(5) Amended

Health Financia	al Systems	Community Health Rehab	Hospital South	In Lieu	1 of Form CMS-2552-10		
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Fail	lure to report can re	esult in all interim	FORM APPROVED		
payments made	since the beginning of the cost	reporting period being	deemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050		
					EXPIRES 09-30-2025		
HOSPITAL AND H	OSPITAL HEALTH CARE COMPLEX COST	REPORT CERTIFICATION	Provider CCN: 15-304		Worksheet S		
AND SETTLEMENT SUMMARY From 01/01/2022 Pai							
				To 12/31/2022	Date/Time Prepared:		
					5/16/2023 12:57 pm		
PART I - COST	REPORT STATUS						
Provi der	1. [X] Electronically prepared	cost report		Date: 5/16/202	23 Time: 12:57 pm		
use only	2. [] Manually prepared cost i	report					
	3. [0] If this is an amended re	eport enter the number	of times the provide	r resubmitted this co	ost report		
	4. [F] Medicare Utilization. E	nter "F" for full, "L"	for low, or "N" for	no.	•		
Contractor	5. [1]Cost Report Status 6.	Date Received:	1	IO. NPR Date:			
use only		Contractor No.		I1. Contractor's Vendo			
, , ,	(2) Settled without Audit 8.	[N] Initial Report fo	r this Provider CCN 1	l2.[0]If line 5, co	lumn 1 is 4: Enter		
	(3) Settled with Audit 9.	[N] Final Report for	this Provider CCN		es reopened = 0-9.		
	(4) Reopened						

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Community Health Rehab Hospital South (15-3044) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C				
	1			SI GNATURE STATEMENT				
1				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				2			
3	Signatory Title	CEO CEO			3			
4	Date				4			

		litle XVIII				
	Title V	Part A	Part B	HI T	Title XIX	
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
HOSPI TAL	0	58, 175	0	0	0	1. 00
SUBPROVIDER - IPF	0	0	0		0	2. 00
SUBPROVI DER - I RF	0	0	0		0	3.00
SWING BED - SNF	0	0	0		0	5. 00
SWING BED - NF	0				0	6. 00
SKILLED NURSING FACILITY	0	0	0		0	7. 00
TOTAL	0	58, 175	0	0	0	200.00
	SUBPROVI DER - I PF SUBPROVI DER - I RF SWI NG BED - SNF	1.00	Title V	1.00 2.00 3.00	Title V Part A Part B HIT 1.00 2.00 3.00 4.00	Title V Part A Part B HIT Title XIX

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3044 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/16/2023 12:57 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 607 Greenwood Springs Drive PO Box: 1.00 State: IN 2.00 City: Greenwood Zip Code: 46143 County: Johnson 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: Community Health Rehab Hospital South 3.00 153044 26900 5 09/18/2018 N 0 3.00 Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 21.00 5 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Ν Ν 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3044 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/16/2023 12:57 pm In-State In-State Out-of Out-of Medi cai d Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 \cap 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. 25.00 If this provider is an IRF, enter the in-state 46 160 0 0 1, 162 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1. 00 2.00 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. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Endi ng: Begi nni ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36, 00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 0 is in effect in the cost reporting period. 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 37.01 instructions) If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39. 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)(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. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν Ν 40.00 "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 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance Ν Ν 45.00 with 42 CFR Section §412.320? (see instructions) 46.00 | Is this facility eligible for additional payment exception for extraordinary circumstances Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Ν Ν Ν 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For Ν 56.00 cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. 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. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, 57.00 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. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

	3, the IME FTE unweighted count. Enter in column 4,						
	the direct GME FTE unweighted count.						
					1.00		
	ACA Provisions Affecting the Health Resources and Sei	rvices Administration	(HRSA)				
62.00	Enter the number of FTE residents that your hospital	trained in this cost	reporting peri	od for which	0.00	62.00	
	your hospital received HRSA PCRE funding (see instruc	ctions)					
62.01	Enter the number of FTE residents that rotated from a	a Teaching Health Cent	er (THC) into	your hospital	0.00	62. 01	
	during in this cost reporting period of HRSA THC program. (see instructions)						
	Teaching Hospitals that Claim Residents in Nonprovide	er Settings					
63.00	Has your facility trained residents in nonprovider se	ettings during this co	st reporting p	eriod? Enter	N	63.00	
	"Y" for yes or "N" for no in column 1. If yes, comple	ete lines 64 through 6	7. (see instru	ctions)			

71.00	recent cost report filed on or before November 15, 2004? Enter "Y" for yes 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes Column 3: If column 2 is Y, indicate which program year began during this co (see instructions)	o. (see i ng o.			Ü	/1.00	
75. 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it cont	tain an IRF		Υ			75. 00
	subprovider? Enter "Y" for yes and "N" for no.			-			
76. 00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching recent cost reporting period ending on or before November 15, 2004? Enter "Y no. Column 2: Did this facility train residents in a new teaching program in CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If co indicate which program year began during this cost reporting period. (see in	"N" for	N	N	0	76. 00	
				-	1.00	<u> </u>	
	Long Term Care Hospital PPS		1.00	,			
80. 00 81. 00		nter	N N		80. 00 81. 00		
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Did this facility establish a new Other subprovider (excluded unit) under 42 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	no.	N		85. 00 86. 00		
87. 00	Is this hospital an extended neoplastic disease care hospital classified und 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N		87. 00	
			Approved Permane Adjustme (Y/N)	nt	Number Appro Perman Adjustm	ved ent ents	
88. 00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		1. 00		2.00		88. 00
		Wkst. A Line No.	Effecti ve	Date	Approx Perman Adjusti Amount Discha	ent ment Per rge	
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00	2.00		0.01		89. 00
	The first carry of amounts por an outraingo.		V 1. 00		XI X		
	Title V and XIX Services				Υ		
90 00	0.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for N						90.00
70.00	yes or "N" for no in the applicable column.						
	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report e full or in part? Enter "Y" for yes or "N" for no in the applicable column.	either in	N		N		91. 00
91. 00	Is this hospital reimbursed for title V and/or XIX through the cost report efull or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification		N		N N		
91. 00 92. 00	Is this hospital reimbursed for title V and/or XIX through the cost report efull or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and X	n)? (see	N N				91. 00 92. 00 93. 00
91. 00 92. 00 93. 00	Is this hospital reimbursed for title V and/or XIX through the cost report efull or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and X "Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in	n)? (see KLX? Enter			N		92. 00
91. 00 92. 00 93. 00 94. 00 95. 00	Is this hospital reimbursed for title V and/or XIX through the cost report e full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and X "Y" for yes or "N" for no in the applicable column.	n)? (see KIX? Enter n the	N		N N	D)	92. 00 93. 00

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

	AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C		In Lie eriod: rom 01/01/2022	Worksheet S-2	2
				0 12/31/2022		
			<u>'</u>	V	XI X	, o, p
98. 00 Do	es title V or XIX follow Medicare (title XVIII) for the in	atorns and ros	idents post	1. 00 Y	2. 00 Y	98.0
st	epdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" 1 Iumn 1 for title V, and in column 2 for title XIX.				·	
C,	es title V or XIX follow Medicare (title XVIII) for the rePt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.			Y	Y	98. 0
98. 02 Do	es title V or XIX follow Medicare (title XVIII) for the ca d costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o		Y	Y	98. 0	
98.03 Do	r title V, and in column 2 for title XIX. es title V or XIX follow Medicare (title XVIII) for a cris imbursed 101% of inpatient services cost? Enter "Y" for ye		N	N	98. 0	
98. 04 Do	r title V, and in column 2 for title XIX. es title V or XIX follow Medicare (title XVIII) for a CAH tpatient services cost? Enter "Y" for yes or "N" for no ir		N	N	98. 0	
98. 05 Do	column 2 for title XIX. es title V or XIX follow Medicare (title XVIII) and add bast. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in a		Y	Y	98. 0	
98. 06 Do	lumn 2 for title XIX. es title V or XIX follow Medicare (title XVIII) when cost s. I through IV? Enter "Y" for yes or "N" for no in columm lumn 2 for title XIX.		Y	Υ	98. 0	
105. 00 Do	ral Providers es this hospital qualify as a CAH? this facility qualifies as a CAH, has it elected the all-	hod of payment	N		105. 0 106. 0	
fo	r outpatient services? (see instructions)	. ,				
tr Co	lumn 1: If line 105 is Y, is this facility eligible for co aining programs? Enter "Y" for yes or "N" for no in column lumn 2: If column 1 is Y and line 70 or line 75 is Y, do proved medical education program in the CAH's excluded IP	n 1. (see ins you train I&R	tructions) s in an			107. C
En 108. 00 I s	this a rural hospital qualifying for an exception to the R Section §412.113(c). Enter "Y" for yes or "N" for no.	ons)	, ,	N		108. 0
CI	N Section 3412. 113(c). Enter 1 101 yes of N 101 no.	Physi cal	Occupati onal	Speech	Respi ratory	
100 001 €	this been tal qualifies as a CAU or a cost provider are	1.00 N	2. 00 N	3. 00 N	4. 00 N	109.0
	this hospital qualifies as a CAH or a cost provider, are	IN IN	I IN	IN IN	IN IN	1109. C
	erapy services provided by outside supplier? Enter "Y" r yes or "N" for no for each therapy.					
					1.00	
fo 110. 00 Di Del Col	r yes or "N" for no for each therapy. d this hospital participate in the Rural Community Hospita monstration) for the current cost reporting period? Enter ' mplete Worksheet E, Part A, lines 200 through 218, and Wor	'Y" for yes or	"N" for no. It	f yes,	1. 00 N	110. 0
10. 00 Di Del	r yes or "N" for no for each therapy. d this hospital participate in the Rural Community Hospita monstration) for the current cost reporting period? Enter '	'Y" for yes or	"N" for no. It	f yes, gh 215, as	N	110. 0
110. 00 Di Der cor ap	d this hospital participate in the Rural Community Hospita monstration) for the current cost reporting period? Enter 'mplete Worksheet E, Part A, lines 200 through 218, and Woiplicable.	'Y" for yes or rksheet E-2, l	"N" for no. It ines 200 throug	f yes, gh 215, as		
10. 00 Die column ap 11. 00 I f He. "Y i n En	d this hospital participate in the Rural Community Hospital monstration) for the current cost reporting period? Enter 'mplete Worksheet E, Part A, lines 200 through 218, and Worplicable. This facility qualifies as a CAH, did it participate in alth Integration Project (FCHIP) demonstration for this community of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for account of the participate in the services of the participate in the services of the property of the participate in the participate	'Y" for yes or rksheet E-2, I the Frontier Cost reporting of Jumn 1 is Y, rticipating in	"N" for no. In ines 200 through the community period? Enter enter the column 2.	f yes, gh 215, as	N	
I10. 00 Die col ap	d this hospital participate in the Rural Community Hospital monstration) for the current cost reporting period? Enter 'mplete Worksheet E, Part A, lines 200 through 218, and Worplicable. This facility qualifies as a CAH, did it participate in alth Integration Project (FCHIP) demonstration for this community for yes or "N" for no in column 1. If the response to cottegration prong of the FCHIP demo in which this CAH is participate.	'Y" for yes or rksheet E-2, I the Frontier Cost reporting of Jumn 1 is Y, rticipating in	ommunity period? Enter enter the column 2.; and/or "C"	f yes, gh 215, as 1.00 N	N 2. 00	
10. 00 Di Dei Corapian di II. 00 I f He. "Y i n En fo	d this hospital participate in the Rural Community Hospital monstration) for the current cost reporting period? Enter 'mplete Worksheet E, Part A, lines 200 through 218, and Worplicable. This facility qualifies as a CAH, did it participate in the alth Integration Project (FCHIP) demonstration for this community for yes or "N" for no in column 1. If the response to contegration prong of the FCHIP demo in which this CAH is participated in the all that apply: "A" for Ambulance services; "B" for according to the content of the c	'Y" for yes or rksheet E-2, I the Frontier Cost reporting olumn 1 is Y, rticipating indditional beds	ommunity period? Enter enter the column 2. ; and/or "C"	f yes, gh 215, as	N	111. (
10. 00 Di Deconapionale de la conapionale della conapionale de la conapionale de la conapionale de la conapionale della	d this hospital participate in the Rural Community Hospital monstration) for the current cost reporting period? Enter 'mplete Worksheet E, Part A, lines 200 through 218, and Worplicable. This facility qualifies as a CAH, did it participate in talth Integration Project (FCHIP) demonstration for this community of the FCHIP demoin which this CAH is participate in the response to compare the response to the response to compare the response to compare the response to the respon	'Y" for yes or rksheet E-2, I the Frontier Cost reporting olumn 1 is Y, rticipating in dditional beds th Model eporting olumn 1 is porting olumn 1 is porting olumn 1 is porting in the	ommunity period? Enter enter the column 2.; and/or "C"	f yes, gh 215, as 1.00 N	N 2. 00	111. (
10. 00 Die Columbia Der Columbia Der Columbia Der Columbia Die Columbi	d this hospital participate in the Rural Community Hospital monstration) for the current cost reporting period? Enter 'mplete Worksheet E, Part A, lines 200 through 218, and Worplicable. this facility qualifies as a CAH, did it participate in tall the Integration Project (FCHIP) demonstration for this compose of the FCHIP demonstration for this compose of the FCHIP demonstration for the categoration prong of the FCHIP demonstration for any participate in the Pennsylvania Rural Heal ARHM) demonstration for any portion of the current cost region of the FCHIP demonstration for any portion of the current cost region of the current current current cost region of the current current current c	the Frontier Cost reporting of Jumn 1 is Y, rticipating in dditional beds th Model eporting of Jumn 1 is said the model eporting of Jumn 1 is said and Rural	ommunity period? Enter enter the column 2. ; and/or "C"	f yes, gh 215, as 1.00 N	N 2. 00	111. (
10. 00 Di Deconapo de la compansión de l	d this hospital participate in the Rural Community Hospital monstration) for the current cost reporting period? Enter 'mplete Worksheet E, Part A, lines 200 through 218, and Worplicable. This facility qualifies as a CAH, did it participate in talth Integration Project (FCHIP) demonstration for this complication prong of the FCHIP demoin which this CAH is parter all that apply: "A" for Ambulance services; "B" for active tele-health services. In this hospital participate in the Pennsylvania Rural Heal ARHM) demonstration for any portion of the current cost reportion. In column 2, the date the hospital began participate in the date the hospital cearticipation in the demonstration, if applicable. In the Community Health Access ansformation (CHART) model for any portion of the current porting period? Enter "Y" for yes or "N" for no. Scellaneous Cost Reporting Information This an all-inclusive rate provider? Enter "Y" for yes or column 1. If column 2 is "E", enter in column 3 either "Y" resport term hospital or "98" percent for long term care by chiatric, rehabilitation and long term hospitals provider	'Y" for yes or rksheet E-2, I the Frontier Cost reporting olumn 1 is Y, rticipating in dditional beds th Model eporting olumn 1 is oating in the ased s and Rural cost "N" for no 3, or E only) 93" percent (includes	ommunity period? Enter enter the column 2. ; and/or "C"	f yes, gh 215, as 1.00 N	2. 00 3. 00	111. (
10. 00 Di Deconapo de la compansión de l	d this hospital participate in the Rural Community Hospital monstration) for the current cost reporting period? Enter 'mplete Worksheet E, Part A, lines 200 through 218, and Worplicable. this facility qualifies as a CAH, did it participate in talth Integration Project (FCHIP) demonstration for this complication prong of the FCHIP demoniant of this CAH is participate in the response to contegration prong of the FCHIP demoniant of this CAH is participate in the all that apply: "A" for Ambulance services; "B" for activate all that apply: "A" for Ambulance services; "B" for activate all that apply: "A" for Ambulance services; "B" for activate all that apply: "A" for Ambulance services; "B" for activate all that apply: "A" for Ambulance services; "B" for activate all this hospital participate in the Pennsylvania Rural Heal ARHM) demonstration for any portion of the current cost regions for any portion of the current promonstration. In column 3, enter the date the hospital cean tricipation in the demonstration, if applicable. definition to this hospital participate in the Community Health Access ansformation (CHART) model for any portion of the current porting period? Enter "Y" for yes or "N" for no. seel laneous Cost Reporting Information this an all-inclusive rate provider? Enter "Y" for yes or column 1. If column 1 is yes, enter the method used (A, column 2. If column 1 is yes, enter the column 3 either "created and the provider and the column 3 either "created and the provider	the Frontier Cost reporting of umn 1 is Y, rticipating in dditional beds the Model eporting of umn 1 is soating in the ased so and Rural cost "N" for no 3, or E only) 93" percent (includes rs) based on	ommunity period? Enter enter the column 2. ; and/or "C"	f yes, gh 215, as 1.00 N	2. 00 3. 00	111. C
110. 00 Die Co ap	d this hospital participate in the Rural Community Hospital monstration) for the current cost reporting period? Enter 'mplete Worksheet E, Part A, lines 200 through 218, and Worplicable. This facility qualifies as a CAH, did it participate in the alth Integration Project (FCHIP) demonstration for this community in the gration prong of the FCHIP demoin which this CAH is participate all that apply: "A" for Ambulance services; "B" for active tele-health services. In this hospital participate in the Pennsylvania Rural Heal ARHM) demonstration for any portion of the current cost regretation. In column 2, the date the hospital began participate in the date the hospital certicipation in the demonstration, if applicable. In column 3, enter the date the hospital certicipation in the demonstration, if applicable. In the Community Health Access ansformation (CHART) model for any portion of the current porting period? Enter "Y" for yes or "N" for no. seel laneous Cost Reporting Information This an all-inclusive rate provider? Enter "Y" for yes or column 1. If column 1 is yes, enter the method used (A, E column 2. If column 2 is "E", enter in column 3 either "C short term hospital or "98" percent for long term care by yes of the column 1 is CMS Pub. 15-1, chapter 22, \$2208.1.	the Frontier Cost reporting olumn 1 is Y, rticipating in dditional beds th Model eporting olumn 1 is soating in the ased so and Rural cost "N" for no 3, or E only) 93" percent (includes rs) based on for yes or	ommunity period? Enter enter the column 2. ; and/or "C"	f yes, gh 215, as 1.00 N	2. 00 3. 00	1110. CC 1111. CC 1112. CC 1115. CC

141. OOMAINE. LITEI OTNI TILALITI	Contractor 3	Name. I ALWELLIO ODA	Contractor	3 Nulliber . 1000	1	1141.00
142.00 Street: 330 SEVEN SPRINGS WAY	PO Box:					142. 00
143.00 City: BRENTWOOD	State:	TN	Zi p Code:	3702	7	143. 00
			• •			
					1.00	
144.00 Are provider based physicians' costs	included in Wo	rksheet A?			Υ	144. 00
				1. 00	2. 00	
145.00 If costs for renal services are clai	med on Wkst. A,	line 74, are the c	osts for	Υ		145. 00
inpatient services only? Enter "Y" f	or yes or "N" f	or no in column 1.	If column 1 is			
no, does the dialysis facility inclu	de Medicare uti	lization for this c	ost reporting			
period? Enter "Y" for yes or "N" fo	r no in column :	2.				
146.00 Has the cost allocation methodology	changed from the	e previously filed	cost report?	N		146. 00
Enter "Y" for yes or "N" for no in c	olumn 1. (See Cl	MS Pub. 15-2, chapt	er 40, §4020) If			
yes, enter the approval date (mm/dd/	yyyy) in column	2.	,			

Health Financial Systems	Community Healt	h Rehab	o Hospital So	uth			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA		Fr				/01/2022 /31/2022		epared:
								1.00	
147.00 Was there a change in the statisti								N	147. 00
148.00 Was there a change in the order of 149.00 Was there a change to the simplifi					for n			N N	148. 00 149. 00
149.00 was there a change to the simpiffi	ed cost finding metho	ou? Ente	Part A	Part			tle V	Title XIX	149.00
			1. 00	2.00			3. 00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or '									
155.00 Hospi tal			N	N			N	N	155. 00
156.00 Subprovi der - IPF			N	N N			N	N	156. 00
157. 00 Subprovi der - I RF 158. 00 SUBPROVI DER			N	N			N	N	157. 00 158. 00
158. 00 S0BPR0V1DER 159. 00 SNF			N	l N			N	N	158.00
160.00 HOME HEALTH AGENCY			N	N N			N	N N	160. 00
161. 00 CMHC				N N			N	N	161. 00
								1.00	
Mul ti campus									
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that ha	is one (or more campu	ises in di	ffere	nt CBS	SAs?	N	165. 00
·	Name		County	State			CBSA	FTE/Campus	
166.00 f ine 165 is yes, for each	0		1. 00	2. 00	3.	00	4. 00	5. 00	0 166. 00
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) 166.01									0 166. 01
166. 02									0 166. 02
166. 03								0.0	0 166. 03
								1.00	
Heal th Information Technology (HI						Act		l N	1/7 00
167.00 s this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	05 is "Y") and is a me	ani ngfi	ul user (line			enter	the	N	167. 00 168. 00
168.01 If this provider is a CAH and is reception under §413.70(a)(6)(ii)?	not a meaningful user,	does	this provider			hards	shi p		168. 01
169.00 If this provider is a meaningful utransition factor. (see instruction	user (line 167 is "Y")					"), er	nter the	0.0	0169.00
transition factor. (See Thistractive	, , , , , , , , , , , , , , , , , , ,					Beg	i nni ng	Endi ng	
							1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	peginning date and end	li ng da [.]	te for the re	eporting					170. 00
							1. 00	2.00	
171.00 If line 167 is "Y", does this proving section 1876 Medicare cost plans re "Y" for yes and "N" for no in column 1876 Medicare days in column 2.	reported on Wkst. S-3, umn 1. If column 1 is	Pt. I	, line 2, col	. 6? Ente			N N		0 171. 00

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-3044	Peri od: From 01/01/2022	Worksheet S-2 Part II	2
				To 12/31/2022	Date/Time Pro 5/16/2023 12:	
				Y/N	Date	. 37 pii
	DADT LL LIGEDITAL AND HOEDITAL HEATHOADE CONDUEY DELINDUDGE	IENT OUECTLON	ALDE	1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEM General Instruction: Enter Y for all YES responses. Enter N			er all dates in t	he	
	mm/dd/yyyy format.		<u> </u>			
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the			N		1.0
	reporting period? If yes, enter the date of the change in co	olumn 2. (see	instructions Y/N) Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	of termination and in column 3, "V" for				2.
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide	fices, drug	Y			3.
	officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	the board				
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
00	Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	03/31/2023	4.0			
00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit reco		N	V/N	11 0	5.
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for a nursing program? Column 2 the legal operator of the program?	2: IT yes, IS	tne provide	r N		6.
00 00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing programs and/or allied health programs approved cost reporting period? If yes, see instructions.		ed during th	e N		7. 8.
00	Are costs claimed for Interns and Residents in an approved g		al education	N		9.
0. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or		he current	N		10.
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	roved	N		11.
	reaching Frogram on worksheet A: IT yes, see this tructions.				Y/N	
	Rad Dahta				1. 00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes,	see instruct	i ons.		Υ	12.
	If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.	, ,	G	. 0	N	13.
1. 00	If line 12 is yes, were patient deductibles and/or coinsurar instructions. Bed Complement	nce amounts wa	ived? If yes	, see	N	14.
5. 00	Did total beds available change from the prior cost reporting			tructions.	N	15.
		Y/N Par	t A Date	Par Y/N	t B Date	
		1. 00	2.00	3. 00	4. 00	
. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	02/28/2023	Y	02/28/2023	16.
. 00	date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for	N		N		17.
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					
J. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions	N		N		18.
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.

HOSPI T	Financial Systems Community Health Rel FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-3044	Peri od: From 01/01/2022	u of Form CMS- Worksheet S-2 Part II			
				To 12/31/2022				
		Descr	i pti on	Y/N	Y/N			
			0	1. 00	3. 00			
20. 00				N	N	20. 0		
	Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date			
		1.00	2.00	3. 00	4. 00			
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 0		
	records: 11 yes, see mistractions.	<u> </u>						
	COMPLETED BY COCT DELMBURGED AND TEEDA HOODITALC ONLY (EVO	DT OULL DDENG I	100DL TAL C)		1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	EPT CHILDRENS F	HUSPITALS)			-		
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e instructions				22. 0		
23. 00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost							
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered	ed into during	this cost re	eporting period?		24. 0		
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repor	rting period	? If yes, see		25. 0		
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during th	•	0 .			26. 0		
	instructions.	•						
27. 00	Has the provider's capitalization policy changed during the copy. Interest Expense	e cost reportir	ng period? I	r yes, submit		27.0		
28. 00	Were new Loans, mortgage agreements or letters of credit er	ntered into du	ing the cos	t reporting		28.0		
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		ebt Service I	Reserve Fund)		29.0		
0. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If yes	s, see		30.0		
31. 00	instructions. Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes	s, see		31.0		
	instructions. Purchased Services					ļ		
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ea through co	ontractual		32.0		
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 approx, see instructions.	olied pertainin	ng to competi	tive bidding? If		33. 0		
	Provi der-Based Physi ci ans							
34. 00	Were services furnished at the provider facility under an allf yes, see instructions.	arrangement wi	th provider-l	pased physicians?		34.0		
35. 00	If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-based		35. C		
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date			
				1. 00	2. 00			
	Home Office Costs							
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	renared by the	home office	? Y Y		36. 0 37. 0		
	If yes, see instructions.							
38. 00	the provider? If yes, enter in column 2 the fiscal year end	d of the home o	offi ce.			38. 0		
39. 00	If line 36 is yes, did the provider render services to othe see instructions.	er chain compor	nents? If yes	S, N		39. 0		
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 0		
		1	00	2	00	-		
	Cost Report Preparer Contact Information			Ζ.				
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	DAVI D		SIMPSON		41.0		
11. 00	respecti vel y.	1						
	Enter the employer/company name of the cost report	LIFEPOINT HEAL	_TH			42.0		
41. 00 42. 00 43. 00	Enter the employer/company name of the cost report preparer.	LI FEPOI NT HEAL 5025967945	_TH	DAVI D. SI MPSON@I	LI FEPOI NTHEALT	42. C		

Heal th	Financial Systems	Community Health	Rehab	Hospi tal	South		In Lie	u of Form CMS	-2552-10
HOSPI T	TAL AND HOSPITAL HEALTH CARE REIMBURSEME	NT QUESTIONNAIRE		Provi der	CCN: 15-3044		eri od:	Worksheet S-	2
						To	com 01/01/2022 0 12/31/2022		epared: :57 pm_
					3. 00				
	Cost Report Preparer Contact Information	n							
41.00	Enter the first name, last name and the	e title/position	REI	I MBURSEMEN	T MANAGER				41. 00
	held by the cost report preparer in col	umns 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 a	ddress of the cost							43.00
	report preparer in columns 1 and 2, re-	specti vel y.							

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Heal th FinancialSystemsCommunity Heal th RehabHospitalSouthHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider CCN: 15-3044

					1	0 12/31/2022	5/16/2023 12:5	
							I/P Days / 0/P	57 piii
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Li ne No.			Avai I abl e			
		1. 00		2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA		<u> </u>				2. 22	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		44	16, 060	0, 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7.00	Total Adults and Peds. (exclude observation			44	16, 060	0.00	0	7.00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		0	0	0.00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY							13.00
14. 00	Total (see instructions)			44	16, 060	0.00	0	14. 00
15.00	CAH visits						0	15.00
16.00	SUBPROVIDER - I PF							16.00
17. 00	SUBPROVI DER - I RF							17. 00
18.00	SUBPROVI DER	44.00		0				18.00
19. 00	SKILLED NURSING FACILITY	44. 00		0	0		0	19.00
20.00	NURSING FACILITY							20.00
21. 00 22. 00	OTHER LONG TERM CARE HOME HEALTH AGENCY							21. 00 22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPICE							24. 00
24. 00	HOSPICE (non-distinct part)	30. 00						24. 00
25. 00	CMHC - CMHC	30.00						25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)	07.00		44			Ĭ	27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambulance Trips						Ĭ	29. 00
30. 00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0	0			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges							33. 01
34. 00		30. 00		0	0		0	34.00

Heal th FinancialSystemsCommunity Heal th RehabHospitalSouthHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider CCN: 15-3044

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | 5/16/2023 | 12: 57 pm

Component Title XVIII Title XIX Total Internet Employees On Payrol Patterns Employees On Payrol Patterns Employees On Payrol Pa							5/16/2023 12:	57 pm
PART I - STATISTICAL DATA 6.00 7.00 8.00 9.00 10.00			I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
PART I - STATISTICAL DATA 1.00 Hospit Tal Adults & Peds. (colums 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) 1,457		Component	Title XVIII	Title XIX				
PART I - STATISTICAL DATA				7.00				
1.00		DADT I CTATICTICAL DATA	6.00	7.00	8.00	9.00	10.00	
8 exclude Swing Bed. Observation Bed and Hospice days) (see instructions for cot . 2 for the portion of LDP room available beds)	1 00		F 410	47	11 550			1 00
3.00 HMD I PF Subprovider	1.00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	5, 412	40	11, 552			1.00
4. 00 HMO RF Subprovider 5. 00 0 0 5. 00 0 0 5. 00 0 0 0 0 0 0 0 0 0	2.00	HMO and other (see instructions)	1, 457	1, 322				2. 00
5.00 Hospit tal Adult ts & Peds. Swing Bed NF	3.00	HMO IPF Subprovider	0	0				3. 00
6.00 Hospital Adults & Peds. Swing Bed NF 0 0 0 6.000 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 7.00 8.00 INTERSIVE CARE UNIT 0 0 0 0 0 0 8.00 INTERSIVE CARE UNIT 10.00 9.00 CORONARY CARE UNIT 11.00 11.00 SURRI INTERSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 14.00 Total (see instructions) 5.412 46 11.552 0.00 91.30 16.00 Alvisits 18.00 18.00 17.00 SUBPROVIDER - IPF 0 0 0 0 0 18.00 SUBPROVIDER - IPF 16.00 17.00 SUBPROVIDER - IRF 18.00 18.00 SUBPROVIDER - IRF 18.00 19.00 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00	HMO IRF Subprovider	0	o				4. 00
7. 00	5.00	Hospital Adults & Peds. Swing Bed SNF	O	o	0			5. 00
Bods See instructions 8.00	6.00	Hospital Adults & Peds. Swing Bed NF		o	0			6. 00
9. 00 CORONARY CARE UNIT	7. 00	`	5, 412	46	11, 552			7. 00
10. 00 BURN INTENSIVE CARE UNIT	8.00	INTENSIVE CARE UNIT	0	0	0			8. 00
11. 00 SURGICAL INTENSIVE CARE UNIT	9.00	CORONARY CARE UNIT						9. 00
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (See instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 19. 00 ONLRSING FACILITY 19. 00 ONLRSING FACILITY 10. 00 OTHER LONG TERM CARE 10. 00 ONLRSING FACILITY 10. 00 OTHER LONG TERM CARE 10. 00 ONLRSING FACILITY 10. 00 OTHER LONG TERM CARE 10. 00 ONLRSING FACILITY 10. 00 OTHER LONG TERM CARE 10. 00 ONLRSING FACILITY 10. 00 OTHER LONG TERM CARE 10. 00 ONLRSING FACILITY 10. 00 OTHER LONG TERM CARE 10. 00 ONLRSING FACILITY 10. 00 OTHER LONG TERM CARE 10. 00 ONLRSING FACILITY 10. 00 OTHER LONG TERM CARE 10. 00 ONLRSING FACILITY 10. 00 OTHER LONG TERM CARE 10. 00 ONLRSING FACILITY 10. 00 OTHER LONG TERM CARE 10. 00 ONLRSING FACILITY 10. 00 OTHER LONG TERM CARE 10. 00 ONLRSING FACILITY 10. 00 OTHER LONG TERM CARE 10. 00 ONLRSING FACILITY 10. 00 OTHER LONG TERM CARE 10. 00 ONLRSING FACILITY 10. 00 OTHER LONG TERM CARE 10. 00 ONLRSING FACILITY 10. 00 OTHER LONG TERM CARE 10. 00 ONLRSING FACILITY 10. 00 OTHER LONG TERM CARE 11. 00 OTHER LONG TERM CARE 12. 00 OTHER LONG TERM CARE 13. 00 OTHER LONG TERM CARE 14. 00 OTHER LONG TERM CARE 15. 00 OTHER LONG TERM CARE 18. 00 OTHER LON	10.00	BURN INTENSIVE CARE UNIT						10.00
13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
14.00	12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
15. 00 CAH visits	13.00	NURSERY						13.00
16. 00 SUBPROVIDER - IPF 16. 00 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER 18. 00 18. 00 19. 00 0.00 0.00 19. 00 19. 00 0.00 19. 00	14.00	Total (see instructions)	5, 412	46	11, 552	0.00	91. 30	14.00
17. 00 SUBPROVI DER - IRF 17. 00 18. 00 SUBPROVI DER 18. 00 18. 00 19.	15.00	CAH visits	0	o	0			15. 00
18. 00 SUBPROVI DER 18. 00 19. 00 0. 00 0. 00 19. 00 0. 00 19. 00 0. 00 19. 00 0. 00 19. 00 0. 00 19. 00 0. 00 19. 00 0. 00 19. 00 0. 00 19. 00 0. 00 19. 00 0. 00 19. 00 0. 00 19. 00 0. 00 19. 00 0. 00 19. 00 0. 00 19. 00 0. 00 0. 00 19. 00 0. 00	16.00	SUBPROVI DER - I PF						16. 00
19.00 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0	17.00	SUBPROVI DER - I RF						17. 00
20.00 NURSING FACILITY 20.00 21.00 21.00 21.00 22.00 22.00 40ME HEALTH AGENCY 22.00 22.00 40MBULATORY SURGICAL CENTER (D.P.) 22.00 24.00 40.00 40.00 40.00 40.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.10 25.00 24.00 25.00 26.25 60.00 26.25 60.00 60.00 60.00 60.00 60.25 60.00 60.00 60.00 60.00 60.25 60.00 6	18.00	SUBPROVI DER						18. 00
21. 00	19.00	SKILLED NURSING FACILITY	O	o	0	0.00	0.00	19. 00
22.00	20.00	NURSING FACILITY						20.00
23. 00	21.00	OTHER LONG TERM CARE						21. 00
24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 00 Total ancillary labor & delivery room outpatient days (see instructions) 31. 00 LTCH non-covered days 31. 00 LTCH site neutral days and discharges	22.00	HOME HEALTH AGENCY						22. 00
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges	23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 30. 00 LTCH site neutral days and discharges 25. 00 26. 00 0 0 0 0 0. 00 0. 00 0 0 0 0 0 0 0 0 0 0 0	24.00	HOSPI CE						24. 00
26.00 RURAL HEALTH CLINIC 26.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 26.25 27.00 Total (sum of lines 14-26) 0 0 0 91.30 27.00 28.00 Observation Bed Days 0 0 28.00 28.00 29.00 Ambul ance Trips 0 29.00 30.00 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 31.00 32.00 Total ancillary labor & delivery room outpatient days (see instructions) 0 0 33.00 LTCH non-covered days 0 33.00 33.01 LTCH site neutral days and discharges 0	24. 10	HOSPICE (non-distinct part)			0			24. 10
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 0.00 91. 30 27. 00 28. 00 Observation Bed Days 0 0 0 0 0 0 0 0.00 91. 30 27. 00 28. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25.00	CMHC - CMHC						25. 00
27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26.00	RURAL HEALTH CLINIC						26. 00
28. 00 Observation Bed Days 0 0 29. 00 29. 00 30. 00 Employee discount days (see instruction) 30. 00 Employee discount days - IRF 0 31. 00 32. 00 Labor & delivery days (see instructions) 0 0 0 32. 00 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 0 33. 01 LTCH site neutral days and discharges 0 0 0 0 0 0 0 0 0	26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	O	0	0.00	0.00	26. 25
29. 00 Ambulance Trips 0 30. 00 Employee discount days (see instruction) 0 31. 00 Employee discount days - IRF 0 32. 00 Labor & delivery days (see instructions) 0 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 0 33. 00 LTCH non-covered days 0 33. 01 LTCH site neutral days and discharges 0	27.00	Total (sum of lines 14-26)				0.00	91. 30	27. 00
30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 0 31.00 32.00 Labor & delivery days (see instructions) 0 0 0 0 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.01 LTCH site neutral days and discharges 0 33.01	28.00	Observation Bed Days		0	0			28. 00
31.00 Employee discount days - IRF 0 31.00 32.00 Labor & delivery days (see instructions) 0 0 0 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.01 33.01 LTCH site neutral days and discharges 0 33.01	29.00		0					29. 00
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 31.00 0 0 0 0 32.00 0 32.01	30.00	Employee discount days (see instruction)			0			30.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 32.01	31.00				0			31. 00
outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 33.01	32.00	Labor & delivery days (see instructions)	0	o	0			32. 00
33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 33.00 33.01	32. 01	Total ancillary labor & delivery room			0			32. 01
33.01 LTCH site neutral days and discharges 0 33.01	33. 00		ol					33. 00
			ol					1
34.00 Temporary Expansi on COVID-19 PHE Acute Care 0 0 0 34.00			Ō	0	0			34. 00

34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3044

Peri od: Worksheet S-3 From 01/01/2022 Part I 12/31/2022 Date/Time Prepared: To

5/16/2023 12:57 pm Full Time Di scharges Equi val ents Title XVIII Title XIX Total All Component Nonpai d Title V Workers Pati ents 14.00 15.00 12.00 13.00 11.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 478 1,010 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 119 120 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider ol 4.00 Hospital Adults & Peds. Swing Bed SNF 5.00 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 Total (see instructions) 478 1,010 14.00 14.00 0.00 3 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 SUBPROVI DER 18.00 18.00 19 00 SKILLED NURSING FACILITY 0 00 19 00 NURSING FACILITY 20.00 20.00 21.00 OTHER LONG TERM CARE 21.00 HOME HEALTH AGENCY 22.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23 00 24.00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 24. 10 25.00 CMHC - CMHC 25.00 26. 00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26. 25 27.00 Total (sum of lines 14-26) 0.00 27.00 Observation Bed Days 28.00 28.00 29 00 Ambul ance Trips 29 00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) 32.00 32.00 32.01 Total ancillary labor & delivery room 32.01 outpatient days (see instructions) LTCH non-covered days 33.00 LTCH site neutral days and discharges 0 33.01 33.01 34.00 Temporary Expansion COVID-19 PHE Acute Care

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/ Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Community Health Rehab Hospital South
Provider CCN: 15-3044

					'	o 12/31/2022	Date/lime Pre 5/16/2023 12:	
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst.	(col.2 ± col.	Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3.00	3) 4.00	col . 4 5. 00	6. 00	
	PART II - WAGE DATA							
1.00	SALARIES Total salaries (see	200. 00	7, 390, 145	0	7, 390, 145	189, 717. 00	38. 95	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	C	0.00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		0	0	C	0.00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		0	0	C	0.00	0. 00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	0	1	0. 00 0. 00		
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	С	0.00	0.00	6. 00
7. 00	services Interns & residents (in an	21. 00	0	0	C	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0	C	0.00	0.00	7. 01
8. 00	programs) Home office and/or related organization personnel		0	0	C	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0	0 502, 058	502, 058	0. 00 14, 368. 00	l .	
	instructions) OTHER WAGES & RELATED COSTS							Ī
11. 00	Contract labor: Direct Patient Care		3, 053, 040	0	3, 053, 040	47, 502. 00	64. 27	11. 00
12. 00	Contract labor: Top level management and other management and administrative		0	0	C	0.00	0. 00	12. 00
13. 00	services Contract Labor: Physician-Part A - Administrative		103, 320	0	103, 320	574.00	180. 00	13. 00
14. 00	Home office and/or related organization salaries and		0	О	С	0.00	0. 00	14. 00
14. 01 14. 02 15. 00	wage-related costs Home office salaries Related organization salaries Home office: Physician Part A - Administrative		1, 207, 375 0 0	0 0 0	C	19, 862. 00 0. 00 0. 00	0. 00	14. 01 14. 02 15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	C	0.00	0. 00	16. 00
16. 01	Home office Physicians Part A - Teaching		0	0	C	0.00	0. 00	16. 01
16. 02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	C	0.00	0.00	16. 02
17. 00	Wage-related costs (core) (see instructions)		996, 054	0	996, 054			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		72, 600 0	0	72, 600 C			19. 00 20. 00
21. 00	Non-physician anesthetist Part B		0	0	C			21. 00
22. 00	Physician Part A - Administrative		0	0	С			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0	· ·	1			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	· ·	1			24. 00 25. 00
25. 50	approved program) Home office wage-related		0	0	С			25. 50
25. 51	(core) Related organization wage-related (core)		0	0	С			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	C			25. 52

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

Provider CCN: 15-3044 Period: From 01/01/2022 Part II To 12/31/2022 Part II To 12/31/2022 Part II Date/Time Prepared: 5/16/2023 12:57 pm

Wkst. A Line Amount Reclassificati Adjusted Paid Hours Average Hourly Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

		Number		on of Salaries	Sal ari es	Related to	Wage (set 4)	
		Nullibei	керог геа	(from Wkst.		Salaries in	Wage (col. 4 ÷	
					(col . 2 ± col .		col . 5)	
		1.00	2.00	A-6)	3)	<u>col . 4</u>	/ 00	
05.50	Lu 661 51 1 5 1 4	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	05.50
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	0	0	0	0. 00		
27.00	Administrative & General	5. 00	1, 393, 459	0	1, 393, 459	26, 971. 00	51. 67	27. 00
28.00	Administrative & General under		0	0	0	0.00	0.00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00	0.00	29. 00
30.00	Operation of Plant	7. 00	30, 340	0	30, 340	1, 360. 00	22. 31	30.00
31.00	Laundry & Linen Service	8. 00	0	0	O	0.00	0.00	31.00
32.00	Housekeepi ng	9. 00	173, 685	0	173, 685	9, 330. 00	18. 62	32. 00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33. 00
	(see instructions)							
34.00	Di etary	10. 00	441, 457	0	441, 457	20, 269. 00	21. 78	34.00
35. 00	Di etary under contract (see		0	0	0	0.00		
	instructions)				_			
36. 00	Cafeteri a	11. 00	0	0	0	0.00	0.00	36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38. 00	Nursing Administration	13. 00	202, 396	0	202, 396	5, 928. 00		
39. 00	Central Services and Supply	14. 00	0	0	0	0.00	1	
40. 00	Pharmacy	15. 00	232, 026	0	232, 026	5, 206. 00		40. 00
41. 00	Medical Records & Medical	16. 00	244, 926		244, 926	7, 957. 00		
41.00	Records Li brary	10.00	244, 720	0	244, 720	7, 737.00	30.70	41.00
42. 00	Social Service	17. 00	502, 058	-502, 058	٥	0.00	0.00	42. 00
	Other General Service	18. 00	302, 030 n	302, 030		0.00		43. 00
43.00	Tottier deficial 3elvice	10.00	U	l 0	ı	0.00	J 0. 00	43.00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part III | To 12/31/2022 | Date/Time Prepared: | Part | Part

							5/16/2023 12:	57 pm
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		7, 390, 145	0	7, 390, 145	189, 717. 00	38. 95	1. 00
	instructions)							
2.00	Excluded area salaries (see		0	502, 058	502, 058	14, 368. 00	34. 94	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		7, 390, 145	-502, 058	6, 888, 087	175, 349. 00	39. 28	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		4, 363, 735	0	4, 363, 735	67, 938. 00	64. 23	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		996, 054	0	996, 054	0.00	14. 46	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		12, 749, 934	-502, 058	12, 247, 876	243, 287. 00	50. 34	6. 00
7.00	Total overhead cost (see		3, 220, 347	-502, 058	2, 718, 289	77, 021. 00	35. 29	7. 00
	instructions)							

In Lieu of Form CMS-2552-10
Worksheet S-3
Part IV
Bate/Time Prepared:
5/16/2023 12: 57 pm
Amount Health Financial Systems
HOSPITAL WAGE RELATED COSTS Community Health Rehab Hospital South
Provider CCN: 15-3044 Peri od: From 01/01/2022 To 12/31/2022

		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1. 00	401K Employer Contributions	11, 151	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		l
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	317, 856	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	3, 374	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	19, 474	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	119, 780	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumul ati ve porti on)		l
	TAXES		l
17. 00	FICA-Employers Portion Only	491, 630	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	28, 129	20. 00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		I
22.00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	4, 660	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	996, 054	24. 00
	Part B - Other than Core Related Cost		l
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	Community Health Rehab Hospital South	h	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN:	15-3044 Peri od:	Worksheet S-3

		From 01/01/2022 To 12/31/2022	Date/Time Pre	
	Cost Center Description	Contract Labor	5/16/2023 12: Benefit Cost	5/ pm
	3330 7 50 30	1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	3, 053, 040	996, 054	1. 00
2.00	Hospi tal	3, 053, 040	996, 054	2. 00
3.00	SUBPROVI DER - I PF			3. 00
4.00	SUBPROVI DER - I RF			4. 00
5. 00	Subprovi der - (Other)	0	0	5. 00
6. 00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	SKILLED NURSING FACILITY	0	0	8. 00
9.00	NURSING FACILITY			9. 00
10.00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA			11. 00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12. 00
13.00	Hospi tal -Based Hospi ce			13. 00
14.00	Hospital-Based Health Clinic RHC			14. 00
15. 00	Hospital-Based Health Clinic FQHC			15. 00
16.00	Hospi tal -Based-CMHC		ļ	16. 00
17. 00	RENAL DIALYSIS I	0	0	17. 00
18. 00	Other	0	0	18. 00

Heal th	Financial Systems Community Healt	h Rehab Hospital Sc	outh	In Lie	eu of Form CMS-:	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co	CN: 15-3044 I	Peri od:	Worksheet S-1	0
				rom 01/01/2022		
				Γο 12/31/2022		
					5/16/2023 12:	57 pm
					1, 00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 colu	umn 3 divided by li	ne 202 column	8)	0. 432103	1.00
	Medicaid (see instructions for each line)	<u> </u>				1
2.00	Net revenue from Medicaid				0	2.00
3.00	Did you receive DSH or supplemental payments from Medic	cai d?				3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or su		s from Medicai	d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental pay	ments from Medicai	d		0	5.00
6.00	Medi cai d charges	,			0	6.00
7.00	Medicaid cost (line 1 times line 6)				0	
8.00	Difference between net revenue and costs for Medicaid p	orogram (line 7 min	us sum of line	es 2 and 5; if	0	8. 00
	< zero then enter zero)	5				
	Children's Health Insurance Program (CHIP) (see instruc	ctions for each lin	e)			
9.00	Net revenue from stand-alone CHIP				0	9. 00
10.00	Stand-alone CHIP charges				0	10.00
11.00	1.00 Stand-alone CHIP cost (line 1 times line 10)					
12.00	Difference between net revenue and costs for stand-alor	ne CHIP (line 11 mi	nus line 9; it	f < zero then	0	12. 00
	enter zero)					
	Other state or local government indigent care program (
13.00	Net revenue from state or local indigent care program (•			0	
14.00	Charges for patients covered under state or local indig	gent care program (Not included i	n lines 6 or	0	14. 00
	10)					
15. 00	State or local indigent care program cost (line 1 times				0	
16. 00	Difference between net revenue and costs for state or I	ocal indigent care	program (line	e 15 minus line	0	16. 00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medic	caid, CHIP and stat	e/Local Indige	ent care program	ns (see	
17. 00	<pre>instructions for each line) Private grants, donations, or endowment income restrict</pre>	tod to funding chan	ity care		0	17. 00
18. 00	Government grants, appropriations or transfers for supp				0	
19. 00	Total unreimbursed cost for Medicaid , CHIP and state a			(cum of lines	0	
19.00	8, 12 and 16)	and rocal indigent	care programs	(Sull Of Titles		19.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
			1.00	2. 00	3.00	
	Uncompensated Care (see instructions for each line)				3.00	
20.00	Charity care charges and uninsured discounts for the er	ntire facility		0	0	20.00
	(see instructions)	•				
21.00	Cost of patients approved for charity care and uninsure	ed discounts (see		0	0	21. 00
	instructions)					
22. 00	Payments received from patients for amounts previously	written off as		0	0	22. 00
	chari ty care					

		pati ents	pati ents	+ col . 2)		
		1.00	2. 00	3. 00		
	Uncompensated Care (see instructions for each line)					
20. 00	Charity care charges and uninsured discounts for the entire facility (see instructions)	0	0	0	20. 00	
21. 00		0	0	0	21. 00	
22. 00	Payments received from patients for amounts previously written off as charity care	0	0	0	22. 00	
23. 00	Cost of charity care (line 21 minus line 22)	0	0	0	23. 00	
				1. 00		
24. 00	24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?					
25. 00	If line 24 is yes, enter the charges for patient days beyond the indigent stay limit	care program's	s length of	0	25. 00	
26 00	Total bad debt expense for the entire hospital complex (see instructions)			0	26. 00	
	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			21, 516		
	27. 01 Medicare allowable bad debts for the entire hospital complex (see instructions)					
28. 00						
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see	instructions)		-2, 717	29. 00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			-2, 717	30. 00	
31. 00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			-2, 717	31. 00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-3044 Peri od: Worksheet A From 01/01/2022 12/31/2022 Date/Time Prepared: 5/16/2023 12:57 pm Total (col. Cost Center Description Sal ari es 0ther 1 Reclassi fi cati Reclassi fied + col. 2) ons (See A-6) Trial Balance (col. 3 +-col. 4) 1.00 2.00 3.00 4.00 5.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1, 751, 704 1, 751, 704 39, 045 1, 790, 749 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 237, 384 237, 384 142, 765 380, 149 2.00 00300 OTHER CAP REL COSTS 181, 810 3.00 181.810 -181, 810 0 3 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 176, 163 1, 176, 163 170 1, 176, 333 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 1, 393, 459 2, 245, 697 3, 639, 156 0 3, 639, 156 5.00 00700 OPERATION OF PLANT 540, 687 540, 687 30, 340 510, 347 7.00 0 7.00 00800 LAUNDRY & LINEN SERVICE 0 8.00 77, 492 77, 492 77, 492 8.00 9.00 00900 HOUSEKEEPI NG 173.685 42, 966 216, 651 0 216, 651 9.00 01000 DI ETARY 0 657, 137 10.00 10.00 441, 457 215, 680 657, 137 11 00 01100 CAFETERI A 11.00 \cap Ω 01300 NURSING ADMINISTRATION 13.00 202, 396 56, 270 258, 666 -34, 777 223, 889 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 42, 336 42, 336 42, 336 14.00 56, 303 01500 PHARMACY 232, 026 288, 329 0 288, 329 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 244, 926 16.00 846 245, 772 245, 772 16.00 17.00 01700 SOCIAL SERVICE 502,058 4,088 506, 146 -506, 146 0 17.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 425, 022 3,060,313 5, 485, 335 391, 742 5, 877, 077 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 0 44.00 04400 SKILLED NURSING FACILITY 0 44.00 0 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 759 759 -759 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 205, 277 205, 277 -205, 277 54.00 0 60 00 06000 LABORATORY 28 329 28 329 34, 231 62 560 60 00 0 06500 RESPIRATORY THERAPY 65.00 66,580 30, 623 97, 203 97, 203 65.00 0 06600 PHYSI CAL THERAPY 730, 951 18, 069 749, 020 0 749, 020 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 624, 163 322 624, 485 o 624, 485 67.00 06800 SPEECH PATHOLOGY 68 00 323,082 323 082 323, 082 68 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 185, 160 185, 160 -185, 160 0 71.00 07300 DRUGS CHARGED TO PATIENTS 0 248, 954 248, 954 248, 784 -170 73.00 176, 061 74.00 07400 RENAL DIALYSIS 0 176, 061 0 176, 061 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 0 0 09100 EMERGENCY 0 91.00 0 0 91.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 0 44.626 44.626 0 44.626 09850 OTHER REIMBURSABLE COST CENTERS 98.00 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 7, 390, 145 10, 597, 579 -506, 146 17, 481, 578 118. 00 17, 987, 724 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 194. 00 07950 NONALLOWABLE CASE MANAGER 000000000 506, 146 194. 00 0 506, 146 0 194. 01 07951 I DLE SPACE 0 0 0 0 194. 01 194. 02 07952 DI STRI CT 0 0 194. 02 0 194. 03 07953 DI STRI CT SALES 0 0 0 194. 03 194. 04 07954 CENTRALIZED ADMISSIONS (CAD) 0 0 194. 04 C 194. 05 07955 CENTRALIZED BUSINESS (CBO) 0 194. 05 0 0 0 0 0 194.06 07956 CENTRALIZED STAFFING 0 0 0 194. 06 194. 07 07957 HR MANAGED CARE 0 0 194, 07 0 194. 08 07959 LACUNA HEALTH 0 0 0 194. 08 0 194. 09 07958 SALES & MARKETING 0 0 0 194. 09 194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 10 0 0 194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION 0 194. 11 Ω 0 194. 12 07960 VISITOR MEALS 0 0 0 0 194. 12 TOTAL (SUM OF LINES 118 through 199) 7, 390, 145 10, 597, 579 17, 987, 724 17, 987, 724 200. 00

	Financial Systems Commu	nity Health Reh F EXPENSES	ab Hospital Sou Provider CCI	In Li Peri od:	eu of Form CMS-: Worksheet A	2552-10
				From 01/01/2022 To 12/31/2022		
	Cost Center Description		Net Expenses For Allocation 7.00			
	GENERAL SERVICE COST CENTERS		'			
1.00	00100 CAP REL COSTS-BLDG & FIXT	-8, 358	1, 782, 391			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-21, 686	358, 463			2.00
3.00	00300 OTHER CAP REL COSTS	0	0			3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-326, 917	849, 416			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	2, 135, 618	5, 774, 774			5. 00
7.00	00700 OPERATION OF PLANT	-1, 063	539, 624			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	o	77, 492			8. 00
9.00	00900 HOUSEKEEPI NG	o	216, 651			9. 00
10.00	01000 DI ETARY	-16, 888	640, 249			10.00
11.00	01100 CAFETERI A	o	0			11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	ol	223, 889			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	o	42, 336			14. 00
15.00	01500 PHARMACY	o	288, 329			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-124	245, 648			16. 00
17. 00	01700 SOCIAL SERVICE	o	0			17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	o	o			23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>	<u> </u>			1
30.00	03000 ADULTS & PEDI ATRI CS	112, 870	5, 989, 947			30.00
	03100 INTENSIVE CARE UNIT	o	0			31.00
	04400 SKILLED NURSING FACILITY	ol	o			44.00
	ANCILLARY SERVICE COST CENTERS					1
50.00	05000 OPERATING ROOM	0	0			50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	o			54.00
60.00	06000 LABORATORY	o	62, 560			60.00
65.00	06500 RESPIRATORY THERAPY	ol	97, 203			65.00
66. 00	06600 PHYSI CAL THERAPY	ol	749, 020			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	ol	624, 485			67. 00
68.00	06800 SPEECH PATHOLOGY	o	323, 082			68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0			71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	248, 784			73. 00
	07400 RENAL DIALYSIS	O	176, 061			74. 00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>				1
90.00	09000 CLI NI C	0	0			90.00
91.00	09100 EMERGENCY	o	O			91.00
	OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>			1
95.00	09500 AMBULANCE SERVI CES	-44, 626	0			95. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	o	o			98. 00
	SPECIAL PURPOSE COST CENTERS	<u>'</u>	<u> </u>			1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 828, 826	19, 310, 404			118. 00
	NONREI MBURSABLE COST CENTERS					1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	ol	o			192. 00
	07950 NONALLOWABLE CASE MANAGER	l ol	506, 146			194. 00
	07951 I DLE SPACE	l ol	O			194. 01
	07952 DI STRI CT	ol	O			194. 02
	07953 DISTRICT SALES	l	Ö			194. 03
	07954 CENTRALIZED ADMISSIONS (CAD)	o	o			194. 04
	07955 CENTRALIZED BUSINESS (CBO)	o	Ö			194. 05
	07956 CENTRALIZED STAFFING	0	o			194. 06
	07957 HR MANAGED CARE	ا	o			194. 07
	07959 LACUNA HEALTH	ا	o			194. 08
	07958 SALES & MARKETI NG	ا	o			194. 09
	07962 OTHER NONREIMBURSABLE COST CENTERS	ا	o			194. 10
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	l o	o			194. 11
	07960 VI SI TOR MEALS	l o	o			194. 12
200.00		1, 828, 826	19, 816, 550			200.00
	, , , , , , , , , , , , , , , , , , ,		, , , , , , , , ,			

Community Health Rehab Hospital South
Provider CCN: 15-3044 Peri od: Worksheet A-6 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

Cost Center						10 12/31/2022	5/16/2023 12	
2.00			Increases					
A - RECLASS NON ALLOWABLE CASE MANAGER		Cost Center	Li ne #	Sal ary	Other			
1.00				4. 00	5. 00			
TOTALS		A - RECLASS NON ALLOWABLE CAS	E MANAGER					
B - RECLASS RELATED PARTY 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 170 1.00	1.00	NONALLOWABLE CASE MANAGER	1 <u>94.</u> 00	502, 058				1. 00
1. 00 EMPLOYEE BENEFITS DEPARTMENT				502, 058	4, 088			
2. 00 ADULTS & PEDI ATRI CS 30. 00 0 546 TOTALS 0 716 C - RECLASS OR 1. 00 ADULTS & PEDI ATRI CS 30. 00 0 759 TOTALS 0 759 TOTALS 0 759 TOTALS 1. 00 TOTALS 1. 0								
TOTALS			4. 00	0				1. 00
C - RECLASS OR 1. 00 ADULTS & PEDI ATRI CS	2.00		<u>30.</u> 00	0_				2. 00
1. 00 ADULTS & PEDI ATRI CS 30. 00 0 759 TOTALS 0 759 D - RECLASS PURCHASED SERVI CES 1. 00 LABORATORY 60. 00 34, 231 TOTALS 0 30. 00 34, 231 TOTALS 0 30. 00 34, 231 TOTALS 0 205, 277 TOTALS 0 205, 277 TOTALS 0 205, 277 TOTALS 0 205, 277 F - RECLASS MED SUPPLI ES 1. 00 ADULTS & PEDI ATRI CS 0 30. 00 0 205, 277 TOTALS 0 205, 277 TOTA				0	716]
TOTALS 0 759 D - RECLASS PURCHASED SERVI CES 1. 00 LABORATORY 60. 00 34, 231 TOTALS 0 34, 231 E - RECLASS RADI OLOGY 1. 00 ADULTS & PEDI ATRI CS 0 205, 277 TOTALS 0 205, 277 F - RECLASS MED SUPPLI ES 1. 00 ADULTS & PEDI ATRI CS 0 10. 00 205, 277 TOTALS 0 10. 00 205, 277 F - RECLASS MED SUPPLI ES 1. 00 ADULTS & PEDI ATRI CS 0 10. 00 185, 160 TOTALS 0 185, 160								
D - RECLASS PURCHASED SERVI CES 1. 00 LABORATORY	1. 00		30.00	0_				1. 00
1. 00 LABORATORY 60. 00 34, 231 1. 00 TOTALS 0 30. 00 0 205, 277 1. 00 ADULTS & PEDI ATRI CS 0 205, 277 1. 00 ADULTS & PEDI ATRI CS 0 205, 277 1. 00 ADULTS & PEDI ATRI CS 0 205, 277 1. 00 TOTALS 1. 00 185, 160 1. 00 TOTALS 0 185, 160 1. 00 185, 180 1. 00 185, 1				0	759			
TOTALS E - RECLASS RADI OLOGY 1. 00 ADULTS & PEDI ATRI CS 30. 00 0 205, 277 TOTALS 0 205, 277 F - RECLASS MED SUPPLIES 1. 00 ADULTS & PEDI ATRI CS 30. 00 0 185, 160 TOTALS 0 185, 160								
E - RECLASS RADI OLOGY 1. 00 ADULTS & PEDI ATRI CS 30. 00 0 205, 277 TOTALS 0 205, 277 F - RECLASS MED SUPPLI ES 1. 00 ADULTS & PEDI ATRI CS 30. 00 0 185, 160 TOTALS 0 185, 160	1. 00		60.00	•				1. 00
1. 00 ADULTS & PEDI ATRI CS 30. 00 0 205, 277 TOTALS 0 205, 277 F - RECLASS MED SUPPLI ES 1. 00 ADULTS & PEDI ATRI CS 30. 00 0 185, 160 TOTALS 0 185, 160				0	34, 231			_
TOTALS 0 205, 277 F - RECLASS MED SUPPLIES 1. 00 ADULTS & PEDIATRICS 30.00 0 185, 160 1.00 TOTALS 0 185, 160								
F - RECLASS MED SUPPLIES 1. 00 ADULTS & PEDIATRICS 30.00 0 185, 160 1.00 TOTALS 0 185, 160	1. 00		30.00	•				1. 00
1. 00 ADULTS & PEDIATRICS 0 185, 160 TOTALS 0 185, 160				0	205, 277			
TOTALS 0 185, 160				_1				
	1.00		30.00					1.00
500.00 Jurand Total: Increases 502,058 430,231 500.00	F00 00			0				500.00
	500.00	urand iotal: Increases		502, 058	430, 231			500. 00

Health Financial Systems RECLASSIFICATIONS Community Health Rehab Hospital South
Provider CCN: 15-3044

Period: Worksheet A-6
From 01/01/2022
To 12/31/2022 Date/Time Prepared: 5/16/2023 12:57 pm

TOTALS							5/16/2023 12:	57 pm
Color			Decreases					
A - RECLASS NON ALLOWABLE CASE MANAGER 1.00 SOCI AL SERVI CE 17.00 502,058 4,088 0 1.00 B - RECLASS RELATED PARTY 1.00 NURSI NG ADMI NI STRATI ON 13.00 0 546 0 1.00 2.00 DRUGS CHARGED TO PATI ENTS 73.00 0 170 0 2.00 TOTALS 0 716 1		Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
1. 00 SOCI AL SERVI CE		6. 00	7. 00	8. 00	9. 00	10. 00		
TOTALS		A - RECLASS NON ALLOWABLE CAS	SE MANAGER					
B - RECLASS RELATED PARTY	1.00	SOCIAL SERVICE	1700	502, 058	4, 088	<u> </u>		1. 00
1. 00		TOTALS		502, 058	4, 088			
2. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 170 0 2. 00 TOTALS 0 716 C - RECLASS OR 1. 00 OPERATING ROOM 50. 00 759 0 1. 00 TOTALS 0 759 D - RECLASS PURCHASED SERVICES 1. 00 NURSING ADMINISTRATION 13. 00 34, 231 0 1. 00 TOTALS 0 34, 231 0 1. 00 TOTALS 0 34, 231 0 1. 00 TOTALS 0 205, 277 TE - RECLASS MED SUPPLIES 1. 00 MEDICAL SUPPLIES CHARGED TO 71. 00 0 185, 160 0 185, 160 0 1. 00 PATIENTS 0 185, 160		B - RECLASS RELATED PARTY						
TOTALS	1.00	NURSING ADMINISTRATION	13. 00	0	546	0		1. 00
C - RECLASS OR 1. 00 OPERATI NG ROOM	2.00	DRUGS CHARGED TO PATIENTS	73. 00	0	170	0		2. 00
1. 00 OPERATI NG ROOM 50. 00 759 0 1. 00 TOTALS 0 759 0 1. 00 D - RECLASS PURCHASED SERVI CES 1. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 34, 231 0 1. 00 TOTALS 0 34, 231 0 1. 00 TOTALS 0 205, 277 0 1. 00 TOTALS 0 205, 277 0 1. 00 TOTALS 0 1. 00 TOTALS 0 205, 277 0 1. 00 TOTALS 0 1. 00 TOTAL		TOTALS		0	716			
TOTALS		C - RECLASS OR						
D - RECLASS PURCHASED SERVICES 1. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 34, 231 0 1. 00 TOTALS 0 34, 231 0 1. 00 E - RECLASS RADI OLOGY 1. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 205, 277 0 1. 00 TOTALS 0 205, 277 0 1. 00 F - RECLASS MED SUPPLIES 1. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 185, 160 0 1. 00 PATI ENTS 0 185, 160	1.00	OPERATING ROOM	50.00	0	759	0		1. 00
1. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 34, 231 0 1. 00 TOTALS 0 34, 231 0 1. 00 E - RECLASS RADI OLOGY 1. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 205, 277 0 1. 00 TOTALS 0 205, 277 T		TOTALS			759			
TOTALS E - RECLASS RADI OLOGY 1. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 205, 277 0 1. 00 TOTALS 0 205, 277 F - RECLASS MED SUPPLI ES 1. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 185, 160 0 1. 00 PATI ENTS TOTALS 0 185, 160		D - RECLASS PURCHASED SERVICE	S					
E - RECLASS RADI OLOGY 1. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 205, 277 0 1. 00 TOTALS 0 205, 277 0 1. 00 F - RECLASS MED SUPPLI ES 1. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 185, 160 0 1. 00 PATI ENTS 0 185, 160 0 1. 00	1.00	NURSING ADMINISTRATION	13. 00	0	34, 231	0		1. 00
1. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 205, 277 0 1 1. 00 TOTALS 0 205, 277 0 1 1. 00 F - RECLASS MED SUPPLI ES CHARGED TO 71. 00 0 185, 160 0 1. 00 PATI ENTS 0 185, 160 0 185, 160		TOTALS			34, 231			
TOTALS 0 205, 277 F - RECLASS MED SUPPLIES 1. 00 MEDICAL SUPPLIES CHARGED TO 71. 00 0 185, 160 0 1. 00 PATIENTS 0 185, 160 0		E - RECLASS RADIOLOGY						
F - RECLASS MED SUPPLIES 1. 00 MEDICAL SUPPLIES CHARGED TO 71. 00 0 185, 160 0 1. 00 PATIENTS 0 185, 160	1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	205, 277	0		1. 00
1. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 185, 160 0 1. 00 PATI ENTS 0 185, 160 0 185, 160		TOTALS		₀	205, 277			
PATI ENTS		F - RECLASS MED SUPPLIES						
TOTALS 0 185, 160	1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	185, 160	0		1. 00
		PATI ENTS						
		TOTALS		0	185, 160			
500.00 Grand Total: Decreases 502,058 430,231 500.00	500.00	Grand Total: Decreases		502, 058	430, 231			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

| Period: | Worksheet A-7 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

				1	0 12/31/2022	Date/lime Prep 5/16/2023 12:	
				Acqui si ti ons		0, 10, 2020 12.	, p
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4. 00	5. 00	
PAR		BALANCES					
1.00 Lar		0	0	0	0	0	1. 00
	nd Improvements	0	0	0	0	0	2. 00
	Ildings and Fixtures	0	0	0	0	0	3. 00
	ilding Improvements	544, 503	13, 995	0	13, 995		4. 00
	xed Equi pment	0	0	0	0	0	5. 00
	vable Equipment	2, 037, 264	4, 867	0	4, 867	0	6. 00
	T designated Assets	0	0	0	0	0	7. 00
	ototal (sum of lines 1-7)	2, 581, 767	18, 862	0	18, 862	0	8. 00
	conciling Items	0	0	0	0	0	9. 00
10. 00 Tot	tal (line 8 minus line 9)	2, 581, 767	18, 862	0	18, 862	0	10. 00
		Ending Balance	Fully				
			Depreciated Assets				
		6, 00	7. 00	-			
PAR	RT I - ANALYSIS OF CHANGES IN CAPITAL ASSET		7.00				
1. 00 Lar		0	0				1.00
	nd Improvements	0	0			ļ	2. 00
	Idings and Fixtures	0	0			ļ	3.00
	ilding Improvements	558, 498	0			ļ	4.00
	xed Equipment	0	0			ļ	5. 00
	vable Equipment	2, 042, 131	0			l	6.00
	T designated Assets	0	0			ļ	7. 00
8. 00 Sub	ototal (sum of lines 1-7)	2, 600, 629	0				8. 00
9.00 Rec	conciling Items	O	0			ļ	9. 00
	tal (line 8 minus line 9)	2, 600, 629	0				10.00
·		·					

Health Financial Systems	Community Health Rehab	Hospital South	In Lie	u of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-3	044 Peri od:	Worksheet A-7

From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared: 5/16/2023 12:57 pm SUMMARY OF CAPITAL Taxes (see instructions) Insurance (see Cost Center Description Depreciation Lease Interest instructions) 10.00 11.00 9.00 12.00 13.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 CAP REL COSTS-BLDG & FIXT 50, 418 1, 701, 286 0 1.00 1, 635 1, 702, 921 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 235, 749 0 2.00 0 3.00 Total (sum of lines 1-2) 286, 167 0 3.00 SUMMARY OF CAPITAL Total (1) (sum Cost Center Description 0ther Capital-Relate of cols. 9 d Costs (see through 14) instructions) 14.00 15.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 CAP REL COSTS-BLDG & FLXT 1, 751, 704 237, 384 0 1.00 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 Total (sum of lines 1-2) 1, 989, 088 3.00

alth Financial Systems	Community Health Rehab	Hospi tal South	In Lie	u of Form CMS-2552-10
CONCLLIATION OF CADITAL COSTS CENTEDS		Providor CCN: 15 2044	Pori od:	Workshoot A 7

Heal th	n Financial Systems Commu	unity Health Rel	nab Hospital Sc	outh	In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/16/2023 12:	
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C				_		
1.00	CAP REL COSTS-BLDG & FLXT	558, 498	0	558, 49			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2, 042, 131	0	2, 042, 13		·	2. 00
3.00	Total (sum of lines 1-2)	2, 600, 629		2, 600, 62	_	· · · · · · · · · · · · · · · · · · ·	3. 00
		ALLOCA	TION OF OTHER (CAPITAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C				- 10.000	1 701 001	
1.00	CAP REL COSTS-BLDG & FLXT	33, 665		39, 04			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	123, 095	l e	142, 76		·	2.00
3.00	Total (sum of lines 1-2)	156, 760		181, 81		1, 702, 921	3. 00
				JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see	,		Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		44.00	10.00	10.00	instructions)	45.00	
	DART 111 DECOMOLITATION OF CARLEY COOTS O	11.00	12. 00	13. 00	14. 00	15. 00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS C		0.0	20.44	-	4 700 004	1 00
1.00	CAP REL COSTS-BLDG & FLXT	0	l .			1, 782, 391	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0				,	2.00
3.00	Total (sum of lines 1-2)	0	18, 808	156, 76	0 0	2, 140, 854	3. 00

Expense ClassIff Taction of Nort-Sheet A To/Prom Which the Amount is to be Agliusted						o 12/31/2022	Date/lime Prep 5/16/2023 12:	
Cost Center Description Sesis/Cose (2)					Expense Classification on	Worksheet A		
1.00 Investment Income - GAR REL					To/From Which the Amount is	to be Adjusted		
1.00 Investment Income - GAR REL								
1.00 Investment Income - GAR REL								
1.00 Investment Income - GAR REL 00 2.00 3.00 4.00 5.00 1.00 00 1.00 00 1.00 00								
1.00 Investment income - CAP REL OCAP REL OSTS-BELG & FIXT 1.00 0 1.00		Cost Center Description						
2	4 00		1.00					4 00
Investment Income - CAP RTL COSTS-WOILE FOUR P COSTS - WOILE F	1.00			O	CAP REL CUSTS-BLDG & FIXI	1.00	0	1.00
3. 00 Investment Finance - other (Chepter 2) 8 -10,497 AUMINISTRATIVE & GENERAL 5.00 0 3.00 0 4.00 0 4.00 0 5.00 0 5.00 0 5.00 0 5.00 0 6.00 0	2.00			o	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
Chapter 2				[
1.00 Control	3.00		В	-10, 497	ADMINISTRATIVE & GENERAL	5. 00	0	3. 00
discounts (chapter 8)	4 00			0		0.00		4 00
Separation Sep	4.00			ď		0.00	U	4.00
Sental of provider space by soppliers (chapter 8) 0 0.00	5.00			О		0.00	0	5. 00
Suppliers (chapter 8)								
Telephone services (pay stations excluded) (chapter 21) 10 10 10 10 10 10 10	6.00			0		0.00	0	6.00
Stations excluded) (chapter 21) 10 10 10 10 10 10 10	7. 00		A	-7. 850	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
1.00 1.00				.,				
Chapter 21)		1 /						
9.00 Parking iot (chapter 21) 0 0.00	8.00		Α	-1, 063	OPERATION OF PLANT	7.00	0	8.00
10.00 Provider-based physician adjustment adjustm	9. 00	, ,		0		0.00	0	9. 00
11.00 Saire of scrap, waste, etc. (chapter 23) 12.00 Related organization 13.00 Laundry and I linen service 13.00 Laundry and I linen service 15.00 Rental of quarters to employee 15.00 Rental of quarters to employee 16.00 Saire of medical and surgical supplies to other than patients 18.00 Saire of medical records and supplies to other than patients 18.00 Saire of medical records and supplies to other than patients 18.00 Saire of medical records and supplies to other than patients 18.00 Nursing and allied health education (tultion, fees, books, etc.) 20.00 Vending machines 21.00 Income from imposition of Interest, finance or penality charges (chapter 14) 11 initiation (chapter 14) 12.00 Utilization review - physicians' compensation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 14) 26.00 Utilization review - physicians' compensation (chapter 14) 27.00 Depreciation - CAP REL (COSTS-BLOG & FIXT 37.00 Depreciation - CAP REL (COSTS-BLOG & FIXT 38.00 Depreciation - CAP REL (COSTS-BLOG & FIXT 39.00 Depr			A-8-2	-116				
Chapter 23)				_			_	
12.00 Related organization Chapter 10	11. 00			0		0.00	0	11. 00
transactions (chapter 10) 13.00 Laundry and I line nervice	12. 00		A-8-1	1, 997, 145			0	12. 00
14.00 Caffeteria-employees and guests B -16,888 DIETARY 10.00 0 14.00				., ,				
15.00 Rental of quarters to employes and others 0 0 0 15.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 17.00 0 0 17.00 0 0 17.00 0 17.00 0 0 18.00 0 0 18.00 0 0 18.00 0 0 18.00 0 0 0 18.00 0 0 0 0 18.00 0 0 0 0 0 0 19.00 0 0 0 0 0 0 0 0 0				0				
and others				-16, 888	DI ETARY			
16.00 Sale of medical and surgical supplies to other than patients 0 0.00 0.	15.00		1	U		0.00	U	15.00
patients	16.00			О		0.00	0	16. 00
17.00 Sale of drugs to other than partients 0 0 0 17.00 0 17.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 19.00 0 19.00 0 0 0 0 0 0 0 0 0								
patients patients	17 00					0.00		17 00
18.00 Sale of medical records and abstracts 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 19.0	17.00			U		0.00	U	17.00
19.00 Nursing and allied health education (tuition, fees, books, etc.) 20.00 Vending machines 0 0.00	18.00	1.	В	-124	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
education (tuition, fees, books, etc.)		•		_			_	
Dooks, etc.) O Vending machines O Vending machines O O O O O O O O O	19. 00			0		0.00	0	19. 00
20.00 Vending machines 0 0.00								
Interest, finance or penal ty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical chapter 14) 24.00 Adjustment for physical chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 0.00 0.26.00 0.00 0.27.00 0.00	20. 00			o		0.00	0	20. 00
Charges (chapter 21) Chapter 14) Chapter 21)	21. 00			0		0.00	0	21. 00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00								
overpayments and borrowings to repay Medi care overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24.00 Horapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26.00 costs-BLDG & FIXT 0 COS	22. 00			o		0.00	0	22. 00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0.26.00 27.00 27.00 28.00 Non-physician Anesthetist 0.00 0.00 0.29.00 29.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0.00 0.32.00 32.00 CAH HIT Adjustment for 0.00 0.32.00 0.00 0.32.00 0.00								
therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT					DEOD! DATORY THERARY			
Limitation (chapter 14)	∠3. 00	, ,	A-8-3	O	KESPIKATUKY THEKAPY	65.00		23.00
therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 28. 00 Non-physician Anesthetist 29. 00 Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAP REL COSTS-BLDG & FIXT 32. 00 CAP REL COSTS-BLDG & FIXT 34. 00 CAP REL COSTS-BLDG & FIXT 35. 00 CAP REL COSTS-BLDG & FIXT 36. 00 CAP REL COSTS-BLDG & FIXT 37. 00 CAP REL COSTS-BLDG & FIXT 38. 00 CAP REL COSTS-BLDG & FIXT 38. 00 CAP REL COSTS-BLDG & FIXT 39. 00 CAP REL COSTS-BLDG & FIXT 31. 00 CAP REL COSTS-BLDG & FIXT 32.								
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25.00 Utilization review - physicians' compensation (chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP COSTS-MVBLE EQUIP COSTS-MVBLE EQUIP Depreciation - CAP REL COSTS-MVBLE EQUIP								
physicians' compensation (chapter 21)	25 00			0	*** Cost Center Deleted ***	114 00		25 00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26.00 27.00 Depreciation - CAP REL COSTS-BLDG & FIXT 0 CAP REL COSTS-MVBLE EQUIP 0 27.00 28.00 Non-physician Anesthetist 0 0 28.00 19.00 28.00 29.00 Physicians' assistant 0 0 0 0 0 29.00 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) A-8-3 0 0 0 0 0 29.00 30.99 Hospice (non-distinct) (see instructions) 0 0 ADULTS & PEDIATRICS 30.00 30.99 31.00 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 0 0 0 0 0 0	20.00			Š	ocot conten per crea			20.00
COSTS-BLDG & FIXT Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 0 27.00								
27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 2.00 0 27.00 28. 00 Non-physician Anesthetist 0 **** Cost Center Deleted *** 19.00 28.00 29. 00 Physicians' assistant 0 0 00 0 29.00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) A-8-3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26. 00			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
COSTS-MVBLE EQUIP Non-physician Anesthetist O **** Cost Center Deleted *** 19.00 28.00 29.00 29.00 30.00 Adj ustment for occupational therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see instructions) 31.00 Adj ustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 O SPEECH PATHOLOGY O SPEECH PAT	27 00			0	CAP REL COSTS-MVRLE FOLLE	2 00	0	27 00
29. 00 Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for O COCCUPATIONAL THERAPY O ADULTS & PEDIATRICS O ADULTS & PEDIATRICS O SPEECH PATHOLOGY O CAH HIT Adjustment for O O O O O O O O O O O O O O O O O O O	27.00			ŏ	0/11 NEE 00010 III/DEE EQ011	2.00	Ŭ	27.00
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limitation (chapter 14) Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Can be described by the content of th	3U. UU		A-8-3	٥	OCCUPATIONAL IMEKAPY	67.00		30.00
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31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0 SPEECH PATHOLOGY 68.00 31.00	30. 99	Hospice (non-distinct) (see		О	ADULTS & PEDIATRICS	30.00		30. 99
pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0 0.00 0 32.00	21 00		1 100		SDEECH DATHOLOGY	40 00		21 00
limitation (chapter 14) 32.00 CAH HIT Adjustment for 0 0 0 32.00	31.00		H-0-3	o o	SELLON PAINULUGY	08.00		31.00
		limitation (chapter 14)						
Depreciation and Interest	32. 00			0		0.00	0	32. 00
		Depreciation and Interest	1 1	I		I		I

Health Financial Systems

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-3044

Peri od: Worksheet A-8 From 01/01/2022

12/31/2022 Date/Time Prepared: 5/16/2023 12:57 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 2.00 3.00 4.00 5.00 33.00 OTHER ADJUSTMENTS (SPECIFY) 33. 00 0.00 33.01 MISCELLANEOUS INCOME В -13, 692 ADMINISTRATIVE & GENERAL 5.00 33.01 33.02 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.02 OTHER ADJUSTMENTS (SPECIFY) 33.03 0.00 33.03 33.04 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.04 33.05 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.05 OTHER ADJUSTMENTS (SPECIFY) 33.06 0.00 33.06 (3) 33.07 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.07 MEDICARE BAD DEBT - PART A -33, 102 ADMINI STRATI VE & GENERAL 33.08 5.00 33.08 33.09 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.09 -2, 490 ADMI NI STRATI VE & GENERAL 33.10 OTHER MEDICARE NON ALLOWABLE 5.00 33.10 33.11 OTHER OPERATING - PATIENT -8, 360 ADMINISTRATIVE & GENERAL 5.00 33.11 RELATI ONS OTHER ADJUSTMENTS (SPECIFY) 33.12 0 00 33 12 -5, 145 ADMINI STRATI VE & GENERAL OTHER OPERATING - MARKETING 33 13 5.00 33.13 33.14 OTHER OPERATING - INTEREST -49 ADMINISTRATIVE & GENERAL 5.00 33.14 OTHER ADJUSTMENTS (SPECIFY) 33. 15 0.00 33. 15 OTHER ADJUSTMENTS (SPECIFY) 33. 16 0.00 33, 16 OTHER OPER - LITIGATION 33.17 -1.500 ADMINISTRATIVE & GENERAL 5.00 33.17 SETTLEMENT OTHER ADJUSTMENTS (SPECIFY) 33.18 0.00 33.18 33. 19 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.19 33.20 OTHER ADJUSTMENTS (SPECIFY) 0.00 33. 20 33. 21 OTHER ADJUSTMENTS (SPECIFY) 0.00 33. 21 (3)OTHER ADJUSTMENTS (SPECIFY) 33, 22 0.00 33, 22 33.23 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.23 OTHER ADJUSTMENTS (SPECIFY) 33. 24 0.00 33. 24 33. 25 OTHER ADJUSTMENTS (SPECIFY) 0.00 33. 25 33.26 OTHER ADJUSTMENTS (SPECIFY) 0.00 33. 26 OTHER ADJUSTMENTS (SPECIFY) 33. 27 33.27 0.00 OTHER ADJUSTMENTS (SPECIFY) 33.28 0.00 33.28 CABLE TV AND SATELLITE -17, 907 ADMI NI STRATI VE & GENERAL 33 29 33 29 5 00 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.30 33. 31 MARKETING BONUS -18, 790 ADMI NI STRATI VE & GENERAL 5.00 33. 31 33.32 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.32 33. 33 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.33 33.34 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.34 (3)OTHER ADJUSTMENTS (SPECIFY) 33.35 0.00 33.35 33.36 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.36 33 37 OTHER ADJUSTMENTS (SPECIFY) 0.00 33. 37 (3) OTHER ADJUSTMENTS (SPECIFY) 33 38 0 00 33 38 (3)

Community Health Rehab Hospital South In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-3044 Peri od: Worksheet A-8 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/16/2023 12:57 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basi s/Code (2) Cost Center Description Cost Center Line # Wkst. A-7 Ref. Amount 2.00 3.00 4.00 5.00 33.39 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.39 33.40 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.40 33.41 NON ALLOW AMBULANCE COSTS Α -44, 626 AMBULANCE SERVICES 95.00 33.41 OTHER ADJUSTMENTS (SPECIFY) 33.42 0.00 33.42 OTHER ADJUSTMENTS (SPECIFY) 33.43 0.00 33.43 33. 44 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.44 (3)BUSINESS INTERRUPTIONS INS -6, 242 CAP REL COSTS-BLDG & FIXT 33.45 1.00 12 33.45 PRFMI UM 34.00 MEDICARE VS BOOK BLDG -2, 116 CAP REL COSTS-BLDG & FIXT 1.00 34.00 MEDICARE VS BOOK MOV EQUIP -18,092 CAP REL COSTS-MVBLE EQUIP 34.01 2.00 34.01 34.02 OTHER ADJUSTMENTS (SPECIFY) 0.00 34.02 OTHER ADJUSTMENTS (SPECIFY) 34.03 0.00 34.03 34.04 OTHER ADJUSTMENTS (SPECIFY) 0.00 34.04 34.05 OTHER ADJUSTMENTS (SPECIFY) 0.00 34.05 OTHER ADJUSTMENTS (SPECIFY) 34.06 0.00 34.06 34.07 OTHER ADJUSTMENTS (SPECIFY) 0.00 34.07 34.08 OTHER ADJUSTMENTS (SPECIFY) 0.00 34.08 34 09 OTHER ADJUSTMENTS (SPECIFY) 0 00 34 09 34. 10 OTHER ADJUSTMENTS (SPECIFY) 0.00 34.10 (3)34. 11 OTHER ADJUSTMENTS (SPECIFY) 0.00 34.11 (3) -377 ADMI NI STRATI VE & GENERAL 34 12 NON ALLOWABLE LOBBYING FEES Α 5 00 34 12 34.13 OTHER ADJUSTMENTS (SPECIFY) 0.00 34.13 34.14 OTHER ADJUSTMENTS (SPECIFY) 0.00 34.14 OTHER ADJUSTMENTS (SPECIFY) 34.15 0.00 34.15 (3) 34.16 OTHER ADJUSTMENTS (SPECIFY) 0.00 34.16 OTHER ADJUSTMENTS (SPECIFY) 0.00 34.17 34 18 OTHER ADJUSTMENTS (SPECIFY) 0 00 34 18 34 19 OTHER ADJUSTMENTS (SPECIFY) 0.00 34 19 34.20 OTHER ADJUSTMENTS (SPECIFY) 0.00 34.20 (3) 34, 21 PATIENT PHONE - DEPREC EQUIP -3, 594 CAP REL COSTS-MVBLE EQUIP 2.00 34. 21 Α OTHER ADJUSTMENTS (SPECIFY) 34 22 0.00 34. 22 OTHER ADJUSTMENTS (SPECIFY) 34.23 0.00 34.23 (3)OTHER ADJUSTMENTS (SPECIFY) 34.24 0.00 34.24 34 25 DFFFRRED PRE OPENING COSTS 371, 218 ADMINISTRATIVE & GENERAL Α 5 00 34 25 OTHER ADJUSTMENTS (SPECIFY) 34. 26 34.26 0.00 34. 27 OTHER ADJUSTMENTS (SPECIFY) 0.00 34. 27 OTHER ADJUSTMENTS (SPECIFY) 34 28 34 28 0.00NONALLOWABLE VEBA EXPENSE -341, 024 EMPLOYEE BENEFITS DEPARTMENT 34.40 4.00 34.40

14, 107 EMPLOYEE BENEFITS DEPARTMENT

-112, 986 ADMINISTRATIVE & GENERAL

4.00

0.00

5.00

34.41

35.00

0 35.01

ALLOWABLE VEBA CLAIMS

PHYSICIAN FEE ADJUSTMENT

OTHER ADJUSTMENTS (SPECIFY)

Α

Α

34.41

35, 00

35.01

Provider CCN: 15-3044

Peri od: Worksheet A-8

From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

				10 12/31/2022	5/16/2023 12:5	
			Expense Classification of			
			To/From Which the Amount i	s to be Adjusted		
Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
35. 02 OTHER ADJUSTMENTS (SPECIFY)	1.00	2.00	3. 00	4. 00	5. 00	35. 02
(3) 35. 03 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 03
(3)						
35. 04 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35. 04
35.05 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	o	35. 05
35.06 OTHER ADJUSTMENTS (SPECIFY)		О		0.00	О	35. 06
35. 07 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 07
(3) 35.08 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 08
(3) 35.09 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 09
(3) 35. 10 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 10
(3) 35.11 PHYSICIAN FEE ADJUSTMENT	А	112, 986	ADULTS & PEDIATRICS	30.00	0	35. 11
35. 12 OTHER ADJUSTMENTS (SPECIFY) (3)		O		0.00	o	35. 12
35. 13 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35. 13
35.14 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	О	35. 14
(3) 35. 15 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 15
(3) 35. 16 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 16
(3) 35. 17 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 17
(3) 35. 18 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 18
(3) 35. 19 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 19
(3) 35. 20 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 20
(3) 35. 21 OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	35. 21
(3) 35. 22 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 22
(3) 35. 23 OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	35. 23
(3) 35. 24 OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	35. 24
(3) 35. 25 OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	35. 25
50.00 TOTAL (sum of lines 1 thru 49 (Transfer to Worksheet A,		1, 828, 826				50. 00
column 6, line 200.)						

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME

Provider CCN: 15-3044

Worksheet A-8-1

From 01/01/2022 OFFICE COSTS 12/31/2022 Date/Time Prepared: 5/16/2023 12:57 pm

					3/10/2023 12.	o/ pill
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5. 00	ADMINISTRATIVE & GENERAL	Home Office Costs - Actual	3, 208, 721	1, 211, 576	1. 00
2.00	0.00			0	0	2. 00
3.00	0.00			0	0	3. 00
4.00	0.00			0	0	4. 00
4.08	4.00	EMPLOYEE BENEFITS DEPARTMENT	Hospital Related services	147	147	4. 08
4.09	5. 00	ADMINISTRATIVE & GENERAL	Hospital Related services	186, 047	186, 047	4. 09
4. 17	15.00	PHARMACY	Hospital Related services	39, 000	39, 000	4. 17
4. 20	30.00	ADULTS & PEDIATRICS	Hospital Related services	62, 390	62, 390	4. 20
4. 26	54.00	RADI OLOGY-DI AGNOSTI C	Hospital Related services	136, 728	136, 728	4. 26
4.33	73.00	DRUGS CHARGED TO PATIENTS	Hospital Related services	2, 833	2, 833	4. 33
5.00	0		0	3, 635, 866	1, 638, 721	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.

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
 B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

	Comonit under the tro mining		
6.00	В	49. 00 LI FEPOI NT HEALT 100. 00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00	В	51.00 Community HIth Network 100.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

5.00 1, 997, 145 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

4.08

4 09

4.17

4. 20

4 26

4.33

1105 1101	been posted to not kencet A,	cordinate transfer 2, the amount arrowable should be that eated the cordinate to this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		1
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	Home Office Cost	6.00
7.00		7.00
8.00		8.00
9.00	Hospi tal Servi ces	9.00
10.00		10.00
100.00		100.00

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

0

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Λ

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

4.08

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4.33

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

								10 12/31/2022	5/16/2023 12:	
	Wkst. A Line #	Cost	Center/Physician	Total	Professi on	al	Provi der	RCE Amount	Physi ci an/Prov	
			I denti fi er	Remuneration	Component		Component		ider Component	
									Hours	
	1. 00		2. 00	3. 00	4.00		5. 00	6. 00	7. 00	
1.00	0. 00			0		0	0		0	
2.00	30. 00			116		116	0	211, 500	0	
3.00	0. 00			0		0	0	0	0	
4.00	0. 00			0		0	0	0	0	
5.00	0. 00			0		0	0	0	0	
6.00	0. 00			0		0	0	0	0	0.00
7. 00	0. 00			0		0	0	0	0	
8. 00	0. 00			0		0	0	0	0	0.00
9.00	0. 00			0		0	0	0	0	,, 00
10. 00	0. 00			0		0	0	0	0	10. 00
200.00				116		116	0		0	200.00
	Wkst. A Line #	Cost		Unadjusted RCE			Cost of	Provi der	Physician Cost	
			Identi fier	Limit		RCE	Memberships &	Component	of Malpractice	
					Limit		Conti nui ng	Share of col.	Insurance	
	1.00		0.00	0.00	0.00		Educati on	12	14.00	
1 00	1. 00		2. 00	8.00	9. 00	0	12. 00	13.00	14.00	1. 00
1. 00 2. 00	30.00					0	0		0	
3. 00	0.00	DK. B		0		0	0	0	0	
4. 00	0.00			0		0	0	0	0	i
5. 00	0.00			0		0	0	0	0	i
6. 00	0.00					0	0	0	0	
7. 00	0.00					0	0	0	0	
8. 00	0.00			0		0	0		0	
9. 00	0.00			0		0	0		0	9. 00
10. 00	0.00			0		0	0	١	l ő	
200.00	0.00			0		0	0	١	0	
	Wkst. A Line #	Cost	Center/Physician	Provi der	Adjusted R	CE	RCE	Adjustment	0	200.00
	mrst. A Line "	0031	I denti fi er	Component	Limit	OL.	Di sal I owance	/ Aug us timerre		
			. 46	Share of col.	2 0		D. 001 / 01101100			
				14						
	1. 00		2. 00	15. 00	16. 00		17. 00	18. 00		
1.00	0. 00			0		0	0	0		1. 00
2.00	30. 00	DR. B		0		0	0	116		2. 00
3.00	0. 00			0		0	0	0		3. 00
4.00	0. 00			0		0	0	0		4. 00
5.00	0. 00			0		0	0	0		5. 00
6.00	0. 00			0		0	0	0		6. 00
7.00	0. 00			0		0	0	0		7. 00
8.00	0. 00			0		0	0	0		8. 00
9. 00	0. 00			0		0	0	0		9. 00
10.00	0. 00			0		0	0	0		10. 00
200.00				0		0	0	116		200. 00

Provider CCN: 15-3044

Peri od:

COST ALLOCATION - GENERAL SERVICE COSTS

From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/16/2023 12:57 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1, 782, 391 1, 782, 391 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 358, 463 358, 463 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 849, 416 45, 953 9, 242 904, 611 4.00 00500 ADMINISTRATIVE & GENERAL 5, 774, 774 9. 878 6, 004, 338 5 00 49, 115 170, 571 5 00 7.00 00700 OPERATION OF PLANT 539, 624 143, 257 28, 811 3, 714 715, 406 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 77, 492 77, 492 8.00 9.00 00900 HOUSEKEEPI NG 216, 651 20, 741 4, 171 21, 260 262, 823 9.00 01000 DI ETARY 10.00 140, 328 28, 222 862.837 10 00 640, 249 54,038 11.00 01100 CAFETERI A 146, 419 29, 447 175, 866 11.00 01300 NURSING ADMINISTRATION 223, 889 11, 797 2, 372 13.00 24, 775 262, 833 13.00 01400 CENTRAL SERVICES & SUPPLY 93, 218 18, 747 154, 301 14.00 42.336 14.00 6, 404 354, 979 15.00 01500 PHARMACY 288.329 31,844 28 402 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 245, 648 10, 563 2, 124 29, 981 288, 316 16.00 01700 SOCIAL SERVICE 17.00 13,879 2, 791 16,670 17.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 557, 453 30.00 03000 ADULTS & PEDIATRICS 5, 989, 947 112, 113 296, 839 6, 956, 352 30.00 31.00 03100 INTENSIVE CARE UNIT 0 O 31.00 04400 SKILLED NURSING FACILITY 44.00 0 44.00 0 0 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 0 0 0 54.00 06000 LABORATORY 60.00 6, 245 1.256 70, 061 60.00 62,560 0 06500 RESPI RATORY THERAPY 65.00 97, 203 10, 563 2, 124 8, 150 118, 040 65.00 06600 PHYSI CAL THERAPY 749, 020 347, 118 1, 255, 422 66.00 69,810 89, 474 66.00 67.00 06700 OCCUPATIONAL THERAPY 624, 485 92, 524 18, 608 76, 403 812, 020 67.00 68.00 06800 SPEECH PATHOLOGY 323, 082 27, 526 5, 536 39, 548 395, 692 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 248, 784 0 0 248, 784 73.00 07400 RENAL DIALYSIS 176, 061 33, 848 6, 807 74.00 0 216, 716 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 09100 EMERGENCY 0 91.00 91.00 0 0 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 1, 782, 391 19, 248, 948 118. 00 118.00 19, 310, 404 358, 463 843, 155 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192 00 Ω 0 194.00 07950 NONALLOWABLE CASE MANAGER 506, 146 0 0 61, 456 567, 602 194. 00 194. 01 07951 I DLE SPACE 0 0 0 194. 01 0 0 194. 02 07952 DI STRI CT 0 0 0 0 0 194. 02 0 0 194. 03 07953 DISTRICT SALES 0 0 194 03 0 194.04 07954 CENTRALIZED ADMISSIONS (CAD) 0 0 0 0 0 194. 04 194. 05 07955 CENTRALIZED BUSINESS (CBO) 0 194. 05 0 0 0 0 0 194. 06 07956 CENTRALIZED STAFFING 0 0 0 0 194.06 0 194. 07 07957 HR MANAGED CARE 0 0 194, 07 0 194.08 07959 LACUNA HEALTH 0 194. 08 194. 09 07958 SALES & MARKETING 0 0 0 194. 09 0 0 194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS 0 194, 10 Ω 0 194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION 0 0 0 0 194. 11 194. 12 07960 VISITOR MEALS 0 194. 12 0 0 200. 00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers C0 201.00 202.00 TOTAL (sum lines 118 through 201) 19, 816, 550 1, 782, 391 358, 463 904, 611 19, 816, 550 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

| Period: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | 5/16/2023 | 12: 57 pm

						5/16/2023 12:	57 pm
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS						1
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	6, 004, 338					5. 00
7.00	00700 OPERATION OF PLANT	310, 996	1, 026, 402				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	33, 687	0	111, 179			8. 00
9.00	00900 HOUSEKEEPI NG	114, 252	13, 787	0	390, 862		9. 00
10.00	01000 DI ETARY	375, 086	93, 281	0	36, 006	1, 367, 210	10.00
11. 00	01100 CAFETERI A	76, 451	97, 330		,	238, 018	1
13. 00	01300 NURSING ADMINISTRATION	114, 257	7, 842	0	3, 027	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	67, 076	61, 965	0	23, 918	0	14. 00
15. 00	01500 PHARMACY	154, 314	21, 168	0	8, 171	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	125, 334	7, 022	0	2, 710	0	16. 00
17. 00	01700 SOCIAL SERVICE	7, 247	9, 226	0	3, 561	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00	03000 ADULTS & PEDI ATRI CS	3, 024, 014	370, 563	1		1, 129, 192	
31. 00	03100 INTENSIVE CARE UNIT	0	0	0	_	0	1
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS			,	,		
50. 00	05000 OPERATI NG ROOM	0	0	· -		0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0		0	1
60. 00	06000 LABORATORY	30, 456	4, 152		.,	0	
65. 00	06500 RESPI RATORY THERAPY	51, 313	7, 022		2, 710	0	
66. 00	06600 PHYSI CAL THERAPY	545, 747	230, 743		89, 065	0	
67. 00	06700 OCCUPATI ONAL THERAPY	352, 995	61, 504	0	23, 740	0	
68. 00	06800 SPEECH PATHOLOGY	172, 012	18, 297	0	7, 063	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	108, 149	0	0		0	
74. 00	07400 RENAL DIALYSIS	94, 209	22, 500	0	8, 685	0	74. 00
	OUTPATIENT SERVICE COST CENTERS			1	_		
90. 00	09000 CLI NI C	0	0			0	
91. 00	09100 EMERGENCY	0	0	0	0	0	91. 00
05.00	OTHER REIMBURSABLE COST CENTERS			1	1		
95. 00	09500 AMBULANCE SERVI CES	0	0			0	1
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
	SPECIAL PURPOSE COST CENTERS	o-l	4 007 400		222 242	4 0/7 040	
118. 00		5, 757, 595	1, 026, 402	111, 179	390, 862	1, 367, 210	1118.00
100.00	NONREI MBURSABLE COST CENTERS					0	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	07950 NONALLOWABLE CASE MANAGER	246, 743	0	0	0		194. 00
	07951 IDLE_SPACE	0	0	0	0		194. 01
	2 07952 DI STRI CT	0	0	0	0		194. 02
	3 07953 DISTRICT SALES	0	0	0	0		194. 03
	1 07954 CENTRALIZED ADMISSIONS (CAD)	0	0	0	0		194. 04
	5 07955 CENTRALIZED BUSINESS (CBO)	0	0	0			194. 05
	07956 CENTRALIZED STAFFING	0	0				194. 06
	7 07957 HR MANAGED CARE	0	0		0		194. 07
	3 07959 LACUNA HEALTH	0	0	0	0		194. 08
	07958 SALES & MARKETING	0	0		0		194. 09
	07962 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	_		194. 10
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	_		194. 11
	207960 VISITOR MEALS	0	0	0	0	0	194. 12
200.00			^	_		_	200. 00
201.00		4 004 330	1 024 402	111 170	300.043		201. 00
202.00	of Tiotal (Sum times 118 through 201)	6, 004, 338	1, 026, 402	111, 179	390, 862	1, 367, 210	12U2. UU

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

			10) 12/31/2022	5/16/2023 12:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	<u> </u>
· ·		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13.00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10. 00
11. 00 01100 CAFETERI A	625, 234					11. 00
13.00 01300 NURSING ADMINISTRATION	28, 857	416, 816				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	C	0	307, 260			14. 00
15. 00 01500 PHARMACY	28, 857	0	91, 445	658, 934		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	38, 476	0	0	0	461, 858	16. 00
17. 00 01700 S0CIAL SERVICE	C	0	0	0	0	17. 00
23. 00 O2300 PARAMED ED PRGM-(SPECIFY)	C	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	317, 426	416, 816	6, 797	90	225, 727	30. 00
31.00 03100 INTENSIVE CARE UNIT	C	0	0	0	0	31. 00
44.00 O4400 SKILLED NURSING FACILITY	C	0	0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	C	0	0	0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C	이	0	0	0	54.00
60. 00 06000 LABORATORY	C	0	0	0	6, 445	60.00
65. 00 06500 RESPIRATORY THERAPY	9, 619	0	0	0	2, 903	65. 00
66. 00 06600 PHYSI CAL THERAPY	96, 190	0	205, 129	0	74, 853	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	67, 333	0	3, 889	0	74, 590	67. 00
68.00 06800 SPEECH PATHOLOGY	38, 476	0	0	0	49, 138	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0	0	0	0	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	0	0	658, 844	24, 993	73. 00
74. 00 07400 RENAL DIALYSIS	C	0	0	0	3, 209	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	C	이	0	0	0	90.00
91. 00 09100 EMERGENCY	C	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	C	이	0	0	0	95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	C	0	0	0	0	98. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	625, 234	416, 816	307, 260	658, 934	461, 858	118. 00
NONREI MBURSABLE COST CENTERS	T	1				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	이	0	0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	C	이	0	0		192. 00
194.00 07950 NONALLOWABLE CASE MANAGER	C	이	0	0		194. 00
194. 01 07951 I DLE SPACE	C	이	0	0		194. 01
194. 02 07952 DI STRI CT	C	이	0	0		194. 02
194. 03 07953 DI STRI CT SALES	C	이	0	0		194. 03
194.04 07954 CENTRALIZED ADMISSIONS (CAD)	C	이	0	0		194. 04
194. 05 07955 CENTRALIZED BUSINESS (CBO)	C	0	0	0		194. 05
194. 06 07956 CENTRALI ZED STAFFI NG	C	0	0	0		194. 06
194. 07 07957 HR MANAGED CARE	C	0	0	0		194. 07
194. 08 07959 LACUNA HEALTH	C	0	0	0		194. 08
194. 09 07958 SALES & MARKETI NG	_ C	9	0	0		194. 09
194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS	[C	<u> </u>	0	0		194. 10
194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	C	l 이	0	이		194. 11
194. 12 07960 VISITOR MEALS	C	이	0	0	0	194. 12
200.00 Cross Foot Adjustments]				200. 00
201.00 Negative Cost Centers	(0.5.5.5.5.5.5.5.5.5.5.5.5.5.5.5.5.5.5.5	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	625, 234	416, 816	307, 260	658, 934	461, 858	J202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-3044 Peri od: Worksheet B From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/16/2023 12:57 pm Cost Center Description SOCIAL SERVICE PARAMED ED Subtotal Intern & Total PRGM Residents Cost & Post Stepdown Adjustments 17.00 23.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16.00 17.00 01700 SOCIAL SERVICE 36, 704 17.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 36, 704 12, 737, 895 12, 737, 895 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 0 04400 SKILLED NURSING FACILITY 44.00 0 44.00 0 0 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 54.00 60.00 06000 LABORATORY 00000 0 112, 716 0 112, 716 60.00 06500 RESPIRATORY THERAPY 0 191, 607 191, 607 65.00 65 00 66.00 06600 PHYSI CAL THERAPY 2, 497, 149 2, 497, 149 66.00 06700 OCCUPATIONAL THERAPY 1, 396, 071 1, 396, 071 67.00 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 680, 678 680, 678 68.00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 1, 040, 770 0 1, 040, 770 73.00 07400 RENAL DIALYSIS 74.00 345, 319 0 345, 319 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0 0 0 0 0 09100 EMERGENCY 0 0 0 91.00 91.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 0 0 0 0 0 09850 OTHER REIMBURSABLE COST CENTERS 98.00 0 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 36, 704 0 19, 002, 205 0 19, 002, 205 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192.00 0 814, 345 194. 00 194.00 07950 NONALLOWABLE CASE MANAGER 000000000000 0 814, 345 194. 01 07951 I DLE SPACE 0 0 0 194. 01 194. 02 07952 DI STRI CT 0 0 0 0 0 0 0 0 0 0 0 0 0 194. 02 194. 03 07953 DI STRI CT SALES 0 0 0 194. 03 194. 04 07954 CENTRALIZED ADMISSIONS (CAD) 0 194 04 0 0 0 194. 05 194. 05 07955 CENTRALIZED BUSINESS (CBO) 0 0 194.06 07956 CENTRALIZED STAFFING 0 0 194.06 194. 07 07957 HR MANAGED CARE 0 0 0 194.07 194. 08 07959 LACUNA HEALTH 0 194. 08 0 0 194. 09 07958 SALES & MARKETING 0 0 0 194. 09 194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS 0 194. 10 194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION 0 0 0 194, 11 194. 12 07960 VISITOR MEALS 0 0 0 0 194, 12 200.00 Cross Foot Adjustments 0 200. 00 0 201.00 Negative Cost Centers 0 0 201.00 0 0

36.704

19, 816, 550

19, 816, 550 202. 00

202.00

TOTAL (sum lines 118 through 201)

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2022	Part II
To 12/31/2022	Date/Time Prepared:
5/16/2023	12:57 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Community Health Rehab Hospital South
Provider CCN: 15-3044

					12/31/2022	5/16/2023 12:	
			CAPI TAL REI	ATED COSTS		, .,	
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	45, 953	9, 242	55, 195	55, 195	1
5. 00	00500 ADMINISTRATIVE & GENERAL	472, 323			531, 316	10, 408	1
7. 00	00700 OPERATION OF PLANT	0	143, 257		172, 068	227	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	20, 741	4, 171	24, 912	1, 297	9. 00
10.00	01000 DI ETARY	0	140, 328	28, 222	168, 550	3, 297	10.00
11. 00	01100 CAFETERI A	0	146, 419	29, 447	175, 866	0	11. 00
13.00	01300 NURSING ADMINISTRATION	0	11, 797	2, 372	14, 169	1, 512	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	93, 218	18, 747	111, 965	0	14. 00
15. 00	01500 PHARMACY	0	31, 844		38, 248	1, 733	
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	10, 563		12, 687	1, 829	
17. 00	01700 SOCIAL SERVICE	0	13, 879		16, 670	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		F F 7 4 F 0	440 440	((0.5()	10.111	
30.00	03000 ADULTS & PEDIATRICS	0			669, 566	18, 111	1
31.00	03100 I NTENSI VE CARE UNI T	0	ł		O O	0	
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS		0	l o	······································	0	44. 00
50. 00	05000 OPERATING ROOM	0	0	0	n	0	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	
60. 00	06000 LABORATORY	0	6, 245	١	7, 501	0	1
65. 00	06500 RESPIRATORY THERAPY	0	10, 563		12, 687	497	1
66. 00	06600 PHYSI CAL THERAPY	0	347, 118		416, 928	5, 459	1
67.00	06700 OCCUPATI ONAL THERAPY	0	92, 524		111, 132	4, 662	
68.00	06800 SPEECH PATHOLOGY	0	27, 526	5, 536	33, 062	2, 413	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74. 00	07400 RENAL DIALYSIS	0	33, 848	6, 807	40, 655	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLINIC	0			0	0	
91. 00	09100 EMERGENCY	0	0	0	0	0	91.00
05.00	OTHER REIMBURSABLE COST CENTERS						05.00
95. 00 98. 00	09500 AMBULANCE SERVICES	0	l		0	0	
98.00	O9850 OTHER REIMBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS			<u> </u>	<u> </u>	0	98. 00
118. 00		472, 323	1, 782, 391	358, 463	2, 613, 177	51 1/15	118. 00
110.00	NONREI MBURSABLE COST CENTERS	472, 323	1, 702, 371	330, 403	2,013,177	31, 443	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	Ö	Ö	ol		192. 00
	07950 NONALLOWABLE CASE MANAGER	0	0	0	0		194. 00
194. 01	07951 I DLE SPACE	0	0	0	0	0	194. 01
194. 02	07952 DI STRI CT	0	0	0	0	0	194. 02
194.03	07953 DI STRI CT SALES	0	0	0	o	0	194. 03
	07954 CENTRALIZED ADMISSIONS (CAD)	0	0	0	O	0	194. 04
194. 05	07955 CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194. 05
	07956 CENTRALIZED STAFFING	0			0		194. 06
	07957 HR MANAGED CARE	0	0	-	0		194. 07
	07959 LACUNA HEALTH	0			0		194. 08
	07958 SALES & MARKETING	0	· -	-	0		194. 09
	07962 OTHER NONREIMBURSABLE COST CENTERS	0	1	-	0		194. 10
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION		0	-	0		194. 11
194. 12 200. 00	07960 VISITOR MEALS	0	0	0	0	0	194. 12 200. 00
200.00	,		_		0	^	200.00
201.00		472, 323	1, 782, 391	358, 463	2, 613, 177		202.00
202.00	TOTAL (Sum Times The through 201)	1 412, 323	1, 102, 371	1 330, 403	2,013,177	33, 173	1202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022

				Т	o 12/31/2022	Date/Time Pre 5/16/2023 12:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	J/ piii
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8.00	9. 00	10.00	
	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	F 44 704					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	541, 724					5. 00
7.00	00700 OPERATION OF PLANT	28, 059	200, 354	1			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	3, 039	2 (01	3, 039			8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	10, 308 33, 841	2, 691 18, 209	1		227 500	9. 00 10. 00
11. 00	01100 CAFETERI A	6, 898	18, 999	1	-,	227, 509 39, 607	
13. 00	01300 NURSING ADMINISTRATION	10, 309	1, 531	1	3, 709	34,007	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	6, 052	12, 096	1	2, 399	0	14. 00
15. 00	01500 PHARMACY	13, 923	4, 132	1	820	0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	11, 308	1, 371	1	272	0	16.00
17. 00	01700 SOCI AL SERVI CE	654	1, 801	1		0	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	1, 001	Ö		0	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			<u> </u>		20.00
30.00	03000 ADULTS & PEDIATRICS	272, 829	72, 332	3, 039	14, 348	187, 902	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	0	0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	1	0	
60. 00	06000 LABORATORY	2, 748	810			0	60. 00
65. 00	06500 RESPI RATORY THERAPY	4, 630	1, 371	1		0	65. 00
66. 00	06600 PHYSI CAL THERAPY	49, 239	45, 041	l .		0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	31, 848	12, 006	1	2, 381	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	15, 519	3, 572	1	708	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0 750	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	9, 758	4 202	0	1	0	73.00
74. 00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	8, 500	4, 392	. 0	871	U	74. 00
90. 00	09000 CLINIC	0	0	0	0	0	90.00
91. 00	09100 EMERGENCY	o o	0	1			
	OTHER REIMBURSABLE COST CENTERS	-1	-	-			
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
	SPECIAL PURPOSE COST CENTERS						
118. 00		519, 462	200, 354	3, 039	39, 208	227, 509	118. 00
100.00	NONREI MBURSABLE COST CENTERS				ام		400 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	1		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 NONALLOWABLE CASE MANAGER	22, 262	0	0	0		192. 00 194. 00
	07950 NONALLOWABLE CASE MANAGER	22, 202	0		0		194. 00
	207951 TDLE SPACE	0	0		0		194. 01
	07953 DISTRICT SALES	0	0		0		194. 02
	07954 CENTRALIZED ADMISSIONS (CAD)	0	0		0		194. 04
	07955 CENTRALIZED BUSINESS (CBO)	0	0	Ö	0		194. 05
	07956 CENTRALIZED STAFFING	0	0	ō	O		194. 06
	07957 HR MANAGED CARE	0	0	o			194. 07
194. 08	07959 LACUNA HEALTH	o	0	0	ol		194. 08
	07958 SALES & MARKETING	0	0	0	o		194. 09
194.10	07962 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 10
194. 11	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	o	0	0	o		194. 11
	07960 VISITOR MEALS	0	0	0	0	0	194. 12
200.00	1						200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	541, 724	200, 354	3, 039	39, 208	227, 509	202. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Community Health Rehab Hospital South
Provider CCN: 15-3044

				To	12/31/2022	Date/Time Pre 5/16/2023 12:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	J Pill
	oust deliter bescription	ON ETERNIA	ADMI NI STRATI ON	SERVICES &	111/11/11/11/101	RECORDS &	
				SUPPLY		LI BRARY	
		11.00	13.00	14.00	15. 00	16. 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
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE		İ				8. 00
9.00	00900 HOUSEKEEPI NG		İ				9. 00
10.00	01000 DI ETARY		İ				10.00
11. 00	01100 CAFETERI A	245, 139					11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	11, 314	39, 139				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	o	132, 512			14. 00
15.00	01500 PHARMACY	11, 314	o	39, 437	109, 607		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	15, 085	o	0	o	42, 552	16. 00
17.00	01700 SOCIAL SERVICE	0	o	0	o	0	17. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	o	0	o	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			<u></u>			
30.00	03000 ADULTS & PEDIATRICS	124, 456	39, 139	2, 931	15	20, 787	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	o	0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0	o	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS			<u>.</u>			
50.00	05000 OPERATING ROOM	0	0	0	0	0	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	o	0	O	0	54.00
60.00	06000 LABORATORY	0	o	0	0	594	60.00
65.00	06500 RESPI RATORY THERAPY	3, 771	o	0	0	268	65. 00
66.00	06600 PHYSI CAL THERAPY	37, 714	0	88, 467	0	6, 899	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	26, 400	o	1, 677	0	6, 875	67. 00
68.00	06800 SPEECH PATHOLOGY	15, 085	0	0	0	4, 529	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o	0	0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	o	0	109, 592	2, 304	73. 00
74.00	07400 RENAL DIALYSIS	0	o	0	0	296	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91. 00	09100 EMERGENCY	0	0	0	0	0	91.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	245, 139	39, 139	132, 512	109, 607	42, 552	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
194.00	07950 NONALLOWABLE CASE MANAGER	0	0	0	0	0	194. 00
194. 01	07951 I DLE SPACE	0	0	0	0	0	194. 01
194. 02	07952 DI STRI CT	0	0	0	0	0	194. 02
	07953 DI STRI CT SALES	0	0	0	0		194. 03
	07954 CENTRALIZED ADMISSIONS (CAD)	0	0	0	0		194. 04
194.05	07955 CENTRALIZED BUSINESS (CBO)	0	0	0	0	0	194. 05
	07956 CENTRALIZED STAFFING	0	0	0	0		194. 06
	07957 HR MANAGED CARE	0	0	0	0		194. 07
	07959 LACUNA HEALTH	0	0	0	0		194. 08
	07958 SALES & MARKETING	0	O	0	0		194. 09
	07962 OTHER NONREIMBURSABLE COST CENTERS	0	O	0	0		194. 10
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0		194. 11
	07960 VISITOR MEALS	0	0	0	0	0	194. 12
200.00							200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	245, 139	39, 139	132, 512	109, 607	42, 552	202. 00

ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der Co	CN: 15-3044	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Pre 5/16/2023 12:	
	Cost Center Description	SOCI AL SERVI CE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17. 00	23.00	24. 00	25. 00	26.00	
4 00	GENERAL SERVICE COST CENTERS	1		1			
1. 00 2. 00	OO100 CAP REL COSTS-BLDG & FIXT OO200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14.00	01400 CENTRAL SERVI CES & SUPPLY						14. 00
15.00	01500 PHARMACY						15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	19, 482					16. 00 17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	19, 402	0				23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	1			23.00
30. 00	03000 ADULTS & PEDIATRICS	19, 482		1, 444, 93	37 0	1, 444, 937	30. 00
31. 00	03100 NTENSI VE CARE UNI T	0			0 0	0	1
44.00	04400 SKILLED NURSING FACILITY	0			0 0	0	44. 00
	ANCILLARY SERVICE COST CENTERS	,					
50.00	05000 OPERATING ROOM	0			0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0			0	0	54. 00
60.00	06000 LABORATORY	0		11, 81		11, 814	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0		23, 49 658, 68		23, 496	1
67. 00	06700 OCCUPATIONAL THERAPY			196, 98		658, 681 196, 981	67. 00
68. 00	06800 SPEECH PATHOLOGY			74, 88		74, 888	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			1 ,,,,,,	o o	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0		121, 65	64 0	121, 654	1
74.00	07400 RENAL DIALYSIS	0		54, 71	4 0	54, 714	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0			0 0	0	
91. 00	09100 EMERGENCY	0			0 0	0	91. 00
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0		T	0 0	0	95. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS				0 0	0	1
70.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		1	0 0	0	70.00
118.00		19, 482	0	2, 587, 16	5 0	2, 587, 165	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0 0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0			0		192. 00
	07950 NONALLOWABLE CASE MANAGER	0		26, 01			194. 00
	07951 I DLE SPACE	0			0 0		194. 01
	07952 DI STRI CT 07953 DI STRI CT SALES	0			0 0		194. 02 194. 03
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194.04	07955 CENTRALIZED BUSINESS (CBO)						194. 05
	07956 CENTRALIZED STAFFING				0 0		194. 06
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	07959 LACUNA HEALTH	0			0 0	0	194. 08
194.09	07958 SALES & MARKETING	0			0 0	0	194. 09
	07962 OTHER NONREIMBURSABLE COST CENTERS	0			0 0		194. 10
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0					194. 11
	07960 VISITOR MEALS	0	_		0		194. 12
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202.00		17, 402	U	ر کر ۱۵ کی ۱	' ₁	۷,013,177	1202.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: From 01/01/2022

CAPITAL SELATED COSTS					rom 01/01/2022 o 12/31/2022	Date/Time Pre	
COURT SPEND OF CORT CHITTES 1.00 2.00 4.00 5A 5.00		CAPITAL REL	ATED COSTS			5/16/2023 12:	57 pm
COURT SPEND OF CORT CHITTES 1.00 2.00 4.00 5A 5.00	Cost Contor Description	DIDC & FLVT	MVDLE FOLLD	EMDI OVEE	Doconci Li ati on	ADMI NI STDATI VE	
FINE PAIR SERVICE COST CENTERS 1.00 2.00 4.00 5A 5.00	cost center bescription				Reconciliation		
SAMMEST 1.00		#1)	#2)			(ACCUM. COST)	
BIN MAL SERVICE COST CENTERS				•			
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2.00		23, 117					1. 00
5.00 00500 ADMINISTRATIVE & CEMERAL 647 637 1.393, 459 -6,004,338 13,912,121 5.00 1.00							•
0.00 00800 LANNOY & LINES SERVICE 0 0 0 775, 400 7.00						13 812 212	•
0,000 00990 NUSEKEEPING 269 269 173,685 0 202,823 9.00	7.00 00700 OPERATION OF PLANT	1					•
10.00 01000 DETARY 1,820		_			· ·		•
13.00 01300 NURSIN CADMINISTRATION 15.3 15.3 20.2 306 0 26.2, 833 13.00		1					•
14.00 01400 (PRININGLY SERVICES & SUPPLY 1, 209 1, 209 0 154, 301 14.00 16.00 16.00 (PRININGLY 137 137 137 244, 926 0 384, 979 16.00 16.00 16.00 (PRININGLY 137 137 137 244, 926 0 288, 316 16.00 17.00 17.00 17.00 (PRININGLY 137 137 137 244, 926 0 288, 316 16.00 17.00 1	1						ı
15.00 01500 PHARMACY 14.3							1
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31.00 03100 INTENSIVE CARE UNIT		7 220	7 220	2 425 022		4 054 353	20.00
44. 00 04-00 SKILLED MURSING FACILITY 0 0 0 0 0 0 0 0 0		1					•
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66.00 06600 PHYSICAL THERAPY				_	_		
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18.00 SUBTOTALS (SUM OF LINES 1 through 117) 23, 117 23, 117 6, 888, 087 -6, 004, 338 13, 244, 610 118.00 NONNEI MBURSABLE COST CENTERS 0		0	0	0	0	0	98. 00
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Parts and V)	207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
	PartS III and IV)						l

In Lieu of Form CMS-2552-10 Health Financial Systems Community Health Rehab Hospital South COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-3044 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/16/2023 12:57 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE (SQUARE FEET (MEALS SERVED) PLANT (CAFETERI A (SQUARE FEET (PATIENT DAYS) #4) FTES) #3) 11.00 8.00 9.00 10.00 7.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 20,026 00800 LAUNDRY & LINEN SERVICE 11, 552 8.00 00900 HOUSEKEEPI NG 9.00 269 19, 757 10.00 01000 DI ETARY 1,820 1,820 41, 961 01100 CAFETERI A 1,899 1,899 7, 305 11.00 65 01300 NURSING ADMINISTRATION 153 13.00 153 3 14.00 01400 CENTRAL SERVICES & SUPPLY 1, 209 1, 209 0 0 15.00 01500 PHARMACY 413 413 0 3 o 01600 MEDICAL RECORDS & LIBRARY 16.00 137 C 137 01700 SOCIAL SERVICE 17.00 180 180 0 0 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS

1.00 2.00 4 00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 23.00 30.00 11, 552 33 30.00 03000 ADULTS & PEDLATRICS 7 230 7, 230 34, 656 31.00 03100 INTENSIVE CARE UNIT 0 31.00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 50 00 0 n O 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 54.00 60.00 06000 LABORATORY 81 81 0 0 60.00 06500 RESPIRATORY THERAPY 65 00 65 00 137 Ω 137 06600 PHYSI CAL THERAPY 66.00 4,502 4,502 10 66.00 0 06700 OCCUPATIONAL THERAPY 1, 200 1, 200 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 357 0 357 4 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS Ω 0 71 00 71 00 0 C 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 C 0 0 73.00 07400 RENAL DIALYSIS 74.00 74.00 439 0 439 0 0 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 Ω 0 09000 CLI NI C 0 0 0 91.00 09100 EMERGENCY 0 0 0 0 91.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 О 0 0 0 95.00 09850 OTHER REIMBURSABLE COST CENTERS 98.00 0 0 0 0 0 98.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 20,026 11, 552 19, 757 41, 961 65 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 O 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192.00 194. 00 07950 NONALLOWABLE CASE MANAGER 0 0 0 0 0 0 0 0 0 0 0 0 194.00 194. 01 07951 I DLE SPACE 000000000 0 194, 01 0 0 194. 02 07952 DI STRI CT 0 0 0 194. 02 194. 03 07953 DI STRI CT SALES 0 194. 03 194. 04 07954 CENTRALIZED ADMISSIONS (CAD) 0 0 194. 04 194. 05 07955 CENTRALIZED BUSINESS (CBO) 0 0 194. 05 C 194.06 07956 CENTRALIZED STAFFING 0 194.06 194.07 07957 HR MANAGED CARE 0 0 194. 07 194. 08 07959 LACUNA HEALTH 0 194, 08 0 194. 09 07958 SALES & MARKETING 0 194. 09 0 0 194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 10 194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION 0 194. 11 0 194. 12 07960 VISITOR MEALS 0 194 12 \cap 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 625, 234 202. 00 Cost to be allocated (per Wkst. B, 390, 862 202.00 1,026,402 111, 179 1, 367, 210 Part I) 9, 618. 984615 203. 00 203 00 Unit cost multiplier (Wkst. B, Part I) 51 253470 19 783469 32. 582875 9 624221 245, 139 204. 00 204.00 Cost to be allocated (per Wkst. B, 200, 354 3, 039 39, 208 227, 509 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 10.004694 0. 263071 1. 984512 5. 421916 3, 771. 369231 205. 00 II)206.00 NAHE adjustment amount to be allocated 206.00

(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

From 01/01/2022 12/31/2022 Date/Time Prepared: 5/16/2023 12:57 pm Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON SERVICES & (COSTED RECORDS & SUPPLY REQUIS.) LI BRARY (PATIENT DAYS) (NURSING FTES) (COSTED (GROSS REVENUE) REQUIS.) 17.00 13.00 14.00 15.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 24, 095 14.00 0 15.00 01500 PHARMACY 7, 171 248, 988 15.00 01600 MEDICAL RECORDS & LIBRARY 43, 976, 141 16 00 16.00 0 17.00 01700 SOCIAL SERVICE 0 0 11, 552 17.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 33 533 34 21, 491, 795 11, 552 30.00 03100 INTENSIVE CARE UNIT 0 0 31.00 31.00 44.00 04400 SKILLED NURSING FACILITY 0 44.00 0 0 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54.00 60.00 06000 LABORATORY 0 0 0 0 613, 682 60.00 0 06500 RESPIRATORY THERAPY 0 65.00 C 276, 404 0 65 00 66.00 06600 PHYSI CAL THERAPY 16,086 0 7, 127, 457 0 66.00 0 06700 OCCUPATIONAL THERAPY 0 67.00 305 7, 102, 422 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 0 4, 678, 962 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 C 0 71.00 07300 DRUGS CHARGED TO PATIENTS 0 0 248, 954 2, 379, 811 0 73.00 73.00 07400 RENAL DIALYSIS 74.00 305, 608 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0 0 0 0 0 09100 EMERGENCY 0 0 91.00 91.00 0 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 0 0 0 09850 OTHER REIMBURSABLE COST CENTERS 98.00 0 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 33 24, 095 248, 988 43, 976, 141 11, 552 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 0 194.00 07950 NONALLOWABLE CASE MANAGER 0 0 194, 00 0 194. 01 07951 I DLE SPACE 0 0 0 0 194, 01 194. 02 07952 DI STRI CT 0 0 0 0 0 0 0 194. 02 194. 03 07953 DI STRI CT SALES 0 0 0 194. 03 194. 04 07954 CENTRALIZED ADMISSIONS (CAD) 0 194 04 0 C 194. 05 07955 CENTRALIZED BUSINESS (CBO) 0 194. 05 194.06 07956 CENTRALIZED STAFFING 0 0 0 0 0 194.06 194. 07 07957 HR MANAGED CARE 0 194.07 194. 08 07959 LACUNA HEALTH 0 194. 08 0 0 194. 09 07958 SALES & MARKETING 0 0 194. 09 194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194. 10 0 0 o 194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION 0 0 194, 11 Ω 194. 12 07960 VISITOR MEALS 0 0 0 194. 12 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 36, 704 202. 00 202.00 Cost to be allocated (per Wkst. B, 416, 816 307, 260 658.934 461, 858 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 12, 630. 787879 12. 752023 2.646449 0.010502 3. 177285 203. 00 204.00 Cost to be allocated (per Wkst. B, 39, 139 132, 512 109, 607 42, 552 19, 482 204. 00 Part II) 0.440210 0.000968 1. 686461 205. 00 205 00 Unit cost multiplier (Wkst. B, Part 1 186 030303 5 499564 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3044
| Period: From 01/01/2022 To 12/31/2022 | Date/Time Prepared:

			To 12/31/2022	Date/Time Prepared: 5/16/2023 12:57 pm
	Cost Center Description	PARAMED ED		37 107 2023 12. 37 pili
		PRGM		
		(ASSIGNED TIME)		
		23. 00		
GENE	RAL SERVICE COST CENTERS			
1	O CAP REL COSTS-BLDG & FIXT			1.00
1	CAP REL COSTS-MVBLE EQUIP DEMPLOYEE BENEFITS DEPARTMENT			2. 00 4. 00
1	D ADMINISTRATIVE & GENERAL			5. 00
1	OPERATION OF PLANT			7. 00
	D LAUNDRY & LINEN SERVICE			8. 00
	HOUSEKEEPI NG DI ETARY			9. 00 10. 00
	D CAFETERI A			11. 00
13. 00 0130	NURSING ADMINISTRATION			13. 00
1	O CENTRAL SERVICES & SUPPLY			14. 00
	D PHARMACY D MEDICAL RECORDS & LIBRARY			15. 00 16. 00
	SOCIAL SERVICE			17. 00
23. 00 0230	PARAMED ED PRGM-(SPECIFY)	0		23. 00
	TIENT ROUTINE SERVICE COST CENTERS	0		20.00
1	DADULTS & PEDIATRICS INTENSIVE CARE UNIT	0		30. 00 31. 00
	SKILLED NURSING FACILITY	0		44.00
ANCI I	LARY SERVICE COST CENTERS			
	O OPERATING ROOM	0		50.00
	RADI OLOGY-DI AGNOSTI C LABORATORY	0		54. 00 60. 00
	RESPIRATORY THERAPY	0		65. 00
66. 00 06600	PHYSI CAL THERAPY	0		66. 00
1	O OCCUPATI ONAL THERAPY	0		67. 00
	SPEECH PATHOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0		68. 00 71. 00
	D DRUGS CHARGED TO PATIENTS	0		73. 00
	RENAL DIALYSIS	O		74. 00
	ATIENT SERVICE COST CENTERS OCLINIC	0		90.00
	DEMERGENCY	o		91.00
	R REIMBURSABLE COST CENTERS			
1	O AMBULANCE SERVICES O OTHER REIMBURSABLE COST CENTERS	0		95. 00 98. 00
	AL PURPOSE COST CENTERS	O _I		70.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0		118. 00
	EIMBURSABLE COST CENTERS DIGIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
1	O PHYSICIANS' PRIVATE OFFICES	0		190.00
	NONALLOWABLE CASE MANAGER	0		194. 00
	1 I DLE SPACE	0		194. 01
194. 02 0795		0		194. 02
	DISTRICT SALES 4 CENTRALIZED ADMISSIONS (CAD)	0		194. 03 194. 04
194. 05 0795	CENTRALIZED BUSINESS (CBO)	O		194. 05
194. 06 0795	6 CENTRALIZED STAFFING	o		194. 06
	7 HR MANAGED CARE	0		194. 07
	P LACUNA HEALTH B SALES & MARKETING	0		194. 08 194. 09
1	2 OTHER NONREIMBURSABLE COST CENTERS	o		194. 10
	NONREIMB NEW BUSINESS IMPLEMENTATION	0		194. 11
	O VISITOR MEALS	0		194. 12
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers			200. 00 201. 00
202. 00	Cost to be allocated (per Wkst. B,	О		202. 00
	Part I)			
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0. 000000		203. 00 204. 00
204.00	Part II)	١		204.00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000		205. 00
206. 00		0		206. 00
200.00	(per Wkst. B-2)			200.00
207. 00	NAHE unit cost multiplier (Wkst. D,	0. 000000		207. 00
	Parts III and IV)	l I		1

near th i i ne	inci di Systems	and by near the Ker	lab Hospi tai se	74 (11	TIT LIC	u or rorm omo .	2002 10
COMPUTATI O	N OF RATIO OF COSTS TO CHARGES		Provi der C	F	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/16/2023 12:	pared:
			Title	: XVIII	Hospi tal	PPS	37 piii
			11 110	7,7,7,7,7	Costs	110	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	5551 551151 25551 Pt. 511	(from Wkst. B,	Adj.	10101 00010	Di sal I owance	70141 00010	
		Part I, col.	,				
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	OO ADULTS & PEDIATRICS	12, 737, 895		12, 737, 895	0	12, 737, 895	30.00
31.00 0310	OO INTENSIVE CARE UNIT	0		(0	0	31.00
44.00 0440	OO SKILLED NURSING FACILITY	0		(0	0	44. 00
ANCI	LLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	0		(0	0	50.00
	OO RADI OLOGY-DI AGNOSTI C	0		(0	0	54.00
	O LABORATORY	112, 716		112, 716	0	112, 716	60.00
	O RESPI RATORY THERAPY	191, 607	0	191, 607	7 0	191, 607	65. 00
	O PHYSI CAL THERAPY	2, 497, 149	l e	2, 497, 149		2, 497, 149	
	OO OCCUPATI ONAL THERAPY	1, 396, 071	l e	1, 396, 07		1, 396, 071	
	O SPEECH PATHOLOGY	680, 678	0	680, 678	0	680, 678	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		(0	0	1 / 00
	DO DRUGS CHARGED TO PATIENTS	1, 040, 770		1, 040, 770		1, 040, 770	
	O RENAL DIALYSIS	345, 319		345, 319	9 0	345, 319	74. 00
	ATIENT SERVICE COST CENTERS	_			_		
90.00 0900		0		(0	0	1 /0.00
	OO EMERGENCY	0		(0	0	91.00
	R REIMBURSABLE COST CENTERS						1
	OO AMBULANCE SERVICES	0		(0	0	70.00
	O OTHER REIMBURSABLE COST CENTERS	0		(0	0	98. 00
200. 00	Subtotal (see instructions)	19, 002, 205	0	19, 002, 205	0	19, 002, 205	
201. 00	Less Observation Beds	0		(201. 00
202. 00	Total (see instructions)	19, 002, 205	0	19, 002, 205	5 0	19, 002, 205	202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 15-3044 Peri od: Worksheet C From 01/01/2022 To 12/31/2022 Part I Date/Time Prepared: 5/16/2023 12:57 pm Title XVIII Hospi tal PPS Charges TEFRA Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDI ATRI CS 21, 491, 795 21, 491, 795 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 44.00 04400 SKILLED NURSING FACILITY 0 0 44.00 ANCILLARY SERVICE COST CENTERS 0.000000 50.00 0.000000 50.00 05000 OPERATING ROOM 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0.000000 54.00 60.00 06000 LABORATORY 613, 682 613, 682 0.183672 0.000000 60.00 06500 RESPIRATORY THERAPY 0.693214 65.00 276, 404 0 276, 404 0.000000 65.00 06600 PHYSI CAL THERAPY 7, 127, 457 0 7, 127, 457 0. 350356 0.000000 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 7, 102, 422 0 7, 102, 422 0.196563 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 4, 678, 962 0 4, 678, 962 0. 145476 0.000000 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0.000000 0.000000 71.00 0 71.00 2, 379, 811 2, 379, 811 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0.437333 0.000000 73.00 07400 RENAL DIALYSIS 305, 608 305, 608 1.129941 0.000000 74.00 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 0.000000 0.000000 90.00 91.00 09100 EMERGENCY 0 0 0.000000 0.00000091.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0.000000 0.000000 95.00 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0.000000 0.000000 98.00 200.00 Subtotal (see instructions) 43, 976, 141 0 43, 976, 141 200.00 Less Observation Beds 201.00 201.00 202.00 43, 976, 141 202. 00 Total (see instructions) 0 43, 976, 141

			10 12/31/2022	5/16/2023 12:57 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
44. 00 O4400 SKILLED NURSING FACILITY				44. 00
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
60. 00 06000 LABORATORY	0. 183672			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 693214			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 350356			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 196563			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 145476			68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 437333			73. 00
74. 00 O7400 RENAL DIALYSIS	1. 129941			74. 00
OUTPATIENT SERVICE COST CENTERS	0.00000			
90. 00 09000 CLI NI C	0.000000			90.00
91. 00 09100 EMERGENCY OTHER REI MBURSABLE COST CENTERS	0. 000000			91. 00
95. 00 09500 AMBULANCE SERVICES	0, 000000			95, 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98.00
	0.000000			200.00
200.00 Subtotal (see instructions) 201.00 Less Observation Beds				200.00
				201.00
202.00 Total (see instructions)	I I			J202. 00

near tii	Financial systems commit	illity neal til kei	iau nospi tai st	Jutii	III LI E	u or Form CW3-2	2002-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der Co	CN: 15-3044	Peri od:	Worksheet C	
					From 01/01/2022	Part I	
					To 12/31/2022		
						5/16/2023 12:	57 pm
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	12, 737, 895		12, 737, 89	0	12, 737, 895	30.00
31.00	03100 INTENSIVE CARE UNIT	0			0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0			0 0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0			0 0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0			0	0	54.00
60.00	06000 LABORATORY	112, 716		112, 71	6 0	112, 716	60.00
65.00	06500 RESPI RATORY THERAPY	191, 607	0	191, 60	0	191, 607	65.00
66. 00	06600 PHYSI CAL THERAPY	2, 497, 149	0	2, 497, 14	.9	2, 497, 149	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 396, 071	0	1, 396, 07	'1 o	1, 396, 071	67. 00
68. 00	06800 SPEECH PATHOLOGY	680, 678	0	680, 67	8 0	680, 678	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o			0 0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 040, 770		1, 040, 77	o o	1, 040, 770	73. 00
74.00	07400 RENAL DIALYSIS	345, 319		345, 31	9 0	345, 319	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0			0 0	0	90.00
91.00	09100 EMERGENCY	o			o o	0	91.00
	OTHER REIMBURSABLE COST CENTERS	'					
95.00	09500 AMBULANCE SERVICES	0			0 0	0	95.00
	09850 OTHER REIMBURSABLE COST CENTERS	o			0	0	98. 00
200.00		19, 002, 205	0	19, 002, 20	05	19, 002, 205	
201.00		0	· ·	1.,,002,,20	ام		201. 00
202. 00	l	19, 002, 205	0	19, 002, 20	05		
202.00	1.523. (500 111511 4011 6115)	17,002,200	0	17,002,20	اح.	17,002,200	1232.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3044 Peri od: Worksheet C From 01/01/2022 To 12/31/2022 Part I Date/Time Prepared: 5/16/2023 12:57 pm Title XIX Hospi tal Cost Charges TEFRA Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDI ATRI CS 21, 491, 795 21, 491, 795 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 44.00 04400 SKILLED NURSING FACILITY 0 0 44.00 ANCILLARY SERVICE COST CENTERS 0.000000 50.00 0.000000 50.00 05000 OPERATING ROOM 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0.000000 54.00 60.00 06000 LABORATORY 613, 682 613, 682 0.183672 0.000000 60.00 06500 RESPIRATORY THERAPY 0.693214 65.00 276, 404 0 276, 404 0.000000 65.00 06600 PHYSI CAL THERAPY 7, 127, 457 0 7, 127, 457 0. 350356 0.000000 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 7, 102, 422 0 7, 102, 422 0.196563 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 4, 678, 962 0 4, 678, 962 0. 145476 0.000000 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0.000000 0.000000 71.00 0 71.00 2, 379, 811 2, 379, 811 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0.437333 0.000000 73.00 07400 RENAL DIALYSIS 305, 608 305, 608 1.129941 0.000000 74.00 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 0.000000 0.000000 90.00 91.00 09100 EMERGENCY 0 0 0.000000 0.00000091.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0.000000 0.000000 95.00 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0.000000 0.000000 98.00 200.00 Subtotal (see instructions) 43, 976, 141 0 43, 976, 141 200.00 Less Observation Beds 201.00 201.00 202.00 43, 976, 141 202. 00 Total (see instructions) 0 43, 976, 141

			10 12/31/2022	5/16/2023 12:57 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
44.00 04400 SKILLED NURSING FACILITY				44. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 0CCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
74. 00 07400 RENAL DIALYSIS	0. 000000			74. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90. 00
91. 00 09100 EMERGENCY	0. 000000			91. 00
OTHER REIMBURSABLE COST CENTERS	I I			
95. 00 09500 AMBULANCE SERVI CES	0. 000000			95. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	Community Health Rel	hab Hospital So	outh	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	PLITAL COSTS	Provi der C		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
		Ti tl e	xVIII	Hospi tal	5/16/2023 12: PPS	57 piii
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost		ĺ	
	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, 444, 937	0	1, 444, 93	7 11, 552	125. 08	30.00
31.00 INTENSIVE CARE UNIT	0			0	0.00	31. 00
44.00 SKILLED NURSING FACILITY	0			0	0.00	44. 00
200.00 Total (lines 30 through 199)	1, 444, 937		1, 444, 93	7 11, 552		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 ADULTS & PEDIATRICS	5, 412	676, 933				30.00
31.00 INTENSIVE CARE UNIT	0	0	1			31. 00
44.00 SKILLED NURSING FACILITY	0	0	1			44. 00
200.00 Total (lines 30 through 199)	5, 412	676, 933				200. 00

H	Health Financial Systems	Community He	alth Rehab Ho	ospital S	outh	In Lie	u of Form CMS-2	2552-10
7	APPORTIONMENT OF INPATIENT ANCILLARY SERV	ICE CAPITAL COSTS	P	rovider C		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Prep 5/16/2023 12:	
_				Titl∈	e XVIII	Hospi tal	PPS	
	Cost Center Description	Capi			Ratio of Cos	t Inpatient	Capital Costs	

						5/16/2023 12:	57 pm
			Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col . 1 ÷ col .	Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	O5000 OPERATI NG ROOM	0	0	0.000000	0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0.000000	0	0	54. 00
60.00	06000 LABORATORY	11, 814	613, 682	0. 019251	271, 761	5, 232	60.00
65.00	06500 RESPI RATORY THERAPY	23, 496	276, 404	0. 085006	131, 377	11, 168	65. 00
66.00	06600 PHYSI CAL THERAPY	658, 681	7, 127, 457	0. 092415	3, 318, 562	306, 685	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	196, 981	7, 102, 422	0. 027734	3, 264, 032	90, 525	67.00
68. 00	06800 SPEECH PATHOLOGY	74, 888	4, 678, 962	0. 016005	2, 219, 885	35, 529	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	121, 654	2, 379, 811	0. 051119	1, 068, 542	54, 623	73. 00
74.00	07400 RENAL DIALYSIS	54, 714	305, 608	0. 179033	168, 359	30, 142	74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	O	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0	0	0. 000000	0	0	91.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0. 000000	0	0	98. 00
200.00	Total (lines 50 through 199)	1, 142, 228	22, 484, 346	1	10, 442, 518	533, 904	200. 00

Health Financial Systems Commu	nity Health Reh	nab Hospital S	outh	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA				Peri od:	Worksheet D	
				From 01/01/2022		
				To 12/31/2022		
		T: +1 a	e XVIII	Hospi tal	5/16/2023 12: PPS	5/ pm
Cost Center Description	Nursi ng	Nursing		Allied Health	All Other	
cost center bescription	Program	Program	Post-Stepdowr		Medical	
	Post-Stepdown	Pi ogi alli	Adjustments		Education Cost	
	Adjustments		Aujustillerits		Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA I	1.00		2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	n l	(1	0	0	30.00
31. 00 03100 NTENSI VE CARE UNIT				0	0	
44. 00 O4400 SKILLED NURSING FACILITY				0	0	44. 00
200.00 Total (lines 30 through 199)				0	_	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Dation	Per Diem (col.	Inpati ent	200.00
cost center bescriptron	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	Days	3 + coi . 0)	110graiii bays	
	`	minus col. 4)				
	4. 00	5.00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	(11, 55	2 0.00	5, 412	30.00
31. 00 03100 NTENSI VE CARE UNI T	Ĭ	Č	, 55	0.00		
44. 00 04400 SKI LLED NURSING FACILITY		Č		0.00		
200.00 Total (lines 30 through 199)		Č	11, 55		•	200. 00
Cost Center Description	Inpatient		1.700	_	07.1.2	200.00
2222 2222. 200011 pt1 0	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
LUBATI FUT DOUTLUE OFFICE OF COOT OFFITEDO						

0 0 0 30. 00 31. 00 44. 00

200. 00

30. 00 | 03000 ADULTS & PEDIATRICS | 03100 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 01000 | 0

Health Financial Systems	Community Heal	th Rehab	Hospi tal	South	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHE	R PASS	Provi der	CCN: 15-3044	From 01/01/2022	Worksheet D Part IV Date/Time Prepared:

						5/16/2023 12:	57 pm
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0) c	0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0) c	0	0	54. 00
60.00	06000 LABORATORY	0	0) c	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	C	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0) c	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0) c	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0) c	0	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0) c	0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0) c	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0) c	0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	C	0	0	90.00
91.00	09100 EMERGENCY	0	0) c	0	0	91.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0) c	0	0	98. 00
200.00	Total (lines 50 through 199)	0	0) c	0	0	200. 00

	munity Health Rel		outh	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SITHROUGH COSTS	ERVICE OTHER PAS	S Provider C		Period: From 01/01/2022 To 12/31/2022		pared:
		Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	1	0	0. 000000	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0	0. 000000	1
60. 00 06000 LABORATORY	0	0	1	0 613, 682	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	1	0 276, 404	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	1	0 7, 127, 457	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 7, 102, 422	0.000000	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0)	0 4, 678, 962	0.000000	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0 0	0.000000	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0 2, 379, 811	0.000000	73. 00
74. 00 07400 RENAL DIALYSIS	0	0		0 305, 608	0. 000000	74. 00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	0)	0	0.000000	90.00
91. 00 09100 EMERGENCY	0	0		0 0	0. 000000	91.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0.000000	98. 00
200.00 Total (lines 50 through 199)	0	0		0 22, 484, 346		200. 00

Health Financial Systems Commi APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVI CE OTHER PASS	Provi der Co		Period: From 01/01/2022 To 12/31/2022		pared:
					5/16/2023 12:	57 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col . 6 ÷ col .		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col . 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCI LLARY SERVI CE COST CENTERS			T	_1	_	
50. 00 05000 OPERATING ROOM	0. 000000	0		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0		0	0	54.00
60. 00 06000 LABORATORY	0. 000000	271, 761		0	0	00.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	131, 377		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	3, 318, 562		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	3, 264, 032		0	0	07.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	2, 219, 885		0	0	00.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	,
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 068, 542		0	0	73. 00
74. 00 07400 RENAL DIALYSIS	0. 000000	168, 359		0	0	74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0	0	,
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0	0	98. 00
200.00 Total (lines 50 through 199)		10, 442, 518		0	0	200.00

Community Health Rehab Hospital	South	In Lie	u of Form CMS-2	2552-10
Provi der	CCN: 15-3044	Peri od:	Worksheet D-1	
			Date/Time Pre	
Ti	tle XVIII	Hospi tal	PPS	
	Provi der	Community Health Rehab Hospital South Provider CCN: 15-3044 Title XVIII	Provi der CCN: 15-3044 Peri od: From 01/01/2022 To 12/31/2022	Provider CCN: 15-3044 Period: Worksheet D-1 From 01/01/2022 To 12/31/2022 Date/Time Pre 5/16/2023 12:

		Title XVIII	Hospi tal	5/16/2023 12: PPS	57 pm
	Cost Center Description		·	1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			11, 552	
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day		vate room days	11, 552 0	2. 00 3. 00
3.00	do not complete this line.	ys). If you have only pri	vate room days,		3.00
4.00	Semi-private room days (excluding swing-bed and observation be			11, 552	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roomstring period	om days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December :	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	m davs) after December 3	1 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	the Program (excluding	swi ng-bed and	5, 412	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII on	nly (including private ro	oom days)	0	10. 00
	through December 31 of the cost reporting period (see instruc				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
.2.00	through December 31 of the cost reporting period	t am y (the daing private	o room dayo,		12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	ő	15. 00		
16.00	Nursery days (title V or XIX only)	0	16. 00		
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	as through December 21 or	f the cost	0.00	17 00
17.00	reporting period	es through becember 31 of	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	0.00	19. 00		
19.00	reporting period	0.00	19.00		
20. 00	Medical drate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	5)		12, 737, 895	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
22.00	5 x line 17)	21 -6			22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (iine 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25. 00	$7 ext{ x line 19}$ Swing-bed cost applicable to NF type services after December 3	R1 of the cost reporting	neriod (line 8	0	25. 00
20.00	x line 20)	or the cost reporting	por rod (11110 0		20.00
26. 00	Total swing-bed cost (see instructions)	(1: 04 : 1: 04)		0	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		12, 737, 895	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	Line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	- 111le 20 <i>)</i>		0.00000	•
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	•
34. 00	Average per diem private room charge differential (line 32 mi)		tions)	0.00	•
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
36.00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	12, 737, 895	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 102. 66	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			5, 967, 596	
40.00	Medically necessary private room cost applicable to the Progra			0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ IIne 40)		5, 967, 596	41.00

Health Financial Systems	Community Health Rehab	Hospital South	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-3044		Worksheet D-1
			From 01/01/2022	Dato/Timo Propared:

	ATTOM OF THE ATTEM OF ENATITIES COST		Trovider o		From 01/01/2022 To 12/31/2022	Date/Time Pre 5/16/2023 12:	
	Cost Center Description	Total Inpatient Cost	Total			PPS Program Cost (col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)						42. 00
42.00	Intensive Care Type Inpatient Hospital Units			0.0	20	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	(0.0	00 0	0	43. 00 44. 00
	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3. line 200)			2, 925, 738	48. 00
48. 01	Program inpatient cellular therapy acquisiti			III, line 10,	column 1)	0	48. 01
49. 00	Total Program inpatient costs (sum of lines	41 through 48.0	01)(see instrud	ctions)		8, 893, 334	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routino	sorvices (from	m Wkst D sum	of Parts L and	676, 933	50.00
30.00	Pass through costs appricable to Program the	attent routine	Services (110	II WKSt. D, Suii	I OI PAILS I AIIU	070, 933	30.00
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	ry services (fr	rom Wkst. D, s	sum of Parts II	533, 904	51. 00
52. 00	Total Program excludable cost (sum of lines					1, 210, 837	52.00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		erated, non-phy	ysician anesth	etist, and	7, 682, 497	53. 00
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge					0.00	
55. 02 56. 00	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55	J /				0.00	55. 02 56. 00
57. 00	Difference between adjusted inpatient operat			ine 56 minus	line 53)	0	1
58. 00	Bonus payment (see instructions)	g coot and to	901 404 (.			0	58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	n the cost repo	orting period	endi ng 1996,	0.00	59. 00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	0.00	60. 00				
61. 00	market basket) Continuous improvement bonus payment (if lin	e 53 ÷ line 54	is less than t	the Lowest of	lines 55 plus	0	61.00
0.1.00	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)		01100				
62. 00	Relief payment (see instructions)					0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Docs	mbor 21 of the	o cost roporti	ng pariod (Saa	1 0	64. 00
04.00	instructions)(title XVIII only)	ts through bece	silber 31 Of the	e cost reporti	ilg period (see		04.00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the o	cost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	65)(title XVII	I only); for	0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	of the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	December 31 of	the cost reno	orting period	0	68. 00
	(line 13 x line 20)				g p		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY		0	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70. 00 71. 00
72. 00	Program routine service cost (line 9 x line			-/			72.00
73. 00	Medically necessary private room cost applic	abĺe to Program					73. 00
74. 00	Total Program general inpatient routine serv	•					74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (trom v	worksneet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00	Inpatient routine service cost (line 74 minu			1. 3			78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			*.	us line 70)		79. 00 80. 00
81. 00	Inpatient routine service costs for comp		tati Ui	. (1116 70 11111	11110 17)		81.00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	* .				82. 00
83.00	Reasonable inpatient routine service costs (ns)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		nns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PAS]
87. 00	Total observation bed days (see instructions		1: 0)			0	
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se					0.00	
37.00	(Se	5 1115t1 dot1 0115)					1 07.00

Health Financial Systems Comm	nunity Health Re	hab Hospital Sc	outh	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od: From 01/01/2022	Worksheet D-1	
				To 12/31/2022		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 444, 937	12, 737, 895	0. 11343	6 0	0	90.00
91.00 Nursing Program cost	0	12, 737, 895	0.00000	0	0	91.00
92.00 Allied health cost	0	12, 737, 895	0.00000	0	0	92. 00
93.00 All other Medical Education	0	12, 737, 895	0. 00000	0 0	0	93. 00

Health Financial Systems	Community Health Rehab H	Hospi tal	South	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	F	Provi der	CCN: 15-3044	Peri od: From 01/01/2022	Worksheet D-1
				To 12/31/2022	Date/Time Prepared: 5/16/2023 12:57 pm
		Ti	tle XIX	Hospi tal	Cost

		Title XIX	Hospi tal	5/16/2023 12: Cost	57 pm
	Cost Center Description		·	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l	,		11, 552 11, 552	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed day		vate room days	11, 552	3. 00
0.00	do not complete this line.	,e, yeuave e y p	rato room dayo,	· ·	0.00
4.00	Semi-private room days (excluding swing-bed and observation be			11, 552	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room	om days) through Decembe	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om davs) after December (R1 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becomber .	or the cost	O	0.00
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	a days) arter becomber o	1 01 110 0031	· ·	0.00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	46	9. 00
10.00	newborn days) (see instructions)			0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruc-		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	Conty (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	14.00
15. 00 16. 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			0	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	os after Necember 31 of :	the cost	0.00	18. 00
10.00	reporting period	23 ditter becember 31 of	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medical d rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	5)		12, 737, 895	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
22.00	5 x line 17)	21 -6		0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (iine 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)	. 3			
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 24)		0 12, 737, 895	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Title 21 IIII lius Title 20)		12, 737, 693	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	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)	Line 20)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	: II ne 28)		0. 000000 0. 00	31. 00 32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin		´	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 di	fferential (line	12, 737, 895	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 102. 66	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		50, 722	39. 00
40.00	Medically necessary private room cost applicable to the Progra	,		0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ IINE 4U)	l	50, 722	41.00

Health Financial Systems	Community Health Rehab	Hospi tal South	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	-	Provider CCN: 15-3044	Peri od:	Worksheet D-1

Cost Center Description		THE CONTRACT OF ENTITIES CONTR		Tiorida		From 01/01/2022 To 12/31/2022	Date/Time Pre 5/16/2023 12:	
		Cost Center Description		Total	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
Interest vice Care type Impartient Respirate Units	10.00	AND SERVICE AND AND AND AND AND AND AND AND AND AND	1. 00	2.00	3.00	4. 00		10.00
	42. 00							42.00
45.00 SBR6 INTENSIVE CASE UNIT	43. 00		C		0.0	0 0	0	43. 00
46.00 Cost Center Description 45.00 1.00								
1.00								
Cost Center Description 1.00 8.00								
1.00 Region inputient unciliarly service cost (Misst. D-3, col. 3, line 200) 0.48.00 0.4	47.00							47.00
Program Inpatient cell ular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)		·					1. 00	
Total Program ingatient costs (sum of lines 41 through 48, 01)(see instructions)								
PASS TRROUGH COST ADJUSTMENTS						column 1)		
0.00 Pass through costs applicable to Program inpatient routine services (from Wist. D., sum of Parts I and 1.00 1.	49.00		41 through 48.	JI) (See Thistruc	etrons)		50, 722	49.00
51.00 Pasis through costs applicable to Program inpatient ancillary services (From West, D. sum of Parts II and II of 1979 are excludable cost (sum of lines 50 and 51) 52.00 1018 Program excludable cost (sum of lines 50 and 51) 52.00 1018 Program inpatient operating cost excluding capital related, non-physician anesthetist, and	50.00		atient routine	services (from	n Wkst. D, sum	of Parts I and	0	50.00
and IV) 5.0.00 Total Program excludable cost (sum of lines 50 and 51) 5.0.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 5.5.00 Potal Program inpatient operating cost excluding capital related, non-physician anesthetist, and 5.5.00 Potal circum and costs (line 40 minus line 52) 6.6.00 Potal and scharges 6.6.00 Potal and scharges 7.5.00 Potal and scharges 8.6.00 Pota	F4 00							F4 00
10 10 10 10 10 10 10 10	51.00	9 11	atient ancillai	ry services (fi	om Wkst. D, s	um of Parts II	0	51.00
10 Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and ended aductation costs (line 49 minus line 52)	52. 00		50 and 51)				0	52. 00
TARGET MOUNT AND LIMIT COMPUTATION	53.00			elated, non-phy	ysician anesth	etist, and	0	53. 00
54.00 Program discharges 0.00 55.00 55.00 Total amount per discharge 0.00 55.00 55.00 Total amount per discharge 0.00 55.00 55.00 26.00 December 31 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 0.00 55.00 0.00			52)					
55.00 Target amount per discharge 0.00 55.01	54. 00						0	54.00
55.00 Aglustment amount per discharge (contractor use only) 0.00 55.00 56.00 17 56.00 17 57 57.00 17 56.00 17 57 57.00 17 57 57.00 17 57 57.00 17 57.00							0.00	
55.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 57.00 Bonus payment (see instructions) 58.00 Bonus payment (see instructions) 59.00 Treded costs (lesser of line 53 + line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 60.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 61.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 50, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 Relider payment (see instructions) 63.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) production (line x 11 x x 111 and x) 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for Contain Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for Contain Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for Contain Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for Contain Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for Contain Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for Contain Medicare swing-bed SNF inpatient routine costs (line 67 + line 68) 60.00 Title Vor XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Stitle Vor IXI Swing-bed NF inpatient routine costs (line 67 + line 68) 80.00 Title Journal of the cost reporting period (line 13 x line 20) 80.00 Total title Vor XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 80.00 Total program engeneral inpatient routine service costs (line 72 + line 73) 70.00 Stitle du							1	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 58.00 Brous payment (see instructions) 0 58.00 Expected costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 0 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 1 0 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 0 62.00 Relief payment (see instructions) 0 63.00 Relief payment (see instru		, , , , , , , , , , , , , , , , , , , ,	J /	`			1	1
88.00 Bonus payment (see Instructions) 0, 95.00 59.00 Treded costs (clesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, 0, 00, 59.00 60.00 Expected costs (clesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 0, 00 60.00 Expected costs (clesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 0, 00 61.00 Collina 10, 00 10, 00 10, 00 10, 00 10, 00 62.01 10, 00 10, 00 10, 00 10, 00 10, 00 10, 00 63.02 Tree is than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 0, 63.00 63.00 Relide payment (see instructions) 0, 63.00 64.00 All lowable lippatient cost plus incentive payment (see instructions) 0, 63.00 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) 0, 64.00 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 0 0, 60.00 66.00 Title Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) 0, 67.00 67.00 Title Wedicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 0 0, 67.00 68.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 0, 67.00 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period 0, 67.00 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0, 00 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0, 00 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 0, 00 69.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 77 + line 78) 0, 00 69.00 Total title V or					ine 56 minus	line 53)	1	
updated and compounded by the market basket) 60.00			g coot and to	ar got amourte (.			1	
60.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 61.00 Continuous improvement borus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medic are swin-pbed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medic are swin-pbed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medic are swin-pbed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions 67.00 Title Vor XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title Vor XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 20) 71.00 Skilled nursing facility/other	59. 00		or line 55 from	m the cost repo	orting period	endi ng 1996,	0.00	59. 00
market basket) 1.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 2.00 Relief payment (see instructions) 3.00 Allowable Inpatient cost plus incentive payment (see instructions) 4.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (lite XVIII only) 4.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (lite XVIII only) 4.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions) 4.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) 4.00 Total Medicare swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions 4.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 4.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 4.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 4.00 Total title V or XIX swing-bed NF inpatient routine costs (line 72 + line 73) 4.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37) 4.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 79 + line 2) 4.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 79 + line 2) 4.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 79 + line 2) 4.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 79 + line 2) 4.00 Porgram routine service cost (line 9 x line 71) 4.00 Porgram capital related costs (line 9 x line 71)	60.00		or line 55 fro	om prior vear o	rost renort u	ndated by the	0.00	60.00
55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus Incentive payment (see instructions) 64.00 Mallowable Inpatient cost plus Incentive payment (see instructions) 64.00 Medicare swing-bed SMF Inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) of instructions) (title XVIII only) of instructions) (title XVIII only) of instructions) (title XVIII only) of instructions) (title XVIII only) of instructions) (title XVIII only) of instructions) (title XVIII only) of instructions) (title XVIII only) of instructions) (title XVIII only) of instructions) (title XVIII only) of instructions) (title XVIII only) of instructions) (title XVIII only) of instructions) (title XVIII only) of instructions) (title XVIII only) of instructions) (title VIIII only) of instructions) (title XVIII only) of instructions) (title VIIII only) of instructions) of instructions of instructions of instructions) (title VIIII only) of instructions of instructions) (title VIIII only) of instructions) (title VIIII only) of instructions) (title VIIII only) of instructions of instructions) (title VIIII only) of instructions of instructions) (title VIIII only) of instructions of instructions) of instructions of instructions) of instructions of instructions of instructions) of instructio	00.00		01 11110 00 111	om prior year c	sost roport, a	paarea by the	0.00	00.00
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83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 89.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routine services		·		1)				
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Representation of the service of the second of the secon		•		* .				1
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Occurrence of the content of the cost per diem (line 27 ÷ line 2) 88.00 Occurrence of the cost per diem (line 27 ÷ line 2) 89.00 Occurrence of the cost per diem (line 27 ÷ line 2)		•		13)				
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00		Utilization review - physician compensation	(see instruction					
87.00 Total observation bed days (see instructions) 0 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00	86. 00			nrough 85)				86. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00	87 00							87 00
				÷ line 2)				
	89. 00						1	

Health Financial Systems Co	mmunity Health Rel	hab Hospital So	outh	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2022	Worksheet D-1	
				To 12/31/2022	Date/Time Pre 5/16/2023 12:	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	SH COST					
90.00 Capital-related cost	1, 444, 937	12, 737, 895	0. 11343	6 0	0	90. 00
91.00 Nursing Program cost	0	12, 737, 895	0.00000	0	0	91. 00
92.00 Allied health cost	0	12, 737, 895	0.00000	0	0	92. 00
93.00 All other Medical Education	0	12, 737, 895	0. 00000	0 0	0	93. 00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 15-3044 Peri od: Worksheet D-2 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/16/2023 12:57 pm Health Care Program Inpati<u>ent Days</u> Cost Center Description Percent of Expense Total Average Cost Title V Inpatient Day Assigned Time Allocation Per Day All Patients 1.00 2.00 4.00 5.00 3.00 PART I - NOT IN APPROVED TEACHING PROGRAM Total cost of services rendered 0.00 0 1.00 1.00 Hospital Inpatient Routine Services: 2.00 ADULTS & PEDIATRICS 0. 00 0 11, 552 0.00 2.00 0 3.00 INTENSIVE CARE UNIT 0.00 0.00 3.00 CORONARY CARE UNIT 4 00 4 00 5.00 BURN INTENSIVE CARE UNIT 5.00 6.00 SURGICAL INTENSIVE CARE UNIT 6.00 OTHER SPECIAL CARE (SPECIFY) 7.00 7 00 8.00 NURSERY 8.00 9.00 Subtotal (sum of lines 2 through 8) 0.00 0 9.00 SUBPROVI DER - I PF SUBPROVI DER - I RF 10.00 10.00 11 00 11 00 12.00 SUBPROVI DER 12.00 SKILLED NURSING FACILITY 0.00 0.00 0 13.00 13.00 0 NURSING FACILITY 14.00 14.00 15.00 OTHER LONG TERM CARE 15.00 16.00 HOME HEALTH AGENCY 16.00 17.00 CMHC 17.00 18.00 AMBULATORY SURGICAL CENTER (D. P.) 18.00 HOSPI CE 19.00 19.00 20.00 Subtotal (sum of lines 9 through 19) 0.00 20.00 Titles V and XIX Outpatient and Title XVIII Part B Charges Cost Center Description Total Charges Ratio of Cost Title V (from to Charges Worksheet C. (col. 2 ÷ col 3 Part I, column 8, lines 88 through 93) 1.00 2.00 3.00 4.00 5.00 Hospital Outpatient Services: 21.00 RURAL HEALTH CLINIC 21.00 22.00 FEDERALLY QUALIFIED HEALTH CENTER 22.00 CLI NI C 0.000000 23.00 23.00 0.00 24. 00 EMERGENCY 0.00 0.000000 24.00 OBSERVATION BEDS (NON-DISTINCT PART) 25.00 25.00 OTHER OUTPATIENT SERVICE COST CENTER 26.00 26.00 Subtotal (sum of lines 21 through 26) 27.00 0.00 27.00 28.00 Total (sum of lines 20 and 27) 0.00 28.00 Cost Center Description Expenses Swing bed Net cost Total Average Cost Allocated To (column 1 plus|Inpatient Days|Per Day (col. Amount cost centers - All Patients column 2) 3 ÷ col . 4) on Worksheet B. Part I columns 21 and 22 1.00 2.00 3.00 4.00 5.00 PART B INPATIENT ROUTINE COSTS ONLY) PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, Hospital Inpatient Routine Services: 0 00 29. 00 ADULTS & PEDIATRICS 29 00 30.00 Swing Bed - SNF 0 0 0.00 30.00 Swing Bed - NF 31.00 31.00 INTENSIVE CARE UNIT 0 0 0.00 0 32.00 32 00 33.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 34.00 SURGICAL INTENSIVE CARE UNIT 35.00 35.00 OTHER SPECIAL CARE (SPECIFY) 36.00 36.00 37.00 Subtotal (sum of lines 29, and 32 through 0 37.00 SUBPROVIDER - IPF 38.00 38.00 SUBPROVIDER - IRF 39.00 39.00 SUBPROVI DER 40.00 40.00 41.00 SKILLED NURSING FACILITY 0 0.00 41.00 42.00 Total (sum of lines 37 through 41) 42.00

col. 9, line 13.00

46. 00 47. 00

48.00

49.00

Ocol. 9, line 41.00

46. 00 SUBPROVI DER – I PF 47. 00 SUBPROVI DER – I RF

49.00 SKILLED NURSING FACILITY

48. 00 SUBPROVI DER

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 15-3044 Peri od: Worksheet D-2 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/16/2023 12:57 pm Health Care Program Inpatient Days Title V (col. Title XVIII, Title XIX Title XVIII Title XIX Cost Center Description Part B Only 4 x col. 5) (col. 4 x col. (col. 4 x col. less Part A 6) 7) Coverage but no Part B Coverage 7.00 9. 00 10.00 8.00 6.00 PART I - NOT IN APPROVED TEACHING PROGRAM Total cost of services rendered 1.00 Hospital Inpatient Routine Services: 2.00 5, 412 ADULTS & PEDLATRICS 46 2.00 0 0 3.00 INTENSIVE CARE UNIT 0 3.00 4.00 CORONARY CARE UNIT 4.00 5.00 BURN INTENSIVE CARE UNIT 5.00 6.00 SURGICAL INTENSIVE CARE UNIT 6.00 7.00 OTHER SPECIAL CARE (SPECIFY) 7.00 8.00 NURSERY 8.00 9.00 Subtotal (sum of lines 2 through 8) 0 0 9.00 0 SUBPROVIDER - IPF 10.00 10.00 11.00 SUBPROVIDER - IRF 11.00 12.00 SUBPROVI DER 12.00 13.00 SKILLED NURSING FACILITY 0 0 0 13.00 14.00 NURSING FACILITY 14.00 15.00 OTHER LONG TERM CARE 15.00 HOME HEALTH AGENCY 16.00 16.00 CMHC 17.00 17.00 AMBULATORY SURGICAL CENTER (D. P.) 18.00 18.00 19.00 HOSPI CE 19.00 20.00 Subtotal (sum of lines 9 through 19) 20.00 Titles V and XIX Outpatient Titles V and XIX Outpatient and Title and Title XVIII Part B XVIII Part B Cost Charges Title XVIII Title XIX Title V Title XVIII Title XIX Cost Center Description Part B Part B 6.00 7.00 8.00 9.00 10.00 Hospital Outpatient Services: RURAL HEALTH CLINIC 21.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 22.00 22.00 23.00 CLINIC 23.00 **EMERGENCY** 0 0 0 24.00 24.00 OBSERVATION BEDS (NON-DISTINCT PART) 25.00 25.00 26.00 OTHER OUTPATIENT SERVICE COST CENTER 26.00 Subtotal (sum of lines 21 through 26) 0 0 27.00 27.00 Total (sum of lines 20 and 27) 28. 00 28.00 PSA Adj Cost Center Description Title XVIII Expenses Part B Applicable to Interns & npatient Days Title XVIII Resi dents (col. 5 x col 6) 6.00 7.00 11. 00 PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY) Hospital Inpatient Routine Services 29. 00 ADULTS & PEDIATRICS 29.00 30.00 Swing Bed - SNF 30.00 C 31.00 Swing Bed - NF 31.00 32.00 INTENSIVE CARE UNIT 32.00 33.00 CORONARY CARE UNIT 33.00 34.00 BURN INTENSIVE CARE UNIT 34.00 35.00 SURGICAL INTENSIVE CARE UNIT 35.00 36.00 OTHER SPECIAL CARE (SPECIFY) 36.00 Subtotal (sum of lines 29, and 32 through 37.00 37.00 36) SUBPROVIDER - IPF 38.00 38.00 39. 00 SUBPROVIDER - IRF 39.00 40.00 SUBPROVI DER 40.00 SKILLED NURSING FACILITY 41.00 41.00 42.00 Total (sum of lines 37 through 41) 42.00

Health Financial Systems Comm	nunity Health Re	hab Hospital South	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF COST OF SERVICES RENDERED BY INTI	RNS AND RESIDEN	TS Provider CCN: 15-3044	Peri od:	Worksheet D-2	
			From 01/01/2022 To 12/31/2022		pared: 57 pm
	In Approved	Total Title XVIII	Costs		
	Teachi ng				
	Program				
Cost Center Description	Amount	(to Wkst. E, Part B -)	(col. 2 + col.		
			4)		
	4. 00	5. 00	6. 00		
PART III - SUMMARY FOR TITLE XVIII (TO BE C	OMPLETED ONLY IF	BOTH PARTS I AND II ARE U	SED)		
Hospi tal					
43.00 Inpati ent	0		0		43.00
44.00 Outpatient					44.00
45.00 Total Hospital (sum of lines 43 and 44)	0	line 22	0		45. 00
46. 00 SUBPROVI DER - I PF					46. 00
47. 00 SUBPROVI DER - I RF					47.00
48. 00 SUBPROVI DER					48. 00
49.00 SKILLED NURSING FACILITY	0	line 22	0		49. 00

Heal th	Financial Systems Community Health Rehab	Hospital So	outh	In Lie	u of Form CMS-2	<u>2552-10</u>
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
				From 01/01/2022	D-+- /T: D	
				Γο 12/31/2022	Date/Time Prep 5/16/2023 12:	
		Ti tl e	e XVIII	Hospi tal	PPS	J7 PIII
	Cost Center Description	11 61 6	Ratio of Cost		Inpatient	
	5555 551151 55551 Pt 1 511		To Charges	Program	Program Costs	
			9		(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS			9, 977, 502		30. 00
31.00	03100 INTENSIVE CARE UNIT			0		31.00
	ANCILLARY SERVICE COST CENTERS					l
50.00	05000 OPERATING ROOM		0. 00000	0	0	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0.00000	0	0	54. 00
60.00	06000 LABORATORY		0. 18367.	271, 761		
65.00	06500 RESPI RATORY THERAPY		0. 69321	4 131, 377	91, 072	65. 00
66.00	06600 PHYSI CAL THERAPY		0. 35035	3, 318, 562	1, 162, 678	66. 00
	06700 OCCUPATI ONAL THERAPY		0. 19656	3, 264, 032	641, 588	67. 00
	06800 SPEECH PATHOLOGY		0. 14547		322, 940	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 43733		467, 309	73. 00
74.00	07400 RENAL DI ALYSI S		1. 12994	1 168, 359	190, 236	74. 00
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C		0. 00000		1	70.00
91. 00	09100 EMERGENCY		0.00000	0	0	91.00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVI CES					95. 00
	09850 OTHER REIMBURSABLE COST CENTERS		0.00000		0	98. 00
200.00				10, 442, 518		
201 00	Loss DDD Clinic Laboratory Sorvices Program only charges	(Lino 61)	1	Λ.	1	201 00

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

10, 442, 518

93. 00 98. 00 2, 925, 738 200. 00 201. 00 202. 00

201.00 202.00 Health Financial Systems

Community Health Rehab Hospital South

In Lieu of Form CMS-2552-10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-3044

Period:
From 01/01/2022
To 12/31/2022

To 12/31/2022

To 12/31/2022

Part I
Date/Time Prepared:
5/16/2023 12:57 pm

Inpatient Part A

Part B

Inpatient Part A

Part B

mm/dd/yyyy Amount

mm/dd/yyyy Amount

		Title	XVIII	Hospi tal	PPS	
		Inpatien	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		11, 068, 507		0	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					ļ
	Program to Provider		_		_	
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program		1			
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
4 00	3. 50-3. 98)		44 0/0 507			4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		11, 068, 507		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TEMMINE TO THOMBEN		0		Ö	5. 02
5. 03			0		Ö	
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		58, 175		0	6. 01
6.02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		11, 126, 682		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	IN 60 1	()	1. 00	2. 00	0.00
8. 00	Name of Contractor					8. 00

Health Financial Systems	Community Health Rehab	Hospi tal South	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3044	Peri od:	Worksheet E-3

To 12/31/2022 Date/Time Prepared:

0.000000

0.000000 99.01

99 00

5/16/2023 12:57 pm Title XVIII Hospi tal PPS 1.00 PART III - MEDICARE PART A SERVICES - IRF PPS 10, 993, 746 Net Federal PPS Payment (see instructions) 1.00 Medicare SSI ratio (IRF PPS only) (see instructions) 0.0240 2.00 2.00 Inpatient Rehabilitation LIP Payments (see instructions) 474.930 3.00 3.00 4.00 Outlier Payments 12,570 4.00 5.00 Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior 0.00 5.00 to November 15, 2004 (see instructions) Cap increases for the unweighted intern and resident FTE count for residents that were displaced by 5.01 0.00 5. 01 program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) New Teaching program adjustment. (see instructions) 6.00 0.00 6.00 7.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new 0.00 7.00 teaching program" (see instructions) 0 00 8 00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new 8 00 teaching program" (see instructions) 9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 0.00 9 00 10.00 Average Daily Census (see instructions) 31.649315 10.00 Teaching Adjustment Factor (see instructions) 0.000000 11.00 11.00 12.00 Teaching Adjustment (see instructions) 12.00 13.00 Total PPS Payment (see instructions) 11, 481, 246 13.00 14.00 Nursing and Allied Health Managed Care payments (see instruction) 14.00 Ω 15.00 Organ acquisition (DO NOT USE THIS LINE) 15.00 16.00 Cost of physicians' services in a teaching hospital (see instructions) 16.00 11, 481, 246 17.00 Subtotal (see instructions) 17.00 18.00 Primary payer payments 39, 032 18.00 19.00 Subtotal (line 17 less line 18). 11, 442, 214 19 00 20.00 Deducti bl es 139, 824 20.00 21.00 Subtotal (line 19 minus line 20) 11, 302, 390 21.00 22.00 Coi nsurance 55 238 22.00 23.00 Subtotal (line 21 minus line 22) 11, 247, 152 23.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 33, 102 24.00 24.00 25.00 Adjusted reimbursable bad debts (see instructions) 21, 516 25.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 26 00 10,820 26 00 27.00 Subtotal (sum of lines 23 and 25) 11, 268, 668 27.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 28.00 28.00 0 29.00 Other pass through costs (see instructions) 29.00 30 00 Outlier payments reconciliation 30.00 0 31.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 31.00 31.50 Pioneer ACO demonstration payment adjustment (see instructions) 31.50 Recovery of accelerated depreciation. 31.98 31.98 0 ${\tt Demonstration}\ \ {\tt payment}\ \ {\tt adjustment}\ \ {\tt amount}\ \ {\tt before}\ \ {\tt sequestration}$ 31 99 0 31 99 Total amount payable to the provider (see instructions) 32.00 11, 268, 668 32.00 32.01 Sequestration adjustment (see instructions) 141, 986 32.01 32.02 32.02 Demonstration payment adjustment amount after sequestration 33.00 Interim payments 11, 068, 507 33 00 34.00 Tentative settlement (for contractor use only) 34.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 35.00 58, 175 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 36.00 0 36.00 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 12, 570 50.00 Outlier reconciliation adjustment amount (see instructions) 51.00 0 51.00 52.00 The rate used to calculate the Time Value of Money 0.00 52.00 Time Value of Money (see instructions) 53.00 53.00 0 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE

Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.

Calculated Teaching Adjustment Factor for the current year. (see instructions)

99 00

99.01

Health Financial Systems	Community Health Rehab	Hospital South	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-3044	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part IV Date/Time Prepared: 5/16/2023 12:57 pm

			To 12/31/2022	Date/Time Pre 5/16/2023 12:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)			0	1.00
1.01	Full standard payment amount			0	1. 01
1.02	Short stay outlier standard payment amount			0	1. 02
1.03	Site neutral payment amount - Cost			0	1. 03
1.04	Site neutral payment amount - IPPS comparable			0	1. 04
2.00	Outlier Payments			0	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)	`		0	3.00
4.00	Nursing and Allied Health Managed Care payments (see instruction	ons)		0	4. 00
5.00	Organ acquisition (DO NOT USE THIS LINE)			0	5. 00
6.00	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	6.00
7.00	Subtotal (see instructions)				7. 00
8.00	Primary payer payments			0	8. 00 9. 00
9.00	Subtotal (line 7 less line 8).				
10.00	Deductibles			0	10.00
11.00	Subtotal (line 9 minus line 10)			0	11.00
12.00	Coinsurance			0	12.00
13. 00 14. 00	Subtotal (line 11 minus line 12) Allowable bad debts (exclude bad debts for professional service	os) (soo instructions)		0	13. 00 14. 00
		es) (see mistructions,	'	0	15. 00
15. 00 16. 00	, , , , , , , , , , , , , , , , , , , ,	usti ons)		0	16. 00
17. 00	Subtotal (sum of lines 13 and 15)	uctions)		0	17. 00
18. 00	Direct graduate medical education payments (from Wkst. E-4, li	20 40)		0	18.00
19. 00	Other pass through costs (see instructions)	116 49)		0	19.00
20. 00	Outlier payments reconciliation			0	20.00
21. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	21.50
21. 98	Recovery of accelerated depreciation.	,		0	21. 98
21. 99	1			0	21. 99
22. 00	Total amount payable to the provider (see instructions)			0	22. 00
22. 01	Sequestration adjustment (see instructions)			0	22. 01
22. 02				0	22. 02
23. 00				0	23. 00
24. 00	Tentative settlement (for contractor use only)			0	24. 00
25. 00		. 23 and 24)		0	25. 00
26. 00	Protested amounts (nonallowable cost report items) in accordance		chapter 1.	0	26. 00
	§115. 2		' '		
	TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see ins	tructions)		0	50. 00
51.00	Outlier reconciliation adjustment amount (see instructions)			0	51.00
52. 00	1	ctions)		0.00	52. 00
53. 00	Time Value of Money (see instructions)			0	53. 00

Community Health Rehab Hospital South			In Lieu of Form CMS-2552-10			
Т		Provider CCN: 15-3044	Peri od:	Worksheet E-3		

	Financial Systems Community Health Rehab Hos	•		u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT Pro	ovider CCN: 15-3044	Peri od: From 01/01/2022	Worksheet E-3 Part VII	
			To 12/31/2022	Date/Time Pre	pared:
		T' II VIV		5/16/2023 12:	57 pm
		Title XIX	Hospi tal Inpati ent	Cost	
			1. 00	Outpati ent 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	ES FOR TITLES V OR X		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		50, 722	_	1. 00
2.00	Medical and other services			0	2.00
3. 00 4. 00	Organ acquisition (certified transplant programs only) Subtotal (sum of lines 1, 2 and 3)		0 50, 722	0	3. 00 4. 00
5. 00	Inpatient primary payer payments		50, 722	U	5. 00
6. 00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		50, 722	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges		1		
8. 00 9. 00	Routi ne servi ce charges		0	0	8. 00
10.00	Ancillary service charges Organ acquisition charges, net of revenue		0	U	9. 00 10. 00
11. 00	Incentive from target amount computation		o		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		o	0	
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for se	rvices on a charge	0	0	13. 00
14 00	basis	umant for condices o	_	0	14.00
14. 00	Amounts that would have been realized from patients liable for pa a charge basis had such payment been made in accordance with 42 C		n 0	0	14. 00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	110 3415. 15(0)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		0	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only i	f line 16 exceeds	0	0	17. 00
10.00	line 4) (see instructions)	61: 4	F0 700		10.00
18. 00	Excess of reasonable cost over customary charges (complete only i 16) (see instructions)	r iine 4 exceeds iin	e 50, 722	0	18. 00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instruct	i ons)	o	0	•
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	pleted for PPS provi			
22. 00	Other than outlier payments		0	0	•
23. 00 24. 00	Outlier payments Program capital payments		0	U	23. 00 24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		o	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
30. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		50, 722	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32. 00	Deductibles		ő	0	1
33.00	Coi nsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	•
35. 00	Utilization review		0	_	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36. 00
37. 00 37. 01				37. 00 37. 01	
38. 00				38.00	
39. 00	· · · · · · · · · · · · · · · · · · ·			39. 00	
40.00	0 Total amount payable to the provider (sum of lines 38 and 39) 0 0			40. 00	
41. 00				41. 00	
42.00				1	
43. 00	00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 chapter 1, §115.2			43. 00	
	Jonaptor 1, \$110.2		1		I

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

Provider CCN: 15-3044

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/16/2023 12:57 pm

——————————————————————————————————————					5/16/2023 12:	57 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	LOUDDEUT AGGETG	1. 00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	1, 936, 192	0	0	0	1.00
2. 00	Temporary investments	1, 730, 172	0	_		
3.00	Notes recei vabl e	0	Ö	_	ő	3. 00
4.00	Accounts receivable	3, 609, 261	0	0	0	4. 00
5.00	Other recei vabl e	-19, 323	1	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-541, 783	1	0	0	6. 00
7.00	Inventory	132, 533		0	0	
8. 00 9. 00	Prepaid expenses Other current assets	201, 833	0	0	0	
10.00	Due from other funds		0	_	0	10.00
11. 00	Total current assets (sum of lines 1-10)	5, 318, 713				11.00
	FIXED ASSETS			-		
12.00	Land	0	0	0	0	12. 00
13. 00	Land improvements	0	0	_		13. 00
14. 00	Accumulated depreciation	0	0	_	_	14. 00
15. 00	Buildings	0	0	0		15.00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	558, 498	0	0	0	16. 00 17. 00
18. 00	Accumulated depreciation	-212, 015	1	_	0	18.00
19. 00	Fi xed equipment	0	Ö	_	ő	19. 00
20. 00	Accumul ated depreciation	0	Ō	_	ō	20.00
21.00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	2, 042, 130	1	0	0	23. 00
24. 00	Accumulated depreciation	-988, 945	i	_	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	_	0	25. 00
26. 00 27. 00	Accumulated depreciation HIT designated Assets	0	0	0	0	26. 00 27. 00
28. 00	Accumulated depreciation		0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e		Ö	_		29. 00
30.00	Total fixed assets (sum of lines 12-29)	1, 399, 668	0	0	0	30.00
	OTHER ASSETS					
31. 00	Investments	0	0	_	_	1
32. 00	Deposits on Leases	16, 395	1	_	_	32.00
33.00	Due from owners/officers	10 1/5 100	0	_	0	33.00
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	12, 165, 190 12, 181, 585	1		0	34. 00 35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	18, 899, 966	1	_		36.00
00.00	CURRENT LIABILITIES	10/0////				00.00
37.00	Accounts payable	1, 287, 639	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	337, 110	1	0	_	38. 00
39. 00	Payroll taxes payable	109, 911	1	0	0	1
40. 00	Notes and loans payable (short term)	0	0	0	0	40.00
41. 00 42. 00	Deferred income Accelerated payments	0	U	0	0	41. 00 42. 00
43.00	Due to other funds		0	0	0	43.00
44. 00	Other current liabilities	962, 892	Ö	0	ő	
45.00	Total current liabilities (sum of lines 37 thru 44)	2, 697, 552	1	0		1
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0	_	_	
47. 00	Notes payable	0	0	_	_	
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	12, 309, 555	0	_		48. 00 49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12, 309, 555	1	_		50.00
51. 00	Total liabilities (sum of lines 45 and 50)	15, 007, 107	1			51.00
	CAPITAL ACCOUNTS		-			
52.00	General fund balance	3, 892, 859				52. 00
53.00	Specific purpose fund		0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0	1	56.00
57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0 0	57. 00 58. 00
50.00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	3, 892, 859	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	18, 899, 966	1	0	0	60. 00
	[59]	1			l	l

Health Financial Systems

Community Health Rehab Hospital South

In Lieu of Form CMS-2552-10

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-3044

Period:
From 01/01/2022
To 12/31/2022
To 1

		1.00	2.00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		4, 013, 172		0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5, 939, 443				2.00
3.00	Total (sum of line 1 and line 2)		9, 952, 615		o		3.00
4.00	Additions (credit adjustments)	0		0		0	•
5. 00	INTERCOMPANY TRANSFERS\ROUNDING	0		0		0	
6. 00	THE ROOM AND TRANSPERS TROOMED NO	0				0	
7. 00				0		0	1
8. 00		0		0		0	
		0		U		_	•
9.00	T	0		0		0	
10. 00	Total additions (sum of line 4-9)		0		0		10. 00
11. 00	Subtotal (line 3 plus line 10)		9, 952, 615		0		11. 00
12.00	Deductions (debit adjustments)	0		0		0	12. 00
13.00	INTERCOMPANY TRANSFERS\ROUNDING	6, 059, 756		0		0	13.00
14.00		0		0		0	14. 00
15.00		0		0		0	15. 00
16.00		0		0		0	16. 00
17. 00		0		Ö		0	•
18. 00	Total deductions (sum of lines 12-17)	Ĭ	6, 059, 756		0		18. 00
19. 00	Fund balance at end of period per balance		3, 892, 859		0		19. 00
17.00	sheet (line 11 minus line 18)		3,072,037		Ŭ		19.00
	Islicet (Trie II illinius Trie 10)	Endowment Fund	PI ant	Fund			
		Litaowilletti Taria	TTant	Turiu			
		6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0		0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments)	1	0	-			4. 00
5. 00	INTERCOMPANY TRANSFERS\ROUNDING		o o				5. 00
6. 00	THE ROOM ANT TRANSPERS (ROOM) NO		0				6. 00
7. 00			0				7. 00
		4	0				8.00
8.00			0				
9.00			U				9. 00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11. 00	Subtotal (line 3 plus line 10)	0		0			11. 00
12.00	Deductions (debit adjustments)		0				12. 00
13.00	INTERCOMPANY TRANSFERS\ROUNDING		0				13. 00
14.00			0				14. 00
15.00			0				15. 00
16.00			0				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	0		0			19.00
	sheet (line 11 minus line 18)						''' "
	12 (1	1	1			'

Heal th FinancialSystemsCommunity Heal th RehabHospitalSouthSTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSESProvider CCN: 15-3044

			Го 12/31/2022	Date/Time Prep 5/16/2023 12:	
	Cost Center Description	I npati ent	Outpati ent	Total	or pili
	<u> </u>	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	21, 441, 54	1	21, 441, 544	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF		1	0	5. 00
6.00	Swing bed - NF	1		0	6. 00
7. 00	SKILLED NURSING FACILITY	(0	7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	21, 441, 54	1	21, 441, 544	10. 00
44 00	Intensive Care Type Inpatient Hospital Services			0	44 00
11.00	INTENSIVE CARE UNIT	1		0	11. 00
12.00	CORONARY CARE UNIT				12. 00
13.00	BURN INTENSIVE CARE UNIT				13.00
14. 00 15. 00	SURGICAL INTENSIVE CARE UNIT				14. 00 15. 00
16. 00	OTHER SPECIAL CARE (SPECIFY)			0	16. 00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	·		U	16.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	21, 441, 54	1	21, 441, 544	17. 00
18. 00	Ancillary services	22, 534, 59		22, 534, 597	18. 00
19. 00	Outpatient services	22, 334, 37		22, 334, 347	19. 00
20. 00	RURAL HEALTH CLINIC			Ö	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			Ö	21. 00
22. 00	HOME HEALTH AGENCY	·		o l	22. 00
23. 00	AMBULANCE SERVICES	1		0	23. 00
24. 00	CMHC			· ·	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)		ol	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	43, 976, 14	ı o	43, 976, 141	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		17, 987, 724		29. 00
30.00	ADD (SPECIFY)				30.00
31.00					31. 00
32.00					32.00
33. 00					33. 00
34.00					34. 00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00					38. 00
39. 00		1			39. 00
40.00		1			40.00
41. 00	T	1	기 _		41.00
42. 00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		17, 987, 724		43. 00
	to Wkst. G-3, line 4)	1	1		

olth Financial Systems	Community Health Rehab	Hospital South	In Lie	u of Form CMS-2552-10
ATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-3044	Peri od:	Worksheet G-3

Heal th	Financial Systems Community Health Rehab Hospital	South	In Lie	eu of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES Provider	CCN: 15-3044	Peri od:	Worksheet G-3	
			From 01/01/2022		
			To 12/31/2022		
				5/16/2023 12:	o / pili
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			43, 976, 141	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			20, 052, 996	2.00
3.00	Net patient revenues (line 1 minus line 2)			23, 923, 145	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			17, 987, 724	4.00
5.00	Net income from service to patients (line 3 minus line 4)			5, 935, 421	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			10, 497	7. 00
8.00	Revenues from telephone and other miscellaneous communication services			0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10. 00	Purchase di scounts			0	10.00
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			16, 888	
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to other than patient	ts		0	16. 00
	Revenue from sale of drugs to other than patients			0	17. 00
	Revenue from sale of medical records and abstracts			124	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
	Rental of vending machines			0	
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24.00	MI SCELLANEOUS I NCOME			13, 692	24.00
24. 50	COVI D-19 PHE Fundi ng			-37, 179	24. 50
25.00	Total other income (sum of lines 6-24)			4, 022	
	Total (line 5 plus line 25)			5, 939, 443	26. 00
	OTHER EXPENSES			0	27. 00
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			5, 939, 443	29. 00