(5) Amended

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-3043 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/12/2023 10:47 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: Ti me: use only] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Community Health Network Rehab Hosp (15-3043) 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		
		1	2	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	CE0			3
4	Date				4

			Title XVIII				
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	8, 005	0	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2. 00
3.00	SUBPROVIDER - IRF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
200.00	TOTAL	0	8, 005	0	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 674 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-3043 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/12/2023 10:47 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 7343 Clearvista Drive PO Box: 1.00 State: IN 2.00 City: Indianapolis Zip Code: 46256 County: Marion 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 153043 26900 5 07/16/2013 N 0 3.00 Community Health Network Rehab Hosp 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.

Heal th	Financial Systems Community He	ealth Netwo	rk Rehab Ho	sp		In Lieu	u of For	m CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC			1/2022	Part I Date/Ti 5/12/20	023 10:	pared:
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	ys Med	ther di cai d days	
		1.00	2. 00	3. 00	4. 00	5. 00		5. 00	
24. 0025. 00	If this provider is an IPPS hospital, enter the 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. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state				0	1,	860	0	24. 00
	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/Ru		Date of 2.		-
26. 00	Enter your standard geographic classification (not w		at the beg	ginning of t		1	2.	<u> </u>	26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	age) status r "2" for r	ural. If ap		t	1			27. 00
35. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35.00
	errect in the cost reporting perrou.				Begi nn		Endi		
36. 00	Enter applicable beginning and ending dates of SCH s	tatus. Subs	cript line	36 for numb	1.0	00	2.	00	36.00
	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), ente	es.	·			0			37.00
37. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f								37. 01
38. 00	instructions) If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.								38.00
					Y/I		Υ/		
39. 00	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent	ter in colum nts in	ın		2. I		39.00
40. 00	Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	r "Y" for y				N	I	40.00
	ino in condinin 2, nor discharges on or arter october i	. (See Hist	ructrons)			V	XVIII		
	Prospective Payment System (PPS)-Capital					1.00	2. 00	3.00	
45. 00	Does this facility qualify and receive Capital payme	nt for disp	roporti onat	te share in	accordance	N	N	N	45. 00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					N	N	N	46.00
47. 00 48. 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals					N N	N N	N N	47. 00 48. 00
56.00	Is this a hospital's Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to c involved in training residents in approved GME progr	"Y ["] for yes r 27, 2020, olumn 1 is	or "N" for under 42 ("Y", or if	no in colu CFR 413.78(b this hospit	mn 1. For)(2), see al was	N			56.00
57. 00	and are you are impacted by CR 11642 (or applicable "Y" for yes; otherwise, enter "N" for no in column 2 For cost reporting periods beginning prior to Decemb is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no i residents start training in the first month of this "N" for no in column 2. If column 2 is "Y", complet complete Wkst. D, Parts III & IV and D-2, Pt. II, if	CRs) MA dir er 27, 2020 residents n column 1. cost report e Worksheet	ect GME pay , if line 5 in approvec If column ing period? E-4. If co	men't reduct 66, column 1 d GME progra 1 is "Y", d P Enter "Y" blumn 2 is " reporting p	ion? Enter , is yes, ms trained id for yes or N", eriods				57.00
58. 00	beginning on or after December 27, 2020, under 42 CF which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not compl If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	on duty, i ete column bursement f	f the respo 2, and comp or physicia	onse to line olete Worksh	56 is "Y" eet E-4.				58. 00

From 01/01/2022 Date/Time Prepared: 12/31/2022 5/12/2023 10: 47 am XVIII XIX 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2 IMF Direct GME IME Direct GME 1. 00 2. 00 3. 00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA Ν 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61 03 Enter the base line FTE count for primary care 61 03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 2.00 1.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00

Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)

column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

				Site					
		1. 00	2. 00	3. 00	4.00)	5. (00	1
68. 00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?								68. 00
						1.00	2. 00	3.00	
	Inpatient Psychiatric Facility							T	ļ
70. 00			PF), or does it conta	ain an IPF subp	provi der?	N			70.00
71. 00	Enter "Y" for yes or "N" for no If line 70 is yes: Column 1: Did		approved CME teaching	na program in t	the most	1		0	71.00
71.00	recent cost report filed on or I							0	/1.00
	42 CFR 412. 424(d)(1)(iii)(c)) Co								
	program in accordance with 42 CI								
	Column 3: If column 2 is Y, indi								
	(see instructions)	. eare e. p. eg. a ye	sa. Bogan aag tii o	ooot roportrii	, por . ou.				
	Inpatient Rehabilitation Facili	tv PPS							1
75. 00			(IRF), or does it co	ontain an IRF		Υ			75. 00
	subprovider? Enter "Y" for yes		, , , , ,						
76.00		d the facility have ar	n approved GME teachi	ng program in t	the most	N	N	0	76. 00
	recent cost reporting period end								
	no. Column 2: Did this facility								
	CFR 412.424 (d)(1)(iii)(D)? Ente								
	indicate which program year bega	<u>an during this cost re</u>	eporting period. (see	instructions)		<u> </u>			
						-	1 /	20	-
	Long Term Care Hospital PPS						1. (JU	
80. 00	-	al (ITCH)2 Enter "V"	for was and "N" for I	no			N	I	80.00
	Is this a LTCH co-located within				neriod? E	nter	, ,		81.00
01.00	"Y" for yes and "N" for no.	another hospital for	part of arr or the	cost reporting	perrou. E	11101		•	01.00
	TEFRA Provi ders								1
85.00	Is this a new hospital under 42	CFR Section §413.40(f	f)(1)(i) TEFRA? Ente	r "Y" for yes o	or "N" for	no.	N	I	85. 00
86.00				42 CFR Section	า				86. 00
	§413.40(f)(1)(ii)? Enter "Y" for								
87. 00		oplastic disease care	hospital classified u	under section			N	I	87. 00
	1886(d)(1)(B)(vi)? Enter "Y" for	r yes or "N" for no.				ı e	Ni sasta a		
					Approved Permane		Numbe Appro		
					Adjustm		Perma		
					(Y/N)		Adjust		
					1.00		2. (1
88. 00	Column 1: Is this hospital appro	oved for a permanent a	adjustment to the TEF	RA target	1. 55			0	88. 00
	amount per discharge? Enter "Y"	for yes or "N" for no	o. If yes, complete co	ol. 2 and line					
	89. (see instructions)								
	Column 2: Enter the number of a	oproved permanent adju	ustments.	1		_			
				Wkst. A Line	Effecti ve	Date	Appro		
				No.			Perma		
							Adj us		
							Amoun ⁻ Disch		
				1. 00	2.00)	3. (-
89. 00	Column 1: If line 88, column 1 i	is V enter the Worksh	neet A line number	0.00		,	3. (0	89.00
69.00	on which the per discharge perma	anent adjustment annro	oval was hased	0.00	1			U	09.00
	Column 2: Enter the effective da								
	beginning date) for the permaner								
	per di scharge.		3						
	Column 3: Enter the amount of the	he approved permanent	adjustment to the						
	TEFRA target amount per discharg	ge.							

Community Health Netwo	ork Rehab Hosp	In Lieu of Form CMS-2552-10

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Network Rehab Ho	CN: 15-3043	Period: From 01/01/2022 To 12/31/2022	Worksheet S- Part I Date/Time Pr 5/12/2023 10	epared:
			1. 00	XI X 2. 00	
Title V and XIX Services			1.00	2.00	
.00 Does this facility have title V and/or XIX inpatient hosp	ital services? E	nter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column. .00 Is this hospital reimbursed for title V and/or XIX throug full or in part? Enter "Y" for yes or "N" for no in the a			N	N	91. 00
.00 Are title XIX NF patients occupying title XVIII SNF beds instructions) Enter "Y" for yes or "N" for no in the appl	(dual certificat			N	92.00
P3.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.				N	93. 00
.00 Does title V or XIX reduce capital cost? Enter "Y" for ye applicable column.	N	N	94.00		
.00 If line 94 is "Y", enter the reduction percentage in the			0.00	0.00	95.00
.00 Does title V or XIX reduce operating cost? Enter "Y" for applicable column.	yes or "N" for n	o in the	N	N	96. 00
.00 If line 96 is "Y", enter the reduction percentage in the	applicable colum	n.	0. 00	0.00	97. 00
.00 Does title V or XIX follow Medicare (title XVIII) for the stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00		
Old Does title V or XIX follow Medicare (title XVIII) for the C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.	. Y	Y	98. 01		
B. 02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.				Y	98. 02
.03 Does title V or XIX follow Medicare (title XVIII) for a c reimbursed 101% of inpatient services cost? Enter "Y" for for title V, and in column 2 for title XIX.			N 1	N	98. 03
.04 Does title V or XIX follow Medicare (title XVIII) for a Coutpatient services cost? Enter "Y" for yes or "N" for no			N	N	98. 04
in column 2 for title XIX. .05 Does title V or XIX follow Medicare (title XVIII) and add Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no i				Υ	98. 05
column 2 for title XIX. 18.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.				Y	98. 06
Rural Providers				1	
5.00 Does this hospital qualify as a CAH? 6.00 If this facility qualifies as a CAH, has it elected the a for outpatient services? (see instructions)	II-inclusive met	hod of paymen	t		105. 00
7.00 Column 1: If line 105 is Y, is this facility eligible for training programs? Enter "Y" for yes or "N" for no in col Column 2: If column 1 is Y and line 70 or line 75 is Y, approved medical education program in the CAH's excluded	umn 1. (see ins do you train I&R	tructions) s in an			107.00
Enter "Y" for yes or "N" for no in column 2. (see instru 8.00 is this a rural hospital qualifying for an exception to t CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 42	N		108. 00
101 N 300 CT OH 3712. 113(0). LINCOL 1 101 YES OF N 101 110.	Physi cal	Occupati ona	I Speech	Respi ratory	
	1.00	2. 00	3.00	4.00	
9.00 If this hospital qualifies as a CAH or a cost provider, a therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	re N	N	N	N	109. 00
				1.00	
0.00 Did this hospital participate in the Rural Community Hosp Demonstration) for the current cost reporting period? Ente complete Worksheet E, Part A, lines 200 through 218, and applicable.	r "Y" for yes or	"N" for no.	lf yes,	N	110.00
			1.00	2.00	
1.00 f this facility qualifies as a CAH, did it participate i Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to	cost reporting	period? Enter	1. 00 N	2.00	111.00

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC		Period: From 01/01/2022	Worksheet S	S-2
			To 12/31/2022	Date/Time F 5/12/2023 1	
					10. 47
2.00 Did this hospital participate in the Pennsylvania Rural Heal	th Model	1. 00 N	2. 00	3. 00	112
(PARHM) demonstration for any portion of the current cost re	eporti ng				
period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began partici;					
demonstration. In column 3, enter the date the hospital cea					
participation in the demonstration, if applicable.					
3.00 Did this hospital participate in the Community Health Access					113
Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no.	COST				
Miscellaneous Cost Reporting Information					
5.00 s this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N			0 11!
in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "G					
for short term hospital or "98" percent for long term care					
psychiatric, rehabilitation and long term hospitals provider	rs) based on				
the definition in CMS Pub.15-1, chapter 22, §2208.1. 5.00 Is this facility classified as a referral center? Enter "Y"	for yes or	l N			11
"N" for no.	Tor yes or	IN IN			' '
7.00 Is this facility legally-required to carry malpractice insur	ance? Enter	Y			11
"Y" for yes or "N" for no.	. 0.5.1.4				1.0
3.00 Is the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurrence.			1		111
The port of the starm made. Enter 2 in the port of the seeds.	0.1001	Premi ums	Losses	Insurance	
		1. 00	2.00	3.00	
3.01 List amounts of malpractice premiums and paid losses:		188, 55	7 0		0 11
			1. 00	2.00	
3.02 Are malpractice premiums and paid losses reported in a cost	center other t	han the	N N	2.00	11
Administrative and General? If yes, submit supporting sched					
and amounts contained therein.					111
9.00 DO NOT USE THIS LINE).00 Is this a SCH or EACH that qualifies for the Outpatient Hold	Harmless nrow	vision in ACA	N	N	119
§3121 and applicable amendments? (see instructions) Enter in			14		'2'
"N" for no. Is this a rural hospital with < 100 beds that qu	ualifies for th	ne Outpatient			
Hold Harmless provision in ACA §3121 and applicable amendmen	nts? (see instr	ructions)			
Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla	antable devices	charged to	N		12
patients? Enter "Y" for yes or "N" for no.		g			
2.00 Does the cost report contain healthcare related taxes as det			N		12
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.	i is "Y", enter	r in column 2			
3.00 Did the facility and/or its subproviders (if applicable) pur	chase professi	onal			12
services, e.g., legal, accounting, tax preparation, bookkeep	oing, payroll,	and/or			
management/consulting services, from an unrelated organizati	on? In column	1, enter "Y"			
for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e.,	greater than	50% of total			
professional services expenses, for services purchased from					
located in a CBSA outside of the main hospital CBSA? In colu	umn 2, enter "Y	" for yes or			
"N" for no. Certified Transplant Center Information					
5.00 Does this facility operate a Medicare-certified transplant	center? Enter "	Y" for yes	N		12
and "N" for no. If yes, enter certification date(s) (mm/dd/y		,			
5.00 f this is a Medicare-certified kidney transplant program,		fication date			12
in column 1 and termination date, if applicable, in column 2 7.00 If this is a Medicare-certified heart transplant program, er	nter the certif	ication date			12
in column 1 and termination date, if applicable, in column 2	2.				
3.00 If this is a Medicare-certified liver transplant program, en		ication date			12
in column 1 and termination date, if applicable, in column 2 2.00 If this is a Medicare-certified lung transplant program, en	ter the certifi	cation date			12
in column 1 and termination date, if applicable, in column 2	2.				
0.00 If this is a Medicare-certified pancreas transplant program,		ti fi cati on			13
date in column 1 and termination date, if applicable, in col 1.00 f this is a Medicare-certified intestinal transplant progra		erti fi cati on			13
date in column 1 and termination date, if applicable, in col	umn 2.				
2.00 If this is a Medicare-certified islet transplant program, er		ication date			13
in column 1 and termination date, if applicable, in column 2 3.00Removed and reserved	<u>.</u>				13
a.oo Reliioved and reserved 4.00 If this is a hospital-based organ procurement organization ((OPO), enter th	ne OPO number			13
in column 1 and termination date, if applicable, in column 2					
All Providers		Dub 15 1	\/	LIDO/1/	
	defined in CMS		Y	HB0616	14

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-3043 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/12/2023 10:47 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 OO Name: LIFFPLONT HEALTH Contractor's Name: PALMETTOA GBA Contractor's Number: 10001 141 00 142.00 Street: 330 SEVEN SPRINGS WAY PO Box: 142.00 143.00 Ci ty: BRENTWOOD 37027 143. 00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 γ 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no 147. 00 Ν N 148 00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no N 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 Ν N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν 159. 00 Ν 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 0.00 166.01 166.01 166. 02 0.00 166.02 0.00 166.03 166.03 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167.00 168.00| If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions) Endi ng Begi nni ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170. 00 period respectively (mm/dd/yyyy) 1.00 2.00 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in Ν 0 171. 00 section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-3043	Peri od: From 01/01/2022		
				To 12/31/2022	Date/Time Pro 5/12/2023 10:	
				Y/N	Date	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEN	MENT OUESTIONN	IAI RF	1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N			er all dates in	the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the			N		1.
	reporting period? If yes, enter the date of the change in co	olumn 2. (see	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.		N			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	ffices, drug	Y			3.
	officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	f 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 Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.				03/31/2023	4.
00	Are the cost report total expenses and total revenues differentiations on the filed financial statements? If yes, submit reco		N			5.
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities				2.00	
00	Column 1: Are costs claimed for a nursing program? Column 2 the legal operator of the program?	2: If yes, is	the provide	r N		6.
00 00	Are costs claimed for Allied Health Programs? If "Y" see in: Were nursing programs and/or allied health programs approved	e N		7. 8.		
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved (graduate medio	cal education	N		9.
0. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		the current	N		10.
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	V/AI	11.
					1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	Y N	12. 13.
4. 00	If line 12 is yes, were patient deductibles and/or coinsurar instructions. Bed Complement	nce amounts wa	nived? If yes	, see	N	14.
5. 00	Did total beds available change from the prior cost reporting	ng period? If	yes, see ins		N	15.
			T A	Par Y/N	t B	
		Y/N 1.00	2. 00	3.00	Date 4.00	
0.5	PS&R Data					1
. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	02/28/2023	Y	02/28/2023	16.
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.
3. 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	N		N		18.
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19.

Heal th	Financial Systems Community Health No	etwork Rehab Ho	osp	In Lie	u of Form CMS-:	2552-10	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-3043	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pre 5/12/2023 10:	pared:	
			pti on	Y/N	Y/N		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00	
20.00	Report data for Other? Describe the other adjustments:			IN	IV	20.00	
		Y/N	Date	Y/N	Date		
21. 00	Was the cost report prepared only using the provider's	1. 00 N	2. 00	3. 00 N	4. 00	21. 00	
	records? If yes, see instructions.	.,				21.00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)				
22. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	e instructions				22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense		als made duri	ng the cost		23. 00	
	reporting period? If yes, see instructions.						
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	eu into during	ınıs cost rep	porting period?		24. 00	
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see		25. 00	
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost renorti	na period? If	f ves see		26. 00	
	instructions.	·	0 .				
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportir	g period? If	yes, submit		27. 00	
	Interest Expense						
28. 00	Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.	ntered into dur	ing the cost	reporti ng		28. 00	
29. 00							
20.00	treated as a funded depreciation account? If yes, see instr		dobt2 lf vos	500		20.00	
30. 00	Has existing debt been replaced prior to its scheduled maturinstructions.	irity with new	debt? IT yes,	See		30.00	
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes,	see		31. 00	
	Purchased Services						
32. 00			d through cor	ntractual		32. 00	
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app	uctions. Dijed pertainir	a to competii	tive biddina? If		33. 00	
	no, see instructions.						
34. 00	Provider-Based Physicians Were services furnished at the provider facility under an a	arrangomont wit	h providor ba	seed physicians?		34.00	
34.00	If yes, see instructions.	irrangement wrt	ii provider-ba	aseu priysi ci aris:		34.00	
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		its with the p	provi der-based		35. 00	
	The second secon	.511 4511 51151		Y/N	Date		
	Home Office Costs			1. 00	2. 00		
36. 00	Were home office costs claimed on the cost report?			Y		36. 00	
37. 00	If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	Y		37. 00	
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off	ice different	from that of	N		38. 00	
	the provider? If yes, enter in column 2 the fiscal year end	d of the home o	ffi ce.				
39. 00	If line 36 is yes, did the provider render services to other see instructions.	er chain compor	ents? If yes,	N		39. 00	
40. 00	If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40. 00	
	i nstructi ons.						
	1.00 2.						
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	DAVI D		SIMPSON		41.00	
41.00	held by the cost report preparer in columns 1, 2, and 3,	DVAI D		ST WE SON		41.00	
42. 00	respectively. Enter the employer/company name of the cost report	LIFEPOINT HEAL	TH			42. 00	
43. 00	preparer. Enter the telephone number and email address of the cost	5025967945		DAVI D. SI MPSON@I	I FEPOI NTHEALT	43. 00	
10.00	report preparer in columns 1 and 2, respectively.	5520,0,,,,		H. NET	L L. OIMINEALI	13. 55	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-3043 Period: From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared: 5/12/2023 10: 47 am	Health Financial Systems Community Health			twork Rehab Ho	osp		In Lie	u of Form CMS	-2552-10
	HOSPI	FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT Q	QUESTI ONNAI RE	Provider C		From 01/0		Part II Date/Time Pr	epared:
2.00					00				
3.00				3.	00				
Cost Report Preparer Contact Information		Cost Report Preparer Contact Information							
41.00 Enter the first name, last name and the title/position REIMBURSEMENT MANAGER 41.00	41.00	Enter the first name, last name and the ti	tle/position F	REIMBURSEMENT	MANAGER				41. 00
held by the cost report preparer in columns 1, 2, and 3,		held by the cost report preparer in columns	ns 1, 2, and 3,						
respecti vel y.		respecti vel y.							
42.00 Enter the employer/company name of the cost report 42.00	42.00	Enter the employer/company name of the cos	st report						42. 00
preparer.		preparer.							
43.00 Enter the telephone number and email address of the cost	43.00	Enter the telephone number and email address	ess of the cost						43.00
report preparer in columns 1 and 2, respectively.		report preparer in columns 1 and 2, respec	cti vel y.						

		To 12/31/2022 Date/Time Pre	
		5/12/2023 10:	47 am
		1.00	
	Cost Report Preparer Contact Information	DAM D	
1.00	First Name	DAVI D	1.00
2.00	Last Name	SIMPSON	2. 00
3.00	Ti tl e	REIMBURSEMENT MANAGER	3. 00
4.00	Empl oyer	LI FEPOI NT HEALTH	4. 00
5.00	Phone Number	(502) 596-7945	5. 00
6.00	E-mail Address	DAVI D. SI MPSON@LI FEPOI NTHEALT	6. 00
		H. NET	
7. 00	Department	REI MBURSEMENT	7. 00
8.00	Mailing Address 1	680 SOUTH FOURTH STREET	8. 00
9.00	Mailing Address 2	ATTN: REIMBURSEMENT	9. 00
10.00	Ci ty	LOUI SVI LLE	10. 00
11. 00	State	KY	
12.00	Zi p	40202	12. 00
	Officer or Administrator of Provider Contact Information		
13.00	First Name	ANNETTE	13. 00
14.00	Last Name	SEABROOK SEABROOK	14. 00
15.00	Ti tl e	CEO	15. 00
16.00	Empl oyer		16. 00
17.00	Phone Number	(317) 585-5401	17. 00
18.00	E-mail Address	ASEABROOK@CHREHABNORTH. COM	18. 00
19.00	Department		19. 00
20.00	Mailing Address 1	7343 CLEARVISTA DRIVE	20.00
21. 00	Mailing Address 2		21. 00
22. 00	Ci ty	I NDI ANPOLI S	22. 00
23.00	State	I N	23. 00
24.00	Zi p	46256	24. 00
	•	,	•

	Financial Systems Community Health Net			Non-CMS HFS Wo	
HFS S	upplemental Information	Provider CCN: 15-3043	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part IX Date/Time Pre 5/12/2023 10:	epared:
			Title V	Title XIX	
			1. 00	2. 00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE				
1. 00	Do Title V or XIX follow Medicare (Title XVIII) for the Intestepdown adjustments on W/S B, Part I, column 25? Enter Y/N and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	in column 1 for Title V	Y	Y	1. 00
2. 00	Do Title V or XIX follow Medicare (Title XVIII) for the report I (e.g. net of Physician's component)? Enter Y/N in colin column 2 for Title XIX. (see S-2, Part I, line 98.01)	orting of charges on W/S C		Y	2. 00
3. 00	Do Title V or XIX follow Medicare (Title XVIII) for the calc Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for 2 for Title XIX. (see S-2, Part I, line 98.02)			Y	3. 00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3. 01
3. 02	Does Title XIX transfer managed care (HMO) days from Workshe sum of lines 2, 3, and 4 to Worksheet E-4, column 2, line 26			Υ	3. 02
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	CRITICAL ACCESS HOSPITALS				
4. 00	Does Title V follow Medicare (Title XVIII) for Critical Accereimbursed 101% of cost? Enter Y or N in column 1 for inpatifor outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N 2	N	4. 00
5. 00	Does Title XIX follow Medicare (Title XVIII) for Critical Acreimbursed 101% of cost? Enter Y or N in column 1 for inpati for outpatient. (see S-2, Part I, lines 98.03 and 98.04)			N	5. 00
			Title V	Title XIX	
			1. 00	2. 00	
	RCE DI SALLOWANCE		_		
6.00	Do Title V or XIX follow Medicare and add back the RCE Disal column 4? Enter Y/N in column 1 for Title V and Y/N in column S-2, Part I, line 98.05)		Y	Y	6. 00
7 00	PASS THROUGH COST		Y	Y	7 00
7. 00	Do Title V or XIX follow Medicare when cost reimbursed (paym worksheets D, parts I through IV? Enter Y/N in column 1 for 2 for Title XIX. (see S-2, Part I, line 98.06)		Y	Y	7. 00
	RHC				4
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? En Title V and Y/N in column 2 for Title XIX.	ter Y/N in column 1 for	N	N	8.00
9. 00	For fiscal year beginning on/after 10/01/2014, use M-series XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 f		N	N	9. 00
				ate 00	
	STATE MEDICALD FORMS		1.		
10.00	Select the state when using state Medicaid forms.				10.00
	1		II.		11

 Heal th Financial
 Systems
 Community Health
 Network
 Rehab
 Hospital

 HOSPITAL
 AND
 HOSPITAL
 HEALTH
 CARE
 COMPLEX
 STATISTICAL
 DATA
 Provider
 CCN:
 Provider CCN: 15-3043

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

				10) 12/31/2022	5/12/2023 10:	
	·					I/P Days / 0/P	47 aiii
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	Component	Li ne No.		Avai I abl e	07.11 1.10 d.1 0		
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA			0.00			
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	60	21, 900	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		60	21, 900	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)		60	21, 900	0.00	0	14. 00
15.00	CAH visits					0	15. 00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	44. 00	0	0		0	19.00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		60				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00
33. 01							33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	0		0	34. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-3043

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

5/12/2023 10:47 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 18, 825 1.00 8, 109 108 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) 2,544 2, 175 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider 0 4.00 0 Hospital Adults & Peds. Swing Bed SNF 5.00 0 C 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 8, 109 108 18,825 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 0 C 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 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 Total (see instructions) 8, 109 134.70 14.00 108 18,825 0.00 14.00 15.00 CAH visits 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19 00 SKILLED NURSING FACILITY 0 Ω O 0 00 0.00 19 00 20.00 NURSING FACILITY 20.00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23 00 24.00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 0 24. 10 25.00 CMHC - CMHC 25.00 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) 0.00 134. 70 27.00 Observation Bed Days 28.00 0 0 28.00 29 00 Ambul ance Trips 29 00 30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 0 31.00 0 Labor & delivery days (see instructions) 0 0 32.00 32.00 32.01 Total ancillary labor & delivery room 0 32.01 outpatient days (see instructions) LTCH non-covered days 33.00 LTCH site neutral days and discharges 33.01 33.01 34.00 Temporary Expansion COVID-19 PHE Acute Care 0 34.00

34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-3043

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

5/12/2023 10:47 am Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX 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 1.00 710 8 1,605 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) 207 190 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 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 Total (see instructions) 710 1, 605 14.00 14.00 0.00 8 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

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-3043

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

5/12/2023 10:47 am Wkst. A Line Recl assi fi cati Adj usted Paid Hours Average Hourly Amount on of Salaries Number Reported Sal ari es Related to Wage (col. 4 (from Wkst. (col.2 ± col. Salaries in col. 5) A-6)3) col. 4 2.00 5.00 6. 00 1.00 3.00 4.00 PART II - WAGE DATA SALARI ES 1.00 200. 00 10, 789, 174 10, 789, 174 280, 412. 00 38. 48 1.00 Total salaries (see instructions) 2.00 Non-physician anesthetist Part 0 0 0.00 0.00 2.00 3.00 Non-physician anesthetist Part 0 0.00 0.00 3.00 4.00 Physician-Part A -0 0.00 0.00 4.00 Administrative 4.01 Physicians - Part A - Teaching 0 0.00 0.00 4.01 Physician and Non 0 0.00 5.00 0.00 5.00 Physician-Part B Non-physician-Part B for 6.00 0.00 0.00 6.00 hospital-based RHC and FQHC servi ces 7.00 Interns & residents (in an 21.00 0 0.00 0.00 7.00 approved program) 7.01 Contracted interns and 0.00 0.00 7.01 residents (in an approved programs) Home office and/or related 8.00 0 0.00 0.00 8.00 organization personnel 9.00 44.00 0.00 0.00 9.00 820, 085 820, 085 10.00 Excluded area salaries (see 21, 468.00 38. 20 10.00 instructions) OTHER WAGES & RELATED COSTS 11.00 Contract labor: Direct Patient 4, 696, 550 4, 696, 550 70, 874. 00 66. 27 11.00 0.00 12.00 Contract labor: Top level 0 0.00 12.00 management and other management and administrative servi ces Contract Labor: Physician-Part 13.00 145, 440 145, 440 808.00 180.00 13.00 A - Administrative 14.00 Home office and/or related 0.00 0.00 14.00 organization salaries and wage-related costs 1, 793, 371 29, 501. 00 60.79 14.01 Home office salaries 1, 793, 371 14.01 14.02 Related organization salaries 0.00 0.00 14.02 15.00 Home office: Physician Part A 0 0 0.00 0.00 15.00 - Administrative Home office and Contract 0 0.00 0.00 16.00 16.00 Physicians Part A - Teaching 16.01 Home office Physicians Part A 0 0.00 0.00 16.01 Teachi ng 16. 02 Home office contract 0 0.00 0.00 16.02 Physicians <u>Part A - Teaching</u> WAGE-RELATED COSTS 1, 602, 311 17.00 Wage-related costs (core) (see 1, 602, 311 17.00 instructions) 18.00 Wage-related costs (other) 18.00 (see instructions) 19.00 Excluded areas 131, 811 131, 811 19.00 Non-physician anesthetist Part 20.00 C 20.00 21.00 Non-physician anesthetist Part 0 21.00 22.00 Physician Part A -0 22.00 Admi ni strati ve 22.01 Physician Part A - Teaching 0 22 01 23.00 Physician Part B 0 23.00 24.00 Wage-related costs (RHC/FQHC) 24.00 Interns & residents (in an 0 25.00 0 0 25.00 approved program) 25.50 Home office wage-related C 0 25.50 (core) 25.51 Related organization 0 25.51 wage-related (core) Home office: Physician Part A 0 25, 52 25. 52 - Administrative wage-related (core)

In Lieu of Form CMS-2552-10

Period: Worksheet S-3

From 01/01/2022 Part II

To 12/31/2022 Date/Time Prepared: 5/12/2023 10:47 am Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Community Health Network Rehab Hosp
Provider CCN: 15-3043

							5/12/2023 10:	47 am
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARII							
26.00	Employee Benefits Department	4. 00	0	0	0	0. 00	0. 00	26.00
27.00	Administrative & General	5. 00	845, 210	0	845, 210	22, 141. 00	38. 17	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		29.00
30.00	Operation of Plant	7. 00	0	0	0	0. 00	0. 00	30.00
31.00	Laundry & Linen Service	8. 00	0	0	0	0.00	0.00	31.00
32.00	Housekeepi ng	9. 00	388, 805	0	388, 805	14, 865. 00	26. 16	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	Di etary	10. 00	499, 164	0	499, 164	22, 641. 00	22. 05	34.00
35.00	Dietary under contract (see		0	0	0	0.00	0.00	35.00
	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	408, 969	0	408, 969	8, 226. 00	49. 72	38.00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15. 00	367, 386	0	367, 386	6, 520. 00	56. 35	40.00
41.00	Medical Records & Medical	16. 00	449, 335	0	449, 335	11, 461. 00	39. 21	41.00
	Records Library							
42.00	Social Service	17. 00	820, 085	-820, 085	0	0.00	0. 00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

Total overhead cost (see

instructions)

7.00

Provi der CCN: 15-3043

-820, 085

2, 958, 869

85, 854. 00

Peri od:

34. 46

7.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: From 01/01/2022 To 12/31/2022 5/12/2023 10:47 am Average Hourly Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 4.00 5.00 6.00 2.00 3.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 10, 789, 174 10, 789, 174 280, 412. 00 38. 48 1.00 instructions) 2.00 Excluded area salaries (see 0 820, 085 820, 085 21, 468. 00 38. 20 2.00 instructions) 3.00 Subtotal salaries (line 1 10, 789, 174 -820, 085 9, 969, 089 258, 944. 00 38.50 3.00 minus line 2) 4.00 Subtotal other wages & related 6, 635, 361 6, 635, 361 101, 183. 00 65. 58 4.00 costs (see inst.) Subtotal wage-related costs 5.00 1, 602, 311 C 1, 602, 311 0.00 16.07 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 19, 026, 846 -820, 085 18, 206, 761 360, 127. 00 50. 56

3, 778, 954

Health Financial Systems Community Health Network Rehab Hosp In Lieu of Form CMS-2552-10 HOSPITAL WAGE RELATED COSTS Provider CCN: 15-3043 Peri od: Worksheet S-3 From 01/01/2022 Part IV 12/31/2022 Date/Time Prepared: 5/12/2023 10:47 am Amount Reported 1.00 PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 1.00 401K Employer Contributions 19, 373 1.00 2 00 Tax Sheltered Annuity (TSA) Employer Contribution 2.00 0 3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00 Qualified Defined Benefit Plan Cost (see instructions) 0 4.00 4.00 PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 5.00 5.00 401K/TSA Plan Administration fees 0 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 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) 653, 833 8.02 Health Insurance (Purchased) 8.03 0 8.03 9.00 Prescription Drug Plan 0 9.00 Dental, Hearing and Vision Plan 10.00 46 10.00 Life Insurance (If employee is owner or beneficiary) 5, 549 11.00 11.00 Accident Insurance (If employee is owner or beneficiary) 12.00 Λ 12.00 Disability Insurance (If employee is owner or beneficiary) 52, 634 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 14.00 'Workers' Compensation Insurance 108, 864 15.00 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Noncumulative portion) TAXES FICA-Employers Portion Only 17 00 736, 430 17 00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 19.00 0 State or Federal Unemployment Taxes 20, 773

Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see

20.00

22.00

23.00

24.00

25.00

0 21.00

4,809

1, 602, 311

20.00

21.00

22.00

23.00

24.00

OTHER

instructions))

Day Care Cost and Allowances

Total Wage Related cost (Sum of lines 1 -23)

Part B - Other than Core Related Cost OTHER WAGE RELATED COSTS (SPECIFY)

Tuition Reimbursement

Health Financial Systems	Community Health Network Rehab Hosp	In Lieu of Form CMS-2552-10			
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-3043	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part V Date/Time Prepared:		

		To	12/31/2022	Date/Time Prep 5/12/2023 10:4	
	Cost Center Description		Contract Labor	Benefit Cost	
			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		4, 696, 550	1, 602, 311	1.00
2.00	Hospi tal		4, 696, 550	1, 602, 311	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				16.00
17. 00	RENAL DIALYSIS I		0	0	17.00
18. 00	Other		o	0	18. 00

	Financial Systems Community Health Netw			eu of Form CMS-:		
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-3043	Peri od: From 01/01/2022 To 12/31/2022		pared:	
				1. 00		
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di Medicaid (see instructions for each line)	vided by line 202 col	umn 8)	0. 369928	1.00	
2.00	Net revenue from Medicaid			0	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	ntal navments from Med	li cai d?		4.00	
5. 00	If line 4 is no, then enter DSH and/or supplemental payments to		ii cai a .	0		
6. 00	Medicaid charges	. oour our u		0		
7. 00	Medicaid cost (line 1 times line 6)			0		
8.00	Difference between net revenue and costs for Medicaid program	(line 7 minus sum of	lines 2 and 5; if	0	8. 00	
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions f	for each line)				
9.00	Net revenue from stand-alone CHIP			0	9. 00	
10.00	Stand-alone CHIP charges			0	1	
11. 00	Stand-alone CHIP cost (line 1 times line 10)			0	11. 00 12. 00	
12. 00						
	enter zero)		`		_	
	Other state or local government indigent care program (see ins				40.00	
13.00	Net revenue from state or local indigent care program (Not inc Charges for patients covered under state or local indigent car			0		
14. 00	10)	e program (Not includ	ied in lines 6 or	0	14. 00	
15. 00	State or local indigent care program cost (line 1 times line 1	14)		0	15. 00	
16. 00	Difference between net revenue and costs for state or local in		ling 15 minus ling			
10.00	13; if < zero then enter zero)	largerit care program (Title 15 millius Title		10.00	
	Grants, donations and total unreimbursed cost for Medicaid, Ch	IIP and state/local in	ndi gent care progra	ms (see		
	instructions for each line)		3			
17.00	Private grants, donations, or endowment income restricted to 1	funding charity care		0	17. 00	
18.00	Government grants, appropriations or transfers for support of			0	18. 00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local	al indigent care progr	ams (sum of lines	0	19. 00	
	8, 12 and 16)					
		Uni nsur		Total (col. 1		
		patient		+ col . 2)		
	Uncompanyated Care (ace instructions for each line)	1.00	2. 00	3. 00		
20. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa	oci Li tv	0 (0	20.00	
20.00	(see instructions)	ici i ty	U C	Ί	20.00	
21. 00	Cost of patients approved for charity care and uninsured disco	ounts (see	0	0	21. 00	
21.00	instructions)	,411.5		1	21.00	
22. 00	Payments received from patients for amounts previously written	n off as	0 0	0	22. 00	
	chari ty care					
23.00	Cost of charity care (line 21 minus line 22)		0 (0	23. 00	

24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

imposed on patients covered by Medicaid or other indigent care program?

Total bad debt expense for the entire hospital complex (see instructions)

Non-Medicare bad debt expense (see instructions)

30.00 Cost of uncompensated care (line 23 column 3 plus line 29)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Medicare reimbursable bad debts for the entire hospital complex (see instructions)

Medicare allowable bad debts for the entire hospital complex (see instructions)

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)

1.00

24. 00

25. 00

27.00

27.01

28.00

29.00

30.00

-461 31.00

0 26.00

15, 036

23, 133

-23, 133

-461

-461

25.00

26.00

27.00

28. 00

stay limit

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provi der CCN: 15-3043 Peri od: Worksheet A From 01/01/2022 12/31/2022 Date/Time Prepared: 5/12/2023 10:47 am 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 4.00 3.00 5.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1, 759, 100 1, 759, 100 5, 452 1, 764, 552 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 77, 920 77, 920 352, 505 430, 425 2.00 00300 OTHER CAP REL COSTS 357, 957 357, 957 3.00 -357, 957 3 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1,869,463 1, 869, 463 143 1, 869, 606 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 845, 210 3, 804, 876 4, 650, 086 -455, 216 4, 194, 870 5.00 00700 OPERATION OF PLANT 453, 919 453.919 3, 916 457, 835 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 101, 386 101, 386 101, 386 8.00 9.00 00900 HOUSEKEEPI NG 388, 805 47.547 436, 352 0 436, 352 9.00 01000 DI ETARY 499, 164 351, 558 850, 722 0 850, 722 10.00 10.00 11 00 01100 CAFETERI A 11.00 \cap Ω 01300 NURSING ADMINISTRATION 13.00 408, 969 251, 185 660, 154 -57, 524 602, 630 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 6, 791 6, 791 190, 125 196, 916 14.00 565, 979 01500 PHARMACY 367, 386 172, 218 539, 604 26, 375 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 449, 335 16.00 2, 426 451, 761 451, 761 16.00 17.00 01700 SOCIAL SERVICE 820,085 7,681 827, 766 -827, 766 0 17.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 C 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 937, 352 4, 815, 334 8, 752, 686 325, 067 9, 077, 753 30.00 03100 INTENSIVE CARE UNIT 31.00 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 0 0 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 76, 543 76, 543 285, 631 362, 174 54.00 60 00 06000 LABORATORY 109 829 109.829 -120 375 60 00 0 -10.546 06500 RESPIRATORY THERAPY 65.00 113,809 40, 807 154, 616 1, 182 155, 798 65.00 06600 PHYSI CAL THERAPY 1, 404, 247 37, 107 1, 441, 354 761 1, 442, 115 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 1, 182, 537 233 1, 182, 770 1, 182, 770 67.00 0 06800 SPEECH PATHOLOGY 68 00 372, 275 372 727 372, 727 68 00 452 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 389, 960 389, 960 -199, 982 189, 978 71.00 07300 DRUGS CHARGED TO PATIENTS 0 347, 711 347, 711 347, 608 73.00 -103 74.00 07400 RENAL DIALYSIS 0 19,036 19,036 19,036 74.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 0 0 09100 EMERGENCY 91.00 0 0 91.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 117, 390 95.00 0 117, 390 117, 390 0 09850 OTHER REIMBURSABLE COST CENTERS 98.00 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 10, 789, 174 -827, 766 25, 179, 837 118. 00 15, 218, 429 26, 007, 603 118.00 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 827, 766 194. 00 0 0 827, 766 194. 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 0 194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION 0 0 194. 11 Ω 0 194. 12 07960 VISITOR MEALS 0 0 0 194. 12 TOTAL (SUM OF LINES 118 through 199) 26, 007, 603 200. 00 10, 789, 174 15, 218, 429 26, 007, 603

		etwork Rehab Hos			of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CCN	I: 15-3043	Peri od: From 01/01/2022	Worksheet A	
				To 12/31/2022	Date/Time Pro 5/12/2023 10:	
Cost Center Description	Adjustments	Net Expenses			37 127 2023 10.	77 (1111
		For Allocation				
GENERAL SERVICE COST CENTERS	6. 00	7. 00				
1. 00 O0100 CAP REL COSTS-BLDG & FLXT	-22, 649	1, 741, 903				1.00
2.00 OO200 CAP REL COSTS-MVBLE EQUIP	-20, 517	409, 908				2. 00
3.00 00300 OTHER CAP REL COSTS	0	0				3. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	-335, 055	1, 534, 551				4.00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT	2, 517, 447 -1, 732	6, 712, 317 456, 103				5. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	-1, 732	101, 386				8. 00
9. 00 00900 HOUSEKEEPI NG	o	436, 352				9. 00
10. 00 01000 DI ETARY	-15, 546	835, 176				10.00
11. 00 01100 CAFETERI A	0	0				11. 00
13.00 01300 NURSING ADMINISTRATION	0	602, 630				13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	196, 916				14.00
15. 00 O1500 PHARMACY 16. 00 O1600 MEDI CAL RECORDS & LI BRARY	0 -298	565, 979 451, 463				15. 00 16. 00
17. 00 01700 SOCIAL SERVICE	-270	451, 403				17. 00
23. 00 02300 PARAMED ED PRGM- (SPECI FY)	l o	o				23. 00
INPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00 03000 ADULTS & PEDIATRICS	144, 472	9, 222, 225				30. 00
31. 00 03100 INTENSIVE CARE UNIT	0	0				31.00
44.00 O4400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0				44. 00
50. 00 05000 OPERATING ROOM	O	0				50.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		362, 174				54.00
60. 00 06000 LABORATORY	O	-10, 546				60.00
65. 00 06500 RESPI RATORY THERAPY	o	155, 798				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	1, 442, 115				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 182, 770				67.00
68. 00 06800 SPEECH PATHOLOGY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	372, 727 189, 978				68. 00 71. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		347, 608				73.00
74. 00 07400 RENAL DI ALYSI S	o	19, 036				74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90. 00
91. 00 09100 EMERGENCY	0	0				91. 00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	117 200	0				95. 00
95. 00 09500 AMBULANCE SERVI CES 98. 00 09850 OTHER REI MBURSABLE COST CENTERS	-117, 390 0	0				98.00
SPECIAL PURPOSE COST CENTERS	<u></u>	<u> </u>				70.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 148, 732	27, 328, 569				118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192. 00
194.00 07950 NONALLOWABLE CASE MANAGER 194.01 07951 IDLE SPACE	0	827, 766				194. 00 194. 01
194. 02 07952 DI STRI CT	0	0				194. 01
194. 03 07953 DI STRI CT SALES	o o	o				194. 03
194.04 07954 CENTRALIZED ADMISSIONS (CAD)	o	o				194. 04
194.05 07955 CENTRALIZED BUSINESS (CBO)	0	0				194. 05
194. 06 07956 CENTRALI ZED STAFFI NG	0	0				194. 06
194. 07 07957 HR MANAGED CARE	0	0				194. 07
194. 08 07959 LACUNA HEALTH 194. 09 07958 SALES & MARKETI NG	0	0				194. 08 194. 09
194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS		0				194. 09
194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	l o	Ö				194. 11
194. 12 07960 VI SI TOR MEALS	o	0				194. 12
200.00 TOTAL (SUM OF LINES 118 through 199)	2, 148, 732	28, 156, 335				200. 00

Health Financial Systems
COST CENTERS USED IN COST REPORT Community Health Network Rehab Hosp
Provider CCN: 15-3043 Peri od: Worksheet Non-CMS W From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/12/2023 10:47 am Worksheet Non-CMS W

			o 12/31/2022 Date/Time F 5/12/2023 1	
	Cost Center Description	CMS Code	Standard Label For	0. 47 dill
	'		Non-Standard Codes	
	OFNEDAL CEDILOG COCT OFNEDO	1.00	2.00	
1 00	GENERAL SERVICE COST CENTERS	00100		1.00
1.00	CAP REL COSTS-BLDG & FLXT	00100		1.00
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP OTHER CAP REL COSTS	00200		2.00
4. 00	EMPLOYEE BENEFITS DEPARTMENT	00400		3. 00 4. 00
5. 00	ADMINISTRATIVE & GENERAL	00500		5. 00
7. 00	OPERATION OF PLANT	00700		7. 00
8. 00	LAUNDRY & LINEN SERVICE	00800		8.00
9. 00	HOUSEKEEPI NG	00900		9. 00
10. 00	DI ETARY	01000		10.00
11. 00	CAFETERI A	01100		11.00
13.00	NURSI NG ADMI NI STRATI ON	01300		13.00
14. 00	CENTRAL SERVICES & SUPPLY	01400		14. 00
15.00	PHARMACY	01500		15. 00
16.00	MEDICAL RECORDS & LIBRARY	01600		16. 00
17.00	SOCI AL SERVI CE	01700		17. 00
23.00	PARAMED ED PRGM-(SPECIFY)	02300		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31. 00	INTENSIVE CARE UNIT	03100		31.00
44. 00	SKILLED NURSING FACILITY	04400		44. 00
	ANCILLARY SERVICE COST CENTERS		_	
50. 00	OPERATI NG ROOM	05000		50.00
54. 00	RADI OLOGY-DI AGNOSTI C	05400		54. 00
60.00	LABORATORY	06000		60.00
65. 00	RESPI RATORY THERAPY	06500		65. 00
66. 00	PHYSI CAL THERAPY	06600		66. 00
67. 00	OCCUPATIONAL THERAPY	06700		67. 00
68. 00	SPEECH PATHOLOGY	06800		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100 07300		71.00
73. 00 74. 00	DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	07400		73. 00 74. 00
74.00	OUTPATIENT SERVICE COST CENTERS	07400		74.00
90. 00	CLINIC	09000		90.00
91. 00	EMERGENCY	09100		91.00
,	OTHER REIMBURSABLE COST CENTERS	7 37.00		
95.00	AMBULANCE SERVICES	09500		95. 00
98.00	OTHER REIMBURSABLE COST CENTERS	09850		98. 00
	SPECIAL PURPOSE COST CENTERS	•		
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118. 00
	NONREI MBURSABLE COST CENTERS			
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190. 00
	PHYSICIANS' PRIVATE OFFICES	19200		192. 00
	NONALLOWABLE CASE MANAGER	07950		194. 00
	I DLE SPACE	07951		194. 01
	DI STRI CT	07952		194. 02
	DI STRI CT SALES	07953		194. 03
	CENTRALIZED ADMISSIONS (CAD)	07954		194. 04
	CENTRALIZED BUSINESS (CBO)	07955		194. 05
	CENTRALIZED STAFFING	07956		194. 06
	HR MANAGED CARE	07957		194. 07
	LACUNA HEALTH	07959		194. 08 194. 09
	SALES & MARKETING OTHER NONREIMBURSABLE COST CENTERS	07958 07962		194. 09
	NONREIMB NEW BUSINESS IMPLEMENTATION	07962		194. 10
	VISITOR MEALS	07961		194. 11
	TOTAL (SUM OF LINES 118 through 199)	07700		200.00
200.00	1. c (c c	1	I	₁₁ 200.00

CLASSIFICATIONS Provider CCN: 15-3043 Period: From 01/01/2022

Peri od: Worksheet A-6
From 01/01/2022
To 12/31/2022 Date/Time Prepared: F/12/2023 10.47 cm

					5/12/2023 10:	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
	A - RECLASS NON ALLOWABLE CAS	E MANAGER				
1.00	NONALLOWABLE CASE MANAGER	1 <u>94.</u> 00	82 <u>0, 0</u> 85	<u>7, 6</u> 81		1. 00
	TOTALS		820, 085	7, 681		
	B - RECLASS RELATED PARTY					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	143		1. 00
2.00	OPERATION OF PLANT	7. 00	0	3, 916		2. 00
3.00	PHARMACY	15. 00	0	26, 375		3. 00
4.00	ADULTS & PEDIATRICS	30. 00	0	215, 865		4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	285, 631		5. 00
6.00	DRUGS CHARGED TO PATIENTS	7300	0_	2		6. 00
	TOTALS		0	531, 932		_
	C - RECLASS PURCHASED SERVICE					
1.00	ADULTS & PEDIATRICS	30. 00	0	103, 881		1. 00
2.00		<u>0.</u> 00	•	0		2. 00
	TOTALS		0	103, 881		_
	D - RECLASS NON-CHARGEABLE ME					
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 750		1. 00
2. 00	NURSING ADMINISTRATION	13. 00	0	843		2. 00
3.00	CENTRAL SERVICES & SUPPLY	14. 00	0	190, 125		3. 00
4.00	ADULTS & PEDIATRICS	30. 00	0	5, 321		4. 00
5.00	RESPIRATORY THERAPY	65. 00	0	1, 182		5. 00
6. 00	PHYSICAL THERAPY	6600	•			6. 00
	TOTALS		0	199, 982		
500.00	Grand Total: Increases		820, 085	843, 476		500.00

					'	5/12/2023 10	
		Decreases		<u> </u>			
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - RECLASS NON ALLOWABLE CAS						
1.00	SOCI AL SERVI CE	<u> </u>		<u>7, 6</u> 81			1.00
	TOTALS		820, 085	7, 681			_
	B - RECLASS RELATED PARTY						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	456, 966	0		1. 00
2.00	LABORATORY	60.00	0	74, 861	0		2. 00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	105	0		3. 00
4.00		0.00	0	0	0		4. 00
5.00		0.00	0	0	0		5. 00
6.00		0. 00	0_	0	0		6. 00
	TOTALS		0	531, 932			_
	C - RECLASS PURCHASED SERVICE						
1.00	NURSING ADMINISTRATION	13. 00	0	58, 367			1. 00
2.00	LABORATORY	6000	0_	4 <u>5, 5</u> 14			2. 00
	TOTALS		0	103, 881			_
	D - RECLASS NON-CHARGEABLE ME						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	199, 982	0		1. 00
	PATI ENTS						
2.00		0. 00	0	0	0		2. 00
3.00		0. 00	0	0	0		3. 00
4.00		0. 00	0	0	0		4. 00
5.00		0.00	0	0	0		5. 00
6.00		0.00	0_	0	0		6. 00
	TOTALS		0	199, 982			
500.00	Grand Total: Decreases		820, 085	843, 476			500.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-3043

In Lieu of Form CMS-2552-10

Peri od: Worksheet A-6
From 01/01/2022 Non-CMS Worksheet
To 12/31/2022 Date/Time Prepared:
5/12/2023 10:47 am

								5/12/2023 10:	47 am	
		Increa	ases			Decre	Decreases			
	Cost Center	Li ne #	Sal ary	0ther	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4.00	5. 00	6. 00	7.00	8. 00	9. 00		
	A - RECLASS NON ALLOWA	BLE CASE	MANAGER							
1.00	NONALLOWABLE CASE	194. 00	820, 085	7, 681	SOCIAL SERVICE	17. 00	820, 085	7, 681	1.00	
	MANAGER	\perp				\perp				
	TOTALS		820, 085	7, 681	TOTALS		820, 085	7, 681		
	B - RECLASS RELATED PA				_					
1.00	EMPLOYEE BENEFITS	4. 00	0		ADMINISTRATIVE &	5. 00	0	456, 966	1. 00	
	DEPARTMENT				GENERAL					
2.00	OPERATION OF PLANT	7. 00	0		LABORATORY	60.00	O	74, 861	2. 00	
3.00	PHARMACY	15. 00	0		DRUGS CHARGED TO	73.00	O	105	3. 00	
4 00	ADULTO A DEDLATRIAG	00.00			PATI ENTS	0.00			4 00	
4.00	ADULTS & PEDIATRICS	30.00	0	215, 865		0.00	0	0	4.00	
5.00	RADI OLOGY-DI AGNOSTI C	54.00	O ₁	285, 631		0.00	0	0	5. 00	
6. 00	DRUGS CHARGED TO	73. 00	O	2		0.00	O	0	6. 00	
	TOTALS	-+	— — — _d	531, 932	TOTAL C — — —	\vdash				
	C - RECLASS PURCHASED	CEDVI CE		531, 932	TUTALS		U	531, 932		
1. 00	ADULTS & PEDIATRICS	30. 00	EXPENSE 0	102 001	NURSI NG	13.00	O	58, 367	1. 00	
1.00	ADULTS & PEDIATRICS	30.00	٩		ADMI NI STRATI ON	13.00	۷	36, 307	1.00	
2. 00		0.00	0		LABORATORY	60.00	0	45, 514	2. 00	
2.00	TOTALS — — —	0.00	— — — ŏ	00 103, 881		00.00	— —)	103, 881	2.00	
	D - RECLASS NON-CHARGE	ARLE MED		103, 001	TIOTALS		<u> </u>	103, 001		
1.00	ADMI NI STRATI VE &	5. 00	0	1 750	MEDICAL SUPPLIES	71.00	0	199, 982	1. 00	
1.00	GENERAL	3.00	ĭ		CHARGED TO PATIENTS	71.00	ď	177, 702	1.00	
2.00	NURSI NG	13. 00	o	843		0.00	0	0	2. 00	
	ADMI NI STRATI ON		٦					Ī		
3.00	CENTRAL SERVICES &	14. 00	ol	190, 125		0.00	ol	0	3. 00	
	SUPPLY									
4.00	ADULTS & PEDIATRICS	30.00	o	5, 321		0.00	o	0	4.00	
5.00	RESPIRATORY THERAPY	65. 00	o	1, 182		0.00	o	0	5. 00	
6.00	PHYSICAL THERAPY	66. 00	o	761		0.00	О	O	6. 00	
	TOTALS			199, 982	TOTALS			199, 982		
500.00	Grand Total:		820, 085	843, 476	Grand Total:		820, 085	843, 476	500.00	
	Increases				Decreases					

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

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

				''	0 12/31/2022	5/12/2023 10:	47 am
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES	_	_	т _	T	
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2. 00
3.00	Buildings and Fixtures	0	0	0	0	0	3. 00
4.00	Building Improvements	10, 041	0	0	0	0	4. 00
5. 00	Fi xed Equi pment	0	0	0	0	0	5. 00
6.00	Movable Equipment	616, 076	33, 143	0	33, 143		6. 00
7. 00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	626, 117	33, 143	0	33, 143		8. 00
9. 00	Reconciling Items	0	0	0	0	0	9. 00
10. 00	Total (line 8 minus line 9)	626, 117	33, 143	0	33, 143	0	10. 00
		Endi ng Bal ance					
			Depreci ated				
		(00	Assets				
	DADT I ANALYCIC OF CHANCEC IN CARLTAL ACCET	6.00	7. 00				
1. 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES	0				1 00
		0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	10.044	0				3.00
4.00	Building Improvements	10, 041	0				4. 00
5.00	Fi xed Equi pment	0	0				5. 00
6.00	Movable Equipment	649, 219	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8. 00	Subtotal (sum of lines 1-7)	659, 260	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	659, 260	0				10. 00

Health Financial Systems	Community Health Network Rehab Hosp	In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-3043	Peri od: From 01/01/2022	Worksheet A-7 Part II	

					o 12/31/2022	Date/Time Pre 5/12/2023 10:4	
			SL	IMMARY OF CAPIT	ΓAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10.00	11. 00	12.00	13. 00	
PA	ART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 CA	AP REL COSTS-BLDG & FLXT	1, 453	1, 757, 647	C	0	0	1. 00
2.00 CA	AP REL COSTS-MVBLE EQUIP	73, 380	4, 540	C	0	0	2. 00
3.00 To	otal (sum of lines 1-2)	74, 833	1, 762, 187	C	0	0	3. 00
		SUMMARY OF	F CAPITAL				
	Cost Center Description	Other '	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	ART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	•				
	AP REL COSTS-BLDG & FLXT	0	1, 759, 100				1. 00
	AP REL COSTS-MVBLE EQUIP	0	77, 920				2. 00
3. 00 To	otal (sum of lines 1-2)	0	1, 837, 020				3. 00

Health Financial Systems Community Health Network Rehab Hosp In Lieu of Form CMS-255							
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der CCN: 15-3043			Period: Worksheet A-7		
					From 01/01/2022 Part III		
					Γo 12/31/2022		
		COM	L PUTATION OF RAT	TLOS	ALLOCATION OF	5/12/2023 10: OTHER CAPITAL	47 alli
		COIVII	PUTATION OF RA	1103	ALLOCATION OF	UINER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col.			
				2)			
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	10, 041	0	10, 04°	0. 015231	1, 428	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	649, 219	0	649, 219	0. 984769	92, 350	2.00
3.00	Total (sum of lines 1-2)	659, 260	0	659, 260	1. 000000	93, 778	3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
		_		l 			
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel ate				
		/ 00	d Costs	through 7)	0.00	10.00	
	DART III DECONCILIATION OF CARLTAL COCTE OF	6. 00	7. 00	8. 00	9. 00	10.00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS CI		1		4 450	4 757 (47	4 00
1.00	CAP REL COSTS-BLDG & FLXT	4, 024		5, 452	· ·		1
2.00	CAP REL COSTS-MVBLE EQUIP	260, 155		352, 50			
3.00	Total (sum of lines 1-2)	264, 179		357, 95		1, 762, 187	3. 00
			Sl	JMMARY OF CAPI	IAL		

Interest

11. 00

0 0

Insurance (see

instructions)

12.00

-21, 221 92, 350 71, 129 Taxes (see

instructions)

13.00

4, 024 260, 155 264, 179 0ther

Capi tal -Rel ate d Costs (see

instructions)

14.00

0

Total (2) (sum of cols. 9

through 14)

15.00

1, 741, 903 1. 00 409, 908 2. 00 2, 151, 811 3. 00

Cost Center Description

CAP REL COSTS-BLDG & FIXT

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

1.00

2.00

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

Health Financial Systems
ADJUSTMENTS TO EXPENSES Community Health Network Rehab Hosp
Provider CCN: 15-3043 In Lieu of Form CMS-2552-10
Worksheet A-8

				To	12/31/2022	Date/Time Prep 5/12/2023 10:4	
				Expense Classification on	Worksheet A	5/12/2023 10.4	47 all
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
. 00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FLXT	1.00	5.00	1.
	COSTS-BLDG & FLXT (chapter 2)						
00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2.
00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other	В	_999	ADMINISTRATIVE & GENERAL	5. 00	0	3.
00	(chapter 2)		,,,	7.5 11 51.0.11 72 0 52.12.0.12	0.00		
00	Trade, quantity, and time	В	-969	ADMINISTRATIVE & GENERAL	5. 00	0	4.
00	di scounts (chapter 8) Refunds and rebates of		0		0. 00	0	5.
00	expenses (chapter 8)		3		0.00		
00	Rental of provider space by		0		0.00	0	6.
00	suppliers (chapter 8) Telephone services (pay	A	_3 635	ADMINISTRATIVE & GENERAL	5. 00	0	7.
00	stations excluded) (chapter	A	-3, 033	ADMINISTRATIVE & GENERAL	5.00	O	′.
	21)						
00	Television and radio service	A	-1, 732	OPERATION OF PLANT	7. 00	0	8.
00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9.
0. 00	Provi der-based physi ci an	A-8-2	-1, 958			0	10.
- 00	adjustment				0.00		
. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11.
2. 00	Related organization	A-8-1	2, 780, 213			0	12.
	transactions (chapter 10)		_			_	
. 00	Laundry and linen service Cafeteria-employees and guests	В	12 070	DI ETARY	0. 00 10. 00	0	
. 00	Rental of quarters to employee		-13,670	DIETART	0.00	0	•
	and others		_				
. 00	Sale of medical and surgical		0		0. 00	0	16.
	supplies to other than patients						
. 00	Sale of drugs to other than		0		0. 00	0	17.
	patients			MEDI 041 DE00000 0 110040V	47.00		
. 00	Sale of medical records and abstracts	В	-298	MEDICAL RECORDS & LIBRARY	16. 00	0	18.
. 00	Nursing and allied health		0		0.00	0	19.
	education (tuition, fees,						
. 00	books, etc.) Vending machines	В	_1 676	DI ETARY	10. 00	0	20.
. 00	Income from imposition of	В	-1, 070	DILIARI	0.00	0	
	interest, finance or penalty						
00	charges (chapter 21)		0		0.00	0	22
. 00	Interest expense on Medicare overpayments and borrowings to		Ü		0. 00	0	22.
	repay Medicare overpayments						
. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23.
	therapy costs in excess of limitation (chapter 14)						
. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24.
	therapy costs in excess of						
. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25.
. 00	physicians' compensation		Ü	cost center bereted	114.00		25.
	(chapter 21)						
. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26.
. 00	COSTS-BLDG & FLXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27.
. 00	COSTS-MVBLE EQUIP		9	07.1 NEE 00010 IIIVBEE EQ011	2.00	Ŭ	
. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28.
00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 30.
. 00	therapy costs in excess of	N-0-3	Ü	SOOSI ATTOMAL THEMAFT	67.00		50.
	limitation (chapter 14)						
. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30.
. 00	instructions) Adjustment for speech	A-8-3	n	SPEECH PATHOLOGY	68. 00		31.
20	pathology costs in excess of		0		55. 50		ັ ''
	limitation (chapter 14)		_		0.00	<u></u>	
:. 00	CAH HIT Adjustment for Depreciation and Interest		0		0. 00	0	32.
	popi col att on and Titterest	1			I		1

| Peri od: | Worksheet A-8 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

					To 12/31/2022	Date/Time Pre 5/12/2023 10:	
				Expense Classification To/From Which the Amount i		77 127 2023 10.	47 4111
C	cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
33. 00 OTHER (3)	ADJUSTMENTS (SPECIFY)	1.00	0		0.00		33. 0
3. 01 MI SCELI	LANEOUS INCOME ADJUSTMENTS (SPECIFY)	В	-9, 635 0	ADMINISTRATIVE & GENERAL	5. 00 0. 00		33. 0 33. 0
	ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 0
	ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 0
3. 05 OTHER A	ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 0
	ADJUSTMENTS (SPECIFY)		0		0.00	0	33. (
	ADJUSTMENTS (SPECIFY)		0		0.00	0	33. (
	RE BAD DEBT - PART A ADJUSTMENTS (SPECIFY)	А	-23, 133 0	ADMINISTRATIVE & GENERAL	5. 00 0. 00		33. (33. (
3. 10 OTHER I	MEDICARE NON ALLOWABLE OPERATING - PATIENT ONS	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00		33. 1 33. 1
1	ADJUSTMENTS (SPECIFY)		0		0.00	0	33.
3. 13 OTHER (OPERATING - MARKETING ADJUSTMENTS (SPECIFY)	A	-19, 303 0	ADMINISTRATIVE & GENERAL	5. 00 0. 00		33. 33.
1 ' '	ADJUSTMENTS (SPECIFY)		0		0. 00	0	33.
	ADJUSTMENTS (SPECIFY)		0		0. 00	0	33.
	ADJUSTMENTS (SPECIFY)		0		0. 00	0	33.
	ADJUSTMENTS (SPECIFY)		0		0.00	0	33.
	ADJUSTMENTS (SPECIFY)		0		0.00	0	33.
	ADJUSTMENTS (SPECIFY)		0		0.00	0	33.
	ADJUSTMENTS (SPECIFY)		0		0.00	0	33.
1 ' '	ADJUSTMENTS (SPECIFY)		0		0.00	0	33.
3. 23 OTHER /	ADJUSTMENTS (SPECIFY)		0		0.00	0	33.
	ADJUSTMENTS (SPECIFY)		0		0.00	0	33.
	ADJUSTMENTS (SPECIFY)		0		0.00	0	33.
	ADJUSTMENTS (SPECIFY)		0		0.00	0	33.
	ADJUSTMENTS (SPECIFY)		0		0.00	0	33.
	ADJUSTMENTS (SPECIFY)		0		0.00	0	33.
	TV AND SATELLITE ADJUSTMENTS (SPECIFY)	А	-20, 887 0	ADMINISTRATIVE & GENERAL	5. 00 0. 00		33. 33.
3. 31 MARKET	ING BONUS ADJUSTMENTS (SPECIFY)	А	-13, 207 0	ADMINISTRATIVE & GENERAL	5. 00 0. 00		
	ADJUSTMENTS (SPECIFY)		0		0.00	0	33.
1 7 7	ADJUSTMENTS (SPECIFY)		0		0.00	0	33.
3. 35 OTHER /	ADJUSTMENTS (SPECIFY)		0		0.00	0	33.
	ADJUSTMENTS (SPECIFY)		0		0.00	0	33.
3. 37 (3) OTHER 7	ADJUSTMENTS (SPECIFY)		0		0. 00	0	33.

Health Financial Systems
ADJUSTMENTS TO EXPENSES Community Health Network Rehab Hosp
Provider CCN: 15-3043 In Lieu of Form CMS-2552-10
Worksheet A-8

Dependence Case Canton on Montaheet A Control of the Adjustment Septiment Case					Ti	o 12/31/2022	Date/Time Prep 5/12/2023 10:	
1.00 2.00 3.00 4.00 5.00 3.3 3.39 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 0 3.3 3.39 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 0 0 3.3 3.40 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 0 0 3.4 3.41 NOR ADJUSTNENTS (SPECIFY) 0 0 0 0 0 0 3.4 3.42 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 0 0 3.4 3.43 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 0 0 3.44 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 0 0 3.45 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 0 3.46 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 0 3.47 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 3.48 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 3.49 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 3.40 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 3.41 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 3.42 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 3.42 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 3.43 OTHER ADJUSTNENTS (SPECIFY) 0 0								
1.00 2.00 3.00 4.00 5.00 3.3 3.39 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 0 3.3 3.39 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 0 0 3.3 3.40 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 0 0 3.4 3.41 NOR ADJUSTNENTS (SPECIFY) 0 0 0 0 0 0 3.4 3.42 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 0 0 3.4 3.43 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 0 0 3.44 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 0 0 3.45 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 0 3.46 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 0 3.47 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 3.48 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 3.49 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 3.40 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 3.41 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 3.42 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 3.42 OTHER ADJUSTNENTS (SPECIFY) 0 0 0 0 3.43 OTHER ADJUSTNENTS (SPECIFY) 0 0						-		
1.00 2.00 3.00 4.00 5.00 3.33 3.33 3.38 3.38 3.39 3.40 3.40 3.30 3.40 3.30 3.40 3.30 3.40 3.30 3.40 3.30 3.40 3.30 3.40 3.30								
33 30 OTHER ADJUSTMENTS (SPECIFY) 0 0.00 0 33.39		Cost Center Description						
33.39 OTHER ADJUSTMENTS (SPECIFY) O O.00	33. 38			0		0.00	0	33. 38
33.40 OFFICE ADJUSTNENTS (SPECIFY) O 0.00 0.34.01	33. 39	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 39
100 ALLON AMBULANCE COSTS A -117, 390 AMBULANCE SERVICES 95.00 0 33.42 33.43 (1)	33. 40	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 40
33. 43 OFFICE ADJUSTMENTS (SPECIFY) 0 0 0.00 0.33. 43 (30 0.00 0.33. 43 (30 0.00 0.00 0.33. 43 (30 0.00 0.00 0.33. 43 (30 0.00 0.00 0.33. 43 (30 0.00 0.00 0.33. 43 (30 0.00 0.00 0.33. 43 (30 0.00 0.00 0.33. 45 (30 0.00 0.00 0.33. 45 (30 0.00 0.00 0.33. 45 (30 0.00 0.00 0.33. 45 (30 0.00 0.00 0.33. 45 (30 0.00 0.00 0.33. 45 (30 0.00 0.00 0.33. 45 (30 0.00 0.00 0.33. 45 (30 0.00 0.00 0.33. 45 (30 0.00 0.00 0.33. 45 (30 0.00 0.00 0.33. 45 (30 0.00 0.00 0.33. 45 (30 0.00 0.00 0.33. 45 (30 0.00 0.00 0.33. 45 (30 0.00 0.00 0.33. 45 (30 0.00 0.00 0.33. 45 (30 0.00 0.00 0.33. 45 (30 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.00 0.33. 45 (30 0.00 0.00 0.00 0.00 0.00 0.00 0.00		NON ALLOW AMBULANCE COSTS OTHER ADJUSTMENTS (SPECIFY)	А	-117, 390 0	AMBULANCE SERVICES			
33.44 OTHER ADJUSTMENTS (SPECIFY) O O.00 O.34.46	33. 43	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 43
33. 45 PREDICTIONS INS A -22,649CAP REL COSTS-BLOG & FIXT 1.00 23.45 PREDICTION	33. 44	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 44
MEDICARE VS BOOK MON FOULP A -20,517/CAP REL COSTS-MVBLE FOULP 2.00 9 34.01	33. 45	BUSINESS INTERRUPTIONS INS	А	-22, 649	CAP REL COSTS-BLDG & FIXT	1. 00	12	33. 45
34. 03 OTHER ADJUSTMENTS (SPECIFY) 34. 04 OTHER ADJUSTMENTS (SPECIFY) 34. 05 OTHER ADJUSTMENTS (SPECIFY) 35 OTHER ADJUSTMENTS (SPECIFY) 36 OTHER ADJUSTMENTS (SPECIFY) 37 OTHER ADJUSTMENTS (SPECIFY) 38 OTHER ADJUSTMENTS (SPECIFY) 39 OTHER ADJUSTMENTS (SPECIFY) 30 OTHER ADJUSTMENTS (SPECIFY) 30 OTHER ADJUSTMENTS (SPECIFY) 31 OTHER ADJUSTMENTS (SPECIFY) 32 OTHER ADJUSTMENTS (SPECIFY) 33 OTHER ADJUSTMENTS (SPECIFY) 34 OTHER ADJUSTMENTS (SPECIFY) 35 OTHER ADJUSTMENTS (SPECIFY) 36 OTHER ADJUSTMENTS (SPECIFY) 37 OTHER ADJUSTMENTS (SPECIFY) 38 OTHER ADJUSTMENTS (SPECIFY) 39 OTHER ADJUSTMENTS (SPECIFY) 40 OTHER ADJUSTMENTS (SPECIFY) 50 OTHER ADJUSTMENTS (SPECIFY) 51 OTHER ADJUSTMENTS (SPECIFY) 52 OTHER ADJUSTMENTS (SPECIFY) 53 OTHER ADJUSTMENTS (SPECIFY) 54 OTHER ADJUSTMENTS (SPECIFY) 55 OTHER ADJUSTMENTS (SPECIFY) 56 OTHER ADJUSTMENTS (SPECIFY) 57 OTHER ADJUSTMENTS (SPECIFY) 58 OTHER ADJUSTMENTS (SPECIFY) 59 OTHER ADJUSTMENTS (SPECIFY) 50 OTHER ADJUSTMENTS (SPECIFY) 50 OTHER ADJUSTMENTS (SPECIFY) 50 OTHER ADJUSTMENTS (SPECIFY) 51 OTHER ADJUSTMENTS (SPECIFY) 52 OTHER ADJUSTMENTS (SPECIFY) 53 OTHER ADJUSTMENTS (SPECIFY) 54 OTHER ADJUSTMENTS (SPECIFY) 50 OTHER ADJUSTMENTS (SPECIFY) 51 OTHER ADJUSTMENTS (SPECIFY) 52 OTHER ADJUSTMENTS (SPECIFY) 53 OTHER ADJUSTMENTS (SPECIFY) 54 OTHER ADJUSTMENTS (SPECIFY) 55 OTHER ADJUSTMENTS (SPECIFY) 56 OTHER ADJUSTMENTS (SPECIFY) 57 OTHER ADJUSTMENTS (SPECIFY) 58 OTHER ADJUSTMENTS (SPECIFY) 59 OTHER ADJUSTMENTS (SPECIFY) 50 OTHER ADJUSTMENTS (SPECIFY) 50 OTHER ADJUSTMENTS (SPECIFY) 50 OTHER ADJUSTMENTS (SPECIFY) 50 OTHER ADJUSTMENTS (SPECIFY) 51 OTHER ADJUSTMENTS (SPECIFY) 52 OTHER ADJUSTMENTS (SPECIFY) 53 OTHER ADJUSTMENTS (SPECIFY) 51 OTHER ADJUSTMENTS (SPECIFY) 52 OTHER ADJUSTMENTS (SPECIFY) 53 OTHER ADJUSTMENTS (SPECIFY) 51 OTHER ADJUSTMENTS (SPECIFY) 52 OTHER ADJUSTMENTS (SPECIFY) 53 OTHER ADJUSTMENTS (SPECIFY) 51 OTHER ADJUSTMENTS (SPECIFY) 52 OTHER ADJUSTMENT	34. 01	MEDICARE VS BOOK MOV EQUIP OTHER ADJUSTMENTS (SPECIFY)	1			2. 00	9	34. 01
34. 04 OTHER ADJUSTMENTS (SPECIFY) 0 0.00 0 34. 04	34. 03	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	34. 03
34. 05 OTHER ADJUSTMENTS (SPECIFY) 34. 06 OTHER ADJUSTMENTS (SPECIFY) 34. 06 OTHER ADJUSTMENTS (SPECIFY) 35. 07 OTHER ADJUSTMENTS (SPECIFY) 36. 08 OTHER ADJUSTMENTS (SPECIFY) 37. 08 OTHER ADJUSTMENTS (SPECIFY) 38. 08 OTHER ADJUSTMENTS (SPECIFY) 39. 09. 00. 00. 00. 00. 00. 00. 00. 00. 0	34. 04	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	34. 04
34. 06 OTHER ADJUSTMENTS (SPECIFY) O O. 00 O. 34. 06	34. 05	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	34. 05
34. 07 OTHER ADJUSTMENTS (SPECIFY) O O.00 O 34. 07	34. 06	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	34. 06
34. 08 OTHER ADJUSTMENTS (SPECIFY) O O O O O O O O O	34. 07	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	34. 07
34. 00 OTHER ADJUSTMENTS (SPECIFY) O O.00	34. 08	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	34. 08
34. 10 OTHER ADJUSTMENTS (SPECIFY) O O. 00 O. 34. 10	34. 09	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	34. 09
34. 11 OTHER ADJUSTMENTS (SPECIFY)	34. 10	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	34. 10
34. 12 NOW ALLOWABLE LOBBYING FEES A -652 ADMINISTRATIVE & GENERAL 5. 00 0 34. 12	34. 11	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	34. 11
34. 14 OTHER ADJUSTMENTS (SPECI FY) (3)		NON ALLOWABLE LOBBYING FEES OTHER ADJUSTMENTS (SPECIFY)	А	-652 0	ADMINISTRATIVE & GENERAL		0	
34. 15 OTHER ADJUSTMENTS (SPECIFY) 0 0.00 0 34. 15 (3) 34. 16 (3) 34. 17 (3) 34. 18 (3) 34. 18 (3) 34. 20 (3) 34. 21 (3) 34. 23 (3) 34. 23 (3) 34. 24 (3) 34. 25 OTHER ADJUSTMENTS (SPECIFY) 0 0 0.00 0 34. 28 (3) 34. 28 (3	34. 14	1 . ,		0		0.00	0	34. 14
34. 16 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 17 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 18 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 19 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 20 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 21 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 22 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 23 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 24 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 25 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 26 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 27 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 28 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 26 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 27 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 28 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 26 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 27 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 28 OTHER ADJUSTMENTS (SPECIFY) (4) 35. 40 40 40 40 40 40 40 40 40 40 40 40 40 4	34. 15	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	34. 15
34. 17 OTHER ADJUSTMENTS (SPECIFY) 0 0 0 0 34. 18 (3) 34. 19 OTHER ADJUSTMENTS (SPECIFY) 0 0 0 0 34. 19 (3) 34. 20 OTHER ADJUSTMENTS (SPECIFY) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	34. 16			0		0.00	0	34. 16
34. 18 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 19 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 20 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 21 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 22 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 23 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 24 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 25 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 26 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 27 (3) 34. 28 OTHER ADJUSTMENTS (SPECIFY) (3) (3) (3) (3) (4) (4) (5) (5) (6) (7) (7) (8) (8) (8) (8) (8) (8) (8) (8) (8) (8	34. 17	1 . ,		0		0.00	0	34. 17
34. 19 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 20 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 21 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 22 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 23 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 24 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 25 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 26 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 27 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 28 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 26 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 27 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 28 OTHER ADJUSTMENTS (SPECIFY)	34. 18			0		0.00	0	34. 18
34. 20 OTHER ADJUSTMENTS (SPECI FY) (3) 0.00 0 34. 20 (3) 34. 21 OTHER ADJUSTMENTS (SPECI FY) (3) 0.00 0 34. 21 (3) 34. 22 OTHER ADJUSTMENTS (SPECI FY) (3) 0.00 0 34. 22 (3) 34. 23 OTHER ADJUSTMENTS (SPECI FY) (3) 0.00 0 34. 23 (3) 34. 24 (3) 0THER ADJUSTMENTS (SPECI FY) (3) 0.00 0 34. 24 (3) 34. 25 OTHER ADJUSTMENTS (SPECI FY) (3) 0.00 0 34. 25 (3) 34. 26 OTHER ADJUSTMENTS (SPECI FY) (3) 0.00 0 34. 26 (3) 34. 27 OTHER ADJUSTMENTS (SPECI FY) (3) 0.00 0 34. 27 (3) 34. 28 OTHER ADJUSTMENTS (SPECI FY) (3) 0.00 0 34. 28	34. 19	1 . ,		0		0. 00	0	34. 19
34. 21 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 22 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 23 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 24 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 25 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 26 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 27 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 28 OTHER ADJUSTMENTS (SPECIFY)	34. 20			0		0. 00	0	34. 20
34. 22 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 23 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 24 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 25 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 26 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 27 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 28 OTHER ADJUSTMENTS (SPECIFY) (3) (3) (3) (3) (3) (4) (5) (6) (7) (7) (8) (8) (8) (8) (8) (8) (9) (9) (9) (9) (9) (9) (9) (9) (9) (9	34. 21	1 . ,		0		0. 00	0	34. 21
34. 23 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 24 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 25 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 26 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 27 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 28 OTHER ADJUSTMENTS (SPECIFY) (3) (3) (3) (3) (3) (3) (3) (3) (3) (3	34. 22			0		0. 00	0	34. 22
34. 24 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 25 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 26 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 27 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 28 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 28 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 28 OTHER ADJUSTMENTS (SPECIFY) (3) (3) (3) (4) (5) (6) (7) (8) (8) (9) (9) (9) (9) (9) (9) (9) (9) (9) (9	34. 23			0		0.00	0	34. 23
34. 25 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 26 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 27 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 28 OTHER ADJUSTMENTS (SPECIFY) (3) 34. 28 OTHER ADJUSTMENTS (SPECIFY) (3) (3) (3) (4) (5) (6) (7) (8) (9) (9) (9) (9) (9) (9) (9) (9) (9) (9	34. 24	1 7 7		0		0. 00	0	34. 24
34. 26 OTHER ADJUSTMENTS (SPECIFY) 0 0.00 0 34. 26 34. 27 OTHER ADJUSTMENTS (SPECIFY) 0 0.00 0 34. 27 34. 28 OTHER ADJUSTMENTS (SPECIFY) 0 0.00 0 34. 28	34. 25			0		0. 00	0	34. 25
34. 27 OTHER ADJUSTMENTS (SPECIFY) 0 0.00 0 34. 27 (3) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	34. 26	1 7 7		0		0. 00	0	34. 26
(3)	34. 27	1 . ,		0		0. 00	0	34. 27
	34. 28	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	34. 28
	34. 40	1 . /	A	-707, 576	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	34. 40

Health Financial Systems ADJUSTMENTS TO EXPENSES Provider CCN: 15-3043 Peri od: Worksheet A-8 From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

					0 12/31/2022	5/12/2023 10:	
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Pasis (Codo (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2.00	3. 00	4. 00	5. 00	
34. 41	ALLOWABLE VEBA CLAIMS	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0.00	34. 41
35. 00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 00
35. 01	(3) PHYSICIAN FEE ADJUSTMENT	A	-146 430	ADMINISTRATIVE & GENERAL	5. 00	0	35. 01
35. 01	OTHER ADJUSTMENTS (SPECIFY)		0	ADMINISTRATIVE & GENERAL	0.00	0	35. 02
05.00	(3)						05.00
35. 03	OTHER ADJUSTMENTS (SPECIFY) (3)		O		0. 00	0	35. 03
35. 04	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 04
25 05	(3)		0		0.00	0	25 05
35. 05	OTHER ADJUSTMENTS (SPECIFY) (3)		Ü		0. 00	0	35. 05
35. 06	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 06
25 07	(3)		0		0.00		25 07
35. 07	OTHER ADJUSTMENTS (SPECIFY) (3)		Ü		0. 00	0	35. 07
35. 08	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	35. 08
25 00	(3)		0		0.00	0	25 00
35. 09	OTHER ADJUSTMENTS (SPECIFY) (3)		Ü		0. 00	0	35. 09
35. 10	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	35. 10
25 11	(3)		147 420	ADULTS & DEDLATRICS	20.00	0	25 11
35. 11 35. 12	PHYSICIAN FEE ADJUSTMENT OTHER ADJUSTMENTS (SPECIFY)	A	146, 430	ADULTS & PEDIATRICS	30. 00 0. 00	0	35. 11 35. 12
	(3)					_	
35. 13	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 13
35. 14	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	35. 14
	(3)						
35. 15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	35. 15
35. 16	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	35. 16
	(3)						
35. 17	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	35. 17
35. 18	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 18
05.40	(3)		0		0.00		05.40
35. 19	OTHER ADJUSTMENTS (SPECIFY) (3)		O		0. 00	0	35. 19
35. 20	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	35. 20
25 21	(3)		0		0.00	0	25 21
35. 21	OTHER ADJUSTMENTS (SPECIFY) (3)		U		0. 00	0	35. 21
35. 22	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 22
35. 23	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 23
JJ. ∠3	(3)		U		0.00		30.23
35. 24	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 24
35. 25	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	35. 25
JJ. ZJ	(3)		U		0.00		33. 23
50.00	TOTAL (sum of lines 1 thru 49)		2, 148, 732				50. 00
	(Transfer to Worksheet A, column 6, line 200.)						
	1						

⁽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 OFFICE COSTS

Provider CCN: 15-3043 Peri od:

Worksheet A-8-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

				10 12/31/2022	5/12/2023 10:	
	Li ne No.	Cost Center	Expense I tems	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 ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1. 00	5. 00	ADMINISTRATIVE & GENERAL	Home Office Costs - Actual	4, 766, 063	1, 985, 850	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
4.05	1.00	CAP REL COSTS-BLDG & FIXT	Hospital Related services	62, 183	62, 183	4. 05
4.08	4. 00	EMPLOYEE BENEFITS DEPARTMENT	Hospital Related services	143	143	4. 08
4.09	5. 00	ADMINISTRATIVE & GENERAL	Hospital Related services	64, 609	64, 609	4. 09
4. 10	7. 00	OPERATION OF PLANT	Hospital Related services	3, 916	3, 916	4. 10
4. 17	15. 00	PHARMACY	Hospital Related services	26, 375	26, 375	4. 17
4. 20	30.00	ADULTS & PEDIATRICS	Hospital Related services	215, 865	215, 865	4. 20
4. 26	54.00	RADI OLOGY-DI AGNOSTI C	Hospital Related services	330, 164	330, 164	4. 26
4.33	73.00	DRUGS CHARGED TO PATIENTS	Hospital Related services	80	80	4. 33
5.00	0		0	5, 469, 398	2, 689, 185	5. 00
* TI						

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.

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
- 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.

4.00

4.05

4 08

4.09

4. 10

4 17

4.20

4. 26

4.33

5.00

5.00 2, 780, 213 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		
Type of Business		
Type of business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

i ei ilibui	erinburseniert under titte Aviii.						
	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:
- 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.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

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Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Community Health Network Rehab Hosp
Provider CCN: 15-3043 In Lieu of Form CMS-2552-10 | Peri od: | Worksheet A-8-2 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

							To 12/31/2022	2 Date/Time Pre 5/12/2023 10:	
	Wkst. A Line #	Cost	Center/Physician	Total	Professi onal	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	0	1. 00
2.00	30.00	DR. B		4, 500		0 4,50	0 211, 500	25	2. 00
3.00	0.00			0		0	0 0	0	3. 00
4.00	0.00			0		0	0 0	0	4. 00
5.00	0.00			0		0	o c	0	5. 00
6.00	0.00			0		0	o c	0	6. 00
7.00	0.00			0		0	o c	0	7. 00
8.00	0.00			0		0	o c	0	8. 00
9.00	0.00			0		0	o c	0	9. 00
10.00	0.00			0		0	o c	0	10.00
200.00				4, 500		0 4,50	o	25	200.00
	Wkst. A Line #	Cost	: Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
			Identi fi er	Limit		CE Memberships 8		of Malpractice	
					Limit	Conti nui ng	Share of col.	Insurance	
						Educati on	12		
	1. 00		2. 00	8. 00	9. 00	12.00	13.00	14.00	
1.00	0. 00			0			0 0		
2.00	30. 00	JR. B		2, 542			0 0		
3.00	0. 00			0		0	0	0	
4.00	0.00			0		0	0	0	
5.00	0.00			0		0	0	0	
6.00	0.00			0		0		0	
7.00	0.00			0		0		0	
8. 00 9. 00	0. 00 0. 00			0		0		0	
				0		0		0	
10.00	0. 00			2 542	12	0	0	1	
200.00	Wkst. A Line #	Coot	Center/Physician	2, 542 Provi der	Adjusted RCE		Adjustment	0	200. 00
	WKSt. A LINE #	COST	I denti fi er	Component	Limit	Di sal I owance	Adj us tillerit		
			ruentiffei	Share of col.	LIIIII	DI Sai i Owance			
				14					
	1. 00		2. 00	15. 00	16. 00	17. 00	18.00		
1. 00	0.00			0			0 0		1, 00
2. 00	30.00	OR. B		0	2, 54	1, 95	1, 958		2. 00
3. 00	0.00			0	, -	0	ol c	1	3. 00
4.00	0.00			0		0	ol c		4. 00
5. 00	0.00			0		0	ol c		5. 00
6. 00	0.00			0		0	ol d		6. 00
7.00	0.00			0		0	ol c		7. 00
8. 00	0.00			l o		0	ol d		8. 00
9. 00	0. 00			l o		0	ol d		9. 00
10. 00	0.00			0		0	o c		10.00
200.00				0	2, 54	1, 95	1, 958	s	200.00
	. '			•	'			•	

Peri od: Worksheet B
From 01/01/2022 Part I
To 1/21/2022 Part Jime Propagad:

				To	12/31/2022	Date/Time Pre	pared:
			CAPI TAL REI	ATED COSTS		5/12/2023 10:	47 am
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		col. 7) 0	1. 00	2. 00	4. 00	4A	
	GENERAL SERVICE COST CENTERS		1.00	2.00	1. 00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 741, 903	1, 741, 903				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	409, 908		409, 908			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 534, 551	0	0	1, 534, 551		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	6, 712, 317	62, 543		120, 215	6, 909, 793	
7. 00	00700 OPERATION OF PLANT	456, 103	57, 696		0	527, 376	1
8.00	00800 LAUNDRY & LINEN SERVICE	101, 386	20, 303		0	126, 467	8. 00
9.00	00900 HOUSEKEEPI NG	436, 352	8, 753		55, 300	502, 465	1
10.00	01000 DI ETARY	835, 176	112, 622	26, 502	70, 997	1, 045, 297	10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	602, 630	13, 295	3, 129	58, 168	0 677, 222	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	196, 916	13, 293	3, 129	30, 100	196, 916	1
15. 00	01500 PHARMACY	565, 979	1, 911	450	52, 254	620, 594	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	451, 463	2, 770		63, 909	518, 794	1
17. 00	01700 SOCIAL SERVICE	0	0	i e	0	0.07.77	1
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDI ATRI CS	9, 222, 225	1, 257, 512	295, 920	560, 010	11, 335, 667	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS				-1		
50.00	05000 OPERATING ROOM	0	0		0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	362, 174	0	0	0	362, 174	1
60.00	06000 LABORATORY	-10, 546	31, 299		14 107	28, 118	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	155, 798 1, 442, 115	2, 770 64, 704		16, 187 199, 727	175, 407 1, 721, 772	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 182, 770	62, 792		168, 193	1, 721, 772	67. 00
68. 00	06800 SPEECH PATHOLOGY	372, 727	35, 205		52, 949	469, 165	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	189, 978	0 0	0, 204	32, 747	189, 978	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	347, 608	0	Ö	o	347, 608	1
74.00	07400 RENAL DIALYSIS	19, 036	0	0	0	19, 036	1
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	0	0		0	0	90. 00
91.00	09100 EMERGENCY	0	0	0	0	0	91. 00
	OTHER REIMBURSABLE COST CENTERS				-1		
95. 00	09500 AMBULANCE SERVICES	0	0		0	0	
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	27, 328, 569	1, 734, 175	408, 089	1, 417, 909	27, 202, 380	110 00
110.00	NONREI MBURSABLE COST CENTERS	21, 320, 307	1, 734, 173	400, 007	1, 417, 707	21, 202, 300	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	O	0		o		192. 00
	07950 NONALLOWABLE CASE MANAGER	827, 766	0	0	116, 642	944, 408	
	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		194. 03
	07954 CENTRALIZED ADMISSIONS (CAD)	0	0		0		194. 04
	07955 CENTRALIZED BUSINESS (CBO)	0	0	-	0		194. 05
	07956 CENTRALIZED STAFFING	0	0	0	0		194. 06
	707957 HR MANAGED CARE	0	0	0	0		194. 07
	07959 LACUNA HEALTH 07958 SALES & MARKETING	0	7, 728	1, 819	0		194. 08 194. 09
	07956 SALES & MARKETING 07962 OTHER NONREIMBURSABLE COST CENTERS	0	1, 120	1, 019	0		194. 09
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION		0		0		194. 10
	207960 VISITOR MEALS		0		0		194. 11
200.00	1				Ĭ		200. 00
201.00	1 1		0	o	o	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	28, 156, 335	1, 741, 903	409, 908	1, 534, 551	28, 156, 335	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-3043

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared: | 5/12/2023 10: 47 am

						5/12/2023 10:	47 am
	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	•		•			
1.00	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, 909, 793					5.00
	00700 OPERATION OF PLANT	The state of the s	400.000				
7.00		171, 513	698, 889				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	41, 130	8, 750		,,,,,,,,		8. 00
9. 00	00900 HOUSEKEEPI NG	163, 412	3, 772		669, 649		9. 00
10. 00	01000 DI ETARY	339, 951	48, 537	0	47, 355	1, 481, 140	1
11. 00	01100 CAFETERI A	0	0	0	0	102, 662	11. 00
13.00	01300 NURSING ADMINISTRATION	220, 246	5, 730	0	5, 590	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	64, 041	0	0	o	0	14. 00
15.00	01500 PHARMACY	201, 830	824	l 0	804	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	168, 722	1, 194		1, 165	0	16. 00
17. 00	01700 SOCI AL SERVI CE	0	1, 1, 1	l o	1, 100	0	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0	0	23. 00
23.00		U	U		U	U	23.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2 (0/ 577	F41 0F0	17/ 247	F20 740	1 2/0 024	20.00
30.00	03000 ADULTS & PEDIATRICS	3, 686, 577	541, 950	1	528, 748	1, 369, 024	
31. 00	03100 INTENSIVE CARE UNIT	0	0	_	O	0	31.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	117, 786	0	0	0	0	54.00
60.00	06000 LABORATORY	9, 145	13, 489	0	13, 161	0	60.00
65.00	06500 RESPI RATORY THERAPY	57, 046	1, 194		1, 165	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	559, 955	27, 885		27, 206	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	464, 587	27, 062		26, 403	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	1			14, 803	0	68. 00
		152, 582	15, 172	0	14, 603		1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	61, 785	0	0	U	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	113, 049	0	0	0	0	73. 00
74. 00	07400 RENAL DI ALYSI S	6, 191	0	0	0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						1
90. 00	09000 CLI NI C	0	0	0			90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
70.00	SPECIAL PURPOSE COST CENTERS				9		70.00
118.00		6, 599, 548	695, 559	176, 347	666, 400	1, 471, 686	110 00
110.00		0, 399, 340	090, 009	170, 347	000, 400	1, 471, 000	1110.00
400.00	NONREI MBURSABLE COST CENTERS		0		ام	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	307, 140	0	0	0		194. 00
194. 01	07951 I DLE SPACE	0	0	0	0	0	194. 01
194. 02	2 07952 DI STRI CT	0	0	0	0	0	194. 02
194. 03	07953 DISTRICT SALES	0	0	0	ol	0	194. 03
	1 07954 CENTRALIZED ADMISSIONS (CAD)	0	0	0	0	0	194. 04
	07955 CENTRALIZED BUSINESS (CBO)	0	0	l o	0		194. 05
	07956 CENTRALIZED STAFFING	0	0	١	0	_	1
	707957 HR MANAGED CARE	0	0	0	0		194. 06 194. 07
		0	0		U o		
	3 07959 LACUNA HEALTH	0	0	0	0		194. 08
	9 07958 SALES & MARKETING	3, 105	3, 330	0	3, 249		194. 09
	07962 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 10
	07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0		194. 11
194. 12	207960 VISITOR MEALS	0	0	0	0	9, 454	194. 12
200.00	Cross Foot Adjustments						200. 00
201.00		0	0	0	ol	0	201. 00
202.00		6, 909, 793	698, 889	176, 347	669, 649	1, 481, 140	202.00

			10) 12/31/2022	5/12/2023 10:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	, , <u>G</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 0PERATION 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	102, 662	1				11. 00
13.00 01300 NURSING ADMINISTRATION	3, 838	1				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	C	_	260, 957			14. 00
15. 00 01500 PHARMACY	2, 878	1	2, 170	829, 100		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	5, 757	1	12, 929	0	708, 561	16. 00
17. 00 01700 SOCI AL SERVI CE	C		1, 284	0	0	17. 00
23. 00 O2300 PARAMED ED PRGM-(SPECIFY)	C	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS			0.004	al	0.40 /.40	
30. 00 03000 ADULTS & PEDI ATRI CS	55, 648	1	3, 321	0	343, 613	30.00
31. 00 03100 INTENSIVE CARE UNIT	C		0	0	0	31.00
44. 00 O4400 SKILLED NURSING FACILITY	C	0	0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS		ا		ما		F0 00
50. 00 05000 OPERATING ROOM	C		0	0	7 022	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C		0	0	7, 833	
60. 00 06000 LABORATORY	1 010		0	12 7/2	11, 576	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 919		0	13, 762	1, 199	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	16, 311		0	0	107, 556	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	12, 473	1	2 242	0	127, 442 57, 443	68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 838	1	3, 262 237, 991	0		71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		-		015 220	104	73.00
73.00 07300 DROGS CHARGED TO PATTENTS 74.00 07400 RENAL DIALYSIS	C	1	0	815, 338	47, 943	•
OUTPATIENT SERVICE COST CENTERS		v <u>l</u>	U _I	U	3, 852	74. 00
90. 00 09000 CLINIC	C	ol	0	0	0	90.00
91. 00 09100 EMERGENCY		1	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS		y O	U _I	<u> </u>	U	71.00
95. 00 09500 AMBULANCE SERVICES	C	ol ol	0	O	0	95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS			0	0	0	98.00
SPECIAL PURPOSE COST CENTERS		<u>'l</u>	9	<u> </u>	0	70.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	102, 662	912, 626	260, 957	829, 100	708, 561	118 00
NONREI MBURSABLE COST CENTERS	102,002	712,020	200, 707	027, 100	700,001	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	ol ol	0	0	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES		ol	0	Ö		192. 00
194.00 07950 NONALLOWABLE CASE MANAGER		ol	0	Ö		194. 00
194. 01 07951 I DLE SPACE	C	ol	0	0	0	194. 01
194. 02 07952 DI STRI CT	C	o	0	0		194. 02
194. 03 07953 DI STRI CT SALES	C	ol	0	0	0	194. 03
194.04 07954 CENTRALIZED ADMISSIONS (CAD)	C	ol	0	0	0	194. 04
194. 05 07955 CENTRALI ZED BUSI NESS (CBO)	C	ol	0	0	0	194. 05
194.06 07956 CENTRALIZED STAFFING	C	ol	0	0	0	194. 06
194.07 07957 HR MANAGED CARE	C	o	0	0	0	194. 07
194.08 07959 LACUNA HEALTH	C	ol ol	0	o	0	194. 08
194.09 07958 SALES & MARKETING	C	ol ol	0	o	0	194. 09
194.10 07962 OTHER NONREIMBURSABLE COST CENTERS	C	ol ol	0	o	0	194. 10
194.11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	C	ol ol	0	o	0	194. 11
194.12 07960 VISITOR MEALS	C	ol ol	0	0	0	194. 12
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	C	이	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	102, 662	912, 626	260, 957	829, 100	708, 561	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Peri od: Worksheet B
From 01/01/2022 Part I
To 1/21/2022 Part Jime Propagad:

			T		Date/Time Pre 5/12/2023 10:	
Cost Center Description	SOCI AL SERVI CE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	47 аш
	17. 00	23. 00	24. 00	25. 00	26. 00	
GENERAL SERVICE COST CENTERS	T T			I		1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIBRARY 17.00 01700 SOCIAL SERVICE 23.00 O2300 PARAMED ED PRGM-(SPECIFY)	1, 284 0	0				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
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 204	ما	10.054.005	0	10.054.005	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 44. 00 04400 SKILLED NURSING FACILITY	1, 284 0 0	0 0 0	18, 954, 805 0 0	0	18, 954, 805 0 0	30. 00 31. 00 44. 00
ANCILLARY SERVICE COST CENTERS 50. 00 OPERATING ROOM	O	0	0	ol	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o o	Ö	487, 793	o	487, 793	1
60. 00 06000 LABORATORY	0	0	75, 489	0	75, 489	1
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0	251, 692 2, 460, 685	0	251, 692 2, 460, 685	1
67. 00 06700 OCCUPATIONAL THERAPY	0	0	2, 460, 663	1	2, 460, 665	1
68. 00 06800 SPEECH PATHOLOGY	l o	o	716, 265	1	716, 265	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	О	489, 858	1	489, 858	1
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	1, 323, 938	I I	1, 323, 938	1
74. 00 O7400 RENAL DIALYSIS	0	0	29, 079	0	29, 079	74. 00
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 OP000 CLINIC	0	0	0	0	0	90.00
91. 00 09100 EMERGENCY	o	ő	0		0	1
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0	0	0		0	
98. 00 09850 OTHER REI MBURSABLE COST CENTERS SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	98. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 284	0	26, 876, 102	0	26, 876, 102	118 00
NONREI MBURSABLE COST CENTERS	1,720.1	<u> </u>	20,0,0,102	<u> </u>	20, 0, 0, 102	1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	-		192. 00
194.00 07950 NONALLOWABLE CASE MANAGER 194.01 07951 IDLE SPACE	0	0	1, 251, 548 0		1, 251, 548	194. 00
194. 02 07952 DI STRI CT	0	0	0			194. 01
194. 03 07953 DI STRI CT SALES	o	ō	0			194. 03
194.04 07954 CENTRALIZED ADMISSIONS (CAD)	0	0	0			194. 04
194. 05 07955 CENTRALIZED BUSINESS (CBO)	0	0	0			194. 05
194.06 07956 CENTRALIZED STAFFING 194.07 07957 HR MANAGED CARE	0	0	0			194. 06 194. 07
194. 08 07959 LACUNA HEALTH	0	o	0	-		194. 07
194. 09 07958 SALES & MARKETING	o	O	19, 231	0		194. 09
194. 10 07962 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194. 10
194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0 454	0		194. 11
194.12 07960 VISITOR MEALS 200.00 Cross Foot Adjustments	0	0	9, 454 0	1		194. 12 200. 00
201.00 Negative Cost Centers	O	ő	0	o		201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 284	О	28, 156, 335	o	28, 156, 335	202. 00

Health Financial Systems Community Health Network Rehab Hosp In Lieu of Form CMS-2552-10

COST ALLOCATION STATISTICS
Provider CCN: 15-3043
Period: From 01/01/2022 To 12/31/2022 Date/Time Prepared:

			5/12/2023 10:	47 am
	Cost Center Description	Statistics	Statistics Description	
		Code		
		1. 00	2. 00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET #1	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	SQUARE FEET #2	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	7	SQUARE FEET #3	7.00
8.00	LAUNDRY & LINEN SERVICE	Р	PATIENT DAYS	8.00
9.00	HOUSEKEEPI NG	9	SQUARE FEET #4	9.00
10.00	DI ETARY	10	MEALS SERVED	10.00
11. 00	CAFETERI A	11	CAFETERIA FTES	11.00
13.00	NURSI NG ADMINI STRATI ON	13	NURSING FTES	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15. 00	PHARMACY	15	COSTED REQUIS.	15. 00
16.00	MEDICAL RECORDS & LIBRARY	С	GROSS REVENUE	16.00
17.00	SOCI AL SERVI CE	Р	PATIENT DAYS	17.00
23.00	PARAMED ED PRGM-(SPECIFY)	23	ASSIGNED TIME	23.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Community Health Network Rehab Hosp
Provider CCN: 15-3043

				То	12/31/2022	Date/Time Pre	
	·		CAPI TAL REI	LATED COSTS		5/12/2023 10:	47 alli
			57.11 T.	271728 00010			
	Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs	4 00	0.00	0.4	4.00	
	CENEDAL CEDVICE COST CENTEDS	0	1.00	2. 00	2A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & TTAT						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	o	o	0	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	701, 564	62, 543	- 1	778, 825	0	5. 00
7. 00	00700 OPERATION OF PLANT	0	57, 696		71, 273	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	20, 303		25, 081	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	8, 753	2, 060	10, 813	0	9. 00
10.00	01000 DI ETARY	0	112, 622	26, 502	139, 124	0	10.00
11. 00	01100 CAFETERI A	0	0	0	0	0	11. 00
13.00	01300 NURSING ADMINISTRATION	0	13, 295	3, 129	16, 424	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14. 00
15. 00	01500 PHARMACY	0	1, 911		2, 361	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	2, 770		3, 422	0	16.00
17. 00	01700 SOCIAL SERVICE	0	0		0	0	17. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	U	0	0	0	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	0	1, 257, 512	295, 920	1, 553, 432	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	1, 237, 312	1	1, 555, 452	0	31.00
44. 00	04400 SKILLED NURSING FACILITY	0	Ö		ő	0	44. 00
00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		
50.00	05000 OPERATI NG ROOM	0	0	0	0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	o	0	54.00
60.00	06000 LABORATORY	0	31, 299	7, 365	38, 664	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	2, 770	652	3, 422	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	64, 704		79, 930	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	62, 792		77, 568	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	35, 205		43, 489	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	-	0	0	73. 00 74. 00
74.00	OUTPATIENT SERVICE COST CENTERS	U		U U	<u> </u>	0	74.00
90. 00	09000 CLINIC	0	0	0	o	0	90.00
91. 00	09100 EMERGENCY	0	o		o	0	91. 00
	OTHER REIMBURSABLE COST CENTERS		-	-1	-,		1
95.00	09500 AMBULANCE SERVI CES	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		701, 564	1, 734, 175	408, 089	2, 843, 828	0	118. 00
	NONREI MBURSABLE COST CENTERS	_			_1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	- 1	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
	07950 NONALLOWABLE CASE MANAGER 07951 IDLE SPACE	0	0	0	0		194. 00
	07951 TDLE SPACE 07952 DI STRI CT	0	0	0	ol Ol		194. 01 194. 02
	07953 DI STRI CT SALES	0	0	0	0		194. 02
	07954 CENTRALIZED ADMISSIONS (CAD)	0	0	Ö	Ö		194. 04
	07955 CENTRALIZED BUSINESS (CBO)	0	0	Ö	Ö		194. 05
	07956 CENTRALIZED STAFFING	0	Ö	Ō	ō		194. 06
	07957 HR MANAGED CARE	0	Ö	0	ō		194. 07
	07959 LACUNA HEALTH	0	0	0	o		194. 08
	07958 SALES & MARKETING	0	7, 728	1, 819	9, 547		194. 09
	07962 OTHER NONREIMBURSABLE COST CENTERS	0	0	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	, ,		_		0	_	200.00
201.00		701 574	0	400 000	0 050 075		201. 00
202.00	TOTAL (sum lines 118 through 201)	701, 564	1, 741, 903	409, 908	2, 853, 375	Ü	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3043

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

5/12/2023 10:47 am Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 778.825 5 00 7.00 00700 OPERATION OF PLANT 19, 332 90, 605 7.00 4,636 30, 851 00800 LAUNDRY & LINEN SERVICE 8.00 1, 134 8.00 9.00 00900 HOUSEKEEPI NG 18, 419 489 29, 721 9.00 C 01000 DI ETARY 185, 835 10.00 0 10.00 38, 317 6, 292 2.102 11.00 01100 CAFETERI A 12,881 11.00 13.00 01300 NURSING ADMINISTRATION 24,825 743 0 248 Ω 13.00 01400 CENTRAL SERVICES & SUPPLY 7, 218 0 14.00 14 00 C 0 0 0 15.00 01500 PHARMACY 22, 749 107 36 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 19,017 155 0 52 0 16.00 01700 SOCIAL SERVICE 0 17.00 17.00 0 0 0 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 Ω 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 30 851 30.00 415, 523 70, 259 23, 467 171, 768 03100 INTENSIVE CARE UNIT 31.00 31.00 0 0 0 04400 SKILLED NURSING FACILITY 0 44.00 0 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 13, 276 0 0 54.00 C 0 0 54.00 06000 LABORATORY 60.00 1,031 1,749 584 0 60.00 65.00 06500 RESPIRATORY THERAPY 6,430 155 0 52 0 65.00 66.00 06600 PHYSI CAL THERAPY 63, 115 3, 615 0 1, 207 0 66.00 06700 OCCUPATIONAL THERAPY 3, 508 0 67.00 52, 366 1, 172 Λ 67.00 68.00 06800 SPEECH PATHOLOGY 17, 198 1,967 0 657 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 6, 964 0 71.00 0 0 71.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 12.742 ol 0 73.00 C 07400 RENAL DIALYSIS 0 74.00 698 C 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 91 00 09100 EMERGENCY 0 0 0 0 Ω 91 00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 0 09850 OTHER REIMBURSABLE COST CENTERS 98.00 0 0 0 0 98.00 SPECIAL PURPOSE COST CENTERS 30, 851 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 743,856 90, 173 29, 577 184, 649 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN n O 0 0 190, 00 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 194.00 07950 NONALLOWABLE CASE MANAGER 34, 619 0 0 194.00 0 194. 01 07951 I DLE SPACE 0 0 0 0 194. 01 0 0 194. 02 07952 DI STRI CT 0 194. 02 0 Ω 194. 03 07953 DI STRI CT SALES 0 0 0 0 194. 03 194.04 07954 CENTRALIZED ADMISSIONS (CAD) 0 0 0 0 0 194. 04 194. 05 07955 CENTRALIZED BUSINESS (CBO) 0 0 0 194. 05 0 0 194.06 07956 CENTRALIZED STAFFING 0 194 06 Ω 194. 07 07957 HR MANAGED CARE 0 0 0 0 0 194. 07 194.08 07959 LACUNA HEALTH 0 0 0 194. 08 194. 09 07958 SALES & MARKETING 0 0 194. 09 350 432 144 194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS 0 0 C 0 0 194 10 194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION 0 0 0 0 194. 11 0 194. 12 07960 VISITOR MEALS 0 0 0 1, 186 194. 12 Cross Foot Adjustments 200.00 200.00 201 00 Negative Cost Centers Γ 0 201.00 202.00 TOTAL (sum lines 118 through 201) 778, 825 29, 721 185, 835 202. 00 90,605 30, 851

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-3043

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

5/12/2023 10:47 am Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL ADMI NI STRATI ON SERVICES & RECORDS & SUPPLY LI BRARY 11. 00 13.00 15.00 14.00 16,00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 12,881 11.00 01300 NURSING ADMINISTRATION 42, 722 13.00 13.00 482 01400 CENTRAL SERVICES & SUPPLY 7, 218 14.00 Λ 14.00 15.00 01500 PHARMACY 361 0 60 25, 674 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 722 358 23, 726 16.00 01700 SOCIAL SERVICE 17.00 0 36 0 17.00 C 0 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 981 42, 722 92 0 11, 491 30.00 03100 INTENSIVE CARE UNIT 0 31.00 0 0 Λ 31.00 44.00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 0 0 263 54.00 60.00 06000 LABORATORY 0 0 0 0 388 60.00 06500 RESPIRATORY THERAPY 65.00 241 0 426 40 65.00 66 00 06600 PHYSI CAL THERAPY 2 047 0 0 3, 606 66 00 0 06700 OCCUPATIONAL THERAPY 67.00 1,565 0 0 0 4, 273 67.00 68.00 06800 SPEECH PATHOLOGY 482 90 0 1, 926 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 6,582 0 71.00 3 07300 DRUGS CHARGED TO PATIENTS 1, 607 73.00 0 C 0 25, 248 73.00 74.00 07400 RENAL DIALYSIS 0 129 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 n O 0 n 90.00 09100 EMERGENCY 0 91.00 0 0 91.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 O Ω 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 12, 881 42, 722 7, 218 25, 674 23, 726 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 194.00 07950 NONALLOWABLE CASE MANAGER 0 0 0 0 0 194.00 194. 01 07951 I DLE SPACE 0000000000 0 0 0 0 0 0 0 0 0 0 0 194. 01 0 194. 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) 0 194. 04 194. 05 07955 CENTRALIZED BUSINESS (CBO) 0 0 194. 05 0 194.06 07956 CENTRALIZED STAFFING 0 0 194.06 0 194. 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 0 194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS Ω 0 0 194. 10 194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION 0 0 0 0 194. 11 194. 12 07960 VISITOR MEALS 0 0 194. 12 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201. 00 202.00 TOTAL (sum lines 118 through 201) 12, 881 42, 722 7, 218 25, 674 23, 726 202. 00

Health Financial Systems In Lieu of Form CMS-2552-10 Community Health Network Rehab Hosp ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-3043 Peri od: Worksheet B From 01/01/2022 Part II 12/31/2022 Date/Time Prepared: 5/12/2023 10:47 am 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 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16.00 17.00 01700 SOCIAL SERVICE 36 17.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 36 2, 326, 622 2, 326, 622 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 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 00000000 05400 RADI OLOGY-DI AGNOSTI C 13, 539 0 13, 539 54.00 54.00 60.00 06000 LABORATORY 42, 416 0 42, 416 60.00 06500 RESPIRATORY THERAPY 10, 766 10, 766 65.00 65 00 66.00 06600 PHYSI CAL THERAPY 153, 520 153, 520 66.00 06700 OCCUPATIONAL THERAPY 140, 452 140, 452 67.00 0 67.00 06800 SPEECH PATHOLOGY 65, 809 65, 809 68.00 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 13, 549 13, 549 71.00 71.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 39, 597 0 39, 597 73.00 74.00 07400 RENAL DIALYSIS 74.00 827 0 827 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0 0 0 0 09100 EMERGENCY 0 0 91.00 91.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 0 0 0 0 09850 OTHER REIMBURSABLE COST CENTERS 98.00 0 0 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 36 0 2, 807, 097 0 2, 807, 097 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 000000000000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 192.00 0 34, 619 194. 00 194.00 07950 NONALLOWABLE CASE MANAGER 34, 619 194. 01 07951 I DLE SPACE 0 0 194. 01 194. 02 07952 DI STRI CT 0 0 194. 02 0 194. 03 194. 03 07953 DI STRI CT SALES 0 194.04 07954 CENTRALIZED ADMISSIONS (CAD) 0 194 04 0 0 194. 05 194. 05 07955 CENTRALIZED BUSINESS (CBO) 194.06 07956 CENTRALIZED STAFFING 0 0 194.06 194. 07 07957 HR MANAGED CARE 0 194.07 0 194. 08 07959 LACUNA HEALTH 0 194. 08

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0

10, 473 194. 09

1, 186 194. 12

2, 853, 375 202. 00

0 194. 10

0 194, 11

0 200. 00

0 201.00

10, 473

1, 186

2, 853, 375

194. 09 07958 SALES & MARKETING

194. 12 07960 VISITOR MEALS

200.00

201.00

202.00

194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS

Cross Foot Adjustments

Negative Cost Centers

194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION

TOTAL (sum lines 118 through 201)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-3043

Peri od: Worksheet B-1 From 01/01/2022

12/31/2022 Date/Time Prepared: 5/12/2023 10:47 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SOUARE FEET (SQUARE FEET BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT #1) #2) (GROSS SALARI ES) 1.00 2.00 5A 5. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 62 888 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 62, 888 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 10, 789, 174 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 2 258 2 258 845, 210 -6, 909, 793 21, 246, 542 5 00 7.00 00700 OPERATION OF PLANT 2,083 2,083 527, 376 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 733 733 126, 467 8.00 00900 HOUSEKEEPI NG 316 316 388, 805 0 502, 465 9.00 9.00 0 01000 DI ETARY 1,045,297 10 00 10.00 4,066 4,066 499, 164 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 677, 222 13.00 480 480 408, 969 13.00 0 01400 CENTRAL SERVICES & SUPPLY 196, 916 14.00 14.00 0 620, 594 15.00 01500 PHARMACY 69 69 367, 386 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 100 100 449, 335 0 518, 794 16.00 01700 SOCIAL SERVICE 17.00 0 17.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 45, 400 45, 400 3, 937, 352 11, 335, 667 0 30.00 31.00 03100 INTENSIVE CARE UNIT C 0 31.00 04400 SKILLED NURSING FACILITY 44.00 0 44.00 0 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 362, 174 54.00 54.00 06000 LABORATORY 0 28, 118 60.00 1, 130 1, 130 0 60.00 06500 RESPI RATORY THERAPY 65.00 100 100 113, 809 0 175, 407 65.00 06600 PHYSI CAL THERAPY 66.00 2, 336 2, 336 1, 404, 247 0 1, 721, 772 66, 00 67.00 06700 OCCUPATIONAL THERAPY 2.267 2, 267 1, 182, 537 1, 428, 531 67.00 68.00 06800 SPEECH PATHOLOGY 1, 271 1, 271 372, 275 469, 165 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 189, 978 71.00 71.00 o 73.00 07300 DRUGS CHARGED TO PATIENTS 0 C 0 347, 608 73.00 07400 RENAL DIALYSIS 19, 036 74.00 0 C 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 09100 EMERGENCY 91.00 0 0 0 91.00 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 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 118.00 62,609 62, 609 9, 969, 089 -6, 909, 793 20, 292, 587 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 0 C 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192 00 O Ω 194.00 07950 NONALLOWABLE CASE MANAGER 0 820, 085 0 944, 408 194. 00 194. 01 07951 I DLE SPACE 0 0 0 194. 01 C 0 194. 02 07952 DI STRI CT 0 0 0 0 0 0 0 0 0 194. 02 194. 03 07953 DI STRICT SALES 0 0 194 03 Ω 194.04 07954 CENTRALIZED ADMISSIONS (CAD) 0 C 0 0 194. 04 194. 05 07955 CENTRALIZED BUSINESS (CBO) 0 194. 05 0 194.06 07956 CENTRALIZED STAFFING 0 0 194.06 0 194. 07 07957 HR MANAGED CARE 0 0 194, 07 Ω 194.08 07959 LACUNA HEALTH 0 0 194. 08 194. 09 07958 SALES & MARKETING 9, 547 194. 09 279 270 0 194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS 0 0 194 10 0 194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION 0 0 0 194. 11 194. 12 07960 VISITOR MEALS 0 0 194. 12 C 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1, 741, 903 409, 908 1, 534, 551 6, 909, 793 202. 00 Part I) 0. 325220 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 27. 698496 6.518064 0.142231 204 00 Cost to be allocated (per Wkst. B, 778, 825 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0. 036657 205. 00 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207 00 NAHE unit cost multiplier (Wkst. D, 207 00 Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	O 12/31/2022	Date/Time Prep 5/12/2023 10: CAFETERIA	
	PLANT (SQUARE FEET	LINEN SERVICE (PATIENT DAYS)	(SQUARE FEET #4)	(MEALS SERVED)	(CAFETERI A FTES)	
	#3) 7. 00	8.00	9.00	10.00	11. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT					 -	1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP					 -	2.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT 5.00 O0500 ADMINISTRATIVE & GENERAL					 -	4. 00 5. 00
7. 00 00700 OPERATION OF PLANT	58, 547				 -	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	733				ļ	8. 00
9. 00 00900 HOUSEKEEPI NG	316		57, 498		 -	9. 00
10. 00 01000 DI ETARY	4, 066	0	4, 066		 -	10. 00
11. 00 01100 CAFETERI A	0		0	4, 235	107	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	480	0	480	0	4	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	69 100		69 100	0	3	15. 00 16. 00
17. 00 01700 SOCIAL SERVICE	0		100	0	0	17. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0		Ö	o	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>		•			
30. 00 03000 ADULTS & PEDIATRICS	45, 400	18, 825	45, 400	56, 475	58	30. 00
31. 00 03100 INTENSIVE CARE UNIT	0	l .	0		0	31. 00
44. 00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	0	0	0		0	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
60. 00 06000 LABORATORY	1, 130	0	1, 130	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	100	l .	100	o o	2	65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 336		2, 336	Ö	17	66. 00
67.00 06700 OCCUPATIONAL THERAPY	2, 267	0	2, 267	0	13	67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 271	0	1, 271	0	4	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 O7400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	0		l 0	0	74. 00
90. 00 09000 CLI NI C	0	0	0	ol	0	90. 00
91. 00 09100 EMERGENCY	Ö				0	91. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	l .	0		0	95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
SPECIAL PURPOSE COST CENTERS	E0 2/0	10.005	F7 210	(0.710	107	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	58, 268	18, 825	57, 219	60, 710	107	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	O	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	Ō	0	Ö		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		194. 01
194. 02 07952 DI STRI CT	0	0	0	0		194. 02
194. 03 07953 DI STRICT SALES	0	0		0		194. 03 194. 04
194. 04 07954 CENTRALIZED ADMISSIONS (CAD) 194. 05 07955 CENTRALIZED BUSINESS (CBO)	0			0		194. 04
194. 06 07956 CENTRALIZED STAFFING	0			0		194. 06
194. 07 07957 HR MANAGED CARE	Ö	_	Ö	o		194. 07
194.08 07959 LACUNA HEALTH	0	0	0	o	0	194. 08
194.09 07958 SALES & MARKETING	279	0	279	0		194. 09
194. 10 07962 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 10
194. 11 07961 NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0		194. 11
194.12 07960 VISITOR MEALS 200.00 Cross Foot Adjustments	0	0	0	390	0	194. 12 200. 00
201.00 Negative Cost Centers					 -	200.00
202.00 Cost to be allocated (per Wkst. B,	698, 889	176, 347	669, 649	1, 481, 140	102, 662	
Part I)]	1, 121, 110		
203.00 Unit cost multiplier (Wkst. B, Part I)	11. 937230	9. 367703	11. 646475	24. 241244	959. 457944	
204.00 Cost to be allocated (per Wkst. B,	90, 605	30, 851	29, 721	185, 835	12, 881	204. 00
Part II)	4 5 4 7 5 1 -	4 (0005)	0 51/0	0.01115	100 0001=-	205 22
205.00 Unit cost multiplier (Wkst. B, Part	1. 547560	1. 638831	0. 516905	3. 041489	120. 383178	205. 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)	l	I	I		ļ	

COST A	LLOCA	TION - STATISTICAL BASIS	<u> </u>	Provider CO		Peri od:	Worksheet B-1	
						From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
			NUDCLNO	OFNEDAL	DUA DIA OV	MEDICAL	5/12/2023 10:	47 am_
		Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDICAL RECORDS &	SOCIAL SERVICE	
				SUPPLY	REQUIS.)	LI BRARY	(PATIENT DAYS)	
			(NURSING FTES)	(COSTED	·	(GROSS		
			13.00	REQUI S.) 14. 00	15. 00	16. 00	17. 00	
	GENER	AL SERVICE COST CENTERS	13.00	14.00	13.00	10.00	17.00	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00		OPERATION OF PLANT						7. 00
8. 00	00800	LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY						9. 00 10. 00
11. 00	1	CAFETERIA						11. 00
13. 00	1	NURSI NG ADMI NI STRATI ON	58					13. 00
14.00		CENTRAL SERVICES & SUPPLY	0	17, 681	050 50			14.00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	0	147 876	353, 58	0 72, 652, 326		15. 00 16. 00
17. 00	1	SOCIAL SERVICE		87		0 72,032,320	18, 825	1
23. 00		PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	23. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS		225		0 25 222 220	10.005	20.00
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	58	225 0		0 35, 233, 339 0 0	18, 825 0	30. 00 31. 00
44. 00	1	SKILLED NURSING FACILITY	o o	0		0 0	ő	•
		LARY SERVICE COST CENTERS						
50. 00 54. 00	1	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	0	0		0 000	0 0	
60. 00		LABORATORY	0	0		0 803, 098 0 1, 186, 891	0	60.00
65. 00		RESPI RATORY THERAPY	o	0	5, 86		0	65. 00
66. 00	1	PHYSI CAL THERAPY	0	0		0 11, 028, 013	0	66.00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0 221		0 13, 066, 962 0 5, 889, 816	0	67. 00 68. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS		16, 125		0 10, 627		71.00
73. 00	07300	DRUGS CHARGED TO PATIENTS	O	0			0	ı
74. 00		RENAL DIALYSIS	0	0		0 394, 989	0	74. 00
90. 00		TIENT SERVICE COST CENTERS	0	0		0 0	0	90. 00
91. 00	1	EMERGENCY	Ö	0		0 0		•
05.00		REIMBURSABLE COST CENTERS						
95. 00 98. 00		AMBULANCE SERVICES OTHER REIMBURSABLE COST CENTERS	0	0		0 0		
70. 00		AL PURPOSE COST CENTERS	<u> </u>	<u> </u>		0		70.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58	17, 681	353, 58	72, 652, 326	18, 825	118. 00
100.00		MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN		0				100 00
		PHYSICIANS' PRIVATE OFFICES	0	0		0 0	l	190. 00 192. 00
		NONALLOWABLE CASE MANAGER	O	0		0 0		194. 00
		I DLE SPACE	0	0		0 0		194. 01
		DISTRICT DISTRICT SALES	0	0		0		194. 02 194. 03
		CENTRALIZED ADMISSIONS (CAD)		0		0 0		194. 04
194. 05	07955	CENTRALIZED BUSINESS (CBO)	0	0		0 0	0	194. 05
		CENTRALIZED STAFFING	0	0		0	l e	194. 06
	1	HR MANAGED CARE LACUNA HEALTH	0	0		0 0	l e	194. 07 194. 08
		SALES & MARKETING	O	0		0 0	l e	194. 09
	1	OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194. 10
		NONREIMB NEW BUSINESS IMPLEMENTATION VISITOR MEALS	0	0		0		194. 11 194. 12
200.00		Cross Foot Adjustments	0	U		0	0	200. 00
201.00		Negative Cost Centers						201. 00
202.00)	Cost to be allocated (per Wkst. B,	912, 626	260, 957	829, 10	708, 561	1, 284	202. 00
203.00		Part I) Unit cost multiplier (Wkst. B, Part I)	15, 734. 931034	14. 759177	2. 34487	0. 009753	0. 068207	203 00
204.00	1	Cost to be allocated (per Wkst. B,	42, 722	7, 218	1		l e	204. 00
		Part II)						
205.00	ľ	Unit cost multiplier (Wkst. B, Part	736. 586207	0. 408235	0. 07261	2 0. 000327	0. 001912	205.00
206.00)	NAHE adjustment amount to be allocated						206. 00
207.00)	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
		Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Community Health Network Rehab Hosp
Provider CCN: 15-3043

			То	12/31/2022 Date/Time Pre 5/12/2023 10:4	
Cost	Center Description	PARAMED ED		37 127 2023 10.	77 (311)
		PRGM			
		(ASSI GNED TIME)			
		23. 00			
	RVICE COST CENTERS				
	REL COSTS-BLDG & FIXT REL COSTS-MVBLE EQUIP				1. 00 2. 00
	DYEE BENEFITS DEPARTMENT				4. 00
5.00 00500 ADMIN	NISTRATIVE & GENERAL				5. 00
	ATION OF PLANT				7. 00
8. 00 00800 LAUNE 9. 00 00900 HOUSE	DRY & LINEN SERVICE				8. 00 9. 00
10. 00 01000 DI ETA	-				10. 00
11. 00 01100 CAFE	1				11. 00
	NG ADMINISTRATION RAL SERVICES & SUPPLY				13.00
15. 00 01500 PHARM	1				14. 00 15. 00
	CAL RECORDS & LIBRARY				16. 00
17. 00 01700 SOCIA	1				17. 00
	MED ED PRGM-(SPECIFY) ROUTINE SERVICE COST CENTERS	0			23. 00
	TS & PEDIATRICS	0			30. 00
31.00 03100 I NTEN	NSIVE CARE UNIT	0			31. 00
	LED NURSING FACILITY	0			44. 00
50. 00 05000 OPERA	SERVICE COST CENTERS	0			50. 00
I I	DLOGY-DI AGNOSTI C	0			54. 00
60. 00 06000 LABOR		O			60. 00
	RATORY THERAPY	0			65. 00
	CAL THERAPY PATIONAL THERAPY	0			66. 00 67. 00
	CH PATHOLOGY	0			68. 00
71.00 07100 MEDIC	CAL SUPPLIES CHARGED TO PATIENTS	0			71. 00
1	S CHARGED TO PATIENTS	0			73. 00
74. 00 07400 RENAL	_ DIALYSIS	O ₁			74. 00
90. 00 09000 CLI NI		0			90. 00
91.00 09100 EMER		0			91. 00
	BURSABLE COST CENTERS _ANCE SERVICES	ol			05 00
	R REIMBURSABLE COST CENTERS	0			95. 00 98. 00
	RPOSE COST CENTERS				
	OTALS (SUM OF LINES 1 through 117)	0			118. 00
	SABLE COST CENTERS FLOWER, COFFEE SHOP & CANTEEN	0			190. 00
	CLANS' PRIVATE OFFICES	o			192. 00
	LOWABLE CASE MANAGER	0			194. 00
194. 01 07951 I DLE		0			194. 01
194. 02 07952 DI STF 194. 03 07953 DI STF		0			194. 02 194. 03
194. 04 07954 CENTE	RALIZED ADMISSIONS (CAD)	Ö			194. 04
	RALIZED BUSINESS (CBO)	0			194. 05
194. 06 07956 CENTF 194. 07 07957 HR MA		0			194. 06 194. 07
194. 08 07959 LACUN		0			194. 07
194. 09 07958 SALES		O			194. 09
	R NONREIMBURSABLE COST CENTERS	0			194. 10
194. 11 0 / 961 NONRE	EIMB NEW BUSINESS IMPLEMENTATION	0			194. 11 194. 12
1 1	s Foot Adjustments	O			200. 00
201. 00 Negat	tive Cost Centers				201. 00
	to be allocated (per Wkst. B,	0			202. 00
Part 203.00 Uni t	cost multiplier (Wkst. B, Part I)	0. 000000			203. 00
1	to be allocated (per Wkst. B,	0			204. 00
Part	11)	2 25			005 05
205. 00 Uni t	cost multiplier (Wkst. B, Part	0. 000000			205. 00
1 1 1	adjustment amount to be allocated	О			206. 00
(per	Wkst. B-2)				
	unit cost multiplier (Wkst. D, s III and IV)	0. 000000			207. 00
raits	5 and 1 v)			l	I

Health Financ	cial Systems Comm	nunity Health Ne	etwork Rehab Ho	osp	In Lie	u of Form CMS-:	2552-10
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provi der CO	!	Period: From 01/01/2022 To 12/31/2022	5/12/2023 10:	
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	0.00	0.00	4.00	F 00	
LNDATI	ENT DOUTINE CEDVICE COCT CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
	ADULTS & PEDIATRICS	10 054 005		10.054.00	1 050	10.057.773	30.00
1 1	INTENSIVE CARE UNIT	18, 954, 805		18, 954, 80	1, 958	18, 956, 763 0	1
	SKILLED NURSING FACILITY	0				0	
	LARY SERVICE COST CENTERS	l o		'	기 이		44.00
	OPERATING ROOM	0				0	50.00
	RADI OLOGY-DI AGNOSTI C	487, 793		487, 79		487. 793	
	LABORATORY	75, 489		75, 48		75, 489	
	RESPI RATORY THERAPY	251, 692	0	251, 69:		251, 692	
	PHYSI CAL THERAPY	2, 460, 685	0	2, 460, 68		2, 460, 685	
	OCCUPATI ONAL THERAPY	2, 086, 498	0	2, 086, 49		2, 086, 498	
	SPEECH PATHOLOGY	716, 265	0	716, 26		716, 265	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	489, 858		489, 85		489, 858	
73. 00 07300	DRUGS CHARGED TO PATIENTS	1, 323, 938		1, 323, 93	3 ol	1, 323, 938	73. 00
74.00 07400	RENAL DIALYSIS	29, 079		29, 07		29, 079	74. 00
OUTPAT	FIENT SERVICE COST CENTERS						
90.00 09000	CLI NI C	0		(0	0	90.00
91.00 09100	EMERGENCY	0		(0	0	91. 00
	REI MBURSABLE COST CENTERS						
	AMBULANCE SERVICES	0		(0	0	95. 00
98. 00 09850	OTHER REIMBURSABLE COST CENTERS	0			0	0	98. 00
	Subtotal (see instructions)	26, 876, 102	0	26, 876, 10:	1, 958		
1	Less Observation Beds	0		(201. 00
202. 00	Total (see instructions)	26, 876, 102	0	26, 876, 10	1, 958	26, 878, 060	202. 00

202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3043 Peri od: Worksheet C From 01/01/2022 To 12/31/2022 Part I Date/Time Prepared: 5/12/2023 10:47 am 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 35, 233, 339 35, 233, 339 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 54.00 05400 RADI OLOGY-DI AGNOSTI C 803, 098 803, 098 0.607389 0.000000 54.00 60.00 06000 LABORATORY 1, 186, 891 0 1, 186, 891 0.063602 0.000000 60.00 06500 RESPIRATORY THERAPY 122, 924 2.047542 65.00 122, 924 0 0.000000 65.00 06600 PHYSI CAL THERAPY 0 11, 028, 013 0. 223130 0.000000 66.00 11, 028, 013 66.00 67.00 06700 OCCUPATIONAL THERAPY 13, 066, 962 0 13, 066, 962 0.159677 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 5, 889, 816 0 5, 889, 816 0. 121611 0.000000 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 10, 627 0.000000 71.00 10, 627 46. 095606 71.00 4, 915, 667 73.00 07300 DRUGS CHARGED TO PATIENTS 0 4, 915, 667 0. 269330 0.000000 73.00 07400 RENAL DIALYSIS 394, 989 394, 989 0.073620 0.000000 74.00 74.00 0 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 0.000000 0.000000 95.00 0 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 \cap 0.000000 0.000000 98.00 200.00 Subtotal (see instructions) 72, 652, 326 0 72, 652, 326 200.00 Less Observation Beds 201.00 201.00

72, 652, 326

0

72, 652, 326

202.00

Total (see instructions)

			10 12/31/2022	5/12/2023 10: 47 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31. 00
44.00 04400 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. 607389			54. 00
60. 00 06000 LABORATORY	0. 063602			60.00
65. 00 06500 RESPI RATORY THERAPY	2. 047542			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 223130			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 159677			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 121611			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	46. 095606			71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 269330			73. 00
74. 00 07400 RENAL DIALYSIS	0. 073620			74. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financ	cial Systems Comm	nunity Health Ne	etwork Rehab Ho	osp	In Lie	u of Form CMS-:	2552-10
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provider Co	!	Period: From 01/01/2022 To 12/31/2022	5/12/2023 10:	
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	0.00	0.00	4.00	F 00	
LNDATI	ENT DOUTINE CEDVICE COCT CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
	ADULTS & PEDIATRICS	10 054 005		10.054.00	1 050	10.057.773	30.00
1 1	INTENSIVE CARE UNIT	18, 954, 805		18, 954, 80	1, 958	18, 956, 763 0	1
	SKILLED NURSING FACILITY	0				0	
	LARY SERVICE COST CENTERS	l o		'	기 이		44.00
	OPERATING ROOM	0				0	50.00
	RADI OLOGY-DI AGNOSTI C	487, 793		487, 79		487. 793	
	LABORATORY	75, 489		75, 48		75, 489	
	RESPI RATORY THERAPY	251, 692	0	251, 69:		251, 692	
	PHYSI CAL THERAPY	2, 460, 685	0	2, 460, 68		2, 460, 685	
	OCCUPATI ONAL THERAPY	2, 086, 498	0	2, 086, 49		2, 086, 498	
	SPEECH PATHOLOGY	716, 265	0	716, 26		716, 265	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	489, 858		489, 85		489, 858	
73. 00 07300	DRUGS CHARGED TO PATIENTS	1, 323, 938		1, 323, 93	3 ol	1, 323, 938	73. 00
74.00 07400	RENAL DIALYSIS	29, 079		29, 07		29, 079	74. 00
OUTPAT	FIENT SERVICE COST CENTERS						
90.00 09000	CLI NI C	0		(0	0	90.00
91.00 09100	EMERGENCY	0		(0	0	91. 00
	REI MBURSABLE COST CENTERS						
	AMBULANCE SERVICES	0		(0	0	95. 00
98. 00 09850	OTHER REIMBURSABLE COST CENTERS	0			0	0	98. 00
	Subtotal (see instructions)	26, 876, 102	0	26, 876, 10:	1, 958		
1	Less Observation Beds	0		(201. 00
202. 00	Total (see instructions)	26, 876, 102	0	26, 876, 10	1, 958	26, 878, 060	202. 00

202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3043 Peri od: Worksheet C From 01/01/2022 To 12/31/2022 Part I Date/Time Prepared: 5/12/2023 10:47 am 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 35, 233, 339 35, 233, 339 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 54.00 05400 RADI OLOGY-DI AGNOSTI C 803, 098 803, 098 0.607389 0.000000 54.00 60.00 06000 LABORATORY 1, 186, 891 0 1, 186, 891 0.063602 0.000000 60.00 06500 RESPIRATORY THERAPY 122, 924 2.047542 65.00 122, 924 0 0.000000 65.00 06600 PHYSI CAL THERAPY 0 11, 028, 013 0. 223130 0.000000 66.00 11, 028, 013 66.00 67.00 06700 OCCUPATIONAL THERAPY 13, 066, 962 0 13, 066, 962 0.159677 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 5, 889, 816 0 5, 889, 816 0. 121611 0.000000 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 10, 627 0.000000 71.00 10, 627 46. 095606 71.00 4, 915, 667 73.00 07300 DRUGS CHARGED TO PATIENTS 0 4, 915, 667 0. 269330 0.000000 73.00 07400 RENAL DIALYSIS 394, 989 394, 989 0.073620 0.000000 74.00 74.00 0 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 0.000000 0.000000 95.00 0 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 \cap 0.000000 0.000000 98.00 200.00 Subtotal (see instructions) 72, 652, 326 0 72, 652, 326 200.00 Less Observation Beds 201.00 201.00

72, 652, 326

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72, 652, 326

202.00

Total (see instructions)

			10 12/31/2022	5/12/2023 10: 47 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31. 00
44.00 04400 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. 607389			54. 00
60. 00 06000 LABORATORY	0. 063602			60.00
65. 00 06500 RESPI RATORY THERAPY	2. 047542			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 223130			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 159677			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 121611			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	46. 095606			71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 269330			73. 00
74. 00 07400 RENAL DIALYSIS	0. 073620			74. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

SOME CITATION OF NATION OF SOCIETY OF SIMMOLE		Trovider of	1	From 01/01/2022 To 12/31/2022	Part I Date/Time Pre 5/12/2023 10:4	
		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	1.00	2.00	3.00	4.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS	18, 954, 805		18, 954, 80!	1, 958	18, 956, 763	30.00
31. 00 03100 NTENSI VE CARE UNI T	0		(0	0	31. 00
44.00 04400 SKILLED NURSING FACILITY	0		(o	0	44. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0		(o o	0	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	487, 793		487, 793		487, 793	1
60. 00 06000 LABORATORY	75, 489		75, 489		75, 489	1
65. 00 06500 RESPI RATORY THERAPY	251, 692	0	251, 692		251, 692	1
66. 00 06600 PHYSI CAL THERAPY	2, 460, 685	0	2, 460, 68!		2, 460, 685	ł
67. 00 06700 OCCUPATI ONAL THERAPY	2, 086, 498	0	2, 086, 498		2, 086, 498	1
68. 00 06800 SPEECH PATHOLOGY	716, 265	O	716, 26!		716, 265	1
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	489, 858		489, 858		489, 858	1
73.00 07300 DRUGS CHARGED TO PATTENTS 74.00 07400 RENAL DIALYSIS	1, 323, 938 29, 079		1, 323, 938 29, 079		1, 323, 938 29, 079	73. 00 74. 00
OUTPATIENT SERVICE COST CENTERS	27,017		29,07	7 0	27, 077	74.00
90. 00 09000 CLINI C	0			ol	0	90.00
91. 00 09100 EMERGENCY	0			ol ol	0	91. 00
OTHER REIMBURSABLE COST CENTERS				-		
95. 00 09500 AMBULANCE SERVICES	0		(0	0	95. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0		(o	0	98. 00
200.00 Subtotal (see instructions)	26, 876, 102	0	26, 876, 102	1, 958	26, 878, 060	
201.00 Less Observation Beds	0		(201. 00
202.00 Total (see instructions)	26, 876, 102	0	26, 876, 102	1, 958	26, 878, 060	202. 00

Health Financial Systems Community Health Network Rehab Hosp COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-3043 Peri od: Worksheet C From 01/01/2022 To 12/31/2022 Part I Date/Time Prepared: 5/12/2023 10:47 am 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 35, 233, 339 35, 233, 339 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 54.00 05400 RADI OLOGY-DI AGNOSTI C 803, 098 803, 098 0.607389 0.000000 54.00 60.00 06000 LABORATORY 1, 186, 891 0 1, 186, 891 0.063602 0.000000 60.00 06500 RESPIRATORY THERAPY 122, 924 2.047542 65.00 122, 924 0 0.000000 65.00 06600 PHYSI CAL THERAPY 0 11, 028, 013 0. 223130 0.000000 66.00 11, 028, 013 66.00 67.00 06700 OCCUPATIONAL THERAPY 13, 066, 962 0 13, 066, 962 0.159677 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 5, 889, 816 0 5, 889, 816 0. 121611 0.000000 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 10, 627 46. 095606 0.000000 71.00 10, 627 71.00 4, 915, 667 73.00 07300 DRUGS CHARGED TO PATIENTS 0 4, 915, 667 0. 269330 0.000000 73.00 07400 RENAL DIALYSIS 394, 989 394, 989 0.073620 0.000000 74.00 74.00 0 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 0.000000 0.000000 95.00 0 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS

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72, 652, 326

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0.000000

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98.00

200.00

201.00

202. 00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

			10 12/31/2022	5/12/2023 10:47 am
		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 RESPI RATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
74. 00 07400 RENAL DIALYSIS	0. 000000			74. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90. 00
91. 00 09100 EMERGENCY	0. 000000			91. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVI CES	0. 000000			95. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems Co	mmunity Health N	etwork Rehab Ho	osp	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2022 To 12/31/2022		narad.
				To 12/31/2022	Date/Time Pre 5/12/2023 10:	
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	2, 326, 622	2	2, 326, 62	2 18, 825	123. 59	30.00
31.00 INTENSIVE CARE UNIT	C)		0	0.00	31.00
44.00 SKILLED NURSING FACILITY	C)		0	0.00	44.00
200.00 Total (lines 30 through 199)	2, 326, 622		2, 326, 62	2 18, 825		200.00
Cost Center Description	I npati ent	I npati ent		•		
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	8, 109	1, 002, 191				30.00
31.00 INTENSIVE CARE UNIT	C	0)			31.00
44.00 SKILLED NURSING FACILITY	C	0)			44. 00
200.00 Total (lines 30 through 199)	8, 109	1, 002, 191				200. 00

Health Financial Systems	Comm	uni ty Hool th Ne	stwark Dabab He	ocn.	In Lie	u of Form CMS-2	DEE2 10
Health Financial Systems APPORTIONMENT OF INPATIENT ANCIL		unity Health Ne L COSTS	Provider Co	CN: 15-3043	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II	pared:
			Title	XVIII	Hospi tal	PPS	
Cost Center Descript	i on	Capi tal	Total Charges	Ratio of Cost	Inpati 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 CEN	ITERS				-		
50. 00 05000 OPERATI NG ROOM		0	0	0. 00000		0	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		13, 539					54.00
60. 00 06000 LABORATORY		42, 416	1, 186, 891	0. 03573	7 490, 410	17, 526	60.00
65. 00 06500 RESPIRATORY THERAPY		10, 766	122, 924	0. 08758	3 49, 803	4, 362	65. 00
66. 00 06600 PHYSI CAL THERAPY		153, 520	11, 028, 013	0. 01392	1 4, 948, 901	68, 894	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	•	140, 452	13, 066, 962	0. 01074	9 5, 624, 068	60, 453	67. 00
68.00 06800 SPEECH PATHOLOGY		65, 809	5, 889, 816	0. 01117	3 2, 380, 628	26, 599	68. 00
71.00 07100 MEDICAL SUPPLIES CHA	RGED TO PATIENTS	13, 549	10, 627	1. 27496	0 801	1, 021	71. 00
73.00 07300 DRUGS CHARGED TO PAT	TENTS	39, 597	4, 915, 667	0. 00805	5 1, 999, 522	16, 106	73. 00
74.00 07400 RENAL DIALYSIS		827	394, 989	0. 00209	4 114, 454	240	74.00
OUTPATIENT SERVICE COST CE	NTERS						
90. 00 09000 CLI NI C		0	0	0.00000	0 0	0	90. 00
91. 00 09100 EMERGENCY		0	0	0. 00000	0 0	0	91. 00
OTHER RELABILISCARIE COCT OF	NTEDC						

0 480, 475

37, 418, 987

0.000000

15, 856, 273

95. 00 0 98. 00 199, 376 200. 00

95. 00 OTHER REIMBURSABLE COST CENTERS
95. 00 O9500 AMBULANCE SERVICES
98. 00 O9850 OTHER REIMBURSABLE COST CENTERS
200. 00 Total (lines 50 through 199)

Health Financial Systems Community Health Network Rehab Hosp In Lieu of Form CMS-2552						
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA				Peri od:	Worksheet D	
				rom 01/01/2022		
			7	To 12/31/2022		
		T: +1 o	: XVIII	Hooni tal	5/12/2023 10: PPS	4/ am_
C+ C+ D	N			Hospi tal		
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other Medical	
	Program	Program	Post-Stepdown			
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments	1.00	24	2.00	3.00	
INDATIONE DOUTING CODY CONTEDC	1A	1.00	2A	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1		1		1 0	00.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0	0	
31. 00 03100 INTENSI VE CARE UNIT	0	0		0	0	0 00
44.00 04400 SKILLED NURSING FACILITY	0	0		0	_	44. 00
200.00 Total (lines 30 through 199)	0	0	(0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	ı	T				
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	18, 825			
31.00 03100 INTENSIVE CARE UNIT		0	(0.00		
44.00 04400 SKILLED NURSING FACILITY		0	(0.00	0	44.00
200.00 Total (lines 30 through 199)		0	18, 825	5	8, 109	200. 00
Cost Center Description	I npati ent	PSA Adj. All				
	Program	Other Medical				
	Pass-Through	Education Cost				
	Cost (col. 7 x					
	col. 8)					
LANDATI ENT. DOUTINE OFFICE OF COOT OFFITEDO	9. 00	13. 00				

0 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 | 010000 | 010000 | 010000 | 010000 | 010000 | 010000 | 010000 | 010000 | 0

Health Financial Systems	th Financial Systems Community Health Network Rehab Hosp			
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-3043	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/12/2023 10:47 am
•		T: +1 o V/////	Heeni tel	DDC

						5/12/2023 10:	47 am
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anestheti st	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	(0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54. 00
60.00	06000 LABORATORY	0	0	(0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	(0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	(0	0	90.00
91.00	09100 EMERGENCY	0	0	(0	0	91. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	(0	0	98. 00
200.00	Total (lines 50 through 199)	0	0	(0	0	200. 00

	nunity Health Ne				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2022 To 12/31/2022		narodi
				10 12/31/2022	5/12/2023 10:	pareu. ∡7 am
Title XVIII Hospital PPS						17 (1111
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 + col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0. 000000	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 803, 098	0. 000000	54. 00
60. 00 06000 LABORATORY	0	0		0 1, 186, 891	0. 000000	60. 00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 122, 924	0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 11, 028, 013	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 13, 066, 962	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 5, 889, 816	0. 000000	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 10, 627	0. 000000	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 4, 915, 667	0. 000000	73. 00
74.00 07400 RENAL DIALYSIS	0	0		0 394, 989	0. 000000	74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	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 37, 418, 987		200. 00
	•		•	*		•

Heal th	Financial Systems Comm	nunity Health Net	twork Rehab Ho	osp	In Lie	eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS			CN: 15-3043	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV	pared:
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	0		0 0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	247, 686		0	0	54.00
60.00	06000 LABORATORY	0. 000000	490, 410		0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	49, 803		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	4, 948, 901		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	5, 624, 068		0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	2, 380, 628		0 0	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	801		0 0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 999, 522		0 0	0	73. 00
	1	0. 000000	114, 454		0 0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0.000000	0		0 0	0	90. 00
91. 00	09100 EMERGENCY	0. 000000	0		0	0	91. 00
	OTHER RELABILE COST CENTERS				-1 -		1

0.000000

15, 856, 273

95. 00 0 98. 00 0 200. 00

0

0

95. 00 OTHER REIMBURSABLE COST CENTERS
95. 00 O9500 AMBULANCE SERVICES
98. 00 O9850 OTHER REIMBURSABLE COST CENTERS
200. 00 Total (lines 50 through 199)

Health Financial Systems	Community Health Netw	ork Rehab Hosp	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-3043	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/12/2023 10:47 am

		Title	XVIII	Hospi tal	PPS	.,
Cost Center Description	PSA Adj. Non	PSA Adj. All	,,,,,,	, noopi tai		
		Other Medical				
		Education Cost				
	Cost					
	21.00	24. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
74. 00 07400 RENAL DIALYSIS	0	0				74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90. 00
91. 00 09100 EMERGENCY	0	0				91. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98. 00
200.00 Total (lines 50 through 199)	0	0				200. 00

Health Financial Systems Co	mmunity Health N	etwork Rehab Ho	osp	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2022 To 12/31/2022		narad.
				To 12/31/2022	Date/Time Pre 5/12/2023 10:	
		Ti tl e	xVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	,	Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 326, 622	2	2, 326, 62	2 18, 825	123. 59	30.00
31.00 INTENSIVE CARE UNIT	C)		0	0.00	31.00
44.00 SKILLED NURSING FACILITY	C)		0	0.00	44.00
200.00 Total (lines 30 through 199)	2, 326, 622		2, 326, 62	2 18, 825		200.00
Cost Center Description	I npati ent	I npati ent		•		
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	8, 109	1, 002, 191				30.00
31.00 INTENSIVE CARE UNIT	C	0)			31.00
44.00 SKILLED NURSING FACILITY	C	0)			44.00
200.00 Total (lines 30 through 199)	8, 109	1, 002, 191				200. 00

Health Financial Systems Comme	nuni tv. Hool th. N	otwork Robob U	ocn	In Lie	u of Form CMS-2	2552 10
Health Financial Systems CommaPPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	nunity Health No AL COSTS	Provider C	CN: 15-3043	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II	pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	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 05000 OPERATING ROOM	0		0.00000		0	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	13, 539					1
60. 00 06000 LABORATORY	42, 416	1, 186, 891	0. 03573	7 490, 410	17, 526	60.00
65. 00 06500 RESPI RATORY THERAPY	10, 766	122, 924	0. 08758	3 49, 803	4, 362	65. 00
66. 00 06600 PHYSI CAL THERAPY	153, 520	11, 028, 013	0. 01392	1 4, 948, 901	68, 894	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	140, 452	13, 066, 962	0. 01074	9 5, 624, 068	60, 453	67. 00
68. 00 06800 SPEECH PATHOLOGY	65, 809	5, 889, 816	0. 01117	3 2, 380, 628	26, 599	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 549	10, 627	1. 27496	0 801	1, 021	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	39, 597	4, 915, 667	0.00805	5 1, 999, 522	16, 106	73. 00
74.00 07400 RENAL DIALYSIS	827	394, 989	0. 00209	4 114, 454	240	74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
91. 00 09100 EMERGENCY	0	0	0. 00000	0 0	0	91. 00
OTHER RELABILISTADI E COCT OFFITERS						I

0 480, 475

37, 418, 987

0.000000

15, 856, 273

95. 00 0 98. 00 199, 376 200. 00

95. 00 OTHER REIMBURSABLE COST CENTERS
95. 00 O9500 AMBULANCE SERVICES
98. 00 O9850 OTHER REIMBURSABLE COST CENTERS
200. 00 Total (lines 50 through 199)

Health Financial Systems Community Health Network Rehab Hosp In Lieu of Form CMS-259						
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA				Peri od:	Worksheet D	
				rom 01/01/2022		
			7	To 12/31/2022		
		T: +1 o	: XVIII	Hooni tal	5/12/2023 10: PPS	<u>4/ am</u>
C+ C+ D	N			Hospi tal		
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other Medical	
	Program	Program	Post-Stepdown			
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments	1.00	24	2.00	2.00	
LNDATIENT DOUTINE CEDVICE COCT CENTEDO	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1		1			00.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0	0	
31. 00 03100 INTENSI VE CARE UNIT	0	0		0	0	011 00
44.00 04400 SKILLED NURSING FACILITY	0	0		0	_	44. 00
200.00 Total (lines 30 through 199)	0	0	(0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	T	Г	T	T	T	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	18, 825			
31.00 03100 INTENSIVE CARE UNIT		0	(0.00		
44.00 04400 SKILLED NURSING FACILITY		0	(0.00	•	1
200.00 Total (lines 30 through 199)		0	18, 825	5	8, 109	200.00
Cost Center Description	I npati ent	PSA Adj. All				
	Program	Other Medical				
	Pass-Through	Education Cost				
	Cost (col. 7 x					
	col. 8)					
LANDATI FAIT DOUTLAND OFFICE COOT OFFITTED	9. 00	13. 00				

0 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 | 010000 | 010000 | 010000 | 010000 | 010000 | 010000 | 010000 | 010000 | 0

Health Financial Systems	Community Health Netw	u of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-3043	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/12/2023 10:47 am
		T' 11 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	11 1 1	DDC

						5/12/2023 10:	47 am
			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 SERVICES						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

Health Financial Systems Community Health Network Rehab Hosp In Lieu of Form CMS-2552						
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2022 To 12/31/2022		narodi
				10 12/31/2022	5/12/2023 10:	pareu. ∡7 am
-		Title	: XVIII	Hospi tal	PPS	17 (1111
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 + col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0. 000000	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 803, 098	0. 000000	54. 00
60. 00 06000 LABORATORY	0	0		0 1, 186, 891	0. 000000	60. 00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 122, 924	0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 11, 028, 013	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 13, 066, 962	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 5, 889, 816	0. 000000	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 10, 627	0. 000000	71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 4, 915, 667	0. 000000	73. 00
74.00 07400 RENAL DIALYSIS	0	0		0 394, 989	0. 000000	74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	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 37, 418, 987		200. 00
			•	*		•

Heal th	Financial Systems Comm	nunity Health Net	twork Rehab Ho	osp	In Lie	eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS				Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV	pared:
			Title	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	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11. 00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	0		0 0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	247, 686		0 0	0	54.00
60.00	06000 LABORATORY	0. 000000	490, 410		0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	49, 803		0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	4, 948, 901		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	5, 624, 068		0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	2, 380, 628		0 0	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	801		0 0	0	71. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 999, 522		0 0	0	73. 00
	1	0. 000000	114, 454		0 0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90. 00
91. 00	09100 EMERGENCY	0. 000000	0		o o	0	91. 00
	OTHER RELABILE COST CENTERS						1

0.000000

15, 856, 273

95. 00 0 98. 00 0 200. 00

0

0

95. 00 OTHER REIMBURSABLE COST CENTERS
95. 00 O9500 AMBULANCE SERVICES
98. 00 O9850 OTHER REIMBURSABLE COST CENTERS
200. 00 Total (lines 50 through 199)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-3043 Period: Worksheet D	Ith Financial Systems	Community Health Ne	twork Rehab Hosp	In Lie	u of Form CMS-2552-10
THROUGH COSTS From 01/01/2022 Part IV To 12/31/2022 Date/Time Prep 5/12/2023 10:4		PATIENT ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-3043	From 01/01/2022 To 12/31/2022	Part IV

		Title	XVIII	Hospi tal	PPS	.,
Cost Center Description	PSA Adj. Non	PSA Adj. All	,,,,,,	, noopi tai		
		Other Medical				
		Education Cost				
	Cost					
	21.00	24. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
74. 00 07400 RENAL DIALYSIS	0	0				74. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90. 00
91. 00 09100 EMERGENCY	0	0				91. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98. 00
200.00 Total (lines 50 through 199)	0	0				200. 00

Health Financial Systems	Community Health Networ	rk Rehab Hosp	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	F	Provider CCN: 15-3043	Peri od: From 01/01/2022	Worksheet D-1	
				Date/Time Pre	pared:
				5/12/2023 10:	
		Title XVIII	Hospi tal	PPS	
Cost Center Description					

		T: +1 o V/// 1 1	Heeni tel	5/12/2023 10:	47 am_
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	oost deliter bescription			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			18, 825	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-le Private room days (excluding swing-bed and observation bed day		ivato room dave	18, 825 0	2. 00 3. 00
3.00	do not complete this line.	ys). It you have only pr	i vate i ooni days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		18, 825	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through Docombor	21 of the cost	0	7. 00
7.00	reporting period	i days) through becember	31 Of the Cost	0	7.00
8. 00	Total swing-bed NF type inpatient days (including private room	n davs) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 7			
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	8, 109	9. 00
40.00	newborn days) (see instructions)				40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		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, er				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including privat	e room days)	0	12. 00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	(0	15. 00
16.00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
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	as after December 31 of	the cost	0.00	18. 00
10.00	reporting period	es arter becember 51 or	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	-)		18, 956, 763	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	18, 430, 703	22.00
22.00	5 x line 17)	or or the cost report	ing period (inic	· ·	22.00
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 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
23.00	x line 20)	or the cost reporting	perrou (Trie o		25.00
26.00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		18, 956, 763	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			0	20.00
28.00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	1
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			Ö	
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	1
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
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 mir		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)	ie 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	18, 956, 763	1
37.00	27 minus line 36)			.5, 755, 765	000
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				[
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see	*		1, 007. 00	1
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line	•		8, 165, 763 0	39. 00 40. 00
	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			8, 165, 763	1
11.00	1.5ta Sgram general impationt routine service cost (fille 37			5, 105, 705	1 11.00

		unity Health Ne				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co	CN: 15-3043	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Pre	
						5/12/2023 10:	
	Cook Cooker Decoriation	T-4-1		XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpati ent Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only)						42. 00
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0	0.0	00	0	43.00
4. 00	CORONARY CARE UNIT		0	0. 0	0		44. 00
5. 00	BURN INTENSIVE CARE UNIT	•					45. 00
5. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					4.00	
3. 00	Program innations ancillary sorvice cost (Wk	ct D 2 col 2	lino 200)			1. 00 3, 159, 280	19 00
						3, 159, 280 0	1
00	Total Program inpatient costs (sum of lines				corumii 1)	11, 325, 043	
	PASS THROUGH COST ADJUSTMENTS		., (, ===, =	1
00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sun	of Parts I and	1, 002, 191	50. 00
00)	ationt oncillor	u comilece (fin	om Wko+ D o	um of Dorto II	100 27/	F1 00
00	Pass through costs applicable to Program inpand IV)	atient anciliar	y services (Tr	om wkst. D, s	sum or Parts II	199, 376	51.00
00	Total Program excludable cost (sum of lines	50 and 51)				1, 201, 567	52.00
00	Total Program inpatient operating cost exclu		lated, non-phy	sician anesth	netist, and	10, 123, 476	
	medical education costs (line 49 minus line	52)					
	TARGET AMOUNT AND LIMIT COMPUTATION					_	
	Program di scharges					0	
00 01	Target amount per discharge Permanent adjustment amount per discharge						55. 00 55. 01
02	Adjustment amount per discharge (contractor	use only)				0.00	
00	Target amount (line 54 x sum of lines 55, 55					0	
00	Difference between adjusted inpatient operat			ine 56 minus	line 53)	0	57. 00
00	Bonus payment (see instructions)					0	
00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	rting period	endi ng 1996,	0.00	59. 00
. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m nrior vear c	ost renort i	indated by the	0.00	60.00
00	market basket)	of Title 33 Tro	iii piroi yeai c	ost report, t	ipuated by the	0.00	00.00
00	Continuous improvement bonus payment (if line					0	61.00
	55.01, or line 59, or line 60, enter the les		,	•	•		
	53) are less than expected costs (lines 54 x	60), or 1 % of	the target am	ount (line 56), otherwise		
00	enter zero. (see instructions) Relief payment (see instructions)					0	62. 00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	•	,				1
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
5. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the o	ost reporting	neriod (Soc	0	65.00
. 00	instructions) (title XVIII only)	is after Decellic	er ar or the C	οσε τεμοιειηί	perrou (see		05.00
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	l only); for	0	66.00
	CAH, see instructions	·	•		3,		
00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost re	eporting period	0	67. 00
00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	a costs after D	ecember 31 of	the cost reno	orting period	0	68. 00
00	(line 13 x line 20)	e costs arter b	ecember 31 01	the cost repo	iting period		00.00
. 00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N						
	Skilled nursing facility/other nursing facil						70.00
. 00	Adjusted general inpatient routine service of		ine /U ÷ line	2)			71.00
. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 1/ v li	ne 35)			72. 00 73. 00
. 00	Total Program general inpatient routine serv			ne 30 <i>)</i>			74.00
. 00	Capital -related cost allocated to inpatient	•		orksheet B, F	Part II, column		75. 00
	26, line 45)		•	•			
	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
	Program capital_related costs (line 9 x line	7/\					77 00

Health Financial Systems Comm	etwork Rehab Ho	work Rehab Hosp		In Lieu of Form CMS-2552-1		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Prep 5/12/2023 10:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	2, 326, 622	18, 956, 763	0. 12273	3 0	0	90.00
91.00 Nursing Program cost	0	18, 956, 763	0.00000	0	0	91.00
92.00 Allied health cost	0	18, 956, 763	0.00000	0	0	92.00
93.00 All other Medical Education	0	18, 956, 763	0. 00000	0 0	0	93. 00

Health Financial Systems	Community Health Networ	rk Rehab Hosp	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	F	Provider CCN: 15-3043	Peri od: From 01/01/2022	Worksheet D-1	
				Date/Time Pre 5/12/2023 10:	
		Title XIX	Hospi tal	Cost	
Cost Contar Doscription					

		Title XIX	Hospi tal	5/12/2023 10: 4 Cost	47 am_		
	Cost Center Description	THE ATA	поэрг саг				
	PART I - ALL PROVIDER COMPONENTS			1. 00			
	INPATIENT DAYS						
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			18, 825 18, 825	1. 00 2. 00		
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	vate room days,	O	3. 00		
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room reporting period	18, 825 0	4. 00 5. 00				
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)						
7.00							
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)						
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	9 . 9	· ·	108			
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc-	tions)		0			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, et	nter O on this line)	3 /	0	11.00		
12. 00 13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	3 .	,	0	12.00		
14. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Program	0	13. 00				
15. 00	Total nursery days (title V or XIX only)	ő	15. 00				
16. 00							
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	0.00	17. 00				
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	0.00	18. 00				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period		19. 00				
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period		20. 00				
21. 00 22. 00	Total general inpatient routine service cost (see instructions $Swing$ -bed cost applicable to SNF type services through December S x line 17)		ng period (line	18, 954, 805 0	21. 00		
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00		
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	·		0	24. 00		
25. 00	Swing-bed cost applicable to NF type services after December (x line 20)	31 of the cost reporting	period (line 8	0	25. 00		
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		0 18, 954, 805	26. 00 27. 00		
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00		
29. 00	Private room charges (excluding swing-bed charges)			0	ł		
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			
32. 00	Average private room per diem charge (line 29 ÷ line 3)	- 111le 26)		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)	nus line 33)(see instruc	tions)	0.00	1		
35. 00	Average per diem private room cost differential (line 34 x li		•	0.00			
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	0 18, 954, 805	36. 00 37. 00		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY						
00.05	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			4 224 ==	00.05		
38.00	Adjusted general inpatient routine service cost per diem (see			1, 006. 90			
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	,		108, 745 0	39. 00 40. 00		
	Total Program general inpatient routine service cost (line 39	*		108, 745			
	,	,					

		unity Health Ne				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-3043	Peri od: From 01/01/2022	Worksheet D-1	
					To 12/31/2022	Date/Time Pre	
			Ti tl	e XIX	Hospi tal	5/12/2023 10: Cost	47 am
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)						42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0	0.0	0 00	0	43.00
44. 00	CORONARY CARE UNIT		_				44. 00
45.00	BURN INTENSIVE CARE UNIT						45.00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
						1. 00	
48. 00 48. 01	Program inpatient ancillary service cost (Wks Program inpatient cellular therapy acquisition	·	. ,	III line 10	column 1)	0	48. 00 48. 01
49. 00	Total Program inpatient costs (sum of lines				cordilli 1)	108, 745	
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sur	n of Parts I and	0	50.00
51. 00							51.00
52. 00	Total Program excludable cost (sum of lines!	50 and 51)				0	52.00
53.00	00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and						53. 00
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00	Program discharges						54. 00
55.00	Target amount per discharge						55. 00
55. 01 55. 02	Permanent adjustment amount per discharge						55. 01 55. 02
56. 00	Adjustment amount per discharge (contractor use only) Target amount (line 54 x sum of lines 55, 55.01, and 55.02)						56.00
57. 00							57. 00
58.00	Bonus payment (see instructions)	l' 55 6			l' 4007	0	58.00
59. 00	Trended costs (lesser of line 53 ÷ line 54, oupdated and compounded by the market basket)	or line 55 Trom	the cost repo	orting period	enaing 1996,	0.00	59. 00
60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior year o	cost report, ι	updated by the	0.00	60. 00
61. 00	market basket) Continuous improvement bonus payment (if line	o 53 ≟ lino 54	ie lace than t	he lowest of	linge 55 nlue	0	61.00
01.00	55.01, or line 59, or line 60, enter the less					0	01.00
	53) are less than expected costs (lines 54 \times	60), or 1 % of	the target am	nount (line 56	5), otherwise		
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62. 00
	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			Ö	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine costinstructions)(title XVIII only)	ts after Decemb	er 31 of the c	ost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing CAH, see instructions	ne costs (line	64 plus line 6	5)(title XVII	I only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing ((line 12 x line 19)	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili)		70. 00
71. 00	Adjusted general inpatient routine service co	ost per diem (I					71. 00
72.00	Program routine service cost (line 9 x line	,		05)			72.00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine servi						73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient	,			Part II, column		75. 00
	26, line 45)						76.00
16 ()()							

Health Financial Systems Comm	etwork Rehab Ho	work Rehab Hosp		In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/12/2023 10:	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	2, 326, 622	18, 954, 805	0. 12274	6 0	0	90.00
91.00 Nursing Program cost	0	18, 954, 805	0.00000	0	0	91.00
92.00 Allied health cost	0	18, 954, 805	0.00000	0	0	92. 00
93.00 All other Medical Education	0	18, 954, 805	0. 00000	0 0	0	93. 00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS | Provider CCN: 15-3043 Peri od: Worksheet D-2 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/12/2023 10:47 am 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 18, 825 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 32.00 0 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

		no Part B					
		Coverage					
		6.00	7. 00	8.00	9. 00	10.00	
P.	PART I - NOT IN APPROVED TEACHING PROGRAM						
1.00 T	Total cost of services rendered						1.00
Н	lospital Inpatient Routine Services:			•			1
	ADULTS & PEDIATRICS	8, 109	108	0	0	0	2.00
3.00 1	NTENSIVE CARE UNIT	0	0	0	0	0	3.00
	CORONARY CARE UNIT		_				4. 00
	BURN INTENSIVE CARE UNIT						5. 00
	SURGICAL INTENSIVE CARE UNIT						6.00
	OTHER SPECIAL CARE (SPECIFY)						7. 00
	NURSERY						8.00
	Subtotal (sum of lines 2 through 8)			1 0	0	0	
	SUBPROVIDER - IPF				U	U	10.00
	SUBPROVIDER - IPF						11.00
	SUBPROVI DER						12.00
	SKILLED NURSING FACILITY	0	0	0	0	0	
	NURSING FACILITY						14. 00
	OTHER LONG TERM CARE						15. 00
	HOME HEALTH AGENCY						16. 00
	CMHC						17. 00
	AMBULATORY SURGICAL CENTER (D.P.)						18. 00
19.00 F	HOSPI CE						19. 00
20. 00 S	Subtotal (sum of lines 9 through 19)						20. 00
		Titles V and >	KIX Outpatient	Titles V an	d XIX Outpatier	nt and Title	
		and Title X	VIII Part B	X	VIII Part B Cos	t	
		Char					
	Cost Center Description	Title XVIII	Title XIX	Title V	Title XVIII	Title XIX	
		Part B			Part B		
		6. 00	7. 00	8.00	9. 00	10.00	
	lospital Outpatient Services:						
21. 00 R	RURAL HEALTH CLINIC						21. 00
22. 00 F	FEDERALLY QUALIFIED HEALTH CENTER						22. 00
23.00	CLINIC	0	0	0	0	0	23. 00
24. 00 E	EMERGENCY	0	0	0	0	0	24. 00
25. 00	OBSERVATION BEDS (NON-DISTINCT PART)						25. 00
	OTHER OUTPATIENT SERVICE COST CENTER						26. 00
	Subtotal (sum of lines 21 through 26)			l 0	0	0	
	Total (sum of lines 20 and 27)			1			28. 00
	Cost Center Description	Title XVIII	Expenses	PSA Adj.			
	2222 20co. 2000 p.c. o		Applicable to				
		Inpatient Days		Resi dents			
			(col. 5 x col.				

PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)	
11 11 1 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
Hospital Inpatient Routine Services:	
29. 00 ADULTS & PEDI ATRI CS 0	29.00
30.00 Swing Bed - SNF 0	30.00
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
37.00 Subtotal (sum of lines 29, and 32 through 0	37.00
(36)	
38. 00 SUBPROVI DER - I PF	38.00
39. 00 SUBPROVI DER - I RF	39. 00
40. 00 SUBPROVI DER	40.00
41.00 SKILLED NURSING FACILITY 0	41.00
42.00 Total (sum of lines 37 through 41)	42.00

Heal th	Financial Systems Comm	unity Health Ne	etwork Rehab Hosp	In Lie	u of Form CMS-2	2552-10
APPORTI	ONMENT OF COST OF SERVICES RENDERED BY INTER	NS AND RESIDENT	TS Provider CCN: 15-3043	Peri od:	Worksheet D-2	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/12/2023 10:	pared: 47 am
		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		
<u>F</u>	PART III - SUMMARY FOR TITLE XVIII (TO BE COM	MPLETED ONLY IF	BOTH PARTS I AND II ARE US	SED)		
<u> </u>	Hospi tal					
43. 00	Inpatient	0		0		43.00
44.00	Outpati ent					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 Network Rehab H	OSP	In Lie	eu of Form CMS-	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-3043	Peri od:	Worksheet D-3	3
				From 01/01/2022 To 12/31/2022		
		Ti tl e	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS			15, 014, 927		30.00
31. 00	03100 INTENSIVE CARE UNIT			0		31. 00
	ANCILLARY SERVICE COST CENTERS					4
50.00	05000 OPERATING ROOM		0.00000		0	00.00
	05400 RADI OLOGY-DI AGNOSTI C		0. 60738			
	06000 LABORATORY		0. 06360			60.00
	06500 RESPI RATORY THERAPY		2. 04754			
66.00	06600 PHYSI CAL THERAPY		0. 22313			1
	06700 OCCUPATI ONAL THERAPY		0. 1596			
	06800 SPEECH PATHOLOGY		0. 1216			
	07100 MEDICAL SUPPLIES CHARGED TO PATIEN	TS	46. 09560		36, 923	
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 26933	1, 999, 522	538, 531	73. 00
74.00	07400 RENAL DI ALYSI S		0. 07362	20 114, 454	8, 426	74. 00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C		0.00000	00	0	90.00
91.00	09100 EMERGENCY		0.00000	00	0	91. 00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES					95. 00
98.00	09850 OTHER REIMBURSABLE COST CENTERS		0.00000	00	0	98. 00
200.00	Total (sum of lines 50 through 94	and 96 through 98)		15, 856, 273	3, 159, 280	200.00
201 00	Loce DDD Clinic Laboratory Sorvice	c Program only charges (line 61)	1	0	1	201 00

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

15, 856, 273

3, 159, 280 200. 00 201. 00 202. 00

201.00 202.00

Part I

1 00

2 00

8.00

From 01/01/2022 Date/Time Prepared: 12/31/2022 5/12/2023 10:47 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 16, 993, 690 1. 00 0 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 0 3.02 0 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 0 3.51 0 0 3.52 3.52 0 3.53 0 3.53 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.99 3.50-3.98) 16, 993, 690 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5. 99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 8,005 0 6.01 6 02 SETTLEMENT TO PROGRAM 0 6.02 7.00 Total Medicare program liability (see instructions) 17, 001, 695 7.00 Contractor NPR Date (Mo/Day/Yr) Number 0

8.00 Name of Contractor

Health Financial Systems	Community Health Network Rehab Hosp	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-3043	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part III Date/Time Prepared: 5/12/2023 10:47 am

PART III - MEDICARE PART A SERVICES - IRF PPS			Title XVIII	Hospi tal	PPS	47 alli
PART II MIDICANE PART A SENVICES - IBR PPS						
1.00					1. 00	
2.00 Medicare SSI ratio (IRF PPS only) (see instructions) 0.0477 2.00 0.00	4 00				44 444 004	4 00
Inpati ent Rehabilitation LIP Payments (see instructions)		1				
4.00 Outlier Payments 0.00 0.						
Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 200d (see instructions) 0.00 5.00		1 · · · · · · · · · · · · · · · · · · ·				
to November 15, 2004 (see instructions) 5. 01 Cap Increases for the unwel ghtded intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR and a set of the count of 12 MeV and the counted without a temporary cap adjustment under 42 CFR and 12 MeV and						
program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR 941-424(d) ([)(I)(I)(F)(f) or (2) (see instructions) 8.00 Wew Teaching program adjustment. (see instructions) 8.00 Unterity year's unneighted FTE count of IRR excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 9.00 Interin and resident exclusions (see instructions) 9.01 Interin and resident count for IRR PPS medical education adjustment (see instructions) 9.02 Interin and resident count for IRR PPS medical education adjustment (see instructions) 10.03 Average Bell y Census (see instructions) 10.04 Average Bell y Census (see instructions) 10.05 Intering Adjustment factor (see instructions) 10.06 Teaching Adjustment factor (see instructions) 10.07 Teaching Adjustment factor (see instructions) 10.08 Teaching Adjustment factor (see instructions) 10.09 Teaching Adjustment factor (see instructions) 10.00 Teaching Adjustment factor (see instructions) 10.00 Teaching Adjustment (see instructions) 10.01 Teaching Adjustment factor (see instructions) 10.01 Teaching Adjustment (see instructions) 10.02 Teaching Adjustment (see instructions) 10.03 Teaching Adjustment (see instructions) 10.04 Teaching Adjustment (see instructions) 10.05 Teaching Adjustment (see instructions) 10.06 Teaching Adjustment (see instructions) 10.07 Teaching Adjustment (see instructions) 10.08 Teaching Adjustment (see instructions) 10.09 Teaching Adjustment (see instructions) 10.00 Teac	5.00		ost reporting period en	aing on or prior	0.00	5.00
0.00 New Teaching program adjustment. (see instructions) 0.00 0.	5. 01	program or hospital closure, that would not be counted withou		'	0.00	5. 01
teaching program" (see instructions) 10.00 8.00 10.00						
teaching program" (see instructions) 0.00 0.00 Average Daily Census (see instructions) 0.00 9.00 0.00 Average Daily Census (see instructions) 0.000 0.000000 11.00 10.00 12.00	7.00		the new program growth p	eriod of a "new	0.00	7. 00
9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 0.00 9.00 0.00 Teaching Adjustment Factor (see instructions) 0.000000 11.00 12.00	8. 00		the new program growth p	eriod of a "new	0. 00	8. 00
10.00 Average Dail y Census (see instructions) 51.575342 10.00	9.00		tment (see instructions)		0.00	9. 00
11.00 Teaching Adjustment Factor (see instructions) 0.00000 11.00 12			,			
12.00 Teaching Adjustment (see instructions) 0 12.00 13.00 Total PSP Payment (see instructions) 17,493,612 13.00 10.10 PSP Payment (see instructions) 0 14.00 15.00 17.493,612 17.00 18.00 17.493,612 17.00 18.00 17.493,612 17.00 17.00 18.00 17.493,612 17.00 18.00 17.493,612 17.00 17.00 17.00 17.00 17.493,612 17.00 17.00 17.00 17.00 17.00 17.493,612 17.00 17.00 17.00 17.00 17.493,612 17.00	11. 00					
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15. 00	13.00				17, 493, 612	13.00
15. 00	14.00	Nursing and Allied Health Managed Care payments (see instructi	on)		0	14.00
17, 403, 412 17, 403, 412 17, 403, 412 17, 403, 412 17, 403, 412 17, 403, 412 17, 403, 412 17, 403, 412 17, 403, 403 19, 403	15. 00		•			
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19. 00 Subtotal (line 17 less line 18). 17. 484,033 19. 00 20. 00	17.00	Subtotal (see instructions)	ŕ		17, 493, 612	17. 00
20.00 Deductible's 22.0, 37.6 20.00 21.00 Subtotal (line 19 minus line 20) 17, 263, 657 21.00 22.00 Coinsurance 60.043 22.00 22.00 Subtotal (line 21 minus line 22) 17, 203, 614 23.00 24.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 13, 333 24.00 25.00 Adjusted reimbursable bad debts (see instructions) 15, 036 25.00 27.00 Subtotal (sum of lines 23 and 25) 17, 218, 650 27.00 Subtotal (sum of lines 23 and 25) 17, 218, 650 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 28.00 29.00 Other pass through costs (see instructions) 28.00 29.0	18.00	Primary payer payments				
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29. 00 30. 00 31. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32		· · · · · · · · · · · · · · · · · · ·	ne 49)			
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52.00 The rate used to calculate the Time Value of Money Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00						
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99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00	53. UU		DECLINIUM DEFORE THE FAIR) OF THE COVER 10		ეკ. 00
	00.00					00.00
99. Of [Carculated Teaching Adjustment Factor for the current year. (see Instructions) 0.000000 99. Of			3.	i y 29, 2020.		
	77. U I	poarcurated reaching Aujusthent Factor for the current year. (see Thisti ucti Ons)	l	0.000000	99.01

Health Financial Systems	Community Health Network Reha	b Hosp	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi de	r CCN: 15-3043	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part IV Date/Time Prepared: 5/12/2023 10:47 am
	_			07 127 2020 10: 17 dill

				5/12/2023 10:	<u>47 am</u>
		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	Site neutral payment amount - IPPS comparable			0	1
2.00	Outlier Payments			0	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)			0	
4. 00	Nursing and Allied Health Managed Care payments (see instruct	i one)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)	i ons)		0	5.00
		rusti ana)		0	1
6.00	Cost of physicians' services in a teaching hospital (see inst	ructions)			
7.00	Subtotal (see instructions)			0	7. 00
8.00	Primary payer payments			0	
9.00	Subtotal (line 7 less line 8).			0	
10.00	Deductibles			0	
11.00	Subtotal (line 9 minus line 10)			0	11.00
12. 00	Coinsurance			0	12. 00
13. 00	Subtotal (line 11 minus line 12)			0	
14. 00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		0	
15. 00	Adjusted reimbursable bad debts (see instructions)			0	15. 00
16. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
17. 00	Subtotal (sum of lines 13 and 15)			0	17. 00
18. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 49)		0	18. 00
19. 00	Other pass through costs (see instructions)			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	s)		0	21. 50
21. 98	Recovery of accelerated depreciation.			0	21. 98
21. 99	Demonstration payment adjustment amount before sequestration			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	Demonstration payment adjustment amount after sequestration			0	22. 02
23.00	Interim payments			0	23. 00
24.00	Tentative settlement (for contractor use only)			0	24. 00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.0)	2, 23 and 24)		0	25. 00
26.00	Protested amounts (nonallowable cost report items) in accordan		chapter 1.	0	26. 00
	§115. 2		,		
	TO BE COMPLETED BY CONTRACTOR				1
50. 00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see in:	structions)		0	50.00
	Outlier reconciliation adjustment amount (see instructions)			0	1
52. 00	The rate used to calculate the Time Value of Money (see instru	uctions)		0.00	
	Time Value of Money (see instructions)	,			53.00
55. 50	The raids of money (see that doctions)			1	1 30.00

Health Financial Systems	Community Health Network Rehab Hosp	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-3043	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part III Date/Time Prepared: 5/12/2023 10:47 am

PART III - MEDICARE PART A SERVICES - IRF PPS			Title XVIII	Hospi tal	PPS	47 alli
PART II MIDICANE PART A SENVICES - IBR PPS						
1.00					1. 00	
2.00 Medicare SSI ratio (IRF PPS only) (see instructions) 0.0477 2.00 0.00	4 00				44 444 004	4 00
Inpati ent Rehabilitation LIP Payments (see instructions)		1				
4.00 Outlier Payments 0.00 0.						
Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 200d (see instructions) 0.00 5.00		1				
to November 15, 2004 (see instructions) 5. 01 Cap Increases for the unwel ghtded intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR and a set of the count of 12 MeV and the counted without a temporary cap adjustment under 42 CFR and 12 MeV and						
program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR 941-424(d) ([)(I)(I)(F)(f) or (2) (see instructions) 8.00 Wew Teaching program adjustment. (see instructions) 8.00 Unterity year's unneighted FTE count of IRR excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 9.00 Interin and resident exclusions (see instructions) 9.01 Interin and resident count for IRR PPS medical education adjustment (see instructions) 9.02 Interin and resident count for IRR PPS medical education adjustment (see instructions) 10.03 Average Bell y Census (see instructions) 10.04 Average Bell y Census (see instructions) 10.05 Intering Adjustment factor (see instructions) 10.06 Teaching Adjustment factor (see instructions) 10.07 Teaching Adjustment factor (see instructions) 10.08 Teaching Adjustment factor (see instructions) 10.09 Teaching Adjustment factor (see instructions) 10.00 Teaching Adjustment factor (see instructions) 10.00 Teaching Adjustment (see instructions) 10.01 Teaching Adjustment factor (see instructions) 10.01 Teaching Adjustment (see instructions) 10.02 Teaching Adjustment (see instructions) 10.03 Teaching Adjustment (see instructions) 10.04 Teaching Adjustment (see instructions) 10.05 Teaching Adjustment (see instructions) 10.06 Teaching Adjustment (see instructions) 10.07 Teaching Adjustment (see instructions) 10.08 Teaching Adjustment (see instructions) 10.09 Teaching Adjustment (see instructions) 10.00 Teac	5.00		ost reporting period en	aing on or prior	0.00	5.00
0.00 New Teaching program adjustment. (see instructions) 0.00 0.	5. 01	program or hospital closure, that would not be counted withou		'	0.00	5. 01
teaching program" (see instructions) 10.00 8.00 10.00						
teaching program" (see instructions) 0.00 0.00 Average Daily Census (see instructions) 0.00 9.00 0.00 Average Daily Census (see instructions) 0.000 0.000000 11.00 10.00 12.00	7.00		the new program growth p	eriod of a "new	0.00	7. 00
9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 0.00 9.00 0.00 Teaching Adjustment Factor (see instructions) 0.000000 11.00 12.00	8. 00		the new program growth p	eriod of a "new	0. 00	8. 00
10.00 Average Dail y Census (see instructions) 51.575342 10.00	9.00		tment (see instructions)		0.00	9. 00
11.00 Teaching Adjustment Factor (see instructions) 0.00000 11.00 12			,			
12.00 Teaching Adjustment (see instructions) 0 12.00 13.00 Total PSP Payment (see instructions) 17,493,612 13.00 10.10 PSP Payment (see instructions) 0 14.00 15.00 17.493,612 17.00 18.00 17.493,612 17.00 18.00 17.493,612 17.00 17.00 18.00 17.493,612 17.00 18.00 17.493,612 17.00 17.00 17.00 17.00 17.493,612 17.00 17.00 17.00 17.00 17.00 17.493,612 17.00 17.00 17.00 17.00 17.493,612 17.00	11. 00					
13. 00 Total PPS Payment (see instructions) 17, 493, 612 13. 00 14. 00 15. 00 0rgan acquisition (D0 NOT USE THIS LINE) 15. 00 16. 00 16. 00 16. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 17.	12.00				0	12.00
15. 00	13.00				17, 493, 612	13.00
15. 00	14.00	Nursing and Allied Health Managed Care payments (see instructi	on)		0	14.00
17, 403, 412 17, 403, 412 17, 403, 412 17, 403, 412 17, 403, 412 17, 403, 412 17, 403, 412 17, 403, 412 17, 403, 403 19, 403	15. 00		•			
17, 493, 612 17, 493, 612 17, 493, 612 17, 493, 612 19, 90 19,		, , ,	ructions)		0	
19. 00 Subtotal (line 17 less line 18). 17. 484,033 19. 00 20. 00	17.00	Subtotal (see instructions)	ŕ		17, 493, 612	17. 00
20.00 Deductible's 22.0, 37.6 20.00 21.00 Subtotal (line 19 minus line 20) 17, 263, 657 21.00 22.00 Coinsurance 60.043 22.00 22.00 Subtotal (line 21 minus line 22) 17, 203, 614 23.00 24.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 13, 333 24.00 25.00 Adjusted reimbursable bad debts (see instructions) 15, 036 25.00 27.00 Subtotal (sum of lines 23 and 25) 17, 218, 650 27.00 Subtotal (sum of lines 23 and 25) 17, 218, 650 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 28.00 29.00 Other pass through costs (see instructions) 28.00 29.0	18.00	Primary payer payments				
21.00 Subtotal (line 19 minus line 20) 17, 263, 657 21.00 60.043 22.00 22.00 Colinsurance 60.043 23.00 22.00 23.00 Subtotal (line 21 minus line 22) 17, 203, 614 23.00 24.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 23, 133 24.00 25.00 Adjusted reimbursable bad debts (see instructions) 15, 036 25.00 26.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 12, 160 26.00 27.00 Subtotal (sum of lines 23 and 25) 27.00 Subtotal (sum of lines 23 and 25) 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0.28.00 29.00 0.00						
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29. 00 30. 00 31. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32. 00 32		· · · · · · · · · · · · · · · · · · ·	ne 49)			
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	00.00					00.00
99. Of [Carculated Teaching Adjustment Factor for the current year. (see Instructions) 0.000000 99. Of			3.	i y 29, 2020.		
	77. U I	poarcurated reaching Aujusthent Factor for the current year. (see Thisti ucti Ons)	l	0.000000	99.01

Health Financial Systems	Community Health Network Reha	b Hosp	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi de	r CCN: 15-3043	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part IV Date/Time Prepared: 5/12/2023 10:47 am
	_			07 127 2020 10: 17 dill

				5/12/2023 10:	<u>47 am</u>
		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	Site neutral payment amount - IPPS comparable			0	1
2.00	Outlier Payments			0	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)			0	
4. 00	Nursing and Allied Health Managed Care payments (see instruct	i one)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)	i ons)		0	5.00
		rusti ana)		0	1
6.00	Cost of physicians' services in a teaching hospital (see inst	ructions)			
7.00	Subtotal (see instructions)			0	7. 00
8.00	Primary payer payments			0	
9.00	Subtotal (line 7 less line 8).			0	
10.00	Deductibles			0	
11.00	Subtotal (line 9 minus line 10)			0	11.00
12. 00	Coinsurance			0	12. 00
13. 00	Subtotal (line 11 minus line 12)			0	
14. 00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		0	
15. 00	Adjusted reimbursable bad debts (see instructions)			0	15. 00
16. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
17. 00	Subtotal (sum of lines 13 and 15)			0	17. 00
18. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 49)		0	18. 00
19. 00	Other pass through costs (see instructions)			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	s)		0	21. 50
21. 98	Recovery of accelerated depreciation.			0	21. 98
21. 99	Demonstration payment adjustment amount before sequestration			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	Demonstration payment adjustment amount after sequestration			0	22. 02
23.00	Interim payments			0	23. 00
24.00	Tentative settlement (for contractor use only)			0	24. 00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.0)	2, 23 and 24)		0	25. 00
26.00	Protested amounts (nonallowable cost report items) in accordan		chapter 1.	0	26. 00
	§115. 2		,		
	TO BE COMPLETED BY CONTRACTOR				1
50. 00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see in:	structions)		0	50.00
	Outlier reconciliation adjustment amount (see instructions)			0	1
52. 00	The rate used to calculate the Time Value of Money (see instru	uctions)		0.00	
	Time Value of Money (see instructions)	,			53.00
55. 50	The raids of money (see that doctions)			1	1 30.00

Health Financial Systems	Community Health Network Rel	hab Hosp	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi	der CCN: 15-3043	Peri od: From 01/01/2022	Worksheet E-3 Part VII
				Date/Time Prepared:

5/12/2023 10:47 am Title XIX Hospi tal Cost Outpati ent Inpati ent 1.00 2.00 PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 108, 745 1.00 Inpatient hospital/SNF/NF services 2.00 Medical and other services Λ 2.00 3.00 Organ acquisition (certified transplant programs only) 3.00 Subtotal (sum of lines 1, 2 and 3) 4.00 108, 745 4.00 5.00 Inpatient primary payer payments 5.00 Outpatient primary payer payments 6.00 \cap 6.00 7.00 Subtotal (line 4 less sum of lines 5 and 6) 108, 745 Ω 7.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 0 8.00 9.00 Ancillary service charges 0 0 9.00 10.00 Organ acquisition charges, net of revenue 0 10.00 0 Incentive from target amount computation 11 00 11 00 12.00 Total reasonable charges (sum of lines 8 through 11) 0 0 12.00 CUSTOMARY CHARGES Amount actually collected from patients liable for payment for services on a charge 13.00 0 0 13.00 basi s Amounts that would have been realized from patients liable for payment for services on 14.00 O 0 14.00 a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0.000000 0.000000 15.00 16.00 Total customary charges (see instructions) 16.00 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 17.00 0 0 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 108, 745 0 18.00 (see instructions) 19.00 Interns and Residents (see instructions) 19.00 0 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 20.00 21.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 0 21.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers 22.00 0 0 22.00 Other than outlier payments 0 23.00 23.00 Outlier payments Λ 24.00 Program capital payments 24.00 25.00 Capital exception payments (see instructions) 0 25.00 26 00 Routine and Ancillary service other pass through costs 0 26 00 Subtotal (sum of lines 22 through 26) 27.00 0 27.00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 0 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 108, 745 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 0 31.00 32.00 Deducti bl es 32.00 0 0 33 00 33 00 Coi nsurance 0 34.00 Allowable bad debts (see instructions) Λ 34.00 Utilization review 0 0 0 0 0 0 0 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36, 00 36, 00 37.00 37.00 OTHER ADJUSTMENTS 0 37. 01 OTHER ADJUSTMENTS 37.01 0 38.00 Subtotal (line 36 ± line 37) 38.00 Direct graduate medical education payments (from Wkst. E-4) 39.00 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 0 40.00 41.00 Interim payments 41.00 0 Balance due provider/program (line 40 minus line 41) 42.00 42.00 0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00 43 00 0 chapter 1, §115.2 OVERRI DES 0 0 109. 00 109.00 Override Ancillary service charges (line 9)

Heal th Financial Systems

Community Heal th
BALANCE SHEET (If you are nonproprietary and do not maintain
fund-type accounting records, complete the General Fund column
only)

Provider CCN: 15-3043

Peri od: Worksheet G From 01/01/2022 To 12/31/2022 Date/Time Prepared:

onl y)			'	0 12/31/2022	5/12/2023 10:	
		General Fund	Speci fi c	Endowment Fund		
		1. 00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS		1			
1.00	Cash on hand in banks	3, 562, 962	0	0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	0		-	0	2. 00 3. 00
4. 00	Accounts receivable	5, 310, 741		0	0	4.00
5. 00	Other recei vabl e	167	ď	0	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-595, 989	l .	0	0	6. 00
7.00	Inventory	128, 903	C	0	0	7. 00
8.00	Prepai d expenses	240, 194	C	0	0	
9.00	Other current assets	0	C	0	0	
10.00	Due from other funds	0	O		0	10.00
11. 00	Total current assets (sum of lines 1-10)	8, 646, 978	C	0	0	11. 00
12. 00	FI XED ASSETS Land	0	0	O	0	12. 00
13. 00	Land improvements	0		-	0	13. 00
14. 00	Accumul ated depreciation	0	d		0	14. 00
15. 00	Bui I di ngs	0	C	0	0	15. 00
16. 00	Accumulated depreciation	0	C	0	0	16. 00
17. 00	Leasehold improvements	10, 041	C	0	0	17. 00
18. 00	Accumulated depreciation	-7, 614	i		0	18.00
19.00	Fixed equipment	0	O	-	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	0	O	0	0	20.00
22. 00	Accumulated depreciation	0		0	0	22.00
23. 00	Major movable equipment	649, 218	ď	Ö	0	23. 00
24. 00	Accumulated depreciation	-296, 625	l .	0	0	24. 00
25.00	Mi nor equi pment depreci able	0	o c	0	0	25. 00
26. 00	Accumulated depreciation	0	C	0	0	26. 00
27. 00	HIT designated Assets	0	O C	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	355 020	C	-	0	29.00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	355, 020	<u> </u>	U	0	30.00
31. 00	Investments	0	C	0	0	31.00
32.00	Deposits on Leases	27, 390	C	0	0	32. 00
33.00	Due from owners/officers	0	o c	0	0	33. 00
34. 00	Other assets	16, 364, 960	1	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	16, 392, 350	1		0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	25, 394, 348	C	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	2, 539, 498	C	O	0	37. 00
38. 00	Salaries, wages, and fees payable	738, 746	1	0	0	38.00
39. 00	Payroll taxes payable	157, 744	1	o	0	39. 00
40.00	Notes and Loans payable (short term)	0	o c	0	0	40. 00
41.00	Deferred income	0	o c	0	0	41. 00
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	0	0	0	0	1
44. 00	Other current liabilities	1, 795, 323			0	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	5, 231, 311		U	0	45. 00
46. 00	Mortgage payable	0		0	0	46. 00
47. 00	Notes payable	0	i c	-	0	
48.00	Unsecured Loans	0	o c	0	0	48. 00
49. 00	Other long term liabilities	7, 187, 470	C	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7, 187, 470	l .		0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	12, 418, 781	<u> </u>	0	0	51.00
E2 00	CAPITAL ACCOUNTS	12 075 547	1			F2 00
52. 00 53. 00	General fund balance Specific purpose fund	12, 975, 567				52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
E0.00	replacement, and expansion	12 075 577			_	FO 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	12, 975, 567 25, 394, 348	l .	0	0	
00.00	59)	25, 574, 540	1			55. 55
			1	1		1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

					10 12/31/2022	5/12/2023 10:	
		General	Fund	Special P	urpose Fund	Endowment Fund	
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		12, 799, 593		(1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13, 217, 867				2.00
3.00	Total (sum of line 1 and line 2)		26, 017, 460		(3. 00
4.00	Additions (credit adjustments)	0			O	0	
5.00	INTERCOMPANY TRANSFERS\ROUNDING	0		(O	0	
6.00		0		(O	0	
7.00		0		(O	0	
8.00		0		(O	0	
9.00		0	_	(0	0	1
10. 00	Total additions (sum of line 4-9)		0)	10. 00
11. 00	Subtotal (line 3 plus line 10)		26, 017, 460		_)	11. 00
12. 00	Deductions (debit adjustments)	0			O	0	
13. 00	INTERCOMPANY TRANSFERS\ROUNDING	13, 041, 893			O	0	
14. 00		0			O	0	
15. 00		0			O	0	
16.00		0		(0	0	
17. 00	T	0	40.044.000	(J ,	0	
18.00	Total deductions (sum of lines 12-17)		13, 041, 893				18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12, 975, 567		(7	19. 00
	Sheet (Title II illinus IIIIe 10)	Endowment Fund	PI ant	Fund			
		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		(O		3. 00
4.00	Additions (credit adjustments)		0				4. 00
5.00	INTERCOMPANY TRANSFERS\ROUNDING		0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				8. 00
9.00			0				9. 00
10.00	Total additions (sum of line 4-9)	0		(O		10.00
11. 00	Subtotal (line 3 plus line 10)	0		(O		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		(O		19. 00
	sheet (line 11 minus line 18)						

 Heal th Financial
 Systems
 Community Health Network
 Rehab Hosp

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 Provider CCN:
 Provider CCN: 15-3043

PART I - PATIENT REVENUES General Inpatient Routine Services	2. 00
PART I - PATIENT REVENUES General Inpatient Routine Services	2. 00
	2. 00
	2. 00
2.00 SUBPROVIDER - I PF	3.00
3. 00 SUBPROVIDER - I RF	
4. 00 SUBPROVI DER	4. 00
5.00 Swing bed - SNF	0 5.00
6.00 Swing bed - NF	0 6.00
7. 00 SKILLED NURSING FACILITY 0	0 7.00
8.00 NURSING FACILITY	8.00
9. OO OTHER LONG TERM CARE	9. 00
10.00 Total general inpatient care services (sum of lines 1-9) 35,233,339 35,233,	•
Intensive Care Type Inpatient Hospital Services	10.00
11. 00 INTENSIVE CARE UNIT	0 11.00
12. OO CORONARY CARE UNI T	12. 00
13. 00 BURN I NTENSI VE CARE UNI T	13. 00
14. 00 SURGI CAL INTENSI VE CARE UNI T	14. 00
15. 00 OTHER SPECIAL CARE (SPECIFY)	15. 00
16.00 Total intensive care type inpatient hospital services (sum of lines 0	0 16, 00
11-15)	0 10.00
17.00 Total inpatient routine care services (sum of lines 10 and 16) 35,233,339 35,233,	339 17. 00
17.00 Total Tripatrent Toutrie care services (sum of Tries to and To) 33, 233, 337 33, 233, 233, 337 33, 233, 337 33, 233, 337 33, 233, 337 33, 233, 233, 337 33, 233, 233, 337 33, 233, 233, 337 33, 233, 233, 337 33, 233, 233, 233, 233, 233, 233, 233	•
19. 00 Outpatient services 0 0 0	0 19.00
22. 00 HOME HEALTH AGENCY	22. 00
23. 00 AMBULANCE SERVI CES 0 0	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) 0 0 0	0 27.00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 72,652,326 0 72,652,	326 28. 00
G-3, line 1)	
PART II - OPERATING EXPENSES	20.00
29. 00 Operating expenses (per Wkst. A, column 3, line 200) 26, 007, 603	29. 00
30. 00 ADD (SPECIFY) 0	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)	36. 00
37. 00 DEDUCT (SPECIFY) 0 0	37. 00
38.00	38. 00
39.00	39. 00
40.00	40. 00
41.00	41. 00
42.00 Total deductions (sum of lines 37-41)	42. 00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 26,007,603	43. 00
to Wkst. G-3, line 4)	I

Health Financial Systems	Community Health Netw	work Rehab Hosp	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-3043	Peri od:	Worksheet G-3	
			From 01/01/2022		
			To 12/31/2022	Date/Time Pre	pared:
				5/12/2023 10: 4	17 am
				1. 00	
1.00 Total patient revenues (from Wk	t. G-2, Part I, column 3, lin	ne 28)		72, 652, 326	1. 00
		•			

	To 12/31/2022	Date/Time Prep 5/12/2023 10:4		
		3/12/2023 10.4	47 alli	
		1. 00		
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	72, 652, 326	1. 00	
2. 00	Less contractual allowances and discounts on patients' accounts	33, 306, 062	2. 00	
3.00	Net patient revenues (line 1 minus line 2)	39, 346, 264	3. 00	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26, 007, 603	4. 00	
5.00	Net income from service to patients (line 3 minus line 4)	13, 338, 661	5. 00	
	OTHER I NCOME			
6.00	Contributions, donations, bequests, etc	0	6. 00	
7.00	Income from investments	999	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 discounts	969	10.00	
11. 00	Rebates and refunds of expenses	0	11. 00 12. 00	
12. 00	12.00 Parking Lot receipts			
13. 00	13.00 Revenue from Laundry and Linen service			
14. 00	14.00 Revenue from meals sold to employees and guests			
15. 00	15.00 Revenue from rental of living quarters			
16. 00	16.00 Revenue from sale of medical and surgical supplies to other than patients			
17. 00	Revenue from sale of drugs to other than patients	0 298	17. 00 18. 00	
18. 00				
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19. 00	
20. 00	Revenue from gifts, flowers, coffee shops, and canteen	0	20. 00	
21. 00	Rental of vending machines	1, 676		
22. 00	0 Rental of hospital space		22. 00	
23. 00	Governmental appropriations	0	23. 00	
24. 00	MI SCELLANEOUS I NCOME	9, 635		
24. 50	COVI D-19 PHE Fundi ng	-148, 241		
25. 00	Total other income (sum of lines 6-24)	-120, 794		
26. 00	Total (line 5 plus line 25)	13, 217, 867		
27. 00	OTHER EXPENSES	0	27. 00	
28. 00	Total other expenses (sum of line 27 and subscripts)	0	28. 00	
29. 00	Net income (or loss) for the period (line 26 minus line 28)	13, 217, 867	29. 00	