Health Financial Systems COMMUNITY STROK				u of Form CMS-2	552-10				
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)									
payments made since the beginning of the cost reporting period	being dee	med overpayments (42	2 USC 1395g).	OMB NO. 0938-0					
				EXPIRES 03-31-	-2022				
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFIC	ATI ON Pro	ovider CCN: 15-3045	Period: From 07/01/2021	Worksheet S					
AND SETTLEMENT SUMMARY			To 06/30/2022	Parts I-III Date/Time Prep	hared.				
11/22/2022									
PART I - COST REPORT STATUS									
Provider 1. [X] Electronically prepared cost report			Date: 11/22/2	022 Time: 9	:37 am				
use only 2. [ ] Manually prepared cost report									
3.[ 0 ]If this is an amended report enter the r 4.[ F ]Medicare Utilization. Enter "F" for full	umber of t or "L" fa	imes the provider r pr low.	esubmitted this co	ost report					
Contractor 5. [1] Cost Report Status 6. Date Received:			NPR Date:						
use only (1) As Submitted 7. Contractor No.		11. (	Contractor's Vendo	or Code:	. 4				
(2) Settled without Audit 8. [N]Initial Rep (2) Settled with Audit 9. [N]Final Repor	ort for th	nis Provider CCN 12.							
(3) Settled with Addit		S FIOVILLEI CCN	number of tim	es reopened = (	J-9.				
(4) Reopened (5) Amended									
(5) Allerided									
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINI	STRATOR OF	PROVIDER(S)							
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINE	D IN THIS	COST REPORT MAY BE F	PUNISHABLE BY CRIM	NAL, CIVIL AN	D				
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL									
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTL	Y OF A KIC	KBACK OR WERE OTHERW	VISE ILLEGAL, CRIN	NAL, CIVIL AN	D				
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.									
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRA	TOR OF PRO	VVI DER(S)							
I HEREBY CERTIFY that I have read the above certificat									
electronically filed or manually submitted cost report									
Statement of Revenue and Expenses prepared by COMMUNIT									
reporting period beginning 07/01/2021 and ending 06/30									
report and statement are true, correct, complete and p									
accordance with applicable instructions, except as not									
regulations regarding the provision of health care services, and that the services identified in this cost									
report were provided in compliance with such laws and regulations.									
SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		ELECTRONI C						
1	2	SI GI	NATURE STATEMENT						
1		I have read and agr	a with the above	certification	1				

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Mary	/ F. Sudicky	Ŷ	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Mary F. Sudicky			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	96, 100	8, 240	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
200. 00 Total	0	96, 100	8, 240	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.

	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provi c			Period: From 07/01/ To 06/30/	2021 2022	Part I Date/Ti 11/22/2		pare
	1.00	2.00		3.00		2	1.00			
	Hospital and Hospital Health Care Co	mplex Address:								
0	Street: 10215 BROADWAY	PO Box:								1.
0	City: CROWN POINT	State: IN	Zip Cod	e: 46307	Count	y: LAKE				2.
		Component Name	CCN	CBSA	Provi der	Date	Payme	nt Syst	em (P,	
			Number	Number	Туре	Certified		0, or		
							V	XVIII	XIX	1
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	1
	Hospital and Hospital-Based Componen	t Identification:			•	•				
C	Hospi tal	COMMUNITY STROKE AND	153045	23844	5	08/30/2019	Ν	Р	Р	3
		REHABI LI TATI ON								
C	Subprovider - IPF									4
)	Subprovider - IRF									5
)	Subprovider - (Other)			1					1	6
)	Swing Beds - SNF									7
)	Swing Beds - NF									8
)	Hospi tal -Based SNF									9
	Hospi tal -Based NF									10
	Hospital-Based OLTC									11
	Hospital-Based HHA									12
	Separately Certified ASC									13
	Hospi tal -Based Hospi ce									14
	Hospital-Based Health Clinic - RHC									15
	Hospital-Based Health Clinic - FQHC									16
	Hospital-Based (CMHC) I									17
	Renal Dialysis									18
0	Other									19
						From:		То	:	
						1.00		2.0	00	1
0	Cost Reporting Period (mm/dd/yyyy)					07/01/2	021	06/30/	/2022	20
	Type of Control (see instructions)					2				21
						_				
					1.00	2.00		3. (	00	1
	Inpatient PPS Information									
00	Does this facility qualify and is it	currently receiving pa	yments for	·   _	N	N				22
	disproportionate share hospital adjus			2						
	§412.106? In column 1, enter "Y" for									
	facility subject to 42 CFR Section §4		endment							
	hospital?) In column 2, enter "Y" fo	r yes or "N" for no.								
D1	Did this hospital receive interim und				N	N				22
	cost reporting period? Enter in colur	nn 1, "Y" for yes or "N	" for no f	for						
	the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N	0.1								
	reporting period occurring on or afte									
)2	Is this a newly merged hospital that			re	Ν	N				22
•	payments to be determined at cost rep									
	Enter in column 1, "Y" for yes or "N									
	cost reporting period prior to Octobe									
	or "N" for no, for the portion of the									
	October 1.	s soot i opoi tring por ou								
12	Did this hospital receive a geographi	c reclassification fro	m urhan +/	,	Ν	N		Ν		22
	rural as a result of the OMB standard				14	IN IN		IN IN		22
	adopted by CMS in FY2015? Enter in co									
	for the portion of the cost reporting									
	in column 2, "Y" for yes or "N" for i			7						
	reporting period occurring on or after Deep this bespital contain at least									
	Does this hospital contain at least									
	counted in accordance with 42 CFR 412	2. 105)? Enter in Column	i. 3, 1° TC	"						1
	yes or "N" for no.				N					
4	Did this hospital receive a geographi				N	N		N		22
	rural as a result of the revised OMB									
	adopted by CMS in FY 2021? Enter in a									
	for the portion of the cost reporting			er						
	in column 2, "Y" for yes or "N" for ı									
	reporting period occurring on or afte									
	Does this hospital contain at least	100 but not more than 4	99 beds (a	is						
	counted in accordance with 42 CFR 412									
	yes or "N" for no.									
0	Which method is used to determine Med	dicaid days on lines 24	and/or 25	5		3 N				23
	below? In column 1, enter 1 if date of									
				-		1				1
		of identifving the davs	in this o	cost			1			
	if date of discharge. Is the method o	of identifying the days	in this o	cost						

HOSH IAL AND HOSH IAL HEALTH CARE CONFLEX LIBRITIFICATION IDATA       Provider COX: 15-SUB       Iperiod To COV/SU222       Description       Description <thdescription< th="">       Description       De</thdescription<>	Health Financial Systems COMMUNITY S	FROKE AND R	EHABI LI TATI	ON		In Lieu	u of For	m CMS-	2552-10
In State         In State         Out of the ou	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provider CC		)1/2021		eet S-2		
Medicaid         Medicaid         State         Material         Material <t< td=""><td></td><td></td><td></td><td></td><td></td><td>30/2022</td><td></td><td></td><td></td></t<>						30/2022			
Image: 100         2.00         3.00         4.00         5.00         6.00           24.00         If this provider is an IPPS hospital, enter the action state Wellcald paid days in colum 1, in-state back of state Wellcald and sign in colum 1, autor state Wellcald of lighted unpaid days in colum 2, but-of-state Wellcald of lighted unpaid days in colum 3, but-of-state Wellcald and sign in colum 2, but-of-state Wellcald and sign in colum 3, but-of-state Wellcald and sign in colum 3, but-of-state Wellcald and sign in colum 4, Wellcald of lighted unpaid days in colum 4, bedicald of lighted unpaid days in colum 4, but reads and sign in colum 3, but-of-state Wellcald and sign in colum 4, but reads and sign in colum 4, but reads and sign in colum 5, but reads and sign in colum 4, but reads and sign in colum 5, but reads and sign in colum 4, but reads and sign in colum 5, but reads and sign in colum 4, but reads and sign in colum 6, but reads and sin the colum 6, but reads and sind and sign in colum 1, bu		Medi cai d	Medi cai d el i gi bl e unpai d	State Medi cai d	State Medi cai d el i gi bl e		ys Med	di cai d	
in-state Medicaid paid days in column 1, in-state Medicaid and paid days in column 2, court-or-state Medicaid paid days in column 3, court-or-state Medicaid paid days in column 4, Medicaid paid days in column 4, column 5, and other Medicaid days in column 4, Medicaid paid days in column 1, the in-state Medicaid paid days in column 1, our-or-state Medicaid eligible but unpaid days in column 4, Medicaid eligible but unpaid days in column 5, Medicaid eligible but eligible but unpaid days in column 5, Medicaid eligible but unpaid days in column 5, Medicaid eligible but eligible b			2.00		4.00	5.00			
Medical of eligible unpaid days in colum 4. Medical d         Medical and eligible but unpaid days in colum 5.         Uthan/Rural S Dute of Ceorg           26.00         Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1': for urban or '2' for rural.         1         2.00         3.00         1         3.00         1' this is a sole commant by hospital (SOL), enter the number of periods SOL status in of periods in excess of one and enter subsequent dates.         30.00         30.00         2.00         35.00           37.00         If this is a Medicare dependent hospital (MOL), enter the number of periods MOL status         0         37.00         37.01         37.01         37.01         37.01         37.01         37.01         37.01         37.01         37.01         37.01         38.00         37.01         38.00         37.01         38.00         37.01         38.00         38.00         38.00         38.00         38.00         38.00         38.00         38.00         38.00         38.00 <td><ul> <li>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.</li> <li>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,</li> </ul></td> <td>62</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>C</td> <td></td>	<ul> <li>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.</li> <li>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,</li> </ul>	62						C	
Under Your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban or '2' for rural. It applicable.         Under Your standard geographic classification (not wage) status at the end of the cost reporting period. Enter '1' for urban or '2' for rural. It applicable.         Items of the cost reporting period.         2.00           25.00         Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter '1' for urban or '2' for rural. It applicable.         1.00         2.00           35.00         If this is a sole community hospital (SDH), enter the number of periods SCH status in effect in the cost reporting period.         0         36.00           36.00         Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.         0         36.00           37.01         If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status on the form MDH into the form the for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)         38.00           39.00         Dest this facility qualify for the inpatient hospital payment adjustent for low uptic in accordance with 42 CFR 512.101(b)(2)(1). (1). or (11)? For yes or 'N' for no.         N         N         40.00           40.00         Is this in accordance with 42 CFR 512.101(b)(2)(1). (1). (1). or (11)? For yes or 'N' for no.         N         N         40.00           41.00	Medicaid eligible unpaid days in column 4, Medicaid								
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban or '2' for rural.     20.00 Exter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in colum 1, '1' for urban or '2' for rural. If applicable, and the effective date of the geographic classification in colum 2. '1' for urban or '2' for rural.     20.00 If this is a sole community hospital (S01), enter the number of periods S01 status in endine 2.00 effect in the cost reporting period.     20.00 Enter applicable beginning and ending dates or SCH status. Subscript Line 36 for number of periods in excess of one and enter subsequent dates.     30.00 If this is a Medicare dependent hospital (M0N), enter the number of periods MDI status is in effect in the cost reporting period.     31.00 effect in the cost reporting period.     32.00     30.00 If shis hospital a former M0H that is eligible for the MDI transitional payment in accordance with PZ 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see inter subsequent dates.     32.00 Externations).     33.00 If shis facility qualify for the inpatient hospital payment adjustment for low volume N N S 0.00 Externations with PZ 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions).     40.00 'W' for no in colum 1, for discharges prior to clotcher 1. Enter 'Y' for yes or 'N' for no (see instructions).     40.00 'W' for no in cloum 1, for discharges prior to clotcher 1. Enter 'Y' for yes or 'N' for no. N N N 45.00 with the 32.300 (See instructions).     40.00 'W' for no in cloum 1, for discharges prior to clotcher 1. Enter 'Y' for yes or 'N' for no. N N N 45.00 with 32.300 (See instructions).     40.00 'W' for no in cloum 1, for discharges prior to clotcher 1. Enter 'Y' for yes or 'N' for no. N N N 45.00 with 32.300 (See instructions).     40.00 'W' for no in cloum 1, for discharges prior to clotcher 1. Inter 'Y' for yes or 'N' for no. N N N 45.00 with 32.3	HMO paid and eligible but unpaid days in column 5.	<u> </u>			Urban/F	Rural S	Date of	Geogr	
cost réporting period. Enter '1' for urban or '2' for rural.       2	26.00 Enter your standard geographic alossification (at w		at the be-	inning of t	1.				
35.00       If this is a sole community hospital (SCII), enter the number of periods SCII status in perfect in the cost reporting period.       Beginning: Ending: 1.00       35.00         36.00       Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.       0       36.00         37.00       If this is a Medicare dependent hospital (WDH), enter the number of periods WDH status of instructions)       0       37.00         37.01       Is this hospital a former WDH that is eligible for the MDH transitional payment in accordance with FV 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)       38.00         30.01       Filme 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.       Y/N       Y/N       Y/N         39.00       Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(1), (1), or (11)? Enter in colum       N       N       N       40.00         40.00       Is this hospital subject to the MAP program reduction adjustment? Enter "Y" for yes or "N" for no locum 1, for discharges prior to 0ctober 1. Enter "Y" for yes or "N" for no.       N       N       40.00         40.00       Is this hospital under 42 CFR §412.010(b)(2)(1), or (11)? Enter in colum 2 'Y' for yes or "N" for no.       N       N       N       40.00	<ul> <li>cost reporting period. Enter "1" for urban or "2" fo</li> <li>27.00 Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o</li> </ul>	r rural. age) status r "2" for r	at the enc ural. If ap	l of the cos		1			
Image: contract of the sequence of the status is subscript line 36 for number of periods in excess of one and enter subsequent dates.         1.00         2.00           36.00         Fine is a Medicare dependent hospital (MMH), enter the number of periods MDH status is in effect in the cost reporting period.         36.00         37.00           37.01         Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)         37.00         38.00           38.00         If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is grater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.         Y/N         Y/N           39.00         Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR \$412.101(b)(2)(1), (11), or (111)? Enter in column 2 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR \$412.101(b)(2)(1), (11), or (111)? Enter in column 2 "Y" for yes or "N" for no in column 1, for discharges on or after October 1. Enter "Y" for yes or "N" for no in column 1, for discharges on or after October 1. See instructions)         V         XVIII XIX           45.00         Does this facility qualify and receive Capital         Some for extraordinary circumstances no in accordance with 42 CFR \$412.30(b) PS capital         N         N         N         45.00           60.00         Is this hospital under 42 CFR \$412.30(b) PS capital         N	35.00 If this is a sole community hospital (SCH), enter th			CH status ir	1	0			35.00
36.00       Enter applicable beginning and ending dates of SCH status. Subscript I line 36 for number of periods in excess of one and enter subsequent dates.       36.00         37.00       If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is enter the cost reporting period.       37.00         37.01       Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with RY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)       38.00         38.00       If fina 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.       Y/N       Y/N         39.00       Does this facility qualify for the inpatient hospital payment adjustment for low volume N       N       39.00         39.00       Is this hospital subject to the thAC GFR \$412.01(b)(2)(1), (11), or (111)? Enter in column 1       N       N       40.00         1.'' for yes or "N" for no. See instructions)       V       V/N       N       40.00         40.00       Is this hospital subject to the thAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no.       N       N       40.00         41.00       Is this hospital subject to the thAC program reduction adjustment? Enter "Y" for yes or "N" for no.       N       N       45.00         45.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>-</td></t<>									-
37.00       If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is effect in the cost reporting period.       37.01         37.01       Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FV 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)       38.00         38.00       If fina 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.       Y/N       Y/N         39.00       Does this facility qualify for the inpatient hospital payment adjustment for low volume net accordance with 42 CFR 412.101(b) (2(1), (1), or (1) or volume net net accordance with 42 CFR 412.101(b) (2(1), (1), or (1) or volume net net accordance with 42 CFR 412.101(b) (2(1), (1), or (1) or volume net net net accordance with 42 CFR 412.101(b) (2(1), (1), or (1) or volum 2." for yes or "N" for no. lose Instructions)       N       N       40.00         40.00       Is is hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to 0ctober 1. Enter "Y" for yes or "N" for no.       N       N       40.00         45.00       Does this facility qualify and receive Capital payment for disproportionate share in accordance in A2 CFR 42.10(b) (2(1), (1), or volum 2." for yes or "N" for no.       N       N       45.00         45.00       Does this facility qualify and receive Capital payment for disproportionate share in accordance in A2 CFR 42.10(A) (2(1), (1), or volum 2." for yes or "N" for no.			cript line	36 for numb		00	2.1		36.00
37.01       Is this hospital a former M0H that is eligible for the M0H transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)       37.01         38.00       If line 37 is 1, enter the beginning and ending dates of M0H status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.       Y/N       Y/N         39.00       Does this facility qualify for the inpatient hospital payment adjustment for low volume N       N       N         39.00       Does this facility qualify for the inpatient hospital payment adjustment for low volume N       N       N         1.00       2.00       See instructions)       N       N       89.00         40.00       Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no. (see instructions)       N       N       40.00         40.00       Is facility qualify and receive Capital       Is enstructions)       V       XVIII       XIX         45.00       Boes this facility qualify and receive Capital payment exception for extraordinary circumstances N       N       N       N       45.00         46.00       Is this a hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.       N       N       N       47.00         45.00       Is facility qualify and receive Capital payment? Enter "Y" for yes or "N" for no.       N<	37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0							37.00	
38.00       If fine 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.       38.00         39.00       Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(1), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)       N       N       39.00         40.00       Is is hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to 0ctober 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after october 1. (see instructions)       N       N       40.00         45.00       Dest this facility end receive Capital       payment for extraordinary circumstances N       N       N       45.00         46.00       Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.       N       N       A         47.00       Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.       N       N       45.00         48.00       Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.       N       N       46.00         56.00       Is this an entity full federal capital payment? Enter "Y" for yes or "N" for no.       N       N       47.00	37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see							37.01	
39.00       Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(1), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(1), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)       N       N       40.00         40.00       Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 2, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)       V       XVIII       XIX         45.00       Does this facility qualify and receive Capital       Prospective Payment System (PPS)-Capital       N       N       N       45.00         45.00       Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.       N       N       N       46.00         48.00       Is this facility eligible for additional payment? Enter "Y" for yes or "N" for no. N       N       N       47.00         56.00       Is this a new hospital under 42 CFR §412.300(b) PS capital? Enter "Y" for yes or "N" for no. N       N       N       N       48.00         56.00       Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or N" for no in column 1.       S6.00       St this a hospital so	38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o	38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and							38.00
hospitals in accordance with 42 CFR §412.101(b) (2)(i), (ii), or (iii)? Enter in column         1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b) (2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no.         00.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges prior to October 1. (see instructions)       V       X/III       XIX         45.00       Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR §412.320? (see instructions)       N       N       N       45.00         46.00       Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.       N       N       N       46.00         48.00       Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.       N       N       N       47.00         56.00       Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.       N       N       N       48.00         60       Is this a new pospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.       N       N       N       N       <					1.				-
"N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)       V       XVIII       XIX         1.00       2.00       3.00         Prospective Payment System (PPS)-Capital       1.00       2.00       3.00         45.00       Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)       N       N       N       45.00         46.00       Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.       N       N       N       46.00         48.00       Is the facility electing full federal capital payment? Enter "Y for yes or "N" for no.       N       N       N       48.00         Teaching Hospital       Involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes, is this the first cost reporting period/ curing which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", compl	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	), (ii), or the mileage	(iii)? Ent requiremer	er in colum nts in	ทา	l	Ν	1	39.00
1.002.003.00Prospective Payment System (PPS)-Capital45.00Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)NNN45.0046.00Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.NNN46.0047.00Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. Teaching HospitalsNNN47.0056.00Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Teaching HospitalNNN48.0056.00Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs? Enter "Y" for yes or was involved in training residents in approved GME programs requestion? Enter "Y" for yes; otherwise, enter "N" for no in column 2.NSolutionSolution57.00If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Wkst. D. Parts III & IV and D-2, Pt. II, if applicable.Solution SolutionSolution SolutionSolution	"N" for no in column 1, for discharges prior to Octo	ber 1. Ente	r"Y" for y			I	Ν	I	40.00
45.00       Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)       N       N       N       N       45.00         46.00       Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.       N       N       N       N       46.00         47.00       Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.       N       N       N       47.00         48.00       Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.       N       N       N       48.00         56.00       Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital       56.00         57.00       If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. Is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.       58.00       58.00								-	
with 42 CFR Section §412.320? (see instructions)NNN46.0046.00Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.NNN46.0047.00Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. Teaching HospitalsNNNA48.00Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Teaching HospitalsNNNA56.00Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or was involved in training residents in approved GME programs? Enter "Y" for yes or was involved in training residents in approved GME programs repend timate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.57.00S6.00S7.00S7.00S7.00S7.00S6.00 min column 2. If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. Is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2.S7.00S7.00S7.00S7.00S6.00S7.00S7.00S7.00S6.00S6.00S7.00S7.00S6.00S6.00S7.00S7.00S7.00S6.00S7.00S7.00S7.00S6.00S7.00S7.00S7.00S7.00S7.00S7.00<	Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payme	nt for disp	roportionat	e share in	accordance	N	N	N	45.00
Pt. 111.47.00Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.NNN47.0048.00Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.NNN48.00Teaching Hospital s56.00Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or NNN48.0056.00Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or NNS6.00S56.00Is this a nospital involved in training residents in approved GME programs? Enter "Y" for yes or NNSS56.00Is this a new you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.SSS57.00If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.SSS58.00If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.SSS	with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exc	eption for	extraordi na	ary circumst	ances				
Teaching Hospitals       56.00         1s this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or N       N         56.00       "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.       56.00         57.00       If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.       58.00         58.00       If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.       58.00	Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS	capital? E	nter "Y for	yes or "N"	for no.				
<ul> <li>"N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.</li> <li>57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III &amp; IV and D-2, Pt. II, if applicable.</li> <li>58.00 If line 56 is yes, 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.</li> </ul>		<u>t? Enter "</u>	Y" for yes	or "N" for	no.	N	<u> </u> N	N	48.00
57.00       If line 56 is yes, is this the first cost reporting period during which residents in approved       57.00         GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1       1         is "Y" did residents start training in the first month of this cost reporting period? Enter "Y"       57.00         for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.       58.00         58.00       If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.       58.00	"N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction?							56.00	
58.00       If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.       58.00	57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is							57.00	
	58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as							58.00	
				Pt. I.		N			59.00

			D REHABILITATI			u of Form CMS-2	
HOSPI	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	IA	Provider CO		eriod: rom 07/01/2021 o 06/30/2022	Worksheet S-2 Part I Date/Time Pre	
				NAHE 413.85	Worksheet A	11/22/2022 9: Pass-Through	
				Y/N	Line #	Qualification Criterion Code	
		(		1.00	2.00	3.00	
60. 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 col is "Y", are you impacted by CR 11642 (or subsequent C	85? (s umn 1.	see If column 1	N			60.00
	adjustement? Enter "Y" for yes or "N" for no in colu	mn 2. Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61.00
61.01	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						61.01
61. 02	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						61. 02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61.03
61.04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.04
61. 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. 05
61.06	61.04 minus line 61.03). (see instructions) 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)						61.06
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
61 10	Of the FTEs in line (1 OF specify each new program		1.00	2.00	3.00	4.00	41 10
61. 10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded				0. 00		61. 10
	program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
						1.00	
62.00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct	trai nec			od for which		62.00
62. 01	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	Teachi ram. (s	<u>see instructio</u>		your hospital	0.00	62.01
63.00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this co	67. (see instru	uctions)	N	63.00
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No.			1.00 This base year	2.00 is your cost r	3.00 reporting	
64.00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	y trair -primar all nor non-pr columr	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0. 00	0. 000000	64.00

IOSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	TA Provider		eriod: ^om 07/01/2021	Worksheet S-2 Part I	
			Te	06/30/2022	Date/Time Pre 11/22/2022 9:	epared:
	Program Name	Program Code	Unwei ghted	Unweighted	Ratio (col. 3/	1
			FTËs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	nospital	4))	
	1.00	2.00	3.00	4.00	5.00	
5.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care			0.00	0. 00	0. 000000	) 65. C
resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der Si te	Hospi tal	2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Settin				
6.00 Enter in column 1 the number of a FTEs attributable to rotations of Enter in column 2 the number of a FTEs that trained in your hospita (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	ovider settings. Ty care resident the ratio of	0.00 Unweighted FTEs Nonprovider Site 3.00	0.00 Unweighted FTEs in Hospital 4.00	0.000000 Ratio (col. 3/ (col. 3 + col. 4)) 5.00	/
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4) (see instructions)			0.00			) 67.0
4)). (see instructions)		I				
Inpatient Psychiatric Facility P	ps			1.00	0 2.00 3.00	
0.00 Is this facility an Inpatient Ps	/chiatric Facility (I	PF), or does it con	tain an IPF subp	rovi der? N		70.0
Enter "Y" for yes or "N" for no. 1.00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFI Column 3: If column 2 is Y, indic (see instructions)	the facility have ar afore November 15, 20 umn 2: Did this faci & 412.424 (d)(1)(iii) cate which program ye	004? Enter "Y" for lity train resident (D)? Enter "Y" for	yes or "N" for r s in a new teach yes or "N" for r	io. (see ii ng io.	0	71.0
5.00 Is this facility an Inpatient Rel	nabilitation Facility	(IRF), or does it	contain an IRF	Y		75.0
subprovider? Enter "Y" for yes a 6.00 If line 75 is yes: Column 1: Did recent cost reporting period endi no. Column 2: Did this facility	and "N" for no. the facility have ar ng on or before Nove	approved GME teach ember 15, 2004? Ente	ing program in t r "Y" for yes or	"N" for	N O	76. 0

Image: Second			eriod: rom 07/01/2021	u of Form CMS- Worksheet S-2 Part I	
Book of a this is into generate hespital (CDI)? Enter "Y" for yos and "N" for no.         N         80.00           00 is this a LIDE colocated within another hespital for part or all of the cost reperting period? Enter N         N         80.00           01 00 is this a new hespital under 42 CR Section §413.40(f)(1)(1) EEA/2 Enter "Y" for yes or "N" for no.         N         85.00           02 00 is this facility establish a new three subground (CRU) deviated and inder 42 CR Section §413.40(f)(1)(1)? EEA/2 Enter "Y" for yes or "N" for no.         N         85.00           03 00 is this facility hexated is deset care hespital classified under section N         N         87.00         N           04 00 for Sin Facility hexate VIII e V and/or XIX inpotent hespital services? Enter "Y" for N         N         Y         90.00           05 00 for Sin Facility hexate VIII e V and/or XIX inpotent hespital services? Enter "Y" for N         N         Y         90.00           90.00 fors Sin Facility hexate VIII e V and/or XIX inpotent hespital services? Enter "Y" for N         N         Y         90.00           91.00 fors This facility hexate VIII e V and/or XIX inpotent hespital services? Enter "Y" for N         N         Y         90.00           92.00 fors this facility operate an IC//1B facility for purpose of this e van XIX? Enter N         N         91.00           92.00 fors this VI and VIX Services         N         92.00         0.00         0.00         0.00					
Book of a this is into generate hespital (CDI)? Enter "Y" for yos and "N" for no.         N         80.00           00 is this a LIDE colocated within another hespital for part or all of the cost reperting period? Enter N         N         80.00           01 00 is this a new hespital under 42 CR Section §413.40(f)(1)(1) EEA/2 Enter "Y" for yes or "N" for no.         N         85.00           02 00 is this facility establish a new three subground (CRU) deviated and inder 42 CR Section §413.40(f)(1)(1)? EEA/2 Enter "Y" for yes or "N" for no.         N         85.00           03 00 is this facility hexated is deset care hespital classified under section N         N         87.00         N           04 00 for Sin Facility hexate VIII e V and/or XIX inpotent hespital services? Enter "Y" for N         N         Y         90.00           05 00 for Sin Facility hexate VIII e V and/or XIX inpotent hespital services? Enter "Y" for N         N         Y         90.00           90.00 fors Sin Facility hexate VIII e V and/or XIX inpotent hespital services? Enter "Y" for N         N         Y         90.00           91.00 fors This facility hexate VIII e V and/or XIX inpotent hespital services? Enter "Y" for N         N         Y         90.00           92.00 fors this facility operate an IC//1B facility for purpose of this e van XIX? Enter N         N         91.00           92.00 fors this VI and VIX Services         N         92.00         0.00         0.00         0.00				1.00	-
01:00         15: this a LTGE co-located within another hospital for part or all of the cost reporting period? Enter         N         61:00           09: 00         TegMA Providers         16:00	<u> </u>				80.00
85.00       is this a new hospital under 42 GR Section \$413.40(2(1)(1) IFEAP Enter 'V' for yes or 'N' for no.       85.00         80.01       bit shish is an exitended negliastic di seasi care hospital classified under section       N       85.00         913.40(7(1)(1)?       Enter 'V' for yes or 'N' for no.       N       87.00         913.40(7(1)(1)?       Enter 'V' for yes or 'N' for no.       N       87.00         90.00       Dist this facility pave title V and/or XIX inpatient hospital services? Enter 'V' for yes or 'N' for no in the applicable colum.       N       Y         90.00       Does this facility pave title V and/or XIX inpatient hospital services? Enter 'V' for on in the applicable colum.       N       Y         90.00       Does this facility pave title V and/or XIX inpatient hospital services? Enter 'N' for on in the applicable colum.       N       Y         90.00       Does this facility operate an IG//ID facility for purposes of title V and XIX? Enter 'N' for no in the applicable colum.       N       9         91.00       Does this facility correcting cost? Enter 'N' for yes or 'N' for no in the applicable colum.       N       9         92.00       Does this facility correctities (this Will) SM beds, dual cartification?       N       N       9         92.00       Does this facility correctification (for no in the applicable colum.       N       N       9       0         93.0		Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	period? Enter		1
66.00       Did this facility establish a new Other subprovider (excluded unit) under 42 CR8 Section S413.40(1)(10)(12) Fatter "Y for yes and "K forn no.       86.00       87.00       Fitter "Y for yes and "K forn no.       87.00       87.	85.00		or "N" for no.	N	85.00
87.00       Sta this hospitial an extended meepfastic disease care hospital classified under section 1986(6)(1)(6)(0)(2) For Yos or 'N' for no in Control 1000 (2)(0)(1)(2)(0)(2) (2) (2) (2) (2) (2) (2) (2) (2) (2)		Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section			86.00
It He V and XIX Services         1.00         2.00           90.00 Does this facility have title V and/ar XIX inputient hospital services? Enter "Y" for yes or "N" for no in the applicable colum.         N         Y         90.00           91.00 Is this hospital relimbursed for Uitle V and/ar XIX through the cost report either in Tull or in party Enter "Y" for yes or "N" for no in the applicable colum.         N         Y         90.00           92.00 Des this facility poprate an ICF/ID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable colum.         N         92.00           93.00 Des this facility poprate an ICF/ID facility for tyre grups and "N" for no in the applicable colum.         0.00         0.00         92.00           94.00 Des title V or XIX reduce capital cast? Enter "Y" for yes or "N" for no in the applicable colum.         0.00         0.00         92.00           95.00 If line 96 is "Y", enter the reduction percentage in the applicable colum.         0.00         0.00         92.00           96.00 If line 96 is "Y", enter the reduction percentage in the applicable colum.         0.00         0.00         92.00           97.00 IF line 96 is "Y", enter the reduction percentage in the applicable colum.         0.00         0.00         92.00           97.00 IF line 96 is "Y", enter the reduction percentage in the applicable colum.         0.00         0.00         92.00           98.00 Does title V or XIX follow Medicare (Itle XVIII	87.00	Is this hospital an extended neoplastic disease care hospital classified under section			87.00
Title V and XX Services       90.00         000000000000000000000000000000000000			-		-
yes or "N" for no in the applicable colum.         N         91.00           100         Is this hospital relativences dot fille V and/or XIX through the cost report either in full or in part2 Enter "V" for yes or "N" for no in the applicable colum.         N         91.00           200         Are title XIX M patients accupying title XVIII SME beds (dual certification)? (see instructions) Enter "V" for yes or "N" for no in the applicable colum.         N         92.00           94.00         Does title XIX M patients accupying title XVIII SME beds (dual certification)? (see instructions)         N         93.00           94.00         Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable colum.         0.00         0.00         95.00           95.00         If end is "", enter the reduction percentage in the applicable colum.         0.00         0.00         96.00           96.01         If in e9 is "", enter the reduction percentage in the applicable colum.         0.00         0.00         96.00           96.01         Does title V or XIX follow Medicare (title XVIII) for the Interns and residents post state on the applicable colum.         0.00         0.00         96.00           98.01         Does title V or XIX follow Medicare (title XVIII) for the calculation of observation N         N         98.01           98.02         Des title V and In columa 2 for title XIX.         Premibursed 1018 of inpatient services cost? There "Y" fo					
rull or in part? Enter "Y" for yes or "N" for no in the applicable column.       92.00         20.00 Kre title XIX.M partial ents occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.       N       92.00         30.00 boes title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.       N       94.00         40.00 boes title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.       0.000       0.000       95.00         50.00 boes title V or XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column.       0.000       0.00       95.00         60.00 boes title V or XIX follow Medicare (title XVIII) for the interns and residents post N       N       98.00         91.00 boes title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst.       N       Y       98.01         92.00 boes title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N       N       98.02         92.01 boes title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N       N       98.03         92.02 boes title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N       N       98.03         92.02 boes title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N       N       98.03         92.04 boes title V or XIX follow Medicare (title	90.00		N	Y	90.00
92.00       Are title XIX WF patients occupying title XVIII SWF beds (dual certification)? (see Instructions). Enter "Y" for yes or "N" for no in the applicable column.       N       92.00         93.00       Does this facility operate an ICF/ID facility for purposes of title V and XIX? Enter N       N       N       93.00         94.00       Does this facility operate an ICF/ID facility for purposes of title V and XIX? Enter N       N       N       93.00         95.00       IF line 94 is "Y", enter the reduction percentage in the applicable column.       0.00       0.00       0.00       95.00         96.00       If us the V at XX reduce operating cost? Enter "Y" for yes or "N" for no in the P4 is or "X Follow Medicare (title XVIII) for the resporting of theres idents post N       N       98.00         97.00       If the V at XX follow Medicare (title XVIII) for the reporting of charges on WKst.       0.00       97.00         98.01       Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst.       N       Y       98.01         98.01       Does title V or XIX follow Medicare (title XVIII) for a citle access hospital (CAH)       N       Y       98.02         98.02       Does title V or XIX follow Medicare (title XVIII) for a cAH reinbursed 101% of no in column 1       N       Y       98.02         98.03       Does title V or XIX follow Medicare (title XVIII) for a CAH reinbursed 101% of no in colu	91.00		Ν	Ν	91.00
93.00 boes this facility operate an ICF/IID facility for purposes of title V and XIX? Enter       N       N       93.00         94.00 boes title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.       N       N       94.00         95.00 IF line 94 is "Y", enter the reduction percentage in the applicable column.       0.00       0.00       0.00       95.00         96.00 boes title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.       0.00       0.00       97.00         97.00 IF line 94 is "Y", enter the reduction percentage in the applicable colum.       0.00       0.00       97.00         98.01 boes title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the interns and residents post is the down adjustments on Wst. Bt. Pt. 1, col. 257. Enter "Y" for yes or "N" for no in the respecting of charges on Wst.       N       N       98.01         98.01 boes title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wst.       N       Y       98.01         98.01 boes title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) no no in column 1 for title XIX.       N       Y       98.01         98.01 boes title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) no no no column 1 for title XIX.       N       N       Y       98.03         98.02 boes title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) no no no column	92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		Ν	92.00
94.00       Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.       N       N       94.00         95.00       If line 94 is "Y", enter the reduction percentage in the applicable column.       0.00       0.00       95.00         90.00       Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.       0.00       0.00       0.00       0.00       95.00         90.01       File 94 is "Y", enter the reduction percentage in the applicable column.       0.00       0.00       0.00       0.00       97.00         91.01       File 94 is "Y", enter the reduction percentage in the applicable column.       0.00       0.00       97.00         92.01       Dest title V or XIX follow Medicare (title XVIII) for the interns and residents post stapdown adjustments on Wkst.       N       N       98.00         92.02       Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst.       N       Y       98.01         92.02       Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH)       N       N       98.02         93.02       Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH)       N       N       98.03         94.03       Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH)       <	93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	N	Ν	93.00
applicable colum.       0.00       0.00       0.00       0.00       0.00       95.00         96.00       Destitle V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable colum.       0.00       0.00       95.00         97.00       If line 96 is "V", enter the reduction percentage in the applicable colum.       0.00       0.00       97.00         98.00       Does title V or XIX follow Medicare (title XVIII) for the interns and residents post N       N       N       98.00         98.01       Tor title V, and in colum 2 for title XXI.       N       Y       98.01         98.02       Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst.       N       Y       98.01         98.02       Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 897 Enter "Y" for yes or "N" for no in column 1 for title V, and in colum 2 for title XXI.       N       Y       98.02         98.03       Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N       N       N       98.03         98.04       Does title V or XIX follow Medicare (title XVIII) for a cluma 1 for title V, and in column 2 for title XX.       N       N       98.04         98.05       Does title V or XIX follow Medicare (title XVIII) for a columa 1 for title V, and in columa 1 for title XX.       N	94.00		N	Ν	94.00
96.00       Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.       N       N       96.00         97.00       If line 96 is "Y", enter the reduction percentage in the applicable column.       0.00       0.00       97.00         98.00       Does title V or XIX follow Medicare (title XVIII) for the interns and residents post in column 1 for title V, and in column 2 for title XIX.       0.00       N       N       98.00         98.01       Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on West.       N       Y       98.01         C, PL, I? Enter "Y" for yes or "N" for no in column 1 for title XX.       N       Y       98.01         98.02       Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on West. D-1, Pt. IV. line 897 Enter "Y" for yes or "N" for no in column 1 for title X.       N       Y       98.02         98.03       Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N       N       98.03         98.04       Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N       N       98.03         98.05       Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N       N       98.04         98.05       Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N       N       98.04		applicable column.			
97.00       I <sup>2</sup> line 96 is "Y", enter the reduction percentage in the applicable column.       0.00       0		Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the			
stepdown adjustments on Wkst. B, Pt. 1, col. 25? Enter "Y" for yes or "N" for no in col unn 1 for title V.X.       Ps. 01         98. 01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C. Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V. and in column 2 for title XIX.       N       Y       98. 01         98. 02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1. Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       Y       98. 03         98. 03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) no vix for on XIX follow Medicare (title XVIII) for a critical access hospital (CAH) no vix for on XIX follow Medicare (title XVIII) for a CH reimbursed 101% of no und 1 column 2 for title XIX.       N       N       98. 03         98. 04 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C. Pt. 1, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       N       98. 05         98. 05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. 0, Pt. 1, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       N       98. 05         98. 06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. 0, Pt. 1, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       N       98. 06         01	97.00	The second	0.00	0.00	97.00
column 1 for title V, and in column 2 for title XIX.       98.01       Over XIX follow Medicare (title XVIII) for the reporting of charges on Wkst.       N       Y       98.01         c, Pt. 17: Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       Y       98.02         20 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       Y       98.02         20 a Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reinbursed 10% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       N       98.03         20.40 Does title V or XIX follow Medicare (title XVIII) for a CAH reinbursed 10% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       N       98.04         98.04 Does title V or XIX follow Medicare (title XVIII) and adb back the RCE disallowance on N       Y       98.05         98.05 Does title V or XIX follow Medicare (title XVIII) when cost reinbursed for Wkst. D, N       N       N       98.06         98.05 Does title V or XIX follow Medicare (title XVIII) when cost reinbursed for Wkst. D, N       N       N       98.06         98.06 Does thite hospital qualify as a CAH?       N       N       N       105.00       N	98.00		N	Ν	98.00
C. Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       98.02         98.02       Does title V or XIX follow Medicare (title XVIII) for the calculation of observation for no in column 1 for title V, and in column 2 for title XIX.       N       Y       96.02         98.03       Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) no in column 1 for title V, and in column 2 for title XIX.       N       N       98.03         98.04       Dest title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of upptient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       N       98.04         98.04       Dest title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of upptient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       N       98.04         98.05       Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on W Wkst. C, Pt. 1, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       N       98.05         98.06       Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, N       N       N       98.06         06       Does title XIX.       N       N       N       N       98.06         05.00       Does this hospital qualify as a CAH?       N	00.01	column 1 for title V, and in column 2 for title XIX.	, N	X	00.01
98.02       Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV. line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XII.       N       Y       98.02         98.03       Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N       N       N       98.03         98.04       Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of N       N       N       98.03         98.04       Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of N       N       N       98.04         98.05       Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       N       98.05         98.05       Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       N       98.05         98.06       Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pt. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       N       N       98.06         98.06       Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pt. I through IV? Enter "Y" for yes or "N" for no in column 1 for titl	98.01	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for	N	Ŷ	98.01
for title V, and in column 2 for title XIX.       98.03         98.03       Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) N       N       98.03         98.04       Dees title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of no column 1 for title V, and in column 2 for title XIX.       N       98.03         98.05       Dees 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 V, and in column 2 for title XIX.       N       98.04         98.05       Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       98.05         98.06       Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, N       N       N       98.06         98.05       Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, N       N       N       98.06         98.06       Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, N       N       N       98.06         001 pt title XIX.       Rural Providers       N       N       105.00       106.00         105.00 Does this hospital qualify as a CAH?       In column 1: (see instructions)       N       106.00       106.00       106.00	98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation	Y	98.02	
reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 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 V, and in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pt. I through I/V? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does this hospital qualify as a CAH? 105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions) Column 1: If line 105 is Y. is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and Ine 70 or 11ne 75 is Y. do you train I&Rs in an 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) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N CFR Section §412.113(c). Enter "Y" for yes or "N" for no. 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 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 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 If this hospital qualifies as	08 03	for title V, and in column 2 for title XIX.	N	N	08 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 V, and in column 2 for title XIX.       N       N       98.04         98.05       Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on WKSt. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       Y       98.05         98.05       Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       N       98.06         98.06       Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       N       98.06         105.00       Does this hospital qualify as a CAH?       N       N       105.00         106.00 If this facility gualifies as a CAH, has it elected the all-inclusive method of payment for or outpatient services? (see instructions)       N       106.00         107.00       Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for 1&R raining programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)       N       107.00         108.00       Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	70.00	reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1		i v	70.05
in column 2 for title XIX.       98.05       Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on MkSt. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       Y       98.05         98.05       Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       N       98.06         98.05       Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       N       98.06         90.05       Does this hospital qualify as a CAH?       N       N       N       105.00         105.00       Does this hospital qualify as a CAH?       N       106.00       106.00       106.00         105.00       Does this hospital qualify as a CAH?       N       107.00       108.00       107.00         106.00       If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for approvement or 18R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)       107.00       106.00         107.00       Immedical education program in the CAH's excluded IPF and/or IRF unit(s)?       N       108.00       108.00         108.01       Sthis a rural hospital qualifying for	98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of	N	Ν	98.04
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       98.06       Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       N       98.06         05.00       Does title vor XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       N       98.06         105.00       Does this hospital qualify as a CAH?       N       105.00       106.00         106.00       If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)       106.00       106.00         107.00       Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)       107.00       107.00         Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?       108.00       108.00       108.00       108.00       108.00       108.00       108.00       108.00       108.00       108.00       108.00       108.00       108.00       109.00       109.00       109.00       109.00       109.00       109.00       109.00       109.00	09 05	in column 2 for title XIX.	Ν	V	09.05
98.06       Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.       N       N       98.06         Mural Providers       Rural Providers       N       N       105.00         106.00 Des this hospital qualify as a CAH?       N       105.00       N       105.00         106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)       N       105.00         107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)       107.00         Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an 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)       108.00       108.00       Speech       Respiratory         108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42       N       108.00       108.00       109.00	70. UJ	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in	IN IN	I	90.05
column 2 for title XIX.       Rural Providers         105. 00 Does this hospital qualify as a CAH?       N         106. 00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)       N       105. 00         107. 00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for 1&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)       N       107. 00         Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train 1&Rs in an approved medical education program in the CAH's excluded IPF and/or 1RF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)       N       108. 00         108. 00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N       N       108. 00         109. 00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"       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"       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"       1.00       1.00       1.00	98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,	N	Ν	98.06
105.00       Does this hospital qualify as a CAH?       N       105.00         106.00       If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)       106.00       106.00         107.00       Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)       107.00       107.00         Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an 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)       108.00       108.00         108.00       Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N       N       108.00         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.       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       109.00		column 2 for title XIX.			
for outpatient services? (see instructions)       107.00       108.00       107.00       108.00       109.00       109.00       109.00       109.00       109.00       109.00       109.00       109.00       109.00       109.00 <t< td=""><td></td><td>Does this hospital qualify as a CAH?</td><td>N</td><td></td><td></td></t<>		Does this hospital qualify as a CAH?	N		
training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)       Image: column 1 is Y and line 70 or line 75 is Y, do you train l&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?       Image: column 1 is Y and line 70 or line 75 is Y, do you train l&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?       Image: column 1 is Y and line 70 or line 75 is Y, do you train l&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?       Image: column 1 is Y and line 70 or line 75 is Y, do you train l&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?       Image: column 1 is Y and line 70 or line 75 is Y, do you train l&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?       Image: column 1 is Y and line 70 or line 75 is Y, do you train l&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?       Image: column 1 is Y and line 70 or line 75 is Y, do you train l&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?       Image: column 1 is Y and line 70 or line 75 is Y, do you train l&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?       Image: column 1 is Y and line 70 or line 75 is Y. do you train l&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?       Image: column 1 is Y and line 70 or line 75 is Y. do you train l&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?       Image: column 1 is Y and line 70 or line 75 is Y. do you train l&Rs in an approximate training training training training training training training transistent and trainit and training transistent and transit and tra	106.00				106.00
Column 2:       If column 1 is Y and line 70 or line 75 is Y, do you train 1&Rs in an approved medical education program in the CAH's excluded 1PF and/or 1RF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)       108.00       109.00       109.00       1.00       2.00       3.00       4.00       108.00       109.00       109.00       109.00       109.00       109.00       109.00       1.00       2.00       3.00       4.00       109.00       1.00 <t< td=""><td>107.00</td><td></td><td></td><td></td><td>107.00</td></t<>	107.00				107.00
Enter "Y" for yes or "N" for no in column 2. (see instructions)       108.00       109.00       100.00       100.00       100.00       100.00       100.00       100.00       100.00       100.00       100.00       100.00       100.00		Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an			
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.       Physical       Occupational       Speech       Respiratory         109.00       If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"       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"       1.00       1.00       1.00       1.00       1.00       1.00					
Physical     Occupational     Speech     Respiratory       109.00     If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"     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"     1.00     1.00     1.00	108.00		N		108.00
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       109.00         Image: therapy services provided by outside supplier? Enter "Y"       Image: therapy services provided by outside supplier? Enter "Y"       109.00         Image: therapy services provided by outside supplier? Enter "Y"       Image: therapy services provided by outside supplier?       109.00         Image: therapy services provided by outside supplier?       Image: therapy services provided by outside supplier?       109.00         Image: therapy services provided by outside supplier?       Image: therapy services provided by outside supplier?       109.00         Image: therapy services provided by outside supplier?       Image: therapy services provided by outside supplier?       109.00         Image: therapy services provided by outside supplier?       Image: therapy services provided by outside supplier?       109.00         Image: therapy services provided by outside supplier?       Image: therapy services provided by outside supplier?       109.00         Image: therapy services provided by outside supplier?       Image: therapy services provided by outside supplier?       109.00         Image: therapy services provided by outside supplier?       Image: therapy services provided by outside supplier?       109.00         Image: therapy services provided by outside supplices provided by outside supplier?       Image: therapy ser		Physical Occupational			_
for yes or "N" for no for each therapy.	109.00	If this hospital qualifies as a CAH or a cost provider, are	3.00	4.00	109.00
				1.00	-
Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,	110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§4 Demonstration) for the current cost reporting period? Enter "V" for yes or "N" for po		N	110.00
complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 throug			

leal th Financial Systems COMMUNITY STROKE AND HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC		Peri od:	u of Form CMS Worksheet S-	
			From 07/01/2021 To 06/30/2022	Part I	epared:
			1.00		_
11.00 If this facility qualifies as a CAH, did it participate in th Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting p umn 1 is Y, e icipating in	period? Enter enter the column 2.	1.00 N	2.00	111.00
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Healt demonstration for any portion of the current cost reporting p Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceas participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	oeriod? "Y", enter e	N			112.00
<ul> <li>15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93 for short term hospital or "98" percent for long term care (i psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub. 15-1, chapter 22, §2208.1.</li> </ul>	or E only) 3" percent ncludes	N			0115.00
<pre>I16.00 Is this facility classified as a referral center? Enter "Y" f</pre>	for yes or	N			116. 00
17.00  s this facility legally-required to carry malpractice insura "Y" for yes or "N" for no.	nce? Enter	Y			117.00
18.00 Is the malpractice insurance a claims-made or occurrence poli			1		118.00
if the policy is claim-made. Enter 2 if the policy is occurre	ince.	Premi ums	Losses	Insurance	
		1.00	2.00	3.00	-
18.01 List amounts of malpractice premiums and paid losses:			1 (		0118.0
			1.00	2.00	_
<ol> <li>18.02 Are malpractice premiums and paid losses reported in a cost c Administrative and General? If yes, submit supporting schedu and amounts contained therein.</li> <li>19.00 DO NOT USE THIS LINE</li> </ol>			N		118.0
20.001s this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" lifies for th	' for yes or ne Outpatient		N	120. 0
21.00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no.	ntable devices	s charged to	N		121.0
22.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.					122. 0
Transplant Center Information 25.00Does this facility operate a transplant center? Enter "Y" for	yes and "N"	for no. If	N		125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, ent		fication date	2		126. 0
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, ente	er the certifi	cation date			127.0
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter on a column 1 and termination date, if applicable, in column 2	er the certifi	cation date			128. 0
in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter		cation date i	n		129. 0
column 1 and termination date, if applicable, in column 2. 30.001f this is a Medicare certified pancreas transplant center, e			130. 0		
			131.0		
					132.0
31.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colu 32.00 If this is a Medicare certified islet transplant center, enter	mn 2. er the certifi	cation date			152.0
31.00 If this is a Medicare certified intestinal transplant center,	mn 2. er the certifi				133. 0 134. 0

Health Financial Systems	COMMUNITY STROKE AN	ID REHABILITATIO	ON		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	ENTIFICATION DATA	Provider CC	N: 15-3045	From	d: 07/01/2021 06/30/2022	Worksheet S-2 Part I Date/Time Pre	pared:
1.00	2.0	0			3.00	11/22/2022 9:	37 am
If this facility is part of a chain or home office and enter the home office of	ganization, enter on I	lines 141 throu		e name a		of the	
	Contractor's Name: WP			actor's M	lumber: 0800	1	141.00
142.00 Street: 10010 DONALD S POWERS DRIVE STE 201	PO Box:						142.00
143.00 City: MUNSTER	State: IN		Zip Co	ode:	4632	1	143.00
						1.00	111.00
144.00 Are provider based physicians' costs in	nciuded in worksheet A	A ?				Y	144.00
145 00 15 agets for rend corrigon are algiment	d on What A line 74	and the easts	for		1.00 Y	2.00	145.00
145.00 If costs for renal services are claimed inpatient services only? Enter "Y" for no, does the dialysis facility include period? Enter "Y" for yes or "N" for r	yes or "N" for no in Medicare utilization	column 1. If c	olumn 1 is		ř		145.00
146.00 Has the cost allocation methodology cha Enter "Y" for yes or "N" for no in colu yes, enter the approval date (mm/dd/yyy	umn 1. (See CMS Pub. 1			lf	N		146.00
						1.00	
147.00 Was there a change in the statistical k 148.00 Was there a change in the order of allo						N	147.00 148.00
149.00 Was there a change to the simplified co		nter "Y" for ye	s or "N"			Ν	149.00
		Part A 1.00	Part 2.00		Title V 3.00	Title XIX 4.00	-
Does this facility contain a provider or charges? Enter "Y" for yes or "N" fo		exemption from	the appl	ication	of the lowe	r of costs	
155.00 Hospi tal		N	N		N	N	155.00
156.00 Subprovider - IPF 157.00 Subprovider - IRF		N N	N N		N N	N	156.00 157.00
158. 00 SUBPROVI DER		IN .	IN		IN	IN IN	158.00
159.00 SNF		N	Ν		Ν	Ν	159.00
160.00HOME HEALTH AGENCY 161.00CMHC		N	N N		N N	N	160.00 161.00
					14	1.00	101.00
Multicampus							
165.00 Is this hospital part of a Multicampus Enter "Y" for yes or "N" for no.		•				N	165.00
	Name O	County 1.00	State 2.00	Zip Code 3.00	e CBSA 4.00	FTE/Campus 5.00	-
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. 00	166.00
	continue in the A	an Dogerse	Doint	mont A .		1.00	
Health Information Technology (HIT) ind 167.00 Is this provider a meaningful user unde 168.00 If this provider is a CAH (line 105 is	er §1886(n)? Enter "\ "Y") and is a meaning	(" for yes or " gful user (line	N" for no			Y	167. 00 168. 00
reasonable cost incurred for the HIT as 168.01 If this provider is a CAH and is not a exception under §413.70(a)(6)(ii)? Enter	meaningful user, does	s this provider			rdshi p		168. 01
169.00 If this provider is a meaningful user ( transition factor. (see instructions)					enter the	9.99	169. 00
				E	egi nni ng 1. 00	Endi ng 2. 00	-
170.00 Enter in columns 1 and 2 the EHR beginn period respectively (mm/dd/yyyy)	ning date and ending o	date for the re	porting		1.00	2.00	170.00
					1.00	2.00	
171.00 If line 167 is "Y", does this provider section 1876 Medicare cost plans report "Y" for yes and "N" for no in column 1. 1876 Medicare days in column 2. (see in	ted on Wkst. S-3, Pt. If column 1 is yes,	I, line 2, col	. 6? Ente		Ν	0	171.00

	Financial Systems COMMUNITY STROKE A AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	ND REHABILITATI Provider C		In Lie Period:	eu of Form CMS Worksheet S-	
105111	AL AND HOST THE HEALTH CARE RELINDURSEMENT QUESTIONNALIRE	TTOWIGET C	CN. 13-3043	From 07/01/2021 To 06/30/2022	Part II Date/Time Pr	epared:
				Y/N	11/22/2022 9 Date	:37 am
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	l for all NO re	esponses. Ente	er all dates in t	the	-
	Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a	e beginning of column 2. (see	the cost instructions)	N		1.00
			Y/N	Date	V/I	_
2.00	Has the provider terminated participation in the Medicare F	Program? If	1.00 N	2.00	3.00	2.00
2.00	yes, enter in column 2 the date of termination and in colur					2.00
2.00	voluntary or "I" for involuntary.					2.00
3.00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of		N			3.00
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members (					
	of directors through ownership, control, or family and other relationships? (see instructions)	er similar				
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					1 1 00
	Column 1: Were the financial statements prepared by a Cerr Accountant? Column 2: If yes, enter "A" for Audited, "C" to		Y	A		4.00
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
5.00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit red		N			5.00
				Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2. If yos is	the provider	~ N	1	6.00
0.00	is the legal operator of the program?	z. II yes, Is	s the provider	IN		0.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		Ν		7.00
8.00	Were nursing programs and/or allied health programs approve	ed and/or renew	ved during the	e N		8.00
9.00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	graduate medic	al education	N		9.00
	program in the current cost report? If yes, see instruction	is.				7.00
10.00	Was an approved Intern and Resident GME program initiated of	or renewed in t	the current	Ν		10.00
	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	& Rin an Ann	proved	N		11.00
11.00	Teaching Program on Worksheet A? If yes, see instructions.		n oved	i v		11.00
					Y/N	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes	s, see instruct	tions.		Y	12.00
	If line 12 is yes, did the provider's bad debt collection p			ost reporting	N	13.00
14 00	period? If yes, submit copy.	ante waiwod2 lf		structions	N	11 00
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents warveu? II	yes, see ms		N	14.00
	Did total beds available change from the prior cost reporti	ng period? If	yes, see inst	tructions.	Y	15.00
			rt A		T B	
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
	PS&R Data		2.00	0100		
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	N		N		16.00
17.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Y	09/27/2022	Y	09/27/2022	17.00
	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					1
18.00	If line 16 or 17 is yes, were adjustments made to PS&R	N		Ν		18.00
	Report data for additional claims that have been billed					1
	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
	COST TOPOLIS IL YES, SEE LISTIUCTIONS.	1	1			1 4 9 9 9
19.00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.00
		N		N		19.00

Health Financial Systems

COMMUNI TY	STROKE	AND	REHABI LI TATI ON

In Lieu of Form CMS-2552-10

Health Financial Systems COMMUNITY STROKE AN	ND REHABILITAT	I ON	In Lie	eu of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-3045	Period: From 07/01/2021 To 06/30/2022	Date/Time Pre	pared:
	Docor	intion	Y/N	11/22/2022 9: Y/N	37 am
		iption O	1.00	3.00	
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		0	N	N N	20.00
Report data for other: bescribe the other adjustments.	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	IOSPI TALS)		1.00	
Capital Related Cost				1	
22.00 Have assets been relifed for Medicare purposes? If yes, see					22.00
23.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.			0		23.00
24.00 Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost rep	oorting period?		24.00
25.00 Have there been new capitalized leases entered into during instructions.	the cost repor	rting period?	lf yes, see		25.00
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reporti	ng period? If	f yes, see		26.00
27.00 Has the provider's capitalization policy changed during the copy.	e cost reportir	ng period?lf	yes, submit		27.00
Interest Expense 28.00 Were new Loans, mortgage agreements or letters of credit en	ntered into dur	ing the cost	reporting		28.00
period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or		C C			29.00
treated as a funded depreciation account? If yes, see instr 30.00 Has existing debt been replaced prior to its scheduled matu	ructions				30.00
instructions. 31.00 Has debt been recalled before scheduled maturity without is	5	5			31.00
instructions. Purchased Services			366		31.00
32.00 Have changes or new agreements occurred in patient care ser		ed through cor	ntractual		32.00
arrangements with suppliers of services? If yes, see instru 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to competit	tive bidding? If		33.00
no, see instructions. Provider-Based Physicians					
34.00 Are services furnished at the provider facility under an ar If yes, see instructions.	rrangement with	n provi der-bas	sed physi ci ans?		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
physicians during the cost reporting period: in yes, see in	istructions.	-	Y/N	Date	
			1.00	2.00	
Home Office Costs				1	
<ul><li>36.00 Were home office costs claimed on the cost report?</li><li>37.00 If line 36 is yes, has a home office cost statement been pr</li></ul>	repared 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					38.00
the provider? If yes, enter in column 2 the fiscal year end 39.00 If line 36 is yes, did the provider render services to othe					39.00
40.00 If line 36 is yes, did the provider render services to the	home office?	lf yes, see			40.00
i nstructi ons.					-
	1.	00	2.	00	
					-
	CATHERI NE		WOERNER		41.00
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.			WOERNER		
<ul> <li>41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.</li> <li>42.00 Enter the employer/company name of the cost report preparer.</li> </ul>	CATHERINE COMMUNITY FOUN IN, INC. 12197031267	IDATION OF NW		) DERNER@COMHS. OR	42.00

Heal th	Financial Systems COMMUNITY STROKE	AN	D REHABILITATION		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-3045		eriod:	Worksheet S-2	
				T	rom 07/01/2021 o 06/30/2022	Part II Date/Time Pre 11/22/2022 9:	pared: <u>37 am</u>
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	F	REIMBURSEMENT MANAGER				41.00
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the cost						43.00
	report preparer in columns 1 and 2, respectively.						

	Financial Systems COMMM AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC,	AL DATA	Provider CC	N: 15-3045		riod: om 07/01/2021	Worksheet S-3 Worksheet S-3 Part I Date/Time Prep 11/22/2022 9:3	pared:
							I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available		CAH Hours	Title V	
		1.00	2.00	3.00		4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	35	12, 7	75	0.00	0	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider							2.0 3.0 4.0
5.00 5.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation		35	12, 7	75	0.00	0 0 0	5. 0 6. 0 7. 0
7.00	beds) (see instructions)		35	12,7	/5	0.00	0	7.00
3.00 9.00 10.00 11.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	31.00	0		0	0.00	0	8. 0 9. 0 10. 0 11. 0
12.00 13.00 14.00 15.00	OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits	43.00	35	12, 7	75	0.00	0 0 0	12. 0 13. 0 14. 0 15. 0
6.00 7.00 8.00 9.00	SUBPROVI DER – I PF SUBPROVI DER – I RF SUBPROVI DER	41.00	0		0		0	16.0 17.0 18.0 19.0
0.00 1.00 2.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY							20. 0 21. 0 22. 0
3.00 4.00 4.10 5.00	AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	116. 00 30. 00	0		0			23. ( 24. ( 24. 25. (
6.00 6.25 7.00 8.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	89.00	35				0	26. ( 26. 2 27. ( 28. (
9.00 0.00 1.00 2.00 2.01	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room		O		0			29. 30. 31. 32. 32.
3. 00 3. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges							33. 33.

)SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-3045		riod: om 07/01/2021 06/30/2022	Worksheet S-3 Part I Date/Time Pre 11/22/2022 9:	pared
		I/P Days	/ O/P Visits	/ Trips		Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients		Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5, 704	62	9, 05	50			1.
00	HMO and other (see instructions)	1, 399	546					2.
00	HMO I PF Subprovi der	0	0					3.
00	HMO I RF Subprovi der	0	0					4.
00	Hospital Adults & Peds. Swing Bed SNF	0	0		0			5.
00	Hospital Adults & Peds. Swing Bed NF	0	0		0			6.
00	Total Adults and Peds. (exclude observation beds) (see instructions)	5, 704	62	9, 05	-			7.
00	INTENSIVE CARE UNIT	o	o		0			8.
00	CORONARY CARE UNIT		J					9.
. 00	BURN INTENSIVE CARE UNIT							10
. 00	SURGICAL INTENSIVE CARE UNIT							11
. 00								12.
. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY		0		0			13.
. 00		5, 704	62	9, 05	-	0.00	124 04	
	Total (see instructions)		02	9, 03		0.00	134.04	
. 00	CAH visits	0	0		0			15
. 00	SUBPROVIDER - IPF				~	0.00	0.00	16
. 00	SUBPROVIDER - IRF	0	0		0	0.00	0.00	
00	SUBPROVIDER							18
. 00	SKILLED NURSING FACILITY							19
. 00	NURSING FACILITY							20
. 00	OTHER LONG TERM CARE							21
00	HOME HEALTH AGENCY							22
. 00	AMBULATORY SURGICAL CENTER (D. P. )							23
. 00	HOSPI CE	0	0		0	0.00	0.00	
10	HOSPICE (non-distinct part)				0			24
. 00	CMHC - CMHC							25
. 00	RURAL HEALTH CLINIC							26
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00	0.00	26
. 00	Total (sum of lines 14-26)					0.00	134.04	27
. 00	Observation Bed Days		0		0			28
. 00	Ambulance Trips	0						29
. 00	Employee discount days (see instruction)				0			30
. 00	Employee discount days - IRF				0			31
. 00	Labor & delivery days (see instructions)	0	0		0			32
. 01	Total ancillary labor & delivery room outpatient days (see instructions)				0			32
. 00	LTCH non-covered days	0						33
	LTCH site neutral days and discharges	0						33

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-3045	Period: From 07/01/2021 To 06/30/2022	Worksheet S-3 Part I Date/Time Pre 11/22/2022 9:	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider		O		95 12 09 44 0	763	1.00 2.00 3.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				0		4.00 5.00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						6. 00 7. 00
3.00 9.00	INTENSIVE CARE UNI T						8. 00 9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL INTENSI VE CARE UNI T						11.00
12.00 13.00	OTHER SPECIAL CARE (SPECIFY) NURSERY						12.00 13.00
14.00	Total (see instructions)	0.00	0	4	95 12	763	
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0		0 0	0	
18.00							18.0
19.00 20.00	SKILLED NURSING FACILITY NURSING FACILITY						19.0 20.0
20.00	OTHER LONG TERM CARE						20.0
22.00	HOME HEALTH AGENCY						22.0
23.00	AMBULATORY SURGICAL CENTER (D. P. )						23.0
24.00	HOSPICE	0, 00					24.0
4. 10	HOSPICE (non-distinct part)						24.1
25.00	CMHC - CMHC						25.0
6. 00	RURAL HEALTH CLINIC						26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.2
27.00	Total (sum of lines 14-26)	0.00					27.0
28.00	Observation Bed Days						28.0
9.00	Ambul ance Trips						29.0
0.00	Employee discount days (see instruction)						30.0
1.00	Employee di scount days - IRF						31.0
32.00	Labor & delivery days (see instructions)						32.0
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.0
33.00	LTCH non-covered days				0		33.0
	LTCH site neutral days and discharges				0		33.0

RECLAS	Financial Systems COMM SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	UNITY STROKE AND F EXPENSES	Provider CC	CN: 15-3045 P	eriod:	u of Form CMS-2 Worksheet A	2552-10
				F	rom 07/01/2021 o 06/30/2022	Date/Time Pre	
	Cost Center Description	Sal ari es	Other		Reclassificati ons (See A-6)	11/22/2022 9: Recl assi fi ed Tri al Bal ance (col. 3 +- col. 4)	37 am
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						-
1.00	00100 CAP REL COSTS-BLDG & FIXT		2, 511, 494	2, 511, 494	25, 174	2, 536, 668	•
2.00	00200 CAP REL COSTS-MVBLE EQUIP		1, 350, 520	1, 350, 520	1, 999	1, 352, 519	2.00
3.00	00300 OTHER CAP REL COSTS	104 054	1 171 517	0	0	0	3.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00560 PURCHASING RECEIVING AND STORES	104, 954 65, 994	1, 171, 517 21, 042	1, 276, 471 87, 036	0	1, 276, 471 87, 036	4.00 5.01
5.01	00570 ADMI TTI NG	330, 238	45, 804	376, 042	0	376, 042	5.01
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	43, 004	0,042	0	0,042	5.02
5.04	00590 OTHER ADMINISTRATI VE & GENERAL	809, 908	2, 437, 666	3, 247, 574	-27, 173	3, 220, 401	5.04
7.00	00700 OPERATION OF PLANT	157, 154	889, 357	1, 046, 511	27,170	1, 046, 511	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	84, 052	84, 052	0	84, 052	•
9.00	00900 HOUSEKEEPI NG	221, 563	263, 445	485, 008	0	485,008	•
10.00	01000 DI ETARY	372, 685	236, 516	609, 201	-138, 324	470, 877	10.00
11.00	01100 CAFETERI A	0	0	0	138, 324	138, 324	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	92, 231	20, 933	113, 164	0	113, 164	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 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.000.07	4 505 407	F 404 404		F 404 404	0.00
30.00	03000 ADULTS & PEDIATRICS	3, 909, 067	1, 585, 427	5, 494, 494	0	5, 494, 494	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.00
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY	0	0	0	0	0	41.00
43.00	ANCI LLARY SERVI CE COST CENTERS	U	0	0	0	0	43.00
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	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	331, 174	157, 992	489, 166	0	489, 166	•
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00	05600 RADI OI SOTOPE	81, 733	165, 686	247, 419	0	247, 419	56.00
57.00	05700 CT SCAN	184, 307	177, 079	361, 386	0	361, 386	57.00
58.00	05800 MRI	103, 874	149, 058	252, 932	0	252, 932	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY	300, 259	564, 565	864, 824	0	864, 824	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	8, 514	8, 514	0	8, 514	
65.00		285, 494	45, 292	330, 786	0	330, 786	•
66.00	06600 PHYSI CAL THERAPY	688, 268	989, 041 814, 635	1, 677, 309 910, 850	0	1, 677, 309 910, 850	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	96, 215 69, 319	814, 635 191, 440	260, 759	0	260, 759	
69.00	06900 ELECTROCARDI OLOGY	96, 682	27, 472	124, 154	0	124, 154	
	07000 ELECTROENCEPHALOGRAPHY	18, 436	5, 111	23, 547	0	23, 547	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	107, 982	107, 982	0	107, 982	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	195, 148	367, 924	563, 072	0	563, 072	73.00
74.00	07400 RENAL DI ALYSI S	0	55, 805	55, 805	0	55, 805	
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	151, 565	33, 489	185, 054	0	185, 054	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS			-	-	-	
	11300 I NTEREST EXPENSE		0	0	0		113.00
	11600 HOSPICE	0	14 470 050	0	0		116.00
118.00		8, 666, 268	14, 478, 858	23, 145, 126	0	23, 145, 126	118.00
100.00	NONREI MBURSABLE COST CENTERS	0	0	0	0	0	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	0	0	0		190.00 191.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		191.00
	19300 NONPALD WORKERS	0	0	0	0	0	193.00
	07950 OTHER NONREIMBURSABLE DEPARTMENTS	0	498	498	0		194.00
	07951 ADVERTI SI NG	o	72, 129	72, 129	0		194.01
200.00		8, 666, 268	14, 551, 485		Ű	23, 217, 753	
200.00				-, , , , , , , , , , , , , , , , , ,	, vi	-, , , , , , , , , , , , , , , , , ,	

Provider CCN: 15-3045

In Lieu of Form CMS-2552-10 Period: Worksheet A From 07/01/2021

				From 07/01/2021 To 06/30/2022	
	Cost Center Description	Adjustments	Net Expenses		11/22/2022 9:37 am
			For Allocation	1	
	GENERAL SERVICE COST CENTERS	6.00	7.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	9, 390	2, 546, 058		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	94, 181			2.00
3.00	00300 OTHER CAP REL COSTS	0	0		3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	182, 330	1, 458, 801		4.00
5.01	00560 PURCHASING RECEIVING AND STORES	0			5.01
5.02	00570 ADMI TTI NG	0	376, 042		5.02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	252, 496	252, 496		5.03
5.04	00590 OTHER ADMINI STRATI VE & GENERAL	-402, 752	2, 817, 649		5.04
7.00	00700 OPERATION OF PLANT	0			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0			8.00
9.00	00900 HOUSEKEEPI NG	0			9.00
10.00	01000 DI ETARY	-44			10.00
11.00	01100 CAFETERIA	-91, 299			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0			13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	-		14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	196, 122	-		16.00
17.00	01700 SOCIAL SERVICE	190, 122			17.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		17.00
30.00	03000 ADULTS & PEDI ATRI CS	0	5, 494, 494	L	30.00
31.00	03100 I NTENSI VE CARE UNI T	0			31.00
41.00	04100 SUBPROVIDER - IRF	0			41.00
43.00	04300 NURSERY	0	0		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0		51.00
53.00	05300 ANESTHESI OLOGY	0	-		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-300			54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	-		55.00
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	0	,		56.00 57.00
57.00	05800 MRI	-1, 425 -630			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	-030			59.00
60.00	06000 LABORATORY	-298			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	8, 514	L	63.00
65.00	06500 RESPI RATORY THERAPY	0			65.00
66.00	06600 PHYSI CAL THERAPY	0	1, 677, 309		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	910, 850		67.00
68.00	06800 SPEECH PATHOLOGY	0	260, 759		68.00
69.00	06900 ELECTROCARDI OLOGY	0	124, 154		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	23, 547		70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	107, 982		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0			73.00 74.00
	07500 ASC (NON-DI STI NCT PART)	0			74.00
75.00	OUTPATIENT SERVICE COST CENTERS	0	0	) 	/5.00
90 00	09000 CLINIC	0	185, 054		90.00
	09100 EMERGENCY	0			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
	SPECIAL PURPOSE COST CENTERS				/2:00
	11300 INTEREST EXPENSE	0	0		113.00
	11600 HOSPI CE	0			116.00
118.00		237, 771	23, 382, 897	/	118.00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
	19100 RESEARCH	0	0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192.00
	19300 NONPALD WORKERS	0	0		193.00
194.00	07950 OTHER NONREI MBURSABLE DEPARTMENTS	0	498		194.00
	07951 ADVERTI SI NG	0	72, 129		194.01
200.00	TOTAL (SUM OF LINES 118 through 199)	237, 771	23, 455, 524	+	200.00

Heal th	Financial Systems	COMM	IUNITY STROKE A	AND REHABILITAT	I ON	In Lie	u of Form CMS	-2552-10
RECLASS	SEFECATIONS			Provider (	CCN: 15-3045	Period: From 07/01/2021	Worksheet A-	6
						To 06/30/2022	Date/Time Pr 11/22/2022 9	epared: :37 am
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	A - RECLASS BUILDING INSURANC	E						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	25, 174				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 999				2.00
	0		0	27, 173				
	B - CAFETERIA RECLASS	· · ·						1
1.00	CAFETERI A	11.00	84, 621	53, 703				1.00
	0		84, 621	53, 703				
500.00	Grand Total: Increases		84, 621	80, 876				500.00

Heal th	Financial Systems	COM	MUNITY STROKE A	ND REHABILITAT	I ON	In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider C	CCN: 15-3045	Period:	Worksheet A-	6
						From 07/01/2021 To 06/30/2022	Date/Time Pr 11/22/2022 9	epared: :37 am
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	A - RECLASS BUILDING INSURANC	È.						
1.00	OTHER ADMINISTRATIVE &	5.04	0	27, 173	1	2		1.00
	GENERAL							
2.00		0.00	0	0	1	2		2.00
	0 — — — — — — —		0	27, 173		7		
	B - CAFETERIA RECLASS							1
1.00	DI ETARY	10.00	84, 621	53, 703		0		1.00
	0 — — — — — — —		84, 621	53, 703		7		
500.00	Grand Total: Decreases		84, 621	80, 876		1		500.00

Heal th	Financial Systems COMM	/UNITY STROKE AN	ID REHABILITATI	ON	In Lie	eu of Form CMS-2	2552-10
	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-3045	Period: From 07/01/2021 To 06/30/2022	Worksheet A-7 Part I	pared:
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	1, 812, 872	50, 200		0 50, 200	0	1.00
2.00	Land Improvements	0	0		0 0	0	2.00
3.00	Buildings and Fixtures	49, 225, 293	177, 077		0 177, 077	0	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	8, 661, 407	343, 719		0 343, 719	0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	59, 699, 572	570, 996		0 570, 996	0	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	59, 699, 572	570, 996		0 570, 996	0	
		Endi ng Bal ance	Fully				
		J J J J J J J J J J J J J J J J J J J	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	1, 863, 072	0				1.00
2.00	Land Improvements	0	o				2.00
3.00	Buildings and Fixtures	49, 402, 370	o				3.00
4.00	Building Improvements	0	o				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	9,005,126	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	60, 270, 568	0				8.00
9,00	Reconciling Items	000, 270, 000	0				9.00
10.00	Total (line 8 minus line 9)	60, 270, 568	0				10.00

Heal th	Financial Systems COMM	IUNI TY STROKE AI	ND REHABILITATI	ON	In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-3045	Period: From 07/01/2021 To 06/30/2022	Date/Time Pre	pared:
			SL	IMMARY OF CAP	ITAL	11/22/2022 9:	37 am
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUN	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	2, 511, 494	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 318, 321	32, 199		0 0	0	2.00
3.00	Total (sum of lines 1-2)	3, 829, 815	32, 199		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	-				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUN	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 511, 494				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 350, 520				2.00
3.00	Total (sum of lines 1-2)	0	3, 862, 014				3.00

RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-3045 P	Period:	Worksheet A-7	
				F	rom 07/01/2021	Part III	
				T	o 06/30/2022	Date/Time Prep 11/22/2022 9:3	barec
							37 an
		COMI	PUTATION OF RAT	10S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col.			
				2)			
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COST	S CENTERS					
. 00	CAP REL COSTS-BLDG & FIXT	51, 265, 442	0	51, 265, 442	0. 850588	0	1.
. 00	CAP REL COSTS-MVBLE EQUIP	9,005,126	0	9, 005, 126	0. 149412	0	2.
. 00	Total (sum of lines 1-2)	60, 270, 568	0	60, 270, 568	1. 000000	0	3.
		ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	Cost center bescription		Capi tal -Rel ate		Depreciation	LCusc	
			d Costs	through 7)			
		6,00	7.00	8.00	9,00	10.00	
	PART III - RECONCILIATION OF CAPITAL COST						
. 00	CAP REL COSTS-BLDG & FIXT	0	0	C	2, 520, 884	0	1.
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	C	1, 412, 502	32, 199	2.
. 00	Total (sum of lines 1-2)	0	0	c	3, 933, 386	32, 199	3.
			SL	IMMARY OF CAPIT	TAL .		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	bost bontor boson prion	interest			Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)	thi ough i i j	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COST						
. 00	CAP REL COSTS-BLDG & FIXT	0	25, 174	C	0 0	2, 546, 058	1.
. 00	CAP REL COSTS-MVBLE EQUIP	0	1, 999	C	0 0	1, 446, 700	2.

	Financial Systems MENTS TO EXPENSES	COMML	JNITY STROKE AN	ND REHABILITATION Provider CCN: 15-3045	In Lie Period: From 07/01/2021 To 06/30/2022	u of Form CMS-2 Worksheet A-8 Date/Time Pre 11/22/2022 9:	pared:
				Expense Classification o To/From Which the Amount is		111 227 2022 7.	
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
	discounts (chapter 8)		0			0	
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service		0		0.00	0	8. 00
9. 00 10. 00	(chapter 21) Parking lot (chapter 21) Provider-based physician	A-8-2	0 -2, 355		0.00	0 0	
11.00	• • •		0		0.00	0	11.00
12. 00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	347, 332			0	12.00
13.00 14.00	Laundry and linen service Cafeteria-employees and guests		0		0.00	0	
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 drugs to other than patients		0		0.00	0	17.00
18.00	1.		0		0.00	0	18. 00
19. 00	1		0		0.00	0	19. 00
20. 00	Vending machines		0		0.00	0	
	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 00
26.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
	Physicians' assistant	A-8-3	0	OCCUPATI ONAL THERAPY	0.00	0	
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		Ω	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)	A-8-3					
	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER REVENUE	В	-50	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	33.00

Heal th	Financial Systems	COMM	JNI TY STROKE A	ND REHABILITATION	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 07/01/2021 To 06/30/2022	Date/Time Pre	pared:
						11/22/2022 9:	37 am
				Expense Classification o			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
	1	1.00	2.00	3.00	4.00	5.00	
33. 01	OTHER REVENUE	В		OTHER ADMINISTRATIVE &	5.04	0	33.01
				GENERAL			
33.02	OTHER REVENUE	В	-44	DI ETARY	10.00	0	33.02
33.03	OTHER REVENUE	В	-91, 299	CAFETERI A	11.00	0	33.03
33.04	TAXABLE LABS	A	-298	LABORATORY	60.00	0	33.04
33.05	PATIENT TELEPHONE SERVICE	A	-8, 132	OTHER ADMINISTRATIVE &	5.04	0	33.05
				GENERAL			
33.06	PATIENT TELEPHONE PURCHASES	A	-175	OTHER ADMINISTRATIVE &	5.04	0	33.06
				GENERAL			
33.07	PATIENT TV DEPRECIATION	A	-4, 480	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.07
50,00	TOTAL (sum of lines 1 thru 49)		237, 771				50.00
	(Transfer to Worksheet A,						
	column 6 Line 200 )						

 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.

Health Financial Systems COMMUNITY STROKE AND REHABILITATION In Lieu of Form CMS-255						
STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 07/01/2021		
				To 06/30/2022	Date/Time Pre 11/22/2022 9:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	<u>57 ann</u>
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00		OTHER ADMINISTRATIVE & GENER		0	112, 162	1.00
2.00		OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOCATION PER G	0	1, 861, 197	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOC-BLDG	9, 390	0	3.00
3.01	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOC-EQUIP	98, 661	0	3.01
3.02	5.04	OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOC-SALARIES	847, 172	0	3.02
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOC-BENEFITS	182, 380	0	3.03
3.04	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE ALLOC-MEDICAL RE	196, 122	0	3.04
3.05	5. 03	CASHI ERI NG/ACCOUNTS RECEI VAB	HOME OFFICE ALLOC-PATIENT AC	252, 496	0	3.05
3.06	5.04	OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOC-OTHER NON	734, 470	0	3.06
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			2, 320, 691	1, 973, 359	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		
					ļ	
Symbol (1)	Name	Percentage of	Name	Percentage of	1	
		Ownership		Ownershi p	1	
1.00	2.00	3.00	4.00	5.00		
 B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00 B	0. 00 CFNI	100.00	6.00
7.00	0.00	0.00	7.00
8.00	0.00	0.00	8.00
9.00	0.00	0.00	9.00
10.00	0.00	0.00	10.00
100.00 G. Other (financial or			100.00
non-financial) specify:			

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

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

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

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

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

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

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

				S/ dill
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	-112, 162	0		1.00
2.00	-1, 861, 197	0		2.00
3.00	9, 390	9		3.00
3.01	98, 661	9		3.01
3.02	847, 172	0		3.02
3.03	182, 380	0		3.03
3.04	196, 122	0		3.04
3.05	252, 496	0		3.05
3.06	734, 470	0		3.06
4.00	0	0		4.00
5.00	347, 332			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

1100 110			
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	51		
	6.00		
	0.00		
	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.

6.00	HEALTHCARE		6.00
7.00			7.00
8.00 9.00			8.00
9.00			9.00
10.00		10	10. 00
10. 00 100. 00		100	00.00

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

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

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

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

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

E. Individual is director, officer, administrator, or key person of provider and related organization. F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th Financial Systems PROVIDER BASED PHYSICIAN ADJUSTMENT COMMUNITY STROKE AND REHABILITATION Provider CCN: 15-3045 Period:

Ιn	Li eı	J Of	Form	CMS-2552-10
		Wor	kshee <sup>.</sup>	t A-8-2

PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (	CCN: 15-3045	Period:	Worksheet A-8	3-2
						From 07/01/2021 To 06/30/2022		narod
						10 06/30/2022	11/22/2022 9:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	57 am
	WKSL A LINE #	I denti fi er	Remuneration			KOL AIIIOUITI	ider Component	
		Tuentiniei	Remuneration	Component	Component		Hours	
	1.00	2.00	3.00	1.00	E 00	( 00	7.00	
1 00	1.00	2.00		4.00	5.00	6.00		1 00
1.00		RADI OLOGY-DI AGNOSTI C	300	300			-	1.00
2.00		CT SCAN	1, 425	1, 425	C	-	-	2.00
3.00	58.00		630	630	C	-	0	3.00
4.00	0.00		0	0	C	0	0	4.00
5.00	0.00		0	0	C	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0		-	0	8.00
9.00	0.00		0	0		, i i i i i i i i i i i i i i i i i i i	0	9.00
			0	0	-	-		
10.00	0.00		0	0	C	, i i i i i i i i i i i i i i i i i i i	0	10.00
200.00			2, 355	2, 355			0	200.00
	Wkst. A Line #		Unadjusted RCE	5 Percent of	Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	1.00
2,00	57.00	CT SCAN	0	0	C	0	o	2.00
3,00	58.00		0	0	Ċ	0	0	3,00
4,00	0.00		0	0	0	-	0	4.00
5.00	0.00		0	0		-	0	5.00
			0	-		-		
6.00	0.00		0	0	-	-	0	6.00
7.00	0.00		0	0	C	u u u u u u u u u u u u u u u u u u u	0	7.00
8.00	0.00		0	0	C	0	0	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00		0	0	C	0	0	10.00
200.00			0	0	C	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.	2.1	Di odi i olidiloo			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		RADI OLOGY-DI AGNOSTI C	0	0				1.00
2.00		CT SCAN	0	0				2.00
2.00	58.00		0	0				2.00
			0		-			
4.00	0.00		0	0	C	U U		4.00
5.00	0.00		0	0	C			5.00
6.00	0.00		0	0	C		,	6.00
7.00	0.00		0	0	C		ļ	7.00
8.00	0.00		0	0	C	0	ļ	8.00
9.00	0.00		0	0	C	0	, I	9.00
10.00	0.00		0	0	Ċ	0		10.00
200.00			0	0	-			200.00
	I	1	. 9	0		2,000	I	

COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C	F	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Pre 11/22/2022 9:	pared: 37 am
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUI P	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS		0.54/ 050	1			1
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	2, 546, 058 1, 446, 700	2, 546, 058	1, 446, 700			1.00 2.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 448, 700	4, 014				4.00
5.01	00560 PURCHASING RECEIVING AND STORES	87, 036	40, 313			139, 769	5. 01
5.02	00570 ADMI TTI NG	376, 042	22, 484				5. 02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	252, 496	0	-	, s	252, 496	5.03
5.04 7.00	00590 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	2, 817, 649 1, 046, 511	47, 627 342, 502			3, 228, 347 1, 442, 070	5.04 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	84, 052	0, 302	20, 100		84, 052	8.00
9.00	00900 HOUSEKEEPI NG	485, 008	47, 849	4, 652	37, 893	575, 402	9.00
10.00	01000 DI ETARY	470, 833	81, 390			689, 175	1
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	47, 025 113, 164	43, 638 3, 891			142, 715 132, 829	11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	3, 871			132, 824	14.00
15.00	01500 PHARMACY	0	0	C	0	0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	196, 122	2, 512		-	198, 634	16.00
17.00	01700 SOCIAL SERVICE	0	0		0 0	0	17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	5, 494, 494	863, 420	260, 076	668, 544	7, 286, 534	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	000, 420			0	31.00
41.00	04100 SUBPROVI DER – I RF	0	0	C	0	0	41.00
43.00	04300 NURSERY	0	0	(	0 0	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	0		0	0	50.00
51.00	05100 RECOVERY ROOM	0	0			0	51.00
53.00	05300 ANESTHESI OLOGY	0	0	C	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	488, 866	102, 913	219, 896	56, 639		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	)	0	0	55.00
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	247, 419 359, 961	7, 782 17, 066			316, 407 504, 534	56.00 57.00
58.00	05800 MRI	252, 302	42, 234			489, 882	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59.00
60.00	06000 LABORATORY	864, 526	55, 114			1, 022, 221	60.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING, & TRANS.	0 8, 514	0		0	0 8, 514	62.00 63.00
65.00	06500 RESPIRATORY THERAPY	330, 786	0	1, 699	48, 826	381, 311	1
66.00	06600 PHYSI CAL THERAPY	1, 677, 309	123, 845			2, 031, 518	1
67.00	06700 OCCUPATI ONAL THERAPY	910, 850	4, 654			938, 655	67.00
68.00	06800 SPEECH PATHOLOGY	260, 759	3, 349				1
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	124, 154 23, 547	10, 343 0			180, 065 37, 663	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	107, 982	0	10, 703		107, 982	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	563, 072	2, 906			632, 038	
74.00 75.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	55, 805 0	13, 889 0			69, 899 0	
75.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	<u>  (</u>	0	0	75.00
90.00	09000 CLI NI C	185, 054	4, 408	0	25, 921	215, 383	90.00
91.00	09100 EMERGENCY	0	0	C	0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
113 00	SPECIAL PURPOSE COST CENTERS						113.00
	11600 HOSPI CE	0	0	0	0	0	116.00
118.00		23, 382, 897	1, 888, 143	1, 446, 700	1, 464, 190		
	NONREI MBURSABLE COST CENTERS	· · · ·		1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES		0 657, 915			0 657, 915	191.00 192.00
	19300 NONPALD WORKERS	0	0		0		193.00
194.00	07950 OTHER NONREIMBURSABLE DEPARTMENTS	498	0	0	0	498	194.00
	07951 ADVERTI SI NG	72, 129	0	0	0	72, 129	1
200.00 201.00			0				200. 00 201. 00
201.00	5	23, 455, 524	2, 546, 058	1, 446, 700	1, 464, 190		
			, ,				

	Financial Systems COMM LLOCATION - GENERAL SERVICE COSTS	IUNI TY STROKE AN	D REHABILITATI Provider CO	CN: 15-3045 Pe	riod: om 07/01/2021	u of Form CMS-2 Worksheet B Part I Date/Time Pre	pared:
	Cost Center Description	PURCHASI NG RECEI VI NG AND	ADMI TTI NG	CASHI ERI NG/ACC OUNTS	Subtotal	11/22/2022 9: OTHER ADMI NI STRATI VE	37 am
		STORES 5.01	5.02	RECEI VABLE 5. 03	5A. 03	& GENERAL 5.04	
	GENERAL SERVICE COST CENTERS						
1.00 2.00 4.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 2.00 4.00
5. 01 5. 02 5. 03 5. 04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMINISTRATIVE & GENERAL	139, 769 2, 825 1, 514 19, 354	474, 066 0 0	254, 010 0	3, 247, 701	3, 247, 701	5. 01 5. 02 5. 03 5. 04
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	8, 645 504	0	0	1, 450, 715 84, 556	233, 152 13, 589	7.00 8.00
11.00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A	3, 450 4, 132 856	0 0 0	0	578, 852 693, 307 143, 571	93, 030 111, 425 23, 074	10.00
14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	796 0 0	0 0 0	0 0 0	133, 625 0 0	21, 476 0 0	13.00 14.00 15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	1, 191 0	0 0	0 0	199, 825 0	32, 115 0	16. 00 17. 00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	43, 673 0	87, 476 0	46, 882 0	7, 464, 565 0	1, 199, 666 0	30. 00 31. 00
	04100 SUBPROVIDER - IRF 04300 NURSERY	0 0	0 0	0 0	0 0	0	41.00 43.00
50.00	ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	0	0	0	0	0	51.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	5, 206 0	49, 617 0	26, 584 0	949, 721 0	152, 634 0	54.00 55.00
	05600 RADI OI SOTOPE 05700 CT SCAN	1, 897 3, 025	20, 548 40, 693	11, 009 21, 802	349, 861 570, 054	56, 228 91, 616	56.00 57.00
59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	2, 937 0	44, 549 0	23, 868 0	561, 236 0	90, 199 0	58.00 59.00
62.00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	6, 128 0	64, 714 0	34, 673 0	1, 127, 736 0	181, 244 0	60. 00 62. 00
65.00	06300 BLOOD STORING, PROCESSING, & TRANS. 06500 RESPIRATORY THERAPY	51 2, 286	772 8, 787	414 4, 708	9, 751 397, 092	1, 567 63, 819	63.00 65.00
	06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY	12, 179 5, 627	47, 042 29, 724	15, 926	2, 115, 943 989, 932	340, 064 159, 097	67.00
69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 663 1, 079	7, 927 27, 341	4, 247 14, 649	291, 169 223, 134	46, 795 35, 861	68.00 69.00
71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	226 647	10, 673 2, 931	5, 719 1, 570	54, 281 113, 130 0	8, 724 18, 182 0	
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	3, 789 419	23, 931 2, 261	12, 822 1, 211	672, 580 73, 790	108, 094 11, 859	73.00
	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	
91.00	09000 CLI NI C 09100 EMERGENCY	1, 291 0	5, 080 0		224, 476 0	36, 077 0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS				0		92.00
	11300 I NTEREST EXPENSE 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0 135, 390	0 474, 066	0 254, 010	0 22, 720, 603		113. 00 116. 00 118. 00
191.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES	0 0 3,944	0	0	0 0 661, 859		190. 00 191. 00 192. 00
193.00 194.00	19300 NONPAID WORKERS 07950 OTHER NONREIMBURSABLE DEPARTMENTS	03	0 0 0	0000	0 501	0 81	193. 00 194. 00
200.00		432	0	0	72, 561 0		194. 01 200. 00 201. 00
201.00 202.00	5	139, 769	474, 066	0 254, 010	0 23, 455, 524		

OST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-3045	Period: From 07/01/2021 To 06/30/2022	Worksheet B Part I Date/Time Pre 11/22/2022 9:	epared: 37 am
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI N		CAFETERI A	
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	11.00	-
. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
5. 00 6. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	1, 683, 867 0 38, 567 65, 602 35, 173 3, 136 0 0 2, 025 0	98, 145 0 0 0 0 0 0 0 0 0 0 0 0 0	710, 4 28, 3 15, 1 1, 3	27 898, 661 38 0	217, 006 3, 031 0 0 0 0 0	13. 0 14. 0 15. 0 16. 0
0 00	INPATIENT ROUTINE SERVICE COST CENTERS	(05.022	00.145	200 5	000 (/1	100 450	
0.00 1.00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	695, 933 0	98, 145 0		09 898, 661 0 0	128, 453 0	1
		0	0		0 0	0	
3.00		0	0		0 0	0	43.00
	ANCI LLARY SERVICE COST CENTERS						1 - 0 - 0
0.00	05000 OPERATI NG ROOM	0	0		0 0	0	
1.00 3.00	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	0	0		0 0	0	
4.00	05400 RADI OLOGY-DI AGNOSTI C	82, 950	0	35, 8	-	10, 883	
5.00	05500 RADI OLOGY - THERAPEUTI C	0	0		0 0	0	1
6.00	05600 RADI OI SOTOPE	6, 272	0	2, 7	0 80	2, 686	56.00
7.00	05700 CT SCAN	13, 755	0	5, 9		6, 057	
8.00		34, 041	0	14, 6		3, 413	
9.00 0.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 44, 423	0	19, 1	0 0	0 9, 867	
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	44, 423	0	17, 1	0 0	<sup>2</sup> , 007	
3.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 0	0	
5.00	06500 RESPI RATORY THERAPY	0	0		0 0	9, 382	65.0
6.00	06600 PHYSI CAL THERAPY	99, 822	0	43, 1		22, 617	
7.00	06700 OCCUPATI ONAL THERAPY	3, 751	0	.,		3, 162	
8.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	2,699	0	1, 1		2, 278	
9.00 0.00	07000 ELECTROEARDTOLOGY	8, 337 0	0	3, 6	0 00	3, 177 606	
		0	0		0 0	000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	1
	07300 DRUGS CHARGED TO PATIENTS	2, 342	0			6, 413	
		11, 195	0			0	
5.00	07500 ASC (NON-DI STI NCT PART)	0	0		0 0	0	75.0
0 00	OUTPATI ENT SERVICE COST CENTERS	3, 553	0	1, 5	34 0	4, 981	90.0
	09100 EMERGENCY	3, 333	0		0 0	4, 901	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		-			-	92.0
	SPECIAL PURPOSE COST CENTERS						1
	D 11300 I NTEREST EXPENSE						113.0
	D 11600 HOSPI CE	0	0		0 0		116. 0
18.00		1, 153, 576	98, 145	481, 4	67 898, 661	217, 006	118. 0
90 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 0
	D19100 RESEARCH	0	0		0 0		191.0
	19200 PHYSICIANS' PRIVATE OFFICES	530, 291	0	228, 9	-		192.0
	19300 NONPAI D WORKERS	0	0		0 0		193.0
	07950 OTHER NONREIMBURSABLE DEPARTMENTS	0	0		0 0		194. 0
	1 07951 ADVERTI SI NG	0	0		0 0	0	194. 0
00.00							200. 0 201. 0
01.00	D Negative Cost Centers						

COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-3045	Period: From 07/01		Worksheet B Part I	
					To 06/30	/2022	Date/Time Pre 11/22/2022 9:	epared: 37 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI C. RECORD LI BRA	S &	SOCI AL SERVI CE	
		13.00	14.00	15.00	16.0		17.00	
	GENERAL SERVICE COST CENTERS				-			
1.00	00100 CAP REL COSTS-BLDG & FIXT							1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT							2.00
5.01	00560 PURCHASING RECEIVING AND STORES							5.01
5.02	00570 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 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING							8.00 9.00
9.00 10.00	01000 DI ETARY							10.00
11.00	01100 CAFETERIA						l	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	162, 622					ĺ	13.00
	01400 CENTRAL SERVICES & SUPPLY	0	0					14.00
15.00	01500 PHARMACY	0	0		0			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0			4, 839 0		16.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0	0	0	17.00
30.00	03000 ADULTS & PEDIATRICS	145, 650	0		0 4	3, 346	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0		0	0	0	
41.00	04100 SUBPROVI DER – I RF	0	0		0	0	0	
43.00	04300 NURSERY	0	0		0	0	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	0		0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0	0	
53.00	05300 ANESTHESI OLOGY	0	0		0	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 2	24, 577	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	
56.00	05600 RADI OI SOTOPE	0	0			0, 178		
57.00 58.00	05700 CT SCAN 05800 MRI	0	0			20, 156 22, 067	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	2,007	0	
60.00	06000 LABORATORY	0	0		0 3	32, 055	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0	383	0	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	10, 638	0		0	4,353	0	65.00 66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			23, 302 4, 723		
68.00	06800 SPEECH PATHOLOGY	0	0		0	3, 926		1
69.00	06900 ELECTROCARDI OLOGY	0	0		0 1	3, 543	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	687	0		0	5, 287	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	1,452	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0 1	1, 854	0	
	07400 RENAL DI ALYSI S	0	0			1, 120		
	07500 ASC (NON-DISTINCT PART)	0	0		0	0		
	OUTPATIENT SERVICE COST CENTERS	1						
	09000 CLINIC	5, 647	0		0	2, 517	0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	0	91.00 92.00
92.00	SPECIAL PURPOSE COST CENTERS							92.00
113.00	11300 I NTEREST EXPENSE							113.00
116.00	11600 HOSPI CE	0	0		0	0		116.00
118.00		162, 622	0		0 23	34, 839	0	118.00
100.00	NONREI MBURSABLE COST CENTERS		<u>م</u>		0	~		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0		190.00 191.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		o	0		191.00
192.00	19300 NONPAI D WORKERS	0	0		0	0		193.00
					. 1	~		
193.00 194.00	07950 OTHER NONREIMBURSABLE DEPARTMENTS	0	0		0	0		194.00
193.00 194.00 194.01	07950 OTHER NONREI MBURSABLE DEPARTMENTS 07951 ADVERTI SI NG	0 0	0 0		0	0	0	194.01
193.00 194.00	07950 OTHER NONREIMBURSABLE DEPARTMENTS 07951 ADVERTISING Cross Foot Adjustments	0	0 0		0	0	0	

	UNITY STROKE AI	ND REHABILITATI			Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-3045	From 07/01/2021 Part To 06/30/2022 Date	sheet B : I 2/Time Prepared: 2/2022 9:37 am
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS	1	I I			1.00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP					1.00
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 7. 00 00700 OPERATION OF PLANT					5. 04 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 CAFETERIA					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY					14.00 15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY					16.00
17. 00 01700 SOCIAL SERVICE					17.00
INPATIENT ROUTINE SERVICE COST CENTERS		· · · ·			
30. 00 03000 ADULTS & PEDI ATRI CS	10, 974, 928		10, 974, 92		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0		0	31.00
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY		0		0	41.00 43.00
ANCI LLARY SERVI CE COST CENTERS				0	10.00
50.00 05000 OPERATI NG ROOM	0	0		0	50.00
51.00 O5100 RECOVERY ROOM	0	0		0	51.00
53. 00 05300 ANESTHESI OLOGY		0	1 257 50	0	53.00
54. 00  05400  RADI OLOGY-DI AGNOSTI C 55. 00  05500  RADI OLOGY-THERAPEUTI C	1, 256, 583	0	1, 256, 58	0	54.00 55.00
56. 00 05600 RADI 01 SOTOPE	427, 933	0	427, 93		56.00
57.00 05700 CT SCAN	707, 578		707, 57		57.00
58. 00 05800 MRI	725, 655		725, 65		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	1 414 50	0	59.00
60.00  06000 LABORATORY 62.00  06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 414, 507	0	1, 414, 50	0	60.00 62.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	11, 701	-	11, 70	-	63.00
65. 00 06500 RESPI RATORY THERAPY	485, 284		485, 28		65.00
66. 00 06600 PHYSI CAL THERAPY	2, 644, 851		2, 644, 85		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 172, 285		1, 172, 28		67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	348, 033 287, 652	0	348, 03 287, 65		68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	69, 585	0	69, 58		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	132, 764		132, 76		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	802, 294		802, 29		73.00
74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART)	102, 798		102, 79	0	74.00 75.00
OUTPATIENT SERVICE COST CENTERS					/ 0. 00
90. 00 09000 CLI NI C	278, 785		278, 78	35	90.00
91.00 09100 EMERGENCY	0	0		0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART SPECIAL PURPOSE COST CENTERS		0			92.00
113.00 11300 I NTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE	0	0		0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	21, 843, 216	0	21, 843, 21	16	118.00
NONREI MBURSABLE COST CENTERS	-	-1			100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190. 00 191. 00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 527, 503		1, 527, 50	-	191.00
193. 00 19300 NONPALD WORKERS	0	0	., 02., 00	0	193.00
194.0007950 OTHER NONREIMBURSABLE DEPARTMENTS	582		58		194.00
194. 01 07951 ADVERTI SI NG	84, 223	0	84, 22		194.01
200.00Cross Foot Adjustments201.00Negative Cost Centers		0		0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	23, 455, 524		23, 455, 52	24	201.00
		, sj	.,, 01	1	1 0

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		OF	C۸		PELATED	C

In Lieu of Form CMS-2552-10

	ancial Systems COMM N OF CAPITAL RELATED COSTS		Provider CC	Fi To	eriod: rom 07/01/2021 o 06/30/2022	Worksheet B Part II Date/Time Pre 11/22/2022 9:	pared: 37 am
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL REI	ATED COSTS	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	ERAL SERVICE COST CENTERS						1 4 00
2.00 002 4.00 004 5.01 005	00 CAP REL COSTS-BLDG & FIXT 00 CAP REL COSTS-MVBLE EQUIP 00 EMPLOYEE BENEFITS DEPARTMENT 60 PURCHASING RECEIVING AND STORES 70 ADMITTING	0 0 0	4, 014 40, 313 22, 484	1, 133		5, 389 42 208	5.01
5.04 005 7.00 007 8.00 008	80 CASHIERING/ACCOUNTS RECEIVABLE 90 OTHER ADMINISTRATIVE & GENERAL 00 OPERATION OF PLANT 00 LAUNDRY & LINEN SERVICE	0 0 0	0 47, 627 342, 502 0	26, 180 0	0 272, 184 368, 682 0	0 509 99 0	5. 04 7. 00 8. 00
10.00 010 11.00 011 13.00 013	00 HOUSEKEEPING 00 DIETARY 00 CAFETERIA 00 NURSING ADMINISTRATION 00 CENTRAL SERVICES & SUPPLY	0 0 0 0	47, 849 81, 390 43, 638 3, 891 0	87, 686	52, 501 169, 076 81, 218 3, 891 0	139 181 53 58 0	10.00 11.00 13.00
15.00 015 16.00 016 17.00 017	00 PHARMACY 00 MEDI CAL RECORDS & LI BRARY 00 SOCI AL SERVI CE ATI ENT ROUTI NE SERVI CE COST CENTERS	0 0 0	0 2, 512 0		0 2, 512 0	0	15. 00 16. 00
31.00     031       41.00     041       43.00     043	00 ADULTS & PEDIATRICS 00 INTENSIVE CARE UNIT 00 SUBPROVIDER - IRF 00 NURSERY	0 0 0 0	863, 420 0 0 0	0	1, 123, 496 0 0 0	2,462 0 0 0	31.00 41.00
	ILLARY SERVICE COST CENTERS	0	0	0	0	0	50.00
51.00 051 53.00 053 54.00 054	00 RECOVERY ROOM 00 ANESTHESI OLOGY 00 RADI OLOGY-DI AGNOSTI C	0	0 0 102, 913	0	0 0 322, 809	0 0 208	51.00 53.00 54.00
56.00 056 57.00 057 58.00 058	00 RADI OLOGY-THERAPEUTI C 00 RADI OI SOTOPE 00 CT SCAN 00 MRI	0 0 0	7, 782 17, 066 42, 234	95, 986 177, 581	55, 010 113, 052 219, 815	0 51 116 65	56.00 57.00 58.00
60.00       060         62.00       062         63.00       063	00 CARDIAC CATHETERIZATION 00 LABORATORY 00 WHOLE BLOOD & PACKED RED BLOOD CELL 00 BLOOD STORING, PROCESSING, & TRANS.	0	0 55, 114 0 0	0 51, 230 0 0	0 106, 344 0 0	0 189 0 0	60.00 62.00 63.00
56.00 066 57.00 067 58.00 068	00 RESPI RATORY THERAPY 00 PHYSI CAL THERAPY 00 OCCUPATI ONAL THERAPY 00 SPEECH PATHOLOGY	0 0 0 0	0 123, 845 4, 654 3, 349	6, 696 1, 369			66.00 67.00 68.00
70.00         070           71.00         071           72.00         072	00 ELECTROCARDIOLOGY 00 ELECTROENCEPHALOGRAPHY 00 MEDICAL SUPPLIES CHARGED TO PATIENT 00 IMPL. DEV. CHARGED TO PATIENTS	0 0 0	10, 343 0 0 0	10, 963 0 0	39, 376 10, 963 0 0	61 12 0 0	70.00 71.00
74.00 074 75.00 075	00 DRUGS CHARGED TO PATIENTS 00 RENAL DIALYSIS 00 ASC (NON-DISTINCT PART) PATIENT SERVICE COST CENTERS	0 0 0	2, 906 13, 889 0	205	35, 591 14, 094 0	123 0 0	1
92.00 092	00 CLINIC 00 EMERGENCY 00 OBSERVATION BEDS (NON-DISTINCT PART CIAL PURPOSE COST CENTERS	0	4, 408 0	0	4, 408 0 0	95 0	
116. 00 116 118. 00	00 INTEREST EXPENSE 00 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	0	0 1, 888, 143	0 1, 446, 700	0 3, 334, 843		113. 00 116. 00 118. 00
190. 00 190 191. 00 191 192. 00 192 193. 00 193	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 00 RESEARCH 00 PHYSICIANS' PRIVATE OFFICES 00 NONPAID WORKERS	0 0 0	0 0 657, 915 0	0	0 0 657, 915 0	0 0 0	190.00 191.00 192.00 193.00
	50 OTHER NONREIMBURSABLE DEPARTMENTS 51 ADVERTISING Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118 through 201)	0 0	0 0 2, 546, 058	0 0 1, 446, 700	0 0 0 3, 992, 758	0	194. 00 194. 01 200. 00 201. 00 202. 00

	Financial Systems COMM TION OF CAPITAL RELATED COSTS	IUNI TY STROKE AN	Provi der CC		Peri od:	u of Form CMS-2 Worksheet B	
					From 07/01/2021 To 06/30/2022	Part II Date/Time Pre 11/22/2022 9:3	
	Cost Center Description	PURCHASI NG RECEI VI NG AND STORES	ADMI TTI NG	CASHI ERI NG/AC OUNTS RECEI VABLE	COTHER ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	
		5.01	5.02	5.03	5.04	7.00	
4 00	GENERAL SERVICE COST CENTERS	1					1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
4.00 5.01	00560 PURCHASING RECEIVING AND STORES	41, 488					4.00 5.01
5.02	00570 ADMI TTI NG	838	39, 766				5.02
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	449	39,700	44	9		5.02
5.04	00590 OTHER ADMINISTRATIVE & GENERAL	5, 743	0		278, 436		5.04
7.00	00700 OPERATION OF PLANT	2, 565	0	(		391, 335	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	150	0	(	1, 165	0	8.00
9.00	00900 HOUSEKEEPI NG	1, 024	0	(	7, 976	8, 963	9.00
10.00	01000 DI ETARY	1, 226	0	(	9, 553	15, 246	10.00
11.00	01100 CAFETERI A	254	0	(	0 1, 978	8, 174	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	236	0	(	0 1, 841	729	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 MEDI CAL RECORDS & LI BRARY	353	0		2, 753	471	16.00
17.00	01700 SOCIAL SERVICE	0	0	(	0 0	0	17.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	12,974	7, 352		102 047	161, 736	20.00
30.00 31.00	03100 INTENSIVE CARE UNIT	12, 974	7,352	6	8 102, 847 0 0	101, 730	30.00 31.00
41.00	04100 SUBPROVIDER - IRF	0	0			0	41.00
43.00	04300 NURSERY	0	0			0	41.00
45.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	<u> </u>		<u> </u>	0	+5.00
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	(	o o	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 545	4, 160	4	9 13, 086	19, 278	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(	o c	0	55.00
56.00	05600 RADI OI SOTOPE	563	1, 723	20	0 4, 821	1, 458	56.00
57.00	05700 CT SCAN	898	3, 412	40		3, 197	57.00
58.00	05800 MRI	872	3, 735	4.		7, 911	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(	-	0	59.00
60.00	06000 LABORATORY	1, 819	5, 426	6-		10, 324	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62.00
63.00 65.00	06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 06500 RESPI RATORY THERAPY	15 678	65 737		1 134 9 5,472	0	63.00 65.00
66.00	06600 PHYSI CAL THERAPY	3, 614	3, 944	4		23, 199	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1,670	2, 492	29		872	67.00
68.00	06800 SPEECH PATHOLOGY	493	665	2		627	68.00
69.00	06900 ELECTROCARDI OLOGY	320	2, 292	2		1, 937	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	67	895	1(		0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	192	246	:	3 1, 559	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	o c	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 124	2, 006	2	4 9, 267	544	73.00
	07400 RENAL DI ALYSI S	124	190		2 1, 017	2, 602	
75.00	07500 ASC (NON-DISTINCT PART)	0	0	(	0 0	0	75.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	383	426		5 3, 093	826	90.00
91.00		0	0	(	0 0	0	91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART SPECIAL PURPOSE COST CENTERS						92.00
112 00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	0	0	(	0	0	116.00
		40, 189	39, 766	44		268, 094	
116.00	SUBTOTALS (SUM OF LINES 1 through 117)		37,700		200,007	200, 074	
116.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS						
116.00 118.00		0	0	(	0 0	0	<sup>1</sup> 190. 00
116.00 118.00 190.00	NONREIMBURSABLE COST CENTERS	0	0	(	0 0 0 0	-	
116.00 118.00 190.00 191.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 0 1, 170	0 0 0	(	0 0 0 0 0 9, 120	-	191.00
116.00 118.00 190.00 191.00 192.00 193.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES 19300 NONPAI D WORKERS	000	0 0 0 0	(	0 0 0 0 9, 120 0 0	0 123, 241 0	191. 00 192. 00 193. 00
116.00 118.00 190.00 191.00 192.00 193.00 194.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES 19300 NONPAI D WORKERS 07950 OTHER NONREI MBURSABLE DEPARTMENTS	0 0 1,170 0 1	0 0 0 0 0		0 0 7	0 123, 241 0 0	193. 00 194. 00
116. 00 118. 00 190. 00 191. 00 192. 00 193. 00 194. 00 194. 01	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES 19300 NONPAI D WORKERS 07950 OTHER NONREI MBURSABLE DEPARTMENTS 07951 ADVERTI SI NG	000	0 0 0 0 0 0		0 0 0 0 0 9, 120 0 0 0 7 0 7 0 1, 000	0 123, 241 0 0 0	191. 00 192. 00 193. 00 194. 00 194. 01
116. 00 118. 00 190. 00 191. 00 192. 00 193. 00 194. 01 200. 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES 19300 NONPAI D WORKERS 07950 OTHER NONREI MBURSABLE DEPARTMENTS 07951 ADVERTI SI NG Cross Foot Adj ustments	0 0 1,170 0 1	0 0 0 0 0		0 0 7	0 123, 241 0 0 0	191. 00 192. 00 193. 00 194. 00 194. 01 200. 00
116.00 118.00 190.00 191.00 192.00 193.00 194.00	NONREI MBURSABLE       COST       CENTERS         19000       GIFT,       FLOWER,       COFFEE       SHOP & CANTEEN         19100       RESEARCH       19200       PHYSI CI ANS'       PRI VATE       OFFICES         19300       NONPAI D       WORKERS       07950       OTHER NONREI MBURSABLE       DEPARTMENTS         07951       ADVERTI SI NG       Cross       Foot       Adj ustments         Negati ve       Cost       Centers	0 0 1,170 0 1	0 0 0 0 0 0 39, 766	44	0 0 0 7 0 1,000 0 0	0 123, 241 0 0 0	191. 00 192. 00 193. 00 194. 00 194. 01 200. 00 201. 00

		IUNI TY STROKE AM	ND REHABILITATI	ON	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC		eriod: com 07/01/2021 0 06/30/2022	Worksheet B Part II Date/Time Pre	pared:
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	CAFETERI A	11/22/2022 9: NURSI NG ADMI NI STRATI ON	37 am
		8.00	9.00	10.00	11.00	13.00	
-	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560 PURCHASING RECEIVING AND STORES						5.01
5.02	00570 ADMI TTI NG						5.02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.03
5.04	00590 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.04
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	1, 315					7.00 8.00
8.00 9.00	00900 HOUSEKEEPING	1, 315	70, 603				9.00
10.00	01000 DI ETARY	0	2, 815	198, 097			10.00
11.00	01100 CAFETERIA	0	1, 509	170, 077	93, 186		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	135	0	1, 301	8, 191	
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 MEDI CAL RECORDS & LI BRARY	0	87	0	0	0	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	1, 315	29, 863	198, 097	55, 161	7, 336	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.00
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
43.00	04300 NURSERY	0	0	0	0	0	43.00
	ANCI LLARY 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	53.00
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	3, 560	0	4, 673	0	54.00 55.00
56.00	05600 RADI OLOGI - THERAPEOTIC	0	269	0	1, 153	0	56.00
57.00	05700 CT SCAN	0	209 590	0	2, 601	0	57.00
58.00	05800 MRI	0	1, 461	0	1, 466	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	1, 906	0	4, 237	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0	0	0	4, 029	536	65.00
66.00	06600 PHYSI CAL THERAPY	0	4, 284	0	9, 712	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	161	0	1, 358	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	116	0	978	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	358	0	1, 364	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	260	35	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	101	0	0 754	0	
73.00	07400 RENAL DIALYSIS	0	101	0	2, 754	0	73.00 74.00
	07500 ASC (NON-DI STI NCT PART)	0	480	0	0	0	75.00
75.00	OUTPATIENT SERVICE COST CENTERS	0	U	0	0	0	75.00
90.00	09000 CLINIC	0	152	0	2, 139	284	90.00
	09100 EMERGENCY	0	0	0 0	2, 107	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		-	-	-	-	92.00
	SPECIAL PURPOSE COST CENTERS		. <u> </u>				
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPI CE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 315	47, 847	198, 097	93, 186	8, 191	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	19100 RESEARCH	0	00	0	0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	22, 756	0	0		192.00
	19300 NONPALD WORKERS	0	0	0	0		193.00
	07950 OTHER NONREI MBURSABLE DEPARTMENTS	0	0	0	0		194.00
194.01 200.00	07951 ADVERTISING Cross Foot Adjustments	0	0	0	0		194. 01 200. 00
200.00			0	0	0		200.00 201.00
201.00		1, 315	70, 603	198, 097	93, 186		201.00
202.00		1,010	, 0, 000	170,077	,0,100	0,171	

Health Financial Syste ALLOCATION OF CAPITAL		UNITY STROKE AND	Provi der CC		Period: From 07/01/2021	u of Form CMS- Worksheet B Part II	
					To 06/30/2022	Date/Time Pre 11/22/2022 9:	
Cost Cent	er Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE		
		14.00	15.00	16.00	17.00	24.00	
GENERAL SERVICE	OSTS-BLDG & FIXT						1.00
	OSTS-MVBLE EQUIP						2.00
	BENEFITS DEPARTMENT						4.00
5.01 00560 PURCHASI N	G RECEIVING AND STORES						5. 01
5. 02 00570 ADMI TTI NG							5. 02
	G/ACCOUNTS RECEIVABLE						5.03
	INISTRATIVE & GENERAL						5.04
7.00 00700 OPERATI ON 8.00 00800 LAUNDRY &							7.00
9.00 00900 HOUSEKEEP							9.00
10.00 01000 DI ETARY							10.00
11. 00 01100 CAFETERIA							11.00
13.00 01300 NURSING A							13.00
	ERVICES & SUPPLY	0					14.00
15.00 01500 PHARMACY	ECORDS & LI BRARY	0	0	4 1	74		15.00 16.00
16.00 01600 MEDICAL R 17.00 01700 SOCIAL SE		0	0		0 0		17.00
	NE SERVICE COST CENTERS	<u> </u>	0		0 0		17.00
30.00 03000 ADULTS &		0	0	1, 1	12 0	1, 703, 819	30.00
31.00 03100 I NTENSI VE		0	0		0 0	0	31.00
41.00 04100 SUBPROVI D	ER – IRF	0	0		0 0	0	
43.00 04300 NURSERY	OF COST CENTERS	0	0		0 0	0	43.00
50.00 05000 OPERATING	CE COST CENTERS	0	0		0 0	0	50.00
51.00 05100 RECOVERY		0	0		0 0	0	51.00
53.00 05300 ANESTHESI		0	0		0 0	0	
54.00 05400 RADI OLOGY	-DI AGNOSTI C	0	0	6	50 0	370, 018	54.00
55. 00 05500 RADI OLOGY		0	0		0 0	0	
56. 00 05600 RADI 0I SOT	OPE	0	0		69 0	65, 337	1
57.00 05700 CT SCAN 58.00 05800 MRI		0	0		33 0 84 0	132, 294 243, 686	1
59.00 05900 CARDI AC C	ATHETERI ZATI ON	0	0		0 0	243,000	
60. 00 06000 LABORATOR		0	0	8	48 0	146, 696	
62.00 06200 WHOLE BLO	OD & PACKED RED BLOOD CELL	О	0		0 0	0	62.00
	RING, PROCESSING, & TRANS.	0	0		10 0	225	
65. 00 06500 RESPI RATO		0	0		15 0	13, 455	
66.00 06600 PHYSI CAL		0	0		16 0	311, 503	
67.00 06700 0CCUPATI0 68.00 06800 SPEECH PA		0	0		89 0 04 0	32, 022 11, 765	
69.00 06900 ELECTROCA		0	0		58 0	49, 168	
70.00 07000 ELECTROEN	CEPHALOGRAPHY	0	0		40 0	13, 130	70.00
	UPPLIES CHARGED TO PATIENT	0	0		38 0	2, 038	71.00
72.00 07200 I MPL. DEV		0	0		0 0	0	
73.00 07300 DRUGS CHA 74.00 07400 RENAL DIA		0	0		13 0 30 0		73.00
75.00 07500 ASC (NON-		0	0		30 0 0 0	10, 539	74.00 75.00
	I CE COST CENTERS	<b>0</b>			0 0	0	/0.00
90.00 09000 CLINIC		0	0		67 0	11, 878	90.00
91.00 09100 EMERGENCY		0	0		0 0	0	
	ON BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE 113.00 11300 INTEREST							113.00
116. 00 11600 H0SPI CE	EXPENSE	0	0		0 0	0	116.00
	(SUM OF LINES 1 through 117)	0	0			3, 177, 420	
NONREIMBURSABLE			-				
	WER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
191.00 19100 RESEARCH		0	0		0 0		191.00
192.00 19200 PHYSI CI AN		0	0		0 0	814, 202	
193.00 19300 NONPALD W	URKERS REIMBURSABLE DEPARTMENTS	0	0				193.00 194.00
194. 01 07951 ADVERTI SI		0	0		0 0		194.00
	t Adjustments		0				200.00
201.00 Negative	Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (su	m lines 118 through 201)	0	0	6, 1	76 0	3, 992, 758	202.00
		•					

Total         Total         Total         Total         Total           0	Health Financial Systems COMM ALLOCATION OF CAPITAL RELATED COSTS	MUNITY STROKE AN	D REHABILITATI Provider CC	Peri od:	eu of Form CMS Worksheet B	-2552-10
Cost Center Rescription         Inten 8 Beildents Corr Steptam         Total Beildents Corr 3.00         Total Beildents Corr 3.00         Total Beildents Corr 3.00           Do Corrobors Miller Corr 0.00 Corrobors Miller Corr 0.00 Corrobors Miller English 0.00 Corrobors File Corr 0.00 Cor 0.00 Corr 0.00 Corr 0.00 Corr 0.00 Cor 0.00 Corr 0					2 Date/Time Pr	
INTERAL SERVICE CAST CONTERS         1.00           1.00         00000 (AP REL CASTS-MURLE EDUPATION CONTENTS)         2.00           1.00         00000 (AP REL CASTS-MURLE EDUPATION CONTENTS)         5.01           1.00         00000 (AP REL CASTS-MURLE EDUPATION CONTENTS)         1.00           1.00         00000 (AP REL CASTS-MURLE EDUPATION CONTENTS)         1.00           1.00         00000 (AP REL CASTS-MURLE EDUPATION CONTENTS)         1.00           1.00         01000 (AP REL CASTS AP REL CASTS	Cost Center Description	Residents Cost & Post Stepdown Adjustments		1.	11/22/2022 9	: 37 am
2 00 00200 CAP REL COSTS-MUSE EQUIP 4 4 00 4400 MINUTOR TO TRUETS IN MAIN MINUTOR 10000 MINUTOR 100000 MINUTOR 1000000 MINUTOR 1000000 MINUTOR 1000000 MINUTOR 100000 MINUTOR 10000000 MINUTOR 1000000 MINUTOR 1000000 MINUTOR 100000	GENERAL SERVICE COST CENTERS	23.00	20.00			
10.00         0 TODOD DI ELARY         10.00         11.00         11.00         11.00         10.00         11.00         10.00         11.00         10.00         11.00         10.00         11.00         10.00	2.00         00200         CAP         REL         COSTS-MVBLE         EQUIP           4.00         00400         EMPLOYEE         BENEFITS         DEPARTMENT           5.01         00560         PURCHASING         RECEIVING         AND         STORES           5.02         00570         ADMITTING         OS80         CASHIERING/ACCOUNTS         RECEIVABLE           5.03         00580         CASHIERING/ACCOUNTS         RECEIVABLE         OS90         OTHER         ADMINISTRATIVE         & GENERAL           7.00         00700         OPERATION         OF         PLANT         8.00         00800         LAUNDRY         & LINEN         SERVICE					2.00 4.00 5.01 5.02 5.03 5.04 7.00 8.00
30:00         03:000         AULTS & PEDIATRICS         0         1,703,810         30.00           41:00         VALUES         0         0         41.00         41.00           41:00         VALUES         0         0         0         41.00           41:00         VALUES         CONTRESING VERCE         0         0         41.00           41:00         VALUES         CONTRESING VERCE         0         0         43.00           41:00         VALUES         CONTRESING VERCE         0         0         43.00           41:00         VALUES         CONTRESING VERCE         0         0         50.00           50:00         05:00         CONTRESING VERCE         0         0         51.00           50:00         05:00         CANDERANCINE         0         243.666         56.00           50:00         05:00         CANDERANCINE         0         146.696         60.00           60:00         CANDERSING ANDERSING ANDERSING ANDER         0         225         63.00           60:00         CANDERSING ANDERSING ANDER	10.00       01000       DI ETARY         11.00       01100       CAFETERIA         13.00       01300       NURSI NG ADMI NI STRATI ON         14.00       01400       CENTRAL SERVI CES & SUPPLY         15.00       01500       PHARMACY         16.00       01600       MEDI CAL RECORDS & LI BRARY         17.00       01700       SOCI AL SERVI CE					10.00 11.00 13.00 14.00 15.00 16.00
41.00       04100       SUBPOVI DER - 1 RF       0       0       41.00         43.00       43.00       ANCILLARY SERVICE COST CENTERS       43.00         ANCILLARY SERVICE COST CENTERS       0       0       0         50.00       DS000 (PECATING ROOM       0       0         51.00       S50.00 (PECATING ROOM       0       0         53.00       DS00 (PECATING ROOM       0       0         53.00       DS00 (PECATING ROOM       0       0         53.00       DS00 (PECATING ROOM       0       0         55.00       DS00 (PECATING ROOM       0       0         55.00       DS00 (PECATING ROOM       0       0         56.00       DS00 (PECATING ROOM       132, 294       57.00         57.00       DS00 (PECATING CATHER LATION       0       243, 666         50.00       DS00 (PECATING ROOM ROOM ROAM       134, 55       65.00         60.00       DS00 (PECATING ROOM ROAM ROAM ROAM ROAM ROAM ROAM ROAM	30. 00 03000 ADULTS & PEDIATRICS	-	1, 703, 819			30.00
43. 00       04300       MACILLARY SERV       0       0         50. 00       05000       FECOREN ROM       0       0         51. 00       05000       RECOVERY ROM       0       0         53. 00       05300       RESOVERSTRESI OLGY       0       0         54. 00       05000       REOVERY ROM       0       0         55. 00       05500       RADI OLGY - THERAPCUTI C       0       0       55. 00         50. 00       05000       RADI OLGY - THERAPCUTI C       0       0       55. 00         50. 00       05000       RADI OLGY - THERAPCUTI C       0       0       55. 00         50. 00       05000       RADI OLGY - THERAPCUTI C       0       0       55. 00         50. 00       05000       RADI OLGY - THERAPCUTI C       0       0       55. 00         50. 00       05000       RADI AC CATHETERI ZATI ON       0       124.294       57. 00         50. 00       05000       LADI AK CATHETERI ZATI ON       0       0       62. 00         60. 00       00000       LADI AK CATHETERI ZATI ON       0       225       63. 00         60. 00       00000       LADI AK CATHETERI ZATI ON       0       225						
50. 00         00         00         00         50. 00         50. 00         50. 00         50. 00         51. 00           51. 00         05.00         RECVERY ROOM         0         0         53. 00         53. 00           54. 00         56.00         REDORERY ROOM         0         0         53. 00         55. 00         65. 00         65. 00         65. 00         65. 00         65. 00         65. 00         65. 00         65. 00         65. 00         65. 00         65. 00		-				
51.00       DO       0       0       0       51.00         53.00       DS300       AND ATSHES LOLOGY       0       0       0         54.00       DS300       ANSTHES LOLOGY       0       0       0         55.00       DS300       ANSTHES LOLOGY       0       0       0       54.00         55.00       DS500       DS500       ANSTHES LOLOGY       0       0       0       56.00       55.00       56.00       55.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       56.00       57.00       58.00       58.00       58.00       58.00       58.00       58.00       59.00       60.00			0			F0.00
54.00     05.00		-				
55. 00     b5. 00 <td></td> <td>-</td> <td>-</td> <td></td> <td></td> <td>1</td>		-	-			1
56.00     05.00     05.00     65.337     56.00       57.00     05.00     05.00     132.294     57.00       58.00     06800     MRI     0     243.686     58.00       59.00     06000     LABORATORY     0     146.696     60.00       62.00     06200     MIDLE     BLOOD & PACKED RED BLOOD CELL     0     0     62.00       63.00     06300     BLOOD STORIN MC, PROCESSIN K, & TRANS.     0     225     63.00       64.00     06000     PHSICAL THERAPY     0     311.503     66.00       65.00     06500     RESPI RATORY THERAPY     0     312.022     67.00       66.00     067.00     05700     CCUPATI ONAL THERAPY     0     312.022     67.00       68.00     06600     SPECI PATHOLOGRAPHY     0     13.455     68.00       69.00     66000     SPECI PATHOLOGRAPHY     0     11.765     68.00       69.00     06000     ELCTEROCARDI DLOGY     0     14.765     68.00       69.00     0000     ELCTROCARDI DLOGY     0     17.765     72.00       71.00     71.00     DYTON     DATHENCY     0     0     73.00       72.00     73.00     73.00     73.00     73.00		0				
58.00         05800         MRI         59.00         62800         MRI         59.00         66000         LABORATORY         0         59.00         66.00         66000         LABORATORY         0         146.696         60.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         62.00         63.00         60.00         70.00         70.00         70.00         70.00         70.00 <td< td=""><td></td><td>0</td><td>-</td><td></td><td></td><td>1</td></td<>		0	-			1
59:00         OS900         CARDIAC CATHETERIZATION         0         59:00         59:00         59:00         59:00         60:00         62:00         60:00         60:00         61:00         60:00         62:00         60:00         63:00         60:00         61:00         60:00         61:00         60:00         61:00         60:00         61:00 <td>57.00 05700 CT SCAN</td> <td>0</td> <td>132, 294</td> <td></td> <td></td> <td>57.00</td>	57.00 05700 CT SCAN	0	132, 294			57.00
60.00         06000         LABORATORY         0         146,696         60.00           62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELL         0         0         62.00           63.00         06300         BLOOD STORING, PROCESSING, & TRANS.         0         225         63.00           65.00         06500         RESPIRATORY THERAPY         0         13,455         65.00           66.00         6600         PHYSICAL THERAPY         0         311,503         66.00           67.00         06700         OCCUPATIONAL THERAPY         0         312,022         67.00           68.00         6800 SPEECH PATHOLOGY         0         11,765         68.00         69.00           69.00         6900 ELECTROCARDI OLOGY         0         13,130         71.00         70.00           70.00         07000 ELECARDE TO PATIENT         2,038         71.00         72.00           70.00         07000 RELCARABED TO PATIENTS         0         51,847         73.00           74.00         07400 RENAL DI ALYSI S         0         11,878         90.00           90.00         09000 ELECTROE COST CENTERS         90.00         90.00         91.00           9200 OBSERVATI ON BEDS (NON-DI STINCT PART <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0				
62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       62.00         63.00       06300       06500       RESPIRATORY THERAPY       0       13,455       65.00         66.00       06600       PHYSI CAL THERAPY       0       311,503       66.00       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       311,503       66.00       66.00         68.00       06800       SPECH PATHOLOGY       0       11,765       68.00       69.00         69.00       06900       ELECTROCARDIOLOGY       0       11,765       68.00       69.00         70.00       07100       BUICAL SUPPLIES CHARGED TO PATIENT       2,038       71.00       71.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       0       72.00       72.00         72.00       07300       DRUS CHARGED TO PATIENTS       0       118,539       71.00       72.00       72.00       72.00       73.00       73.00       73.00       73.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       90.00		0	0			
65.00       06500       RESPI RATORY THERAPY       0       13, 455       65.00         66.00       06600       PHYSI CAL THERAPY       0       311, 503       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0       32, 022       67.00         68.00       06800       SPEECH PATHOLOGY       0       11, 765       68.00         69.00       60900       ELECTROCARDI OLOGY       0       49, 168       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       13, 130       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       71.00         72.00       07300       DRUGS CHARGED TO PATI ENTS       0       51.847       73.00         74.00       07300       DRUGS CHARGED TO PATI ENTS       0       18.539       74.00         0.00       07500 ASC (NON-DI STI NCT PART)       0       0       75.00       0         0.00       09000 CLINI C       0       11.878       90.00       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       91.00         92.00       09200       DENCHARGENCY       0       0		0	1			
66.00       6600       PHYSI CAL THERAPY       0       311, 503       66.00         67.00       0CCUPATI ONAL THERAPY       0       32, 022       67.00         68.00       06800       SPECCH PATHOLOGY       0       11, 765       68.00         69.00       06900       ELECTROCARDI OLOGY       0       49, 168       69.00         70.00       OTION MEDI CAL SUPPLIES CHARGED TO PATIENT       0       2, 038       71.00         71.00       OTION MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       0       72.00       73.00       73.00       72.00       73.00       73.00       73.00       74.00       75.00       0       74.00       75.00       0       74.00       75.00       0       74.00       75.00       0       90.00       9000 CLINIC       91.00       90.00       91.00       92.00       9200       92.00       9200 DESERVATION BEDS (NON-DI STINCT PART       90.00       91.00       92		0				
67.00       06700       00CUPATIONAL THERAPY       0       32,022       67.00         68.00       06800       SPEECH PATHOLOGY       0       11.765       68.00         69.00       06900       ELECTROCARDIOLOGY       0       49,168       69.00         70.00       O7000       LECTROENCEPHALOGRAPHY       0       13,130       70.00         71.00       OT100       MEDI CAL       SUPPLIES CHARGED TO PATI ENT       0       2.038       71.00         72.00       07200       IMPL       Dev. CHARGED TO PATI ENTS       0       0       72.00       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       18.539       74.00       74.00         75.00       OSOD ASC (NON-DI STI NCT PART)       0       0       0       75.00       0         90.00       OPODOL ELI NIC       COST CENTERS       91.00       92.00       0       91.00       92.00       0       91.00       92.00       000C CLI NIC       91.00       92.00       92.00       0       91.00       92.00       92.00       0       91.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00		J J				
69.00       06900       ELECTROCARDIOLOGY       0       49, 168       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       13, 130       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       2, 038       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       72.00       73.00         74.00       07400       RENAL DI ALYSIS       0       18, 539       74.00       75.00         07500       ASC (NON-DI STINCT PART)       0       0       0       75.00       75.00         09000       CLI N IC       0       11, 878       90.00       90.00       91.00       92.00		J J				
70.00       07000       ELECTROENCEPHALOGRAPHY       0       13, 130       70.00         71.00       O7100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       2, 038       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       51, 847       73.00         74.00       07500       ASC (NON-DI STINCT PART)       0       0       75.00         0000       090000       CLINIC       0       11, 878       90.00         90.00       092000       OBSERVATION BEDS (NON-DI STINCT PART       0       0       92.00       92.00       00       92.00       92.00       00 SUBTOTALS (SUM OF LINES 1 through 117)       0       3, 177, 420       113.00       113.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       0       3, 177, 420       118.00       110.00       190.00       190.00       191.00       191.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00		0				
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       2,038       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       18,539       73.00         74.00       07400       RENAL DI ALYSIS       0       18,539       74.00         75.00       07500       ASC (NON-DI STINCT PART)       0       0       0         00000       CLINIC       0       11,878       90.00       90.00         09000       CLINIC       0       11,878       90.00       91.00         92.00       092000 DESERVATION BEDS (NON-DI STINCT PART       0       0       91.00       92.00         92.01       092000 CLINIC       0       11,878       92.00       92.00         92.01       092000 DESERVATION BEDS (NON-DI STINCT PART       0       0       0       91.00         113.00       ITTREST EXPENSE       113.00       11300       INTEREST EXPENSE       114.00       118.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       0       3,177,420       118.00       118.00         190.00       197.00       197.00		0				
73.00       07300       DRUGS CHARGED TO PATIENTS       0       51,847       73.00         74.00       07400       RENAL DI ALYSI S       0       18,539       74.00         75.00       OT500       ASC (NON-DI STINCT PART)       0       0       74.00         00       OUTPATIENT SERVICE COST CENTERS       0       11,878       90.00       90.00         90.00       09000       CLINIC       0       11,878       90.00       91.00         92.00       09200       DEENVALION BEDS (NON-DI STINCT PART       0       0       91.00       91.00         92.00       OSECIAL PURPOSE COST CENTERS       0       0       113.00       11300       INTEREST EXPENSE       92.00         113.00       11300       INTEREST EXPENSE       0       0       116.00         118.00       11300       INTEREST EXPENSE       0       0       116.00         118.00       INTREIMBURSABLE COST CENTERS       0       0       116.00       116.00         118.00       11400       INTEREST EXPENSE       0       0       118.00       119.00         118.00       11400       INTEREST EXPENSE       0       0       0       119.00       192.00       193.00 </td <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0				
74.00       07400       RENAL DI ALYSI S       0       18,539       74.00         75.00       07500       ASC (NON-DI STINCT PART)       0       0       75.00         0UTPATI ENT SERVICE COST CENTERS       0       11,878       90.00       90.00         09000       CLINIC       0       11,878       90.00       90.00         91.00       09100       EMERGENCY       0       0       91.00       92.00       005ERVATION BEDS (NON-DI STINCT PART       92.00       92.00       92.00       005ERVATION BEDS (NON-DI STINCT PART       92.00       92.00       92.00       92.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       114.00       114.00       114.00       113.00       113.00       113.00       113.00       114.00       190.00       190.00       190.00 <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0				
75.00         07500         ASC (NON-DI STINCT PART)         0         0         75.00           OUTPATIENT SERVICE COST CENTERS         90.00         09100         CLINIC         0         11,878         90.00         90.00         91.00         92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART         0         91.00         92.00         113.00         113.00         113.00         113.00         113.00         113.00         113.00         118.00         118.00         118.00         118.00         118.00         118.00         190.00         191.00         192.00         192.00         192.00         193.00         193.00         193.00         193.00         193.00		0				
OUTPATI ENT SERVICE COST CENTERS         90.00         00000 CLINIC         90.00         90.00         90.00         90.00         90.00         91.00         90.00         91.00         90.00         91.00         90.00         91.00         91.00         92.00		-				
91.00       09100       EMERGENCY       0       0       0       91.00       92.00         92.00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART       0       92.00       92.00         SPECI AL PURPOSE COST CENTERS         113.00       INTREEST EXPENSE       0       0       113.00         116.00       11600       HOSPI CE       0       0       116.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       0       3, 177, 420       118.00         NONREI MBURSABLE COST CENTERS         190.00       I9000       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0         191.00       19100       RESEARCH       0       0       191.00         192.00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       814, 202       192.00         193.00       19300       NONPAI D WORKERS       0       0       193.00       194.00       193.00         194.00       0750       OTHER NONREI MBURSABLE DEPARTMENTS       0       8       194.00       194.00         194.01       07951       ADVERTI SI NG       0       1, 128       194.01       194.01         200.00       Cross Foot Adj ustments <td< td=""><td>OUTPATIENT SERVICE COST CENTERS</td><td></td><td></td><td></td><td></td><td></td></td<>	OUTPATIENT SERVICE COST CENTERS					
92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART         0         92.00           SPECIAL PURPOSE COST CENTERS         113.00         INTREST EXPENSE         113.00         113.00           113.00         11300         INTEREST EXPENSE         0         0         116.00           116.00         11600         HOSPICE         0         0         116.00           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         0         3, 177, 420         118.00           NONREI MBURSABLE COST CENTERS           190.00         IP000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0           191.00         19000         RESEARCH         0         0         191.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         814, 202         192.00           193.00         19300         NONPAI D WORKERS         0         0         193.00           194.00         07950         OTHER NONREI MBURSABLE DEPARTMENTS         8         194.00           194.01         07951         ADVERTI SI NG         0         1, 128         194.01           200.00         Cross Foot Adj ustments         0         0         0         200.00         2			11, 878			
SPECIAL PURPOSE COST CENTERS         113.00         INTEREST EXPENSE         113.00           113.00         11300         INTEREST EXPENSE         0         0         116.00           116.00         11600         HOSPICE         0         0         116.00           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         0         3, 177, 420         118.00           NONREI MBURSABLE COST CENTERS           190.00         IP100         RESEARCH         0         0         190.00           191.00         19000         RESEARCH         0         0         191.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         814, 202         192.00           193.00         19300         NONPAI D WORKERS         0         0         193.00           194.00         07950         OTHER NONREI MBURSABLE DEPARTMENTS         8         194.00           194.01         07951         ADVERTI SI NG         0         1, 128         194.01           200.00         Cross Foot Adj ustments         0         0         200.00         201.00			0			
116.00         11600         HOSPICE         0         0         116.00           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         0         3, 177, 420         118.00           NONREI MBURSABLE COST CENTERS           190.00         I9000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         190.00           191.00         PHYSI CI ANS' PRI VATE OFFICES         0         814, 202         192.00           193.00         19300         NONPAI D WORKERS         0         0         193.00           194.01         07950         OTHER NONREI MBURSABLE DEPARTMENTS         0         8         194.00           194.01         07951         ADVERTI SI NG         0         1, 128         194.01           200.00         Cross Foot Adj ustments         0         0         200.00         201.00	SPECIAL PURPOSE COST CENTERS		1			
SUBTOTALS         SUBTOTALS <t< td=""><td></td><td></td><td>~</td><td></td><td></td><td></td></t<>			~			
NONREI MBURSABLE COST CENTERS           190.00         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         190.00           191.00         RESEARCH         0         0         191.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         814,202         192.00           193.00         19300         NONPAI D WORKERS         0         0         193.00           194.00         07950         OTHER NONREI MBURSABLE DEPARTMENTS         0         8         194.00           194.01         07951         ADVERTI SI NG         0         1, 128         194.01           200.00         Cross Foot Adj ustments         0         0         200.00         201.00						
191.00       19100       RESEARCH       0       0       191.00         192.00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       814,202       192.00         193.00       19300       NONPAI D       WORKERS       0       0       193.00         194.00       07950       OTHER NONREI MBURSABLE DEPARTMENTS       0       8       194.00         194.01       07951       ADVERTI SI NG       0       1, 128       194.01         200.00       Cross Foot Adj ustments       0       0       200.00       201.00	NONREI MBURSABLE COST CENTERS	·				
192.00         19200         PHYSI CI ANS' PRI VATE OFFICES         0         814, 202         192.00           193.00         19300         NONPAI D. WORKERS         0         0         193.00           194.00         07950         OTHER NONREI MBURSABLE DEPARTMENTS         0         8         194.00           194.01         07951         ADVERTI SI NG         0         1, 128         194.01           200.00         Cross Foot Adjustments         0         0         200.00         201.00		0	0			
193.00       19300       NONPAI D WORKERS       0       193.00         194.00       07950       OTHER NONREI MBURSABLE DEPARTMENTS       0       8       194.00         194.01       07951       ADVERTI SI NG       0       1,128       194.01         200.00       Cross Foot Adjustments       0       0       200.00       201.00		0	814. 202			
194.01       07951       ADVERTISING       0       1,128       194.01         200.00       Cross Foot Adjustments       0       0       200.00       200.00         201.00       Negative Cost Centers       0       0       201.00       201.00	193. 00 19300 NONPALD WORKERS	0	0			193.00
200.00         Cross Foot Adjustments         0         0         200.00           201.00         Negative Cost Centers         0         0         201.00		0	8			
201.00 Negative Cost Centers 0 0 0 201.00		0				
202.00        TOTAL (sum lines 118 through 201)       0       3,992,758       202.00	201.00 Negative Cost Centers	0	0			201.00
	202.00   TOTAL (sum lines 118 through 201)	0	3, 992, 758			202.00

1.00       0         2.00       0         4.00       0         5.01       0         5.02       0         5.03       0         5.04       0	Cost Center Description GENERAL SERVICE COST CENTERS DO100 CAP REL COSTS-BLDG & FIXT	BLDG & FI XT (SQUARE FEET)	ATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE	rom 07/01/2021 o 06/30/2022 Reconciliation	Date/Time Pre	
1.00       0         2.00       0         4.00       0         5.01       0         5.02       0         5.03       0         5.04       0	GENERAL SERVICE COST CENTERS	BLDG & FI XT (SQUARE FEET)	MVBLE EQUIP		Reconciliation		<u>37 am</u>
1.00       0         2.00       0         4.00       0         5.01       0         5.02       0         5.03       0         5.04       0	GENERAL SERVICE COST CENTERS	BLDG & FI XT (SQUARE FEET)	MVBLE EQUIP		Reconciliation		
1.00       0         2.00       0         4.00       0         5.01       0         5.02       0         5.03       0         5.04       0				BENEFITS DEPARTMENT (GROSS		PURCHASING RECEIVING AND STORES (ACCUM. COST)	
1.00       0         2.00       0         4.00       0         5.01       0         5.02       0         5.03       0         5.04       0		1.00	2.00	SALARIES) 4.00	5A. 01	5. 01	
2.00       0         4.00       0         5.01       0         5.02       0         5.03       0         5.04       0	DOTOO CAP REL COSTS_BLDG & FLYT						
4.00 ( 5.01 ( 5.02 ( 5.03 ( 5.04 (		103, 388					1.00
5.01 ( 5.02 ( 5.03 ( 5.04 (	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	1/0	5, 466, 475				2.00
5.02 ( 5.03 ( 5.04 (	00560 PURCHASING RECEIVING AND STORES	163 1, 637				23, 315, 755	4.00 5.01
5.04 0	20570 ADMI TTI NG	913				471, 241	•
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	0	-	252, 496	5.03
$i \cap \mu$	00590 OTHER ADMINISTRATIVE & GENERAL	1, 934				3, 228, 347	
	20700 OPERATION OF PLANT 20800 LAUNDRY & LINEN SERVICE	13, 908 0	98, 923			1, 442, 070 84, 052	•
	00900 HOUSEKEEPING	1, 943	-	221, 563	-	575, 402	
	D1000 DI ETARY	3, 305			0	689, 175	
	D1100 CAFETERI A	1, 772	141, 998	84, 621	0	142, 715	11.00
	01300 NURSI NG ADMI NI STRATI ON	158		92, 231	0	132, 829	
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0		0	0	0	14.00
	D1600 MEDICAL RECORDS & LIBRARY	102			0	198, 634	16.00
	01700 SOCIAL SERVICE	0	0	0	-	0	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	D3000 ADULTS & PEDI ATRI CS	35, 061	982, 726		0	7, 286, 534	•
	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	0	0	0	-	0	31.00
	04300 NURSERY	0		0	0	0	
	ANCI LLARY SERVICE COST CENTERS		0	0	0		10.00
	D5000 OPERATI NG ROOM	0	0	0	0	0	50.00
	D5100 RECOVERY ROOM	0	0	0	0	0	51.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 4, 179	0 830, 895	0	0	0	53.00 54.00
	05500 RADI OLOGY - DI AGNOSTI C	4,179	030, 893	331, 174	0	868, 314 0	55.00
	D5600 RADI OI SOTOPE	316	178, 455	81, 733	0	316, 407	
	D5700 CT SCAN	693	362, 692	184, 307	0	504, 534	57.00
	05800 MRI	1, 715	671,005		0	489, 882	•
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	2, 238	0 193, 576	0 300, 259	0	0 1, 022, 221	59.00 60.00
	D6200 WHOLE BLOOD & PACKED RED BLOOD CELL	2,230	0	0	0	1, 022, 221	62.00
	D6300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	8, 514	•
	D6500 RESPI RATORY THERAPY	0	6, 421	285, 494		381, 311	
	06600 PHYSI CAL THERAPY	5,029				2, 031, 518	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	189 136				938, 655 277, 332	•
	D6900 ELECTROCARDI OLOGY	420				180, 065	
70.00	07000 ELECTROENCEPHALOGRAPHY	0				37, 663	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	107, 982	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	118 564			0	632, 038 69, 899	
	07500 ASC (NON-DISTINCT PART)	0			0	07,077	
	DUTPATIENT SERVICE COST CENTERS		-				
	09000 CLI NI C	179		151, 565		215, 383	
	09100 EMERGENCY	0	0	0	0	0	
	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART SPECI AL PURPOSE COST CENTERS						92.00
	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	76, 672	5, 466, 475	8, 561, 314	-139, 769	22, 585, 213	118.00
	NONREI MBURSABLE COST CENTERS					0	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	0	0			190.00 191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	26, 716		0	0	657, 915	
	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	72, 129	194.01
200.00 201.00	Cross Foot Adjustments Negative Cost Centers						200.00
201.00	Cost to be allocated (per Wkst. B,	2, 546, 058	1, 446, 700	1, 464, 190		139, 769	•
	Part I)	2, 8, 8, 800	.,0, .00	.,,			
203.00	Unit cost multiplier (Wkst. B, Part I)	24. 626243	0. 264650			0. 005995	
204.00	Cost to be allocated (per Wkst. B, Part II)			5, 389		41, 488	204.00

Health Financial Systems CON	MUNITY STROKE A	ND REHABILITATI	ON	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-3045		Period: From 07/01/2021	Worksheet B-1	
	_			To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: <u>37 am</u>
	CAPI TAL REI	LATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	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. 00062	9	0. 001779	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

To         0.00000000000000000000000000000000000	ALLOCA	ncial Systems COMM TION - STATISTICAL BASIS	UNITY STROKE AN	Provider CCN		<u>In Lie</u> Period: Trom 07/01/2021	Worksheet B-1	
Cost Center Description         Augu TTING (CR05S CH4 202)         CASII TRUE //CCR26Cence1   1et on OUTS (CR05S CH4 075)         OTHER WOR CR05S CH4 075)         OTHER WOR 075)         OTHER WOR CR05S CH4 075)         OTHER WOR CR05S CH4 075) <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th>Date/Time Pre</th> <th>pare</th>							Date/Time Pre	pare
BERN         REEX         REEL VAILE (GROSS OF 200         A. C. L. VAILE (GROSS OF 200         A. C. L. VAILE (GROSS OF 200         A. C. A. C. VAILE (GROSS OF 2000)         A. C. A. C. VAILE (GROSS OF 2000)         A. C. A. C. VAILE (GROSS OF 2000)         C. A. C. VAILE (GROSS OF 2000)         C. A. C. VAILE (GROSS OF 2000)         C. C. VAILE (GROSS OF 2000) <thc. c.="" vaile<br="">(GROSS OF 2000)         C. C. VAILE (GROSS OF</thc.>		Cost Center Description			econciliation		OPERATION OF	
Image: Stand Cross Contrement         5.02         5.03         56.04         5.04         7.00           0         00100 CAP REL_COSTS UNITIES         5.02         5.03         56.04         5.04         7.00           00100 CAP REL_COSTS UNITIES         00100 CAP REL_COSTS UNITIES         7.627.400			`					
CHINAL SHALL COST CATHER         5.02         5.03         6A.04         5.04         7.00           00         CODIC (AP REL COST SHD0.6 F IXT)         0			GES)				(SQUARE FEET)	
CEREAL SERVICE COST CENTERS           00         0000 (Day Part IC OST STAVELE EQUIP 0000) CARL SERVICE SERVICE ENDAVIES 10000 (DAYUNGE SERVICE IS DEVAILABLE 10000 (DAYUNGE SERVICE IS DEVAILABLE 10000) CARLING IN MATCHING MATCHING 10000 (DAYUNGE SERVICE IS DEVAILABLE 10000 (DAYUNGE NA CALIFIER MATCHING SCIEVARLE 00000) CARLING IN MATCHING SCIEVARLE 00000 (DAYUNGE NA CALIFIER MATCHING SCIEVARLE 000000 (DAYUNGE NA CALIFIER MATCHING SCIEVARLE 000000 (DAYUNGE NA CALIFIE			F 02		FA 04	F 04	7.00	<u> </u>
0.00         0.00000000000000000000000000000000000	GENER	AL SERVICE COST CENTERS	5.02	5.03	5A. 04	5.04	7.00	-
0.00         0.0000         PREVAYEE         FIGURATION           0.0000         0.0000         PREVAYER SINC RECEIVABLE         0	00100	CAP REL COSTS-BLDG & FIXT						1.
0.1         0.0020         PURCHASING RECELVING AND STORES         77, 627, 490           0.00200         PURCHASING RECELVING & CENERAL         0         0         0.0020								2.
02         00570         AVMITTING         77, 627, 490         -3, 247, 701         20, 207, 823           00         00050         CASAR TONG OF FLANKIN STRATT VE & GENERAL.         0         0         0         0         1, 450, 715         84, 82           00         00000         CASAR TONG OF FLANKIN         0         0         1, 450, 715         84, 82           00         00000         CASAR TONG OF FLANKIN         0         0         0         647, 850         1, 97, 97, 97, 97, 97, 97           00         00000         CASAR TONG OF FLANKIN         0         0         0         647, 850         1, 97, 97, 97, 97         3, 3, 55           00         01000         CASAR TATION         0         0         0         133, 65         14           00         0100         CASAR TON, 97, 87, 97         0         0         0         0         10           00         0100         CASAR TATION         0								4.
0.02         0.02 <td< td=""><td></td><td></td><td>77, 627, 490</td><td></td><td></td><td></td><td></td><td>5.</td></td<>			77, 627, 490					5.
000         0000         0000         00000         0000000         000000         000000         0000000         0000000         000000000000         000000000000000000000000000000000000			0	77, 627, 490				5.
000         0000         000000         000000         000000         00000000000000000000         000000000000000000000000000000000000			0	0	_		04.000	5
000         0000         00000         00000         0000000         0000000         0000000         0000000         0000000         00000000         00000000000000         000000000000000000000000000000000000			0	0			84, 833	
0.00         0.00 <th< td=""><td></td><td></td><td>0</td><td>0</td><td>C</td><td></td><td>1, 943</td><td></td></th<>			0	0	C		1, 943	
3 00         0 00         00         00         00         133.625         115           0.00         01400         00         0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td>C</td> <td></td> <td>3, 305</td> <td></td>			0	0	C		3, 305	
0         0			0	0	C		1, 772	
0         0			0	0			158 0	
0 00         0000         0000         0000         000000         000000         000000         000000         000000         000000         000000000000000000000000000000000000			0	0		-	0	
INPATI ENT ROUT NE SERVICE COST CENTERS           00         000000 ADULTS & PEDIATRICS           00         0100 INTENSIVE CARE UNIT           00         000 ISTOR           000 ISTOR CREATINE ROOM         0           000 ISTOR CREATINE ROOM         0 <td></td> <td></td> <td>0</td> <td>0</td> <td>C</td> <td>199, 825</td> <td>102</td> <td></td>			0	0	C	199, 825	102	
0.00         0.000         0.0000         ADULTS & PEDIATRICS         14, 324, 538         14, 324, 538         0         7, 464, 565         35, 00           0.00         0.0100         0.00         0			0	0	C	0	0	17
100         0 atool INTENSIVE CARE UNIT         100         0 <t< td=""><td></td><td></td><td>14 224 520</td><td>14 224 520</td><td></td><td></td><td>25.0(1</td><td>1 20</td></t<>			14 224 520	14 224 520			25.0(1	1 20
0.00         0 Hotol SUBPROVIDER - I RF         0         0         0         0           ANCILLARY SERVICE COST CENTERS         0			14, 324, 538	14, 324, 538			35,061	
AMCILLARY SERVICE COST CENTERS         0         0           0.0         005000 PECATING ROOM         0         <			0	0		-	0	
0.00         DSOOD         DEPERATING ROOM         0         0         0         0           0.00         DSOOD         DO STAOQ RESTIESIOLOGY         0 <t< td=""><td>04300</td><td>NURSERY</td><td>0</td><td>0</td><td>C</td><td>0</td><td>0</td><td>43</td></t<>	04300	NURSERY	0	0	C	0	0	43
100         05100         RECOVERY ROOM         0         0         0         0           100         05400         RADIOLOGY-DIAGNOSTIC         8, 124, 658         8, 124, 658         0         949, 721         4, 11           100         05500         RADIOLOGY-THERPEUTIC         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>								1
100         0 Sadol ANESTHESI OLOGY         0         0         0         0         0         0           00         0 Sadol ANESTHESI OLOGY         8.124, 658         0.244, 658         0.949, 721         4, 13           00         0 Sadol ANDIONOST-INCENAPEUTI C         0.244, 658         0.344, 647         3.364, 647         0.364, 647         0.364, 647         0.364, 647         0.364, 647         0.364, 647         0.364, 647         0.364, 647         0.364, 647         0.364, 647         0.364, 647         0.364, 647         0.0         0.360         0.360, 663, 301         0.561, 236         1.77         0.0         0.00         0.			0	0		-	0	
1:00         05400 RADIOLOV-DIAGNOSTIC         8, 124, 658         0         949, 721         4, 11           00         05500 RADIOLOV-THERAPEUTIC         0			0	0	0	0	0	
0:00         05400 RADIOLSTOPE         3.346.47         0         349.861         33           0:00         05700 CT SCAN         6.663.301         6.633.301         0         570.054         66           0:00         05900 CARDIAC CATHETERIZATION         0<			8, 124, 658	8, 124, 658	C	949, 721	4, 179	
1.00         05700         CT SCAN         6, 663, 301         0, 6600         570, 054         66           0.00         05600         CARDIAC CATHETERIZATION         0			0	0	C	0	0	
0.00         05000         NRI         7, 294, 733         7, 294, 733         0         551, 236         1, 71           0.00         05000         CARDI AC CATHETERI ZATI ON         0					C		316	
2.00         05900         CARDIA C CATHETER IZATION         0         0         0         0           0.00         06000         LABORATORY         10, 596, 773         0         1, 127, 736         2, 23           0.00         06300         BLOOD & PACKED RED BLOOD CELL         0         <							693	
2.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELL         0			0	0	-		0	
0.00         06300         BLODD STORING, PROCESSING, & TRANS.         126,448         126,448         0         9,751           0.00         06500         RESPIRATORY THERAPY         1,438,880         1,438,880         0         397,092           0.00         06000         PHYSICAL THERAPY         4,867,270         4,867,270         0         989,932         18           0.00         06000         SPECCH PATHOLOGY         1,297,969         1,297,969         0         223,134         44           0.00         06900         ELECTROCARDIOLOGY         4,477,056         4,477,056         0         223,134         44           0.00         07000         MELORARDEPTALORAPHY         1,747,735         0         54,281         0         <			10, 596, 773	10, 596, 773	C	1, 127, 736	2, 238	60
0.00         06500         RESPI RATORY THERAPY         1, 438, 880         0         397, 092           0.00         06600         PHYSI CAL THERAPY         7, 702, 976         0         2, 115, 943         5, 02           0.00         06800         SPECCH PATHOLOCY         1, 297, 969         0         2, 115, 943         5, 02           0.00         06800         SPECCH PATHOLOCY         1, 297, 969         0         291, 169         13           0.00         06000         ELECTROCARDIOLOGY         4, 477, 056         4, 477, 056         0         223, 134         44           0.00         07000         ELECTROCARDEPHALOGRAPHY         1, 747, 735         0         54, 281         0           0.00         07000         ELECTROCARGED TO PATIENTS         3, 918, 558         0         622, 580         11           0.00         07400         RENAL DIALYSIS         370, 173         370, 173         0         73, 790         56           0.00         OR400         RESCHARGED TO PATIENTS         3, 918, 558         0         622, 580         11           0.00         0         0         0         0         0         0         0         0         0         0         0         <			0	0	C	0	0	
0.00         06600         PHYSICAL THERAPY         7, 702, 976         7, 702, 976         0, 7, 702, 976         0, 7, 702, 976         0, 7, 702, 976         0, 7, 702, 976         0, 7, 702, 976         0, 7, 702, 976         0, 989, 932         16           0.00         06000         SPEECH PATHOLOGY         1, 297, 969         0, 291, 169         17           0.00         06000         ELECTRORCARDIOLOGY         4, 477, 056         4, 477, 056         0, 231, 314         42           0.00         07000         ELECTRORCARDHALORCAPHY         1, 747, 735         0, 747, 735         0         54, 281           0.00         07000         REUAL, DIALYSIS         3, 918, 558         0 <td< td=""><td></td><td></td><td></td><td></td><td>0</td><td></td><td>0</td><td></td></td<>					0		0	
1.00         06700         00CUPATIONAL THERAPY         4, 867, 270         0         989, 932         18           0.00         06800         SPEECH PATHOLOGY         1, 297, 969         0         291, 169         13           0.00         06000         ELECTROCARDIOLOGY         4, 477, 056         4, 477, 056         0         223, 134         42           0.00         07000         ELECTROCARDIOLOGY         1, 747, 735         0         54, 281         0           0.00         07000         MEDICAL SUPPLIES CHARGED TO PATIENTS         0<					0		5, 029	
1.00         06900         ELECTROCARDIOLOGY         4,477,056         4,477,056         0         223,134         442           0.00         07000         ELECTROENCEPHALOGRAPHY         1,747,735         0         54,281         0         54,281           0.00         07000         MEDICAL SUPPLIES CHARGED TO PATIENT         479,861         479,861         0         113,130           0.00         07300         DRUGS CHARGED TO PATIENTS         3,918,558         0         672,580         111           0.00         07500 ASC (NON-DISTINCT PART)         0							189	
00         07000         ELECTROENCEPHALOGRAPHY         1, 747, 735         0         54, 281           00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENT         479, 861         479, 861         0							136	
00         07100         MEDICAL SUPPLIES CHARGED TO PATIENT         479,861         0         113,130           00         07200         IMPL. DEV. CHARGED TO PATIENTS         3,918,558         3,918,558         0         672,580         111           00         07400         REMARCED TO PATIENTS         3,918,558         3,918,558         0         672,580         111           00         07400         REMAL DI ALYSI S         370,173         0         73,790         56           00         07500 ASC (NON-DI STINCT PART)         0         0         0         0         0         0         0         0         73,790         56           00         09000         CLINIC         831,914         0         224,476         17         0							420	
00         07200         IMPL         DEV. CHARGED TO PATIENTS         0         <							0	70
00         07300         DRUGS CHARGED TO PATIENTS         3,918,558         3,918,558         3,918,558         0         672,580         11           00         07400         RENAL DIALYSIS         370,173         370,173         0         73,790         56           00         07500         ASC (NON-DISTINCT PART)         0			477,001	479,001	C	0	0	
.00         07500         ASC (NON-DISTINCT PART)         0         0         0         0           0UTPATIENT SERVICE COST CENTERS	07300	DRUGS CHARGED TO PATIENTS			C	672, 580	118	
OUTPATIENT SERVICE COST CENTERS           00         09000 CLINIC         831,914         831,914         0         224,476         17           00         09100 EMERGENCY         0			370, 173		C		564	
0.00         09000         CLINIC         831,914         831,914         0         224,476         17           0.00         09100         EMERGENCY         0	-		0	0	C	0	0	75
.00         09100         EMERGENCY         0         0         0         0           .00         09200         DBSERVATI ON BEDS (NON-DI STINCT PART         0         0         0         0           SPECIAL PURPOSE COST CENTERS         SPECIAL PURPOSE COST CENTERS         0         0         0         0         0           3.00         11300         INTEREST EXPENSE         0			831.914	831.914	0	224, 476	179	90
SPECIAL PURPOSE COST CENTERS           3.00         11300         INTEREST EXPENSE         0 <td>09100</td> <td>EMERGENCY</td> <td>0</td> <td>0</td> <td></td> <td></td> <td>0</td> <td></td>	09100	EMERGENCY	0	0			0	
3.00       11300       INTEREST EXPENSE       0       0       0       0       0         6.00       11600       HOSPICE       0       0       0       0       0       0         8.00       SUBTOTALS (SUM OF LINES 1 through 117)       77, 627, 490       77, 627, 490       -3, 247, 701       19, 472, 902       58, 11         NONREI MBURSABLE COST CENTERS         0.00       19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>92</td>								92
6.00         11600         HOSPICE         0						1		1110
8.00         SUBTOTALS (SUM OF LINES 1 through 117)         77, 627, 490         77, 627, 490         -3, 247, 701         19, 472, 902         58, 11           NONREL MBURSABLE COST CENTERS           00.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0			0	0	0	0	0	113 116
NONREI MBURSABLE COST CENTERS           0.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0           1.00         19100         RESEARCH         0         0         0         0         0           2.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         0         0         0         0           3.00         19300         NONPAI D WORKERS         0         0         0         0         0           4.00         07950         OTHER NONREI MBURSABLE DEPARTMENTS         0         0         0         0         0           4.01         07951         ADVERTI SI NG         0         0         0         72, 561           0.00         Cross Foot Adj ustments         0         0         0         72, 561           1.00         Negati ve Cost Centers         0         0         0         72, 561           2.00         Cost to be allocated (per Wkst. B, Part I)         0.006107         0.003272         0.160715         19.84916           3.00         Unit cost multiplier (Wkst. B, Part I)         0.006107         0.003272         0.160715         19.84916           4.00         Cost to be allocated (per Wkst. B,			77, 627, 490	77, 627, 490	-3, 247, 701	19, 472, 902		
1.00       19100       RESEARCH       0       0       0       0         2.00       19200       PHYSICIANS' PRIVATE OFFICES       0       0       0       661,859       26,71         3.00       19300       NONPAID WORKERS       0       0       0       0       0       0       0         4.00       07950       OTHER NONREI MBURSABLE DEPARTMENTS       0 <td></td> <td>IMBURSABLE COST CENTERS</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		IMBURSABLE COST CENTERS						
2.00       19200       PHYSICIANS' PRIVATE OFFICES       0       0       0       661,859       26,71         3.00       19300       NONPAID WORKERS       0       0       0       0       0         4.00       07950       OTHER NONREIMBURSABLE DEPARTMENTS       0       0       0       501         4.01       07951       ADVERTISING       0       0       0       72,561         0.00       Cross Foot Adjustments       0       0       0       72,561         1.00       Negative Cost Centers       -       -       -         2.00       Cost to be allocated (per Wkst. B, Part I)       0.006107       0.003272       0.160715       19.84919         3.00       Unit cost multiplier (Wkst. B, Part I)       0.006107       0.003272       0.160715       19.84919         4.00       Cost to be allocated (per Wkst. B, 39,766       449       278,436       391,33			0	0	-	-		190
3. 00       19300       NONPAID WORKERS       0       0       0         4. 00       07950       OTHER NONREI MBURSABLE DEPARTMENTS       0       0       0       501         4. 01       07951       ADVERTISING       0       0       0       72, 561         0. 00       Cross Foot Adjustments       0       0       0       72, 561         1. 00       Negative Cost Centers       2.00       Cost to be allocated (per Wkst. B, Part I)       474, 066       254, 010       3, 247, 701       1, 683, 86         2. 00       Unit cost multiplier (Wkst. B, Part I)       0. 006107       0. 003272       0. 160715       19. 84919         3. 00       Unit cost to be allocated (per Wkst. B, Part I)       39, 766       449       278, 436       391, 33			0	0		-	0 26, 716	191 192
4. 00       07950       OTHER NONREI MBURSABLE DEPARTMENTS       0       0       501         4. 01       07951       ADVERTISING       0       0       72, 561         0. 00       Cross Foot Adjustments       0       0       72, 561         1. 00       Negative Cost Centers       3, 247, 701       1, 683, 86         2. 00       Cost to be allocated (per Wkst. B, Part I)       0. 006107       0. 003272       0. 160715       19. 84919         3. 00       Unit cost multiplier (Wkst. B, Part I)       0. 006107       0. 003272       0. 160715       19. 84919         4. 00       Cost to be allocated (per Wkst. B, 39, 766       449       278, 436       391, 33			0	0	0	001, 859		192
0.00         Cross Foot Adjustments           1.00         Negative Cost Centers           2.00         Cost to be allocated (per Wkst. B, Part I)           3.00         Unit cost multiplier (Wkst. B, Part I)           0.001         Cost to be allocated (per Wkst. B, Part I)           0.002         Cost to be allocated (per Wkst. B, Part I)           0.004         Cost to be allocated (per Wkst. B, Part I)           0.005         Cost to be allocated (per Wkst. B, Part I)           0.006107         0.003272           0.160715         19.84919           278,436         391,33	07950	OTHER NONREIMBURSABLE DEPARTMENTS	Ő	0	C	501	0	194
1.00         Negative Cost Centers           2.00         Cost to be allocated (per Wkst. B, Part I)           3.00         Unit cost multiplier (Wkst. B, Part I)           4.00         Cost to be allocated (per Wkst. B, Part I)           9.00         Cost to be allocated (per Wkst. B, Part I)           9.00         Cost to be allocated (per Wkst. B, Part I)           9.00         Cost to be allocated (per Wkst. B, Part I)           9.00         Cost to be allocated (per Wkst. B, Part I)           9.00         Cost to be allocated (per Wkst. B, Part I)           9.00         Cost to be allocated (per Wkst. B, Part I)			0	0	C	72, 561	0	194
2.00         Cost to be allocated (per Wkst. B, Part I)         474,066         254,010         3,247,701         1,683,86           3.00         Unit cost multiplier (Wkst. B, Part I)         0.006107         0.003272         0.160715         19.84919           4.00         Cost to be allocated (per Wkst. B, Part II)         39,766         449         278,436         391,33		3						200
D3.00         Part I)         0.006107         0.003272         0.160715         19.84919           04.00         Cost to be allocated (per Wkst. B, Part I)         0.006107         0.449         278,436         391,33		0	474 066	254 010		3 247 701	1, 683, 867	201
U3.00         Unit cost multiplier (Wkst. B, Part I)         0.006107         0.003272         0.160715         19.84919           04.00         Cost to be allocated (per Wkst. B, Part I)         39,766         449         278,436         391,33			1, 4, 000	201,010		5,277,701	1, 000, 007	[
Part II)		Unit cost multiplier (Wkst. B, Part I)					19. 849198	
	00		39, 766	449		278, 436	391, 335	204
05.00 Unit cost multiplier (Wkst. B, Part 0.000512 0.000006 0.013779 4.61300	20		0 000512	0 00006		0 013770	4. 613004	205

Health Financial Systems COMM	IUNI TY STROKE A	ND REHABILITATI	ON	In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-1	
				From 07/01/2021		
				To 06/30/2022	Date/Time Pre 11/22/2022 9:	37 am
Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC	Reconciliatior	n 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 (per Wkst. B-2)						206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

OST A	Financial Systems COMM LLOCATION - STATISTICAL BASIS		Provider C		Period: From 07/01/2021	Worksheet B-1	
				I	o 06/30/2022	Date/Time Prep 11/22/2022 9:	
	Cost Center Description	LAUNDRY & LINEN SERVICE (TOTAL PATI ENT DAYS)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (GROSS SALARI ES)	NURSI NG ADMI NI STRATI ON (NURSI NG SA	
		8.00	9.00	10.00	11.00	LARI ES) 13.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	10.00	11.00	13.00	
. 00 . 00 . 01 . 02 . 03 . 04 . 00 . 00 . 00 . 00 0. 00 1. 00 3. 00 4. 00 5. 00 6. 00 7. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	9, 050 0 0 0 0 0 0 0 0 0 0 0 0 0	82, 890 3, 305 1, 772 158 0 0 102 0	27, 359 0 0 0 0 0 0 0 0	6, 603, 772 92, 231 0 0 0 0 0 0 0	4, 364, 562 0 0 0 0	1. 2. 5. 5. 5. 7. 8. 9. 10. 11. 13. 14. 15. 16. 17.
	INPATIENT ROUTINE SERVICE COST CENTERS						
0.00 1.00 1.00 3.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04300 NURSERY	9, 050 0 0 0	35, 061 0 0 0		0 0 0 0	3, 909, 067 0 0 0	30. 31. 41. 43.
	ANCI LLARY SERVI CE COST CENTERS	0			) 0	0	
0.00 1.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 2.00 3.00 5.00	05100 RECOVERY ROOM 05100 RECOVERY ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 06500 RESPI RATORY THERAPY		0 0 4, 179 316 693 1, 715 0 2, 238 0 0 0 0 0		0 0 331, 174 0 81, 733 184, 307 0 103, 874 0 0 300, 259 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	50. 51. 53. 54. 55. 56. 57. 58. 59. 60. 62. 63. 65.
9.00	06600  PHYSI CAL THERAPY 06700  OCCUPATI ONAL THERAPY 06800  SPEECH PATHOLOGY 06900  ELECTROCARDI OLOGY 07000  ELECTROENCEPHALOGRAPHY 07100  MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200  IMPL. DEV. CHARGED TO PATI ENTS 07300  DRUGS CHARGED TO PATI ENTS 07400  RENAL DI ALYSI S 07500  ASC (NON-DI STINCT PART) 0UTPATI ENT SERVICE COST CENTERS	0 0 0 0 0 0 0 0 0	5, 029 189 420 0 0 0 118 564 0		96, 215           69, 319           96, 682           18, 436           0           0           0           195, 148           0	0 0 0 18, 436 0 0 0 0 0 0	66. 67. 68. 70. 71. 72. 73. 73. 74. 75.
0. 00	09000 CLINIC	0	179		) 151, 565	151, 565	90.
1. 00 2. 00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART SPECI AL PURPOSE COST CENTERS	0	0			0	91. 92.
	11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 9, 050	0 56, 174	27, 359	0 6, 603, 772	0 4, 364, 562	113. 116. 118.
91.00 92.00 93.00 94.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS 07950 OTHER NONREIMBURSABLE DEPARTMENTS 07951 ADVERTISING Cross Foot Adjustments	0 0 0 0 0 0	0 0 26, 716 0 0 0	c c		0 0 0	190. 191. 192. 193. 194. 194. 200.
01.00 02.00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	98, 145	710, 449			162, 622	201.
03.00 04.00	Unit cost multiplier (Wkst. B, Part I)	10. 844751 1, 315	8. 570986 70, 603			0. 037260 8, 191	
05.00	Unit cost multiplier (Wkst. B, Part	0. 145304	0. 851767	7. 240652	0. 014111	0. 001877	205.

Health Financial Systems COMM	IUNI TY STROKE AN	ND REHABILITATI	ON	In Lieu of Form CMS-2552-1		
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 37 am
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	NURSI NG	
	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED	· · ·	ADMI NI STRATI ON	
	(TOTAL PATI			SALARI ES)		
	ENT DAYS)				(NURSING SA	
					LARI ES)	
	8.00	9.00	10.00	11.00	13.00	
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

USI ALL	OCATION - STATISTICAL BASIS		Provider CC		eri od:	Worksheet B-1
					rom 07/01/2021 o 06/30/2022	Date/Time Prepar
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	11/22/2022 9:37
		SERVICES &	(COSTED	RECORDS &		
		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(COSTED REQUIS.)		(GROSS CHAR GES)		
		14.00	15.00	16.00	17.00	
GE	NERAL SERVICE COST CENTERS	11100	101.00	10100		
	0100 CAP REL COSTS-BLDG & FIXT					
	0200 CAP REL COSTS-MVBLE EQUIP					
	0400 EMPLOYEE BENEFITS DEPARTMENT					
	0560 PURCHASING RECEIVING AND STORES					
	0570 ADMI TTI NG 0580 CASHI ERI NG/ACCOUNTS RECEI VABLE					
	0590 OTHER ADMINISTRATIVE & GENERAL					
	0700 OPERATION OF PLANT					
	0800 LAUNDRY & LINEN SERVICE					
	0900 HOUSEKEEPI NG					
0. 00 01	IOOO DI ETARY					1
. 00 01	100 CAFETERI A					1
	1300 NURSING ADMINISTRATION					1
	400 CENTRAL SERVICES & SUPPLY	0				1
		0	0	77 / 67 - 1		1
	1600 MEDICAL RECORDS & LIBRARY	0	0	77, 627, 490		1
	1700 SOCIAL SERVICE	0	0	C	0	1
	IPATI ENT ROUTI NE SERVI CE COST CENTERS 3000 ADULTS & PEDI ATRI CS	0	0	14, 324, 538	0	3
	3100 I NTENSI VE CARE UNI T	0	0	14, 324, 536		3
	100 SUBPROVI DER – I RF	0	0			4
	1300 NURSERY	Ő	0			4
	ICI LLARY SERVI CE COST CENTERS	ц ц.				
. 00 05	5000 OPERATING ROOM	0	0	C	0	5
. 00  05	5100 RECOVERY ROOM	0	0	C	0	5
	5300 ANESTHESI OLOGY	0	0	C	0	5
	5400 RADI OLOGY-DI AGNOSTI C	0	0	8, 124, 658		5
	5500 RADI OLOGY-THERAPEUTI C	0	0	C		5
1	5600 RADI OI SOTOPE	0	0	3, 364, 647		5
	5700 CT SCAN	0	0	6, 663, 301		5
	5800 MRI 5900 CARDI AC CATHETERI ZATI ON	0	0	7, 294, 733	0	5
	5000 LABORATORY	0	0	10, 596, 773	-	6
	5200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	10, 390, 773	0	6
	5300 BLOOD STORING, PROCESSING, & TRANS.	0	0	126, 448	-	6
	5500 RESPIRATORY THERAPY	0	0	1, 438, 880		6
. 00 06	6600 PHYSI CAL THERAPY	0	0	7, 702, 976	0	6
. 00   06	5700 OCCUPATI ONAL THERAPY	0	0	4, 867, 270	0	6
	5800 SPEECH PATHOLOGY	0	0	1, 297, 969		6
. 00   06	5900 ELECTROCARDI OLOGY	0	0	4, 477, 056	0	6
	7000 ELECTROENCEPHALOGRAPHY	0	0	1, 747, 735		7
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	479, 861	0	7
	7200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	7
	7300 DRUGS CHARGED TO PATIENTS 7400 RENAL DIALYSIS	0	0	3, 918, 558 370, 173		7
	7500 ASC (NON-DISTINCT PART)	0	0	370, 173		7
	JTPATIENT SERVICE COST CENTERS	U	0		0	/
		0	0	831, 914	0	9
	P100 EMERGENCY	0	0	C	0	9
	200 OBSERVATION BEDS (NON-DISTINCT PART					9
	PECIAL PURPOSE COST CENTERS					
	1300 INTEREST EXPENSE					11
		0	0	0	-	11
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	77, 627, 490	0	11
	DNREIMBURSABLE COST CENTERS		0		0	10
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2100 RESEARCH		0		0	19
	2200 PHYSI CLANS' PRI VATE OFFI CES		0			19
	2300 NONPALD WORKERS	0	0	1	0	19
	7950 OTHER NONREIMBURSABLE DEPARTMENTS	0	0	0	0	19
	7951 ADVERTI SI NG	o	0	0	o o	19
0.00	Cross Foot Adjustments		-	_		20
1.00	Negative Cost Centers					20
2. 00	Cost to be allocated (per Wkst. B,	0	0	234, 839	0	20
	Part I)					
3.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0.003025		20
94.00	Cost to be allocated (per Wkst. B,	0	0	6, 176	0	20
5. 00	Part II)	0.000000	0 000000	0 000000	0 000000	
	Unit cost multiplier (Wkst. B, Part	0.000000	0. 000000	0. 000080	0.000000	20

Health Financial Systems COMM	UNITY STROKE A	ND REHABILITATI	ON	In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-3045	Period:	Worksheet B-1	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	epared: 37 am
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE		
	SERVICES &	(COSTED	RECORDS &			
	SUPPLY	REQUIS.)	LIBRARY	(TIME SPENT)		
	(COSTED		(GROSS CHAR			
	REQUIS.)		GES)			
	14.00	15.00	16.00	17.00		
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

To 06/30/2022 Date/Tin 11/22/20	2 9:37 am
Title XVIII Hospital	PS
Costs	
Cost Center Description Total Cost Therapy Limit Total Costs RCE Total Co	sts
(from Wkst. B, Adj. Disallowance	
Part I, col.	
1.00 2.00 3.00 4.00 5.00 I NPATI ENT ROUTI NE SERVI CE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS 10, 974, 928 10, 974, 928 0 10, 974, 928	. 928 30. 00
31. 00  03100   NTENSI VE CARE UNIT	0 31.00
41. 00  04100  SUBPROVI DER - I RF 0 0 0 0	0 41.00
43. 00 04300 NURSERY 0 0 0	0 43.00
ANCI LLARY SERVI CE COST CENTERS	43.00
50. 00 05000/0PERATING ROOM	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, 256, 583 1, 256, 583 0, 1, 25	
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0	0 55.00
	, 933 56.00
	, 578 57.00
	, 655 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0	0 59.00
60. 00 06000 LABORATORY 1, 414, 507 1, 414, 507 0 1, 41	, 507 60. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0	0 62.00
	, 701 63.00
	, 284 65.00
66. 00 06600 PHYSI CAL THERAPY 2, 644, 851 0 2, 644, 851 0 2, 64	, 851 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY 1, 172, 285 0 1, 172, 285 0 1, 17	
	, 033 68. 00
69. 00 06900 ELECTROCARDI OLOGY 287, 652 0 28	, 652 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 69, 585 69, 585 0 66	, 585 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 132, 764 132, 764 0 13	, 764 71.00
72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0	0 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 802, 294 0 80	, 294 73.00
	, 798 74.00
75.00 07500 ASC (NON-DISTINCT PART) 0 0 0	0 75.00
OUTPATIENT SERVICE COST CENTERS	
	, 785 90. 00
91.00 09100 EMERGENCY 0 0 0	0 91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0	0 92.00
SPECIAL PURPOSE COST CENTERS	
113.00 11300 I NTEREST EXPENSE	113.00
116.00 11600 HOSPI CE 0 0	0 116.00
	, 216 200. 00
201.00 Less Observation Beds 0 0	0 201.00
202.00       Total (see instructions)       21,843,216       0       21,843,216       0       21,843	, 216 202. 00

alth Financial Systems COM DMPUTATION OF RATIO OF COSTS TO CHARGES	MUNITY STROKE AN	Provider C		Period: From 07/01/2021 To 06/30/2022	u of Form CMS-: Worksheet C Part I Date/Time Pre 11/22/2022 9:	pared:
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
·		·	+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
D. 00 03000 ADULTS & PEDIATRICS	14, 324, 538		14, 324, 53	38		30.0
1.00 03100 INTENSIVE CARE UNIT	0			0		31.0
1.00 04100 SUBPROVIDER – IRF	0			0		41.0
3. 00 04300 NURSERY	0			0		43.0
ANCI LLARY SERVI CE COST CENTERS						
D. 00 05000 OPERATI NG ROOM	0	0		0 0.000000	0.000000	50.0
1.00 05100 RECOVERY ROOM	0	0		0 0.000000	0.000000	51.0
3. 00 05300 ANESTHESI OLOGY	0	0		0 0.000000	0. 000000	53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	429, 282	7, 695, 376	8, 124, 65	0. 154663	0. 000000	54. C
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0.000000	0.000000	55.0
5. 00 05600 RADI OI SOTOPE	13, 209	3, 351, 438	3, 364, 64	47 0. 127185	0.000000	56. C
7.00 05700 CT SCAN	585, 851	6, 077, 450	6, 663, 30	0. 106190	0.000000	57. C
3. 00 05800 MRI	117, 376	7, 177, 357			0.000000	58. C
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0.000000	59.0
D. 00 06000 LABORATORY	2, 234, 623	8, 362, 150	10, 596, 77	73 0. 133485	0.000000	60. C
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0.000000	0.000000	62.0
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	35, 306	91, 142	126, 44		0. 000000	
5. 00 06500 RESPI RATORY THERAPY	902, 554	536, 326			0. 000000	
5. 00 06600 PHYSI CAL THERAPY	4, 143, 538	3, 559, 438			0, 000000	
7. 00 06700 OCCUPATI ONAL THERAPY	4, 278, 052	589, 218			0. 000000	
3. 00 06800 SPEECH PATHOLOGY	962, 706	335, 263			0. 000000	
7. 00 06900 ELECTROCARDI OLOGY	213, 696	4, 263, 360			0.000000	
D. 00 07000 ELECTROENCEPHALOGRAPHY	213, 070	1, 747, 735			0.000000	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	479, 521	340			0.000000	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	477, 321	0-0	477,00	0 0.000000	0.000000	
3. 00 07300 DRUGS CHARGED TO PATIENTS	3, 471, 498	447,060	3, 918, 55		0.000000	
4. 00 07400 RENAL DIALYSIS	370, 173	447,000			0. 000000	
5. 00 07500 ASC (NON-DISTINCT PART)	370, 173	0		0 0.000000	0.000000	
OUTPATIENT SERVICE COST CENTERS	0	0		0 0.00000	0.00000	1 / 5. 0
D. 00 09000 CLINIC	29, 744	802, 170	831, 9	0. 335113	0. 000000	90.0
1. 00 09100 EMERGENCY	29, 744		031,9			
	0	0		0 0.00000	0.000000	
2. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	0	1	0 0.00000	0. 000000	92.0
SPECIAL PURPOSE COST CENTERS	1					1112 0
13. 00 11300 INTEREST EXPENSE		~		0		113.0
16. 00 11600 HOSPI CE		U 45 005 000		0		116.0
00.00 Subtotal (see instructions)	32, 591, 667	45, 035, 823	77, 627, 49	70		200.0
01.00 Less Observation Beds	00 501 // 7	45 005 000				201.0
D2.00 Total (see instructions)	32, 591, 667	45, 035, 823	77, 627, 49	<del>7</del> 0		202.

Health Financial Systems COM	MUNITY STROKE AND	REHABILITATION	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3045	Peri od:	Worksheet C
			From 07/01/2021	Part I
			To 06/30/2022	Date/Time Prepared: 11/22/2022 9:37 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient		10301 tu	113
Cost Conter Description	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 I NTENSI VE CARE UNI T				31.00
41. 00 04100 SUBPROVI DER – I RF				41.00
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVICE COST CENTERS				43.00
50. 00 05000 OPERATING ROOM	0.000000			50.00
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 154663			54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C				55.00
	0.000000			
56. 00 05600 RADI OI SOTOPE	0. 127185			56.00
57. 00 05700 CT SCAN	0. 106190			57.00
58. 00 05800 MRI	0. 099477			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.00000			59.00
60. 00 06000 LABORATORY	0. 133485			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 092536			63.00
65. 00 06500 RESPI RATORY THERAPY	0. 337265			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 343354			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 240851			67.00
68.00 06800 SPEECH PATHOLOGY	0. 268137			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 064250			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 039814			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 276672			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 204742			73.00
74.00 07400 RENAL DIALYSIS	0. 277703			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0.000000			75.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0. 335113			90.00
91.00 09100 EMERGENCY	0.000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE				113.00
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
				1

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-3045	Period: From 07/01/2021 To 06/30/2022	11/22/2022 9:	pared:
		1	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	10, 974, 928		10, 974, 92	28 0	10, 974, 928	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0			0 0	0	31.00
41. 00 04100 SUBPROVI DER – I RF	0			0 0	0	41.00
43. 00 04300 NURSERY	0			0 0	0	43.00
ANCI LLARY SERVICE COST CENTERS				<u> </u>		101.00
50. 00 05000 OPERATING ROOM	0			0 0	0	50.00
51.00 05100 RECOVERY ROOM	0			0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 256, 583		1, 256, 58	33 0	1, 256, 583	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		.,,	0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	427, 933		427, 93	33 0	427, 933	•
57. 00 05700 CT SCAN	707, 578		707, 57		707, 578	
58. 00 05800 MRI	725,655		725, 65		725, 655	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
60. 00 06000 LABORATORY	1, 414, 507		1, 414, 50	07 0	1, 414, 507	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	11, 701		11, 70	01 0	11, 701	63.00
65. 00 06500 RESPI RATORY THERAPY	485, 284	C			485, 284	65.00
66.00 06600 PHYSI CAL THERAPY	2, 644, 851	C	2, 644, 85		2, 644, 851	
67. 00 06700 OCCUPATI ONAL THERAPY	1, 172, 285	0	1, 172, 28		1, 172, 285	
68.00 06800 SPEECH PATHOLOGY	348, 033		348, 03		348, 033	
69. 00 06900 ELECTROCARDI OLOGY	287, 652		287, 65		287, 652	
70. 00 07000 ELECTROENCEPHALOGRAPHY	69, 585		69, 58		69, 585	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	132, 764		132, 76		132, 764	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	802, 294		802, 29	0	802, 294	73.00
74.00 07400 RENAL DI ALYSI S	102, 798		102, 79		102, 798	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0			0 0	0	75.00
OUTPATIENT SERVICE COST CENTERS			1	- <u> </u>		
90. 00 09000 CLINIC	278, 785		278, 78	35 0	278, 785	90.00
91.00 09100 EMERGENCY	0			0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	•
SPECIAL PURPOSE COST CENTERS				u		
113.00 11300 I NTEREST EXPENSE						113.00
116.00 11600 HOSPI CE	0			0		116.00
200.00 Subtotal (see instructions)	21, 843, 216	C	21, 843, 21	16 0		
201.00 Less Observation Beds	0			0		201.00
202.00 Total (see instructions)	21, 843, 216	C	21, 843, 21	0		

alth Financial Systems COMM MPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-3045	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part I Date/Time Pre 11/22/2022 9:	
		Titl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
D. 00 03000 ADULTS & PEDIATRICS	14, 324, 538		14, 324, 53	38		30.0
I. 00 03100 I NTENSI VE CARE UNI T	0			0		31.0
I. 00 04100 SUBPROVIDER – IRF	0			0		41. C
3. 00 04300 NURSERY	0			0		43. C
ANCILLARY SERVICE COST CENTERS						
D. 00 05000 OPERATING ROOM	0	0		0 0.000000	0.000000	50.0
I. 00 05100 RECOVERY ROOM	0	0		0 0.000000	0.000000	51.0
3. 00 05300 ANESTHESI OLOGY	0	0		0 0.000000	0.000000	53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	429, 282	7, 695, 376	8, 124, 65	0. 154663	0. 000000	54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0.000000	0.000000	55.0
5. 00 05600 RADI OI SOTOPE	13, 209	3, 351, 438	3, 364, 64	0. 127185	0.000000	56.0
7. 00 05700 CT SCAN	585, 851	6,077,450	6, 663, 30	0. 106190	0.000000	57.0
3. 00 05800 MRI	117, 376	7, 177, 357			0.000000	58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0.000000	59.0
0. 00 06000 LABORATORY	2, 234, 623	8, 362, 150	10, 596, 77		0,000000	
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0,000,000		0 0.000000	0. 000000	
3. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	35, 306	91, 142	126, 44		0. 000000	
5. 00 06500 RESPI RATORY THERAPY	902, 554	536, 326			0. 000000	
5. 00 06600 PHYSI CAL THERAPY	4, 143, 538	3, 559, 438			0.000000	
7. 00 06700 OCCUPATIONAL THERAPY	4, 278, 052	589, 218			0.000000	
3. 00 06800 SPEECH PATHOLOGY	962, 706	335, 263			0.000000	
2. 00 06900 ELECTROCARDI OLOGY	213, 696	4, 263, 360			0.000000	
0. 00 07000 ELECTROENCEPHALOGRAPHY	213,070	1, 747, 735			0.000000	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	479, 521	340			0. 000000	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	479, 521	340 0	479,00	0 0. 000000	0.000000	
3. 00 07200 TMPL. DEV. CHARGED TO PATIENTS	3, 471, 498	447,060	3, 918, 55		0. 000000	
		-				
4. 00 07400 RENAL DIALYSIS	370, 173	0			0.000000	
5. 00 07500 ASC (NON-DI STINCT PART)	0	0		0 0.000000	0.000000	75. (
OUTPATIENT SERVICE COST CENTERS	00.744	000 470	001.0	0.005440	0,000000	
0. 00 09000 CLINIC	29, 744	802, 170	831, 91		0.000000	
	0	0		0 0.000000	0.000000	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0.000000	0.000000	92.0
SPECIAL PURPOSE COST CENTERS	1 1			1		
13.00 11300 I NTEREST EXPENSE		-				113. (
16.00 11600 HOSPI CE	0	0		0		116. (
00.00 Subtotal (see instructions)	32, 591, 667	45, 035, 823	77, 627, 49	90		200. (
01.00 Less Observation Beds						201. (
02.00 Total (see instructions)	32, 591, 667	45, 035, 823	77, 627, 49	90		202. (

Heal th	Financial Systems CON	IMUNITY STROKE AND	REHABI LI TATI ON	In Lieu	u of Form CMS-2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-3045	Peri od:	Worksheet C
				From 07/01/2021	Part I
				To 06/30/2022	Date/Time Prepared:
					11/22/2022 9: 37 am
			Title XIX	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVI DER – I RF				41.00
43.00	04300 NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0. 000000			51.00
53.00	05300 ANESTHESI OLOGY	0.000000			53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 154663			54.00
	05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
	05600 RADI OI SOTOPE	0. 127185			56.00
	05700 CT SCAN	0. 127185			57.00
		0. 099477			58.00
	05900 CARDI AC CATHETERI ZATI ON	0.000000			59.00
60.00	06000 LABORATORY	0. 133485			60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
	06300 BLOOD STORING, PROCESSING, & TRANS.	0. 092536			63.00
65.00	06500 RESPI RATORY THERAPY	0. 337265			65.00
66.00	06600 PHYSI CAL THERAPY	0. 343354			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 240851			67.00
68.00	06800 SPEECH PATHOLOGY	0. 268137			68.00
69.00	06900 ELECTROCARDI OLOGY	0.064250			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 039814			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 276672			71.00
	07200 I MPL. DEV. CHARGED TO PATI ENTS	0. 000000			72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 204742			73.00
	07400 RENAL DIALYSIS	0. 277703			74.00
	07500 ASC (NON-DI STI NCT PART)	0. 000000			75.00
75.00	OUTPATIENT SERVICE COST CENTERS	0:000000			/3.00
00.00	09000 CLINIC	0. 335113			90.00
	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
	SPECIAL PURPOSE COST CENTERS				
	11300 INTEREST EXPENSE				113.00
	11600 HOSPI CE				116.00
200.00					200.00
201.00					201.00
202.00	Total (see instructions)				202.00

		MUNITY STROKE AN			In Lie	u of Form CMS-2	2552-10
	ON OF OUTPATIENT SERVICE COST TO CHARGE R S FOR MEDICAID ONLY	ATIOS NET OF	Provider C	CN: 15-3045	Period: From 07/01/2021 To 06/30/2022	Worksheet C Part II Date/Time Pre 11/22/2022 9:	pared: 37 am
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cos		Operating Cost	
	•	(Wkst. B, Part	(Wkst. B, Part	Net of Capita	al Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			, ,	col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	I LLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	0	0		0 0	0	50.00
51.00 0510	OO RECOVERY ROOM	0	0		0 0	0	51.00
53.00 0530	OO ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 0540	00 RADI OLOGY-DI AGNOSTI C	1, 256, 583	370, 018	886, 56	5 0	0	54.00
55.00 0550	00 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56.00 0560	OO RADI OI SOTOPE	427, 933	65, 337	362, 59	06 0	0	56.00
57.00 0570	OO CT SCAN	707, 578	132, 294	575, 28	34 0	0	57.00
	OO MRI	725, 655	243, 686			0	58.00
	OO CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
	00 LABORATORY	1, 414, 507	146, 696	1, 267, 81	1 0	0	60.00
	00 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	., 20, , 0	0 0	0	62.00
	00 BLOOD STORING, PROCESSING, & TRANS.	11, 701	225	11, 47	76 O	0	63.00
	00 RESPI RATORY THERAPY	485, 284	13, 455			0	65.00
	00 PHYSI CAL THERAPY	2, 644, 851	311, 503			0	66.00
	OO OCCUPATIONAL THERAPY	1, 172, 285	32, 022			0	67.00
	00 SPEECH PATHOLOGY	348, 033	11, 765			0	68.00
	00 ELECTROCARDI OLOGY	287, 652	49, 168			0	69.00
	00 ELECTROEARDI OLOGI	69, 585	13, 130			0	70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	132, 764	2, 038			0	71.00
		132, 704	2,038		0 0	-	
	OO I MPL. DEV. CHARGED TO PATIENTS		-		-	0	72.00
	OO DRUGS CHARGED TO PATIENTS	802, 294	51, 847			0	73.00
	00 RENAL DI ALYSI S	102, 798	18, 539			0	74.00
	00 ASC (NON-DI STI NCT PART)	0	0		0 0	0	75.00
	PATIENT SERVICE COST CENTERS	070 705	44.070	044.04	2	0	
		278, 785	11, 878			0	90.00
	00 EMERGENCY	0	0		0 0	0	91.00
	00 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	92.00
	CIAL PURPOSE COST CENTERS	1 1		1			
	00 INTEREST EXPENSE						113.00
116.00116		0	0		0 0		116. 00
200.00	Subtotal (sum of lines 50 thru 199)	10, 868, 288	1, 473, 601	9, 394, 68	37 0		200. 00
201.00	Less Observation Beds	0	0		0 0		201.00
202.00	Total (line 200 minus line 201)	10, 868, 288	1, 473, 601	9, 394, 68	37 0	<u>م</u>	202.00

LCULATION OF OUTPATIENT SERVICE COST TO CHARGE	RATIOS NET OF	Provider C	CN: 15-3045	Peri od:	Worksheet C	
DUCTIONS FOR MEDICAID ONLY				From 07/01/2021		
				To 06/30/2022	Date/Time Pr 11/22/2022 9	epare
		Ti †I	e XIX	Hospi tal	PPS	. 57 8
Cost Center Description	Cost Net of	Total Charges				
obst conter beschiption		(Worksheet C,	Cost to Char	ae		
	Operating CostP					
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCI LLARY SERVI CE COST CENTERS					-	
. 00 05000 OPERATING ROOM	0	0	0.0000	00		50.
. 00 05100 RECOVERY ROOM	0	0	1			51
. 00 05300 ANESTHESI OLOGY	0	0	0.0000			53
. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 256, 583	8, 124, 658				54
. 00 05500 RADI OLOGY - THERAPEUTI C	0	0	1			55
. 00 05600 RADI 0I SOTOPE	427, 933	3, 364, 647				56
. 00 05700 CT SCAN	707, 578	6, 663, 301				57
. 00 05800 MRI	725, 655	7, 294, 733				58
. 00 05900 CARDI AC CATHETERI ZATI ON	. 20, 000	0	0.0000			59
. 00 06000 LABORATORY	1, 414, 507	10, 596, 773				60
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	10, 070, 770	1			62
. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	11, 701	126, 448				63
. 00 06500 RESPIRATORY THERAPY	485, 284	1, 438, 880				65
. 00 06600 PHYSI CAL THERAPY	2, 644, 851	7, 702, 976				66
. 00 06700 OCCUPATI ONAL THERAPY	1, 172, 285	4, 867, 270				67
. 00 06800 SPEECH PATHOLOGY	348, 033	1, 297, 969				68
. 00 06900 ELECTROCARDI OLOGY	287, 652	4, 477, 056				69
00 07000 ELECTROENCEPHALOGRAPHY	69, 585	1, 747, 735				70
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	132, 764	479, 861				71
00 07200 IMPL. DEV. CHARGED TO PATIENTS	132,704	479,001				72
. 00 07300 DRUGS CHARGED TO PATIENTS	802, 294	3, 918, 558				73
. 00 07400 RENAL DIALYSIS	102, 798	3, 918, 558				74
. 00 07500 ASC (NON-DISTINCT PART)	102, 798	370, 173	1			75
OUTPATIENT SERVICE COST CENTERS	0	0	0.0000			- / 5
. 00 09000 CLINIC	278, 785	831, 914	0.3351	12		90
. 00  09000 CLINIC . 00  09100 EMERGENCY	278, 785		1			91
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				91
SPECIAL PURPOSE COST CENTERS	0	0	0.0000			- 72
3. 00 11300 I NTEREST EXPENSE			1			113
6. 00 11600 HOSPICE		0	0.0000	00		116
0.00 Subtotal (sum of lines 50 thru 199)	10, 868, 288	63, 302, 952		00		200
	10, 808, 288	03, 302, 952				200
	10.040.000	(2, 202, 052	1			
2.00  Total (line 200 minus line 201)	10, 868, 288	63, 302, 952				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS       Provider CCN: 15-3045       Period: From 07/01/2021 To 06/30/2022       Worksheet D Part I Date/Time Prepared: 11/22/2022 9:37 am         Image: Cost Center Description       Capital Related Cost (from Wkst. B, Part II, col. 26)       Swing Bed Adjustment       Reduced Capital Related Cost (col. 1 - col. 20)       Total Patient Days       Per Diem (col. 3 / col. 4)         Image: Cost Center Description       Capital Related Cost (from Wkst. B, Part II, col. 26)       Swing Bed Adjustment       Reduced Capital Related Cost (col. 1 - col. 20)       Total Patient Days       Per Diem (col. 3 / col. 4)         Image: Cost Center Description       1,00       2.00       3.00       4.00       5.00         Image: Cost Center Description       1,703,819       0       1,703,819       9,050       188.27       30.0         30.00       ADULTS & PEDIATRICS       1,703,819       0
Cost Center DescriptionCapital Related Cost (from Wkst. B, Part II, col. 26)Swing Bed AdjustmentReduced Capital Related Cost (col. 1 - col. 2)Total Patient DaysPer Diem (col. 3 / col. 4)1.002.003.004.005.001.002.003.004.005.0031.00INPATIENT ROUTINE SERVICE COST CENTERS1,703,81901,703,8199,050188.2730.0031.00INTENSIVE CARE UNIT00000.0031.0041.00SUBPROVIDER - IRF00000.0041.0030.00Total (lines 30 through 199)1,703,8191,703,8199,050200.00Cost Center DescriptionInpatient Program days1,703,8199,050200.00
Rel ated Cost (from Wkst. B, Part II, col. 26)         Adj ustment         Capital Rel ated Cost (col. 1 - col. 2)         Days         3 / col. 4)           INPATI ENT ROUTI NE SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           ADULTS & PEDI ATRICS         1,703,819         0         1,703,819         9,050         188.27         30.00           31.00         INTENSI VE CARE UNIT         0         0         0         0         0.00         31.0           41.00         SUBPROVI DER - I RF         0         0         0         0.00         41.0           200.00         Total (Lines 30 through 199)         1,703,819         1,703,819         9,050         200.0           Cost Center Description         Inpati ent Program days         Inpati ent Program         Inpati ent Program         1.00         200.0
INPATI ENT_ROUTINE_SERVICE_COST_CENTERS         1,00         2.00         3.00         4.00         5.00           30.00         ADULTS & PEDI ATRICS         1,703,819         0         1,703,819         9,050         188.27         30.00           31.00         INTENSI VE CARE UNIT         0         0         0         0         0.00         31.00           41.00         SUBPROVIDER - IRF         0         0         0         0         0.00         31.00           41.00         SUBPROVIDER - IRF         0         0         0         0.00         31.00           41.00         SUBPROVIDER - IRF         0         0         0         0.00         31.00           41.00         SUBPROVIDER - IRF         0         0         0         0.00         31.00           41.00         SUBPROVIDER - IRF         0         0         0         0.00         31.00           43.00         NURSERY         0         0         0         0         0         0.00         30.00         43.00           200.00         Total (lines 30 through 199)         1,703,819         1,703,819         9,050         200.00         200.00           Cost Center Description         Inpati ent Pro
Part II, col.         (col. 1 - col.         2)           1.00         2.00         3.00         4.00         5.00           INPATIENT ROUTINE SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           30.00         ADULTS & PEDIATRICS         1,703,819         0         1,703,819         9,050         188.27         30.0           31.00         INTENSIVE CARE UNIT         0         0         0         0.00         31.0           41.00         SUBPROVIDER - I RF         0         0         0         0.00         41.00           43.00         NURSERY         0         1,703,819         9,050         200.0         43.0           200.00         Total (Lines 30 through 199)         1,703,819         1,703,819         9,050         200.0           Cost Center Description         Inpatient Program days         Program         Program         200.0         200.0
26)         2)         20           1.00         2.00         3.00         4.00         5.00           INPATI ENT ROUTINE SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           30.00         ADULTS & PEDIATRICS         1,703,819         0         1,703,819         9,050         188.27         30.0           31.00         INTENSIVE CARE UNIT         0         0         0         0.00         31.0           41.00         SUBPROVIDER - IRF         0         0         0         0.00         41.0           30.00         NURSERY         0         0         0         0.00         43.0           200.00         Total (Lines 30 through 199)         1,703,819         1,703,819         9,050         200.0           Cost Center Description         Inpatient Program days         Program         Program         1         1
INPATIENT ROUTINE SERVICE COST CENTERS           30.00         ADULTS & PEDIATRICS         1,703,819         0         1,703,819         9,050         188.27         30.0           31.00         INTENSIVE CARE UNIT         0         0         0         0         0.00         31.0           41.00         SUBPROVIDER - IRF         0         0         0         0         0.00         41.0           43.00         NURSERY         0         1,703,819         1,703,819         9,050         43.0           200.00         Total (Lines 30 through 199)         1,703,819         1,703,819         200.0         200.0           Cost Center Description
INPATI ENT ROUTI NE SERVICE COST CENTERS           30.00         ADULTS & PEDI ATRI CS         1,703,819         0         1,703,819         9,050         188.27         30.0           31.00         INTENSI VE CARE UNIT         0         0         0         0         0.00         31.0           41.00         SUBPROVI DER - I RF         0         0         0         0         0.00         41.0           43.00         NURSERY         0         0         0         0         0.00         43.0           200.00         Total (Lines 30 through 199)         1,703,819         1,703,819         9,050         200.0           Cost Center Description         Inpatient Program days         Program         Program         1         1
30. 00         ADULTS & PEDIATRICS         1,703,819         0         1,703,819         9,050         188.27         30. 0           31. 00         INTENSIVE CARE UNIT         0         0         0         0         0.00         31. 0           41. 00         SUBPROVIDER - IRF         0         0         0         0         0.00         41. 0           43. 00         NURSERY         0         0         0         0         0.00         43. 0           200. 00         Total (lines 30 through 199)         1,703,819         1,703,819         9,050         200. 0           Cost Center Description           Inpatient Program days
31.00       INTENSIVE CARE UNIT       0       0       0.00       31.0         41.00       SUBPROVIDER - IRF       0       0       0       0.00       41.0         43.00       NURSERY       0       0       0       0.00       43.0         200.00       Total (lines 30 through 199)       1,703,819       1,703,819       9,050       200.0         Cost Center Description         Inpatient Program days
41.00       SUBPROVIDER - IRF       0       0       0       0.00       41.0         43.00       NURSERY       0       0       0       0       0.00       43.0         200.00       Total (lines 30 through 199)       1,703,819       1,703,819       9,050       200.0         Cost Center Description       Inpatient Program days       Program       Program       1
43.00         NURSERY         0         0         0.00         43.00           200.00         Total (lines 30 through 199)         1,703,819         1,703,819         9,050         200.00           Cost Center Description         Inpatient Program days         Inpatient Program         Program         1         1
200.00         Total (lines 30 through 199)         1,703,819         1,703,819         9,050         200.00           Cost Center Description         Inpatient Program days         Inpatient Program         Inpatient         1,703,819         9,050         200.00
Cost Center Description Inpatient Inpatient Program days Program
Cost Center Description Inpatient Inpatient Program days Program
Capital Cost
(col. 5 x col.
6)
6.00 7.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS
30. 00 ADULTS & PEDIATRICS 5, 704 1, 073, 892 30. 0
31.00 INTENSIVE CARE UNIT 0 0 0 31.0
41.00 SUBPROVIDER - IRF 0 0 0 41.0
43. 00 NURSERY 0 0 43. 0
200.00 Total (lines 30 through 199) 5, 704 1, 073, 892 200.0

Health Financial Systems COM	MUNITY STROKE A	ND REHABILITATI	ON	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-3045	Peri od:	Worksheet D	
				From 07/01/2021 To 06/30/2022	Part II Date/Time Pre	norod.
				To 06/30/2022	11/22/2022 9:	
		Title	e XVIII	Hospi tal	PPS	<u>o, an</u>
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATING ROOM	0	0	0.0000		0	
51.00 05100 RECOVERY ROOM	0	0	0.0000		0	
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	370, 018	8, 124, 658			12, 074	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.0000	0 00	0	
56. 00 05600 RADI 0I SOTOPE	65, 337	3, 364, 647	0. 0194	19 4, 737	92	56.00
57.00 05700 CT SCAN	132, 294	6, 663, 301	0. 0198			57.00
58. 00 05800 MRI	243, 686	7, 294, 733	0. 03340	06 61, 832	2, 066	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.0000	0 0	0	59.00
60. 00 06000 LABORATORY	146, 696	10, 596, 773	0. 0138	1, 477, 924	20, 459	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.0000	0 00	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	225	126, 448	0.0017	79 9, 736	17	63.00
65. 00 06500 RESPI RATORY THERAPY	13, 455	1, 438, 880	0.0093	51 621, 089	5, 808	65.00
66. 00 06600 PHYSI CAL THERAPY	311, 503	7, 702, 976	0. 0404	39 2, 629, 011	106, 315	66.00
67.00 06700 OCCUPATI ONAL THERAPY	32, 022	4, 867, 270	0. 0065	79 2, 692, 109	17, 711	67.00
68.00 06800 SPEECH PATHOLOGY	11, 765	1, 297, 969	0.0090	54 562, 956	5, 103	68.00
69. 00 06900 ELECTROCARDI OLOGY	49, 168	4, 477, 056	0. 0109	32 137, 330	1, 508	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	13, 130	1, 747, 735	0.0075	13 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,038	479, 861	0.0042	47 352, 518	1, 497	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	0.0000	0 00	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	51, 847	3, 918, 558	0.0132	2, 138, 517	28, 295	73.00
74.00 07400 RENAL DI ALYSI S	18, 539					
75.00 07500 ASC (NON-DISTINCT PART)	0					75.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	11, 878	831, 914	0.0142	78 0	0	90.00
91.00 09100 EMERGENCY	0	C	0.0000		0	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	c c	0.0000		0	•
200.00 Total (lines 50 through 199)	1, 473, 601	63, 302, 952		11, 514, 440	219, 158	200.00

Health Financial Systems	COMMUNITY STROKE AN	D REHABILITATI	ION	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVI	CE OTHER PASS THROUGH COST	S Provider C	F	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part III Date/Time Pre 11/22/2022 9:	pared: 37 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CEN	ITERS					
30. 00 03000 ADULTS & PEDI ATRI CS	0	C	) (	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	) (	0 0	0	31.00
41. 00 04100 SUBPROVI DER – I RF	0	C		0 0	0	41.00
43. 00 04300 NURSERY	0	C		0 0	0	43.00
200.00   Total (lines 30 through 199)	0	C		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,			0 5	
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CEN	ITERS					
30. 00 03000 ADULTS & PEDI ATRI CS	0	C	9, 050	0.00	5, 704	30.00
31.00 03100 INTENSIVE CARE UNIT		0	) (	0.00	0	31.00
41. 00 04100 SUBPROVI DER – I RF	0	C		0.00	0	41.00
43. 00 04300 NURSERY		C		0.00	0	43.00
200.00 Total (lines 30 through 199)		C	9, 050	)	5, 704	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CEN	ITERS					
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
41.00 04100 SUBPROVIDER - IRF	0					41.00
43.00 04300 NURSERY	0					43.00
200.00   Total (lines 30 through 199)	0					200.00
	· · ·					

Health Financial Systems COMM	UNITY STROKE AN	ND REHABILITATI	ON		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS			То	07/01/2021 06/30/2022	Worksheet D Part IV Date/Time Pre 11/22/2022 9:	pared: 37 am
			XVIII	L F	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Pos	lied Health st-Stepdown djustments	Allied Health	
	1.00	2A	2.00		3A	3.00	
ANCI LLARY SERVI CE COST CENTERS							
50.00         05000         0PERATI NG         ROOM           51.00         05100         RECOVERY         ROOM           53.00         05300         ANESTHESI OLOGY	000000000000000000000000000000000000000	000000000000000000000000000000000000000		0 0 0	0 0 0	0 0 0	50.00 51.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	54.00 55.00
56. 00 05600 RADI 0I SOTOPE	0	0		0	0	0	56.00
57. 00 05700 CT SCAN	0	0		0	0	0	57.00
58. 00 05800 MRI	0	0		0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0			0	0	0	59.00 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL				0	0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0	0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	Ō	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0			0	0	0	74.00 75.00
75. 00 07500 ASC (NON-DI STI NCT PART) OUTPATI ENT SERVICE COST CENTERS	0	0		0	0	0	/5.00
90. 00 09000 CLINIC	0	0		0	0	0	90.00
91.00 09100 EMERGENCY	0	0		0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		0	92.00
200.00  Total (lines 50 through 199)	0	0	1	0	0	0	200. 00

Health Financial Systems COM	MUNITY STROKE A	ND REHABILITATI	ON	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 07/01/2021		
				To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 37 am
		Title	× XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 0		
51.00 05100 RECOVERY ROOM	0	0		0 0	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 8, 124, 658		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	01000000	
56. 00 05600 RADI OI SOTOPE	0	0		0 3, 364, 647		
57.00 05700 CT SCAN	0	0		0 6, 663, 301		
58. 00 05800 MRI	0	0		0 7, 294, 733		
59.00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0. 000000	
60. 00 06000 LABORATORY	0	0		0 10, 596, 773		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0. 000000	
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 126, 448		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 1, 438, 880		
66.00 06600 PHYSI CAL THERAPY	0	0		0 7, 702, 976		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 4, 867, 270		
68.00 06800 SPEECH PATHOLOGY	0	0		0 1, 297, 969		
69.00 06900 ELECTROCARDI OLOGY	0	0		0 4, 477, 056		
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 1, 747, 735		
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0 479, 861		
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	01000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 3, 918, 558		
74.00 07400 RENAL DI ALYSI S	0	0		0 370, 173		
75. 00 07500 ASC (NON-DI STI NCT PART) OUTPATI ENT SERVICE COST CENTERS	0	0		0 0	0.000000	75.00
90. 00 09000 CLINIC	0	0		0 831, 914	0. 000000	90.00
91. 00 09100 EMERGENCY	0	-		0 0 0	0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		-		0 0	0.000000	
200.00 Total (lines 50 through 199)	0	°		0 63, 302, 952		200.00
	1 0		I	00,002,702	I	200.00

Health Financial Systems COM	MUNITY STROKE AND	REHABI LI TATI	ON	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE		Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2021	Part IV	
				To 06/30/2022		
		Titlo	XVIII	Hospi tal	11/22/2022 9: PPS	37 811
Cost Center Description	Outpatient	Inpatient	Inpatient	Outpatient	Outpatient	
oust center beschiption	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	$(col. 6 \div col.$	unar goo	Costs (col.		Costs (col. 9	
	7)		x col. 10)	-	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0	1	0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	265, 105		0 1, 836, 673	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	4, 737		0 1, 075, 971	0	56.00
57.00 05700 CT SCAN	0. 000000	327, 893		0 2, 311, 803	0	57.00
58. 00 05800 MRI	0. 000000	61, 832		0 1, 823, 085	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	1, 477, 924		0 401, 147	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	9, 736		0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	621, 089		0 162, 197	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 629, 011		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	2, 692, 109		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	562, 956		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	137, 330		0 1, 377, 302	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 464, 080	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	352, 518		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 138, 517		0 202, 637	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	233, 683		0 0	-	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
OUTPATIENT SERVICE COST CENTERS			1	-	1	
90. 00 09000 CLINIC	0. 000000	0		0 667		90.00
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
200.00   Total (lines 50 through 199)		11, 514, 440	I	0 9, 655, 562	0	200. 00

	MUNITY STROKE A				u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	Provider C	CN: 15-3045	Period: From 07/01/2021	Worksheet D Part V	
				To 06/30/2022	Date/Time Pre	pared.
				10 00/00/2022	11/22/2022 9:	37 am
		Title	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000			0 0	0	
51.00 05100 RECOVERY ROOM	0. 000000			0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 154663			0 0	284, 065	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 127185			0 0	136, 847	56.00
57.00 05700 CT SCAN	0. 106190	2, 311, 803		0 0	245, 490	57.00
58. 00 05800 MRI	0. 099477	1, 823, 085		0 0	181, 355	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	)	0 0	0	59.00
60. 00 06000 LABORATORY	0. 133485	401, 147		0 0	53, 547	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 092536	0		0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 337265	162, 197		0 0	54, 703	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 343354		)	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 240851	0	)	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 268137	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0.064250	1, 377, 302		0 0	88, 492	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 039814	464, 080		0 0	18, 477	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 276672	0	)	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	)	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 204742	202, 637		0 6, 129	41, 488	73.00
74.00 07400 RENAL DIALYSIS	0. 277703	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0. 335113	667		0 0	224	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)		9, 655, 562		0 6, 129	1, 104, 688	
201.00 Less PBP Clinic Lab. Services-Program	1			0 0		201.00
Only Charges						

Health Financial Systems	COMMUNI TY STRO	KE AND	REHABI LI TATI	ON	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEA	LTH SERVICES AND VACCINE C	OST	Provider CO		Period: From 07/01/2021 To 06/30/2022	Worksheet D Part V Date/Time Pre 11/22/2022 9:	
			Title	XVIII	Hospi tal	PPS	
		Cost	s				
Cost Center Description			Cost				
	Reimburs		Reimbursed				
	Servi ce		Services Not				
	Subject		Subject To				
	Ded. & Coi		ed. & Coins.				
	(see inst	t.)	(see inst.)				
	6.00		7.00				-
ANCI LLARY SERVICE COST CENTER	(5	0	0				F0 00
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM		0	0				50.00
53. 00 05300 ANESTHESI OLOGY		0	0				
		0	0				53.00 54.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C		0	0				54.00
		0	0				
56. 00 05600 RADI OI SOTOPE 57. 00 05700 CT SCAN		0	0				56.00 57.00
58. 00 05800 MRI		0	0				
59. 00 05900 CARDI AC CATHETERI ZATI ON		0	0				58.00 59.00
60. 00 06000 LABORATORY		0	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RE		0	0				62.00
63. 00 06300 BLOOD STORING, PROCESSI		0	0				63.00
65. 00 06500 RESPI RATORY THERAPY		0	0				65.00
66. 00 06600 PHYSI CAL THERAPY		0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0	0				67.00
68. 00 06800 SPEECH PATHOLOGY		0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY		0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		o	0				70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGE	D TO PATIENT	ō	0				71.00
72.00 07200 I MPL. DEV. CHARGED TO P		0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIEN		0	1, 255				73.00
74.00 07400 RENAL DIALYSIS		0	0	1			74.00
75.00 07500 ASC (NON-DISTINCT PART)		0	0				75.00
OUTPATIENT SERVICE COST CENTE	ERS						
90. 00 09000 CLI NI C		0	0				90.00
91.00 09100 EMERGENCY		0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-D	DISTINCT PART	0	0				92.00
200.00 Subtotal (see instructi	ons)	0	1, 255				200.00
201.00 Less PBP Clinic Lab. Se	ervi ces-Program	0					201.00
Only Charges	-						
202.00 Net Charges (line 200 -	line 201)	0	1, 255				202.00

Health Financial Systems	COMMUNI TY STROKE AI	ND REHABILITATI	ON	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SE	RVICE CAPITAL COSTS	Provider C	F	Period: From 07/01/2021 Fo 06/30/2022	11/22/2022 9:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Capital	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST	CENTERS					
30. 00 ADULTS & PEDIATRICS	1, 703, 819	0	1, 703, 819	9 9, 050	188. 27	30.00
31.00 INTENSIVE CARE UNIT	0		(	0 0	0.00	31.00
41.00 SUBPROVIDER - IRF	0	0	(	0 0	0.00	41.00
43.00 NURSERY	0			0 0	0.00	43.00
200.00 Total (lines 30 through 199)	1, 703, 819		1, 703, 819	9,050		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST	CENTERS					
30. 00 ADULTS & PEDIATRICS	62	11, 673				30.00
31.00 INTENSIVE CARE UNIT	0	l o				31.00
41.00 SUBPROVIDER - IRF	0	0				41.00
43.00 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	62	11, 673				200.00
		,	1			

Health Financial Systems COM	MUNITY STROKE A	ND REHABILITATI	ON	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-3045	Period: From 07/01/2021	Worksheet D Part II	
				To 06/30/2022		pared:
					11/22/2022 9:	37 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col. 26)	8)	2)			
	1.00	2.00	3.00	4,00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	5.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0	0	0.0000	0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0.00000		0	
53.00 05300 ANESTHESI OLOGY	0	0	0.00000		0	1
54.00 05400 RADI OLOGY-DI AGNOSTI C	370, 018	8, 124, 658			96	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000		0	55.00
56. 00 05600 RADI OI SOTOPE	65, 337	3, 364, 647			0	56.00
57. 00 05700 CT SCAN	132, 294				0	1
58. 00 05800 MRI	243, 686	7, 294, 733	0. 03340	3, 276	109	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
60. 00 06000 LABORATORY	146, 696	10, 596, 773	0. 01384	13 25, 753	356	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.0000	0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	225	126, 448	0.00177	79 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	13, 455	1, 438, 880	0. 00935	51 982	9	65.00
66. 00 06600 PHYSI CAL THERAPY	311, 503	7, 702, 976	0. 04043	39 27, 257	1, 102	66.00
67.00 06700 OCCUPATI ONAL THERAPY	32, 022	4, 867, 270	0.00657	28, 287	186	67.00
68.00 06800 SPEECH PATHOLOGY	11, 765	1, 297, 969	0.00906	3, 282	30	68.00
69. 00 06900 ELECTROCARDI OLOGY	49, 168	4, 477, 056	0. 01098	32 4, 484	49	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	13, 130	1, 747, 735			0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 038	479, 861	0.00424	17 2, 757	12	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.0000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	51, 847	3, 918, 558	0. 01323	32, 191	426	73.00
74. 00 07400 RENAL DIALYSIS	18, 539	370, 173	0. 05008	32 10, 740	538	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.0000	0 0	0	75.00
OUTPATIENT SERVICE COST CENTERS		1	1			
90. 00 09000 CLINIC	11, 878	831, 914			0	
91.00 09100 EMERGENCY	0	0	0.0000		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.0000		0	
200.00   Total (lines 50 through 199)	1, 473, 601	63, 302, 952	l	141, 113	2, 913	200.00

Health Financial Systems	COMMUNITY STROKE AND	D REHABILITATI	ON	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICI	E OTHER PASS THROUGH COSTS		F	Period: From 07/01/2021 To 06/30/2022	11/22/2022 9:	pared: 37 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown	Ũ	Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENT	ERS					
30. 00 03000 ADULTS & PEDIATRICS	0	0	0	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0 0	0	31.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0 0	0	41.00
43.00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	o	0		0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
		(sum of cols.	Days	5 ÷ col. 6)	Program Days	
		through 3,			5 5	
		minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENT	ERS		•			
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	9, 050	0.00	62	30.00
31.00 03100 INTENSIVE CARE UNIT		0	0	0.00	0	31.00
41.00 04100 SUBPROVIDER - IRF	o	0		0.00	0	41.00
43. 00 04300 NURSERY		0		0.00	0	43.00
200.00 Total (lines 30 through 199)		0	9, 050		62	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENT	ERS			·		
30. 00 03000 ADULTS & PEDI ATRI CS	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)						200.00
	1 01					1200.00

Health Financial Systems COMM	IUNI TY STROKE AN	ND REHABILITATI	ON		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	6 Provider C	CN: 15-3045		7/01/2021 5/30/2022	Worksheet D Part IV Date/Time Pre 11/22/2022 9:	pared: 37 am
		Titl	e XIX	Hos	pi tal	PPS	
Cost Center Description		Nursing Program Post-Stepdown Adjustments	Nursing Program	Post-	Stepdown stments	Allied Health	
	1.00	2A	2.00		3A	3.00	
ANCI LLARY SERVI CE COST CENTERS							
50.00 05000 OPERATI NG 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	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	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	0	0	56.00
57.00 05700 CT SCAN	0	0		0	0	0	57.00
58. 00 05800 MRI	0	0		0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0	0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0	0	0	74.00
75.00 07500 ASC (NON-DI STINCT PART)	0	0		0	0	0	75.00
OUTPATI ENT SERVI CE COST CENTERS				I			1
90. 00 09000 CLINIC	0	0		0	0	0	90.00
91.00 09100 EMERGENCY	0	0		0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		0	92.00
200.00 Total (lines 50 through 199)	0	0		0	0	0	200.00

Health Financial Systems COM	MUNITY STROKE A	ND REHABILITATI	ON	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 07/01/2021	Worksheet D Part IV	
				To 06/30/2022		pared: 37 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	1		1			
50.00 05000 OPERATING ROOM	0	0		0 0	0.00000	
51.00 05100 RECOVERY ROOM	0	0		0 0	0.00000	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0.00000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 8, 124, 658	0.00000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0.00000	55.00
56. 00 05600 RADI 0I SOTOPE	0	0		0 3, 364, 647	0.00000	56.00
57.00 05700 CT SCAN	0	0		0 6, 663, 301	0. 000000	57.00
58. 00 05800 MRI	0	0		0 7, 294, 733	0. 000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0.00000	59.00
60. 00 06000 LABORATORY	0	0		0 10, 596, 773	0.00000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0.00000	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 126, 448	0.00000	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 1, 438, 880	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 7, 702, 976	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 4, 867, 270	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 1, 297, 969	0.00000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 4, 477, 056	0.00000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 1, 747, 735	0.00000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 479, 861	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 3, 918, 558	0.00000	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 370, 173	0.00000	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0.00000	75.00
OUTPATI ENT SERVI CE COST CENTERS	•					1
90. 00 09000 CLI NI C	0	0		0 831, 914	0.00000	90.00
91.00 09100 EMERGENCY	0	0		0 0	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0. 000000	92.00
200.00 Total (lines 50 through 199)	0	0		0 63, 302, 952		200.00
					•	

Health Financial Systems COM	MUNITY STROKE AND	REHABI LI TATI	ON	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS		Provider C	CN: 15-3045	Period: From 07/01/2021 To 06/30/2022	Worksheet D Part IV Date/Time Pre 11/22/2022 9:	pared:
			e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			1		1	
50.00 O5000 OPERATI NG ROOM	0. 000000	0		0 0		50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
53.00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 104		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MRI	0. 000000	3, 276		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	25, 753		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	0		0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	982		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	27, 257		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	28, 287		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	3, 282		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	4, 484		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	2, 757		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	32, 191		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	10, 740		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0 0	75.00
OUTPATIENT SERVICE COST CENTERS	· ·			·	•	1
90. 00 09000 CLINIC	0. 000000	0		0 0	0 0	90.00
91.00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		141, 113		0 0	0	200. 00

COMMUNI TY	STROKE	AND	REHABI LI TATI ON

In Lieu of Form CMS-2552-10

2.00       Injettient days (including sing-bad and observation med days).       9.650       9.050         00       Private room days (sectualing sing-bad and observation med days).       9.050       3.00         00       Sime for trade room days (sectualing sing-bad and observation med days).       9.050       3.00         00       Intal ing bad if type inpatient days (including private room days) after December 31 of the cost       0       0         00       Total sing-bad Site (private room days (including private room days) after December 31 of the cost       0       0.00         01       Total sing-bad Site (private room days (including private room days) after December 31 of the cost       0       0.00         00       Total sing-bad Site (private room days (including private room days) after December 31 of the cost       0       0.00         010       Total sing-bad Site (private room days (applicable to the Program (excluding sing-bad and mays) after December 31 of the cost       0       0         010       Sing-bad Site (private room days applicable to title XVIII only (including private room days) after       0       0       0         02       Sing-bad Site (private room singer) and title Site (Site (and and baserval) (including private room days) after       0       0       0         03       Sing-bad Site (private room days applicable to title XVII only (including private room days) after       0       0 </th <th>Heal th</th> <th>Financial Systems COMMUNITY STROKE AND</th> <th>REHABI LI TATI ON</th> <th>In Lie</th> <th>u of Form CMS-2</th> <th>2552-10</th>	Heal th	Financial Systems COMMUNITY STROKE AND	REHABI LI TATI ON	In Lie	u of Form CMS-2	2552-10
Interview         Interview <t< th=""><th>COMPUT</th><th>ATION OF INPATIENT OPERATING COST</th><th>Provider CCN: 15-3045</th><th></th><th>Worksheet D-1</th><th></th></t<>	COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-3045		Worksheet D-1	
The With         Hoge tal         PFS           00         Total with the concentration         1.00         1.00           100         Input int days (including private room days, and seing-bod days, excluding neatorn)         9.050         1.00           00         Input int days (including private room days, and seing-bod and experime days). It you have only private room days, 0.050         9.050         3.00           00         Semi-private room days (corcluding sering-bod and days-runtion bed days). It you have only private room days, 0.050         3.00           00         Semi-private room days (including private room days) (including private room days) through December 31 of the cost         0.00         5.00           00         Total sein may-bod SMF (ype input int days (including private room days) through December 31 of the cost         0.00         0.00           00         Total sein may-bod SMF (ype input int days (including private room days) after December 31 of the cost         0.00         0.					Date/Time Pre	pared:
Cost Center Description         1.00           DMT1 = ALL PROVIDER COMPONENTS         1.00           Displation Description         9.051           10         Inpatient days (including private room days, and swing-bed day, excluding newsorm)         9.050           200         Inpatient days (including anity-bed and observation bed days). If you have only private room days, of not complete this line.         9.050           000         Total Sampbed SMF type inpatient days (including private room days) after December 31 of the cost peopring period (including private room days) (including private room days) after December 31 of the cost peopring period (including private room days) (including private room days) after December 31 of the cost peopring period (including private room days) after December 31 of the cost peopring period (including private room days, and including anity add and days including private room days) after December 31 of the cost peopring period (including private room days, and including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) and period (including private room days) and becamber 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) and through December 31 of the cost reporting period (including private room days) and through December 31 of the cost reporting period (including private room days) and the days and becomber 31 of th					11/22/2022 9:	
PART I ALL PROVIDES COMPONENTS         1.00           100         Impailing DAYS         Including private room days, sudialing using-bed days, excluding swing-bed memberning)         9.050         2.00           100         Impailing DAYS         Including private room days, sudialing swing-bed memberning)         9.050         2.00           100         Including private room days, sudialing swing-bed and observation bed days)         100         100         6.00         5.00         3.00           100         Including private room days, sudialing private room days) through becenter 31 of the cost         0         5.00           100         Inclusion private room days (including private room days) through becenter 31 of the cost         0         6.00           100         Inclusion private room days (including private room days) through becenter 31 of the cost         0         6.00           101         Inclusion private room days applicable to titls XVII and Y (including private room days)         0         6.00           100         Inclusion days (including private room days applicable to titls XVII and y (including private room days)         0         10           101         String bed SWI type inpatient days applicable to titls XVII and y (including private room days)         0         10         0           102         String bed SWI type inpatient days applicable to titls XVII and y (including private room d		Cast Contar Description	litle XVIII	Hospital	PPS	
PART I - ALL FROM DEE COMPONENTS           INSTITUTE MAYS         Institute Mays         Onling Institute Mays         Onlinstitute Mays         Onling Institute Mays<		cost center bescription			1.00	
1.00       Inpatient days (including private room days, and swing-bed days, excluding newborn days)       9,050       2.00         0.10       Inpatient days (including private room days, and days)       17 you have only private room days, days       9,050       2.00         0.00       Inpatient days (including sing-bed and observation bed days)       17 you have only private room days, days       9,050       4.00         0.00       Inpatient days (including private room days)       16 the cost reporting period (f. calendar yave, areter 0 on this line)       9,050       0.00         0.01       Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (f. calendar yave, areter 0 an this line)       0       0.00       0.00       0.00         0.01       Total swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (f. calendar yave, areter 0 an this line)       0       0.00         0.01       Total swing-bed SW type inpatient days applicable to title XVII only (including private room days)       0       0.00         0.02       Sing-bed SW type inpatient days applicable to title XVII only (including private room days)       0       0         0.03       Sing-bed SW type inpatient days applicable to title XVII only (including private room days)       0       0       0         0.04       Sing-bed W type inpatient days explicable to services after Dec		PART I - ALL PROVIDER COMPONENTS				
2.00       Inplatient days (including yiny tate room days) and the deservation bed days).       9,050       2,00         0.01       Complete this line.       9,050       2,00         0.05       Samp Frivate room days (social ding swing-bed and observation bed days).       9,050       4,00         0.05       Samp Frivate room days (social ding swing-bed and observation bed days).       9,050       4,00         0.05       Total swing-bed K type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line).       0,00         0.00       Total swing-bed K type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line).       0,00         0.00       Total swing-bed SW type inpatient days applicable to the frogram (excluding swing-bed and mays).       0,00         0.01       Swing-bed SW type inpatient days applicable to thits XVIII only (including private room days).       0,00         0.01       Swing-bed SW type inpatient days applicable to the SVIII only (including private room days).       0,100         0.02       Swing-bed SW type inpatient days applicable to the SV XIX and SVIII only (including private room days).       0,100         0.03       Swing-bed SW type inpatient days applicable to the SV XIX and SVIII only apprivate room days).       0,100         0.04       Swing-bed SW type inpatient days applicable to serv						
3.00       Private room days (excluding swing-bed and observation bed days). If you have only private room days.       0       3.00         4.00       Semi-private room days (excluding swing-bed and observation bed days).       0       3.00         5.00       Total swing-bed SK type inpatient days (including private room days) after December 31 of the cost       0       5.00         6.00       Total swing-bed K type inpatient days (including private room days) after December 31 of the cost       0       6.00         7.00       Total swing-bed K type inpatient days (including private room days) after December 31 of the cost       0       6.00         0.00       Total swing-bed K type inpatient days applicable to till exvili on y(including private room days)       0       0.00         0.01       Total swing-bed SK type inpatient days applicable to till exvili on y(including private room days)       0       0.00         0.01       Swing-bed SK type inpatient days applicable to till Exvili on y(including private room days)       0       0.00         0.02       Swing-bed SK type inpatient days applicable to till Exvili on tills into)       0       1.00         0.03       Swing-bed SK type inpatient days applicable to tille XVII on tills into)       0       1.00         0.03       Swing-bed SK type inpatient days applicable to tille XVII on tills into)       0       1.00         0.04       Swing-bed SK typ						1.00
do not complete this line.       9,000         or Semi-Private room days (sociul ding swing-bed and observation bed days)       7,000         for Semi-Private room days (sociul ding swing-bed and observation bed days)       after December 31 of the cost       0         for opporting period       6       0       the cost       0       6         for opporting period       0       non-total swing-bed K type inpatient days (including private room days) through December 31 of the cost       0       6       0         for opporting period       0       0       the cost       0				civata room davc		
4.00       Semi-private room days (excluding swing-bed and observation hed days) through December 31 of the cost reporting period.       9,656       4.00         7.00       Total swing-bed SK type inpatient days (including private room days) after December 31 of the cost reporting period.       0       0         7.00       Total swing-bed KF type inpatient days (including private room days) after December 31 of the cost reporting period.       0       0         0.00       Total swing-bed KF type inpatient days (including private room days) after December 31 of the cost reporting period.       0       0       0         0.00       Saing-bed SK type inpatient days applicable to the true XVII only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       0       0         1.00       Saing-bed SK type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       0         1.00       Saing-bed SK type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       10         1.00       Saing-bed SK type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       10         1.00       Madically necessary private room days	3.00		ays). If you have only p	Tvate Toolii uays,	0	3.00
5.00       Iotal swing-bed SW Type Inpatient days (including private room days) after December 31 of the cost reporting period (realendar year, enter 0 on this 11nc)       0       0         7.00       reporting period (realendar year, enter 0 on this 11nc)       0 <t< td=""><td>4.00</td><td></td><td>ped days)</td><td></td><td>9, 050</td><td>4.00</td></t<>	4.00		ped days)		9, 050	4.00
0.00       Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period.       0.00       0.00       100 <t< td=""><td>5.00</td><td></td><td></td><td>er 31 of the cost</td><td></td><td>5.00</td></t<>	5.00			er 31 of the cost		5.00
reporting period       (1 find and year, enter 0 on this line)       7.00         Total swing-bed K Type inpatient days (including private room days) through December 31 of the cost reporting period       0.00         0.00       Total swing-bed K Type inpatient days (including private room days) after December 31 of the cost reporting period       0.00         0.00       Swing-bed K Type inpatient days applicable to the Program (excluding swing-bed and the period for calculater year, enter 0 on this line)       0.00         10.00       Swing-bed K Type inpatient days applicable to the Program (excluding private room days) through December 31 of the cost reporting period (if calculater year, enter 0 on this line)       0.00         10.00       Swing-bed K Type inpatient days applicable to thtle XVII only (including private room days)       0.10.00         11.00       Swing-bed K Type inpatient days applicable to thtle XVI only (including private room days)       0.10.00         11.00       Swing-bed K Type inpatient days applicable to thtle XV anly (including private room days)       0.10.00         11.01       Swing-bed K Type inpatient days applicable to the Program (excluding swing-bed days)       0.10.00         11.00       Swing-bed K Type inpatient days applicable to the Program (excluding swing-bed days)       0.10.00         11.00       Swing-bed K Type inpatient days applicable to the Program (excluding swing-bed days)       0.10.00         10.00       Swing-bed K Type inpatient days applicable to		June June June June June June June June				
7.00       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)       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)       8.00         9.00       Total inpatient days including private room days applicable to the Program (excluding swing-bed ans) through December 31 of the cost reporting period (see instructions)       5.00       10.02         10.00       Swing-bed SW type inpatient days applicable to the Vite XVII only (including private room days) through December 31 of the cost reporting period (see instructions)       11.00       11.00         11.00       Swing-bed WF type inpatient days applicable to the Program (excluding private room days) through December 31 of the cost reporting period       13.02         12.00       Swing-bed WF type inpatient days applicable to the Program (excluding private room days) through December 31 of the cost reporting period       13.02         14.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       0.00         17.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00         22.00       Swing-bed cost appl	6.00		oom days) after December	31 of the cost	0	6.00
reporting period       8.00         Total sing-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)       8.00         9.00       Total inpatient days including private room days) applicable to the Program (excluding swing-bed and base paper)       5.704       9.00         10.00       Swing-bed Sit type inpatient days applicable to title X/III only (including private room days)       0       10.00         11.00       Swing-bed NF type inpatient days applicable to title X/III only (including private room days)       0       10.00         12.00       Swing-bed NF type inpatient days applicable to title X/III only (including private room days)       0       10.00         13.00       Swing-bed NF type inpatient days applicable to title X/III only (including swing-bed days)       0       13.00         14.00       Medical IV necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         15.00       Total inserve days (III eV or XIX only (including private room days)       0       15.00         16.00       Medical IV necessary private room days applicable to services through December 31 of the cost reporting period (II calendar year, enter 0 on this line)       0       0         10.00       Medical IV necessary private room days applicable to services through December 31 of the cost       0.00       16.00         11	7 00		m dava) through December	a 21 of the east	0	7 00
8.00       Total señg-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) newborn days) (see instructions)       0.00         9.00       Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)       5.704       9.00         10.00       Swing-bed SMF type inpatient days applicable to thite XVIII only (including private room days) after through December 31 of the cost reporting period (See Instructions)       10.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period (If calendar year, enter 0 on this line)       11.00         10.00       New joed NF type inpatient days applicable to trilles V or XIX only (including private room days)       0       13.00         11.00       Medicaid precessary private room days applicable to services through December 31 of the cost       0       14.00         10.00       Nong-bed NF type inpatient days applicable to services through December 31 of the cost       0.00       16.00         11.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0.00       16.00         11.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0.00       0.00         12.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	7.00		om days) through December	r 31 of the cost	0	7.00
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) (see instructions)       9.00         11.00       Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       0         12.00       Swing-bed WF type inpatient days applicable to title XVIII only (including private room days) of through December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       10.00         13.00       Swing-bed WF type inpatient days applicable to the V or XIX only (including private room days)       0       13.00         14.00       Medically necessary private room days applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       13.00         17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       15.00         18.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (inc gar)       0       16.00         19.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (inc fragerid period (inc frager	8 00		om days) after December :	31 of the cost	0	8 00
9.00       Total inplatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)       5,704       9,00         10.00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (ical endar year, enter 0 on this line)       0       10,00         11.00       Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days)       0       11,00         12.00       Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line)       0       12,00         13.00       Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days)       0       14,00         15.00       Total investy days (title V or XIX only (including private room days)       0       14,00         16.00       Muscary days (title V or XIX only)       0       16,00       16,00         16.00       Muscary days (title V or XIX only)       0       16,00       16,00       16,00       16,00       16,00       16,00       16,00       16,00       10,074,828       20,00       16,00       10,074,828       20,00       16,00       10,074,828       20,00       10,074,828       20,00       10,074,828       20,00       10,074,828       20,00       10,074,828       20,00       10,0	0.00				0	0.00
10.00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through becember 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       0.00         11.00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) of thr cost reporting period (if calendar year, enter 0 on this line)       0       0.00         12.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       0       0       0.00         13.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       0	9.00		to the Program (excluding	g swing-bed and	5, 704	9.00
through December 31 of the cost reporting period (see instructions)       11.00         100       Swing-bed SWF type logatient days applicable to title XVIII only (including private room days) after       0         100       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       0         11.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       0         12.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including swing-bed days)       0         13.00       Ming-bed NF type inpatient days applicable to the Program (excluding swing-bed days)       0         15.00       Total nursery days (title V or XIX only)       0         16.00       Mursery days (title V or XIX only)       0         17.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost       0.00         17.00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         10.00       Medicare rate for swing-bed NF type services after December 31 of the cost       0.00         20.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x x line 10)       0.00         21.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 x line 20)       0.000						
11:00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after       0       11.00         12:00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period       0       12.00         13:00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period       0       13.00         14:00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         16:00       Nursery days (title V or XIX only)       0       15.00         17:00       Medicare rate for swing-bed SF services applicable to services through December 31 of the cost       0.00       17.00         18:00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0.00       19.00         19:00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0.00       10.01         10:01       Total general inpatient routine service cost (see instructions)       10.974.928       21.00       10.974.928       21.00       10.974.928       21.00       10.974.928       21.00       10.974.928       21.00       10.974.928       22.00       22.00       20.00       20.00       20.00 <t< td=""><td>10.00</td><td></td><td></td><td>room days)</td><td>0</td><td>10.00</td></t<>	10.00			room days)	0	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)         1           200 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)         0         12.00           310 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)         0         13.00           310 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)         0         14.00           310 Obsting-bed NF type inpatient days applicable to titles V or XIX only (including private room days)         0         14.00           310 Obsting-bed NF type ind         0 or XIX only         0         14.00           310 Obsting-bed SNF services applicable to services through December 31 of the cost         0.00         16.00           110 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost         0.00         10.00           200 Medical rate for swing-bed NF services applicable to services after December 31 of the cost         0.00         20.00           210 Total general inpatient routine service cost (see instructions)         10.974.928         21.00           210 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0         22.00           210 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0         22.00           210 Swing-bed cost applica	11 00			noom dowo) often	0	11 00
12:00       Swing-bed NF type Inpatient days applicable to titles V or XIX only (including private room days)       0       12:00         31:00       Swing-bed NF type Inpatient days applicable to titles V or XIX only (including private room days)       0       13:00         31:00       Wedically necessary private room days applicable to titles V or XIX only (including private room days)       0       14:00         Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       14:00         Medically necessary private room days applicable to services through December 31 of the cost       0.00       16:00         Nursery days (title V or XIX only)       0       16:00       10:00       10:00       10:00         800 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost       0.00       10:00       10:00         12:00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0.00       10:00       10:074,928       21:00       10:074,928       21:00       10:074,928       21:00       10:074,928       21:00       10:074,928       21:00       10:074,928       21:00       10:074,928       21:00       10:074,928       21:00       10:074,928       21:00       10:074,928       21:00       10:074,928       21:00       10:074,928       21:00       10:074,	11.00			oom uays) arter	0	11.00
through December 31 of the cost reporting period       13.00         10.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       13.00         10.00       Main Cale IV necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         10.00       Netsery days (title V or XIX only)       0       16.00         10.00       Netsery days (title V or XIX only)       0       16.00         10.00       Ward care rate for swing-bed SNF services applicable to services after December 31 of the cost       0.00       17.00         10.00       Medical rate for swing-bed SNF services applicable to services after December 31 of the cost       0.00       18.00         10.00       Medical rate for swing-bed NF services applicable to services after December 31 of the cost       0.00       10.974, 928         10.01       Total sensing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 13)       10.974, 928       21.00         10.01       Cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 13)       23.00       23.00         22.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20)       20.00       20.00       20.0	12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	12.00
after December 31 of the cost reporting period (if calendar year, enter O on this line)       0         14.00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         15.00       Total nursery days (title V or XIX only)       0       16.00         16.00       Nursery days (title V or XIX only)       0       16.00         17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       0.00       17.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       18.00         19.00       Medical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       10.974,922         21.00       Total general inpatient routine service cost (see instructions)       10.974,922       21.00         22.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 5 x line 13)       0.010,974,922       21.00         23.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 30)       23.00         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 30)       20.00       20.00       20.00       20.00       2			3 ( 3 )		-	
14.00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         15.00       Total nursery days (title V or XIX only)       0       15.00         15.00       Total nursery days (title V or XIX only)       0       15.00         16.00       Nursery days (title V or XIX only)       0       15.00         17.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       18.00         18.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       18.00         19.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       19.00         20.01       Medicaid rate for swing-bed NF services after December 31 of the cost reporting period (line 5 x line 17)       10.974,928       21.00         21.01       Total general inpatient routine service safter December 31 of the cost reporting period (line 7 x line 18)       0       22.00         23.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 18)       0       22.00         24.00       Swing-bed cost (see instructions)       10.974,928       27.00       26.00         25.00       Swing-bed cost sapplicabl	13.00				0	13.00
15.00       Total nursery days (title V or XIX only)       0       15.00       0       15.00       0					_	
16.00       Nursery days <sup>2</sup> (tile <sup>1</sup> v or XIX only)       0       16.00         SWIND BED ADUSTNENT       0.00       17.00         17.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00         18.00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00         19.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00         10.00       Medicaid rate for swing-bed NF services cost (see instructions)       10.974,928       21.00         22.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)       10.974,928       21.00         23.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 7 x line 18)       0.20       22.00         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)       0       26.00       10.974,928       27.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)       0       26.00       27.00       28.00       29.00       29.00       29.00       29.00       20.00       20.00       20.00       20.00			ram (excluding swing-bed	days)	-	
SWING BED ADJUSTMENT         O           17.00         Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period         0.00         17.00           18.00         Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period         0.00         18.00           19.00         Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period         0.00         19.00           20.01         Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period         0.00         20.00           20.02         Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 18)         10.974.928         21.00           21.00         Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 7 x line 19)         0         24.00           20.01         Swing-bed cost (see instructions)         0         24.00         25.00           21.02         Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)         0         26.00           20.03         Swing-bed cost (see instructions)         0         26.00         27.00           20.03         Swing-bed cost (see instructions)         0         26.00         27.00					-	
17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       0.00       17.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       18.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       18.00         19.00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       10.00       0.00       10.074,928       0.00       10.974,928       0.00       10.974,928	10.00				0	10.00
reporting period reporting period reporting period reporting period reporting period reporting period wedicare rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 18.00 19.00 Wedicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 19.00 20.00 Wedicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 21.00 Total general inpatient routine service cost (see instructions) 10.974,928 21.00 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 0 total swing-bed cost (see instructions) 20.00 22.00 Private room charges (excluding swing-bed cost (line 21 minus line 26) 0 .0.974,928 21.00 22.00 20.00 Cost (see instructions) 20.00 Cost (see instructions) 20.00 Cost (see instructions) 20.00 Semi-gr-bed cost (see instructions) 20.00 Semi-gr-bed cost (see instructions) 20.00 Private room charges (excluding swing-bed charges) 20.00 Cost (see instructions) 20.00 Semi-grey ivate room charges (line 29 + line 3) 0.00 33.00 33.00 Average perivate room charge (line 30 + line 4) 0.00 33.00 33.00 Average perivate room charge (line 30 + line 4) 0.00 33.00 0 correal inpatient routine service cost per diem (see instructions) 10.974,928 30.00 33.00 0 Program general inpatient routine service cost per diem (see instructions) 1.212.70 38.00 Average per diem private room charge HAPS HAPS HAPS HAPS HAPS HAPS HAPS HAPS	17.00		ces through December 31	of the cost	0.00	17.00
reporting period						
19:00       Wedicaid "rate for swing-bed NF services applicable to services through December 31 of the cost reporting period       0.00       19:00         20:00       Medicaid at at for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       20:00         21:00       Total general inpatient routine service cost (see instructions)       10,974,928       21:00         22:00       Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)       0       0         23:00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)       0       23:00         24:00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       24:00         20:00       Tale swing-bed cost (see instructions)       0       26:00       0         20:00       Total swing-bed cost (see instructions)       0       26:00         20:00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       0       0       0         21:00       General inpatient routine service cost/charge ratio (line 32 + line 3)       0       0       0         22:00       General inpatient routine service cost/charge ratio (line 32 + line 3)       0       0       0       0	18.00		ces after December 31 of	the cost	0.00	18.00
reporting period20.00Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost0.0020.00Total general inpatient routine service cost (see instructions)10,974,92821.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line023.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line023.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8026.00Total swing-bed cost (see instructions)027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)10,974,92827.00PRIVATE ROWD INFERENTIAL ADJUSTMENT028.00General inpatient routine service cost/charges (excluding swing-bed charges)020.00Average periater com charges (excluding swing-bed charges)020.01Average periater com periate room charge (line 29 + line 3)0.0000023.00Average periater com charges (line 30 + line 4)0.0024.00Average periater room corts differential (line 32 minus line 33)(see instructions)0.0023.00Average periater room cost adjerential (line 32 minus line 33)0.0024.00Average periater room cost adjerential (line 32 minus line 33)						
20.00Weid caid 'rate for swing-bed NF services applicable to services after December 31 of the cost reporting period0.0020.0021.00Total general inpatient routine service cost (see instructions)10,974,92821.0022.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 18)0.0022.0023.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)0.0023.0024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 18)0.25.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)0.26.0026.00Total swing-bed cost (see instructions)0.26.0027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)0.974,92827.00PRIVATE ROOM DIFFERENTIAL ADJUSTMENT0.0028.00General inpatient routine service cost charges (excluding swing-bed and observation bed charges)0.00000031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.00Average per diem private room charge (line 29 + line 3)0.0032.00Average per diem private room cost differential (line 34 x line 31)0.0033.00Average per diem private room charge differential (line 34 x line 31)0.0033.00Average per diem private room charge SEEDENE PASS THROUGH COST ADJUSTMENT10,974,92837.00General inpatient rou	19.00		es through December 31 o	f the cost	0.00	19.00
reporting period10,974,92821.00Total general inpatient routine service cost (see instructions)10,974,92822.00Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line22.0023.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line23.0024.00Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line23.0024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line24.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)25.0026.00Total swing-bed cost (see instructions)026.0027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)028.0028.00Frivate room charges (excluding swing-bed charges)029.0029.00Private room charges (excluding swing-bed charges)029.0020.01General inpatient routine service cost/charge ratio (line 27 + line 28)0.000000031.0030.00Average peri dem private room charge (line 30 + line 4)0.00033.0030.00Average per diem private room charge differential (line 34 x line 31)0.0033.0030.00Average per diem private room cost differential (line 34 x line 31)0.0034.0030.00General inpatient routine service cost perioe set and private room cost differential (line 34 x line 33)0.0034.0030.00<	20 00		s after December 31 of	the cost	0.00	20 00
21.00Total general inpatient routine service cost (see instructions)10,974,92821.0022.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 17)22.0023.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)23.0024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)026.00Total swing-bed cost (see instructions) Total swing-bed cost (see instructions)026.00PRIVATE ROOM DIFFERNTIAL ADJUSTMENT028.00Semi-private room charges (excluding swing-bed charges) 0028.00Semi-private room charges (excluding swing-bed charges) 0020.01Average perivate room per diem charge (line 27 + line 28) 00.00000020.02Average perivate room per diem charge (line 32 + line 3) 0.0000.00000020.03Average peridem private room cost differential (line 32 minus line 33)(see instructions) 0.0000.00033.00 0.00020.04Verage peridem private room cost differential (line 34 x line 31) 0.000020.05PRIVATLE NOPERATING COST BEFORE PASS THROUGH COST ADJUSTMENT PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS PART 11 - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 0.00020.00Private room cost differential (line 32 x lin	20.00				0.00	20.00
5 x line 17)       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         23.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 7 x line 19)       0       24.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       0       25.00         26.00       Total swing-bed cost (see instructions)       0       0       26.00         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       0       74.00         28.00       General inpatient routine service charges (excluding swing-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       0       0         31.00       General inpatient routine service cost /charge ratio (line 32 + line 3)       0 <td>21.00</td> <td></td> <td>is)</td> <td></td> <td>10, 974, 928</td> <td>21.00</td>	21.00		is)		10, 974, 928	21.00
23.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)       0       23.00         24.00       Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20)       0       24.00       24.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       24.00         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)       10,974,928         28.00       General inpatient routine service charges (excluding swing-bed charges)       0       29.00         29.00       Private room charges (excluding swing-bed charges)       0       0       0         31.00       General inpatient routine service cost/charge ratio (line 27 + line 28)       0.000000       31.00         32.00       Average perivate room charge differential (line 32 minus line 33)(see instructions)       0.00       32.00         33.00       Average per diem private room cost differential (line 3 x line 31)       0.00       33.00         34.00       Average per diem private room cost differential (line 3 x line 35)       0.00       33.00         35.00       Average perd iem private room cost differential (line 3	22.00		per 31 of the cost repor	ting period (line	0	22.00
x line 18)       x line 19)       24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       x line 20)       x line 20)       0       25.00       Swing-bed cost (see instructions)       0       26.00       10,974,928       27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       10,974,928       27.00       28.00         27.00       General inpatient routine service cost net of swing-bed and observation bed charges)       0       28.00         28.00       General inpatient routine service cost/charge ratio (line 27 + line 28)       0       0.000000       31.00         30.00       Semi-private room charges (excluding swing-bed charges)       0       0.00       32.00         31.00       Average private room per diem charge (line 29 + line 3)       0.000       33.00       33.00       Average perivate room per diem charge (line 30 + line 4)       0.00       33.00         34.00       Average peri diem private room cost differential (line 3 x line 35)       0       0.00       35.00         37.00       General inpatient routine service cost per diem (see instructions)       1,212.70       38.00       0       0.00       35.00         38.00 <t< td=""><td></td><td></td><td></td><td></td><td>-</td><td></td></t<>					-	
24.00       Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)       24.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0         26.00       Total swing-bed cost (see instructions)       0         26.00       Total swing-bed cost (see instructions)       0         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       10,974,928         27.00       General inpatient routine service charges (excluding swing-bed and observation bed charges)       0         28.00       Semi-private room charges (excluding swing-bed charges)       0         30.00       Semi-private room per diem charge (line 29 + line 3)       0       0         32.00       Average peri vate room per diem charge (line 30 + line 4)       0.00       33.00         33.00       Average per diem private room cost differential (line 3 x line 31)       0.00       34.00         35.00       Average per diem private room cost differential dj ustment (line 3 x line 35)       0       0       0         37.00       General inpatient routine service cost per diem (see instructions)       1,974,928       37.00         38.00       Average per diem private room cost differential (line 3 x line 35)       0       0       38.00	23.00		- 31 of the cost reportion	ng period (line 6	0	23.00
7 x line 19)       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       25.00         26.00       Total swing-bed cost (see instructions)       0         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       10,974,928         27.00       General inpatient routine service charges (excluding swing-bed cost (line 21 minus line 26)       0         28.00       General inpatient routine service charges (excluding swing-bed and observation bed charges)       0         29.00       Private room charges (excluding swing-bed charges)       0       0         20.00       Semi-private room charges (excluding swing-bed charges)       0       0       0         20.01       General inpatient routine service cost/charge ratio (line 27 + line 28)       0       0       0       0         20.02       Average perivate room per diem charge (line 29 + line 3)       0	24 00		ar 31 of the cost report	ng period (line	0	24 00
25.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)25.0026.00Total swing-bed cost (see instructions)026.00Total swing-bed cost (see instructions)026.00PRIVATE ROOM DIFFERENTIAL ADJUSTMENT10,974,92828.00General inpatient routine service charges (excluding swing-bed and observation bed charges)029.00Private room charges (excluding swing-bed charges)030.00Semi-private room charges (excluding swing-bed charges)031.00General inpatient routine service cost/charge ratio (line 27 + line 28)032.00Average per vate room per diem charge (line 29 + line 3)0.00034.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0035.00Average per diem private room cost differential (line 3 x line 31)0.0036.00Private room cost differential adjustment (line 3 x line 35)037.00General inpatient routine service cost per diem service cost and private room cost differential (line 3 x line 35)037.00Average per diem private room cost BEFORE PASS THROUGH COST ADJUSTMENTS038.00Adjusted general inpatient routine service cost per diem (see instructions)1, 212.7038.00Adjusted general inpatient routine service cost per diem (see instructions)1, 212.7038.00Adjusted general inpatient routine service cost (line 9 x line 38)6, 917, 24140.00Medically necessary private room cost applicable to the Program (line 14 x line 35	24.00		a si oi the cost report	ng period (inne	0	24.00
26.00Total swing-bed cost (see instructions)026.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)10,974,92827.00PRI VATE ROOM DI FFERENTIAL ADJUSTMENT28.00General inpatient routine service charges (excluding swing-bed charges)028.0029.00Private room charges (excluding swing-bed charges)029.0029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 30 + line 4)0.0033.0033.00Average per diem private room cost differential (line 34 x line 31)0.0034.0034.00Average per diem private room cost differential (line 3 x line 35)0.0035.0036.00Private room cost differential adjustment (line 3 x line 35)0.0035.0037.00General inpatient routine service cost per diem (see instructions)10,974,92837.00Program general inpatient routine service cost per diem (see instructions)0.0037.00Adjusted general inpatient routine service cost per diem (see instructions)1,212.7038.00Adjusted general inpatient routine service cost per diem (see instructions)1,212.7038.00Adjusted general inpatient routine service cost per diem (see instructions)1,212.7038.00Adjusted general inpatient routine service cost per diem (see instructions)1,212.7038.00Adjusted general inpatient rout	25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25.00
27. 00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)10,974,92827. 00PRIVATE ROOM DIFFERENTIAL ADJUSTMENT28. 00General inpatient routine service charges (excluding swing-bed charges)028. 0028. 00Private room charges (excluding swing-bed charges)029. 0030. 00Semi-private room charges (excluding swing-bed charges)00031. 00General inpatient routine service cost/charge ratio (line 27 + line 28)0. 000000032. 00Average private room per diem charge (line 29 + line 3)0. 0033. 00Average per idem private room cost differential (line 32 minus line 33) (see instructions)0. 0034. 00Average per diem private room cost differential (line 34 x line 31)0. 0035. 00Private room cost differential adjustment (line 3 x line 35)037. 00Private room cost differential adjustment (line 3 x line 35)037. 00PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1, 212. 7038. 00Adjusted general inpatient routine service cost (line 9 x line 38)6, 917, 24140. 00Medically necessary private room cost applicable to the Program (line 14 x line 35)040. 00Medically necessary private room cost applicable to the Program (line 14 x line 35)0						
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       29.00         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)       0.000       32.00         33.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       32.00         34.00       Average per diem private room cost differential (line 34 x line 31)       0.00       34.00         35.00       Average per diem private room cost differential (line 3 x line 35)       0.00       35.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 10, 974, 928       37.00         27 minus line 36)       PART 11 - HOSPITAL AND SUBPROVIDERS ONLY       0       38.00         Adj usted general inpatient routine service cost per diem (see instructions)       1, 212.70       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       6, 917, 241       39	26.00	<b>a b b b</b>				26.00
28.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.0029.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 29 + line 3)0.0032.0033.00Average semi-private room per diem charge (line 30 + line 4)0.0033.0034.00Average per diem private room charge differential (line 34 x line 31)0.0034.0035.00Average per diem private room cost differential (line 3 x line 35)0.0035.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 10, 974, 928)37.0027 minus line 36)PART II - HOSPITAL AND SUBPROVIDERS ONLY10, 974, 92870.00Adjusted general inpatient routine service cost per diem (see instructions)1, 212.7038.00Adjusted general inpatient routine service cost (line 9 x line 38)6, 917, 24140.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0	27.00		(line 21 minus line 26)		10, 974, 928	27.00
29.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 29 + line 3)0.0032.0033.00Average per diem private room per diem charge (line 30 + line 4)0.0032.0034.00Average per diem private room charge differential (line 34 x line 31)0.0034.0035.00Average per diem private room cost differential (line 3 x line 35)0.0035.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30)37.0027 minus line 36)PART 11 - HOSPITAL AND SUBPROVIDERS ONLY10,974,92870.00Adjusted general inpatient routine service cost per diem (see instructions)1,212.7038.00Adjusted general inpatient routine service cost per diem (see instructions)6,917,24139.00Program general inpatient routine service cost applicable to the Program (line 14 x line 35)040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0	28 00		and observation bed c	parges)	0	28 00
30.00       Semi-private room charges (excluding swing-bed charges)       0       30.00         31.00       General inpatient routine service cost/charge ratio (line 27 ÷ line 28)       0.000000       31.00         32.00       Average private room per diem charge (line 29 ÷ line 3)       0.00       32.00         33.00       Average semi-private room per diem charge (line 30 ÷ line 4)       0.00       32.00         34.00       Average per diem private room cost differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 3 × line 31)       0.00       34.00         36.00       Private room cost differential adjustment (line 3 × line 35)       0.00       35.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 10, 974, 928)       37.00         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       10, 974, 928       37.00         28.00       Adjusted general inpatient routine service cost per diem (see instructions)       1, 212.70       38.00         39.00       Program general inpatient routine service cost (line 9 × line 38)       6, 917, 241       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 × line 35)       0       40.00			and observation bed ci	lai yes)		
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)       0.00000       32.00         33.00       Average semi-private room per diem charge (line 30 + line 4)       0.00       32.00         34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       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 10, 974, 928       37.00         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       10, 974, 928         78.00       Adjusted general inpatient routine service cost per diem (see instructions)       1, 212.70         38.00       Adjusted general inpatient routine service cost (line 9 x line 38)       6, 917, 241       39.00         90.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00	30.00					30.00
32.00       Average private room per diem charge (line 29 + line 3)       0.00       32.00         33.00       Average semi - private room per diem charge (line 30 + line 4)       0.00       33.00         34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       34.00         35.00       Average per diem private room cost differential adjustment (line 3 x line 35)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0.00       35.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 10, 974, 928       37.00         27 minus line 36)       PART 11 - HOSPITAL AND SUBPROVIDERS ONLY       10, 974, 928         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       1, 212.70       38.00         38.00       Adjusted general inpatient routine service cost (line 9 x line 38)       1, 212.70       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       6, 917, 241       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00	31.00		÷line 28)		-	
34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0.00       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 30)       10,974,928         37.00       PART 11 - HOSPITAL AND SUBPROVIDERS ONLY       10,974,928         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       1,212.70         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1,212.70         39.00       Program general inpatient routine service cost (line 9 x line 38)       6,917,241         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0	32.00	Average private room per diem charge (line 29 ÷ line 3)				
35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       36.00       0       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)       0       37.00       10,974,928       37.00         PART 11       HOSPITAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       38.00       1,212.70       38.00         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1,212.70       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       6,917,241       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00	33.00					
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 27 minus line 36)       0       10,974,928         PART 11 - HOSPITAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       0       1,212.70         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1,212.70       38.00         39.00       Program general inpatient routine service cost applicable to the Program (line 14 x line 35)       0       40.00	34.00			ctions)		
37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)       10,974,928       37.00         PART II - HOSPITAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       10,974,928       38.00         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1,212.70       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       6,917,241       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00		5 1 1	ne 31)			
27 minus line 36)         PART 11 - 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)       1, 212.70       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       6, 917, 241       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00			and private room cost d	fferential (line		
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)       1,212.70       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       6,917,241       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00	57.00		and private room cost u		10, 774, 720	57.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS38.00Adjusted general inpatient routine service cost per diem (see instructions)1,212.7039.00Program general inpatient routine service cost (line 9 x line 38)6,917,24140.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0						
38.00Adjusted general inpatient routine service cost per diem (see instructions)1,212.7038.0039.00Program general inpatient routine service cost (line 9 x line 38)6,917,24139.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00			IUSTMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38.00	Adjusted general inpatient routine service cost per diem (see	e instructions)			
	39.00		-			
41.00   10tai Program general inpatient routine service cost (line 39 + line 40) [6, 917, 241 41.00	40.00	3 31 11 8				
	41.00	liotai Program general inpatient routine service cost (line 39	+ IINE 40)		0, 917, 241	41.00

				F	rom 07/01/2021		
					o 06/30/2022	Date/Time Pre 11/22/2022 9:	
			Title	× XVIII	Hospi tal	PPS	37 d
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days		Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	-
00	NURSERY (title V & XIX only)	0	0				42.
	Intensive Care Type Inpatient Hospital Units			1			
00	INTENSIVE CARE UNIT	0	C	0.00	0 0	0	
00 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44
00	SURGI CAL I NTENSI VE CARE UNI T						40
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
00	Program inpatient ancillary service cost (Wks	+ D 2 col 2	line 200)			1.00 2,801,348	8 48
00	Total Program inpatient costs (sum of lines 4			ins)		9, 718, 589	
	PASS THROUGH COST ADJUSTMENTS					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1
00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sum	of Parts I and	1, 073, 892	50
00	III) Dear through costs and include to December include					210 150	
00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (Tr	OM WKST. D, SL	m of Parts II	219, 158	51
00	Total Program excludable cost (sum of lines 5	50 and 51)				1, 293, 050	52
00	Total Program inpatient operating cost exclud	,	lated, non-phy	sician anesthe	tist, and	8, 425, 539	
	medical education costs (line 49 minus line 5	52)				<u> </u>	
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
00	Target amount per discharge					0.00	
00	Target amount (line 54 x line 55)					0	
00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus l	ine 53)	0	
00	Bonus payment (see instructions)	onting poriod	anding 100/	ndated and con	nounded by the	0	
00	Lesser of lines 53/54 or 55 from the cost rep market basket	borting period	enaling 1996, t	ipuated and com	pounded by the	0.00	/  59
00	Lesser of lines 53/54 or 55 from prior year of	cost report, up	dated by the m	arket basket		0.00	60
00	If line 53/54 is less than the lower of lines					0	61
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62
00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	e cost reportir	g period (See	0	64
00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65
00	instructions)(title XVIII only)					Ĭ	
00	Total Medicare swing-bed SNF inpatient routir	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66
00	CAH (see instructions)		December 21	£ +b +			
00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 C	in the cost rep	orting period	0	67
00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repor	ting period	0	68
	(line 13 x line 20)					_	
00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	69
00	Skilled nursing facility/other nursing facili		•				70
00	Adjusted general inpatient routine service co	-				1	71
00	Program routine service cost (line 9 x line 7	,		0.5.			72
00	Medically necessary private room cost applica	U U	•				73
00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r	•			art II column		74
	26, line 45)		20010 (110111			1	′
00	Per diem capital-related costs (line 75 ÷ lir						76
00	Program capital -related costs (line 9 x line						77
00 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der record	ls)			78
00	Total Program routine service costs for compa	• •		· .	ıs line 79)	1	80
00	Inpatient routine service cost per diem limit				·		81
00	Inpatient routine service cost limitation (li		· .				82
00	Reasonable inpatient routine service costs (s		s)				83
00 00	Program inpatient ancillary services (see ins Utilization review - physician compensation (		ns)				84
00	Total Program inpatient operating costs (sum					1	86
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
	Total observation bed days (see instructions)					0	87.
00 00	Adjusted general inpatient routine cost per o				1	0.00	88

Health Financial Systems COMM	ND REHABILITATI	REHABI LI TATI ON I n			2552-10	
COMPUTATION OF INPATIENT OPERATING COST				Period: From 07/01/2021	Worksheet D-1	
				To 06/30/2022	Date/Time Pre 11/22/2022 9:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 703, 819	10, 974, 928	0. 15524	6 0	0	90.00
91.00 Nursing Program cost	0	10, 974, 928	0.00000	0 0	0	91.00
92.00 Allied health cost	0	10, 974, 928	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	10, 974, 928	0. 00000	0 0	0	93.00

## COMMUNITY STROKE AND REHABILITATION

Heal th	Financial Systems COMMUNITY STROKE AND	REHABI LI TATI ON	In Lie	u of Form CMS-2	2552-10	
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-3045	Peri od:	Worksheet D-1		
			From 07/01/2021 To 06/30/2022	Date/Time Pre	pared:	
				11/22/2022 9:		
		Title XIX	Hospi tal	PPS		
	Cost Center Description			1.00		
	PART I - ALL PROVIDER COMPONENTS			1.00		
	INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed day			9, 050	1.00	
2.00	Inpatient days (including private room days, excluding swing-			9, 050	2.00	
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only p	rivate room days,	0	3.00	
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		9, 050	4.00	
5.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5.00	
	reporting period					
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.00	
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m days) through December	- 31 of the cost	0	7.00	
7.00	reporting period				7.00	
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8.00	
	reporting period (if calendar year, enter 0 on this line)					
9.00	Total inpatient days including private room days applicable to newborn days) (see instructions)	o the Program (excluding	g swing-bed and	62	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private i	room days)	0	10.00	
	through December 31 of the cost reporting period (see instruc	tions)	3			
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.00	
12.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		to room dave)	0	12.00	
12.00	through December 31 of the cost reporting period		te room days)	0	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XI.	X only (including priva <sup>.</sup>	te room days)	0	13.00	
	after December 31 of the cost reporting period (if calendar y					
	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14.00	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15.00 16.00	
10.00	SWING BED ADJUSTMENT				10.00	
17.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 (	of the cost	0.00	17.00	
	reporting period					
18.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost	0.00	18.00	
19.00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 o	° the cost	0.00	19.00	
17100	reporting period			0,00		
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of	the cost	0.00	20.00	
21 00	reporting period			10 074 020	21 00	
21.00 22.00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	10, 974, 928 0	21.00	
22.00	5 x line 17)		ing period (inte		22.00	
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23.00	
24.00	x line 18)	- 21 - 6 + +			24.00	
24.00	Swing-bed cost applicable to NF type services through Decembe $7 \times 1$ (ine 19)	r 31 of the cost report	ng period (line	0	24.00	
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		
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		10, 974, 928	27.00	
28.00	General inpatient routine service charges (excluding swing-be	d and observation bed cl	narges)	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	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000		
32.00 33.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	32.00 33.00	
33.00 34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)		34.00	
35.00						
36.00						
37.00	5 1					
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			1	
38.00	Adjusted general inpatient routine service cost per diem (see			1, 212. 70	38.00	
39.00	Program general inpatient routine service cost (line 9 x line	-		75, 187		
	Medically necessary private room cost applicable to the Progr. Total Program general inpatient routine service cost (line 39			0 75, 187		
41.00	Total Trogram general inpatrent routine service cost (TINE 34			/5, 10/	1 41.00	

		JNITY STROKE AN	ID REHABILITAT	TON	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider (	CCN: 15-3045	Period: From 07/01/2021	Worksheet D-1	
					To 06/30/2022	Date/Time Pre 11/22/2022 9:	
				le XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Day	Average Per sDiem (col. 1 col. 2)	÷ Program Days	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 0.0	0 0	0	42.00
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		0 0.0	0 0	0	43.00
	CORONARY CARE UNIT	0		0.0	0	0	44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGI CAL INTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	bost center bescription					1.00	
	Program inpatient ancillary service cost (Wks			-		32, 097	48.00
49.00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	1 through 48)(	see instructi	ons)		107, 284	49.00
50.00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D. sum	of Parts L and	11, 673	50.00
00100						,	00.00
51.00	Pass through costs applicable to Program inpa and ${\rm IV})$		y services (f	rom Wkst. D, s	um of Parts II		51.00
52.00	Total Program excludable cost (sum of lines 5				- 4 ! - 4	14, 586	
53.00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5		rated, non-pn	ysician anestr	etist, and	92, 698	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges					0	
55.00 56.00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55.00 56.00
57.00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (	line 56 minus	line 53)	0	57.00
	Bonus payment (see instructions)		. g			0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost rep	orting period	endi ng 1996,	updated and co	mpounded by the	0.00	59.00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year of	ost report up	dated by the	market hasket		0.00	60.00
	If line 53/54 is less than the lower of lines				the amount by	0.00	61.00
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
62 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62.00
	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	· · ·					
64.00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s through Dece	mber 31 of th	e cost reporti	ng period (See	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cost	s after Decemb	er 31 of the	cost reporting	period (See	0	65.00
66.00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routir</pre>	ne costs (line	64 nlus line	65)(title XVII	lonly) For	0	66.00
	CAH (see instructions)						
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31	of the cost re	porting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	rting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient r			,		0	69.00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili					1	70.00
70.00	Adjusted general inpatient routine service co	-					70.00
72.00	Program routine service cost (line 9 x line 7			,			72.00
	Medically necessary private room cost applica	0	•				73.00
74.00 75.00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r			·	art II column		74.00 75.00
75.00	26, line 45)	outine service	0313 (110	worksheet b, i			/ 5. 00
76.00	Per diem capital-related costs (line 75 ÷ lir						76.00
77.00 78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77.00 78.00
79.00	Aggregate charges to beneficiaries for excess	,	rovi der recor	ds)			79.00
80.00	Total Program routine service costs for compa	• •		· · · · · · · · · · · · · · · · · · ·	us line 79)		80.00
81.00	Inpatient routine service cost per diem limit		<b>`</b>				81.00
82.00 83.00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s		•				82.00 83.00
83.00 84.00	Program inpatient ancillary services (see ins						84.00
85.00	Utilization review - physician compensation (	(see instructio					85.00
86.00	Total Program inpatient operating costs (sum		rough 85)				86.00
87.00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per o		line 2)				88.00
89.00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.00

Health Financial Systems COMM	NUNITY STROKE A	ND REHABILITATI	ON	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 07/01/2021 To 06/30/2022	Date/Time Pre 11/22/2022 9:	pared: 37 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 703, 819	10, 974, 928	0. 15524	6 0	0	90.00
91.00 Nursing Program cost	0	10, 974, 928	0.00000	0 0	0	91.00
92.00 Allied health cost	0	10, 974, 928	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	10, 974, 928	0. 00000	0 0	0	93.00

NPATIENT AN	Cial Systems         COMMUNITY STROKE AND R           ICILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-3045		riod:	Worksheet D-3	
				Fro To	om 07/01/2021 06/30/2022	Date/Time Pre 11/22/2022 9:	parec 37 an
		Titl∈	e XVIII		Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	st	Inpati ent	Inpati ent	
			To Charges		Program Charges	Program Costs (col. 1 x col. 2)	
			1.00		2.00	3.00	
I NPAT	I ENT ROUTI NE SERVI CE COST CENTERS						
0.00 03000	ADULTS & PEDIATRICS				8, 976, 725		30.
	I NTENSI VE CARE UNI T				0		31.
	SUBPROVIDER - IRF				0		41.
	NURSERY						43.
	LARY SERVICE COST CENTERS		1				
	OPERATI NG ROOM		0.0000		0	0	50.
	RECOVERY ROOM		0.0000		0	0	51.
	ANESTHESI OLOGY		0.0000		0	0	53.
	RADI OLOGY-DI AGNOSTI C		0. 1546		265, 105	41, 002	
	RADI OLOGY-THERAPEUTI C		0.0000		0	0	55.
	RADI OI SOTOPE		0. 1271		4, 737	602	56.
	CT SCAN		0. 1061		327, 893	34, 819	
8.00 05800			0.0994		61, 832	6, 151	58.
	CARDI AC CATHETERI ZATI ON		0.0000		0	0	59.
	LABORATORY		0. 1334		1, 477, 924	197, 281	60.
	WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0 70(	0	62. 63.
	BLOOD STORI NG, PROCESSI NG, & TRANS. RESPI RATORY THERAPY		0.0925		9, 736	901	
	PHYSICAL THERAPY		0. 3372		621, 089 2, 629, 011	209, 472 902, 681	
	OCCUPATIONAL THERAPY		0. 3433		2, 629, 011	648, 397	67.
	SPEECH PATHOLOGY		0. 2408		2, 892, 109 562, 956	150, 949	
	ELECTROCARDI OLOGY		0. 2681		137, 330	8, 823	
	ELECTROENCEPHALOGRAPHY		0.0398		137, 330	0, 023	
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0398		352, 518	97, 532	
	IMPL. DEV. CHARGED TO PATIENTS		0.2700		352, 516	97, 552	72.
	DRUGS CHARGED TO PATIENTS		0. 0000		2, 138, 517	437, 844	
	RENAL DIALYSIS		0. 2047		2, 138, 517	64, 894	
	ASC (NON-DISTINCT PART)		0.0000		233, 005	04,074	
	TIENT SERVICE COST CENTERS		0.0000	00		0	1 / 0.
	CLINIC		0. 3351	13	0	0	90.
	EMERGENCY		0.0000		0	0	91.
	OBSERVATION BEDS (NON-DI STINCT PART		0.0000		0	0	92.
00.00	Total (sum of lines 50 through 94 and 96 through 98)		0.0000		11, 514, 440	2, 801, 348	
01.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)			0	2,00.,010	201.
	Net charges (line 200 minus line 201)	(			11, 514, 440		202.

NPATIENT AND	CILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-3045		i od:	Worksheet D-3	
				Fro To	m 07/01/2021 06/30/2022	Date/Time Pre 11/22/2022 9:3	pared 37 am
		Titl	e XIX		Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	st	Inpatient	Inpati ent	
			To Charges			Program Costs (col. 1 x col. 2)	
			1.00		2.00	3.00	
I NPATI	ENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS				99, 372		30.0
31.00 03100	INTENSIVE CARE UNIT				0		31. (
41.00 04100	SUBPROVI DER – I RF				0		41.0
	NURSERY				0		43.0
	ARY SERVICE COST CENTERS		1				
	OPERATING ROOM		0.0000		0	0	50.0
	RECOVERY ROOM		0.0000		0	0	51.0
	ANESTHESI OLOGY		0.0000		0	0	53.0
	RADI OLOGY-DI AGNOSTI C		0. 1546		2, 104	325	54.
	RADI OLOGY-THERAPEUTI C		0.0000		0	0	55.
	RADI OI SOTOPE		0. 1271		0	0	56.
	CT SCAN		0. 1061		0	0	57.
58.00 05800			0. 0994		3, 276	326	
	CARDI AC CATHETERI ZATI ON		0.0000	00	0	0	59.0
	LABORATORY		0. 1334		25, 753	3, 438	60.
	WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0	0	62.
	BLOOD STORING, PROCESSING, & TRANS.		0. 0925	36	0	0	63.
	RESPI RATORY THERAPY		0. 3372		982	331	65.
	PHYSI CAL THERAPY		0. 3433		27, 257	9, 359	
67.00 06700	OCCUPATIONAL THERAPY		0. 2408		28, 287	6, 813	67.
8.00 06800	SPEECH PATHOLOGY		0. 2681	37	3, 282	880	68.
	ELECTROCARDI OLOGY		0.0642		4, 484	288	
	ELECTROENCEPHALOGRAPHY		0. 0398	14	0	0	70.
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2766		2, 757	763	
	IMPL. DEV. CHARGED TO PATIENTS		0.0000		0	0	72.
	DRUGS CHARGED TO PATIENTS		0. 2047	42	32, 191	6, 591	73.
	RENAL DI ALYSI S		0. 2777		10, 740	2, 983	74.
	ASC (NON-DISTINCT PART)		0.0000	00	0	0	75.
	I ENT SERVICE COST CENTERS						
0.00 09000			0. 3351		0	0	90.
	EMERGENCY		0.0000		0	0	91.
	OBSERVATION BEDS (NON-DISTINCT PART		0.0000	00	0	0	
	Total (sum of lines 50 through 94 and 96 through 98)				141, 113	32, 097	
	Less PBP Clinic Laboratory Services-Program only charges	s (line 61)			0	ļ	201.
202.00	Net charges (line 200 minus line 201)				141, 113		202.

.CULA	ATION OF REIMBURSEMENT SETTLEMENT Prov	vider CCN: 15-3045	Period: From 07/01/2021 To 06/30/2022	Worksheet E Part B Date/Time Pre 11/22/2022 9:	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
0	Medical and other services (see instructions)			1, 255	
	Medical and other services reimbursed under OPPS (see instructions	.)		1, 104, 688	
	OPPS payments Outlier payment (see instructions)			969, 285 0	3. 4.
	Outlier reconciliation amount (see instructions)			0	4.
	Enter the hospital specific payment to cost ratio (see instruction	is)		0.000	
	Line 2 times line 5			0	
	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, c	ol 13 line 200		0	
	Organ acquisitions	01. 10, 1110 200		0	10.
	Total cost (sum of lines 1 and 10) (see instructions)			1, 255	11.
- H	COMPUTATION OF LESSER OF COST OR CHARGES				-
	Reasonable charges Ancillary service charges			6, 129	1 1 2
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 6	9)		0, 129	13.
	Total reasonable charges (sum of lines 12 and 13)	.,		6, 129	
	Customary charges				
	Aggregate amount actually collected from patients liable for payme			0	
	Amounts that would have been realized from patients liable for pay had such payment been made in accordance with 42 CFR §413.13(e)	ment for services of	on a chargebasis	0	16.
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.
00	Total customary charges (see instructions)			6, 129	18.
	Excess of customary charges over reasonable cost (complete only if	line 18 exceeds li	ne 11) (see	4, 874	19
	instructions) Excess of reasonable cost over customary charges (complete only if	lino 11 ovcoode li	no 19) (soo	0	20.
	instructions)	TTHE TT EXCEEUS TT	11e 10) (See	0	20
	Lesser of cost or charges (see instructions)			1, 255	21.
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see instructi	ons)		0	23
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			969, 285	24
	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.
00	Deductibles and Coinsurance amounts relating to amount on line 24	(for CAH, see instr	ructions)	202, 994	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus	the sum of lines 22	2 and 23] (see	767, 546	27.
	instructions) Direct graduate medical education payments (from Wkst. E-4, line 5	0)		0	28.
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0)		0	
	Subtotal (sum of lines 27 through 29)			767, 546	30
	Primary payer payments			161	
	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			767, 385	32
	Composite rate ESRD (from Wkst. 1-5, line 11)			0	33
	Allowable bad debts (see instructions)			12, 780	
00	Adjusted reimbursable bad debts (see instructions)			8, 307	35
	Allowable bad debts for dual eligible beneficiaries (see instructi	ons)		9, 581	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			775, 692 0	37
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions)				39
	Demonstration payment adjustment amount before sequestration			0	
	Partial or full credits received from manufacturers for replaced d	evices (see instruc	ctions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 775, 692	39
	Sequestration adjustment (see instructions)			1, 939	
	Demonstration payment adjustment amount after sequestration			0	40
	Sequestration adjustment-PARHM pass-throughs			<b></b>	40
	Interim payments			765, 513	1
	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41
	Tentative settlement-PARHM (for contractor use only)			0	42
	Balance due provider/program (see instructions)			8, 240	
	Balance due provider/program-PARHM (see instructions)			-	43
	Protested amounts (nonallowable cost report items) in accordance w §115.2	ιτη CMS Pub. 15-2,	cnapter 1,	0	44
	TO BE COMPLETED BY CONTRACTOR				1
	Original outlier amount (see instructions)			0	90
00	Outlier reconciliation adjustment amount (see instructions)			0	
00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	93.

Health Financial Systems	MMUNITY STROKE AND REHABILITATION	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3045	Peri od:	Worksheet E	
		From 07/01/2021		
		To 06/30/2022	Date/Time Prep	
			11/22/2022 9:3	37 am
	Title XVIII	Hospi tal	PPS	
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO		Period: From 07/01/2021 To 06/30/2022	Worksheet E-1 Part I Date/Time Prep 11/22/2022 9:3	
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		11, 149, 44	0	765, 513 0	1.00 2.00
3.00	List separately each retroactive lump sum adjustment 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					3.00
3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3.03
3.04 3.05				0	0	3.04 3.05
3.05	Provider to Program			0	0	3.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.51
3.52				0	0	3.52
3.53 3.54				0	0	3.53 3.54
3. 54 3. 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		11, 149, 44	1	765, 513	4.00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5.03
	Provider to Program				-	
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.51
5.51				0	0	5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		96, 10		8, 240	6.01
6.02 7.00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		11, 245, 54	0	0 773, 753	6.02 7.00
7.00			11, 243, 34	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT       Provider CCN: 15-3045       Period: From 07/01/2021 To 06/30/2022       Worksheet E-1 Part II Date/Time Prepared: 11/22/2022 9: 37 am         TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS       1.00       1.00         HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION       1.00         1:00       Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)       3.00         3:00       Medicare HM0 days from Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)       3.00         5:00       Total hospital charges from Wkst. C, Pt. I, col. 6, line 2       5.00         6:00       Total hospital charges from Wkst. C, Pt. I, col. 6, line 20       5.00         7:00       CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I I line 168       5.00         8:00       Galculation of the HIT incentive payment (see instructions)       9.00         9:00       Calculation of the HIT incentive payment after sequestration (see instructions)       9.00         9:00       Calculation of the HIT incentive payment after sequestration (see instructions)       9.00         9:00       Calculation of the HIT incentive payment (see instructions)       9.00	Heal th	Financial Systems COMMUNITY STROKE AND	REHABI LI TATI ON	In Lie	u of Form CMS-	2552-10
To         06/30/2022         Date/Time Prepared: 11/22/2022 9: 37 am           Title XVIII         Hospital         PS           Intervention         1.00           To BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS         1.00           HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION         1.00           1.00         Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14         2.00           Wedicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)         3.00           3.00         Medicare HM0 days from Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)         3.00           5.00         Total hospital charges from Wkst. S-10, col. 3 line 20         5.00           6.00         Total hospital charity care charges from Wkst. S-10, col. 3 line 20         5.00           7.00         CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I         7.00           8.00         Calculation of the HIT incentive payment (see instructions)         9.00           9.00         Sequestration adjustment amount (see instructions)         9.00           10.00         Intal/interim HIT payment adjustment (see instructions)         10.00	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-3045			
Image: Construction of the HIT incentive payment after sequestration (see instructions)       Image: Construction of the HIT incentive payment after sequestration (see instructions)       Image: Construction of the HIT payment adjustment (see instructions)         10.00       Cal cul ation of the HIT payment adjustment (see instructions)       0.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
Title XVIII       Hospital       PPS         Interview of the HIT incentive payment after sequestration (see instructions)         Title XVIII       Hospital       PPS         Interview of the HIT incentive payment after sequestration (see instructions)         Interview of the HIT incentive payment after sequestration (see instructions)         Title XVIII       Hospital       PPS         Interview of the HIT payment adjustment (see instructions)         Interview of the HIT payment adjustment (see instructions)         Title XVIII       Hospital       PPS         Interview of the HIT payment adjustment (see instructions)				10 06/30/2022		
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         2.00         Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)         3.00         4.00         Total hospital charges from Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)         5.00         5.00         Total hospital charges from Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)         5.00         5.00         Total hospital charges from Wkst. S-10, col. 3 line 20         6.00         7.00         Line 168         8.00         8.00         Calculation of the HIT incentive payment (see instructions)         9.00         10.00         Calculation of the HIT incentive payment after sequestration (see instructions)         10.00         10.00         10.00         10.00         10.00         10.01      <			Title XVIII	Hospi tal		<u>57 ann</u>
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)1.003.00Medicare HM0 days from Wkst. S-3, Pt. I, col. 6. Line 2 reporting periods beginning on or after 10/01/2013, line 32)3.004.00Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)3.005.00Total hospital charges from Wkst. C, Pt. I, col. 8 line 2005.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 1688.008.00Gaculation of the HIT incentive payment (see instructions)9.009.00Sequestration adjustment amount (see instructions)9.0010.00InYATLENT HOSPITAL SERVICES UNDER THE IPPS & CAH30.0031.00Other Adjustment (specify)30.00						
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)2.003.00Medicare HM0 days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)3.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 1688.008.00Calculation of the HIT incentive payment (see instructions) Calculation of the HIT incentive payment after sequestration (see instructions)9.0010.00Initial/interim HIT payment adjustment (see instructions) O ther Adjustment (specify)30.0031.00Other Adjustment (specify)30.00					1.00	
1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)2.003.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)3.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.006.00Total hospital charges from Wkst S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 1687.008.00Calculation of the HIT incentive payment (see instructions) INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH9.0030.00Numerical interim HIT payment adjustment (see instructions)30.0031.00Other Adjustment (specify)30.00		TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
2.00       Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)       2.00         3.00       Medicare HM0 days from Wkst. S-3, Pt. I, col. 6. line 2       3.00         4.00       Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)       3.00         5.00       Total hospital charges from Wkst C, Pt. I, col. 8 line 200       5.00         6.00       Total hospital charity care charges from Wkst. S-10, col. 3 line 20       5.00         7.00       CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I       7.00         8.00       Calculation of the HIT incentive payment (see instructions)       8.00       9.00         9.00       Calculation of the HIT incentive payment after sequestration (see instructions)       9.00         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       30.00         31.00       Other Adjustment (specify)       31.00		HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
reporting periods beginning on or after 10/01/2013, line 32)3.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)3.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 2006.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 1687.008.00Calculation of the HIT incentive payment (see instructions) 0.009.009.00Sequestration adjustment amount (see instructions) 10.009.001NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH30.0030.00Initial/interim HIT payment adjustment (see instructions) 31.0030.00	1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	14		1.00
3.00       Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2       3.00         4.00       Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)       3.00         5.00       Total hospital charges from Wkst C, Pt. I, col. 8 line 200       5.00         6.00       Total hospital charity care charges from Wkst S. S-10, col. 3 line 20       5.00         7.00       CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168       7.00         8.00       Calculation of the HIT incentive payment (see instructions)       8.00         9.00       Sequestration adjustment amount (see instructions)       9.00         10.00       InPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       30.00         31.00       Other Adjustment (specify)       30.00	2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and	8 through 12, and plus f	or cost		2.00
4.00Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 32)4.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 1687.008.00Calculation of the HIT incentive payment (see instructions) Sequestration adjustment amount (see instructions)8.009.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH9.0030.00Initial/interim HIT payment adjustment (see instructions) Other Adjustment (specify)30.00						
reporting periods beginning on or after 10/01/2013, line 32) 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 31.00 Other Adjustment (specify)	3.00					3.00
5.00       Total hospital charges from Wkst C, Pt. I, col. 8 line 200       5.00         6.00       Total hospital charity care charges from Wkst. S-10, col. 3 line 20       6.00         7.00       CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I       7.00         8.00       Cal culation of the HIT incentive payment (see instructions)       8.00         9.00       Sequestration adjustment amount (see instructions)       9.00         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       10.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	4.00		1, and 8 through 12, and	plus for cost		4.00
6.00       Total hospital charity care charges from Wkst. S-10, col. 3 line 20       6.00         7.00       CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168       7.00         8.00       Calculation of the HIT incentive payment (see instructions)       8.00         9.00       Sequestration adjustment amount (see instructions)       9.00         10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       9.00         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       30.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00		1 51 5 5				
7.00       CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I       7.00         1 ine 168       8.00       Calculation of the HIT incentive payment (see instructions)       8.00         9.00       Sequestration adjustment amount (see instructions)       9.00         10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       9.00         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       10.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	5.00					
I ine 1688.008.009.00Sequestration adjustment amount (see instructions)9.0010.00Cal cul ation of the HIT incentive payment after sequestration (see instructions)10.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH30.0031.00Other Adjustment (specify)	6.00					6.00
8.00       Calculation of the HIT incentive payment (see instructions)       8.00         9.00       Sequestration adjustment amount (see instructions)       9.00         10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       10.00         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       30.00         30.00       Initial / interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	7.00		ertified HIT technology	Wkst. S-2, Pt. I		7.00
9.00       Sequestration adjustment amount (see instructions)       9.00         10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       10.00         1NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       30.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	8.00					8,00
10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       10.00         INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       30.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	9.00					9.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	10.00		(see instructions)			10.00
31.00 Other Adjustment (specify) 31.00			×			1
	30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
						31.00
			ine 31) (see instruction	s)		32.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3045	Period: From 07/01/2021 To 06/30/2022	Worksheet E-3 Part III Date/Time Prep	
				11/22/2022 9:	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			10, 245, 336	
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0136	
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			256, 133	3.
1.00	Outlier Payments			849, 390	4.
5.00	Unweighted intern and resident FTE count in the most recent to November 15, 2004 (see instructions)	t cost reporting period e	naing on or prior	0.00	5.
5. 01	Cap increases for the unweighted intern and resident FTE co	ount for residents that we	re displaced by	0.00	5.
. 01	program or hospital closure, that would not be counted with			0.00	J.
	CFR §412. 424(d) (1) (iii) (F) (1) or (2) (see instructions)				1
5.00	New Teaching program adjustment. (see instructions)			0.00	6.
7.00	Current year's unweighted FTE count of I&R excluding FTEs i	n the new program growth	period of a "new	0.00	7.
	teaching program" (see instructions)				
3.00	Current year's unweighted I&R FTE count for residents withi	n the new program growth p	period of a "new	0.00	8.
	teaching program" (see instructions)				Į
. 00	Intern and resident count for IRF PPS medical education adj	ustment (see instructions)	)	0.00	9.
	Average Daily Census (see instructions)			24.794521	
	Teaching Adjustment Factor (see instructions)			0.00000	
2.00	Teaching Adjustment (see instructions)			0	12.
3.00				11, 350, 859	
4.00	Nursing and Allied Health Managed Care payments (see instru	uction)		0	14. 15.
5.00	Organ acquisition (DO NOT USE THIS LINE) Cost of physicians' services in a teaching hospital (see in	astructions)		0	16.
	Subtotal (see instructions)	istructrons)		11, 350, 859	17.
	Primary payer payments			11, 330, 839	18.
	Subtotal (line 17 less line 18).			11, 350, 859	
	Deducti bl es			50, 268	
	Subtotal (line 19 minus line 20)			11, 300, 591	
	Coinsurance			43, 817	
3.00	Subtotal (line 21 minus line 22)			11, 256, 774	
4.00	Allowable bad debts (exclude bad debts for professional ser	<pre>rvices) (see instructions)</pre>		26, 078	24
5.00	Adjusted reimbursable bad debts (see instructions)			16, 951	25.
6. 00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		1, 484	26.
7.00	Subtotal (sum of lines 23 and 25)			11, 273, 725	27.
	Direct graduate medical education payments (from Wkst. E-4,	line 49)		0	28
	Other pass through costs (see instructions)			0	29
	Outlier payments reconciliation			0	30.
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	<b>`</b>		0	31.
	Pioneer ACO demonstration payment adjustment (see instructi	ons)		0	31.
1.98				0	31. 31.
	Demonstration payment adjustment amount before sequestration Total amount payable to the provider (see instructions)	ווכ		0 11, 273, 725	
	Sequestration adjustment (see instructions)			28, 184	
	Demonstration payment adjustment amount after sequestration	1		20, 104	
	Interim payments			11, 149, 441	33.
4.00	Tentative settlement (for contractor use only)			0	34.
5.00	Balance due provider/program (line 32 minus lines 32.01, 32	2.02.33. and 34)		96, 100	
6. 00	Protested amounts (nonallowable cost report items) in accor		chapter 1,	0	36.
	\$115.2 TO BE COMPLETED BY CONTRACTOR				
0. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			849, 390	50.
1.00	Outlier reconciliation adjustment amount (see instructions)	)		0	51.
2.00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	53

52.00	The face used to carculate the fille value of money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19	PHE	l
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.00000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.00000	99.01

	Financial Systems COMMUNITY STROKE AN E SHEET (If you are nonproprietary and do not maintain	Provider C		Period: From 07/01/2021	Worksheet G	
nd-t ly)	ype accounting records, complete the General Fund column			o 06/30/2022		pare
5.		General Fund	Speci fi c	Endowment Fund	11/22/2022 9: Plant Fund	3/ 2
		1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS		1			
00	Cash on hand in banks	1,000			0	
00	Temporary investments	0	C	-	0	
00 00		2 251 000	0	0	0	
00	Accounts receivable Other receivable	3, 251, 880 440, 259		0	0	
00	Allowances for uncollectible notes and accounts receivable	440, 239		0	0	
00	Inventory	66, 744			0	
00	Prepaid expenses	00, / 11		0	0	
00	Other current assets	123, 776		0	0	
. 00	Due from other funds	0	C	0 0	0	10
00	Total current assets (sum of lines 1-10)	3, 883, 659	C	0 0	0	11
	FI XED ASSETS					
00	Land	0	C	0 0	0	12
. 00	Land improvements	0	C	0 0	0	
00	Accumulated depreciation	0	C	0 0	0	
00	Bui I di ngs	49, 242, 113	C	0 0	0	
00	Accumulated depreciation	0		0	0	
00	Leasehold improvements	0		0	0	
. 00	Accumulated depreciation	0			0	
. 00 . 00	Fixed equipment Accumulated depreciation	0			0	
. 00	Automobiles and trucks	0			0	
. 00	Accumulated depreciation	0			0	
	Major movable equipment	0		0	0	
	Accumul ated depreciation	0		0	0	
	Minor equipment depreciable	0		0	0	
	Accumulated depreciation	0	C	0	0	
	HIT designated Assets	0	C	0 0	0	2
. 00	Accumulated depreciation	0	C	0 0	0	28
. 00	Minor equipment-nondepreciable	0	C	0 0	0	29
. 00	Total fixed assets (sum of lines 12-29)	49, 242, 113	C	0 0	0	30
	OTHER ASSETS					
. 00	Investments	0	C		0	
. 00	Deposits on Leases	0	C	0	0	
. 00	Due from owners/officers	0		0	0	
. 00	Other assets	66, 901			0	
. 00 . 00	Total other assets (sum of lines 31-34)	66, 901			0	
. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	53, 192, 673			0	30
. 00	Accounts payable	26, 699	C	ol	0	37
. 00	Salaries, wages, and fees payable	1, 066, 180			0	
. 00	Payrol I taxes payable	0000,100		0	0	
	Notes and loans payable (short term)	0		0	0	
	Deferred income	0	C	0	0	
. 00	Accelerated payments	0				42
00	Due to other funds	0	C	0 0	0	4
. 00	Other current liabilities	19, 061	c	0 0	0	44
. 00	Total current liabilities (sum of lines 37 thru 44)	1, 111, 940	C	0 0	0	45
	LONG TERM LIABILITIES		1	1		
. 00	Mortgage payable	0	C	0 0	0	
. 00	Notes payable	0	C	0	0	
00	Unsecured Loans	0		0	0	
00	Other long term liabilities	117, 271		0	0	
. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	117, 271			0	
00	CAPITAL ACCOUNTS	1, 229, 211	L C	<u>, U</u>	0	1 2
00	General fund balance	51, 963, 462				52
00	Specific purpose fund	51, 703, 402				53
00	Donor created - endowment fund balance - restricted					54
. 00	Donor created - endowment fund balance - restricted			0		55
. 00	Governing body created - endowment fund balance			0		56
. 00	Plant fund balance - invested in plant			Ŭ	0	
. 00	Plant fund balance - reserve for plant improvement,				0	
-	replacement, and expansion				Ū	
. 00	Total fund balances (sum of lines 52 thru 58)	51, 963, 462	C	0	0	59
	Total liabilities and fund balances (sum of lines 51 and	53, 192, 673			0	60

	Financial Systems COMM ENT OF CHANGES IN FUND BALANCES	IUNI TY STROKE ANI	) REHABILITATI Provider CC			eriod: com 07/01/2021	w of Form CMS-2 Worksheet G-1 Date/Time Pre 11/22/2022 9:	pared:
		General	Fund	Speci al	Pur	rpose Fund	Endowment Fund	
							5.00	
1.00	Fund balances at beginning of period	1.00	2.00 53,817,916	3.00		4.00	5.00	1.00
2.00 3.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		4, 088, 105 57, 906, 021			0		2.00 3.00
4.00	Additions (credit adjustments) (speci	0			0		0	4.00
5.00 6.00	RESTRI CTED CONTRI BUTI ONS	3, 186			0		0	
7.00		0			0		0	
8.00		0			0		0	
9.00 10.00	Total additions (sum of line 4-9)	0	3, 186		0	0	0	9.00 10.00
11.00	Subtotal (line 3 plus line 10)		57, 909, 207			0		11.00
12.00	Deductions (debit adjustments) (specify)	0			0		0	
13.00 14.00	TRANSFERRED TO/FROM AFFILIATES	5, 945, 745 0			0		0	13.00 14.00
15.00		Ő			0		0	
16.00		0			0		0	
17.00 18.00	Total deductions (sum of lines 12-17)	0	5, 945, 745		0	0	0	17.00 18.00
19.00	Fund balance at end of period per balance		51, 963, 462			0		19.00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
			Franc					
	F	6.00	7.00	8.00				
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0			1.00 2.00
3.00 4.00	Total (sum of line 1 and line 2) Additions (credit adjustments) (speci	0	0		0			3.00 4.00
4.00 5.00	RESTRICTED CONTRIBUTIONS		0					5.00
6.00			0					6.00
7.00 8.00			0					7.00 8.00
9.00			0					9.00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0		0			11.00
13.00	TRANSFERRED TO/FROM AFFILIATES		0					13.00
14.00			0					14.00
15.00 16.00			0					15.00 16.00
17.00			0					17.00
18.00	Total deductions (sum of lines 12-17)	0			0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19.00

	Financial Systems COMMUNITY STROKE AND IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC		Peri od:	u of Form CMS-2 Worksheet G-2	
				From 07/01/2021 To 06/30/2022	Parts   &    Date/Time Pre 11/22/2022 9:	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES General Inpatient Routine Services					+
1.00	Hospital		13, 919, 7	30	13, 919, 730	1 1.00
2.00	SUBPROVIDER - IPF		10, 717, 7		10, 717, 700	2.00
3.00	SUBPROVIDER - IRF			0	0	3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	1 0.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE		40.040.7		10.010.700	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		13, 919, 73	30	13, 919, 730	10.00
11 00	Intensive Care Type Inpatient Hospital Services INTENSIVE CARE UNIT			0	0	1 1 1 0
11.00 12.00	CORONARY CARE UNIT			0	0	11.00
12.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines		0	0	
	11-15)			0	, i i i i i i i i i i i i i i i i i i i	
17.00	Total inpatient routine care services (sum of lines 10 and 16	)	13, 919, 7	30	13, 919, 730	17.00
18.00	Ancillary services		18, 671, 9	37 0	18, 671, 937	18.00
19.00	Outpatient services			0 45, 035, 823	45, 035, 823	19.00
20.00	RURAL HEALTH CLINIC			0 0		
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )			0		25.00
26.00 27.00	HOSPI CE TAXABLE LAB			0 0 0 1,743	0 1, 743	
27.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	32, 591, 6			
20.00	G-3, line 1)	to wkst.	52, 571, 0	43, 037, 300	11,029,233	20.00
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			23, 217, 753		29.00
30.00	ADD (SPECI FY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.0
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.00
39.00 40.00				0		39.00 40.00
40.00				0		40.0
41.00	Total deductions (sum of lines 37-41)			<u>л</u>		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		23, 217, 753		42.00
45.00	to Wkst. G-3, line 4)	2)((10)))		20, 217, 700		+5.00

Health Financial Systems COMMUNITY STROKE AND REHABILITATION In Lieu of Form CMS-2552-10					
STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-3045	Period: From 07/01/2021 To 06/30/2022		
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	ne 28)		77, 629, 233	1.00
2.00	Less contractual allowances and discounts on patients' accounts			50, 604, 159	
3.00	Net patient revenues (line 1 minus line 2)			27, 025, 074	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			23, 217, 753	
5.00	Net income from service to patients (line 3 minus line 4)			3, 807, 321	
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			31, 131	6.00
7.00	Income from investments			677	7.00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			91, 299	
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to other t	han patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			103, 000	
23.00	Governmental appropriations			0	
	OTHER I NCOME			94	
24.01	GRANT I NCOME			51, 855	
24.02	CLASSES			2, 728	24.02
	ASSETS RELEASED FROM RESTRICTION			0	24.03
	GAINS OF SALE OF ASSETS			0	24.04
24.50	COVID-19 PHE Funding Total other income (sum of lines 6-24)			0 280, 784	24.50 25.00
	Total (line 5 plus line 25)			4, 088, 105	
	OTHER EXPENSES (SPECIFY)			4,088,105	27.00
27.00	Total other expenses (sum of line 27 and subscripts)			0	27.00
	Net income (or loss) for the period (line 26 minus line 28)			4, 088, 105	
27.00			I	1, 000, 100	