This report is	required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai	lure to report can res	ult in all interim	FORM APPROVED
payments made	since the beginning of the cost reporting period being	g deemed overpayments (42 USC 1395g).	OMB NO. 0938-0050
				EXPIRES 03-31-2022
HOSPITAL AND H	OSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION	Provider CCN: 15-3045		Worksheet S
AND SETTLEMENT	SUMMARY		From 07/01/2020	
			To 06/30/2021	
				11/23/2021 10:41 am
PART I - COST	REPORT STATUS			
Provi der	 [X] Electronically prepared cost report 		Date: 11/23/20	021 Time: 10:41 am
use only	2. [] Manually prepared cost report			
	3. [0] If this is an amended report enter the number		resubmitted this co	ost report
	4. [F] Medicare Utilization. Enter "F" for full or "	L" for low.		
Contractor	5. [1] Cost Report Status 6. Date Received:	10	. NPR Date:	
use only	(1) As Submitted 7. Contractor No.		. Contractor's Vendo	
,	(2) Settled without Audit 8. [N] Initial Report for	or this Provider CCN 12	. [0]If line 5, co	lumn 1 is 4: Enter
	(3) Settled with Audit 9. [N] Final Report for	this Provider CCN		es reopened = 0-9.
	(4) Reopened			•
	(5) Amended			
	(3) Allierided			

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY STROKE AND REHABILITATION (15-3045) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[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) MARY F. SUDICKY

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)

		Title XVIII					
	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	152, 986	5, 537	0	0	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	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	152, 986	5, 537	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.

Health Financial Systems COMMUNITY STROKE AND REHABILITATION In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3045 Peri od: Worksheet S-2 From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/23/2021 10:41 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 10215 BROADWAY 1.00 PO Box: 1.00 State: IN 2.00 City: CROWN POINT Zip Code: 46307 County: LAKE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COMMUNITY STROKE AND 153045 23844 5 08/30/2019 Ν 3.00 REHABI LI TATI ON Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2020 06/30/2021 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Ν Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N N Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	AIA	Provi der CC	N: 15-3045	Period: From 07/	01/2020	Worksh Part I	neet S-2	
						30/2021	Date/T	ime Pre	
		In-State	In-State	Out-of	Out-of	Medi ca	id (<u>′2021 10</u> Other	41
		Medicaid paid days	Medicaid eligible	State Medi cai d	State Medi cai d	HMO da	- I	di cai d days	
		para days	unpai d	pai d days	el i gi bl e			uays	
			days		unpai d				
1. 00	If this provider is an IPPS hospital, enter the	1.00	2. 00	3. 00	4. 00	5. 00	0	6.00	24
5. 00	in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		0	0			397		25
. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		0	0	Linkon /			f Coogn	25
						Rural S 00		00	1
. 00		age) status	at the beg	inning of t		1			26
'. 00	cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassif	age) status r "2" for r	ural. If ap		st	1			27
5. 00	0 0 .			H status ir		o nni ng:	End	i ng:	35
					1.	00		00	
. 00	Enter applicable beginning and ending dates of SCH's of periods in excess of one and enter subsequent date		cript line	36 for numb	er				36
. 00			r of period	s MDH statu	IS	0			37
. 01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)								37
. 00									38
									_
						/N		/N	
. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i)1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent requiremen	er in colum ts in	1. ime in	/N 00 N	2.	/N 00 N	39
	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage ii)? Enter n adjustmen ber 1. Ente	(iii)? Ent requiremen in column 2 t? Enter "Y r "Y" for y	er in colum ts in "Y" for ye " for yes o	1.	OO N	2.	OO N	39
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. 00	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital), (ii), or the mileage ii)? Enter n adjustmen ber 1. Ente . (see inst	(iii)? Ent requiremen in column 2 t? Enter "Y r "Y" for y ructions)	er in colum ts in "Y" for ye " for yes c es or "N" f	1.	N V 1.00	XVIII 2. 00	N XI X 3. 00	40
. 00	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions)), (ii), or the mileage ii)? Enter n adjustmen ber 1. Ente . (see inst	(iii)? Ent requirement in column 2 t? Enter "Y r "Y" for y ructions)	er in colum ts in "Y" for yes " for yes c es or "N" f e share in ry circumst	1. me in	N V 1.00	2.	N N XIX	40
. 00	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excupursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen), (ii), or the mileage ii)? Enter n adjustmen ber 1. Ente . (see inst nt for disp eption for t. L, Pt. I capital? E	(iii)? Ent requirement in column 2 t? Enter "Y r" for y ructions) roportionat extraordina II and Wkst	er in colum ts in "Y" for yes ces or "N" f e share in ry circumst . L-1, Pt. yes or "N"	accordance ances I through for no.	N V 1.00	2. XVIIII 2. 00	N N XI X 3.00	40 45 46
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5. 00 5. 00 7. 00 3. 00 7. 00	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1 Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the respons was involved in training residents in approved GME pyear, and are you are impacted by CR 11642 (or appliance of the programs trained at this facility? Enter "Y" for yes; otherwise, enter "N" for no in collif line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon	n adjustmen ber 1. Enter n adjustmen for dispeption for t. L, Pt. I capital? Et? Enter n approved Ge to column rograms in cable CRs) lumn 2. period duri r yes or "N th of this y", complet I, if applibursement f	(iii)? Ent requirement in column 2 t? Enter "Y r" for y ructions) roportionat extraordinate and Wkst extraordinate and Wkst extraordinate and with the programs 1 is "Y", the prior y was direct Gong which report e worksheet cable.	er in colum ts in "Y" for yes ces or "N" fees or "N" fees or "N" fees or "N" for "N" for "N" for "N" for "N" for "Sear or penum payment sidents in column 1. ing period? E-4. If co	accordance ances I through for no. no. for yes chospital Itimate reduction? approved If column of Enter "Yolumn 2 is	N V 1.00 N N N N N N N N N N N N N N N N N N	2. XVI I I I 2. 000 N N N N N	N	

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider Co		Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Pre 11/23/2021 10	pared:
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1. 00	2.00	3.00	
0. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent Cadjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. R) NAHE	see If column 1	N			60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4.00	5. 00	-
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61.0
	column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61.0
	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 0
1. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.0
. 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. C
	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.0
	par e er generar sangery. (See Thistraetrons)	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
. 10	Of the FTEs in line 61.05, specify each new program		1.00	2. 00	3.00	4.00	61. 1
	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				0.00	0.00	01. 1
	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	0. 00	61. 2
						1. 00	
	ACA Provisions Affecting the Health Resources and Ser				nied for which		42.0
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ti ons) Teachi	ng Health Cen	ter (THC) int			62.0
8. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	er Setti ettings	ngs during this c	ost reporting		N	63. 0
		TO THE	or thiough	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	

	FTEs	FTEs in	(col. 1 + col.	1
	Nonprovi der	Hospi tal	2))	
	Si te			
	1. 00	2. 00	3. 00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsTh	his base year	is your cost r	eporting	
period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents	0. 00	0. 00	0. 000000	64. 00
in the base year period, the number of unweighted non-primary care				1
resident FTEs attributable to rotations occurring in all nonprovider				
settings. Enter in column 2 the number of unweighted non-primary care				
resident FTEs that trained in your hospital. Enter in column 3 the ratio				
of (column 1 divided by (column 1 + column 2)). (see instructions)				

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3045 Peri od: Worksheet S-2 From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/23/2021 10:41 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. 3/ (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Health Financial Systems COMMUNITY STROKE AND REHABILITATION		In Lie	u of Form CMS	\$ 2552 10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-	F	Period: From 07/01/2020 To 06/30/2021	Worksheet S Part I Date/Time P 11/23/2021	-2 repared:	
			1. 00		
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 81.00 Is this a LTCH co-located within another hospital for part or all of the cost re "Y" for yes and "N" for no.	eporti ng	peri od? Enter	N N	80. 00 81. 00	
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR 86.10 All (10(f)(1)(i) 2 Enter "Y" for year and "N" for year.			N	85. 00 86. 00	
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospital classified under: 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87. 00			
1.000(0)(1)(1) 2.100. 1 10. 10. 10. 10. 10.		V 1. 00	XI X 2. 00		
Title V and XIX Services	\/!! 6		.,		
90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "'yes or "N" for no in the applicable column.	Y" for	N	Y	90. 00	
91.00 Is this hospital reimbursed for title V and/or XIX through the cost report eith full or in part? Enter "Y" for yes or "N" for no in the applicable column.	er in	N	N	91. 00	
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? instructions) Enter "Y" for yes or "N" for no in the applicable column.	(see		N	92. 00	
93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? "Y" for yes or "N" for no in the applicable column.	N	93. 00			
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	he	N	N	94. 00	
95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.		0. 00 N	0.00	95.00	
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column	N	96. 00			
97.00 Filine 96 is "Y", enter the reduction percentage in the applicable column. 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents	N Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in				
98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges (C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column		N	Y	98. 01	
title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observable bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column for title V, and in column 2 for title XIX.		N	Υ	98. 02	
98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in for title V, and in column 2 for title XIX.		N	N	98. 03	
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title lin column 2 for title XIX.	V, and	N	N	98. 04	
98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallow Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V column 2 for title XIX.		N	Υ	98. 05	
98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and column 2 for title XIX.		N	N	98. 06	
Rural Providers 105.00 Does this hospital qualify as a CAH?		N		105. 00	
106.00 f this facility qualifies as a CAH, has it elected the all-inclusive method of for outpatient services? (see instructions)	payment	1		106. 00	
107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for training programs? Enter "Y" for yes or "N" for no in column 1. (see instruction Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in a approved medical education program in the CAH's excluded IPF and/or IRF unit(s) Enter "Y" for yes or "N" for no in column 2. (see instructions)	ons) n			107. 00	
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule?	See 42	N		108. 00	

Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded I					
Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N					108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3. 00	4. 00	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109. 00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	N	110. 00			

			11/23/2021 1	10: 41
		1. 00	2.00	_
1.00 If this facility qualifies as a CAH, did it participate in the Frontier (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 column 2.	N N	2.00	111
	1. 00	2. 00	3.00	
2.00 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. Mi scellaneous Cost Reporting Information	N			112
5.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no	l N			0115
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.	, v			
6.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116
7.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117
8.00 s 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
	Premi ums	Losses	Insurance	
	1. 00	2.00	3. 00	
8.01 List amounts of malpractice premiums and paid losses:	1	C)	0 11
		1. 00	2.00	
8.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein.		N		118
9.00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "\"\"\" for no. Is this a rural hospital with < 100 beds that qualifies for t Hold Harmless provision in ACA §3121 and applicable amendments? (see inst Enter in column 2, "Y" for yes or "\" for no.	/" for yes or the Outpatient	N	N	119
 OOD Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no. 	es charged to	N		12
2.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", ententhe Worksheet A line number where these taxes are included.		N		12
Transplant Center Information	for no. If	N		12
5.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.				
yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, enter the certi in column 1 and termination date, if applicable, in column 2.				
yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter the certification column 1 and termination date, if applicable, in column 2.	ication date			12
yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, enter the certi in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter the certifing column 1 and termination date, if applicable, in column 2.	ication date			12
yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, enter the certification of the column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified lung transplant center, enter the certification of the column 1 and termination date, if applicable, in column 2.	Fication date Fication date cation date in			12 ³
yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified lung transplant center, enter the certification 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified pancreas transplant center, enter the certification column 1 and termination date, if applicable, in column 2.	Fication date Fication date cation date in			127 128 129 130
yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, enter the certification of this is a Medicare certified heart transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter the certification of this is a Medicare certified lung transplant center, enter the certification of this is a Medicare certified pancreas transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified intestinal transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified intestinal transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified intestinal transplant center, enter the certification column 2 and termination date, if applicable, in column 2.	Fication date Fication date cation date in Fitification certification			12° 12° 13° 13°
yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified lung transplant center, enter the certification 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified pancreas transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 1.00 If this is a Medicare certified intestinal transplant center, enter the center in column 1 and termination date, if applicable, in column 2. 2.00 If this is a Medicare certified islet transplant center, enter the center in column 1 and termination date, if applicable, in column 2. 8.00 Removed and reserved	Fication date Fication date cation date in Tification certification Fication date			12° 12° 13° 13° 13° 13°
6.00 If this is a Medicare certified kidney transplant center, enter the certific in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified lung transplant center, enter the certification of this is a Medicare certified pancreas transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 1.00 If this is a Medicare certified intestinal transplant center, enter the certificate in column 1 and termination date, if applicable, in column 2. 1.00 If this is a Medicare certified intestinal transplant center, enter the column 1 and termination date, if applicable, in column 2. 1.00 If this is a Medicare certified islet transplant center, enter the certification of the column 2 and termination date, if applicable, in column 2.	Fication date Fication date cation date in Tification certification Fication date			126 127 128 129 130 131 132 133

Health Financial Systems COMMUNITY STROKE AND REHABILITATION In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3045 Peri od: Worksheet S-2 From 07/01/2020 Part I Date/Time Prepared: To 06/30/2021 11/23/2021 10:41 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141.00 Name: COMMUNITY FOUNDATION OF NW IN | Contractor's Name: WPS Contractor's Number: 08001 141 00 142.00 Street: 10010 DON POWERS DRIVE PO Box: 142.00 143.00 City: MUNSTER 143. 00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 γ 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145 00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν N 148 00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no N 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 Ν N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν 159. 00 Ν 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 9. 99169. 00 transition factor. (see instructions) Begi nni ng Endi ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170. 00 period respectively (mm/dd/yyyy) 1.00 2.00 171.00|If line 167 is "Y", does this provider have any days for individuals enrolled in 0171.00 N section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

	Financial Systems COMMUNITY STROKE AND F AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der	CCN: 15-3045	Peri od: From 07/01/2020 To 06/30/2021		epared:
				Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N fomm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	r all NO r	esponses. Ente	er all dates in t	the	
	Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the be reporting period? If yes, enter the date of the change in colu		e instructions)			1.00
			Y/N	Date	V/I	+
2. 00	Has the provider terminated participation in the Medicare Prog	urom2 lf	1. 00 N	2. 00	3. 00	2.00
	yes, enter in column 2 the date of termination and in column 3 voluntary or "I" for involuntary.	, "V" for				
3. 00	Is the provider involved in business transactions, including m contracts, with individuals or entities (e.g., chain home offi or medical supply companies) that are related to the provider officers, medical staff, management personnel, or members of t of directors through ownership, control, or family and other s relationships? (see instructions)	ces, drug or its the board	N			3.00
			Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports					
4. 00	Column 1: Were the financial statements prepared by a Certifi Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date availa column 3. (see instructions) If no, see instructions.	Compiled, ble in	Y	A		4.00
5. 00	Are the cost report total expenses and total revenues differenthose on the filed financial statements? If yes, submit reconc		N	V/AI		5. 00
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
6. 00	Column 1: Are costs claimed for nursing school? Column 2: If the legal operator of the program?		the provider is			6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see instr Were nursing school and/or allied health programs approved and cost reporting period? If yes, see instructions.	ructions. I/or renewe	ed during the	N N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved graprogram in the current cost report? If yes, see instructions.			N		9. 00
10.00	Was an approved Intern and Resident GME program initiated or r cost reporting period? If yes, see instructions.			N		10.00
11. 00	Are GME cost directly assigned to cost centers other than I & Teaching Program on Worksheet A? If yes, see instructions.	R In an Ap	oproved	N	Y/N	11.00
	Bad Debts				1.00	
12. 00	Is the provider seeking reimbursement for bad debts? If yes, s	ee instru	ctions.		Y	12.00
	If line 12 is yes, did the provider's bad debt collection poliperiod? If yes, submit copy.			ost reporting	N	13. 00
	If line 12 is yes, were patient deductibles and/or co-payments Bed Complement				N	14.00
15. 00	Did total beds available change from the prior cost reporting				N	15. 00
			nrt A		t B	+
		1. 00	2. 00	Y/N 3. 00	Date 4. 00	
	PS&R Data	1.00	2.00	3.00	4.00	
16. 00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00

	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
	instructions)					
17.00	Was the cost report prepared using the PS&R Report for	Υ	09/28/2021	Υ	09/28/2021	17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					

Heal th	Financial Systems COMMUNITY STROKE A	ND REHABILITAT	ION	In Lie	u of Form CMS-	2552-10		
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-3045	Peri od: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Pre 11/23/2021 10	epared:		
			i pti on	Y/N	Y/N			
20.00	LE Line 1/ on 17 in one of the DCOD		0	1. 00	3.00	20.00		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00		
	Incoort data for other. Beserve the other day astmores.	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 records? If yes, see instructions.	N		N		21. 00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	FPT CHILDRENS H	(OSPLTALS)		1.00			
	Capital Related Cost							
22.00	Have assets been relifed for Medicare purposes? If yes, see	e instructions				22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprais	sals made duri	ing the cost		23. 00		
0.4.00	reporting period? If yes, see instructions.							
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ea into auring	this cost re	porting period?		24. 00		
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	If ves. see		25. 00		
	instructions.		9	5-2,				
26. 00	00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.							
27. 00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.							
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er		28. 00					
29. 00	peri od? If yes, see instructions. 00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)							
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If yes,	, see		30. 00		
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is</pre>	ssuance of new	debt? If yes,	, see		31. 00		
	instructions. Purchased Services							
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ed through co	ntractual		32. 00		
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app. no, see instructions.		ng to competi	tive bidding? If		33. 00		
	Provi der-Based Physi ci ans							
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rrangement with	n provi der-bas	sed physicians?		34. 00		
35. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		nts with the p	provi der-based		35. 00		
	The second secting the cost reporting period. It yes, see it			Y/N	Date			
				1. 00	2. 00			
04 00	Home Office Costs					0, 00		
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	renared by the	home office?			36. 00 37. 00		
	If yes, see instructions.							
38. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end	nice uniterent diofithe home o	nrom mar or office.			38. 00		
39. 00	If line 36 is yes, did the provider render services to other see instructions.			,		39. 00		
40. 00		home office?	If yes, see			40. 00		
			00		00			
	Cost Report Preparer Contact Information	1.	00	2.	00			
41. 00		CATHERI NE		WOERNER		41. 00		
42. 00	respectively. Enter the employer/company name of the cost report	COMMUNITY HOSE	PITAL			42. 00		
40.05	preparer.	40407064647		OATHED NE S	EDNIED - 0011110 - 5-	43. 00		
43. 00								

Health Financia	al Systems	COMMUNITY STROKE	AND	REHABI LI TA	ATI ON			In Lie	u of Form CMS-	2552-10
HOSPITAL AND H	OSPITAL HEALTH CARE REIMBURSEME	NT QUESTIONNAIRE		Provi der	CCN:	15-3045		i od:	Worksheet S-2	2
							Froi	m 07/01/2020 06/30/2021	Part II Date/Time Pro	narod:
							10	00/ 30/ 2021	11/23/2021 10): 41 am_
					3.00					
Cost Rep	oort Preparer Contact Informatio	on								
41.00 Enter t	ne first name, last name and th	e title/position	DIF	RECTOR OF	REIMB	URSEMENT				41.00
held by	the cost report preparer in co	lumns 1, 2, and 3,								
respect										
42.00 Enter t	ne employer/company name of the	cost report								42. 00
prepare										
	ne telephone number and email a									43. 00
report	oreparer in columns 1 and 2, re	specti vel y.								

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 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 In Lieu of Form CMS-2552-10 COMMUNITY STROKE AND REHABILITATION Provider CCN: 15-3045

					00/30/2021	11/23/2021 10	
						I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1. 00	2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	30	10, 950	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		30	10, 950	0. 00	0	7. 00
0.00	beds) (see instructions)	21.00	0		0.00		0.00
8.00	INTENSIVE CARE UNIT	31. 00	0	0	0.00	0	8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10. 00 11. 00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT						12.00
13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY	43. 00				0	12.00
14. 00	Total (see instructions)	43.00	30	10, 950	0.00		14. 00
15. 00	CAH visits		30	10, 930	0.00	0	15. 00
16. 00	SUBPROVI DER - I PF					U	16. 00
17. 00	SUBPROVI DER - I RF	41. 00	0	0		0	
18. 00	SUBPROVI DER	41.00	0			U	18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	116. 00	0	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27.00	Total (sum of lines 14-26)		30				27. 00
28.00	Observation Bed Days					0	28. 00
29.00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)		0	0			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01

33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3045

Peri od: Worksheet S-3 From 07/01/2020 Part I To 06/30/2021 Date/Time Prepared:

11/23/2021 10:41 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 7.00 6.00 8.00 9.00 10.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 4, 967 7, 137 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 973 399 2 00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 0 4.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 0 0 6.00 7.00 Total Adults and Peds. (exclude observation 4,967 7, 137 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 0 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 4,967 7, 137 0.00 110.50 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 0 0.00 17.00 0 0.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 0.00 24.00 0 0 0 0.00 24.00 24. 10 HOSPICE (non-distinct part) 0 24.10 CMHC - CMHC 25.00 25.00 26, 00 RURAL HEALTH CLINIC 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0 26.25 C 0.00 26.25 27.00 Total (sum of lines 14-26) 0.00 110.50 27.00 28.00 Observation Bed Days 0 28.00 29.00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 0 32.00 32.00 Total ancillary labor & delivery room 0 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00

33.01 LTCH site neutral days and discharges

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 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provider CCN: 15-3045

Peri od: Worksheet S-3 From 07/01/2020 Part I To 06/30/2021 Date/Time Prepared:

							11/23/2021 10	41 am
		Full Time Equivalents			Di sch	arges		
	Component	Nonpai d	Title V		Title XVIII	Title XIX	Total All	
		Workers					Pati ents	
		11.00	12. 00		13.00	14.00	15. 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)			0	437	1	625	1. 00
2.00	HMO and other (see instructions)				80	34		2. 00
3.00	HMO IPF Subprovider					0		3. 00
4.00	HMO IRF Subprovider					0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF							5. 00
6.00	Hospital Adults & Peds. Swing Bed NF							6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)							7. 00
8.00	INTENSIVE CARE UNIT							8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13. 00
14.00	Total (see instructions)	0.00		0	437	1	625	14. 00
15.00	CAH visits			1				15. 00
16.00	SUBPROVI DER - I PF							16. 00
17.00	SUBPROVI DER - I RF	0.00		0	0	o	0	17. 00
18.00	SUBPROVI DER			1				18. 00
19.00	SKILLED NURSING FACILITY			1				19. 00
20.00	NURSING FACILITY			1				20. 00
21.00	OTHER LONG TERM CARE			1				21. 00
22.00	HOME HEALTH AGENCY			1				22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)			1				23. 00
24.00	HOSPI CE	0.00						24. 00
24. 10	HOSPICE (non-distinct part)							24. 10
25.00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00						26. 25
27.00	Total (sum of lines 14-26)	0.00						27. 00
28.00	Observation Bed Days							28. 00
29.00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30. 00
31.00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			- 1				32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days				0	ļ		33. 00
33. 01	LTCH site neutral days and discharges				0			33. 01
		•			· ·	·		

	•	UNITY STRUKE AND				u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Period: From 07/01/2020 To 06/30/2021	Worksheet A Date/Time Pre 11/23/2021 10	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		2, 538, 374				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		1, 305, 013	1, 305, 01	1, 099		2. 00
3.00	00300 OTHER CAP REL COSTS	104 714	020 012	1 042 52	0 0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	104, 714	938, 812 21, 638			1, 043, 131	4. 00 5. 01
5. 01 5. 02	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING	62, 983 260, 215	30, 925			84, 621 291, 140	
5. 02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	200, 215	30, 7 23	271, 14	0 0	291, 140	5. 02
5. 04	00590 OTHER ADMINISTRATIVE & GENERAL	977, 539	1, 562, 173	2, 539, 71	2 -29, 488	_	5. 04
7. 00	00700 OPERATION OF PLANT	159, 671	733, 619			893, 017	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	73, 665			73, 665	
9.00	00900 HOUSEKEEPI NG	181, 734	219, 838			401, 350	1
10.00	01000 DI ETARY	303, 487	194, 760	498, 24	7 -125, 337	372, 910	10.00
11.00	01100 CAFETERI A	o	0		0 124, 921	124, 921	11. 00
13.00	01300 NURSING ADMINISTRATION	2, 320	1, 251	3, 57	1 0	3, 571	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0		0	0	
15. 00	01500 PHARMACY	0	0		0	0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0)	0 0	0	17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	2, 613, 971	1, 209, 708	3, 823, 67	9 -156	3, 823, 523	30.00
31. 00	03100 INTENSIVE CARE UNIT	2,013,971	1, 209, 706 N	3, 023, 07	0 -130	3, 623, 523	
41. 00	04100 SUBPROVI DER - I RF	0	0			0	
43. 00	04300 NURSERY	l ol	0		o o	ő	
	ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		•			
50.00	05000 OPERATING ROOM	0	0)	0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0	
53. 00	05300 ANESTHESI OLOGY	0	0)	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	271, 794	111, 924	383, 71	8 0	383, 718	
55. 00	05500 RADI OLOGY-THERAPEUTI C	70.450	101 054	101 41	0	101 412	55.00
56. 00 57. 00	05600 RADI OI SOTOPE 05700 CT SCAN	79, 458 150, 906	101, 954 138, 929			181, 412 289, 835	
58. 00	05800 MRI	91, 546	164, 249	1		255, 795	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	200, 77	o o	0	1
60.00	06000 LABORATORY	273, 745	385, 923	659, 66	8 -3, 525	656, 143	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	0		0 0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 3, 525	3, 525	
65. 00	06500 RESPI RATORY THERAPY	193, 295	33, 083			226, 378	
66. 00	06600 PHYSI CAL THERAPY	483, 669	783, 562				1
67.00	06700 OCCUPATI ONAL THERAPY	100, 952	664, 551			765, 359	1
68. 00	06800 SPEECH PATHOLOGY	49, 297	162, 733			211, 942	1
69. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	98, 506 5, 994	23, 658			122, 164	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 994	8, 366 56, 386			'	71.00
72.00			30, 300 0	30, 30	0 0	0 30, 300	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	159, 362	287, 654	447, 01	6 0	447, 016	
	07400 RENAL DIALYSIS	0	91, 716				74. 00
75.00	07500 ASC (NON-DISTINCT PART)	O	0		0 0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	57, 965	22, 297	80, 26	2 -493	79, 769	
	09100 EMERGENCY	0	0		0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
113 00	11300 INTEREST EXPENSE		0)	0 0	0	113. 00
	11600 HOSPI CE	0	0		0 0		116. 00
118.00	1 1	6, 683, 123	11, 866, 761	18, 549, 88	4 -4, 186		
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
	19100 RESEARCH	0	0)	0		191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		192.00
	19300 NONPALD WORKERS 07950 OTHER NONRELMBURSABLE DEPARTMENTS		0				193. 00 194. 00
	07951 ADVERTI SI NG	0	35, 635	35, 63	5 4, 186		194. 00
200.00		6, 683, 123	11, 902, 396				
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			,,	·		,

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-3045

Peri od: From 07/01/2020 To 06/30/2021 Worksheet A

Date/Time Prepared:

11/23/2021 10:41 am Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6.00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 9,415 2, 574, 717 1.00 00200 CAP REL COSTS-MVBLE EQUIP 1, 381, 178 2.00 2.00 75.066 3.00 00300 OTHER CAP REL COSTS 3.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 166, 078 4 00 122 947 4 00 5.01 00560 PURCHASING RECEIVING AND STORES 84, 621 5.01 0 00570 ADMITTING 5.02 291, 140 5.02 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 212, 289 212, 289 5.03 00590 OTHER ADMINISTRATIVE & GENERAL 5.04 904, 446 3, 414, 670 5 04 7.00 00700 OPERATION OF PLANT 893, 017 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 0 73,665 8.00 00900 HOUSEKEEPING 9 00 0 401, 350 9 00 10.00 01000 DI ETARY -35 372, 875 10.00 11.00 01100 CAFETERI A -72, 537 52, 384 11.00 01300 NURSING ADMINISTRATION 13.00 3, 571 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 0 Ω 14.00 15.00 01500 PHARMACY C 15.00 01600 MEDICAL RECORDS & LIBRARY 591, 389 16 00 591, 389 16.00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 30.00 0 3,823,523 0 31.00 03100 INTENSIVE CARE UNIT 31.00 04100 SUBPROVI DER - I RF 41.00 41.00 0 0 43.00 04300 NURSERY 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 05100 RECOVERY ROOM 51.00 0 Λ 51.00 53.00 05300 ANESTHESI OLOGY Ω 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 -6, 010 377, 708 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 05600 RADI OI SOTOPE 181, 412 56.00 0 56.00 57.00 05700 CT SCAN -475 289, 360 57.00 05800 MRI 58.00 -360 255, 435 58.00 59 00 05900 CARDIAC CATHETERIZATION 59 00 06000 LABORATORY 60.00 -3,858 652, 285 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 62.00 0 C 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 3.525 63.00 06500 RESPIRATORY THERAPY 0 226, 378 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0 1, 266, 693 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 0 0 765, 359 67.00 68 00 06800 SPEECH PATHOLOGY 211, 942 68 00 06900 ELECTROCARDI OLOGY 69.00 122, 164 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 14, 360 -3 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 56, 383 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 72 00 Ω 73.00 07300 DRUGS CHARGED TO PATIENTS 447, 016 73.00 74.00 07400 RENAL DIALYSIS 0 91, 716 74.00 07500 ASC (NON-DISTINCT PART) 75.00 75.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 79, 769 90.00 09100 EMERGENCY 0 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 0 116.00 11600 HOSPI CE 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 832, 274 20, 377, 972 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 0 191. 00 19100 RESEARCH 0 0 191.00 192.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 193. 00 19300 NONPALD WORKERS 0 0 193. 00 194. 00 07950 OTHER NONREIMBURSABLE DEPARTMENTS 0 0 194. 00 194. 01 07951 ADVERTI SI NG 39.821 194. 01 0 TOTAL (SUM OF LINES 118 through 199) 200.00 1, 832, 274 20, 417, 793 200.00

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RECLAS:	SIFICATIONS			Provi der C	CN: 15-3045	Peri od:	Worksheet A-	6
						From 07/01/2020		
						To 06/30/2021	Date/Time Pr	epared:
							11/23/2021 1	0:41 am
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	A - RECLASS BUILDING INSURANCE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	26, 928				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	<u>1, 0</u> 99				2. 00
	TOTALS		0	28, 027				
	B - CAFETERIA RECLASS							
1.00	CAFETERI A	11. 00	76, 091	48, 830				1. 00
	TOTALS		76, 091	48, 830				
	C - ADVERTISING NONREIMBURSAE	BLE						1
1.00	ADVERTI SI NG	194. 01	0	4, 186				1. 00
2.00		0.00	o	0				2. 00
3.00		0.00	o	0				3. 00
4.00		0.00	ol	0				4.00
5. 00		0.00	o	0				5. 00
6.00		0.00	0	0				6. 00
7. 00		0.00	o	0				7. 00
8.00		0.00	ō	0				8. 00
9. 00		0.00	ō	0				9. 00
10. 00		0.00	0	0				10. 00
10.00	TOTALS — — — —	— — 	— — — 	4 , 186				10.00
	D - RECLASS BLOOD COSTS		<u> </u>	4, 100				
1.00	BLOOD STORING, PROCESSING, &	63.00	0	3, 525				1.00
1.00	TRANS.	03.00	٩	3, 323				1.00
	TOTALS	+		3, 525				1
E00 00	Grand Total: Increases		76, 091	84, 568				500. 00
500.00	prianti rotar. Thereases		76, 091	84, 508				500.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-3045

						11/2	3/2021 10: 41 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - RECLASS BUILDING INSURANCE						
1.00	OTHER ADMINISTRATIVE &	5. 04	0	28, 027	12		1.00
	GENERAL						
2.00		0.00	•		12		2. 00
	TOTALS		0	28, 027			
	B - CAFETERIA RECLASS					_	
1.00	DI ETARY	1000	7 <u>6, 0</u> 91	4 <u>8, 8</u> 30			1. 00
	TOTALS		76, 091	48, 830			
	C - ADVERTISING NONREIMBURSAE		_1		_		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	395			1. 00
2.00	OTHER ADMINISTRATIVE &	5. 04	0	1, 461	0		2. 00
	GENERAL	7 00		070			
3.00	OPERATION OF PLANT	7. 00	0	273			3. 00
4.00	HOUSEKEEPI NG	9. 00	0	222			4. 00
5.00	DI ETARY	10. 00	0	416			5. 00
6.00	ADULTS & PEDIATRICS	30. 00	0	156	0		6. 00
7.00	PHYSI CAL THERAPY	66.00	0	538	0		7. 00
8.00	OCCUPATI ONAL THERAPY	67.00	0	144	. 0		8. 00
9.00	SPEECH PATHOLOGY	68. 00	0	88	0		9. 00
10.00	CLINIC	90.00	0	493	0		10.00
	TOTALS		0	4, 186			
	D - RECLASS BLOOD COSTS						
1.00	LABORATORY	60.00	0	3, 525	0		1. 00
	TOTALS		0	3, 525			
500.00	Grand Total: Decreases		76, 091	84, 568			500.00

Movable Equipment

Reconciling Items

HIT designated Assets

10.00 Total (line 8 minus line 9)

Subtotal (sum of lines 1-7)

6.00

7.00

8.00

9.00

6.00

7.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-3045 Peri od: Worksheet A-7 From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/23/2021 10:41 am Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1, 812, 872 0 1.00 0 2.00 Land Improvements 0 2.00 0 3. 00 3.00 Buildings and Fixtures 49, 209, 895 15, 398 15, 398 0 Building Improvements 0 4.00 0 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 8, 610, 761 50, 646 50, 646 0 6.00 0 7.00 HIT designated Assets 7.00 0 0 8.00 Subtotal (sum of lines 1-7) 59, 633, 528 66, 044 66, 044 0 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) <u>66, 0</u>44 66, 044 10.00 10.00 59, 633, 528 0 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 1, 812, 872 0 1.00 2.00 Land Improvements 0 2.00 3.00 Buildings and Fixtures 49, 225, 293 0 3.00 0 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 0 5.00

8, 661, 407

59, 699, 572

59, 699, 572

0

0

Health Financial Systems	COMMUNITY STROKE AND REHABILITATION	In Lie	u of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-3045	Peri od: From 07/01/2020	Worksheet A-7 Part II

				0 06/30/2021	Date/Time Pre 11/23/2021 10	
		SU	IMMARY OF CAPIT	AL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9. 00	10.00	11. 00	12. 00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 ar	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	2, 538, 374	0	0	0	0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	1, 266, 154	38, 859	0	0	0	2. 00
3.00 Total (sum of lines 1-2)	3, 804, 528		0	0	0	3. 00
	SUMMARY O	F CAPITAL				
	0.1.1	T (4) (
Cost Center Description		Total (1) (sum				
	Capi tal -Relate					
	d Costs (see	through 14)				
	instructions) 14.00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1. 00 CAP REL COSTS-BLDG & FLXT	0	2, 538, 374				1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	0	1, 305, 013				2. 00
3.00 Total (sum of lines 1-2)	0	3, 843, 387				3.00
0.00 10tal (3am 01 111103 1 2)	١	3, 343, 307				1 0.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-3045 Period: From 07/01/2020 Part III To 06/30/2021 Date/Time F	
To 06/30/2021 Date/Time F	
11/23/2021	repared: 10:41 am
COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITA	
Cost Center Description Gross Assets Capitalized Gross Assets Ratio (see Insurance	
Leases for Ratio instructions)	
(col. 1 - col.	
1,00 2.00 3.00 4.00 5.00	
1.00 2.00 3.00 4.00 5.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS	
1. 00 CAP REL COSTS-BLDG & FIXT 51, 038, 165 0 51, 038, 165 0. 854917	0 1.00
2. 00 CAP REL COSTS-MVBLE EQUIP 8, 661, 407 0 8, 661, 407 0. 145083	0 2.00
3.00 Total (sum of lines 1-2) 59,699,572 0 59,699,572 1.000000	0 3.00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL	0.00
ALESSATION OF STREET STREET STREET	
Cost Center Description Taxes Other Total (sum of Depreciation Lease	
Capi tal -Rel ate col s. 5	
d Costs through 7)	
6.00 7.00 8.00 9.00 10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS	
1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 2,547,789	0 1.00
2.00 CAP REL COSTS-MVBLE EQUIP 0 0 1,341,220 38,8	
3.00 Total (sum of lines 1-2) 0 0 3,889,009 38,8	3.00
SUMMARY OF CAPITAL	
Cost Center Description Interest Insurance (see Taxes (see Other Total (2) (s	ım
instructions) instructions) Capital -Relate of cols. 9	
d Costs (see through 14	
i nstructi ons)	
11.00 12.00 13.00 14.00 15.00 15.00 14.00 15.00 15.00 14.00 15.0	

0 0 0

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT

26, 928 1, 099 28, 027

0 0 0

2, 574, 717 1, 381, 178 3, 955, 895

1.00

2. 00

0 0 0

1.00

2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

| Period: | Worksheet A-8 | From 07/01/2020 | To 06/30/2021 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES COMMUNITY STROKE AND REHABILITATION

Provider CCN: 15-3045

Cost Center Description Basil s/Code (2) Amount Cost Center Line * Wast A-7 Ref.						o 06/30/2021	Date/Time Prep	
Cost Center Description Basis/Code (2) Amount Cost Center Line # Mist. A-7 Ref.							11/23/2021 10.	41 dill
1.00 Investment Income					To/From Which the Amount is	to be Adjusted		
1.00 Investment Income								
1.00 Investment Income								
Investment Income		Cost Center Description						
Investment income - CAP PEL OCAP REL COSTS-MABLE FOULP 2.00 0.200	1. 00	Investment income - CAP REL	1.00					1. 00
COSTS-MRILE EQUITP (chapter 2) 0	2 00			0	CAD DEL COSTS MADLE FOLLID	2.00	0	2 00
Chapter 2)	2.00			U	CAP REL CUSTS-WVBLE EQUIP	2.00		
1 1 1 2 2 2 2 2 2 2	3. 00			0		0.00	0	3. 00
Second S	4.00	Trade, quantity, and time		0		0.00	О	4. 00
0.00 Rehtal of provider space by suppliers (chapter 8)	5. 00			0		0.00	0	5. 00
Suppliers (chapter 8) 7,00 Telephone services (pay stations excluded) (chapter 2) 8,00 10,00 0,	<i>(</i> 00			0		0.00		4 00
Stati ons excluded) (chapter 21)	6.00			U		0.00	o o	6.00
210	7. 00			0		0.00	0	7. 00
Cchapter 21)		21)						
9.00 Parking lot (chapter 21) 0 0.00	8. 00			0		0.00	9	8. 00
adjustment		Parking Lot (chapter 21)	4.0.2	0		0.00		
Chapter 23 Chapter 10 Chapter 11 Chapter 10 Chapter 11 Chapter 10 Chapter 11 Cha	10.00		A-8-2	- 10, 048				10.00
12.00 Related organization	11. 00			0		0.00	0	11. 00
13.00 Laundry and Linen service 0 0.00 0 13.00 14.00 Cafterial-employees and guests 0 0.00 0.00 0 14.00 16.00 Rental of quarters to employee and others 0 0.00 0 15.00 16.00 Sale of medical and surgical supplies to other than patients 0 0.00 0 16.00 17.00 Sale of drugs to other than patients 0 0.00 0 17.00 18.00 Sale of medical records and abstracts 0 0.00 0 18.00 18.00 Sale of medical records and abstracts 0 0.00 0 18.00 19.00 Nursing and allied health education (tuition, fees, books, etc.) 0 0.00 0 19.00 19.00 Verding machines 0 0.00 0 20.00 10.00 Income from imposition of interest, finance or penalty charges (chapter 21) 0 11.00 10.00 Income from imposition of illimitation (chapter 14) 0 0.00 0 22.00 22.00 Verding machines 0 0.00 0 22.00 23.00 Aljustment for respiratory therapy costs in excess of illimitation (chapter 14) 0 0.00 0.00 0.00 24.00 1.00 25.00 0.00 0.00 0.00 0.00 25.00 0.00	12. 00	Related organization	A-8-1	2, 221, 171			О	12. 00
14. 00 Cafeteria employees and guests 0 0. 00 0 14. 00 15. 00 Rental of quarters to employee and others 0 0. 00 0 15. 00 16. 00 Sale of medical and surgical supplies to other than patients 0 0. 00 0 16. 00 17. 00 Sale of medical records and patients 0 0. 00 0 17. 00 18. 00 Sale of medical records and abstracts 0 0. 00 0 18. 00 19. 00 Nursing and allied health education (tuition, fees, books, etc.) 0 0. 00 0 19. 00 19. 00 Vending machines 0 0. 00 0 21. 00 10. 00 Income from imposition of interest, finance or penalty charges (chapter 21) 0 0. 00 0 21. 00 20. 00 Vending machines 0 0. 00 0 0. 00 0 21. 00 10. 00 10. 00 0. 00 0. 00 0 0. 00 0	13. 00			0		0.00	0	13. 00
16.00 Sale of medical and surgical supplies to other than patients 0 0 0 0 0 0 16.00	14.00	Cafeteria-employees and guests		0		0.00		14.00
Supplies to other than patients 17.00 Sale of drugs to other than patients 0 0.00 0 17.00	15.00			0		0.00	U	15.00
Datients Sale of drugs to other than Datients Sale of drugs to other than Datients Dati	16. 00			0		0.00	0	16. 00
Datients Sale of medical records and abstracts Sale of medical records and abstracts 19.00 Nursing and allied health education (tuition, fees, books, etc.) 0 0 0 0 0 0 0 0 0		pati ents						
18.00 Sale of medical records and abstracts 0 0.00 0 18.00 abstracts 19.00 Nursing and allied health education (tuition, fees, books, etc.) 20.00 Vending machines 0 0.00	17. 00			0		0.00	0	17. 00
19.00 Nursing and allied health education (tuition, fees, books, etc.) 20.00 Vending machines 0 0 0 0 0 0 0 0 0	18. 00	Sale of medical records and		0		0.00	0	18. 00
Dooks, etc.) Dooks, etc.) Double Dooks, etc.) Dooks, etc.) Double Dooks, etc.) Double Dooks, etc.) Dooks,	19. 00	1		0		0.00	0	19. 00
20.00 Vending machines 0 1 1 1 1 1 1 1 1 1								
interest, finance or penal ty charges (chapter 21) 22. 00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments 23. 00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24. 00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist 29. 00 Physicians' assistant 0 OCCUPATIONAL THERAPY 0 0. 00 0 0 22. 00 0 22. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Vending machines		0				
Charges (Chapter 21) Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments O O O O O O O O O	21. 00			0		0.00	0	21. 00
overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14) Adjustment for physical A-8-3 OPHYSICAL THERAPY A-8-3 OPHYSIC	22.00	charges (chapter 21)		0		0.00		22.00
23. 00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24. 00 Adjustment for physical A-8-3 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist 29. 00 Physicians' assistant 20 RESPIRATORY THERAPY 20 CRESPIRATORY THERAPY 30 CRESPIRATORY THERAPY 30 CRESPIRATORY THERAPY 30 CAP REL COSTS CENTER 30 CAP REL COSTS CENTER Deleted *** 31 COSTS SUBJECT CO	22.00			Ü		0.00	U	22.00
therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24.00 therapy costs in excess of limitation (chapter 14) Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP 27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist Non-physicians' assistant 0 *** Cost Center Deleted *** OCAP REL COSTS-MVBLE EQUIP 0 CAP REL COSTS-MVBLE EQUIP 0 *** Cost Center Deleted *** OCAP REL COSTS-MVBLE EQUIP 28.00 Adjustment for occupational A-8-3 OCCUPATIONAL THERAPY 67.00 24.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 OCCUPATIONAL THERAPY 67.00	23 00		Δ_8_3	0	RESDIRATORY THERADY	65.00		23 00
24. 00 Adj ustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist 29. 00 Physicians' assistant 30. 00 Adj ustment for occupational 24. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 20.	23.00	therapy costs in excess of	A 0 3	0	REST HATORT THERAIT	03.00		23.00
therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	24. 00		A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
25. 00 Utilization review -								
Chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 O 26.00	25. 00	Utilization review -		0	*** Cost Center Deleted ***	114.00		25. 00
26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 2.00 0 27. 00 28. 00 Non-physician Anesthetist 0 0*** Cost Center Deleted *** 19. 00 28. 00 29. 00 Physicians' assistant 0 0 0 0 0 30. 00 Adjustment for occupational A-8-3 0 0CCUPATIONAL THERAPY 67. 00 30. 00								
27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 2. 00 0 27. 00 28. 00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19. 00 28. 00 29. 00 Physicians' assistant 0 0 0 0 0 0 30. 00 Adjustment for occupational A-8-3 0 0 0 0 0 30. 00	26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	О	26. 00
28. 00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19. 00 28. 00 29. 00 Physicians' assistant 0 0 0 0 0 29. 00 30. 00 Adjustment for occupational A-8-3 0 0 0 67. 00 30. 00	27. 00			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
29.00 Physicians' assistant 0 0.00 0 29.00 30.00 Adjustment for occupational A-8-3 0 OCCUPATIONAL THERAPY 67.00 30.00	28 00			0	*** Cost Cantar Dalated ***	19.00		28 00
	29. 00	Physicians' assistant		0		0.00	О	29. 00
therapy costs in excess of	30. 00		A-8-3	0	OCCUPATIONAL THERAPY	67.00		30. 00
limitation (chapter 14)	20.00	limitation (chapter 14)		_	ADULTO A DEDLATELOS	20.22		20.00
30.99 Hospice (non-distinct) (see instructions) OADULTS & PEDIATRICS 30.00 30.99	JU. 99			0	JADULIS & PEDIATRICS	30.00		JU. 99
31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00	31. 00		A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
limitation (chapter 14)	0.5	limitation (chapter 14)						
32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest	32. 00	1		0		0.00	0	32. 00
33. 00 PART B CONTRACTED SERVICES A -1,500 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 00	33. 00		A	-1, 500	RADI OLOGY-DI AGNOSTI C	54. 00	o	33. 00

ADJUSTMENTS TO EXPENSES Provi der CCN: 15-3045 Peri od: Worksheet A-8 From 07/01/2020 06/30/2021 Date/Time Prepared: 11/23/2021 10:41 am Expense Classification on Worksheet A 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. 01 PART B CONTRACTED SERVICES -475 CT SCAN 57.00 33. 01 Α PART B CONTRACTED SERVICES -360 MRI 33.02 Α 58.00 33.02 33.03 PATIENT TELEPHONES Α -6, 866 OTHER ADMINISTRATIVE & 5.04 33.03 GENERAL 33.04 TV DEPRECIATION -4, 480 CAP REL COSTS-MVBLE EQUIP 2.00 33.04 Α -21, 602 EMPLOYEE BENEFITS DEPARTMENT COVID VACCINE CLINIC 0 33.05 4.00 33.05 В 33.06 COVID VACCINE CLINIC В -270, 956 OTHER ADMINISTRATIVE & 5.04 33.06 GENERAL COVID VACCINE CLINIC -3 MEDICAL SUPPLIES CHARGED TO 33.07 33.07 В 71.00 PATI ENT OTHER REVENUE -15 EMPLOYEE BENEFITS DEPARTMENT 33 08 В 4 00 33.08 ol OTHER REVENUE 33.09 В -20 OTHER ADMINISTRATIVE & 5.04 33.09 GENERAL OTHER REVENUE В -35 DI ETARY 33. 10 10.00 OTHER REVENUE -72, 537 CAFETERI A 33. 11 В 11.00 0 33. 11 TOTAL (sum of lines 1 thru 49) 50.00 1, 832, 274 50.00

(Transfer to Worksheet A,

[|] column 6, line 200.) | (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME

Provider CCN: 15-3045

Worksheet A-8-1

From 07/01/2020 OFFICE COSTS 06/30/2021 Date/Time Prepared: 11/23/2021 10:41 am

					11/23/2021 10	7. 4 i aiii		
	Li ne No.	Cost Center	Expense Items	Amount of	Amount			
				Allowable Cost	Included in			
					Wks. A, column			
					5			
	1. 00	2.00	3. 00	4. 00	5. 00			
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED							
	HOME OFFICE COSTS:							
1.00	5. 04	OTHER ADMINISTRATIVE & GENER	CFNI NONCAPITAL COSTS ALLOCA	1, 437, 005	854, 144	1. 00		
2.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE CAPITAL COSTS	9, 415	0	2. 00		
3.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE CAPITAL COSTS	79, 546	0	3. 00		
3. 01	5. 04	OTHER ADMINISTRATIVE & GENER	CFNI SALARY ALLOCATION	701, 052	0	3. 01		
3.02	4. 00	EMPLOYEE BENEFITS DEPARTMENT	CFNI BENEFITS ALLOCATION	144, 564	0	3. 02		
4.00	5. 03	CASHI ERI NG/ACCOUNTS RECEI VAB	PATIENT ACCOUNTING ALLOCATIO	212, 289	0	4. 00		
4.01	16. 00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS ALLOCATION	591, 389	0	4. 01		
4.02	5. 04	OTHER ADMINISTRATIVE & GENER	PHYSICIAN ALLOCATION	0	99, 945	4. 02		
5.00	TOTALS (sum of lines 1-4).			3, 175, 260	954, 089	5. 00		
	Transfer column 6, line 5 to				·			
	Worksheet A-8, column 2,							
	line 12.							

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

				Related Organization(s) and/	or Home Office				
				norated organization(e) and	0 0 00				
	0 1 1 (1)				5				
	Symbol (1)	Name	Percentage of	Name	Percentage of				
			Ownership		Ownarahi n				
			Owner Sni p		Ownershi p				
	1. 00	2.00	3.00	4. 00	5. 00				
1.00 2.00 3.00 4.00 5.00									
	R INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:						
	B. THIERRELATIONSHIT TO RELAT	LD ORGANIZATION(3) AND OR THE	WL OITTOL.			d .			

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

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

6.00	В	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 organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Health Financial S	stems	CON	MUNITY STROKE	AND REHABILITA	ATI ON		In Lie	u of Form CMS	-2552-1
STATEMENT OF COSTS	OF SERVICES FROM	RELATED ORGANI	ZATIONS AND HO	ME Provi der	CCN: 15-3045	Peri o		Worksheet A-	8-1
OFFICE COSTS							07/01/2020		
						lo	06/30/2021	Date/Time Pr	epared:
								11/23/2021 1	<u>0:41 am</u>
Net	Wkst. A-7 Ref.								
Adjustment	s								
(col. 4 mir	us								
col. 5)*									
6. 00	7. 00								
A. COSTS IN	CURRED AND ADJUST	MENTS REQUIRED	AS A RESULT OF	TRANSACTI ONS	WITH RELATED	ORGANI Z	ZATIONS OR (CLAI MED	

1.00

2.00

3.00

3. 01

3.02

4 00

4.01

4.02

5.00 | 2,221,171 | 5.00

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

nas not	been posted to worksheet A,	cordinate and of 2, the amount arrowable should be marcated in cordinate of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

	HEALTHCARE	6.00
7.00		7.00
8.00		8.00
8. 00 9. 00		9.00
10.00		10.00
100.00		100.00

- $(1) \ \ \text{Use the following symbols to indicate interrelationship to related organizations:}$
- 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.

HOME OFFICE COSTS:

582, 861

9, 415

79, 546

701, 052

144, 564

212, 289

591, 389

-99, 945

9

0

0

0

1.00

2.00

3.00

3.01

3.02

4 00

4.01

4.02

						0 06/30/2021	11/23/2021 10	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	71 11 (4.11)
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	5. 04	AGGREGATE-OTHER	15, 000	0	15, 000	211, 500	131	1. 00
2. 00	F4 00	ADMINISTRATIVE & GEN	10 000	0	10,000	271 000	40	2. 00
2.00	54.00	AGGREGATE-RADI OLOGY-DI AGNOST I C	10, 000	0	10, 000	271, 900	42	2.00
3. 00	60.00	AGGREGATE - LABORATORY	10, 240	0	10, 240	260, 300	51	3. 00
4. 00	0. 00	, to on E of the E de la tront	0	Ö	0	0	0	
5. 00	0. 00		0	0	0	0	0	5. 00
6. 00	0. 00		0	0	0	0	0	6. 00
7. 00	0. 00		0	0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	0	0.00
9. 00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	
200.00	MI+ A I : //	C+ C+ /Dh	35, 240		35, 240		224	200. 00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	Unadjusted RCE	Cost of		Physician Cost of Malpractice	
		ruenti i i ei	LIIIII	Li mi t	Continuing	Share of col.	Insurance	
				2111111	Educati on	12	Trisur unce	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14.00	
1. 00	5. 04	AGGREGATE-OTHER	13, 320	666	0	0	0	1. 00
		ADMINISTRATIVE & GEN						
2.00	54. 00	AGGREGATE-RADI OLOGY-DI AGNOST	5, 490	275	0	0	0	2. 00
3. 00	40.00	AGGREGATE-LABORATORY	4 202	319	0	0	0	3. 00
3. 00 4. 00	0.00	AGGREGATE - LABURATURY	6, 382	319	0	0	0	
5. 00	0.00		0	0	0	0	0	5. 00
6. 00	0.00		0	0	0	0	ĺ	
7. 00	0. 00		Ö	l o	0	0	Ö	
8. 00	0. 00		0	0	0	0	0	
9. 00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	
200.00			25, 192	1, 260		0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col. 14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		AGGREGATE-OTHER	0			1, 680		1. 00
		ADMINISTRATIVE & GEN			,	,		
2.00	54. 00	AGGREGATE-RADI OLOGY-DI AGNOST	0	5, 490	4, 510	4, 510		2. 00
		I C						
3. 00		AGGREGATE-LABORATORY	0	-,	· ·	3, 858		3. 00
4.00	0.00		0	0	_	0		4. 00
5.00	0. 00 0. 00		0	0	0	0		5. 00
6. 00 7. 00	0.00					0		6. 00 7. 00
8. 00	0.00		0			0		8.00
9. 00	0.00		١	1 0		0		9. 00
10. 00	0. 00		Ö	0	ő	o O		10.00
200.00			o	25, 192	10, 048	10, 048		200. 00

Period: Worksheet B
From 07/01/2020 Part I
To 04/20/2021 Part VI me Propagate Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-3045

				To	o 06/30/2021	Date/Time Pre	
			CAPI TAL REI	LATED COSTS		11/23/2021 10	: 41 am
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7) 0	1. 00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	2, 574, 717 1, 381, 178	2, 574, 717	1, 381, 178			1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 166, 078	4, 059		1, 171, 567		4. 00
5. 01	00560 PURCHASING RECEIVING AND STORES	84, 621	40, 767		11, 217	137, 647	5. 01
5.02	00570 ADMITTING	291, 140	22, 737		46, 342	374, 428	5. 02
5. 03 5. 04	OO580 CASHI ERI NG/ACCOUNTS RECEI VABLE OO590 OTHER ADMI NI STRATI VE & GENERAL	212, 289 3, 414, 670	0 48, 163	0 220, 608	0 174, 093	212, 289 3, 857, 534	5. 03 5. 04
7. 00	00700 OPERATION OF PLANT	893, 017	346, 357	14, 819	28, 436	1, 282, 629	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	73, 665	0	0	0	73, 665	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	401, 350 372, 875	48, 387 82, 306	4, 870 114, 650	32, 366 40, 498	486, 973 610, 329	9. 00 10. 00
11. 00	01100 CAFETERI A	52, 384	44, 129		13, 551	110, 064	11.00
13. 00	01300 NURSING ADMINISTRATION	3, 571	3, 935		413	7, 919	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00 16. 00	O1500 PHARMACY O1600 MEDI CAL RECORDS & LI BRARY	591, 389	2, 540	0	0	0 593, 929	15. 00 16. 00
17. 00	01700 SOCI AL SERVI CE	0	2,310	Ö	Ö	0,0,727	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	0.000.500	077 500	000 07/	445 500	F 000 000	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	3, 823, 523	877, 599 0	233, 276 0	465, 530 0	5, 399, 928 0	30. 00 31. 00
41. 00	04100 SUBPROVI DER – I RF	0	0	_	o	0	41. 00
43.00	04300 NURSERY	0	0	0	0	0	43. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS	0	0	0	ol	0	E0 00
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	0	0	0	0	0	50. 00 51. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0	ō	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	377, 708	104, 071	193, 850	48, 405	724, 034	54. 00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0 181, 412	0 7, 869	0 53, 173	0 14, 151	0 256, 605	55. 00 56. 00
57. 00	05700 CT SCAN	289, 360	17, 258		26, 875	444, 753	57. 00
58.00	05800 MRI	255, 435	42, 709		16, 304	516, 809	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	(52, 205	0	20.004	40.752	705 ((5	59.00
60. 00 62. 00	O6000 LABORATORY O6200 WHOLE BLOOD & PACKED RED BLOOD CELL	652, 285 0	55, 734 0	38, 894 0	48, 752 0	795, 665 0	60. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	3, 525	0	Ö	Ö	3, 525	63. 00
65. 00	06500 RESPI RATORY THERAPY	226, 378	0	1, 563	34, 424	262, 365	1
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	1, 266, 693 765, 359	125, 239 4, 707	101, 149 3, 327	86, 138 17, 979	1, 579, 219 791, 372	1
68. 00	06800 SPEECH PATHOLOGY	211, 942	3, 387	1, 465	8, 779	225, 573	68. 00
69. 00	06900 ELECTROCARDI OLOGY	122, 164	10, 459		17, 543	178, 539	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	14, 360	0	10, 614	1, 067	26, 041	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	56, 383	0	0	ol Ol	56, 383 0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	447, 016	2, 939	30, 056	28, 381	508, 392	73. 00
	07400 RENAL DIALYSIS	91, 716	14, 046		0	105, 951	1
75. 00	O7500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	75. 00
90. 00	09000 CLINIC	79, 769	0	0	10, 323	90, 092	90.00
	09100 EMERGENCY	0	0	0	o	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	0	0	o	0	116. 00
118. 00		20, 377, 972	1, 909, 397	1, 381, 178	1, 171, 567	19, 712, 652	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	ol	0	190. 00
	19100 RESEARCH	0	0	_	o		191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	665, 320	0	О	665, 320	192. 00
	19300 NONPALD WORKERS	0	0	0	0		193.00
	07950 OTHER NONREIMBURSABLE DEPARTMENTS 07951 ADVERTISING	39, 821) 0 0		0		194. 00 194. 01
200.00	1 1	37,321]	Ĭ		200. 00
201.00	1 1 0	00 117 7	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	20, 417, 793	2, 574, 717	1, 381, 178	1, 171, 567	20, 417, 793	J202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3045

				10	06/30/2021	11/23/2021 10	
	Cost Center Description	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	Subtotal	OTHER	TI dili
		RECEIVING AND		OUNTS		ADMI NI STRATI VE	
		STORES		RECEI VABLE		& GENERAL	
		5. 01	5. 02	5. 03	5A. 03	5. 04	
	GENERAL SERVICE COST CENTERS					1	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	127 (47					4.00
5. 01 5. 02	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING	137, 647	27/ 0/0				5. 01 5. 02
5. 02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	2, 541 1, 441	376, 969	213, 730			5. 02
5. 04	00590 OTHER ADMINISTRATIVE & GENERAL	26, 181	0	213, 730	3, 883, 715	3, 883, 715	5. 04
7. 00	00700 OPERATION OF PLANT	8, 705	0		1, 291, 334		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	500	0		74, 165		8. 00
9. 00	00900 HOUSEKEEPING	3, 305	Ö		490, 278		9. 00
10. 00	01000 DI ETARY	4, 142	0	o	614, 471		10. 00
11. 00	01100 CAFETERI A	747	O	0	110, 811		11. 00
13.00	01300 NURSING ADMINISTRATION	54	0	0	7, 973	1, 873	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00	01500 PHARMACY	0	0	0	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	4, 031	0	0	597, 960	140, 456	16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	36, 654	66, 245	37, 561	5, 540, 388		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	43. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS	0					FO 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM		0		0	0	50. 00 51. 00
53.00	05300 ANESTHESI OLOGY		0		0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 914	34, 788	19, 723	783, 459		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	4, 714	34, 700	17, 725	703, 437	104, 020	55. 00
56. 00	05600 RADI OI SOTOPE	1, 742	20, 729	11, 753	290, 829		56. 00
57. 00	05700 CT SCAN	3, 019	26, 450		489, 218		57. 00
58. 00	05800 MRI	3, 508	41, 301		585, 034		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	5, 400	47, 827	27, 116	876, 008	205, 767	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	24	428	243	4, 220	991	63.00
65.00	06500 RESPI RATORY THERAPY	1, 781	6, 050	3, 430	273, 626	64, 273	65.00
66.00	06600 PHYSI CAL THERAPY	10, 718	40, 170	22, 775	1, 652, 882	388, 249	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	5, 371	25, 802	14, 629	837, 174		67.00
68. 00	06800 SPEECH PATHOLOGY	1, 531	6, 548		237, 364		68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 212	26, 119		220, 679		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	177	6, 229		35, 978		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	383	2, 879		61, 278	l .	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	00.054	0	547.040	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 450	22, 954	1	547, 810		73. 00
	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	719	2, 315 0		110, 297		74. 00 75. 00
75.00	OUTPATIENT SERVICE COST CENTERS	U		ıj U		0	75.00
90. 00	09000 CLINIC	611	135	77	90, 915	21, 355	90. 00
	09100 EMERGENCY		133		70, 719	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		· ·		0		92. 00
	SPECIAL PURPOSE COST CENTERS	<u> </u>			-	1	
113.00	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	0	0	0	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	132, 861	376, 969	213, 730	19, 707, 866	3, 716, 959	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191.00	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	4, 516	0		669, 836		
	19300 NONPAI D WORKERS	0	0		0		193. 00
	07950 OTHER NONREIMBURSABLE DEPARTMENTS	0	0		0		194. 00
	07951 ADVERTI SI NG	270	0	ا	40, 091	9, 417	194. 01
200.00			_	,	0	_	200. 00
201.00		127 447	274 040	212 720	20 417 702		201. 00
202.00	TOTAL (Suil TITIES TO LITUUGH 201)	137, 647	376, 969	213, 730	20, 417, 793	J 3, 003, / 15	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3045

Period: Worksheet B From 07/01/2020 Part I To 06/30/2021 Date/Time Prepared:

11/23/2021 10:41 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A **PLANT** LINEN SERVICE 9.00 10.00 11.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00560 PURCHASING RECEIVING AND STORES 5 01 5 01 5.02 00570 ADMITTING 5.02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 5.03 00590 OTHER ADMINISTRATIVE & GENERAL 5.04 5.04 00700 OPERATION OF PLANT 7.00 1, 594, 658 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 91, 586 8.00 9.00 00900 HOUSEKEEPI NG 36, 524 641, 964 9 00 10.00 01000 DI FTARY 25, 596 846, 527 62, 126 10 00 C 11.00 01100 CAFETERI A 33, 309 13, 724 183, 873 11.00 13.00 01300 NURSING ADMINISTRATION 2,970 1, 224 0 92 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 C C 0 0 01500 PHARMACY 15.00 0 C 0 0 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1,917 790 0 0 16.00 01700 SOCIAL SERVICE 17.00 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 103, 745 30.00 03000 ADULTS & PEDIATRICS 662, 429 91, 586 272, 927 846, 527 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 0 04100 SUBPROVI DER - I RF 41.00 0 C 0 0 0 41.00 04300 NURSERY 43.00 0 0 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 С 0 0 50.00 0 51.00 05100 RECOVERY ROOM 0 51.00 0 0 0 05300 ANESTHESI OLOGY 53.00 0 \cap 0 Λ 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 78, 555 0 32, 365 0 10, 788 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 0 0 0 55.00 05600 RADI OI SOTOPE 5.940 0 56.00 2.447 3.154 56.00 05700 CT SCAN 57.00 13,027 C 5, 367 5, 989 57.00 58.00 05800 MRI 32, 238 13, 282 3,633 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 59.00 C 0 60 00 06000 LABORATORY 42 069 17, 333 10 865 60 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0 0 0 0 62.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 0 0 63.00 0 63.00 0 65.00 06500 RESPIRATORY THERAPY 0 7.672 65.00 0 06600 PHYSI CAL THERAPY 66.00 94,533 0 38, 948 19, 197 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 3,553 0 1, 464 4,007 67.00 06800 SPEECH PATHOLOGY 68.00 2,556 1,053 0 1, 957 68.00 3, 910 69 00 06900 ELECTROCARDI OLOGY 7 895 Ω 3, 253 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 C C 238 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 2, 218 914 6, 325 Ω 73 00 73 00 74.00 07400 RENAL DIALYSIS 10,602 0 4, 368 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 90 00 0 0 0 2.301 91.00 09100 EMERGENCY 0 C 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113 00 116. 00 11600 HOSPI CE 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 092, 461 91, 586 435, 055 846, 527 183, 873 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 O 0 190 00 191. 00 19100 RESEARCH 0 0 0 191.00 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 502, 197 0 206, 909 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193, 00 194.00 07950 OTHER NONREIMBURSABLE DEPARTMENTS 0 C 0 0 0 194. 00 194. 01 07951 ADVERTI SI NG 0 0 0 0 194. 01 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 TOTAL (sum lines 118 through 201) 1, 594, 658 183, 873 202. 00 202.00 91,586 641, 964 846, 527

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3045

				Т	06/30/2021	Date/Time Pre 11/23/2021 10	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	11 4111
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
		10.00	SUPPLY	45.00	LI BRARY	47.00	
	GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	17. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00560 PURCHASING RECEIVING AND STORES						5. 01
5.02	00570 ADMI TTI NG						5. 02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL						5. 04
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	14, 132					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0				14. 00
15. 00	01500 PHARMACY	o	0	О			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	O	0	0	741, 123		16. 00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	13, 145	0		130, 256	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 ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	43. 00
50. 00	05000 OPERATING ROOM	O	0	0	0	0	50.00
51. 00	05100 RECOVERY ROOM		0		0	Ö	51.00
53. 00	05300 ANESTHESI OLOGY	o	0	Ö	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	68, 391	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0	0	40, 753	0	56. 00
57. 00	05700 CT SCAN	0	0	0	51, 999	0	57. 00
58. 00	05800 MRI	0	0	0	81, 195	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	04.025	0	59.00
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0 0	0	0	94, 025	0	60. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		841	0	63.00
65. 00	06500 RESPI RATORY THERAPY	733	0	0	11, 893	Ö	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	Ö	78, 973	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	50, 726	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0	12, 873	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	51, 350	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	29	0	0	12, 245	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5, 661	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	45, 126	0	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	0	0		4, 550		74.00
	07500 ASC (NON-DISTINCT PART)	0	0	l o	0		1
	OUTPATIENT SERVICE COST CENTERS	,	_				
90.00	09000 CLI NI C	225	0	0	266	0	
91. 00		0	0	0	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 INTEREST EXPENSE 11600 HOSPICE		0	_	0	_	113. 00 116. 00
118. 00		14, 132	0		741, 123		118.00
110.00	NONREI MBURSABLE COST CENTERS	14, 132	U		741, 123	0	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19100 RESEARCH	o	0	Ö	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	07950 OTHER NONREIMBURSABLE DEPARTMENTS	0	0	0	0		194. 00
	07951 ADVERTI SI NG	0	0	0	0	0	194. 01
200.00			0	_	_	_	200.00
201. 00 202. 00		14, 132	0	0	0 741, 123		201. 00 202. 00
∠∪∠. Ul		14, 132	U	٠ ٠	/41, 123	ı	₁ 202. UU

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3045

			To	o 06/30/2021 Date/Time 11/23/2021	
Cost Center Description	Subtotal	Intern &	Total	,	
		Residents Cost			
		& Post Stepdown			
		Adjustments			
	24. 00	25.00	26. 00		
GENERAL SERVICE COST CENTERS	I				1 00
1. 00 00100 CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP					1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.01 00560 PURCHASING RECEIVING AND STORES					5. 01
5. 02 00570 ADMI TTI NG					5. 02
5. 03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 04 00590 OTHER ADMINI STRATI VE & GENERAL					5. 03 5. 04
7. 00 00700 OPERATION OF PLANT					7. 00
8.00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY		,			10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMINI STRATI ON					11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00 01500 PHARMACY					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS					17. 00
30. 00 03000 ADULTS & PEDIATRICS	8, 962, 389	lo le	8, 962, 389		30.00
31. 00 03100 I NTENSI VE CARE UNI T	C, 102, 00	1	0		31.00
41. 00 04100 SUBPROVI DER - I RF	C		0		41. 00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	C) 0	0		43. 00
50. 00 OFERATING ROOM		ol l	0		50.00
51. 00 05100 RECOVERY ROOM	C		Ö		51.00
53. 00 05300 ANESTHESI OLOGY	С		0		53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	1, 157, 586	1	1, 157, 586		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	411, 436	′I "I	411, 436		55. 00 56. 00
57. 00 05700 CT SCAN	680, 513	1	680, 513		57.00
58. 00 05800 MRI	852, 802	0	852, 802		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0		59. 00
60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 246, 067		1, 246, 067		60. 00 62. 00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	6, 052		6, 052		63. 00
65. 00 06500 RESPIRATORY THERAPY	358, 197	1	358, 197		65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 272, 782	1	2, 272, 782		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 093, 569	1	1, 093, 569		67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	311, 558 338, 923		311, 558 338, 923		68. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	56, 941	1	56, 941		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	81, 333		81, 333		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	이	0		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	731, 069		731, 069		73. 00
74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART)	155, 725 (1	155, 725 0		74. 00 75. 00
OUTPATIENT SERVICE COST CENTERS		,,	<u> </u>		70.00
90. 00 09000 CLI NI C	115, 062	0	115, 062		90. 00
91. 00 09100 EMERGENCY	C		0		91. 00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS		l ol			92. 00
113. 00 11300 INTEREST EXPENSE					113. 00
116. 00 11600 HOSPI CE	(0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	18, 832, 004	I 0	18, 832, 004		118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		ol lo	0		190. 00
191. 00 19100 RESEARCH	Ċ		Ö		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 536, 281	0	1, 536, 281		192. 00
193. 00 19300 NONPALD WORKERS			0		193. 00
194. 00 07950 OTHER NONREIMBURSABLE DEPARTMENTS 194. 01 07951 ADVERTISING	49, 508		49, 508		194. 00 194. 01
200.00 Cross Foot Adjustments	47, 500	ól ől	47, 500		200. 00
201.00 Negative Cost Centers	0	o	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	20, 417, 793	s o	20, 417, 793		202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-3045

					To	06/30/2021	Date/Time Prep 11/23/2021 10	
				CAPI TAL REI	LATED COSTS		11/23/2021 10	41 alli
		Coat Contar Decement on	Dimontly	DIDC 0 FLVT	MVDLE FOULD	Cubtatal	EMDL OVEE	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs 0	1.00	2.00	2A	4. 00	
	GENER	AL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
1.00	00100	CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP		4 050	1 420	F 400	F 400	2.00
4. 00 5. 01		EMPLOYEE BENEFITS DEPARTMENT PURCHASING RECEIVING AND STORES	0	4, 059 40, 767		5, 489 41, 809	5, 489 53	4. 00 5. 01
5. 02		ADMITTING	0	22, 737		36, 946	217	5. 02
5.03	1	CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	_	0	0	5. 03
5.04	1	OTHER ADMINISTRATIVE & GENERAL	0	48, 163		268, 771	815	5. 04
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	0	346, 357 0		361, 176	133	7. 00 8. 00
9. 00		HOUSEKEEPING	0	48, 387		53, 257	152	9. 00
10.00	1	DI ETARY	0	82, 306		196, 956	190	10.00
11. 00	1	CAFETERI A	0	44, 129		44, 129	63	11.00
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	0	3, 935 0		3, 935 0	2	13. 00 14. 00
15. 00		PHARMACY	0	Ö	_	o	0	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0	2, 540	0	2, 540	0	16. 00
17. 00		SOCIAL SERVICE	0	0	0	0	0	17. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	0	877, 599	233, 276	1, 110, 875	2, 184	30. 00
31. 00		INTENSIVE CARE UNIT	Ō	0		0	0	31. 00
41. 00		SUBPROVI DER - I RF	0	0		o	0	41. 00
43. 00		NURSERY LARY SERVICE COST CENTERS	0	0	0	0	0	43. 00
50. 00		OPERATING ROOM	0	0	0	ol	0	50. 00
51. 00		RECOVERY ROOM	0	Ö		Ō	0	51. 00
53. 00		ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 55. 00		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	0	104, 071	193, 850	297, 921	227 0	54. 00 55. 00
56. 00		RADI OLOGI - THERAPEUTI C	0	7, 869	53, 173	61, 042	66	56. 00
57. 00		CT SCAN	0	17, 258		128, 518	126	
58. 00	05800		0	42, 709		245, 070	76	58. 00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	0	0		04 429	0	59. 00 60. 00
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	0	55, 734 0	_	94, 628 0	228 0	62. 00
63. 00		BLOOD STORING, PROCESSING, & TRANS.	0	Ö	Ö	Ö	0	63. 00
65. 00		RESPI RATORY THERAPY	0	0	1, 563	1, 563	161	65. 00
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	125, 239		226, 388	403	66. 00 67. 00
68. 00		SPEECH PATHOLOGY	0	4, 707 3, 387		8, 034 4, 852	84 41	68. 00
69. 00		ELECTROCARDI OLOGY	Ō	10, 459		38, 832	82	69. 00
70. 00		ELECTROENCEPHALOGRAPHY	0	0		10, 614	5	70. 00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73.00		DRUGS CHARGED TO PATTENTS	0	2, 939	30, 056	32, 995	133	
74. 00		RENAL DIALYSIS	0	14, 046		14, 235	0	
75. 00		ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
90. 00		TIENT SERVICE COST CENTERS CLINIC	0	0	O	0	48	90. 00
91. 00	1	EMERGENCY	0	1		o	0	
	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
110.00		AL PURPOSE COST CENTERS			ı			110 00
		I NTEREST EXPENSE HOSPI CE	0	0	0	0		113. 00 116. 00
118.00	1	SUBTOTALS (SUM OF LINES 1 through 117)	0		1, 381, 178	3, 290, 575		118. 00
		IMBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
		RESEARCH PHYSI CI ANS' PRI VATE OFFI CES	0	0 665, 320	_	665, 320		191. 00 192. 00
		NONPALD WORKERS	0	0 0 0		003, 320		193. 00
194.00	07950	OTHER NONREIMBURSABLE DEPARTMENTS	0	0	0	O	0	194. 00
		ADVERTISING	0	0	0	0		194. 01
200. 00 201. 00	1	Cross Foot Adjustments Negative Cost Centers		0		0		200. 00 201. 00
202. 00	1	TOTAL (sum lines 118 through 201)	О	2, 574, 717	1, 381, 178	3, 955, 895		202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3045

				1	0 06/30/2021	11/23/2021 10	pared: :41 am
	Cost Center Description	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	OTHER	OPERATION OF	
		RECEIVING AND		OUNTS	ADMI NI STRATI VE	PLANT	
		STORES	F 02	RECEI VABLE	& GENERAL	7.00	
	GENERAL SERVICE COST CENTERS	5. 01	5. 02	5. 03	5. 04	7. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00560 PURCHASING RECEIVING AND STORES	41, 862					5. 01
5. 02	00570 ADMI TTI NG	773	37, 936				5. 02
5. 03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	438	0	438			5. 03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL	7, 962	0	0	277, 548		5. 04
7.00	00700 OPERATION OF PLANT	2, 647	0	0	21, 676	385, 632	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	152	0	0	1, 245	0	8. 00
9. 00	00900 HOUSEKEEPI NG	1, 005	0	0	8, 230	8, 832	9. 00
10. 00	01000 DI ETARY	1, 260	0	0	10, 315	15, 024	10. 00
11. 00	01100 CAFETERI A	227	0	0	1, 860	8, 055	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	16	0	0	134	718	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00	01500 PHARMACY	0	0	0	10.027	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 226	0	0	10, 037	464	16.00
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	U	0	U U	0	17. 00
30. 00		11, 149	6, 667	59	93, 008	160, 195	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	0,007	0		100, 143	31. 00
41. 00	04100 SUBPROVI DER – I RF		0	0	_	0	41. 00
43. 00	04300 NURSERY		0	٥		0	43. 00
101.00	ANCILLARY SERVICE COST CENTERS	<u> </u>			٥,		101 00
50.00	05000 OPERATING ROOM	0	0	0	ol	0	50. 00
51.00	05100 RECOVERY ROOM	o	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	1, 494	3, 501	42	13, 151	18, 997	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00	05600 RADI OI SOTOPE	530	2, 086	25	4, 882	1, 436	56.00
57.00	05700 CT SCAN	918	2, 662	32	8, 212	3, 150	57.00
58. 00	05800 MRI	1, 067	4, 156	50	9, 820	7, 796	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0		0	59. 00
60.00	06000 LABORATORY	1, 642	4, 813	1		10, 173	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		0	62. 00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	7	43	•	71	0	63.00
65. 00	06500 RESPI RATORY THERAPY	542	609	•	4, 593	0	65.00
66.00	06600 PHYSI CAL THERAPY	3, 260	4, 042	•	, , , ,	22, 861	66.00
67. 00	06700 OCCUPATIONAL THERAPY	1, 633	2, 596			859	67. 00 68. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	466 369	659 2, 628	•		618 1, 909	69. 00
70. 00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	54	2, 626 627			1, 909	70.00
71. 00	1 1	116	290		1, 029	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	270		1, 027	0	72.00
73. 00	1 1	1, 049	2, 310	28	9, 196	536	73. 00
74. 00	· · ·	219	233			2, 564	74. 00
	07500 ASC (NON-DISTINCT PART)	0	0			0	75. 00
	OUTPATIENT SERVICE COST CENTERS	· I			·		
90.00		186	14	0	1, 526	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						
	D 11300 I NTEREST EXPENSE						113. 00
	D 11600 HOSPI CE	0	0	0			116. 00
118. 00		40, 407	37, 936	438	265, 631	264, 187	118. 00
	NONREI MBURSABLE COST CENTERS			1	1		
190.00	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190. 00
	19100 RESEARCH	0	0	0			191. 00
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 373	0	0	11, 244	121, 445	
	19300 NONPALD WORKERS	0	0		0		193. 00
	07950 OTHER NONREIMBURSABLE DEPARTMENTS	0	0		472		194. 00
194. 0 200. 00		82	0		673	0	194. 01 200. 00
200.00			^	_		Λ	200.00
201.00		41, 862	37, 936	438	277, 548		202 00
232.00	1.5.7.2 (Sam 177.55 176 till Sagir 201)	11,002	37, 730	1 +50	2,7,040	300, 002	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3045

Peri od: Worksheet B From 07/01/2020 Part II To 06/30/2021 Date/Time Prepared:

11/23/2021 10:41 am Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG ADMI NI STRATI ON LINEN SERVICE 9.00 10.00 11.00 13.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00560 PURCHASING RECEIVING AND STORES 5 01 5 01 5.02 00570 ADMITTING 5.02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 5.03 00590 OTHER ADMINISTRATIVE & GENERAL 5.04 5.04 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 1, 397 8.00 9.00 00900 HOUSEKEEPI NG 0 71, 476 9 00 01000 DI ETARY 10.00 226, 595 0 2.850 10 00 11.00 01100 CAFETERI A 0 1,528 55, 862 11.00 13.00 01300 NURSING ADMINISTRATION 0 136 0 28 4,969 13.00 01400 CENTRAL SERVICES & SUPPLY 0 14.00 0 14.00 0 C 0 01500 PHARMACY 0 15.00 C 0 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 88 0 0 0 16.00 01700 SOCIAL SERVICE 17.00 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 1.397 30, 387 226, 595 31, 519 4.622 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 0 04100 SUBPROVI DER - I RF 41.00 0 C 0 0 0 41.00 04300 NURSERY 43.00 0 0 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 С 0 0 50.00 0 51.00 05100 RECOVERY ROOM 0 0 51.00 0 05300 ANESTHESI OLOGY 0 53.00 0 Λ 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 3,604 0 3, 277 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 000000000000000000 0 55.00 56.00 05600 RADI OI SOTOPE 272 0 958 0 56.00 05700 CT SCAN 0 57.00 598 1,820 0 57.00 0 1, 104 58.00 05800 MRI 1, 479 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 0 59.00 60 00 06000 LABORATORY 1.930 0 3 301 0 60 00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0 62.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 0 63.00 63.00 C 0 65.00 06500 RESPIRATORY THERAPY 0 2.331 258 65.00 0 06600 PHYSI CAL THERAPY 66.00 4, 337 5,832 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 163 0 1, 217 0 67.00 06800 SPEECH PATHOLOGY 68.00 117 594 0 68.00 69 00 06900 ELECTROCARDI OLOGY 0 1, 188 69 00 0 362 07000 ELECTROENCEPHALOGRAPHY 0 70.00 C 72 10 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS C 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 1, 922 73 00 102 73 00 0 74.00 07400 RENAL DIALYSIS 0 486 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 OUTPATIENT SERVICE COST CENTERS 79 90 00 90 00 09000 CLI NI C 0 Ω 0 699 91.00 09100 EMERGENCY 0 C 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113 00 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM_OF_LINES_1 through 117) 118.00 1, 397 48, 439 226, 595 55, 862 4, 969 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 O 0 190 00 191. 00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 23, 037 0 193. 00 19300 NONPALD WORKERS 0 0 0 0 193, 00 194.00 07950 OTHER NONREIMBURSABLE DEPARTMENTS 0 0 0 0 194.00 C 194. 01 07951 ADVERTI SI NG 0 0 0 0 194. 01 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 0 201.00 TOTAL (sum lines 118 through 201) 4, 969 202. 00 202.00 1, 397 71, 476 226, 595 55, 862

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY STROKE AND REHABILITATION Provider CCN: 15-3045

				-	To 06/30/2021	Date/Time Pro 11/23/2021 10	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		7.41 (111)
		SERVICES &		RECORDS &			
		SUPPLY 14. 00	15. 00	16. 00	17. 00	24.00	
GE	ENERAL SERVICE COST CENTERS						
	0100 CAP REL COSTS-BLDG & FIXT						1.00
	0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
	D560 PURCHASING RECEIVING AND STORES						5. 01
1	D570 ADMITTING						5. 02
	0580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03
	D590 OTHER ADMINISTRATIVE & GENERAL D700 OPERATION OF PLANT						5. 04 7. 00
	D800 LAUNDRY & LINEN SERVICE						8. 00
	0900 HOUSEKEEPI NG						9. 00
	1000 DI ETARY						10.00
	1100 CAFETERIA 1300 NURSING ADMINISTRATION						11. 00 13. 00
1	1400 CENTRAL SERVICES & SUPPLY	o					14. 00
	1500 PHARMACY	o	C	1			15. 00
	1600 MEDI CAL RECORDS & LI BRARY	0	C				16.00
	1700 SOCIAL SERVICE NPATIENT ROUTINE SERVICE COST CENTERS	U	C	<u>'</u>	0		17. 00
	BOOO ADULTS & PEDIATRICS	0	C	2, 54	2 0	1, 681, 199	30.00
	3100 INTENSIVE CARE UNIT	o	C	1	0 0		
	4100 SUBPROVI DER - I RF 4300 NURSERY	0	C		0 0	l	1
	NCILLARY SERVICE COST CENTERS	U U		'	<u>J</u>		43. 00
	5000 OPERATING ROOM	0	C		0 (0	0	50. 00
	5100 RECOVERY ROOM	0	C	1	0		
	5300 ANESTHESI OLOGY 5400 RADI OLOGY-DI AGNOSTI C	0	C	1	0	242 527	
	5500 RADI OLOGY-THERAPEUTI C	0	C	1, 32	0 0	343, 537 0	
	5600 RADI OI SOTOPE	o	C	78	-	72, 085	1
	5700 CT SCAN	o	C	1, 00			1
	5800 MRI	0	C	1, 57			1
	5900 CARDI AC CATHETERI ZATI ON 5000 LABORATORY	0	C	1, 81	0 8 0	0 133, 296	
1	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	C		0 0	133, 270	1
	6300 BLOOD STORING, PROCESSING, & TRANS.	О	C	1	6 0	138	63. 00
	S500 RESPI RATORY THERAPY	0	C	23		10, 294	
	5600 PHYSICAL THERAPY 5700 OCCUPATIONAL THERAPY	0	C	1, 52 98			1
	5800 SPEECH PATHOLOGY	0		24		29, 652 11, 588	1
	6900 ELECTROCARDI OLOGY	Ö	C	99			1
	7000 ELECTROENCEPHALOGRAPHY	o	C	23		12, 231	1
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	10		1, 548	1
1	7200 IMPL. DEV. CHARGED TO PATIENTS 7300 DRUGS CHARGED TO PATIENTS	0	C	87	0 3	0 49, 144	
	7400 RENAL DIALYSIS	o	C	8		1	
_	7500 ASC (NON-DISTINCT PART)	0	C		0 0	0	75. 00
	JTPATIENT SERVICE COST CENTERS 2000 CLINIC	O		N .		2 557	1 00 00
	9100 EMERGENCY	0	C		5 0		1
	9200 OBSERVATION BEDS (NON-DISTINCT PART	J	_				92. 00
	PECIAL PURPOSE COST CENTERS						
	1300 I NTEREST EXPENSE 1600 HOSPI CE	0	C		0 0		113. 00 116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	o o	C			1	1
	ONREI MBURSABLE COST CENTERS	<u> </u>		, 11,00	<u> </u>	0, 102, 721	1110.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	1	0 0		190. 00
	9100 RESEARCH	0	C	1	0		191. 00
	9200 PHYSICIANS' PRIVATE OFFICES 9300 NONPAID WORKERS	0	C		0	822, 419	192.00
	7950 OTHER NONREIMBURSABLE DEPARTMENTS	o	C		0 0	l e	194. 00
194. 01 07	7951 ADVERTI SI NG	o	C		0	755	194. 01
200.00	Cross Foot Adjustments		-				200.00
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118 through 201)	0	C	14, 35	0 5 0	l e	201.00
202.00	1.5.71E (5411 111105 110 till bugit 201)	٩		1 17, 55	0	1 5, 755, 575	1-02.00

Provider CCN: 15-3045

Peri od:

Part II

From 07/01/2020 Date/Time Prepared: 06/30/2021 11/23/2021 10:41 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00560 PURCHASING RECEIVING AND STORES 5.01 5.01 00570 ADMITTING 5.02 5.02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 5.03 5.04 00590 OTHER ADMINISTRATIVE & GENERAL 5.04 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 1, 681, 199 30.00 03100 INTENSIVE CARE UNIT 0 31.00 Ω 31.00 41.00 04100 SUBPROVI DER - I RF 0 0 41.00 04300 NURSERY 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50 00 Ω 51.00 05100 RECOVERY ROOM 0 0 51.00 05300 ANESTHESI OLOGY 0 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 00000000000000000000 54.00 343, 537 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 56.00 05600 RADI OI SOTOPE 72,085 56.00 05700 CT SCAN 57.00 147, 042 57.00 58.00 05800 MRI 272, 188 58.00 05900 CARDI AC CATHETERI ZATI ON 59 00 r 59 00 06000 LABORATORY 133, 296 60.00 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 C 62.00 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 63.00 138 06500 RESPIRATORY THERAPY 65.00 10, 294 65.00 66,00 06600 PHYSI CAL THERAPY 296, 444 66, 00 67.00 06700 OCCUPATIONAL THERAPY 29, 652 67.00 68.00 06800 SPEECH PATHOLOGY 11, 588 68.00 69.00 06900 ELECTROCARDI OLOGY 50, 099 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 12, 231 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 1, 548 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 r 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 49, 144 73.00 74.00 07400 RENAL DIALYSIS 19, 679 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 75.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 2, 557 90.00 0 09100 EMERGENCY 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 116 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 3, 132, 721 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 0 191. 00 19100 RESEARCH 0000000 191 00 Ω 192.00 19200 PHYSICIANS' PRIVATE OFFICES 822, 419 192.00 193. 00 19300 NONPALD WORKERS 193.00 C 194. 00 07950 OTHER NONREIMBURSABLE DEPARTMENTS Λ 194.00 194. 01 07951 ADVERTI SI NG 194 01 755 200.00 Cross Foot Adjustments 200.00 C 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 3, 955, 895 202.00

Heal th Financial Systems

COMMUNITY STROKE AND REHABILITATION

In Lieu of Form CMS-2552-10

Provider CCN: 15-3045

Period:
From 07/01/2020
To 06/30/2021

COST Center Description

CAPITAL RELATED COSTS

BLDG & FIXT (SQUARE FEET)

BLDG & FIXT (DOLLAR VALUE)

BENEFITS
DEPARTMENT (GROSS SALARIES)

Reconciliation PURCHASING RECEIVING AND STORES (ACCUM. COST)

		CAPITAL REI	LATED COSTS			11/23/2021 10	: 41 alli
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation		
		(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS		RECEIVING AND	
				DEPARTMENT (GROSS		STORES (ACCUM. COST)	
				SALARI ES)		(1000)	
		1.00	2.00	4.00	5A. 01	5. 01	
4 00	GENERAL SERVICE COST CENTERS	100 000	ı			Г	1 00
1. 00 2. 00	OO100 CAP REL COSTS-BLDG & FIXT OO200 CAP REL COSTS-MVBLE EQUIP	103, 388	6, 441, 080				1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	163					4.00
5. 01	00560 PURCHASING RECEIVING AND STORES	1, 637		62, 983		20, 280, 146	
5. 02	00570 ADMI TTI NG	913				374, 428	
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	0	0	212, 289	5. 03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL	1, 934	1, 028, 799	977, 539	0	3, 857, 534	5. 04
7. 00	00700 OPERATION OF PLANT	13, 908	69, 106	159, 671	0	1, 282, 629	1
8.00	00800 LAUNDRY & LINEN SERVICE	1 043	0	101 704	0	73, 665	1
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 943 3, 305		181, 734 227, 396		486, 973 610, 329	1
11. 00	01100 CAFETERI A	1, 772		76, 091	0	110, 064	1
13. 00	01300 NURSING ADMINISTRATION	158		2, 320	0	7, 919	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	1
15. 00	01500 PHARMACY	0	0	0	0	0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	102		0	0	593, 929	1
17. 00	01700 SOCIAL SERVICE NPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	17. 00
30. 00	03000 ADULTS & PEDIATRICS	35, 240	1, 087, 881	2, 613, 971	0	5, 399, 928	30.00
31. 00	03100 NTENSI VE CARE UNI T	0			0		1
41.00	04100 SUBPROVI DER - I RF	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 53. 00	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	0	0	0	0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 179	904, 013	271, 794	0	724, 034	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	7,177		2/1, //4	0	0	1
56. 00	05600 RADI OI SOTOPE	316	247, 970	79, 458	0	256, 605	1
57. 00	05700 CT SCAN	693	518, 859	150, 906	0	444, 753	57. 00
58. 00	05800 MRI	1, 715	943, 701	91, 546	0	516, 809	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	101 270	0 272 745	0	705 //5	
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2, 238		273, 745	0	795, 665 0	1
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0	3, 525	1
65.00	06500 RESPI RATORY THERAPY	0	7, 287	193, 295	0	262, 365	1
66.00	06600 PHYSI CAL THERAPY	5, 029	471, 704	483, 669	0	1, 579, 219	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	189				791, 372	1
68. 00	06800 SPEECH PATHOLOGY	136				225, 573	1
69. 00	06900 ELECTROCARDI OLOGY	420				178, 539	
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	49, 500	5, 994	0	26, 041 56, 383	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS		0		0		72.00
	07300 DRUGS CHARGED TO PATIENTS	118	140, 167	159, 362	0	508, 392	
74.00	07400 RENAL DIALYSIS	564	881	0	0	105, 951	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
00 00	OUTPATIENT SERVICE COST CENTERS			F7.04F		00.000	00 00
	09000 CLI NI C 09100 EMERGENCY	0		57, 965	0	90, 092	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART			Ĭ			92. 00
	SPECIAL PURPOSE COST CENTERS	•		I	<u> </u>	'	
	11300 I NTEREST EXPENSE						113. 00
	11600 H0SPI CE	0	0	0	0		116. 00
118. 00		76, 672	6, 441, 080	6, 578, 409	-137, 647	19, 575, 005	1118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1	0	0	0	<u> </u>	190. 00
	19100 RESEARCH		Ö		0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	26, 716	O	0	0	665, 320	
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	07950 OTHER NONREIMBURSABLE DEPARTMENTS	0	0	0	0		194. 00
	07951 ADVERTI SI NG	0	0	0	0	39, 821	194. 01
200.00		1					200.00
201. 00 202. 00		2, 574, 717	1, 381, 178	1, 171, 567		137, 647	201.00
202.00	Part I)	2,3/4,/1/	1, 301, 170	1, 171, 507		137,047	202.00
203.00		24. 903441	0. 214433	0. 178093		0. 006787	203. 00
204.00				5, 489		41, 862	204. 00
	Part II)	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>

Heal th Finar	ncial Systems COMM	MUNITY STROKE A	ND REHABILITATI	ON	In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provi der CO		Period: From 07/01/2020	Worksheet B-1	
					To 06/30/2021	Date/Time Pre 11/23/2021 10	
		CAPITAL REI	_ATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	PURCHASING RECEIVING AND STORES (ACCUM. COST)	
		1.00	2. 00	4. 00	5A. 01	5. 01	
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00083	4	0. 002064	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

Health Financial Systems COMMUNITY STROKE AND REHABILITATION In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3045 Peri od: Worksheet B-1 From 07/01/2020 06/30/2021 Date/Time Prepared: 11/23/2021 10:41 am Cost Center Description ADMI TTI NG CASHIERING/ACC Reconciliation OTHER OPERATION OF ADMI NI STRATI VE (GROSS CHAR OUNTS PLANT GES) RECEI VABLE & GENERAL (SQUARE FEET) (GROSS CHAR (ACCUM. COST) GES) 5.02 5.03 5A. 04 5.04 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00560 PURCHASING RECEIVING AND STORES 5.01 5.01 00570 ADMITTING 5.02 57, 564, 291 5.02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 57, 564, 291 5.03 5.04 00590 OTHER ADMINISTRATIVE & GENERAL 0 -3, 883, 715 16, 534, 078 5.04 7.00 00700 OPERATION OF PLANT 0 1, 291, 334 84, 833 7.00 C 0 00800 LAUNDRY & LINEN SERVICE 0 8 00 74 165 8 00 0 9.00 00900 HOUSEKEEPI NG 0 490, 278 1, 943 9.00 10.00 01000 DI ETARY 0 614, 471 3, 305 10.00 11.00 01100 CAFETERI A 0 0 0 110, 811 1,772 11.00 01300 NURSING ADMINISTRATION 0 7, 973 13 00 158 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY C 0 0 14.00 01500 PHARMACY 0 15.00 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16 00 597, 960 102 16 00 17.00 01700 SOCIAL SERVICE 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 10, 118, 178 10, 118, 178 0 5, 540, 388 35, 240 30.00 03100 INTENSIVE CARE UNIT 0 31.00 0 31.00 41.00 04100 SUBPROVI DER - I RF 0 0 0 0 0 41.00 04300 NURSERY 0 0 0 43.00 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 50 00 0 0 0 51.00 05100 RECOVERY ROOM 0 0 0 0 51.00 05300 ANESTHESI OLOGY 0 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 5, 311, 903 5, 311, 903 0 783, 459 4, 179 54.00 0 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55 00 56.00 05600 RADI OI SOTOPE 3, 165, 272 3, 165, 272 0 290, 829 316 56.00 05700 CT SCAN 4, 038, 769 57.00 4, 038, 769 489, 218 693 57 00 58.00 05800 MRI 6, 306, 423 6, 306, 423 0 585, 034 1, 715 58.00 05900 CARDIAC CATHETERIZATION 0 59 00 Λ 59 00 7, 302, 933 06000 LABORATORY 7, 302, 933 60.00 876, 008 2, 238 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 Ω 62.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 63.00 4.220 65, 330 65, 330 0 63.00 0 65.00 06500 RESPIRATORY THERAPY 923, 744 923, 744 273, 626 0 65.00 5, 029 66,00 06600 PHYSI CAL THERAPY 6, 133, 824 6, 133, 824 0 1,652,882 66.00 06700 OCCUPATI ONAL THERAPY 3, 939, 908 3, 939, 908 837, 174 67.00 189 67.00 06800 SPEECH PATHOLOGY 999.841 999, 841 0 68.00 237, 364 136 68.00 69.00 06900 ELECTROCARDI OLOGY 3, 988, 312 3, 988, 312 220, 679 420 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 951, 095 951, 095 35, 978 70.00 Ω 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 439, 672 0 61, 278 71.00 71.00 439, 672 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 504, 964 3, 504, 964 547, 810 118 73.00 0 07400 RENAL DIALYSIS 353, 433 110, 297 74.00 353, 433 564 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 0 75.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 20, 690 20, 690 0 90. 915 0 90.00 09100 EMERGENCY 91.00 91.00 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 116 00 11600 HOSPI CE 0 116 00 SUBTOTALS (SUM OF LINES 1 through 117) 58, 117 118. 00 118.00 57, 564, 291 57, 564, 291 -3, 883, 715 15, 824, 151 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 0 0 191 00 19100 RESEARCH 0 0 191 00 Ω 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 669, 836 26, 716 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 0 194. 00 07950 OTHER NONREIMBURSABLE DEPARTMENTS 0 0 0 0 194.00 0 194 01 194. 01 07951 ADVERTI SI NG 0 0 40.091 C 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 376, 969 3, 883, 715 1, 594, 658 202. 00 Cost to be allocated (per Wkst. B, 213, 730 Part I) 18. 797614 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.006549 0.003713 0.234892 204.00 Cost to be allocated (per Wkst. B, 37, 936 438 277, 548 385, 632 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000659 0.000008 0.016786 4. 545778 205. 00

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Health Fina	ancial Systems COMM	IUNI TY STROKE A	ND REHABILITATI	ON	In Lie	u of Form CMS-	2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provi der Co		eri od:	Worksheet B-1	
					rom 07/01/2020		
					o 06/30/2021		pared:
						11/23/2021 10	:41 am
	Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC	Reconciliation	other other	OPERATION OF	
		(GROSS CHAR	OUNTS		ADMI NI STRATI VE	PLANT	
		GES)	RECEI VABLE		& GENERAL	(SQUARE FEET)	
			(GROSS CHAR		(ACCUM. COST)		
			GES)				
		5. 02	5. 03	5A. 04	5. 04	7. 00	
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3045 Peri od: Worksheet B-1 From 07/01/2020 06/30/2021 Date/Time Prepared: 11/23/2021 10:41 am Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG LINEN SERVICE (SQUARE FEET) (MEALS SERVED) (GROSS ADMI NI STRATI ON (TOTAL PATI SALARI ES) (NURSING SA ENT DAYS) LARI ES) 9.00 8.00 10.00 11.00 13.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00560 PURCHASING RECEIVING AND STORES 5.01 5. 01 00570 ADMITTING 5.02 5.02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.03 5.03 5.04 00590 OTHER ADMINISTRATIVE & GENERAL 5.04 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 7 137 8 00 9.00 00900 HOUSEKEEPI NG 82, 890 9.00 10.00 01000 DI ETARY 0 3, 305 22, 348 10.00 0 11.00 01100 CAFETERI A 1,772 4, 632, 780 11.00 C 01300 NURSING ADMINISTRATION 94, 653 13.00 13 00 0 2, 320 158 14.00 01400 CENTRAL SERVICES & SUPPLY 0 C 0 0 14.00 01500 PHARMACY 0 15.00 0 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 102 0 0 0 16 00 17.00 01700 SOCIAL SERVICE 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 137 35, 240 22, 348 2, 613, 971 88, 042 30.00 03100 INTENSIVE CARE UNIT 31.00 C 0 31.00 41.00 04100 SUBPROVI DER - I RF 0 0 0 0 0 41.00 04300 NURSERY 0 43.00 43.00 0 0 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50 00 0 0 0 51.00 05100 RECOVERY ROOM 0 0 0 0 51.00 05300 ANESTHESI OLOGY 0 0 53.00 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0000000000 271, 794 54.00 4, 179 0 0 54.00 0 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55 00 56.00 05600 RADI OI SOTOPE 316 0 79, 458 56.00 0 05700 CT SCAN 57.00 693 150, 906 57.00 58.00 05800 MRI 0 91, 546 0 58.00 1, 715 05900 CARDIAC CATHETERIZATION 0 59 00 0 59 00 06000 LABORATORY 60.00 2, 238 273, 745 0 60.00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL C 0 62.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 63.00 C 0 63.00 65.00 06500 RESPIRATORY THERAPY 193, 295 4, 910 65.00 66,00 06600 PHYSI CAL THERAPY 00000000 5,029 483, 669 0 66.00 06700 OCCUPATI ONAL THERAPY 100, 952 67.00 189 0 67.00 06800 SPEECH PATHOLOGY 0 49, 297 68.00 136 Ω 68.00 69.00 06900 ELECTROCARDI OLOGY 420 98, 506 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 5, 994 196 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 C 0 0 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS r 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 118 159, 362 0 73.00 0 0 07400 RENAL DIALYSIS 74.00 74.00 0 564 07500 ASC (NON-DISTINCT PART) 75.00 0 C 0 0 75.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 57, 965 1, 505 90.00 09100 EMERGENCY 0 91.00 91.00 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 116.00 11600 HOSPI CE C 0 116 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 7, 137 56, 174 22, 348 4, 632, 780 94, 653 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 C 0 0 191.00 191 00 19100 RESEARCH 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 26, 716 0 0 192, 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 194. 00 07950 OTHER NONREIMBURSABLE DEPARTMENTS 0 0 0 0 194.00 0 0 194 01 194. 01 07951 ADVERTI SI NG 0 0 C 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 202.00 91.586 183.873 14, 132 202. 00 Cost to be allocated (per Wkst. B, 641, 964 846, 527 Part I) 0. 149303 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 12.832563 7.744770 37.879318 0.039690 204.00 Cost to be allocated (per Wkst. B, 1, 397 71, 476 226, 595 55, 862 4, 969 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0 195741 0.862299 10 139386 0.012058 0. 052497 205. 00

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Heal th Financial	I Systems COMM	UNITY STROKE AM	ND REHABILITATI	ON	In Lieu of Form CMS-2552-10			
COST ALLOCATION	I - STATISTICAL BASIS		Provi der Co		Peri od: From 07/01/2020	Worksheet B-1		
					To 06/30/2021	Date/Time Pre 11/23/2021 10		
Cos	st Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG		
		LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED) (GROSS	ADMI NI STRATI ON		
		(TOTAL PATI			SALARI ES)			
		ENT DAYS)				(NURSING SA		
		·				LARI ES)		
		8. 00	9. 00	10.00	11.00	13.00		
	HE adjustment amount to be allocated er Wkst. B-2)						206. 00	
207. 00 NAH	HE unit cost multiplier (Wkst. D, ets III and IV)						207. 00	

	<i>y</i>	MUNITY STROKE AN				eu of Form CMS-2552-10
COST A	ILLOCATION - STATISTICAL BASIS		Provi der C		Period: From 07/01/2020	Worksheet B-1
					To 06/30/2021	Date/Time Prepared:
	Cost Contar Decemintion	CENTRAL	DUADMACY	MEDICAL	COCLAL CEDVICE	11/23/2021 10:41 am
	Cost Center Description	CENTRAL SERVICES &	PHARMACY (COSTED	MEDICAL RECORDS &	SOCI AL SERVI CE	
		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(COSTED	Í	(GROSS CHAR		
		REQUIS.)		GES)		
	GENERAL SERVICE COST CENTERS	14.00	15. 00	16. 00	17. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT	1		I		1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 01	00560 PURCHASING RECEIVING AND STORES					5. 01
5. 02	00570 ADMITTING					5. 02
5. 03 5. 04	OO580 CASHI ERI NG/ACCOUNTS RECEI VABLE OO590 OTHER ADMI NI STRATI VE & GENERAL					5. 03
7. 00	00700 OPERATION OF PLANT					7.00
8. 00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0				13.00
15. 00	01500 PHARMACY		0			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	o o	0	1	1	16. 00
17. 00	01700 SOCIAL SERVICE	0	O	1	o	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS	0	0	1		
31.00	03100 I NTENSI VE CARE UNI T	0	0		1	
41. 00 43. 00	04100 SUBPROVI DER - RF 04300 NURSERY	0	0	1		
43.00	ANCI LLARY SERVI CE COST CENTERS	ı o		7	0	43.00
50.00	05000 OPERATI NG ROOM	0	C		0	50.00
51.00	05100 RECOVERY ROOM	0	0		o	51.00
53.00	05300 ANESTHESI OLOGY	0	0		0	
54. 00	O5400 RADI OLOGY - DI AGNOSTI C	0	0	5, 311, 903	0	
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0	3, 165, 272	2 0	55.00
57. 00	05700 CT SCAN	0	0	4, 038, 769		
58.00	05800 MRI	0	O	6, 306, 423		
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		o	59.00
60.00	06000 LABORATORY	0	0	7, 302, 933		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(5.22	0	
63. 00 65. 00	06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 06500 RESPI RATORY THERAPY	0	0) 65, 330 923, 744		
66. 00	06600 PHYSI CAL THERAPY	0	0	6, 133, 824		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	O	3, 939, 908		
68. 00	06800 SPEECH PATHOLOGY	0	0	999, 84	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	1		
	07000 ELECTROENCEPHALOGRAPHY	0	0			7 0. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	439, 672		71.00
	07300 DRUGS CHARGED TO PATIENTS	0	Ö	3, 504, 964	1 0	73.00
	07400 RENAL DIALYSIS	0	0	353, 433		
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0	75. 00
	OUTPATIENT SERVICE COST CENTERS	1				00.00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	0	0	20, 690	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		U			92.00
72.00	SPECIAL PURPOSE COST CENTERS					72.00
113.00	11300 NTEREST EXPENSE					113. 00
	11600 HOSPI CE	0	0	•	0	
118.00		0	0	57, 564, 29	1 0	118. 00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			ol o	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			
	19200 PHYSICIANS' PRIVATE OFFICES	o o	Ö		o o	192.00
	19300 NONPALD WORKERS	0	0		o	193. 00
	07950 OTHER NONREIMBURSABLE DEPARTMENTS	0	0		0	194. 00
	07951 ADVERTI SI NG	0	0		0	194. 01
200. 00 201. 00	, ,					200.00
202.00		0	0	741, 123	3	202.00
202.00	Part I)		O	, , , , , , , , , , , , , , , , , , , ,		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0. 012875	0.000000	203. 00
204.00			0	14, 355	5 0	204. 00
205 22	Part II)	0.00000	0.000000	0.0000:	0.00000	005 33
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0.000249	0.000000	205. 00
	1 1117	1 1		1	1	<u> </u>

Health Fina	ancial Systems COMM	MUNITY STROKE A	ND REHABILITATI	ON	In Lie	u of Form CMS-:	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 07/01/2020		
					To 06/30/2021	Date/Time Pre	pared:
						11/23/2021 10	<u>:41 am</u>
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
		SERVICES &	(COSTED	RECORDS &			
		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)		
		(COSTED	,	(GROSS CHAR			
		REQUIS.)		GES)			
		14.00	15. 00	16. 00	17. 00		
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems COMMUNITY STROKE AND REHABILITATION In Lieu of Form CMS-255						2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			CN: 15-3045 F	Peri od:	Worksheet C	
			F	rom 07/01/2020	Part I	
			7	o 06/30/2021	Date/Time Pre	pared:
			20/11/1		11/23/2021 10	<u>:41 am</u>
		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)	0.00	0.00	4.00	F 00	
INDATI FAIT DOUTLAGE CEDALCE COCT CENTEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.0(0.000		0.0(2.20)		0.0(0.000	20.00
30. 00 03000 ADULTS & PEDI ATRI CS	8, 962, 389	l .	8, 962, 389		8, 962, 389	
31. 00 03100 I NTENSI VE CARE UNI T	0)		0	0	31.00
41. 00 04100 SUBPROVI DER - I RF	0)	(0	0	41. 00
43. 00 04300 NURSERY	0		(0	0	43. 00
ANCILLARY SERVICE COST CENTERS	_	1	1		_	
50.00 05000 OPERATING ROOM	0)	(-	0	50.00
51. 00 05100 RECOVERY ROOM	0)	(0	0	51. 00
53. 00 05300 ANESTHESI OLOGY	0)	(0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 157, 586		1, 157, 586	4, 510	1, 162, 096	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0)	(0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	411, 436	1	411, 436		411, 436	
57. 00 05700 CT SCAN	680, 513		680, 513		680, 513	
58. 00 05800 MRI	852, 802		852, 802	2 0	852, 802	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0)	(0	0	59. 00
60. 00 06000 LABORATORY	1, 246, 067	1	1, 246, 067	3, 858	1, 249, 925	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0)		0	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	6, 052		6, 052	0	6, 052	63.00
65. 00 06500 RESPIRATORY THERAPY	358, 197	0	358, 197	0	358, 197	65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 272, 782	. 0	2, 272, 782	0	2, 272, 782	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 093, 569	0	1, 093, 569	0	1, 093, 569	67. 00
68. 00 06800 SPEECH PATHOLOGY	311, 558	0	311, 558	0	311, 558	68. 00
69. 00 06900 ELECTROCARDI OLOGY	338, 923		338, 923	0	338, 923	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	56, 941		56, 941	0	56, 941	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	81, 333		81, 333	0	81, 333	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	731, 069		731, 069	0	731, 069	73. 00
74. 00 07400 RENAL DI ALYSI S	155, 725		155, 725		155, 725	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0)		0	0	75. 00
OUTPATIENT SERVICE COST CENTERS	•					
90. 00 09000 CLI NI C	115, 062		115, 062	0	115, 062	90.00
91. 00 09100 EMERGENCY	0	l e		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		1 (0	92.00
SPECIAL PURPOSE COST CENTERS						1
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0		(ი	116. 00
200.00 Subtotal (see instructions)	18, 832, 004	. 0	18, 832, 004	8, 368		
201.00 Less Observation Beds	0		()		201. 00
202.00 Total (see instructions)	18, 832, 004	. 0	18, 832, 004	8, 368		
		1				•

201. 00

202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3045 Peri od: Worksheet C From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/23/2021 10:41 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 10, 118, 178 10, 118, 178 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 04100 SUBPROVI DER - I RF 0 0 41.00 41.00 43.00 04300 NURSERY 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0.000000 0.000000 50.00 0 51.00 05100 RECOVERY ROOM 0 0 0.000000 0.000000 51.00 05300 ANESTHESI OLOGY 0.000000 53.00 0.000000 53.00 0 0 05400 RADI OLOGY-DI AGNOSTI C 5, 051, 306 5, 311, 903 0.000000 54.00 260, 597 0.217923 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0.000000 55.00 56.00 05600 RADI OI SOTOPE 3, 439 3, 161, 833 3, 165, 272 0.129984 0.000000 56.00 05700 CT SCAN 3, 739, 196 299.573 4, 038, 769 0.168495 0.000000 57.00 57.00 58.00 05800 MRI 88,004 6, 218, 419 6, 306, 423 0. 135228 0.000000 58.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 59.00 60.00 06000 LABORATORY 1, 434, 302 5, 868, 631 7, 302, 933 0. 170626 0.000000 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0.000000 62.00 62.00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 20, 753 44, 577 65, 330 0.092637 0.000000 63.00 06500 RESPIRATORY THERAPY 488, 457 923, 744 0. 387767 0.000000 65.00 435, 287 65.00 06600 PHYSI CAL THERAPY 2, 761, 671 6, 133, 824 0.370533 0.000000 66.00 3, 372, 153 66.00 06700 OCCUPATIONAL THERAPY 67.00 3, 403, 727 536, 181 3, 939, 908 0.277562 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 705, 841 294,000 999, 841 0.311608 0.000000 68.00 06900 ELECTROCARDI OLOGY 69.00 137, 115 3, 851, 197 3, 988, 312 0.084979 0.000000 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 951, 095 951, 095 0.059869 0 000000 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 425, 915 13, 757 439, 672 0.184986 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0.000000 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3,064,668 440, 296 3, 504, 964 0.208581 0.000000 73.00 07400 RENAL DIALYSIS 74.00 353, 433 353, 433 0.440607 0.000000 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0.000000 75.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 20, 690 n 20 690 5 561237 0.000000 90 00 09100 EMERGENCY 91.00 C 0.000000 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0.000000 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) 24, 196, 845 33, 367, 446 57, 564, 291 200.00

24, 196, 845

33, 367, 446

57, 564, 291

201.00

202.00

Less Observation Beds

Total (see instructions)

From 07/01/2020 To 06/30/2021 Date/Time Prepared: 11/23/2021 10:41 am Title XVIII Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 41. 00 | 04100 | SUBPROVI DER - I RF 41.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 000000 50.00 05100 RECOVERY ROOM 0.000000 51.00 51.00 53. 00 | 05300 | ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 218772 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 05600 RADI OI SOTOPE 56.00 0. 129984 56.00 57.00 05700 CT SCAN 0. 168495 57.00 58.00 05800 MRI 0. 135228 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 0.000000 59.00 60.00 06000 LABORATORY 0. 171154 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 62.00 62.00 0. 092637 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 63.00 06500 RESPIRATORY THERAPY 65.00 0.387767 65.00 66.00 06600 PHYSI CAL THERAPY 0. 370533 66.00 06700 OCCUPATIONAL THERAPY 67.00 0. 277562 67.00 06800 SPEECH PATHOLOGY 0. 311608 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0.084979 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.059869 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 184986 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.208581 73.00 07400 RENAL DIALYSIS 0.440607 74.00 74.00 07500 ASC (NON-DISTINCT PART)
OUTPATIENT SERVICE COST CENTERS 75.00 0.000000 75.00 90.00 09000 CLI NI C 5.561237 90.00 09100 EMERGENCY 0.000000 91.00 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 116. 00

200. 00

201.00

202.00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Heal th	Financial Systems COM	MUNITY STROKE AN	ND REHABILITATI	ON	In Lie	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der Co	CN: 15-3045	Peri od:	Worksheet C	
					From 07/01/2020		
					To 06/30/2021	Date/Time Pre	pared:
-			T: +1	e XIX	Hospi tal	11/23/2021 10 PPS	:41 am_
			11 (1	e xi x	Costs	PPS	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	cost center bescription	(from Wkst. B,	Adj.	Total costs	Di sal I owance	Total Costs	
		Part I, col.	Auj .		Di Sai i Owance		
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30.00	03000 ADULTS & PEDIATRICS	8, 962, 389		8, 962, 38	39 0	8, 962, 389	30.00
31. 00	03100 NTENSI VE CARE UNI T	0		0,702,00	0 0	0	1
41. 00	04100 SUBPROVI DER - I RF	0	l .		o o	Ö	
43. 00	04300 NURSERY	0	l .		0 0	Ö	
43.00	ANCI LLARY SERVI CE COST CENTERS				0 0		43.00
50.00	05000 OPERATI NG ROOM	0			0 0	0	50.00
51. 00	05100 RECOVERY ROOM	0			0 0	Ö	
53. 00	05300 ANESTHESI OLOGY	0				0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 157, 586		1, 157, 58	36 4, 510		
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 157, 560		1, 137, 30	0 4,510	1, 102, 090	
56. 00	05600 RADI OI SOTOPE	411, 436		411, 43	0	411, 436	
57. 00	05700 CT SCAN	680, 513		680, 51		680, 513	
58. 00	05800 MRI	852, 802	l e	852, 80		852, 802	
59. 00	05900 CARDI AC CATHETERI ZATI ON	032, 802	l	032, 00	0 0	052, 602	1
60.00	06000 LABORATORY	1, 246, 067		1, 246, 06	9		
		1, 240, 007		1, 246, 00	3, 838		
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING, & TRANS.	(052		, 05	52 0	0	62. 00 63. 00
63.00		6, 052		6, 05		6, 052	
65. 00	06500 RESPIRATORY THERAPY	358, 197	0			358, 197	65. 00
66.00	06600 PHYSI CAL THERAPY	2, 272, 782	0	_, _, _,		2, 272, 782	
67. 00	06700 OCCUPATI ONAL THERAPY	1, 093, 569	0	1, 093, 56		1, 093, 569	
68. 00	06800 SPEECH PATHOLOGY	311, 558	l e	311, 55		311, 558	
69. 00	06900 ELECTROCARDI OLOGY	338, 923		338, 92		338, 923	1
70.00	07000 ELECTROENCEPHALOGRAPHY	56, 941		56, 94		56, 941	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	81, 333		81, 33		81, 333	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	l		0 0		
73. 00	07300 DRUGS CHARGED TO PATIENTS	731, 069		731, 06		731, 069	
74.00	07400 RENAL DIALYSIS	155, 725		155, 72		155, 725	
75. 00	07500 ASC (NON-DISTINCT PART)	0			0 0	0	75. 00
00.00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	115.0(2	Γ	115.0/	2 0	115 0/2	00 00
90. 00 91. 00	09100 EMERGENCY	115, 062	ł	115, 06		115, 062 0	1
		0 0			0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS	1 0			U	U	92.00
112 00	11300 INTEREST EXPENSE			1			113. 00
	11600 HOSPI CE	0			0	_	116. 00
200.00		18, 832, 004	l	18, 832, 00	-		
200.00		10, 032, 004	١	10, 032, 00	0, 308		200.00
201.00		18, 832, 004	0	18, 832, 00	0 8, 368	l	
202.00	Total (See Histiactions)	10, 032, 004	ı	10,032,00	0, 308	10,040,372	1202.00

202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3045 Peri od: Worksheet C From 07/01/2020 Part I Date/Time Prepared: 06/30/2021 11/23/2021 10:41 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 10, 118, 178 10, 118, 178 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 04100 SUBPROVI DER - I RF 0 0 41.00 41.00 43.00 04300 NURSERY 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0.000000 0.000000 50.00 0 51.00 05100 RECOVERY ROOM 0 0 0.000000 0.000000 51.00 05300 ANESTHESI OLOGY 0.000000 53.00 0.000000 53.00 0 0 05400 RADI OLOGY-DI AGNOSTI C 5, 051, 306 5, 311, 903 0.000000 54.00 260, 597 0.217923 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0.000000 55.00 56.00 05600 RADI OI SOTOPE 3, 439 3, 161, 833 3, 165, 272 0.129984 0.000000 56.00 05700 CT SCAN 3, 739, 196 299.573 4, 038, 769 0.168495 0.000000 57.00 57.00 58.00 05800 MRI 88,004 6, 218, 419 6, 306, 423 0. 135228 0.000000 58.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 59.00 60.00 06000 LABORATORY 1, 434, 302 5, 868, 631 7, 302, 933 0. 170626 0.000000 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0.000000 62.00 62.00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 20, 753 44, 577 65, 330 0.092637 0.000000 63.00 06500 RESPIRATORY THERAPY 488, 457 923, 744 0. 387767 0.000000 65.00 435, 287 65.00 06600 PHYSI CAL THERAPY 2, 761, 671 6, 133, 824 0.370533 0.000000 66.00 3, 372, 153 66.00 06700 OCCUPATIONAL THERAPY 67.00 3, 403, 727 536, 181 3, 939, 908 0.277562 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 705, 841 294,000 999, 841 0.311608 0.000000 68.00 06900 ELECTROCARDI OLOGY 69.00 137, 115 3, 851, 197 3, 988, 312 0.084979 0.000000 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 951, 095 951, 095 0.059869 0 000000 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 425, 915 13, 757 439, 672 0.184986 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0.000000 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3,064,668 440, 296 3, 504, 964 0.208581 0.000000 73.00 07400 RENAL DIALYSIS 74.00 353, 433 353, 433 0.440607 0.000000 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0.000000 75.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 20, 690 n 20 690 5 561237 0.000000 90 00 09100 EMERGENCY 91.00 C 0.000000 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0.000000 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) 24, 196, 845 33, 367, 446 57, 564, 291 200.00 201.00 Less Observation Beds 201. 00

24, 196, 845

33, 367, 446

57, 564, 291

Total (see instructions)

202.00

From 07/01/2020 To 06/30/2021 Date/Time Prepared: 11/23/2021 10:41 am Title XIX Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 41. 00 | 04100 | SUBPROVI DER - I RF 41.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 000000 50.00 05100 RECOVERY ROOM 0.000000 51.00 51.00 53. 00 | 05300 | ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 218772 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 05600 RADI OI SOTOPE 56.00 0. 129984 56.00 57.00 05700 CT SCAN 0. 168495 57.00 58.00 05800 MRI 0. 135228 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 0.000000 59.00 60.00 06000 LABORATORY 0. 171154 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 62.00 62.00 0. 092637 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 63.00 06500 RESPIRATORY THERAPY 65.00 0.387767 65.00 66.00 06600 PHYSI CAL THERAPY 0. 370533 66.00 06700 OCCUPATIONAL THERAPY 67.00 0. 277562 67.00 06800 SPEECH PATHOLOGY 0. 311608 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0.084979 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.059869 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 184986 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.208581 73.00 07400 RENAL DIALYSIS 0.440607 74.00 74.00 07500 ASC (NON-DISTINCT PART)
OUTPATIENT SERVICE COST CENTERS 75.00 0.000000 75.00 90.00 09000 CLI NI C 5.561237 90.00 09100 EMERGENCY 0.000000 91.00 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 116. 00 200.00 Subtotal (see instructions) 200. 00 201.00 201.00 Less Observation Beds

202.00

202.00

Total (see instructions)

Heal th Financial Systems COMMUNITY STROKE CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 07/01/2020 | Part II | To 06/30/2021 | Date/Time Prepared: Provider CCN: 15-3045

				11	06/30/2021	11/23/2021 10:	
			Ti tl	e XIX	Hospi tal	PPS	. 11 GIII
	Cost Center Description	Total Cost		Operating Cost		Operating Cost	
	,	(Wkst. B, Part		Net of Capital	Reduction	Reduction	
		1, col. 26)	`II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	C	0	0	0	50. 00
	05100 RECOVERY ROOM	0	C	0	0	0	51.00
	05300 ANESTHESI OLOGY	0	C	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	1, 157, 586	343, 537	814, 049	0	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	0	C	0	0	0	55. 00
	05600 RADI OI SOTOPE	411, 436	72, 085		0	0	56. 00
	05700 CT SCAN	680, 513	147, 042	533, 471	0	0	57. 00
	05800 MRI	852, 802	272, 188	580, 614	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	C	0	0	0	59. 00
60. 00	06000 LABORATORY	1, 246, 067	133, 296	1, 112, 771	0	0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C	0	0	0	62. 00
	06300 BLOOD STORING, PROCESSING, & TRANS.	6, 052	138		0	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	358, 197	10, 294	347, 903	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 272, 782	296, 444	1, 976, 338	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 093, 569	29, 652	1, 063, 917	0	0	67. 00
	06800 SPEECH PATHOLOGY	311, 558	11, 588	299, 970	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	338, 923	50, 099	288, 824	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	56, 941	12, 231	44, 710	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	81, 333	1, 548	79, 785	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	731, 069	49, 144	681, 925	0	0	73. 00
74. 00	07400 RENAL DIALYSIS	155, 725	19, 679	136, 046	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	C	0	0	0	75. 00
	OUTPAȚI ENT SERVI CE COST CENTERS						
	09000 CLI NI C	115, 062	2, 557	112, 505	0	0	90. 00
	09100 EMERGENCY	0	C	0	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C	0	0	0	92. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	C	0	0		116. 00
200.00		9, 869, 615	1, 451, 522	8, 418, 093	0		200. 00
201.00	Less Observation Beds	0	C	0	0		201. 00
202.00	Total (line 200 minus line 201)	9, 869, 615	1, 451, 522	8, 418, 093	0	0	202. 00

Heal th Financial Systems COMMUNITY STROKE
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 07/01/2020 | Part II | Date/Time Prepared: |

Title XIX Hospital PPS
Capital and Operating Cost Part I, column Ratio (Col. 6 Reduction 8)
Capital and Operating Cost Part I, column Ratio (Col. 6 Reduction 8)
Reduction 8)
ANCI LLARY SERVI CE COST CENTERS
ANCI LLARY SERVI CE COST CENTERS
50. 00 05000 OPERATI NG ROOM 0 0.000000 50. 00 51. 00 05100 RECOVERY ROOM 0 0.000000 51. 00 53. 00 05300 ANESTHESI OLOGY 0 0.000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 157, 586 5, 311, 903 0. 217923 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0.000000 55. 00 56. 00 05600 RADI OI SOTOPE 411, 436 3, 165, 272 0.129984 56. 00 57. 00 05700 CT SCAN 680, 513 4, 038, 769 0.168495 57. 00 58. 00 05800 MRI 852, 802 6, 306, 423 0.135228 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0.000000 59. 00 60. 00 06000 LABORATORY 1, 246, 067 7, 302, 933 0.170626 60. 00 62. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 6, 052 65, 330 0.092637 63. 00 65. 00 06600 PHYSI CAL THERAPY 2, 272, 782 6, 133, 824 0
51. 00 05100 RECOVERY ROOM 0 0.0000000 51. 00 53. 00 05300 ANESTHESI OLOGY 0 0.0000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 157, 586 5, 311, 903 0. 217923 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0.000000 55. 00 56. 00 05600 RADI OI SOTOPE 411, 436 3, 165, 272 0.129984 56. 00 58. 00 05800 MRI 852, 802 6, 306, 423 0. 135228 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0.000000 59. 00 60. 00 06000 LABORATORY 1, 246, 067 7, 302, 933 0. 170626 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0.000000 62. 00 63. 00 06300 BLODD STORI NG, PROCESSI NG, & TRANS. 6, 052 65, 330 0.092637 65. 00 65. 00 06600 PHYSI CAL THERAPY 2, 272, 782 <t< td=""></t<>
53. 00 05300 ANESTHESI OLOGY 0 0.0000000 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 157, 586 5, 311, 903 0. 217923 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0.000000 55.00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0.000000 55.00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0.000000 55.00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0.000000 55.00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0.129984 56.00 57. 00 05700 CT SCAN 680, 513 4, 038, 769 0.168495 57.00 58. 00 05800 MRI 852, 802 6, 306, 423 0.135228 58.00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0.000000 59.00 60. 00 06000 LABORATORY 1, 246, 067 7, 302, 933
54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 157, 586 5, 311, 903 0. 217923 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0. 000000 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0. 000000 55. 00 57. 00 05700 CT SCAN 411, 436 3, 165, 272 0. 129984 56. 00 58. 00 05800 MRI 852, 802 6, 306, 423 0. 135228 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0. 000000 59. 00 60. 00 06000 LABORATORY 1, 246, 067 7, 302, 933 0. 170626 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0. 000000 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 6, 052 65, 330 0. 092637 63. 00 65. 00 06600 PHYSI CAL THERAPY 358, 197 923, 744 0. 387767 65. 00 67. 00 06700 0CCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0.0000000 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0.0000000 55. 00 57. 00 05700 CT SCAN 680, 513 4, 038, 769 0. 168495 57. 00 58. 00 05800 MRI 852, 802 6, 306, 423 0. 135228 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0.000000 59. 00 60. 00 06000 LABORATORY 1, 246, 067 7, 302, 933 0. 170626 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0.000000 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 6, 052 65, 330 0.092637 63. 00 65. 00 06600 PHYSI CAL THERAPY 358, 197 923, 744 0. 387767 65. 00 66. 00 06700 OCCUPATI ONAL THERAPY 2, 272, 782 6, 133, 824 0. 370533 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 67. 00
56. 00 05600 RADI OI SOTOPE 411, 436 3, 165, 272 0. 129984 56. 00 57. 00 05700 CT SCAN 680, 513 4, 038, 769 0. 168495 57. 00 58. 00 05800 MRI 852, 802 6, 306, 423 0. 135228 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0. 000000 59. 00 60. 00 06000 LABORATORY 1, 246, 067 7, 302, 933 0. 170626 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0. 000000 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 6, 052 65, 330 0. 092637 63. 00 65. 00 06500 RESPI RATORY THERAPY 358, 197 923, 744 0. 387767 65. 00 66. 00 06600 PHYSI CAL THERAPY 2, 272, 782 6, 133, 824 0. 370533 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 67. 00
57. 00 05700 CT SCAN 680, 513 4, 038, 769 0. 168495 57. 00 58. 00 05800 MRI 852, 802 6, 306, 423 0. 135228 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0. 000000 59. 00 60. 00 06000 LABORATORY 1, 246, 067 7, 302, 933 0. 170626 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0. 000000 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 6, 052 65, 330 0. 092637 63. 00 65. 00 06500 RESPI RATORY THERAPY 358, 197 923, 744 0. 387767 65. 00 66. 00 06600 PHYSI CAL THERAPY 2, 272, 782 6, 133, 824 0. 370533 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 67. 00
58. 00 05800 MRI 852, 802 6, 306, 423 0. 135228 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0. 0000000 59. 00 60. 00 06000 LABORATORY 1, 246, 067 7, 302, 933 0. 170626 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0. 000000 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 6, 052 65, 330 0. 092637 63. 00 65. 00 06500 RESPI RATORY THERAPY 358, 197 923, 744 0. 387767 65. 00 66. 00 06600 PHYSI CAL THERAPY 2, 272, 782 6, 133, 824 0. 370533 66. 00 67. 00 0670 OCCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 67. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0.0000000 59. 00 60. 00 06000 LABORATORY 1, 246, 067 7, 302, 933 0.170626 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0.000000 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 6, 052 65, 330 0.092637 63. 00 65. 00 06500 RESPI RATORY THERAPY 358, 197 923, 744 0.387767 65. 00 66. 00 06600 PHYSI CAL THERAPY 2, 272, 782 6, 133, 824 0.370533 66. 00 67. 00 0670 0CCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 67. 00
60. 00 06000 LABORATORY 1, 246, 067 7, 302, 933 0. 170626 60. 00 62. 00 62. 00 62. 00 63. 00 65. 00 65. 00 65. 00 665. 00 66600 PHYSI CAL THERAPY 2, 272, 782 6, 133, 824 6. 00 67. 00 06700 0CCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 67. 00 67. 00 06000 0. 000000 0. 000000 62. 00 62. 00 62. 00 62. 00 63. 00 63. 00 63. 00 64. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0.0000000 63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 6, 052 65, 330 0.092637 65. 00 06500 RESPI RATORY THERAPY 358, 197 923, 744 0.387767 65. 00 06600 PHYSI CAL THERAPY 2, 272, 782 6, 133, 824 0.370533 66. 00 06700 0CCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 67. 00 06700
63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 6, 052 65, 330 0. 092637 65. 00 650 RESPI RATORY THERAPY 358, 197 923, 744 0. 387767 65. 00 66. 00 06600 PHYSI CAL THERAPY 2, 272, 782 6, 133, 824 0. 370533 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 67. 00 06700 OCCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 67. 00 06700 OCCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 067. 00 06700 OCCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 067. 00 06700 OCCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 067. 00 06700 OCCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 067. 00 06700 OCCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 067. 00 06700 OCCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 067. 00 06700 OCCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 067. 00 06700 OCCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 067. 00 0670
65. 00 06500 RESPI RATORY THERAPY 358, 197 923, 744 0. 387767 65. 00 66. 00 06600 PHYSI CAL THERAPY 2, 272, 782 6, 133, 824 0. 370533 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 67. 00 067
66. 00 06600 PHYSI CAL THERAPY 2, 272, 782 6, 133, 824 0. 370533 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 67. 00
67. 00 06700 OCCUPATI ONAL THERAPY 1, 093, 569 3, 939, 908 0. 277562 67. 00
68. 00 06800 SPEECH PATHOLOGY 311, 558 999, 841 0. 311608 68. 00
69. 00 06900 ELECTROCARDI OLOGY 338, 923 3, 988, 312 0. 084979 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 56, 941 951, 095 0. 059869 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 81, 333 439, 672 0. 184986 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0.000000 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 731, 069 3, 504, 964 0. 208581 73. 00
74. 00 07400 RENAL DI ALYSI S 155, 725 353, 433 0. 440607 74. 00
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0.000000 75. 00
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLI NI C 115, 062 20, 690 5. 561237 90. 00
91. 00 09100 EMERGENCY 0 0 0.000000 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0.000000 92. 00
SPECIAL PURPOSE COST CENTERS
113. 00 11300 I NTEREST EXPENSE 113. 00
116. 00 11600 HOSPI CE 0 0. 000000 116. 00
200.00 Subtotal (sum of lines 50 thru 199) 9,869,615 47,446,113 200.00
201.00 Less Observation Beds 0 0 201.00
202.00 Total (line 200 minus line 201) 9,869,615 47,446,113 202.00

Health Financial Systems C	OMMUNITY STROKE A	ND REHABILITAT	ION	In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT	AL COSTS	Provi der C		Period: From 07/01/2020 To 06/30/2021		
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capital Related Cost	Days	Per Diem (col. 3 / col. 4)	
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		T				
30. 00 ADULTS & PEDI ATRI CS	1, 681, 199	C	1, 681, 19	7, 137		1
31. 00 INTENSIVE CARE UNIT	0	_		0	0.00	
41. 00 SUBPROVI DER - I RF	0	C)	0	0.00	
43. 00 NURSERY	0		4 (04 40	0	0.00	
200.00 Total (lines 30 through 199)	1, 681, 199		1, 681, 19	9 7, 137		200. 00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost (col. 5 x col.				
		6)				
	6, 00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30, 00 ADULTS & PEDIATRICS	4, 967	1, 170, 027	,			30.00
31.00 INTENSIVE CARE UNIT	0					31.00
41. 00 SUBPROVI DER - I RF	0	C				41. 00
43. 00 NURSERY	0	C				43.00
200.00 Total (lines 30 through 199)	4, 967	1, 170, 027	7			200. 00

Health Financial Systems COMM	UNITY STROKE A	ND REHABILITATI	ON	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Peri od:	Worksheet D	
				From 07/01/2020 To 06/30/2021	Part II Date/Time Pre	narod:
				10 00/30/2021	11/23/2021 10	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	0.00	0.00	4.00	F 00	
ANCILL ADV. SEDVI CE. COST. CENTEDS	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS 50.00 O5000 OPERATI NG ROOM			0.00000	0	0	50.00
51. 00 05100 RECOVERY ROOM	0	0	1		0	51.00
53. 00 05300 ANESTHESI OLOGY	0		0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	343, 537	5, 311, 903	1		-	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	045, 557	3, 311, 303	0.00000	•	12, 417	55.00
56. 00 05600 RADI 01 SOTOPE	72, 085	3, 165, 272	1		-	56.00
57. 00 05700 CT SCAN	147, 042		1	•	6, 307	57. 00
58. 00 05800 MRI	272, 188		1			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		1	•	0	59.00
60. 00 06000 LABORATORY	133, 296	7, 302, 933			18, 502	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0.00000		0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	138	65, 330	0. 00211	11, 970	25	63.00
65. 00 06500 RESPIRATORY THERAPY	10, 294	923, 744	0. 01114	358, 643	3, 997	65. 00
66. 00 06600 PHYSI CAL THERAPY	296, 444	6, 133, 824	0. 04832	2, 349, 327	113, 541	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	29, 652	3, 939, 908	0. 00752	26 2, 374, 453	17, 870	67. 00
68.00 06800 SPEECH PATHOLOGY	11, 588	999, 841	0. 01159	90 445, 371	5, 162	68. 00
69. 00 06900 ELECTROCARDI OLOGY	50, 099	3, 988, 312	0. 01256	97, 688	1, 227	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	12, 231	951, 095	0. 01286	0 0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 548	439, 672	0. 00352	312, 827	1, 101	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.0000		ľ	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	49, 144		1			1
74. 00 07400 RENAL DI ALYSI S	19, 679	353, 433		•	15, 317	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000	00	0	75. 00
OUTPATIENT SERVICE COST CENTERS	T	1	1			
90. 00 09000 CLI NI C	2, 557		1		0	
91. 00 09100 EMERGENCY	0	0			0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	0	0.00000		0	92.00
200.00 Total (lines 50 through 199)	1, 451, 522	47, 446, 113	1	9, 765, 606	226, 811	1200. OO

Health Financial Systems	COMMUNITY STROKE AND REHABILITATION		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT RO	OUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN:	15-3045 Peri od:	Worksheet D		

Health Financial Systems CO	MMUNITY STROKE AT	ND KEHARILITATI	ION	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	TS Provider Co		Peri od:	Worksheet D	
				From 07/01/2020	Part III	
			'	To 06/30/2021	Date/Time Pre	pared:
					11/23/2021 10	: 41 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdowr		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1, 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	.,,	1.00		2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1	n	0	30.00
31. 00 03100 NTENSI VE CARE UNIT	0	١		0	0	
	0	0		0	ľ	
41. 00 04100 SUBPROVI DER - RF	0	0)	0	0	
43. 00 04300 NURSERY	0	0)	0	0	43. 00
200.00 Total (lines 30 through 199)	0	0)	0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4. 00	5. 00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	7, 13	7 0.00	4, 967	30.00
31. 00 03100 I NTENSI VE CARE UNI T	_	0)	0.00		
41. 00 04100 SUBPROVI DER -	0	٥		0.00		1
43. 00 04300 NURSERY	0			0.00		
		0	7 10		l e	
200. 00 Total (lines 30 through 199)		0	7, 13	/	4, 967	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30. 00
31. 00 03100 INTENSIVE CARE UNIT	0					31.00
41. 00 04100 SUBPROVI DER - RF						41.00
43. 00 04300 NURSERY	0					43. 00
	-					
200.00 Total (lines 30 through 199)	0					200. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet D		
From 07/01/2020	Part IV		
To 06/30/2021	Date/Time Prepared:	11/23/2021	10:41 am
 Heal th Financial
 Systems
 COMMUNITY STROKE AND REHABILITATION

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN:
 Provider CCN: 15-3045 THROUGH COSTS

						11/23/2021 10:	41 am
				XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	o	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	o	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	o	55.00
56.00	05600 RADI OI SOTOPE	0	0		0 0	o	56.00
57.00	05700 CT SCAN	0	0		0 0	ol	57.00
58.00	05800 MRI	0	0		0 0	l ol	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	l ol	59.00
60.00	06000 LABORATORY	0	Ö		0 0	o	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	Ö		0 0	o	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	Ö		0 0	ol	63.00
65.00	06500 RESPI RATORY THERAPY	0	Ö		0 0	ol	65.00
66.00	06600 PHYSI CAL THERAPY	0	Ö		0 0	o	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	Ö		0 0	o	67.00
68.00	06800 SPEECH PATHOLOGY	0	Ö		0 0	o	68.00
69.00	06900 ELECTROCARDI OLOGY	0	l o		0 0	l ol	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	o		0 0	ol	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	d		0 0	ol	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	o		0 0	ol	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	o		0 0	ol	73.00
74.00	07400 RENAL DIALYSIS	0	o		0 0	ol	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	O		0 0	ol	75.00
	OUTPATIENT SERVICE COST CENTERS				-		
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	0	0		0 0	l ol	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			o	o	92.00
200.00	,	0	Ó		0 0	0	200.00
		'	ľ	1	-1	١	

Health Financial Systems	COMMUNITY STROKE AND	REHABI LI TATI ON		In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-3045	Peri od:	Worksheet D

From 07/01/2020 Part IV To 06/30/2021 Date/Ti THROUGH COSTS Date/Time Prepared: 11/23/2021 10:41 am Title XVIII Hospi tal All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) col s. 2, 3, 8) 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0.000000 51.00 53.00 05300 ANESTHESI OLOGY 0 0 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54 00 5, 311, 903 0.000000 54 00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 0.000000 55.00 56.00 05600 RADI OI SOTOPE 3, 165, 272 0.000000 56.00 57.00 05700 CT SCAN 0 0 4. 038. 769 0.000000 57.00 05800 MRI 0 0 58.00 6, 306, 423 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 06000 LABORATORY 60.00 7, 302, 933 0.000000 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 62 00 62 00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 65, 330 0.000000 63.00 06500 RESPIRATORY THERAPY 923, 744 0.000000 65.00 06600 PHYSI CAL THERAPY 66.00 6, 133, 824 0.000000 66,00 06700 OCCUPATIONAL THERAPY 67.00 3, 939, 908 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 999, 841 0.000000 68.00 06900 ELECTROCARDI OLOGY 3, 988, 312 0.000000 69.00 69.00 70. 00 07000 ELECTROENCEPHALOGRAPHY 951, 095 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 0 439, 672 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 3, 504, 964 0.000000 73.00 73.00 07400 RENAL DIALYSIS 0 74.00 0 353, 433 0.000000 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 75.00 75.00 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 20, 690 0.000000 90.00 0 91. 00 09100 EMERGENCY 0 0 0.000000 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0.00000092.00 Total (lines 50 through 199) 47, 446, 113 200.00

Health Financial Systems	COMMUNITY STROKE AND	REHABI LI TATI ON		In Lieu of Form CMS-2552-10
ADDODTI ONMENT OF INDATIENT/OUTDATIENT	ANCILLADY SEDVICE OTHER DASS	Drovi don CCN: 15 2045	Pori od:	Workshoot D

Hearth Fina	anciai Systems COMP	MUNITY STRUKE AND	KEHABI LI TATI	ON	In Lie	eu of Form CMS-2	2552-10
APPORTI ONM	ENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der Co	CN: 15-3045	Peri od:	Worksheet D	
THROUGH CO:	STS				From 07/01/2020	Part IV	
					To 06/30/2021	Date/Time Prep	pared:
			T' 11	V0 (1 1 1		11/23/2021 10:	:41 am_
				XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	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)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	LLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	0. 000000	0		0	0	
	OO RECOVERY ROOM	0. 000000	0		0	0	51.00
53.00 0530	OO ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 0540	OO RADI OLOGY-DI AGNOSTI C	0. 000000	192, 033		0 1, 315, 141	0	54.00
55.00 0550	00 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
56.00 0560	OO RADI OI SOTOPE	0. 000000	3, 439		0 1, 070, 849	l ol	56. 00
57. 00 0570	DO CT SCAN	0. 000000	173, 241		0 1, 680, 726	ol	57. 00
58. 00 0580	DO MRI	0. 000000	34, 692		0 1, 780, 569	ol	58. 00
59. 00 0590	OO CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	l ol	59. 00
	OO LABORATORY	0. 000000	1, 013, 708		0 258, 209	ام	60.00
	OO WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	ام	62, 00
	00 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	11, 970		0 0	l ol	63. 00
	OO RESPIRATORY THERAPY	0. 000000	358, 643	l .	0 145, 241	ام	65. 00
	00 PHYSI CAL THERAPY	0. 000000	2, 349, 327	l .	0 0	0	66. 00
	OO OCCUPATIONAL THERAPY	0. 000000	2, 374, 453	l .		٥	67. 00
	O SPEECH PATHOLOGY	0. 000000	445, 371	l .		0	68. 00
	00 ELECTROCARDI OLOGY	0. 000000	97, 688	l .	0 1, 384, 612	١	69.00
•	00 ELECTROENCEPHALOGRAPHY	0. 000000	77, 000 0		0 296, 371	0	70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	312, 827		0 270, 371		71.00
•	ON IMPL. DEV. CHARGED TO PATIENTS	0. 000000	312,027		0	0	72.00
	DO DRUGS CHARGED TO PATIENTS	0. 000000	2, 123, 125		0 194, 256	- 1	
				1		i i	73.00
•	OO RENAL DIALYSIS	0. 000000	275, 089	1	0	0	74.00
	00 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75. 00
	PATIENT SERVICE COST CENTERS	0.000000					
	OO CLI NI C	0. 000000	0		0 0		90.00
	OO EMERGENCY	0. 000000	0		0 0	0	
	OO OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	
200. 00	Total (lines 50 through 199)		9, 765, 606	1	0 8, 125, 974	ا 0	200. 00

				cnarges		COSTS	
	Cost Center Description	Cost to Charge		Cost	Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING 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. 217923	1, 315, 141	0	0	286, 599	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	0	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 129984	1, 070, 849	0	0	139, 193	56.00
57.00	05700 CT SCAN	0. 168495	1, 680, 726	0	0	283, 194	57.00
58. 00	05800 MRI	0. 135228			0	240, 783	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000		0	0	0	59. 00
60. 00	06000 LABORATORY	0. 170626		0	0	44, 057	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000		0	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0. 092637		0	0	0	63.00
65. 00	06500 RESPIRATORY THERAPY	0. 387767		0	0	56, 320	
66. 00	06600 PHYSI CAL THERAPY	0. 370533		l o	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 277562	0	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 311608		0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 084979	1, 384, 612	0	0	117, 663	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 059869		0	0	17, 743	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 184986	0	0	0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 208581		0	7, 660	40, 518	73. 00
74.00	07400 RENAL DIALYSIS	0. 440607		0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	0	0	0	75. 00
	OUTPATIENT SERVICE COST CENTERS		•	•			
90.00	09000 CLI NI C	5. 561237	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	Subtotal (see instructions)		8, 125, 974	0	7, 660	1, 226, 070	200. 00
201.00				0	0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		8, 125, 974	0	7, 660	1, 226, 070	202. 00
				-			

Provider CCN: 15-3045

						То	06/30/2021	Date/Time Pr 11/23/2021 1	
				Title	XVIII		Hospi tal	PPS	
		Cos	sts						
	Cost Center Description	Cost		Cost					
		Rei mbursed		imbursed					
		Servi ces		vices Not					
		Subject To		bject To					
				& Coins.					
		(see inst.)	(se	ee inst.)					
		6. 00		7. 00					
	ANCILLARY SERVICE COST CENTERS			_					
	05000 OPERATI NG ROOM	0		0					50.00
	05100 RECOVERY ROOM	0		0					51.00
	05300 ANESTHESI OLOGY	0		0					53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0		0					54.00
	05500 RADI OLOGY-THERAPEUTI C	0		0					55. 00
	05600 RADI OI SOTOPE	0		0					56. 00
57. 00	05700 CT SCAN	0		0					57. 00
	05800 MRI	0		0					58. 00
	05900 CARDI AC CATHETERI ZATI ON	0		0					59. 00
	06000 LABORATORY	0		0					60. 00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0					62. 00
	06300 BLOOD STORING, PROCESSING, & TRANS.	0		0					63. 00
	06500 RESPI RATORY THERAPY	0		0					65. 00
	06600 PHYSI CAL THERAPY	0		0					66. 00
	06700 OCCUPATI ONAL THERAPY	0		0					67. 00
	06800 SPEECH PATHOLOGY	0		0					68. 00
	06900 ELECTROCARDI OLOGY	0		0					69. 00
	07000 ELECTROENCEPHALOGRAPHY	0		0					70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0					71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0					72. 00
	07300 DRUGS CHARGED TO PATIENTS	0		1, 598					73. 00
	07400 RENAL DIALYSIS	0		0					74. 00
	07500 ASC (NON-DISTINCT PART)	0		0					75. 00
	OUTPATIENT SERVICE COST CENTERS								
	09000 CLI NI C	0		0					90. 00
	09100 EMERGENCY	0		0					91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0					92. 00
200.00		0		1, 598					200. 00
201.00		0							201. 00
	Only Charges								
202. 00	Net Charges (line 200 - line 201)	0	1	1, 598					202. 00

Health Financial Systems	COMMUNITY STROKE AN	ND REHABILITATI	ION	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAI	PITAL COSTS	Provider C	<u> </u>	Period: From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 10	pared: :41 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 & PEDI ATRI CS	1, 681, 199	0	1, 681, 199	7, 137	235. 56	30.00
31.00 INTENSIVE CARE UNIT	0			0	0.00	31.00
41. 00 SUBPROVI DER - I RF	0	0) (0	0.00	41.00
43. 00 NURSERY	0			0	0.00	43.00
200.00 Total (lines 30 through 199)	1, 681, 199		1, 681, 199	7, 137		200.00
Cost Center Description	I npati ent	I npati ent		•		
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	9	2, 120)			30. 00
31.00 INTENSIVE CARE UNIT	0	0				31.00
41. 00 SUBPROVI DER - I RF	O	0				41.00
43. 00 NURSERY	O	o d				43.00
200.00 Total (lines 30 through 199)	9	2, 120	o			200. 00

Health Financial Systems COMM	UNITY STROKE A	ND REHABILITATI	ON	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Peri od:	Worksheet D	
				From 07/01/2020 To 06/30/2021	Part II Date/Time Pre	narod:
				10 00/30/2021	11/23/2021 10	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	0.00	0.00	4.00	F 00	
ANCILL ADV. SEDVI CE. COST. CENTEDS	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM			0.00000	0	0	50.00
51. 00 05100 RECOVERY ROOM	0		0.00000		0	50.00
53. 00 05300 ANESTHESI OLOGY	0		0.00000		0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	343, 537	5, 311, 903			76	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	343, 337	3,311,703	0.00000		0	55.00
56. 00 05600 RADI 01 SOTOPE	72, 085	3, 165, 272	l .		0	56.00
57. 00 05700 CT SCAN	147, 042				0	57.00
58. 00 05800 MRI	272, 188				0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	272, 100				0	59.00
60. 00 06000 LABORATORY	133, 296	· · · · · · · · · · · · · · · · · · ·			99	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0. 00000		0	62. 00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	138	65, 330			0	63. 00
65. 00 06500 RESPIRATORY THERAPY	10, 294				18	65. 00
66. 00 06600 PHYSI CAL THERAPY	296, 444			4, 468	216	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	29, 652				36	67. 00
68. 00 06800 SPEECH PATHOLOGY	11, 588			910	11	68. 00
69. 00 06900 ELECTROCARDI OLOGY	50, 099	3, 988, 312	0. 01256	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	12, 231	951, 095	0. 01286	0 0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 548	439, 672	0. 00352	21 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000	0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	49, 144	3, 504, 964	0. 01402	4, 308	60	73. 00
74. 00 07400 RENAL DI ALYSI S	19, 679	353, 433	0. 05568	0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	C	0.00000	0 0	0	75. 00
OUTPAȚIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	2, 557	20, 690	l .		0	
91. 00 09100 EMERGENCY	0	0			0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0. 00000		0	92. 00
200.00 Total (lines 50 through 199)	1, 451, 522	47, 446, 113		22, 610	516	200. 00

Health Financial Systems		COMMUNITY STROKE AND REHABILITATION	In Lieu of Form CMS-2552-10
	ADDODTIONMENT OF INDATIENT DOLLT	IE SEDVI CE OTHER DASS THROUGH COSTS Drovi dor CCN: 15 2045	Pariod: Warkshoot D

Health Financial Systems CO	OMMUNITY STROKE AI	ND REHABILITATI	I ON	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	TS Provider C		Peri od:	Worksheet D	
				From 07/01/2020		
			"	To 06/30/2021		
					11/23/2021 10): 41 am
			e XIX	Hospi tal	PPS	
Cost Center Description		Nursing School		Allied Health	All Other	
	Post-Stepdown		Post-Stepdowr		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	l 0		0	0	31.00
41. 00 04100 SUBPROVI DER - I RF	0	1		0	0	41.00
43. 00 04300 NURSERY	0			0	0	
200.00 Total (lines 30 through 199)	0				1	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	200.00
oust defited beschiption	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	bays	0 . 601. 6)	l 110gram bays	
	instructions)	minus col. 4)				
	4. 00	5.00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0		7, 13	7 0.00	9	30.00
31. 00 03100 NTENSI VE CARE UNI T			7, 13	0.00	1	
41. 00 04100 SUBPROVI DER - RF				0.00		
	0					
43. 00 04300 NURSERY			7 40	0.00		
200.00 Total (lines 30 through 199)		0	7, 13	/	9	200. 00
Cost Center Description	Inpatient					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
41. 00 04100 SUBPROVI DER - I RF	0					41.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
	•	•				•

 Heal th Financial
 Systems
 COMMUNITY STROKE AND REHABILITATION

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN:
 Provider CCN: 15-3045 THROUGH COSTS

						11/23/2021 10	41 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	I Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	1	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	1	0	0	51.00
53.00	05300 ANESTHESI OLOGY	0	0)	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0)	0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0)	0	0	56.00
57.00	05700 CT SCAN	0	0)	0	0	57.00
58.00	05800 MRI	O	0)	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	0)	0 0	0	59.00
60.00	06000 LABORATORY	o	0)	0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	0)	0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	o	0)	0 0	0	63.00
65.00	06500 RESPIRATORY THERAPY	o	0)	0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	o	0)	0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	o	0	1	0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	O	Ö	1	0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	Ö	1	0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	Ö	1	0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö	1	0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	Ö	1	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	Ö	1	0 0	0	73.00
74.00	07400 RENAL DIALYSIS	0	Ö	1	0 0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	o	O)	0 0	ol	75.00
	OUTPATIENT SERVICE COST CENTERS			,			
90.00	09000 CLI NI C	0	C		0 0	0	90.00
91.00	09100 EMERGENCY	O	O)	0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			o	0	92.00
200.00	Total (lines 50 through 199)	o	O		0 0	ol	200. 00
				•	•		

Health Financial Systems	COMMUNITY STROKE AND	REHABI LI TATI ON	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-3045	Peri od:	Worksheet D

From 07/01/2020 | Part IV To 06/30/2021 | Date/Ti THROUGH COSTS Date/Time Prepared: 11/23/2021 10:41 am Title XIX Hospi tal All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.00000050.00 51.00 05100 RECOVERY ROOM 0 0 0 0.000000 51.00 53.00 05300 ANESTHESI OLOGY 0 0 0.000000 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 5, 311, 903 0.000000 54 00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 0.000000 55.00 56. 00 05600 RADI 0I SOTOPE 3, 165, 272 0.000000 56.00 57.00 05700 CT SCAN 0 0 4. 038. 769 0.000000 57.00 05800 MRI 0 58.00 0 6, 306, 423 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 06000 LABORATORY 60.00 7, 302, 933 0.000000 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 62 00 62 00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 65, 330 0.000000 63.00 65.00 06500 RESPIRATORY THERAPY 923, 744 0.000000 65.00 06600 PHYSI CAL THERAPY 6, 133, 824 0.000000 66.00 66,00 06700 OCCUPATIONAL THERAPY 67.00 3, 939, 908 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 999, 841 0.000000 68.00 06900 ELECTROCARDI OLOGY 3, 988, 312 0.000000 69.00 69.00 70. 00 07000 ELECTROENCEPHALOGRAPHY 951, 095 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 439, 672 0.000000 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0 3, 504, 964 0.000000 73.00 0 73.00 07400 RENAL DIALYSIS 0 74.00 0 353, 433 0.000000 74.00 07500 ASC (NON-DISTINCT PART) 0 0.000000 75.00 75.00 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 20, 690 0.000000 90.00 0 91. 00 09100 EMERGENCY 0 0 0.000000 91.00 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0.000000 92.00

47, 446, 113

200.00

Total (lines 50 through 199)

Health Financial Systems		COMMUNITY STROKE AND	REHABI LI TATI ON	In Li	eu of Form CMS-2552-10
	ADDODTIONMENT OF INDATIENT/OUTDATIENT	ANCILLARY SERVICE OTHER DASS	Provider CCN: 15-3045	Pari od:	Workshoot D

Part IV From 07/01/2020 THROUGH COSTS 06/30/2021 Date/Time Prepared: 11/23/2021 10:41 am Title XIX Hospi tal PPS Cost Center Description Outpati ent Outpati ent Inpatient Inpati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through Pass-Through to Charges Charges Charges Costs (col. (col. 6 ÷ col Costs (col. 8 x col . 12) 13.00 7) x col. 10) 11.00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 0.000000 0 0 50.00 0 51.00 05100 RECOVERY ROOM 0.000000 C 0 51.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0 54.00 54.00 1, 182 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.000000 55.00 C 0 56.00 05600 RADI OI SOTOPE 0.000000 0 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 57.00 0 58.00 05800 MRI 0.000000 Ω 0 58 00 05900 CARDIAC CATHETERIZATION 0 59.00 0.000000 0 59.00 60.00 06000 LABORATORY 0.000000 5, 406 0 60.00 0.000000 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 62.00 0 06300 BLOOD STORING, PROCESSING, & TRANS. 0.000000 63.00 0 63.00 65.00 06500 RESPIRATORY THERAPY 0.000000 1, 576 0 65.00 06600 PHYSI CAL THERAPY 0.000000 0 66.00 4, 468 0 66.00 06700 OCCUPATIONAL THERAPY 0 67 00 0.000000 4 760 0 67 00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 910 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69.00 C 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 0.000000 Ω 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 C 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 4, 308 73.00 07400 RENAL DIALYSIS 0 0 74.00 0.000000 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75.00 75.00 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 0 90.00 0 0 91. 00 09100 EMERGENCY 0.000000 91.00 0 92.00 |09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.000000 0 0 200.00 Total (lines 50 through 199) 22, 610 0 200. 00

Health Financial Systems	COMMUNITY STROKE AND	REHABI LI TATI ON	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	T	Provi der CCN: 15-3045	Period: From 07/01/2020	Worksheet D-1	
			To 06/30/2021	Date/Time Pre 11/23/2021 10	pared: :41 am
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including privat	e room days and swing-bed day	rs, excluding newborn)		7, 137	1.00
2.00 Inpatient days (including privat	e room days, excluding swing-	bed and newborn days)		7, 137	2. 00
3.00 Private room days (excluding swi do not complete this line.	ng-bed and observation bed da	ys). If you have only pr	rivate room days,	0	3. 00

DWIT 1 - ALL PROFILER COMPONENTS		Cost Center Description		
INPACTION DAYS		DADT L. ALL DROWNED COMPONENTS	1. 00	
Inpattient days (Including private room days and swing-bed days, excluding newborn)				
Private room days (excluding swing-bed and observation bed days). If you have only private room days, declined and observation bed days). If you have only private room days, declined and observation bed days). If you have only private room days. 1,000 1,00	1.00		7, 137	1. 00
do not complete this line. 1.00 Self-private room days (excluding swing-bed and observation bed days) 1.01 Total swing-bed SW Type inpatient days. (Including private room days) after December 31 of the cost reporting period reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SW Type inpatient days. (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SW Type inpatient days. (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SW Type inpatient days. (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SW Type inpatient days (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Swing-bed SW Type inpatient days applicable to title XVIII only (Including private room days) 8.00 Swing-bed SW Type inpatient days applicable to title XVIII only (Including private room days) 8.00 Swing-bed SW Type inpatient days applicable to title XVIII only (Including private room days) 9.00 Swing-bed SW Type inpatient days applicable to title XVIII only (Including private room days) 10.00 Swing-bed SW Type inpatient days applicable to title XVIII only (Including private room days) 11.00 Swing-bed SW Type inpatient days applicable to title XVIII only (Including private room days) 12.00 Swing-bed SW Type inpatient days applicable to title XVIII only (Including private room days) 13.00 Swing-bed SW Type inpatient days applicable to title XVIII only (Including private room days) 14.00 Swing-bed SW Type inpatient days applicable to title XVIII only (Including private room days) 15.00 Total runsery days (Itle XVIII only (Including private room days) 16.00 Swing-bed SW Type inpatient days applicable to services after December 31 of the cost reporting period (Including private				
Semi_private room days (excluding swing-ted and observation bed days) 7,137 4.00	3. 00		0	3. 00
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reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed Mr type inpatient days (including private room days) after December 31 of the cost 8.00 Total sing bed Mr type inpatient days (including private room days) after December 31 of the cost 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newtorm days) (if calendar year) on this line) 9.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 pecember 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 14.00 Experimental of the cost reporting period (if calendar year, enter 0 on this line) 15.00 Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 16.00 Write-private (iii) to virtual year of the cost reporting period (if calendar year, enter 0 on this line) 17.00 Total nursery days (title V or XIX only) 18.00 North of the virtual year of the cost reporting period (if calendar year, enter 0 on this line) 18.00 North of the virtual year of the cost reporting period (if calendar year, enter 0 on this line) 18.00 North of the virtual year of the cost reporting period (if calendar year, enter 0 on this line) 18.00 North of the virtual year of the cost reporting period (if calendar year, enter 0 on this line) 18.00 North of the virtual year of the cost reporting period (if calendar year, enter 0 on this line) 18.00 North of the virtual year of the cost reporting period (if calendar year, enter 0 on the year year year year year year year yea				
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reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Saing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 11. 00 SMI ng-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12. 00 SMI ng-bed SMF type inpatient days applicable to titles XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 SWI ng-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 14. 00 SWI ng-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 15. 00 SWI ng-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 16. 00 SWI ng-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 17. 00 Fold call unsersery days (title V or XIX only) 18. 00 SWI ng-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 18. 00 SWI ng-bed SWI swing-bed SMF services applicable to services through December 31 of the cost 18. 00 Fold caller are tare for swing-bed SMF services applicable to services after December 31 of the cost 18. 00 Fold caller are tare for swing-bed SMF services applicable to services after December 31 of the cost 19. 00 Fold caller are tare for swing-bed SMF services applicable to services after December 31 of the cost 19. 00 Fold caller are tare for swing-bed SMF services after December 31 of the cost reporting period (line S X I Ine 17) 20. 00 SWI ng-bed cost applicable to SMF type services through December 31 of the cost reporting period (line	7 00		0	7 00
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37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 389 2, 389 2) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 8, 962, 389 37.00 8, 962, 389 37.00 8, 962, 389 37.00 9, 00 40.00				
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		·		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	3/. UC		ö, 902, 389	37.00
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 255.76 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1, 255.76 38.00 6, 237, 360 39.00				
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 6,237,360 39.00 40.00		PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				

	Laboratory Paris and Laboratory		
21. 00		8, 962, 389	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23.00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8, 962, 389	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi - pri vate room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	, , ,	0.00	33.00
34.00		0.00	34.00
35. 00			35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	8, 962, 389	37. 00
	27 minus line 36)	0, 10=, 001	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00		1, 255. 76	38. 00
	Program general inpatient routine service cost (line 9 x line 38)	6, 237, 360	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	- 1	
11.00	Total Trogram general Tripatront Foatrine Service Cost (Trib O) Tribe 10)	0, 207, 000	11.00

	Financial Systems COMMM ATION OF INPATIENT OPERATING COST	UNITY STROKE AN		CCN: 15-3045	Peri od:	worksheet D-1	
					From 07/01/2020 To 06/30/2021		
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per SDiem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	0	(0.0	00 0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	(0.0	00 0	0	43. 00
44. 00	CORONARY CARE UNIT	0	`	0.1	0	Ĭ	44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1.00	
48. 00	Program inpatient ancillary service cost (Wks					2, 688, 580	1
49. 00	Total Program inpatient costs (sum of lines 4	41 through 48)(see instruction	ons)		8, 925, 940	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (from	m Wkst. D. sur	n of Parts I and	1, 170, 027	50. 00
			·				
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (fi	rom Wkst. D, s	sum of Parts II	226, 811	51. 00
52. 00	Total Program excludable cost (sum of lines 5	50 and 51)				1, 396, 838	52. 00
53.00	Total Program inpatient operating cost exclud		lated, non-phy	ysician anesth	netist, and	7, 529, 102	53. 00
	medical education costs (line 49 minus line 5	52)					-
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge					0.00	1
56. 00	Target amount (line 54 x line 55)					0	
57. 00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	line 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	norting period	ending 1996 ı	undated and co	omnounded by the	0.00	
37.00	market basket	on tring perrou	charing 1770, t	apaarea ana e	simpounded by the	0.00	37.00
60.00	Lesser of lines 53/54 or 55 from prior year of					0.00	1
61. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61. 00
	amount (line 56), otherwise enter zero (see i		3 (TITIES 54 X	00), 01 1% 01	the target		
62. 00	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64. 00
	instructions)(title XVIII only)			•			
65. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts after Decemb	er 31 of the o	cost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line (65)(title XVII	I only). For	0	66. 00
(7.00	CAH (see instructions)		Dogombon 21	of the cost m	narting paried	0	(7.00
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 (or the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient r	coutine costs (line 67 ± line	a 68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NU						07.00
70. 00	Skilled nursing facility/other nursing facili	,		` ,)		70. 00
71.00	Adjusted general inpatient routine service co	1	ine 70 ÷ line	2)			71. 00 72. 00
72. 00 73. 00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applications)		(line 14 x li	ine 35)			73.00
74. 00	Total Program general inpatient routine servi		•				74. 00
75. 00	Capital-related cost allocated to inpatient r	routine service	costs (from \	Worksheet B, F	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
78. 00	Inpatient routine service cost (line 74 minus	,					78. 00
79. 00	Aggregate charges to beneficiaries for excess						79. 00
80.00	Total Program routine service costs for compa		ost limitation	n (line 78 mir	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (s		* .				83. 00
84. 00	Program inpatient ancillary services (see ins						84. 00

84.00 Program inpatient ancillary services (see instructions)

85.00 Utilization review - physician compensation (see instructions)

85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

Total observation bed days (see instructions)

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

88.00 Observation bed cost (line 87 x line 88) (see instructions)

84.00 Program inpatient ancillary services (see instructions)

85.00 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

87.00 Observation bed days (see instructions)

88.00 Observation bed cost (line 87 x line 88) (see instructions)

89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems COMM	IUNITY STROKE AN	ND REHABILITATI	ON	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 07/01/2020	Worksheet D-1	
				To 06/30/2021		pared: :41 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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, 681, 199	8, 962, 389	0. 18758	4 0	0	90.00
91.00 Nursing School cost	0	8, 962, 389	0.00000	0	0	91.00
92.00 Allied health cost	0	8, 962, 389	0.00000	0	0	92. 00
93.00 All other Medical Education	0	8, 962, 389	0. 00000	0 0	0	93. 00

Health Financial Systems	COMMUNITY STROKE AND	REHABI LI TATI ON	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Γ	Provider CCN: 15-3045	Period: From 07/01/2020	Worksheet D-1	
			To 06/30/2021	Date/Time Pre 11/23/2021 10	pared: :41 am
		Title XIX	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS]
1.00 Inpatient days (including privat	e room days and swing-bed day	ys, excluding newborn)		7, 137	1.00
2.00 Inpatient days (including privat	e room days, excluding swing-	-bed and newborn days)		7, 137	2. 00
3.00 Private room days (excluding swi	ng-bed and observation bed da	ays). If you have only p	rivate room days,	0	3. 00

	Cost Center Description		
		1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7, 137	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7, 137	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	7, 137	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	7, 137	5.00
3.00	reporting period	١	3.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)		l
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	9	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	9	9. 00
10. 00		0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	Ĭ	10.00
11. 00		0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		1
12.00		0	12. 00
	through December 31 of the cost reporting period	_	
13. 00	[0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00		0	15. 00
16. 00		0	16.00
10.00	SWING BED ADJUSTMENT		10.00
17. 00		0.00	17. 00
	reporting period		1
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
	reporting period		1
19. 00		0. 00	19. 00
20.00	reporting period	0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20. 00
21. 00		8, 962, 389	21. 00
22. 00		0	22. 00
	5 x line 17)		1
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		1
24. 00		0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8)	0	25. 00
25.00	x line 20)	٥	25.00
26. 00		0	26. 00
27. 00		8, 962, 389	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31. 00		0. 000000	
32. 00	Average private room per diem charge (line 29 + line 3)	0.00	32.00
33.00		0.00	
34.00		0. 00 0. 00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)	0.00	35. 00 36. 00
37. 00		8, 962, 389	37.00
57.00	27 minus line 36)	0, 702, 307	37.00
	PART III - HOSPI TAL AND SUBPROVI DERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		l
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 255. 76	38. 00
39. 00		11, 302	39. 00
40.00		0	40.00
41 00	Total Program general inpatient routine service cost (line 39 + line 40)	11 302	41 00

7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	l o	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	9	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
15. 00	Total nursery days (title V or XIX only)	0	
16. 00	Nursery days (title V or XIX only)	0	16. 00
47.00	SWING BED ADJUSTMENT		4
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
40.00	reporting period		40.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	8, 962, 389	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)	_	
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 \times line 18)	0	
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line $ 7 \times 1 $ x line 19)	0	2 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26.00	Total swing-bed cost (see instructions)	0	26. 00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8, 962, 389	27. 00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)	0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
	Average private room per diem charge (line 29 ÷ line 3)	0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
	Average per diem private room cost differential (line 34 x line 31)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	8, 962, 389	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 055 77	20.00
	Adjusted general inpatient routine service cost per diem (see instructions)	1, 255. 76	
	Program general inpatient routine service cost (line 9 x line 38)	11, 302	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	11 202	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	11, 302	41.00

COMPUT	Financial Systems COMM ATION OF INPATIENT OPERATING COST	IUNI TY STROKE AND	Provider CCN: 15-3045	Peri od:	worksheet D-1	
				From 07/01/2020 To 06/30/2021	Date/Time Pre 11/23/2021 10	
			Title XIX	Hospi tal	PPS	. 41 alli
	Cost Center Description	Total Inpatient Costlr	Total Average Penpatient Days Diem (col.		Program Cost (col. 3 x col.	
		1.00	2.00 col. 2)	4. 00	4) 5. 00	
12. 00	NURSERY (title V & XIX only)	0		. 00 0		42. 00
	Intensive Care Type Inpatient Hospital Units				_	
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0 0	. 00	0	43.00
44. 00 45. 00	BURN INTENSIVE CARE UNIT					45.00
	SURGICAL INTENSIVE CARE UNIT					46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)					47.00
	Cost Center Description				1.00	
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)		1. 00 5, 955	48. 00
					17, 257	
	PASS THROUGH COST ADJUSTMENTS	V , ,	,			
50. 00	Pass through costs applicable to Program inp	atient routine se	ervices (from Wkst. D, s	um of Parts I and	2, 120	50.00
51. 00	<pre>III) Pass through costs applicable to Program inp.</pre>	atient ancillary	services (from Wkst D	sum of Parts II	516	51.00
31.00	and IV)	attent anertrary	Services (110m wkst. b,	Sum of Tarts II	310	31.00
52. 00	Total Program excludable cost (sum of lines				2, 636	
53. 00	Total Program inpatient operating cost exclu		ated, non-physician anes	thetist, and	14, 621	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)				-
54 00	Program discharges				0	54. 00
55. 00	Target amount per discharge				0.00	
6. 00	Target amount (line 54 x line 55)				0	56.0
7. 00	Difference between adjusted inpatient operat	ing cost and tar	get amount (line 56 minu	s line 53)	0	
8. 00	Bonus payment (see instructions)		ading 100/ undeted and	aamnaundad by tha	0	
9. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period er	laring 1996, updated and	compounded by the	0.00	59.00
0.00	Lesser of lines 53/54 or 55 from prior year	cost report, upda	ated by the market baske	t	0.00	60.00
51. 00	If line 53/54 is less than the lower of line				0	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		(lines 54 x 60), or 1%	of the target		
52. 00	Relief payment (see instructions)	ilisti ucti olis)			0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)		0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST					
54. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decemb	per 31 of the cost repor	ting period (See	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the cost reporti	na period (See	0	65.00
	instructions)(title XVIII only)			9		
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	4 plus line 65)(title XV	III only). For	0	66.00
67 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through (December 31 of the cost	reporting period	0	67.00
37.00	(line 12 x line 19)	e costs till ough i	becember 31 of the cost	reporting perrou	٥	07.00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after Dec	cember 31 of the cost re	porting period	0	68.00
(0.00	(line 13 x line 20)	routino costo (li	no (7 . lino (0)			/ 0 00
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N				0	69.00
70. 00	Skilled nursing facility/other nursing facil			7)		70.00
71. 00	Adjusted general inpatient routine service c			•		71.00
72. 00	Program routine service cost (line 9 x line					72.00
73.00	Medically necessary private room cost applic					73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•	*	Part II column		74. 00 75. 00
3. 30	26, line 45)		IIII (a nor norroot b,	c , corailli		. 5. 50
76. 00	Per diem capital-related costs (line 75 ÷ li					76. 00
77.00	Program capital -related costs (line 9 x line					77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	ovider records)			78. 00 79. 00
30.00	Total Program routine service costs for comp		*.	inus line 79)		80.00
31. 00	Inpatient routine service cost per diem limi					81.00
32. 00	Inpatient routine service cost limitation (82.00
3.00	Reasonable inpatient routine service costs ()			83. 00
34.00	Program inpatient ancillary services (see in		-)			84.00
	Utilization review - physician compensation Total Program inpatient operating costs (sum					85. 00 86. 00
					I.	1 55.50
	PART IV - COMPUTATION OF OBSERVATION BED PASS	J 1111(00011 0031				

87.00 0. 00 88. 00 0 89. 00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems COMM	IUNITY STROKE AN	ND REHABILITATI	ON	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 07/01/2020	Worksheet D-1	
				To 06/30/2021		pared: :41 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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, 681, 199	8, 962, 389	0. 18758	4 0	0	90.00
91.00 Nursing School cost	0	8, 962, 389	0.00000	0	0	91.00
92.00 Allied health cost	0	8, 962, 389	0.00000	0	0	92. 00
93.00 All other Medical Education	0	8, 962, 389	0. 00000	0 0	0	93. 00

Heal th	Financial Systems COM	MUNITY STROKE AND REHABILITATI	ON	In Lie	u of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	F	Period: From 07/01/2020	Worksheet D-3	
]	o 06/30/2021	Date/Time Pre 11/23/2021 10	pared: <u>:41 am</u>
		Ti tl e	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cost	I npati ent	I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			7, 036, 633		30.00
31.00	03100 INTENSIVE CARE UNIT			0		31.00
41.00	04100 SUBPROVI DER - I RF			0		41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM		0.000000	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
	1 1		I	1		1

Health Financial Systems	COMMUNITY STROKE AND REHAB	BILITATION	In Lieu	of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Prov		Peri od: From 07/01/2020	Worksheet D-3

	Tier di Oystellis				d of form one	
INPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-3045	Peri od:	Worksheet D-3	
				From 07/01/2020		
				To 06/30/2021	Date/Time Pre 11/23/2021 10	
		Ti +I	e XIX	Hospi tal	PPS	. 4 i dill
	Cost Center Description	11 (1	Ratio of Cos		Inpati ent	
	Cost Center Description		To Charges	Program	Program Costs	
			10 charges		(col. 1 x col.	
				Charges	2)	
			1.00	2. 00	3. 00	
I NPAT	TIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
	ADULTS & PEDIATRICS			13, 140		30.00
	INTENSIVE CARE UNIT			0		31. 00
	SUBPROVI DER - I RF			0		41.00
	NURSERY			0		43. 00
	LLARY SERVICE COST CENTERS		I.			
	OPERATING ROOM		0.00000	0 0	0	50.00
	RECOVERY ROOM		0. 00000		0	1
	ANESTHESI OLOGY		0. 00000		0	1
	D RADI OLOGY-DI AGNOSTI C		0. 2187		_	
	D RADI OLOGY-THERAPEUTI C		0.00000			1
	RADI OI SOTOPE		0. 12998		0	56.00
	OCT SCAN		0. 16849		0	
58. 00 05800			0. 13522		0	1
	CARDI AC CATHETERI ZATI ON		0. 00000		0	59.00
	DLABORATORY		0. 1711!			1
	WHOLE BLOOD & PACKED RED BLOOD CELL		0. 00000		723	
	BLOOD STORING, PROCESSING, & TRANS.		0.09263		0	63.00
	RESPIRATORY THERAPY		0. 38776			
	D PHYSI CAL THERAPY		0. 37053			
	O OCCUPATIONAL THERAPY		0. 3705.			67. 00
			l .			1
	SPEECH PATHOLOGY		0. 31160			
	ELECTROCARDI OLOGY		0. 08497		0	
	ELECTROENCEPHALOGRAPHY		0. 05986		0	
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 18498		0	1
	IMPL. DEV. CHARGED TO PATIENTS		0.00000		0	
	D DRUGS CHARGED TO PATIENTS		0. 20858			
	RENAL DIALYSIS		0. 44060		0	
	D ASC (NON-DISTINCT PART)		0.00000	00 0	0	75. 00
	ATIENT SERVICE COST CENTERS		T .			
90.00 09000			5. 56123		_	
	D EMERGENCY		0.00000		_	
	OBSERVATION BEDS (NON-DISTINCT PART		0. 00000		0	
200. 00	Total (sum of lines 50 through 94 and 96 through 98)			22, 610	5, 955	200. 00
201. 00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00	Net charges (line 200 minus line 201)			22, 610		202. 00

Health Financial Systems	COMMUNITY STROKE AND I	REHABI LI TATI ON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-3045	Peri od: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/23/2021 10:41 am

			10 00/00/2021	11/23/2021 10	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			1, 598	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		1, 226, 070	2. 00
3.00	OPPS payments		862, 619	3. 00	
4.00	Outlier payment (see instructions)			0	4.00
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructi	one)		0 0. 000	4. 01 5. 00
6. 00	Line 2 times line 5	OIIS)		0.000	6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8. 00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			1, 598	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12 00	Reasonable charges			7 440	12 00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	2 60)		7, 880	12. 00 13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	5 07)		7, 660	14. 00
00	Customary charges			,, 000	
15. 00	Aggregate amount actually collected from patients liable for pay	yment for services on a	charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for patients	payment for services on	a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)				
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00 19. 00	Total customary charges (see instructions)	if line 10 evenede lin	0 11) (000	7, 660	18.00
19.00	Excess of customary charges over reasonable cost (complete only instructions)	IT TIME 18 exceeds IIM	e II) (See	6, 062	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds lin	e 18) (see	0	20. 00
	instructions)		, (_	
21. 00	Lesser of cost or charges (see instructions)			1, 598	
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			862, 619	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	25. 00
26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 2	DA (for CAH see instru	ctions)	179, 091	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu	•	'	685, 126	27. 00
	instructions)			,	
28.00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30. 00	Subtotal (sum of lines 27 through 29)			685, 126	30. 00
31.00	Primary payer payments			119	31.00
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	2)		685, 007	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	5)		0	33. 00
34. 00	Allowable bad debts (see instructions)			8. 630	34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			5, 610	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		7, 952	36. 00
37. 00	Subtotal (see instructions)			690, 617	37. 00
	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced	d dovices (see instruct	i ons)	0	39. 97 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	d devices (see ilistruct	1 0115)	0	39. 96 39. 99
40. 00	Subtotal (see instructions)			690, 617	40. 00
40. 01	Seguestration adjustment (see instructions)			0	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs				40. 03
41.00	Interim payments			685, 080	41.00
41. 01	Interim payments-PARHM				41. 01
42.00	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)			E E27	42. 01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			5, 537	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2 o	hapter 1	0	44. 00
00	§115. 2		- 1 1		50
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90. 00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93. 00 94. 00
74. UU	Total (Suil Of Titles 71 and 75)		ı ı	U	74. UU

(Mo/Day/Yr)

2 00

8.00

Number

1 00

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-3045 Peri od: Worksheet E-1 From 07/01/2020 Part I 06/30/2021 Date/Time Prepared: 11/23/2021 10:41 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 9, 139, 785 685, 080 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 0 3.02 0 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 0 3.51 0 0 3.52 3.52 3.53 0 3.53 0 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 Ω 3.99 3.50-3.98) 9, 139, 785 685, 080 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 152, 986 5, 537 6.01 6 02 SETTLEMENT TO PROGRAM 0 6.02 7.00 Total Medicare program liability (see instructions) 9, 292, 771 690, 617 7.00 NPR Date Contractor

8.00 Name of Contractor

Heal th	Financial Systems COMMUNITY STROKE AND	REHABI LI TATI ON	In Lie	u of Form CMS-	2552-10
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-3045 From 07/01/2020 To 06/30/2021				
		Title XVIII	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	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
4.00	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00
7. 00	7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I				7. 00
8. 00	line 168 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
10.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	(See Thati dell'Olis)			10.00
30 00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31. 00
	Polance due provider (line 0 (or line 10) minus line 20 and l	ine 21) (coo inetruetion)		31.00

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

30. 00 31. 00 32. 00

Health Financial Systems	COMMUNITY STROKE AND	REHABI LI TATI ON	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-3045	Peri od: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part III Date/Time Prepared: 11/23/2021 10:41 am
		T1 11 10 11 1		000

		Title XVIII	Hospi tal	PPS	:41 am_
		II the XVIII	Hospi tal	l PP3	
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
1. 00	Net Federal PPS Payment (see instructions)			8, 610, 431	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0000	2. 00
3. 00	Inpatient Rehabilitation LIP Payments (see instructions)			153, 266	3. 00
4. 00	Outlier Payments			616, 300	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent co to November 15, 2004 (see instructions)	ost reporting period en	ding on or prior	0.00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE country program or hospital closure, that would not be counted without		'	0.00	5. 01
6. 00	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) New Teaching program adjustment. (see instructions)			0.00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	7. 00
7.00	teaching program" (see instructions)	the new program growth p	cirou or a new	0.00	7.00
8. 00	Current year's unweighted I&R FTE count for residents within teaching program" (see instructions)	the new program growth p	eriod of a "new	0. 00	8. 00
9.00	Intern and resident count for IRF PPS medical education adjust	tment (see instructions)		0.00	9. 00
10.00	Average Daily Census (see instructions)			19. 553425	10.00
11. 00	Teaching Adjustment Factor (see instructions)			0.000000	
12.00	Teaching Adjustment (see instructions)			0	12. 00
13.00	Total PPS Payment (see instructions)			9, 379, 997	
14. 00	Nursing and Allied Health Managed Care payments (see instructi	on)		0	14. 00
15. 00	Organ acquisition (DO NOT USE THIS LINE)				15. 00
16. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	16. 00
17. 00	Subtotal (see instructions)			9, 379, 997	17. 00
18. 00	Primary payer payments			0	18. 00
19. 00	Subtotal (line 17 less line 18).			9, 379, 997	19. 00
20. 00	Deducti bl es			47, 984	
21. 00	Subtotal (line 19 minus line 20)			9, 332, 013	
22. 00	Coi nsurance			56, 043	
23. 00	Subtotal (line 21 minus line 22)			9, 275, 970	
24. 00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		25, 848	
25. 00	Adjusted reimbursable bad debts (see instructions)			16, 801	
26. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		22, 680	
27. 00	Subtotal (sum of lines 23 and 25)			9, 292, 771	
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 49)		0	28. 00
29. 00	Other pass through costs (see instructions)			0	29. 00
30. 00	Outlier payments reconciliation			0	30. 00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	31. 50
31. 99	Demonstration payment adjustment amount before sequestration			0	31. 99
32. 00	Total amount payable to the provider (see instructions)			9, 292, 771	32. 00
32. 01	Sequestration adjustment (see instructions)			0	32. 01
32. 02	Demonstration payment adjustment amount after sequestration			0	32. 02
33. 00	Interim payments			9, 139, 785	33. 00
34. 00	Tentative settlement (for contractor use only)			0	34. 00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02			152, 986	
36. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2, (chapter 1,	0	36. 00
	TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			616, 300	
51. 00	Outlier reconciliation adjustment amount (see instructions)			0	51.00
52.00	The rate used to calculate the Time Value of Money			0.00	52. 00
53.00	Time Value of Money (see instructions)			0	53. 00

Health Financial Systems	COMMUNITY STROKE AND REHABILITATION	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3045	Peri od: Worksheet E-3

To 06/30/2021 Date/Time Prepared: 11/23/2021 10:41 am Title XIX Hospi tal PPS Inpati ent Outpati ent 1.00 2.00 PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient hospital/SNF/NF services 1.00 0 2.00 Medical and other services Λ 2.00 3.00 Organ acquisition (certified transplant centers only) 0 3.00 Subtotal (sum of lines 1, 2 and 3) 0 4.00 4.00 Inpatient primary payer payments 5.00 5.00 Outpatient primary payer payments 6.00 Ω 6.00 7.00 Subtotal (line 4 less sum of lines 5 and 6) Ω 7.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 13, 140 8.00 9.00 Ancillary service charges 0 9.00 22, 610 10.00 Organ acquisition charges, net of revenue 10.00 0 Incentive from target amount computation 11 00 11 00 0 12.00 Total reasonable charges (sum of lines 8 through 11) 35, 750 0 12.00 CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge 0 0 13.00 basi s Amounts that would have been realized from patients liable for payment for services on 14.00 0 0 14.00 a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0.000000 0.000000 15.00 16.00 Total customary charges (see instructions) 35, 750 16.00 35, 750 17.00 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 0 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0 18.00 0 (see instructions) 19.00 Interns and Residents (see instructions) 0 0 19.00 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 20.00 21.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 0 21.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers 22.00 0 0 22.00 Other than outlier payments 0 23.00 Outlier payments 23.00 Λ 24.00 Program capital payments 24.00 25.00 Capital exception payments (see instructions) 0 25.00 26.00 26 00 Routine and Ancillary service other pass through costs 0 Subtotal (sum of lines 22 through 26) 27.00 0 27.00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 0 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 0 0 31.00 32.00 Deducti bl es 0 0 0 0 0 0 0 0 0 32.00 0 33 00 Coi nsurance 33 00 0 34.00 Allowable bad debts (see instructions) Λ 34.00 35.00 35.00 Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36, 00 0 36, 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 37.00 0 37.00 38.00 Subtotal (line 36 ± line 37) 0 38.00 Direct graduate medical education payments (from Wkst. E-4) 39.00 39.00 40.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 0 41.00 Interim payments 0 41.00 Balance due provider/program (line 40 minus line 41) 42.00 0 42.00 0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00 43.00

chapter 1, §115.2

Health Financial Systems COMMUNITY STROKE
BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 15-3045

Peri od: From 07/01/2020 To 06/30/2021 Worksheet G Date/Ti me Prepared: 11/23/2021 10:41 am

oni y)			'	10 00/00/2021	11/23/2021 10): 41 am
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1, 000	1	0	0	1
2.00	Temporary investments	0	(0	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	2, 137, 946	1	٥	0	
5.00	Other recei vable	2, 137, 740				
6.00	Allowances for uncollectible notes and accounts receivable	l o		o o	Ö	
7.00	Inventory	59, 651		0	0	7. 00
8.00	Prepai d expenses	115, 053	(0	0	
9.00	Other current assets	809, 421	(1	0	
10.00	Due from other funds	0 100 071		0	0	1
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	3, 123, 071		0	0	11. 00
12. 00	Land	0		0	0	12. 00
13. 00	Land improvements	Ö			Ö	
14.00	Accumulated depreciation	0	(0	0	14. 00
15.00	Bui I di ngs	52, 703, 573	(0	0	
16. 00	Accumulated depreciation	0	1	0	0	1
17. 00	Leasehold improvements	0	(0	0	
18. 00 19. 00	Accumulated depreciation	0		0	0	
20.00	Fixed equipment Accumulated depreciation				0	
21. 00	Automobiles and trucks				0	
22. 00	Accumulated depreciation	Ö	1	o o	Ö	
23. 00	Maj or movable equipment	0	(0	0	23. 00
24. 00	Accumulated depreciation	0		0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	(0	0	
26. 00	Accumul ated depreciation	0	(0	0	
27. 00	HIT designated Assets	0		0	0	1
28. 00 29. 00	Accumulated depreciation Minor equipment-nondepreciable	0		0 0	0	
30.00	Total fixed assets (sum of lines 12-29)	52, 703, 573	1			
30. 00	OTHER ASSETS	32, 703, 373		<u> </u>		30.00
31.00	Investments	0	(0	0	31.00
32.00	Deposits on Leases	0	(0	0	
33. 00	Due from owners/officers	0	(1	0	1
34. 00	Other assets	39, 423	1	1	0	
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	39, 423 55, 866, 067	1	٥ -	0	
30.00	CURRENT LIABILITIES	33, 800, 007		<u> </u>		30.00
37. 00	Accounts payable	57, 122	(0	0	37. 00
38.00	Salaries, wages, and fees payable	804, 396	1	0	0	38. 00
39. 00	Payroll taxes payable	0		0	0	
40. 00	Notes and Loans payable (short term)	0	(0	0	
41.00	Deferred income	0	(0	0	
42. 00 43. 00	Accel erated payments Due to other funds	0	,		О	42. 00 43. 00
44. 00	Other current liabilities	979, 474				
45. 00	Total current liabilities (sum of lines 37 thru 44)	1, 840, 992	l .	o o		
	LONG TERM LIABILITIES	, , , , , ,		-		
46.00	Mortgage payable	0	(٥ -	0	
47. 00	Notes payable	0	•	0		1
48. 00	Unsecured Loans	0	(0	
49. 00	Other long term liabilities	207, 159	l .	0	0	1
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	207, 159 2, 048, 151	1	0 0		
31.00	CAPITAL ACCOUNTS	2,040,131		<u> </u>		31.00
52.00	General fund balance	53, 817, 916				52. 00
53.00	Specific purpose fund					53. 00
54.00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57.00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				١	30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	53, 817, 916		o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	55, 866, 067	1	o o	Ö	
	59)					

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2552-10
Worksheet G-1 COMMUNITY STROKE AND REHABILITATION Peri od: Wo From 07/01/2020 Provider CCN: 15-3045

					To 06/30/2021	Date/Time Pre 11/23/2021 10	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2. 00	3.00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0 0 0	56, 183, 523 2, 602, 198 58, 785, 721 0 58, 785, 721		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	4, 967, 805 0 0 0 0	4, 967, 805 53, 817, 916 Pl ant		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	6.00	7. 00 0 0 0 0	8.00	0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) NET ASSETS TRANSFERRED Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0		0 0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems COMMUNISTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES In Lieu of Form CMS-2552-10 Provider CCN: 15-3045

		-	To 06/30/2021	Date/Time Pre		
	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	9, 892, 40	0	9, 892, 400	1. 00	
2.00	SUBPROVI DER - I PF				2. 00	
3.00	SUBPROVI DER - I RF	1	0	0	3. 00	
4.00	SUBPROVI DER				4. 00	
5.00	Swing bed - SNF	1	0	0	5. 00	
6.00	Swing bed - NF	1	0	0	6. 00	
7. 00	SKILLED NURSING FACILITY				7. 00	
8.00	NURSING FACILITY				8. 00	
9.00	OTHER LONG TERM CARE			0 000 400	9. 00	
10. 00	Total general inpatient care services (sum of lines 1-9)	9, 892, 40	U	9, 892, 400	10. 00	
11 00	Intensive Care Type Inpatient Hospital Services	T .	O .	0	11 00	
11. 00 12. 00	INTENSIVE CARE UNIT	'	0	0	11. 00 12. 00	
12.00	BURN INTENSIVE CARE UNIT				12.00	
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00	
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00	
16. 00	Total intensive care type inpatient hospital services (sum of lines		0	0	16. 00	
10.00	11-15)			0	10.00	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	9, 892, 40	0	9, 892, 400	17. 00	
18. 00	Ancillary services	14, 304, 44	-	14, 304, 445	18. 00	
19. 00	Outpati ent servi ces		33, 367, 445	33, 367, 445		
20. 00	RURAL HEALTH CLINIC	1	0 0	0	20.00	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00	
22. 00	HOME HEALTH AGENCY				22. 00	
23.00	AMBULANCE SERVICES				23. 00	
24.00	CMHC				24. 00	
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00	
26.00	HOSPI CE	(0	0	26. 00	
27. 00	OTHER (SPECIFY)		0	0	27. 00	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	24, 196, 84	5 33, 367, 445	57, 564, 290	28. 00	
	G-3, line 1)					
	PART II - OPERATING EXPENSES		10 505 510			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		18, 585, 519		29. 00	
30.00	ADD (SPECIFY)		0		30.00	
31.00			0		31.00	
32. 00 33. 00			0		32. 00 33. 00	
34. 00			0		34.00	
35. 00			0		35. 00	
36. 00	Total additions (sum of lines 30-35)	'	<u>۱</u>		36. 00	
37. 00	DEDUCT (SPECIFY)		n		37. 00	
38. 00	DEDUCT (SECULT)		0		38. 00	
39. 00			ō		39. 00	
40. 00			o O		40.00	
41. 00			O		41. 00	
42. 00	Total deductions (sum of lines 37-41)		0		42.00	
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		18, 585, 519		43.00	
	to Wkst. G-3, line 4)					

	Financial Systems COMMUNITY STROKE AND REHABILITATION		u of Form CMS-2	2552-10				
STATEN		Peri od: From 07/01/2020	Worksheet G-3					
		To 06/30/2021	Date/Time Pre	nared.				
			11/23/2021 10					
			1. 00					
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)		57, 564, 290	1. 00				
2.00	Less contractual allowances and discounts on patients' accounts		37, 801, 773					
3.00	Net patient revenues (line 1 minus line 2)		19, 762, 517	3. 00				
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		18, 585, 519					
5.00	Net income from service to patients (line 3 minus line 4)		1, 176, 998	5. 00				
	OTHER I NCOME							
6. 00	Contributions, donations, bequests, etc		0	6. 00				
7. 00	Income from investments		416	7. 00				
8.00	Revenues from telephone and other miscellaneous communication services		0					
9.00	Revenue from television and radio service		0					
10. 00			0					
11. 00	·		0					
12. 00	3		0	12. 00				
13. 00	1 · · · · · · · · · · · · · · · · · · ·		0	13. 00				
14. 00	1 3		72, 572					
15. 00	3 1		0					
16. 00			0					
17. 00			0	17. 00				
18.00			0	18. 00				
19. 00			0					
20.00	1		0					
21. 00			0					
22. 00			94, 200					
23. 00	The state of the s		0	23. 00				
24. 00			1, 035					
24. 01	GRANT I NCOME		985, 688					
24. 50			271, 289					
25. 00			1, 425, 200					
26. 00			2, 602, 198					
27. 00			0	27. 00				
28. 00	The same of the sa		0	28. 00				
29. 00	Net income (or loss) for the period (line 26 minus line 28)	l	2, 602, 198	29. 00				