< td=""><td>obst conter bescription</td><td></td><td></td><td></td><td></td><td></td><td></td></td<>	obst conter bescription						
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0				buys	0 . 001. 0)		
Impart ENT ROUTI NE SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00 30.00 ADULTS & PEDI ATRI CS 0 0 4,265 0.00 15 30.00 31.00 03000 ADULTS & PEDI ATRI CS 0 0 4,265 0.00 0 31.00 41.00 04100 SUBPROVI DER - I RF 0 0 0 0.00 0 41.00 43.00 04300 NURSERY 0 0 0 0 0.00 0 43.00 200.00 Total (lines 30 through 199) 1npati ent Program Pass-Through Cost (col. 7 x col. 8) 9.00 15 200.00 30.00 30.00 03000 ADULTS & PEDI ATRI CS 0 0 43.00 30.00 31.00 31.00 03100 INPATI ENT ROUTI NE SERVICE COST CENTERS 9.00 41.00 41.00 31.00 03100 INPATI ENT ROUTI NE SERVICE COST CENTERS 0 31.00 31.00 31.00 03100 INTENSI VE CARE UNI T 0 31.00 31.00							
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 0 0 4,265 0.00 15 30.00 31.00 03100 INTENSI VE CARE UNI T 0 0 0.00 0 31.00 41.00 04100 SUBPROVI DER - I RF 0				6.00	7 00	8.00	
30.00 03000 ADULTS & PEDIATRICS 0 0 4,265 0.00 15 30.00 31.00 03100 INTENSI VE CARE UNIT 0 0 0.00 0 31.00 41.00 04100 SUBPROVI DER - I RF 0 0 0 0.00 0 41.00 43.00 04300 NURSERY 0 0 0 0.00 0 43.00 200.00 Total (Lines 30 through 199) 0 4.265 15 200.00 0 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 30.00 31.00 30.00 03000 ADULTS & PEDIATRICS 0 30.00 31.00 31.00 30.00 03000 ADULTS & PEDIATRICS 0 31.00 31.00 03100 INTENSI VE CARE UNI T 0 31.00 31.00 31.00 03100 INTENSI VE CARE UNI T 0 31.00 31.00 31.00 04100 SUBPROVI DER - I RF 0 41.00 43.00 43.00	INPATIENT ROUTINE SERVICE COST CENTER		0100	0.00	1100	0.00	
31.00 03100 INTENSIVE CARE UNIT 0 0 0.00 0 31.00 41.00 04100 SUBPROVIDER - IRF 0 0 0 0.00 0 41.00 43.00 04300 NURSERY 0 0 0 0.00 0 43.00 200.00 Total (lines 30 through 199) 0 4.265 15 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 4.265 15 200.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 31.00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 41.00 04100 SUBPROVIDER - IRF 0 41.00 43.00 <td></td> <td></td> <td>0</td> <td>4, 26</td> <td>5 0.00</td> <td>15</td> <td>30.00</td>			0	4, 26	5 0.00	15	30.00
41.00 04100 SUBPROVIDER - IRF 0 0 0.00 0 41.00 43.00 04300 NURSERY 0 0 0.00 0 43.00 200.00 Total (lines 30 through 199) 0 4.265 15 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 30.00 30.00 03000 ADULTS & PEDIATRICS 0 31.00 03100 INTENSIVE CARE UNIT 0 31.00 41.00 04100 SUBPROVIDER - IRF 0 41.00 43.00 04300 NURSERY 0 43.00		_	0	.,			
43.00 04300 200.00 NURSERY Total (Lines 30 through 199) 0 0 0.00 0 43.00 200.00 Total (Lines 30 through 199) 0 4.265 15 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 30.00 30.00 03000 ADULTS & PEDI ATRICS 0 31.00 31.00 31.00 31.00 03100 INTENSI VE CARE UNI T 0 31.00 31.00 31.00 43.00 04300 NURSERY 0 43.00 43.00		0	0				
200.00 Total (lines 30 through 199) 0 4,265 15 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 1		Ŭ	0				
Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 30.00 03000 ADULTS & PEDI ATRICS 03000 ADULTS & PEDI ATRICS 03100 INTENSI VE CARE UNI T 0 31.00 03100 INTENSI VE CARE UNI T 0 41.00 04100 SUBPROVI DER - I RF 0 43.00 04300 NURSERY 0				1 26			
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 30.00 03000 ADULTS & PEDI ATRI CS 0 30.00 31.00 03100 INTENSI VE CARE UNI T 0 31.00 31.00 04100 SUBPROVI DER - I RF 0 41.00 43.00 04300 NURSERY 0 43.00		Innatient	0	4,20	5	15	200.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 9.00 30.00 03000[ADULTS & PEDI ATRI CS 0 30.00 31.00 31.00 31.00 31.00 04100[SUBPROVI DER - I RF] 0 41.00 41.00 43.00 04300[NURSERY] 0 43.00 0	Cost center beschiption						
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 30.00 03000 ADULTS & PEDI ATRI CS 0 30.00 31.00 03100 I NTENSI VE CARE UNI T 0 31.00 41.00 41.00 43.00 04300 NURSERY 0 43.00							
col. 8) 9.00 9.00 9.00 30.00 03000 ADULTS & PEDI ATRICS 0 31.00 03100 I NTENSI VE CARE UNI T 0 41.00 04100 SUBPROVI DER - I RF 0 43.00 04300 NURSERY 0							
9.00 INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 31.00 03100 INTENSIVE CARE UNIT 0 31.00 41.00 04100 SUBPROVIDER - IRF 0 41.00 43.00 04300 NURSERY 0 43.00							
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 0 30. 00 31. 00 03100 I NTENSI VE CARE UNI T 0 31. 00 41. 00 04100 SUBPROVI DER - I RF 0 41. 00 43. 00 04300 NURSERY 0 43. 00							
30. 00 03000 ADULTS & PEDIATRICS 0 30. 00 31. 00 03100 I NTENSI VE CARE UNI T 0 31. 00 41. 00 04100 SUBPROVI DER - I RF 0 41. 00 43. 00 04300 NURSERY 0 43. 00	INPATIENT POUTINE SERVICE COST CENTED						
31.00 03100 INTENSIVE CARE UNIT 0 31.00 41.00 04100 SUBPROVIDER - LRF 0 41.00 43.00 04300 NURSERY 0 43.00							30.00
41.00 04100 SUBPROVIDER - IRF 0 41.00 43.00 04300 NURSERY 0 43.00		0					
43. 00 04300 NURSERY 0 43. 00		0					
		0					
200.00 10tal (Thes 30 through 199) 0 200.00		0					•
	200.00 Total (Thes 30 through 199)	I U					1200. OO

Health Financial Systems COMM	IUNITY STROKE AN	ID REHABILITAT	ION	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS			Period: From 08/30/2019 To 06/30/2020		pared: :50 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS			-			
50.00 05000 OPERATING ROOM	0	C		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	C)	0 0	0	51.00
53.00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C		0 0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0	C		0 0	0	56.00
57.00 05700 CT SCAN	0	C		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0	C		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	C		0 0	0	75.00
76.00 03020 OTHER ANCI LLARY	0	C		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	0)	0 0	0	90.00
91.00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	C		0 0	0	200. 00

Health Financial Systems COM	MUNITY STROKE A	ND REHABILITATI	ON	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 08/30/2019 To 06/30/2020		narod
				10 00/ 30/ 2020	11/25/2020 11	:50 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
		5.00	6.00		instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	0	0		0	0.00000	
50. 00 05000 OPERATING ROOM	0	0		0 0		
51.00 05100 RECOVERY ROOM	0	0		0 0	0.00000	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 1, 793, 152		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 1 170 000	0.000000	
56. 00 05600 RADI OI SOTOPE	0	0		0 1, 178, 228		
57.00 05700 CT SCAN	0	0		0 1, 635, 868		
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 1, 503, 057		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0		
	0	0		0 2, 338, 913		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 43, 443		
65. 00 06500 RESPIRATORY THERAPY	0	0		0 530, 361		
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0			0 2, 843, 557		
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0			0 2, 312, 142		
69. 00 06900 ELECTROCARDI OLOGY	0			0 484, 180		
70. 00 07000 ELECTROEARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 1, 586, 489 0 232, 135		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 232, 135		
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 18, 940		
73. 00 07200 DRUGS CHARGED TO PATIENTS	0			0 2,022,380		
74. 00 07400 RENAL DI ALYSI S	0			0 208, 100		
75. 00 07500 ASC (NON-DI STINCT PART)	0			0 200, 100		
76. 00 03020 OTHER ANCI LLARY	0	-		0 5, 520		
OUTPATIENT SERVICE COST CENTERS		. 0	1	5, 520	0.00000	, 0. 00
90. 00 09000 CLINIC	0	0		0 0	0.000000	90.00
91. 00 09100 EMERGENCY	0	-		0 0		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	-		0 0		
200.00 Total (lines 50 through 199)	0	-		0 18, 736, 465		200.00
······································			1		1	

Health Financial Systems COMM	IUNITY STROKE AND	REHABI LI TATI	ON	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-3045	Peri od:	Worksheet D	
THROUGH COSTS				From 08/30/2019 To 06/30/2020		pared [.]
					11/25/2020 11	
			e XIX	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.	8	Costs (col. 9	
	7)	10.00	x col. 10)	12.00	x col. 12)	
ANCI LLARY SERVI CE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATING ROOM	0. 000000	0	[0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	0			0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0			0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0			0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0			0	55.00
56. 00 05600 RADI OLSOTOPE	0. 000000	0			0	56.00
57. 00 05700 CT SCAN	0. 000000	0			0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0			0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	754		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	7, 919		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	7, 568		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	2, 359		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	221		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 031		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
76.00 03020 OTHER ANCI LLARY	0. 000000	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		20, 852		0 0	0	200. 00

COMMUNITY STROKE AND REHABILITATION

In Lieu of Form CMS-2552-10

	Financial Systems COMMUNITY STROKE AND	REHABI LI TATI ON	In Lie	u of Form CMS-2	2552
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-3045	Period: From 08/30/2019	Worksheet D-1	
			To 06/30/2020		
		T: +1 o Y/// 1	lloopital	11/25/2020 11	: 50
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	cost center bescription			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				1
. 00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		4, 265	1.
	Inpatient days (including private room days, excluding swing-			4, 265	2.
. 00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3.
	do not complete this line.				
. 00	Semi-private room days (excluding swing-bed and observation k			4, 265	
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decemb	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	nom davs) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	boll days) arter becelliber	ST OF the cost	0	0
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7
	reporting period	<i></i>			
00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
. 00	Total inpatient days including private room days applicable t	to the Program (excludin	g swing-bed and	2, 876	9
0. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including privato	room dave)	0	10
5.00	through December 31 of the cost reporting period (see instruc		room days)	0	
1.00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)	3 /		
2.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	12
	through December 31 of the cost reporting period			_	
3. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
1 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost	0.00	17
	reporting period				
8.00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18
9.00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 21 a	f the cost	0.00	10
7.00	reporting period	es through becember 31 0	I the cost	0.00	17
0. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instruction			6, 936, 378	
2.00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost repor	ting period (line	0	22
2 00	5 x line 17)	a 21 of the east reporti	ng pariod (line (0	1 22
3.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 OF the cost report	ng period (inne o	0	23
4.00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24
4.00	7 x line 19)		ring period (rine	0	27
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
	x line 20)				
	Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 936, 378	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	and and abconvetion had a	harges)	0	28
	Private room charges (excluding swing-bed charges)	ed and observation bed c	nai yes)	0	
	Semi-private room charges (excluding swing bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
2.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi	, ,	ctions)	0.00	
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35)	and private ream east d	ifforontial (liss	6 026 279	
7.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	anu private room cost d	iiierential (line	6, 936, 378	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JUSTMENTS			1
	Adjusted general inpatient routine service cost per diem (see			1, 626. 35	38
	Program general inpatient routine service cost (line 9 x line	•		4, 677, 383	
	Medically necessary private room cost applicable to the Progr			0	
1.00	Total Program general inpatient routine service cost (line 39	9 + line 40)		4, 677, 383	1 11

Heal th	Financial Systems COMM	UNITY STROKE AN	ND REHABILITAT	TON	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider (Period: From 08/30/2019	Worksheet D-1	
					To 06/30/2020		
			T: +1	o VV/111	llaani tal	11/25/2020 11	:50 am
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
	bost bonter beschiptron			s Diem (col. 1		$(col \cdot 3 \times col \cdot$	
				col . 2)		4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00 0 0.00	4.00	5.00	42.00
	Intensive Care Type Inpatient Hospital Units	0		0.0	<u> </u>	0	42.00
43.00	INTENSIVE CARE UNIT	0		0.0	0 0	0	43.00
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46.00 47.00
	Cost Center Description			•			
						1.00	
	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4			onc)		2, 113, 254 6, 790, 637	48.00 49.00
	PASS THROUGH COST ADJUSTMENTS	41 thi ough 46) (see mstructi	0115)		0, 790, 037	49.00
50.00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, sum	of Parts I and	942, 580	50.00
51.00) Pass through costs applicable to Program inpa	atient ancillar	y services (f	rom Wkst. D, su	um of Parts II	202, 025	51.00
	and IV)						
52.00 53.00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud		lated non-ph	vsician anosth	atist and	1, 144, 605 5, 646, 032	
55.00	medical education costs (line 49 minus line !		nated, non-ph			5, 040, 052	55.00
	TARGET AMOUNT AND LIMIT COMPUTATION					1	
	Program di scharges					0	54.00
55.00 56.00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55.00 56.00
	Difference between adjusted inpatient operati	ing cost and ta	irget amount (line 56 minus l	ine 53)	0	57.00
	Bonus payment (see instructions)	-	-			0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost rep market basket	porting period	endi ng 1996,	updated and cor	npounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year (cost report, up	dated by the	market basket		0.00	60.00
	If line 53/54 is less than the lower of lines				the amount by	0	61.00
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
62 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	Instructions)				0	62.00
	Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST					1	
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reportin	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	cost reporting	period (See	0	65.00
	instructions)(title XVIII only)				(_	
66.00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line	64 plus line	65)(title XVIII	only). For	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31	of the cost rep	porting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	rting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient					0	69.00
70 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70.00
71.00	Adjusted general inpatient routine service of	5					71.00
72.00	Program routine service cost (line 9 x line						72.00
	Medically necessary private room cost applica						73.00
74.00 75.00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient i				art II. column		74.00 75.00
	26, line 45)				,		
76.00	Per diem capital-related costs (line 75 ÷ lin						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 recor	ds)			79.00
80.00	Total Program routine service costs for compa		ost limitatio	n (line 78 minu	us line 79)		80.00
81.00 82.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li)				81.00 82.00
82.00 83.00	Reasonable inpatient routine service cost inmitation (in		· .				82.00
84.00	Program inpatient ancillary services (see ins						84.00
	Utilization review - physician compensation						85.00
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rougn 85)				86.00
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per	diem (line 27 ÷				0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.00

Health Financial Systems COMM	IUNI TY STROKE AI	ND REHABILITATI	ON	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 08/30/2019 To 06/30/2020		pared: :50 am_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 397, 812	6, 936, 378	0. 20151	9 0	0	90.00
91.00 Nursing School cost	0	6, 936, 378	0.00000	0 0	0	91.00
92.00 Allied health cost	0	6, 936, 378	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	6, 936, 378	0.00000	0 0	0	93.00

COMMUNITY STROKE AND REHABILITATION

In Lieu of Form CMS-2552-10

Heal th	Financial Systems COMMUNITY STROKE AND	REHABILITATION	In Lie	u of Form CMS-2	2552-1
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-3045	Period: From 08/30/2019 To 06/30/2020 Hospital	Worksheet D-1 Date/Time Pre 11/25/2020 11 PPS	pared:
	Cost Center Description		nospi tui	115	
	·			1.00	
	PART I - ALL PROVIDER COMPONENTS				-
1.00	Inpatient days (including private room days and swing-bed da	vs excluding newborn)		4, 265	1.0
2.00	Inpatient days (including private room days, excluding swing bed days, excluding newborn days)				
3.00	Private room days (excluding swing-bed and observation bed d		ivate room days,	4, 265 0	3.0
	do not complete this line.		-		
4.00	Semi-private room days (excluding swing-bed and observation bed days)			4, 265	4.0
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.0
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost			0	6.0
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private ro	om days) through December	31 of the cost	0	7.0
0 00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost			0	8.0
8.00	reporting period (if calendar year, enter 0 on this line)			0	8.0
9.00	Total inpatient days including private room days applicable	to the Program (excluding	swing-bed and	15	9.0
	newborn days) (see instructions)	0 1 0	, j		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10.0
11 00	through December 31 of the cost reporting period (see instru		and dave) often	0	11 0
11.00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,		com days) arter	0	11.0
12.00	Swing-bed NF type inpatient days applicable to titles V or X		e room days)	0	12.0
	through December 31 of the cost reporting period		_		
13.00	Swing-bed NF type inpatient days applicable to titles V or X			0	13.0
14.00	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Prog			0	14.0
	Total nursery days (title V or XIX only)	i all (excluding swing-bed	uays)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT]
17.00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 c	of the cost	0.00	17.0
18.00	reporting period Medicare rate for swing-bed SNF services applicable to servi	cos after December 21 of	the cost	0.00	18.0
10.00	reporting period	ces arter becember 51 01	the cost	0.00	10.0
19.00	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 of	the cost	0.00	19.0
	reporting period				
20.00	Medicaid rate for swing-bed NF services applicable to servic reporting period	es after December 31 of 1	the cost	0.00	20.0
21.00	Total general inpatient routine service cost (see instructio	ns)		6, 936, 378	21.0
	Swing-bed cost applicable to SNF type services through Decem		ing period (line	0	
	5 x line 17)				
23.00	Swing-bed cost applicable to SNF type services after Decembe	er 31 of the cost reportin	ng period (line 6	0	23.0
24.00	x line 18) Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost reporti	ng period (line	0	24.0
24.00	7 x line 19)		ng period (rine	0	27.0
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.0
	x line 20)				
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(lipo 21 minus lipo 26)		0 6, 936, 378	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 20)		0, 930, 378	27.0
28.00	General inpatient routine service charges (excluding swing-b	ed and observation bed ch	arges)	0	28.0
29.00	Private room charges (excluding swing-bed charges)		0	0	29.0
	Semi-private room charges (excluding swing-bed charges)			0	30.0
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
32.00 33.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 m		tions)	0.00	
	Average per diem private room cost differential (line 34 x l	, ,	,	0.00	
	Private room cost differential adjustment (line 3 x line 35)			0	36.0
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	6, 936, 378	37.0
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PART IT - HOSPITAL AND SUBPROVIDERS UNLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
38.00	Adjusted general inpatient routine service cost per diem (se			1, 626. 35	38.0
39.00	Program general inpatient routine service cost (line 9 x lin	e 38)		24, 395	39.0
	Medically necessary private room cost applicable to the Prog			0	40.0
41.00	Total Program general inpatient routine service cost (line 3	9 + line 40)		24, 395	41.0

		UNITY STROKE AN	ID REHABILITA	TION	In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-3045	Period: From 08/30/2019	Worksheet D-1	
					To 06/30/2020	Date/Time Pre	
					llaani tal	11/25/2020 11	:50 am
	Cost Center Description	Total	Total	I e XIX Average Per	Hospital Program Days	PPS Program Cost	
	bost benter bescription			s Diem (col. 1		$(col \cdot 3 \times col \cdot$	
				col . 2)		4)	
42.00	NUDSERV (+; + a)/ & VIV aply)	1.00	2.00	3.00	4.00	5.00	42.00
	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0 0.0		0	42.00
43.00	INTENSIVE CARE UNIT	0		0 0.0	0 0	0	43.00
	CORONARY CARE UNIT						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					8, 054	48.00
	Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		32, 449	49.00
	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst D sum	of Parts I and	4, 916	50.00
50.00			361 11 663 (11 6	JIII WKSt. D, Sui		4, 710	30.00
51.00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (f	rom Wkst. D, s	um of Parts II	761	51.00
52.00	Total Program excludable cost (sum of lines					5, 677	52.00
53.00	Total Program inpatient operating cost exclu		lated, non-ph	nysi ci an anesth	etist, and	26, 772	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	56.00
	Difference between adjusted inpatient operat	ing cost and ta	rget amount ((line 56 minus	line 53)	0	57.00
58.00 59.00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period	endina 1996	undated and co	mounded by the	0.00	58.00 59.00
57.00	market basket	por tring period	chung 1770,	apuated and ee	inpounded by the	0.00	37.00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	
61.00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54)	(60), or 1% or	the target		
62.00	Relief payment (see instructions)					0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 of th	ne cost reporti	ng period (See	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporting	period (See	0	65.00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31	of the cost re	porting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 of	f the cost repo	orting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lir	ne 68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NU					1	
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)		ine 70 ÷ inie	, 2)			72.00
	Medically necessary private room cost application		(line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine serv	•					74.00
75.00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B, F	Part II, column		75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77.00	Program capital -related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 minu						78.00
79.00	Aggregate charges to beneficiaries for excess						79.00
80. 00 81. 00	Total Program routine service costs for compariant routine service cost per diam limit		ost iimitatio	on (line 78 min	ius line /9)		80.00 81.00
81.00 82.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81.00
83.00	Reasonable inpatient routine service costs (· .				83.00
84.00	Program inpatient ancillary services (see in						84.00
	Utilization review - physician compensation						85.00
80. UU	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rougn 85)			I	86.00
87.00	Total observation bed days (see instructions					0	87.00
88.00	Adjusted general inpatient routine cost per		line 2)			0.00	
89.00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.00

Health Financial Systems COMM	IUNITY STROKE AI	ND REHABILITATI	ON	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 08/30/2019	Worksheet D-1	
				To 06/30/2019		pared: :50 am_
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 397, 812	6, 936, 378	0. 20151	9 0	0	90.00
91.00 Nursing School cost	0	6, 936, 378	0.00000	0 0	0	91.00
92.00 Allied health cost	0	6, 936, 378	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	6, 936, 378	0. 00000	0 0	0	93.00

leal th Finar	ICI AL SYSTEMS COMMUNITY STROKE AI VCILLARY SERVICE COST APPORTIONMENT		CN: 15-3045		In Lie riod:	Worksheet D-3	
				Fro	om 08/30/2019		
				To	06/30/2020	Date/Time Prep 11/25/2020 11	
		Title	e XVIII		Hospi tal	PPS	. 30 a
	Cost Center Description		Ratio of Cos	st	Inpatient	Inpati ent	
			To Charges		Program	Program Costs	
					Charges	(col. 1 x col.	
						2)	
		-	1.00		2.00	3.00	
	I ENT ROUTI NE SERVI CE COST CENTERS		I.		2 (4 (155		1 20 0
	ADULTS & PEDIATRICS INTENSIVE CARE UNIT				3, 646, 155		30.0
	SUBPROVIDER - IRF				0		31.0
	NURSERY				0		41.0
	LARY SERVICE COST CENTERS						43.0
	OPERATING ROOM		0,0000	000	0	0	50.0
51.00 05100	RECOVERY ROOM		0.0000	000	0	0	51.0
53.00 05300	ANESTHESI OLOGY		0.0000	000	0	0	53.0
54.00 05400	RADI OLOGY-DI AGNOSTI C		0. 5024	63	69, 299	34, 820	54.0
5.00 05500	RADI OLOGY-THERAPEUTI C		0.0000	000	0	0	55.0
	RADI OI SOTOPE		0. 1980)73	3, 354	664	56.0
	CT SCAN		0. 2895		72, 425	20, 968	
	MAGNETIC RESONANCE IMAGING (MRI)		0. 3306		3, 276	1, 083	
	CARDI AC CATHETERI ZATI ON		0.0000		0	0	59.0
	LABORATORY		0.3904		420, 288	164, 095	
	WHOLE BLOOD & PACKED RED BLOOD CELLS RESPIRATORY THERAPY		0.0867		9, 789	849	
	PHYSI CAL THERAPY		0. 6091 0. 4578		397,004	241, 840 644, 800	
	OCCUPATIONAL THERAPY		0. 4578		1, 408, 364 1, 423, 728	454, 386	
	SPEECH PATHOLOGY		0. 3693		275, 459	101, 746	
	ELECTROCARDI OLOGY		0. 1419		47,069	6, 680	
	ELECTROENCEPHALOGRAPHY		0.0599		0	0,000	70.
	MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 3973		ō	0	71.
	IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	0	72.
	DRUGS CHARGED TO PATIENTS		0. 2655		1, 318, 405	350, 095	73.
4.00 07400	RENAL DI ALYSI S		0. 3934	94	154, 930	60, 964	74.
	ASC (NON-DISTINCT PART)		0.0000		0	0	75.
	OTHER ANCI LLARY		12.7802	54	2, 368	30, 264	76.
	TIENT SERVICE COST CENTERS		1				
	CLINIC		0.0000		0	0	
	EMERGENCY		0.0000		0	0	91.
	OBSERVATION BEDS (NON-DISTINCT PART)		0.0000	000	0	0	
200.00	Total (sum of lines 50 through 94 and 96 through 98)				5, 605, 758	2, 113, 254	
201.00	Less PBP Clinic Laboratory Services-Program only char	ges (line 61)					201.
02.00	Net charges (line 200 minus line 201)		1	1	5, 605, 758	, I	202.

	ICI AL SYSTEMS COMMUNITY STROK VCILLARY SERVICE COST APPORTIONMENT	E AND REHABILITAT	CN: 15-3045		ri od:	u of Form CMS-2 Worksheet D-3	
					om 08/30/2019 06/30/2020	Date/Time Pre	norod.
				To	00/30/2020	11/25/2020 11	
		Titl	e XIX	L	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	Inpatient	
			To Charges			Program Costs	
					Charges	(col. 1 x col. 2)	
			1.00		2.00	3.00	
I NPAT	IENT ROUTINE SERVICE COST CENTERS				2100	0100	
30.00 03000	ADULTS & PEDIATRICS				19, 575		30. 0
	INTENSIVE CARE UNIT				0		31.0
	SUBPROVIDER - IRF				0		41.0
	NURSERY				0		43.0
	LARY SERVICE COST CENTERS					-	
	OPERATING ROOM		0.0000		0	0	50.0
	RECOVERY ROOM ANESTHESI OLOGY		0.0000		0	0	51.0 53.0
	RADI OLOGY-DI AGNOSTI C		0.0000		0	0	54.0
	RADI OLOGY-THERAPEUTI C		0. 0000		0	0	55.0
	RADI OLOGI - THERAPEOTIC		0. 1980		0	0	56.0
	CT SCAN		0. 2895		0	0	57.0
	MAGNETIC RESONANCE IMAGING (MRI)		0. 3306		o	0	58. C
	CARDI AC CATHETERI ZATI ON		0.0000		0	0	59. C
50. 00 06000	LABORATORY		0. 3904	34	754	294	60. C
52.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 0867	11	0	0	62. C
55.00 06500	RESPI RATORY THERAPY		0. 6091	62	0	0	65. C
	PHYSI CAL THERAPY		0. 4578		7, 919	3, 626	66. C
	OCCUPATIONAL THERAPY		0. 3191		7, 568	2, 415	67.0
	SPEECH PATHOLOGY		0. 3693		2, 359	871	68.0
	ELECTROCARDI OLOGY		0. 1419		0	0	69. (
	ELECTROENCEPHALOGRAPHY		0.0599		0	0	70.0
	MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 3973		221	309	71.0
	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS		0.0000		2, 031	0 539	72.0 73.0
	RENAL DIALYSIS		0. 2035		2,031	0359	74.0
	ASC (NON-DISTINCT PART)		0. 0000		0	0	75.0
	OTHER ANCI LLARY		12. 7802		0	0	76.0
	TIENT SERVICE COST CENTERS		1 1217002				
			0.0000	00	0	0	90.0
91.00 09100	EMERGENCY		0.0000	00	0	0	91.0
	OBSERVATION BEDS (NON-DISTINCT PART)		0.0000	00	0	0	92. (
200.00	Total (sum of lines 50 through 94 and 96 through 9				20, 852	8, 054	
201.00	Less PBP Clinic Laboratory Services-Program only o	charges (line 61)			0		201.0
202.00	Net charges (line 200 minus line 201)				20, 852		202.0

	Financial Systems COMMUNITY STROKE AND REHAB ATION OF REIMBURSEMENT SETTLEMENT Prov	vider CCN: 15-3045	Peri od:	u of Form CMS-2 Worksheet E	2002-10
			From 08/30/2019 To 06/30/2020	Part B Date/Time Pre	pared:
		T		11/25/2020 11	
		Title XVIII	Hospi tal	PPS	
				1.00	
0	PART B - MEDICAL AND OTHER HEALTH SERVICES			2.040	1 1 00
00 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions	;)		2, 040 920, 834	
00	OPPS payments	· ·		356, 183	
00	Outlier payment (see instructions)			0	
01 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instruction	is)		0.000	
00	Line 2 times line 5	,		0	
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
00 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, c	ol. 13. line 200		0	
00	Organ acqui si ti ons			0	10.00
00	Total cost (sum of lines 1 and 10) (see instructions)			2, 040	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
00	Ancillary service charges			7, 682	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 6	9)		0	
00	Total reasonable charges (sum of lines 12 and 13) Customary charges			7,682	14.00
00	Aggregate amount actually collected from patients liable for payme	ent for services on	a charge basis	0	15.00
00	Amounts that would have been realized from patients liable for pay			0	16.00
00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
	Total customary charges (see instructions)			7, 682	
00	Excess of customary charges over reasonable cost (complete only if	fline 18 exceeds li	ne 11) (see	5, 642	19.00
00	instructions) Excess of reasonable cost over customary charges (complete only if	line 11 exceeds li	ne 18) (see	0	20.00
	instructions)		10 10) (000		
	Lesser of cost or charges (see instructions)				21.00
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructi	ons)		0	
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			356, 183	24.00
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	
00 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24	(for CAH, see inst	ructions)	0 70, 644	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus			287, 579	
00	instructions) Direct graduate medical education normante (from What E 4 Line E	:0)		0	28.00
	Direct graduate medical education payments (from Wkst. E-4, line 5 ESRD direct medical education costs (from Wkst. E-4, line 36)	0)		0	
	Subtotal (sum of lines 27 through 29)			287, 579	
	Primary payer payments Subtotal (line 30 minus line 31)			124 287, 455	
00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			207, 435	32.00
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
00 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			3, 330 2, 165	
	Allowable bad debts for dual eligible beneficiaries (see instructi	ons)		3, 183	
	Subtotal (see instructions)			289, 620	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.00
	Demonstration payment adjustment amount before sequestration			0	
98	Partial or full credits received from manufacturers for replaced d	levices (see instruc	ctions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 289, 620	
	Sequestration adjustment (see instructions)			4, 634	
	Demonstration payment adjustment amount after sequestration			0	
	Sequestration adjustment-PARHM pass-throughs Interim payments			282, 752	40.03
	Interim payments-PARHM			202,702	41.01
	Tentative settlement (for contractors use only)			0	
	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			2, 234	42.0 ² 43.00
	Balance due provider/program-PARHM (see instructions)			2,234	43.0
	Protested amounts (nonallowable cost report items) in accordance w	ith CMS Pub. 15-2,	chapter 1,	0	44.00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				-
00	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
				0.00	92.00
00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 08/30/2019 To 06/30/2020	Worksheet E-1 Part I Date/Time Prep 11/25/2020 11:	
			XVIII	Hospi tal	PPS	
		Inpati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4, 892, 64	8	282, 752	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER			0	0	3.01
3.02				0	0	3.02
3.03				0	0	3.03
3.04				0	0	3.04
3.05	Durau data da Dura many			0	0	3.05
3.50	Provider to Program ADJUSTMENTS TO PROGRAM			o	0	3.50
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.5
3.51				0	0	3.52
3.53				0	0	3. 53
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	3.99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 892, 64	8	282, 752	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	-				
5.01	TENTATI VE TO PROVIDER			0	0	5.01
5.02 5.03				0	0	5.02 5.03
5.05	Provider to Program			0	0	5.03
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51				0	0	5.51
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		18, 00	8	2, 234	6. 0 ⁻
6. 01 6. 02	SETTLEMENT TO PROVIDER			8	2, 234	6.02
7.02	Total Medicare program liability (see instructions)		4, 910, 65	-	284, 986	7.00
			.,	Contractor	NPR Date	
				Numbers	(Mo/Day/Yr)	
		C		Number 1.00	2.00	

Health Financial Systems COMMUNITY STROKE AND REHABILITATION In Lieu of Form	CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-3045 Period: Workshee	et E-1
From 08/30/2019 Part II	D 1
To 06/30/2020 Date/Tir	ne Prepared:)20 11:50 am
Ti tle XVI I Hospi tal	PPS
1.00)
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	
1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1.00
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2	3.00
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4.00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200	5.00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I	7.00
line 168	
8.00 Calculation of the HIT incentive payment (see instructions)	8.00
9.00 Sequestration adjustment amount (see instructions)	9.00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)	10.00
I NPATI ENT HOSPI TAL SERVICES UNDER THE I PPS & CAH	
30.00 Initial/interim HIT payment adjustment (see instructions)	30.00
31.00 Other Adjustment (specify)	31.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3045	Period: From 08/30/2019 To 06/30/2020	Worksheet E-3 Part III Date/Time Pre 11/25/2020 11	pare
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
. 00	Net Federal PPS Payment (see instructions)			5, 045, 638	1.
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0000	2.
. 00	Inpatient Rehabilitation LIP Payments (see instructions))		22, 705	
. 00	Outlier Payments			2, 571	
00	Unweighted intern and resident FTE count in the most reation November 15, 2004 (see instructions)	cent cost reporting period er	nding on or prior	0.00	5
. 01	Cap increases for the unweighted intern and resident FT 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	5
. 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 p	period of a "new	0.00	
00	teaching program" (see instructions) Current year's unweighted I&R FTE count for residents w	ithin the new program growth p	period of a "new	0.00	6
	teaching program" (see instructions)				
00	Intern and resident count for IRF PPS medical education	adjustment (see instructions)		0.00	
0.00	5 5 7			13.937908	
. 00	Teaching Adjustment Factor (see instructions)			0.000000	
2.00	Teaching Adjustment (see instructions)			0	1
8.00	Total PPS Payment (see instructions)	-+		5, 070, 914	
1.00 5.00	Nursing and Allied Health Managed Care payments (see in: Organ acquisition (DO NOT USE THIS LINE)	struction)		0	1
5.00	5 1 1	e instructions)		0	
7.00	15 51 1			5, 070, 914	
3.00				0,070,711	
9.00	51515			5, 070, 914	10
0. 00	Deducti bl es			29, 260	20
I. 00	Subtotal (line 19 minus line 20)			5, 041, 654	2
2.00				51, 150	
3.00				4, 990, 504	
	Allowable bad debts (exclude bad debts for professional	services) (see instructions)		0	
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see	e instructions)		0	2
2.00 3.00		E 4 line 40)		4, 990, 504 0	2
	Direct graduate medical education payments (from Wkst. Other pass through costs (see instructions)	L-4, 11110 49)		0	2
). 00				0	30
. 00	1 3			0	3
1.50		uctions)		0	
. 99	Demonstration payment adjustment amount before sequestra	ation		0	3.
2. 00	Total amount payable to the provider (see instructions)			4, 990, 504	32
2. 01	Sequestration adjustment (see instructions)			79, 848	
	Demonstration payment adjustment amount after sequestra	tion		0	
	Interim payments			4, 892, 648	
1.00	Tentative settlement (for contractor use only)			0	34
5.00 5.00			chapter 1,	18, 008 0	35 36
	\$115.2 TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount from Wkst. E-3, Pt. III, line 4			2, 571	
1.00		ons)		0	51
2 00	The rate used to calculate the Time Value of Money			0.00	52

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3045	Peri od:	Worksheet E-3	
			From 08/30/2019 To 06/30/2020		
		Title XIX	Hospi tal	11/25/2020 11 PPS	: 50
			I npati ent	Outpati ent	
			1.00	2.00	
ſ	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR >	(I X SERVICES		4
00	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services Medical and other services		0	0	1.
00	Organ acquisition (certified transplant centers only)		0	0	3
00	Subtotal (sum of lines 1, 2 and 3)		0	0	
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
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		19, 575		8
00	Ancillary service charges		20, 852	0	
	Organ acquisition charges, net of revenue		0		10
	Incentive from target amount computation		0		11
2.00	Total reasonable charges (sum of lines 8 through 11)		40, 427	0	12
	CUSTOMARY CHARGES				
3.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13
. 00	basis Amounts that would have been realized from patients liable for	navment for services (on O	0	14
. 00	a charge basis had such payment been made in accordance with 4				
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0. 000000	15
b. 00	Total customary charges (see instructions)		40, 427	0	16
7.00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	40, 427	0	17
	line 4) (see instructions)	vifling 4 gyogodo li			10
3. 00	Excess of reasonable cost over customary charges (complete onl 16) (see instructions)	y II IIIne 4 exceeds III	ne 0	0	18
7.00	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	
	Cost of covered services (enter the lesser of line 4 or line 1		0	0	21
ſ	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provi			
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments Capital exception payments (see instructions)		0		24
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
3. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28
9.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
1.00 2.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		0	0	
	Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review		0		35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		0	0	
	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		0	0	39
	Interim payments		0	0	
2.00	Balance due provider/program (line 40 minus line 41)		0	0	
			0	. 01	43

LANCE SHE	ncial Systems COMMUNITY STROKE AN EET (If you are nonproprietary and do not maintain	Provider C	CN: 15-3045	Period:	u of Form CMS-2 Worksheet G	
nd-type a	accounting records, complete the General Fund column		1	rom 08/30/2019		n
y)				To 06/30/2020	Date/Time Pre 11/25/2020 11	
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund	2.00	4.00	<u> </u>
CUDDI	ENT ASSETS	1.00	2.00	3.00	4.00	
	on hand in banks	1,000		0 0	0	1 1
	orary investments	0		0 0	0	
	s recei vabl e	0		0	0	
	unts receivable	1, 782, 376		0	0	
	r recei vabl e	0		0	0	
	wances for uncollectible notes and accounts receivable	0		0 0	0	
00 Inve	ntory	40, 811		o o	0	
00 Prep	aid expenses	96, 550		o o	0	8
00 Othe	r current assets	2, 814		0 0	0	9
00 Due	from other funds	0		0 0	0	10
00 Tota	l current assets (sum of lines 1-10)	1, 923, 551	(0 0	0	11
FI XEI	D ASSETS					
00 Land		0	(0 0	0	12
	improvements	0		0 0	0	13
00 Accu	mulated depreciation	0		0 0	0	14
	dings	56, 245, 418		0 0	0	
	mulated depreciation	0		0 0	0	
1	ehold improvements	0		0 0	0	
	mulated depreciation	0		0 0	0	
	d equipment	0		0 0	0	1
	mulated depreciation	0		0 0	0	
	mobiles and trucks	0		0 0	0	
	mulated depreciation	0		0 0	0	
	r movable equipment	0		0 0	0	
	mulated depreciation	0		0	0	
	r equipment depreciable			0	0	
	mulated depreciation				0	1
	designated Assets			0	0	
	mulated depreciation r equipment-nondepreciable				0	
	I fixed assets (sum of lines 12-29)	56, 245, 418			0	
	R ASSETS	0, 243, 410	1	<u> </u>	0	1 30
	stments	0	(0 0	0	3
	sits on leases	0		0	0	
	from owners/officers	0		0	0	
1	r assets	26, 434		0	0	
	l other assets (sum of lines 31-34)	26, 434		0	0	
1	l assets (sum of lines 11, 30, and 35)	58, 195, 403		0 0	0	
	ENT LI ABI LI TI ES					
	unts payable	24, 489	(0 0	0	37
00 Sala	ries, wages, and fees payable	648, 905	(0 0	0	38
00 Payr	oll taxes payable	0		0 0	0	39
00 Note	s and loans payable (short term)	0		o o	0	40
.00 Defe	rred income	0		0 0	0	
	lerated payments	0				42
	to other funds	0		0 0	0	
	r current liabilities	1, 277, 922		0 0	0	
	l current liabilities (sum of lines 37 thru 44)	1, 951, 316	(0 0	0	45
	TERM LIABILITIES		1			Ι.
	gage payable	0		0 0	0	
	s payabl e	0		0 0	0	
	cured Loans	0		0	0	
	r long term liabilities Llong term liabilities (sum of lines 46 thru 40)	60, 564		0	0	
	l long term liabilities (sum of lines 46 thru 49)	60, 564		0	0	
	I liabilities (sum of lines 45 and 50)	2,011,880	(0 0	0	51
	TAL ACCOUNTS ral fund balance	56, 183, 523		1		52
	ific purpose fund	50, 103, 323				52 53
	r created - endowment fund balance - restricted					54
	r created - endowment fund balance - restricted			0		54
	rning body created - endowment fund balance			0		56
	t fund balance - invested in plant			0	0	
1	t fund balance - reserve for plant improvement,				0	
	acement, and expansion				0	"
	I fund balances (sum of lines 52 thru 58)	56, 183, 523	(0 0	0	59
	I liabilities and fund balances (sum of lines 51 and	58, 195, 403		0 0	0	
				- VI		

				N: 15-3045	From 08/30/2019		
					To 06/30/2020) Date/Time Pre 11/25/2020 11	·50 am
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	0.00	2.00	1.00	5.00	
1 00	Fund halances at heginning of period	1.00	2.00	3.00	4.00	5.00	1.00
	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		21, 997, 563 -6, 990, 468				2.00
	Total (sum of line 1 and line 2)		15,007,095		(3.00
	Additions (credit adjustments) (specify)	0	13,007,073		0	0	
	NET ASSETS TRANSFERRED	40, 912, 000			0	0	
	RESTRI CTED CONTRI BUTI ONS	263,000			0	0	
	NET ASSETS RELEASED	158,000			0	0	
	OTHER	1, 428			0	0	8.00
9.00		0			0	0	9.00
10.00	Total additions (sum of line 4-9)		41, 334, 428		(10.00
11.00	Subtotal (line 3 plus line 10)		56, 341, 523		(11.00
	Deductions (debit adjustments) (specify)	0			0	0	12.00
	NET ASSETS RELEASED	158, 000			0	0	13.00
14.00		0			0	0	
15.00		0			0	0	
16.00		0			0	0	
17.00		0			0	0	
	Total deductions (sum of lines 12-17)		158,000				18.00
	Fund balance at end of period per balance sheet (line 11 minus line 18)		56, 183, 523		(D	19.00
	sheet (The Thinhus The To)	Endowment Fund	PI ant	Fund			
1.00	Fund balances at beginning of period	6.00	7.00	8.00	0		1.00
	Net income (loss) (from Wkst. G-3, line 29)	0			0		2.00
	Total (sum of line 1 and line 2)	0			0		3.00
	Additions (credit adjustments) (specify)	0	0		0		4.00
	NET ASSETS TRANSFERRED		0				5.00
6.00	RESTRI CTED CONTRI BUTI ONS		0				6.00
7.00	NET ASSETS RELEASED		0				7.00
8.00	OTHER		0				8.00
9.00			О				9.00
10.00	Total additions (sum of line 4-9)	0			0		10.00
	Subtotal (line 3 plus line 10)	0			0		11.00
	Deductions (debit adjustments) (specify)		0				12.00
	NET ASSETS RELEASED		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
	Total deductions (sum of lines 12-17)	0			0		18.00
	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			U		19.00

CTATE:	Financial Systems COMMUNITY STROKE AND ENT OF PATIENT REVENUES AND OPERATING EXPENSES			Peri od:	u of Form CMS-	
STATEN	LENT OF PATTENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-3045	Period: From 08/30/2019 To 06/30/2020		pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES General Inpatient Routine Services					-
1.00	Hospi tal		5, 483, 74	47	5, 483, 747	1 1.00
2.00	SUBPROVIDER - IPF		5,405,7	- /	3,403,747	2.00
3.00	SUBPROVIDER - IRF			0	0	
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE		F 400 7	47	E 400 747	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		5, 483, 7	47	5, 483, 747	10.00
11.00	Intensive Care Type Inpatient Hospital Services			0	0	1 11. 00
12.00	CORONARY CARE UNIT			0	0	12.00
13.00	BURN I NTENSI VE CARE UNI T					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines		0	0	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5, 483, 7		5, 483, 747	
18.00	Ancillary services		8, 110, 9			
19.00	Outpati ent services			0 0	0	
20.00	RURAL HEALTH CLINIC			0 0	-	
21.00 22.00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY			0 0	0	21.00
22.00	AMBULANCE SERVICES					22.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE			0 0	0	1
27.00	OTHER (SPECIFY)			0 0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	13, 594, 7	20 10, 608, 753	24, 203, 473	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			16, 221, 371		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00 32.00				0		31.00
32.00				0		33.00
33.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		16, 221, 371		43.00
	to Wkst. G-3, line 4)				1	1

STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-3045 Period:			Worksheet G-3		
From 08/30/2019					
	To 06/30/2020		Date/Time Prepared: 11/25/2020 11:50 am		
		•			
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			24, 203, 473	1.00
2.00	Less contractual allowances and discounts on patients' accounts			15, 232, 564	2.00
3.00	Net patient revenues (line 1 minus line 2)			8, 970, 909	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			16, 221, 371	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-7, 250, 462	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			507	6.00
7.00	Income from investments			326	7.00
8.00	Revenues from telephone and other miscellaneous communication services			0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			0	11.00
	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	13.00
	Revenue from meals sold to employees and guests			43, 334	
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to other the	nan patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			0	18.0
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.0
	Rental of vending machines			0	21.00
22.00	Rental of hospital space			23, 000	
23.00	Governmental appropriations			0	23.00
	OTHER INCOME			80, 309	
	COVID-19 PHE Funding			112, 518	24.50
	Total other income (sum of lines 6-24)			259, 994	
	Total (line 5 plus line 25)			-6, 990, 468	
	OTHER EXPENSES (SPECIFY)			0	27.0
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			-6, 990, 468	29.0