Title XVIII Title V Cost Center Description Part A Part B HIT Title XIX 1.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY 1.00 0 580,007 164, 920 0 0 Hospi tal 1.00 0 2 00 Subprovider - IPF 2 00 C С 0 3.00 Subprovider - IRF 0 С 0 0 3.00 Swing Bed - SNF 0 0 0 5.00 5.00 С Swing Bed - NF 6 00 0 0 6.00 200.00 Total 580,007 164, 920 0 200.00 0

Date

(Dated when report is electronically signed.)

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

		DENTIFICATION DA	IA	Provi de	er CCN:	15-0128	Period: From 01/01	/2019		et S-2	
								/2019			
	1.00	2.	. 00		3.00			4.00	0/17/20	20 1. 3	
	Hospital and Hospital Health Care Com										
	Street: 1402 EAST COUNTY LINE ROAD SOU			7in Codo	. 4400-	7					1
)	City: INDIANAPOLIS	State: I Component Na		CCN	CBSA		nty: MARION er Date	Paym	ent Syst	em (P	2.
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		SOUTH		00120	20700						
)	Subprovider - IPF										4
)	Subprovider - IRF Subprovider - (Other)										5. 6.
	Swing Beds - SNF										0. 7.
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	Hospital-Based SNF										9
00	Hospital-Based NF										10.
	Hospital-Based OLTC										11.
	Hospital-Based HHA										12. 13.
	Separately Certified ASC Hospital-Based Hospice										13.
	Hospital-Based Health Clinic - RHC										15
00	Hospital-Based Health Clinic - FQHC										16.
	Hospital-Based (CMHC) I										17
	Renal Dialysis Other										18 19
0	other			I			Fron	1:	То	:	17
	1						1.0		2.0		
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						01/01/	2019	12/31/	2019	20
0	Type of control (see this tructions)						2				21
						1.00	2.0	0	3.0	00	1
	Inpatient PPS Information								1		
00	Does this facility qualify and is it disproportionate share hospital adjus					Y	N				22.
	§412.106? In column 1, enter "Y" for										
	facility subject to 42 CFR Section §4										
	hospital?) In column 2, enter "Y" for										
		5	no.								
01	Did this hospital receive interim unc	ompensated care	payments			Y	Y				22.
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12	cost reporting period? Enter in colum the portion of the cost reporting per Enter in column 2, "Y" for yes or "N" reporting period occurring on or afte Is this a newly merged hospital that payments to be determined at cost rep Enter in column 1, "Y" for yes or "N" cost reporting period prior to Octobe or "N" for no, for the portion of the October 1. Did this hospital receive a geographi rural as a result of the OMB standard adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for n reporting period occurring on or afte Does this hospital contain at least 1 counted in accordance with 42 CFR 412 yes or "N" for no. Which method is used to determine Med below? In column 1, enter 1 if date o reporting period different from the m	ompensated care in 1, "Y" for yes iod occurring pr for no for the r October 1. (se requires final u ort settlement? for no, for the r 1. Enter in co cost reporting c reclassificati s for delineatir lumn 1, "Y" for period prior to o for the portio r October 1. (se 00 but not more .105)? Enter in icaid days on li f admission, 2 i f identifying the ethod used in th	payments s or "N" f rior to 0c portion o ee instruct uncompensa (see instruc- period on on from u ng statist yes or "N" on of the ee instruct than 499 column 3, nes 24 an f census ne days in "N" for n In-State Medicaid	or no fo tober 1. f the cr tions) ted carrer ructions of the Y" for y or afte rban to ical arc "for no 1. Enter cost tions) beds (as "Y" for d/or 25 days, or this co ost 0. In-St Medic s eligi unpa	or ost ess) yes er eas o s - 3 ost aid ble lid p s	N N Out-of State Medicaid	N N 3 N Out-of State Medicaid eligible		aid 0° ays Med d	ther i cai d	22
02	cost reporting period? Enter in colum the portion of the cost reporting per Enter in column 2, "Y" for yes or "N" reporting period occurring on or afte Is this a newly merged hospital that payments to be determined at cost rep Enter in column 1, "Y" for yes or "N" cost reporting period prior to Octobe or "N" for no, for the portion of the October 1. Did this hospital receive a geographi rural as a result of the OMB standard adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for n reporting period occurring on or afte Does this hospital contain at least 1 counted in accordance with 42 CFR 412 yes or "N" for no. Which method is used to determine Med below? In column 1, enter 1 if date o if date of discharge. Is the method o reporting period? In column 2, enter	ompensated care in 1, "Y" for yes iod occurring pr for no for the r October 1. (se requires final u ort settlement? for no, for the r 1. Enter in cc c cost reporting c reclassificati s for delineatir lumn 1, "Y" for period prior to o for the portion r October 1. (se 00 but not more .105)? Enter in icaid days on li f admission, 2 i f identifying the ethod used in th "Y" for yes or	payments s or "N" f rior to Oc portion o ee instruct uncompensa (see instruc- period on on from un g statist yes or "N o October on of the ee instruct than 499 column 3, nes 24 an f census ne days in ne prior c "N" for n In-State Medicaid paid days	or no for tober 1. f the cr tions) ted carrer ructions of the Y" for y or afte rban to ical are "for no 1. Enter cost tions) beds (as "Y" for d/or 25 days, or this co ost o. In-St Medic s eligi unpa day 2.0	or ost ess) yes er eas o s - 3 ost aid ble lid p s	N N Out-of State Medicaid oaid days	3 N Out-of State Medicaid eligible unpaid	HMO da 5.00	aid 0° ays Med d	ther i cai d ays . 00	22.
)2)3)00	cost reporting period? Enter in colum the portion of the cost reporting per Enter in column 2, "Y" for yes or "N" reporting period occurring on or afte Is this a newly merged hospital that payments to be determined at cost rep Enter in column 1, "Y" for yes or "N" cost reporting period prior to Octobe or "N" for no, for the portion of the October 1. Did this hospital receive a geographi rural as a result of the OMB standard adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for n reporting period occurring on or afte Does this hospital contain at least 1 counted in accordance with 42 CFR 412 yes or "N" for no. Which method is used to determine Med below? In column 1, enter 1 if date o if date of discharge. Is the method o reporting period? In column 2, enter	ompensated care in 1, "Y" for yes iod occurring pr for no for the r October 1. (se requires final u ort settlement? for no, for the r 1. Enter in co cost reporting c reclassificati s for delineatir lumn 1, "Y" for period prior to o for the portior r October 1. (se 00 but not more .105)? Enter in icaid days on li f admission, 2 i f identifying the tethod used in th "Y" for yes or enter the 1, in-state	payments s or "N" f rior to 0c portion o ee instruc uncompensa (see inst e portion ol umn 2, " period on on from u ng statist yes or "N o 0ctober on of the ee instruc than 499 col umn 3, nes 24 an f census ne days in In-State Medicaid paid days	or no for tober 1. f the cr tions) ted carrer ructions of the Y" for y or afte rban to ical are "for no 1. Enter cost tions) beds (as "Y" for d/or 25 days, or this co ost o. In-St Medic s eligi unpa day 2.0	or ost ess ess er eas o as as ate aid ble ble s 0	N N N State Medi cai d pai d days	3 N Out-of State Medicaid el igible unpaid 4.00	HMO da 5.00	aid 0° ays Med d	ther i cai d ays . 00	22. 22. 22. 23. 24.
02	cost reporting period? Enter in colum the portion of the cost reporting per Enter in column 2, "Y" for yes or "N" reporting period occurring on or afte Is this a newly merged hospital that payments to be determined at cost rep Enter in column 1, "Y" for yes or "N" cost reporting period prior to Octobe or "N" for no, for the portion of the October 1. Did this hospital receive a geographi rural as a result of the OMB standard adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for n reporting period occurring on or afte Does this hospital contain at least 1 counted in accordance with 42 CFR 412 yes or "N" for no. Which method is used to determine Med bel ow? In column 1, enter 1 if date o if date of discharge. Is the method o reporting period different from the m reporting period? In column 2, enter	ompensated care in 1, "Y" for yes iod occurring pr for no for the r October 1. (se requires final u ort settlement? for no, for the r 1. Enter in co cost reporting c reclassificati s for delineatir lumn 1, "Y" for period prior to o for the portio r October 1. (se 00 but not more .105)? Enter in icaid days on li f admission, 2 i f identifying the thod used in th "Y" for yes or enter the 1, in-state mn 2,	payments s or "N" f rior to 0c portion o ee instruc uncompensa (see inst e portion ol umn 2, " period on on from u ng statist yes or "N o 0ctober on of the ee instruc than 499 col umn 3, nes 24 an f census ne days in In-State Medicaid paid days	or no for tober 1. f the cr tions) ted carrer ructions of the Y" for y or afte rban to ical are "for no 1. Enter cost tions) beds (as "Y" for d/or 25 days, or this co ost o. In-St Medic s eligi unpa day 2.0	or ost ess eas o ate aid ble ble s 0	N N N State Medi cai d pai d days	3 N Out-of State Medicaid el igible unpaid 4.00	HMO da 5.00	aid 0° ays Med d	ther i cai d ays . 00	22.
02	cost reporting period? Enter in colum the portion of the cost reporting per Enter in column 2, "Y" for yes or "N" reporting period occurring on or afte Is this a newly merged hospital that payments to be determined at cost rep Enter in column 1, "Y" for yes or "N" cost reporting period prior to Octobe or "N" for no, for the portion of the October 1. Did this hospital receive a geographi rural as a result of the OMB standard adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for n reporting period occurring on or afte Does this hospital contain at least 1 counted in accordance with 42 CFR 412 yes or "N" for no. Which method is used to determine Med below? In column 1, enter 1 if date o if date of discharge. Is the method o reporting period? In column 2, enter	ompensated care in 1, "Y" for yes iod occurring pr for no for the r October 1. (se requires final u ort settlement? for no, for the r 1. Enter in co cost reporting c reclassificati s for delineatir lumn 1, "Y" for period prior to o for the portior r October 1. (se 00 but not more .105)? Enter in icaid days on li f admission, 2 i f identifying the ethod used in the "Y" for yes or enter the 1, in-state mn 2, lumn 3,	payments s or "N" f rior to 0c portion o ee instruc uncompensa (see inst e portion ol umn 2, " period on on from u ng statist yes or "N o 0ctober on of the ee instruc than 499 col umn 3, nes 24 an f census ne days in In-State Medicaid paid days	or no for tober 1. f the cr tions) ted carrer ructions of the Y" for y or afte rban to ical are "for no 1. Enter cost tions) beds (as "Y" for d/or 25 days, or this co ost o. In-St Medic s eligi unpa day 2.0	or ost ess eas o ate aid ble ble s 0	N N N State Medi cai d pai d days	3 N Out-of State Medicaid el igible unpaid 4.00	HMO da 5.00	aid 0° ays Med d	ther i cai d ays . 00	22.

	Financial Systems COMMUN AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA HOSPITA	Provider CC	CN: 15-0128	Peri od:	In Lieu	Worksh	eet S-2	
					From 01/0 To 12/3			ime Pre 020 1:5	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid	Out-of State Medicaid paid days	Out-of State Medicaid eligible	Medica HMO da	ys Me)ther di cai d days	
		1.00	days	0.00	unpai d	E 00			-
5. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	<u> 1.00 0</u>	2.00	3.00	<u>4.00</u> 0	5.00	0	6.00	25.
						Rural S 00		f Geogr 00	-
. 00	Enter your standard geographic classification (not wa	age) status	at the beg	ginning of t		1	۷.	00	26.
. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status ~ "2" for r cation in	ural. If ap column 2.	opl i cabl e,		2	10/01	/2019	27.
. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods SC	CH status ir		0 pi.pg.	Endi	D.G.	35.
						ni ng: 00	Endi 2.	ng: 00	
. 00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		cript line	36 for numb	ber				36.
. 00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		r of period	ds MDH statu	IS	0			37.
01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)								37
00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38
						/N 00		/N 00	-
. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent requiremer	ter in colum nts in	ime I in	N		N	39.
00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r"Y" for y			N	١	ſ	40
						V 1.00	XVIII 2.00	XI X 3.00	
	Prospective Payment System (PPS)-Capital						2.00	3.00	
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)						Y	N	45
00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N	N	46
00 00	Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals	•		2		N	N N	N N	47 48
00	Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you i GME payment reduction? Enter "Y" for yes or "N" for	mpacted by	CR 11642 (Y		56
00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	period duri r yes or "N th of this Y", complet , if appli	ng which re "for noir cost report e Worksheet cable.	n column 1. ting period? t E-4. lf co	lf column ? Enter "Y olumn 2 is	"			57
00	If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,		1 2	ans' service	es as	N			58
00	Are costs claimed on line 100 of Worksheet A? If yes			Pt. I. NAHE 413.8 Y/N		N neet A e #	Qualifi	hrough cation on Code	
. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent (adjustement? Enter "Y" for yes or "N" for no in col	85? (see umn 1. If CR) NAHE MA	column 1	<u>1.00</u> N	2.	00	3.	00	60.

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		eriod: rom 01/01/2019 p 12/31/2019	Worksheet S-2 Part I Date/Time Pre 8/19/2020 1:5	pared:
		Y/N	IME	Direct GME	IME	Direct GME	
	1	1.00	2.00	3.00	4.00	5.00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see	N			0.00) O. OC	61.0
1. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. C
1. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
1.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. C
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61.1
						1.00	
	ACA Provisions Affecting the Health Resources and Ser						
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ctions) a Teachi gram. (s	ng Health Cent see instruction	ter (THC) into			62. C
3. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co	67. (see instru	ictions)	N	63. 0
				Unweighted FTEs Nonprovider Site	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	_
	Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00 This base year	2.00	<u> </u>	
	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	<u>re June</u> ty trair a-primar all nor d non-pr n columr	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0.00	-		64.0

	LEX IDENTIFICATION DA	TY HOSPITAL SOUTH TA Provider (CCN: 15-0128 Pe	eri od:	Worksheet S-2	2552-10
				om 01/01/2019	Part I Date/Time Pre	pared.
	Program Name	Program Code	Unweighted	Unweighted	8/19/2020 1:5 Ratio (col. 3/	
	FI Ogi ani Name		FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	(4))	
			Si te	-		
5.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)						
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
			Si te	•		
			1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Settin	gsEffective fo	or cost reporti	ng periods	
FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar al. Enter in column 3	ry care resident 3 the ratio of	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			Si te	nospitai	4))	
	1.00	2.00	3.00	4.00	5.00	1
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary	FAMI LY MEDI CI NE	1350	0.00	5. 71	0. 000000	
care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						
care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column				1.0		
care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	PS			1.0	0 2.00 3.00	
care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	sychiatric Facility (I	PF), or does it con	tain an IPF subp		0 2.00 3.00	70.00
<pre>care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility F 0.00 If line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)</pre>	sychiatric Facility (I). d the facility have an pefore November 15, 20 olumn 2: Did this faci FR 412.424 (d)(1)(iii) cate which program ye	approved GME teachi 004? Enter "Y" for y lity train residents (D)? Enter "Y" for y	ing program in t yes or "N" for n s in a new teach yes or "N" for n	rovi der? N he most o. (see i ng o.	0 2.00 3.00	
<pre>care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility F 70.00 Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no 71.00 If line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi </pre>	sychiatric Facility (I). I the facility have an pefore November 15, 20 plumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye ty PPS	approved GME teachi 204? Enter "Y" for lity train residents (D)? Enter "Y" for ear began during this	ing program in t yes or "N" for n s in a new teach yes or "N" for n s cost reporting	rovi der? N he most o. (see i ng o.		70.00
 care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility F Enter "Y" for yes or "N" for no 1f line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions) 	sychiatric Facility (I). I the facility have an before November 15, 20 Jumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye ty PPS shabilitation Facility and "N" for no.	a approved GME teachi 204? Enter "Y" for y lity train residents (D)? Enter "Y" for y ear began during this (IRF), or does it o	ing program in t yes or "N" for n s in a new teach yes or "N" for n s cost reporting contain an IRF	rovi der? N he most o. (see i ng o. peri od. N		71.00

Heal th	Financial Systems COMMUNITY HOSPITAL	SOUTH		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN		Period:	Worksheet S-2	2
				From 01/01/2019 To 12/31/2019	Part I Date/Time Pre	epared:
					8/19/2020 1:5	
					1.00	-
	Long Term Care Hospital PPS					
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or al "Y" for yes and "N" for no.	I of the co	st reporting	period? Enter	N	81.00
	TEFRA Provi ders					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEF				N	85.00
	Did this facility establish a new Other subprovider (excluded ur	nit) under 4	2 CFR Sectio	n		86.00
	\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital cl	assified un	der section		Ν	87.00
	1886(d) (1) (B) (vi)? Enter "Y" for yes or "N" for no.	assi neu un	del section		IN	07.00
				V	XI X	
				1.00	2.00	
	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital se	ervices? Ent	er "V" for	N	Y	90.00
	yes or "N" for no in the applicable column.	Envices: Ent			•	70.00
	Is this hospital reimbursed for title V and/or XIX through the c		either in	N	Ν	91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicab		n)2 (aaa		Ν	
	Are title XIX NF patients occupying title XVIII SNF beds (dual c instructions) Enter "Y" for yes or "N" for no in the applicable		n)? (see		Ν	92.00
	Does this facility operate an ICF/IID facility for purposes of t		XIX? Enter	N	Ν	93.00
	"Y" for yes or "N" for no in the applicable column.					
	Does title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column.	"N" for no	in the	N	Ν	94.00
	fline 94 is "Y", enter the reduction percentage in the applica	able column.		0.00	0.00	95.00
	Does title V or XIX reduce operating cost? Enter "Y" for yes or		in the	Ν	Ν	96.00
	applicable column.			0.00	0.00	07.00
	If line 96 is "Y", enter the reduction percentage in the applica Does title V or XIX follow Medicare (title XVIII) for the interr		onts nost	0.00 Y	0. 00 N	97.00 98.00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for y			1	IN	90.00
	column 1 for title V, and in column 2 for title XIX.					
	Does title V or XIX follow Medicare (title XVIII) for the report			Y	Y	98.01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.	v, and in c	olumn 2 tor			
	Does title V or XIX follow Medicare (title XVIII) for the calcul	ation of ob	servati on	Y	Y	98.02
	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. Does title V or XIX follow Medicare (title XVIII) for a critical	access hos	nital (CAH)	N	Ν	98.03
	reimbursed 101% of inpatient services cost? Enter "Y" for yes or				IN IN	70.03
	for title V, and in column 2 for title XIX.					
	Does title V or XIX follow Medicare (title XVIII) for a CAH reim			N	Ν	98.04
	outpatient services cost? Enter "Y" for yes or "N" for no in col in column 2 for title XIX.	umn i for t	itie v, and			
	Does title V or XIX follow Medicare (title XVIII) and add back t	the RCE disa	llowance on	Y	Y	98.05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colum	nn 1 for tit	le V, and in			
	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reim	bursod for	Wkct D	Y	Y	98.06
	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 f			1	I	70.00
	column 2 for title XIX.					
	Rural Providers					4.05 .00
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-incl	usive metho	d of navment	N		105.00 106.00
	for outpatient services? (see instructions)	usi ve metrio	a or payment			100.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost r	reimbursemen	t for I&R			107.00
	training programs? Enter "Y" for yes or "N" for no in column 1. Column 2: If column 1 is Y and line 70 or line 75 is Y, do you					
	approved medical education program in the CAH's excluded IPF ar					
	Enter "Y" for yes or "N" for no in column 2. (see instructions)					
	Is this a rural hospital qualifying for an exception to the CRNA	A fee schedu	le? See 42	N		108.00
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	hysi cal	Occupati onal	Speech	Respi ratory	
		1.00	2.00	3.00	4.00	-
	If this hospital qualifies as a CAH or a cost provider, are					109.00
	therapy services provided by outside supplier? Enter "Y"					
	for yes or "N" for no for each therapy.					
					1.00	
	Did this hospital participate in the Rural Community Hospital De				N	110.00
	Demonstration)for the current cost reporting period? Enter "Y" f complete Worksheet E, Part A, lines 200 through 218, and Workshe					
	applicable.		55 200 thi 0u	gii 210, as		
				· · · · · · · · · · · · · · · · · · ·		

Heal th Financial Systems COMMUNITY HOSPIT				eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC		Period: From 01/01/2019 To 12/31/2019		epared:
				8/19/2020 1:	
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to colu integration prong of the FCHIP demo in which this CAH is parti Enter all that apply: "A" for Ambulance services; "B" for addi for tele-health services.	reporting p mn 1 is Y, e cipating in	period? Enter enter the column 2.	1.00 N	2.00	111.00
		1.00	2.00	3.00	_
112.00 Did this hospital participate in the Pennsylvania Rural Health demonstration for any portion of the current cost reporting pe Enter "Y" for yes or "N" for no in column 1. If column 1 is " in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	eriod? Y", enter	N			112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or " in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (in psychiatric, rehabilitation and long term hospitals providers) the definition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) percent icludes based on	Ν			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" fo "N" for no.	or yes or	N			116.00
117.00 Is this facility legally-required to carry malpractice insuran "Y" for yes or "N" for no.	nce? Enter	Y			117.00
118.00 Is the malpractice insurance a claims-made or occurrence polic if the policy is claim-made. Enter 2 if the policy is occurren			1		118.00
		Premiums	2.00	I nsurance	_
118.01 List amounts of malpractice premiums and paid losses:		494, 24)	0 118. 01
			1.00	2.00	-
118.02 Are malpractice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein.			N		118.02
119.00D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments	olumn 1, "Y" ifies for th	for yes or ne Outpatient	Ν	N	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.	able devices	s charged to	Y		121.00
122.00 Does the cost report contain healthcare related taxes as defin Act?Enter "Y" for yes or "N" for no in column 1. If column 1 i the Worksheet A line number where these taxes are included.			N		122.00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" for	yes and "N"	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ente	er the certif	ication date			126. 00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter	the certifi	cation date			127.00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter	the certifi	cation date			128.00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter	the certific	ation date ir	۱		129.00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, en		i fi cati on			130. 00
date in column 1 and termination date, if applicable, in colum 131.00 If this is a Medicare certified intestinal transplant center,	enter the ce	erti fi cati on			131.00
date in column 1 and termination date, if applicable, in colum 132.00 If this is a Medicare certified islet transplant center, enter		cation date			132.00
in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 134.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.	0P0 number i	n column 1			133. 00 134. 00
All Providers 140.00 Are there any related organization or home office costs as def chapter 10? Enter "Y" for yes or "N" for no in column 1. If ye			Y	HB0720	140. 00

Health Financial Systems	COMMUNI T	Y HOSPI	TAL SOUTH			I	n Lieu	of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	١	Provider CC	N: 15-012		i od:	(0040	Worksheet S-	2
					From	m 01/01, 12/31,		Part I Date/Time Pro	enared [.]
								8/19/2020 1:	
1.00		2.00					00		
If this facility is part of a chair home office and enter the home offi					he name	and add	dress d	of the	
141. 00 Name: COMMUNI TY HEALTH NETWORK	Contractor's Nar				actor's	Number	· 08101	1	141.00
		SERV			40101 0	, itempor			
142.00 Street: 1500 NORTH RITTER AVENUE	PO Box:								142.00
143.00 City: INDIANAPOLIS	State:	I N		Zip C	Code:		46219	9-3095	143.00
							-	1 00	-
144.00 Are provider based physicians' cost	s included in Works	hoot 12						1.00 Y	144.00
144. OOM e provider based physicians cost		leet A:						1	144.00
						1.00)	2.00	-
145.00 If costs for renal services are cla						Y			145.00
inpatient services only? Enter "Y"									
no, does the dialysis facility incl period? Enter "Y" for yes or "N" f		ation to	or this cost	reporting	9				
146.00 Has the cost allocation methodology		revi ousl	v filed cost	report?		Ν			146.00
Enter "Y" for yes or "N" for no in) If				
yes, enter the approval date (mm/dc	l/yyyy) in column 2.								
							-		-
147.00 Was there a change in the statistic	al bacic2 Entor "V"	for yos	or "N" for	00				1.00 N	147.00
148.00 Was there a change in the order of								N	147.00
149.00 Was there a change to the simplifie					for no.			N	149.00
			Part A	Part	В	Title	V	Title XIX	
			1.00	2.00		3.00		4.00	
Does this facility contain a provid or charges? Enter "Y" for yes or "N	ler that qualifies for	or an e	xemption from	n the appl	lication	n of the	e lower	r of costs	
155.00Hospital	N TOP NO FOP each c	omponen	N N	and Part N	B. (See	<u>e 42 CFF</u> N	<u>x 9</u> 413.	N	155.00
156. 00 Subprovi der – TPF			N	N		N		N	156.00
157.00 Subprovi der – IRF			N	N		N		N	157.00
158. 00 SUBPROVI DER									158.00
159.00 SNF			N	N		N		N	159.00
160.00 HOME HEALTH AGENCY 161.00 CMHC			N	N		N N		N N	160.00 161.00
				IN		IN		IN	101.00
							F	1.00	1
Multicampus									
165.00 Is this hospital part of a Multicam	npus hospital that ha	as one o	or more campu	ises in di	fferent	t CBSAs?	·	N	165. 00
Enter "Y" for yes or "N" for no.	Name		County	State	Zip Co	ndo C	BSA	FTE/Campus	
-	0		1.00	2.00	3.00		. 00	5.00	-
166.00 If line 165 is yes, for each									0 166. 00
campus enter the name in column									
0, county in column 1, state in									
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in									
column 5 (see instructions)									
								1.00	
Heal th Information Technology (HIT)						ct			1/7 00
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 105						tor the		Y	167.00 168.00
reasonable cost incurred for the HI				10/13	i), ei	iter the			100.00
168.01 If this provider is a CAH and is no	ot a meaningful user,	, does t	this provider	qualify	for a h	nardshi p	,		168.01
exception under §413.70(a)(6)(ii)?									
169.00 If this provider is a meaningful us) and is	s not a CAH (line 105	is "N")	, enter	the	9.9	9169.00
transition factor. (see instruction	IS)					Begi nni	ing	Endi ng	
					-	1.00	<u> </u>	2.00	-
170.00 Enter in columns 1 and 2 the EHR be	ginning date and end	ding dat	te for the re	porting					170.00
period respectively (mm/dd/yyyy)		-							
								0.07	_
171 00 lf line 147 is "\\" does this servi	don have any days for	on India	dual a aprol	Lodin		1. OC N)	2.00	0171 00
171.00 If line 167 is "Y", does this provi section 1876 Medicare cost plans re					er	IN			0 171.00
"Y" for yes and "N" for no in colum									
1876 Medicare days in column 2. (se		-							

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0128	Period:	Worksheet S-	2
				From 01/01/2019 To 12/31/2019	Part II Date/Time Pr	
				Y/N	<u>8/19/2020 1:</u> Date	53 piii
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N	lfor all NO re	sponses. Ent	er all dates in t	he	
	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 c	column 2. (see	Y/N) Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare F		N			2.
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	n 3, "V" for				
. 00	Is the provider involved in business transactions, includir	ng management	Y			3.
	contracts, with individuals or entities (e.g., chain home of	offices, drug				
	or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of	ler or its				
	of directors through ownership, control, or family and othe					
	rel ati onshi ps? (see i nstructi ons)	-				
			Y/N 1.00	Type 2.00	Date 3.00	
	Financial Data and Reports		1.00	2.00	3.00	_
. 00	Column 1: Were the financial statements prepared by a Cert	ified Public	Y	A	03/26/2020	4.
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f					
	or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	niadle in				
. 00	Are the cost report total expenses and total revenues diffe	erent from	N			5.
	those on the filed financial statements? If yes, submit rec	conciliation.				_
				Y/N 1.00	Legal Oper. 2.00	_
	Approved Educational Activities			1.00	2.00	-
. 00	Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is th	ne provider i	s N		6.0
00	the legal operator of the program?	atruations		N		
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		l during the	N		7.0
	cost reporting period? If yes, see instructions.		adiring the			
. 00	Are costs claimed for Interns and Residents in an approved		al education	Y		9. (
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c		he current	Ν		10. (
0.00	cost reporting period? If yes, see instructions.					10.
1.00	Are GME cost directly assigned to cost centers other than I	& R in an App	proved	Ν		11. (
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	-
					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 p			ost reporting	Y N	12.
5.00	period? If yes, submit copy.	on cy change a	aring this c	ust reporting	N.	15.
4.00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	yes, see in	structions.	Ν	14. (
5 00	Bed Complement Did total beds available change from the prior cost reporti	na period2 lf	ves see ins	tructions	N	15. (
5.00	The cost report		rt A	Par		10.1
		Y/N	Date	Y/N	Date	
	DC+D Data	1.00	2.00	3.00	4.00	-
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	N		N		16.
	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					
7.00	instructions) Was the cost report prepared using the PS&R Report for	Y	06/26/2020	Y	06/26/2020	17.
	totals and the provider's records for allocation? If		00,20,2020		00,20,2020	
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		Ν		18.
8 00		IN IN		IN		10.
8. 00		1	1			
8. 00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this					
8. 00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
8. 00 9. 00	but are not included on the PS&R Report used to file this	N		Ν		19.

Heal th Financial	Systems
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COMMUNITY HOSPITAL SOUTH

In Lieu of Form CMS-2552-10

ealth Financial Systems COMMUNITY HOS	SPITAL SOUTH		In Lie	eu of Form CM	S-2552-1				
IOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0128	Period: From 01/01/2019 To 12/31/2019		repared:				
	Descri	i pti on	Y/N	Y/N	. 55 pili				
		0	1.00	3.00					
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 0				
	Y/N	Date	Y/N	Date					
	1.00	2.00	3.00	4.00					
1.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.0				
				1.00					
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	IOSPI TALS)							
Capital Related Cost				1					
2.00 Have assets been relifed for Medicare purposes? If yes, see					22.0				
3.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.			0		23.0				
If yes, see instructions	00 Were new leases and/or amendments to existing leases entered into during this cost reporting period?								
5.00 Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	lf yes, see		25.0				
00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.									
7.00 Has the provider's capitalization policy changed during the copy.	e cost reportin	ng period? If	yes, submit		27. (
Interest Expense 3.00 Were new Loans, mortgage agreements or letters of credit en	ntered into dur	ing the cost	reporting		28.				
period? If yes, see instructions. Do Did the provider have a funded depreciation account and/or	bond funds (De	ebt Service Re	eserve Fund)		29.				
treated as a funded depreciation account? If yes, see instr .00 Has existing debt been replaced prior to its scheduled matu		debt? If yes,	see		30.				
instructions. .00 Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see		31.				
instructions. Purchased Services									
2.00 Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ed through cor	ntractual		32.				
3.00 If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	olied pertainin	ng to competit	tive bidding? If		33.				
Provider-Based Physicians 4.00 Are services furnished at the provider facility under an ar	rrangement with	provider-bas	sed physi ci ans?		34.				
If yes, see instructions. 5.00 If line 34 is yes, were there new agreements or amended exi	0				35.				
physicians during the cost reporting period? If yes, see in									
			Y/N	Date					
Home Office Costs			1.00	2.00					
0.00 Were home office costs claimed on the cost report?	constant by the	home office?			36. 37.				
.00 If line 36 is yes, has a home office cost statement been pr If yes, see instructions.									
.00 If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end	d of the home o	offi ce.			38.				
.00 If line 36 is yes, did the provider render services to other see instructions.		-			39.				
.00 If line 36 is yes, did the provider render services to the instructions.	nome office?	IT yes, see			40.				
	1.	00	2.	00	_				
	SHI RLEY		BI SHOP		41.				
1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.			BI SHOP						
 1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 2.00 Enter the employer/company name of the cost report preparer. 	SHI RLEY COMMUNI TY HEAL 317-355-4135	TH NETWORK	BI SHOP SBI SHOP@ECOMMU		41. 42. 43.				

Heal th	Financial Systems COMMUNI	TY HO	SPITAL SOUTH	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAI	RE	Provider CCN: 15-0128	Peri od:	Worksheet S-2	
				From 01/01/2019 To 12/31/2019		pared: <u>3 pm</u>
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	on	NETWORK DIRECTOR OF			41.00
	held by the cost report preparer in columns 1, 2, and	d 3,	REIMBURSEMENT			
	respecti vel y.					
42.00	Enter the employer/company name of the cost report					42.00
	preparer.					
43.00	Enter the telephone number and email address of the	cost				43.00
	report preparer in columns 1 and 2, respectively.					

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	COMMUNITY HOSE	Provi der CO	N. 15_0128	Peri od:	u of Form CMS-2 Worksheet S-3	
1103511	AL AND HOSTIAL HEALTH CARE COMFLEX STATISTIC	AL DATA	FIOVIDEI CO	JN. 13-0120	From 01/01/2019	Part I	
					To 12/31/2019	Date/Time Pre 8/19/2020 1:55	
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	157	57, 30	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2.00	for the portion of LDP room available beds) HMO and other (see instructions)						2.00
2.00	HMO IPF Subprovider						3.00
3.00 4.00	HMO IRF Subprovider						4.00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		157	57, 30	0.00	0	7.00
7.00	beds) (see instructions)		157	57, 50	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4, 38	0.00	0	8.00
9.00	CORONARY CARE UNI T						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		169	61, 68	35 0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00 24.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						23.00 24.00
24.00	HOSPICE HOSPICE (non-distinct part)	30. 00					24.00
24.10	CMHC - CMHC	30.00					24.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)	07.00	169			0	27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-0128		eriod: com 01/01/2019 o 12/31/2019	Worksheet S-3 Part I Date/Time Pre 8/19/2020 1:5	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E		[
	Component	Title XVIII	Title XIX	Total All Patients		Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
1.00 2.00 3.00 4.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider	11, 942 6, 162 0 0	1, 554 6, 210 0 0	34, 87				1.00 2.00 3.00 4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0			5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	11, 942	0 1, 554	34, 87	0 71			6.00 7.00
8.00 9.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT	1, 139	0	2, 99	96			8.00 9.00
10. 00 11. 00 12. 00 13. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY		1, 718	2, 82	29			10.00 11.00 12.00 13.00
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	13, 081 0	3, 272 0	40, 69		7.73	911. 33	•
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC			37	71			24. 10 25. 00
26.00 26.25 27.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	0	0		0	0. 00 7. 73	0.00 911.33	•
28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	0	811 37		54 93 0 33 0			28.00 29.00 30.00 31.00 32.00
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges	0						33. 00 33. 01

	_Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC,		TAL SOUTH	CN: 15-0128	Period:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2019 To 12/31/2019	Part Date/Time Pre 8/19/2020 1:53	
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12.00	13.00	14.00	Patients 15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00			10, 060	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2			0, 2.			
2.00	for the portion of LDP room available beds) HMO and other (see instructions)			1, 3	40 1, 536		2.00
3.00	HMO I PF Subprovi der			1, 5	1, 330		3.00
4.00	HMO I RF Subprovi der				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. OC
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
0 00	beds) (see instructions)						0.00
8.00 9.00	INTENSIVE CARE UNIT CORONARY CARE UNIT						8.00 9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	3, 2	22 320	10, 060	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00 18.00	SUBPROVI DER – I RF SUBPROVI DER						17.00 18.00
19.00	SUBPROVIDER SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00 26.00	CMHC - CMHC RURAL HEALTH CLINIC						25.00 26.00
26.00	FEDERALLY QUALIFIED HEALTH CENTER	0, 00					26.00
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						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)						32.00
32. 01	Total ancillary labor & delivery room						32.01
33.00	outpatient days (see instructions) LTCH non-covered days				0		33.00
	LTCH site neutral days and discharges				0		33.00

PITAL WAGE INDEX INFORMATION	Ι		Provider CC	F	Period: From 01/01/2019 To 12/31/2019		par
	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	-
PART II - WAGE DATA SALARIES							1
0 Total salaries (see	200. 00	65, 210, 982	-332, 459	64, 878, 523	1, 895, 560. 00	34.23	3 1
instructions)	+ D+				0.00	0.00	
0 Non-physician anesthetis A	at Part	C	0	C	0.00	0.00	2
0 Non-physician anesthetis	t Part	C	0	C	0.00	0.00	
B		240.000		010,000	1 000 00	1/0.07	
0 Physician-Part A - Administrative		319, 898	8 0	319, 898	1, 900. 00	168. 37	′ ′
1 Physicians - Part A - Te	achi ng	C	0	C	0.00	0.00	
0 Physician and Non		260, 313	0	260, 313	4, 160. 00	62.58	3 !
Physician-Part B 0 Non-physician-Part B for		C	0	C	0.00	0.00	
hospital -based RHC and F		C	0		0.00	0.00	
servi ces							
0 Interns & residents (in	an 21.00	(0	C	0.00	0.00	
approved program) 1 Contracted interns and		C	0	C	0.00	0.00	
residents (in an approve	d						
programs)	ad				0.00	0.00	
0 Home office and/or relat organization personnel	ed	C	0	(0.00	0.00	
0 SNF	44.00	C		C	0.00	0.00	
00 Excluded area salaries (see	490, 155	0	490, 155	5 17, 883. 00	27.41	1
instructions) OTHER WAGES & RELATED CO	272						-
00 Contract Labor: Direct P		607, 568	0	607, 568	5, 805. 00	104.66	1
Care							
00 Contract labor: Top leve	1	C	0	C	0.00	0.00	12
management and other management and administr	ative						
servi ces							
00 Contract Labor: Physicia	n-Part	1, 486, 311	0	1, 486, 311	16, 994. 00	87.46	1
A - Administrative 00 Home office and/or relat	ed	C	0	C	0.00	0.00	1
organization salaries an						0100	·
wage-related costs		00 047 07		00 047 077	F10 0/0 00	10 (0	
01 Home office salaries 02 Related organization sal	aries	20, 817, 077 (20, 817, 077 (
00 Home office: Physician P		(-	(0.00		
- Administrative							
00 Home office and Contract Physicians Part A - Teac		C	0	C	0.00	0.00	1
01 Home office Physicians P		(0	C	0.00	0.00	1
- Teachi ng							
02 Home office contract Physicians Part A - Teac	hing	(0	C	0.00	0.00	1
WAGE-RELATED COSTS							
00 Wage-related costs (core	e) (see	16, 314, 144	0	16, 314, 144	l		1
instructions)	r)						1
00 Wage-related costs (othe (see instructions)							18
00 Excluded areas		147, 289	0	147, 289			1
00 Non-physician anesthetis	t Part	C	0	0			20
A 00 Non-physician anesthetis	t Part	ſ		ſ			2
B		· · · · ·					_
00 Physician Part A -		20, 631	0	20, 631			22
Administrative 01 Physician Part A - Teach	ina	C		r			2
00 Physician Part B		44, 777	-	44, 777	7		2
00 Wage-related costs (RHC/		C	0 0	· (24
00 Interns & residents (in	an	(0	C			2!
approved program) 50 Home office wage-related		5,049,771	0	5, 049, 771			2
(core)		0,047,77		5, 077, 77			
51 Related organization		C	0	C)		25
wage-related (core) 52 Home office: Physician P	art A	C		r			25
- Administrative -		C					
wage-related (core)							1

Heal th	Financial Systems		COMMUNI TY HOS	PLTAL SOUTH		In Lie	eu of Form CMS-2	2552-10
	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part II	pared:
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.		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			2, 19			26.00
27.00	Administrative & General	5.00						27.00
28.00	Administrative & General under		4, 685, 186	0	4, 685, 18	6 53, 063. 00	88. 29	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00		0		0 0.00		29.00
30.00	Operation of Plant	7.00	1, 638, 673	-3, 831	1, 634, 84			30.00
31.00	Laundry & Linen Service	8.00	0	0		0 0.00		31.00
32.00	Housekeepi ng	9.00	1, 378, 711	-3, 635	1, 375, 07	6 90, 630. 00	15. 17	32.00
33.00	Housekeeping under contract		0	0		0.00	0.00	33.00
	(see instructions)							
34.00	Dietary	10.00	1, 213, 364	-851, 215	362, 14	9 21, 775. 00	16. 63	34.00
35.00	Dietary under contract (see		282, 261	0	282, 26	1 4, 160. 00	67.85	35.00
	instructions)							
36.00	Cafeteri a	11.00	0	849, 009	849, 00	9 50, 739. 00		36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.00
38.00	Nursing Administration	13.00	288, 151	0	288, 15	1 18, 987. 00	15. 18	38.00
39.00	Central Services and Supply	14.00	0	0		0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0		0.00	0.00	40.00
41.00	Medical Records & Medical	16.00	276, 718	-1, 519	275, 19	9 6, 259. 00	43.97	41.00
	Records Library							
42.00	Social Service	17.00	1, 372, 074	-3, 750	1, 368, 32	4 33, 465. 00	40. 89	42.00
43.00	Other General Service	18.00	0	0		0 0.00	0.00	43.00

Heal th	Financial Systems		COMMUNITY HOS	SPITAL SOUTH		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2019		a made
						To 12/31/2019	Date/Time Prep 8/19/2020 1:53	
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	· · · · ·	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY		1		-1		
1.00	Net salaries (see		69, 918, 116	-332, 459	69, 585, 65	7 1, 948, 623. 00	35. 71	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		490, 155	0	490, 15	5 17, 883.00	27.41	2.00
3.00	Subtotal salaries (line 1		69, 427, 961	-332, 459	69, 095, 50	2 1, 930, 740. 00	35. 79	3.00
	minus line 2)							
4.00	Subtotal other wages & related		22, 910, 956	0	22, 910, 95	6 535, 161. 00	42. 81	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		21, 384, 546	0	21, 384, 54	6 0.00	30. 95	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		113, 723, 463					
7.00	Total overhead cost (see		15, 385, 666	-18, 422	15, 367, 24	4 437, 123. 00	35. 16	7.00
	instructions)							

Heal th	Financial Systems	COMMUNITY HOSPITAL S	OUTH		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS	Prov	vider CCN:	15-0128	Peri od:	Worksheet S-3	
					From 01/01/2019	Part IV	
					To 12/31/2019	Date/Time Pre 8/19/2020 1:55	
						Amount	s pili
						Reported	
						1.00	
	PART IV - WAGE RELATED COSTS					1.00	
	Part A - Core List						
	RETIREMENT COST						
1.00	401K Employer Contributions					2, 248, 155	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contrib	ution				0	2.00
3.00	Nongualified Defined Benefit Plan Cost (see					0	3.00
4.00	Qualified Defined Benefit Plan Cost (see ins	tructions)				7, 866	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External (
5.00	401K/TSA Plan Administration fees	<u> </u>				0	5.00
6.00	Legal /Accounting/Management Fees-Pension Pla	n				616, 145	6.00
7.00	Employee Managed Care Program Administration					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 Thir	d Party Administrator)				0	8. 01
8.02	Health Insurance (Self Funded with a Third P	arty Administrator)				6, 499, 614	8. 02
8.03	Health Insurance (Purchased)	-				0	8.03
9.00	Prescription Drug Plan					1, 664, 565	9.00
10.00	Dental, Hearing and Vision Plan					64, 708	10.00
11.00	Life Insurance (If employee is owner or bene	fi ci ary)				36, 559	11.00
12.00	Accident Insurance (If employee is owner or	beneficiary)				0	12.00
13.00	Disability Insurance (If employee is owner o	r beneficiary)				510, 106	13.00
14.00	Long-Term Care Insurance (If employee is own	er or beneficiary)				0	14.00
15.00	'Workers' Compensation Insurance					141, 431	15.00
16.00		ar, not the extraordin	ary accru	al require	d by FASB 106.	0	16.00
	Non cumulative portion)						
	TAXES						
	FICA-Employers Portion Only					4, 648, 594	
18.00	Medicare Taxes - Employers Portion Only					0	18.00
19.00	Unemployment Insurance					0	
20.00	State or Federal Unemployment Taxes					0	20.00
	OTHER						
21.00	Executive Deferred Compensation (Other Than	Retirement Cost Report	ed on lin	es 1 throu	gh 4 above. (see	0	21.00
	instructions))						
	Day Care Cost and Allowances					0	
	Tuition Reimbursement					89,099	
24.00	Total Wage Related cost (Sum of Lines 1 -23)					16, 526, 842	24.00
25 00	Part B - Other than Core Related Cost						25.00
25.00	OTHER WAGE RELATED COSTS (SPECIFY)				l		25.00

Health Financial Systems	COMMUNI TY HOSPI	TAL SOUTH	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0128	Peri od:	Worksheet S-3	
			From 01/01/2019		
			To 12/31/2019	Date/Time Pre 8/19/2020 1:5	
Cost Center Description			Contract Labor		
			1.00	2.00	
PART V - Contract Labor and Benefit	Cost				
Hospital and Hospital-Based Componer	nt Identification:				
1.00 Total facility's contract labor and	benefit cost		607, 568	16, 526, 842	1.00
2.00 Hospi tal			607, 568	16, 379, 553	2.00
3.00 Subprovider - IPF					3.00
4.00 Subprovider - IRF					4.00
5.00 Subprovider - (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 Hospital-Based SNF					8.00
9.00 Hospital-Based NF					9.00
10.00 Hospital-Based OLTC					10.00
11.00 Hospital-Based HHA					11.00
12.00 Separately Certified ASC					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 Hospital-Based-CMHC					16.00
17.00 Renal Dialysis			0	0	17.00
18.00 Other			0	147, 289	18.00

Heal th	Financial Systems COMMUNITY HOSPIT	AL SOUTH		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN	N: 15-0128	Peri od:	Worksheet S-1	0
				From 01/01/2019 To 12/31/2019		
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by lin	e 202 columr	ı 8)	0. 200040	1.00
	Medicaid (see instructions for each line)			,		
2.00	Net revenue from Medicaid				47, 527, 786	
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement			ai d?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicaid			0	5.00
6.00	Medicaid charges				155, 494, 777	6.00
7.00 8.00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program	(lino 7 minu	s sum of Lir	oc 2 and 5: if	31, 105, 175	
8.00	<pre>< zero then enter zero)</pre>		IS SUIL OF TH		0	0.00
	Children's Health Insurance Program (CHIP) (see instructions f	or each line)			
9.00	Net revenue from stand-alone CHIP		,		0	9.00
10.00	Stand-alone CHIP charges				0	
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
12.00		(line 11 min	us line 9; i	f < zero then	0	12.00
	enter zero)					
	Other state or local government indigent care program (see ins				-	
	Net revenue from state or local indigent care program (Not ind				0	
14.00	Charges for patients covered under state or local indigent car 10)	re program (N	ot included	In lines 6 or	0	14.00
15.00	10) State or local indigent care program cost (line 1 times line 1	14)			0	15.00
	Difference between net revenue and costs for state or local in		nrogram (Lir	ne 15 minus line	-	
10.00	13; if < zero then enter zero)	largent care			l °	10.00
	Grants, donations and total unreimbursed cost for Medicaid, CH	IP and state	/local indig	jent care progra	ns (see	
	instructions for each line)				1	
	Private grants, donations, or endowment income restricted to f					17.00
	Government grants, appropriations or transfers for support of				0	
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loca 8, 12 and 16)	ai indigent c	are programs	s (sum of fines	0	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line)		21 400 0		24 042 400	20.00
20.00	Charity care charges and uninsured discounts for the entire fa (see instructions)		21, 490, 83	36 2, 551, 564	24, 042, 400	20.00
21.00	Cost of patients approved for charity care and uninsured disco	ounts (see	4, 299, 02	27 2, 551, 564	6, 850, 591	21.00
21.00	instructions)		1, 277, 02	2,001,001	0,000,071	21.00
22.00	Payments received from patients for amounts previously writter	n off as	88	30 25	905	22.00
	chari ty care					
23.00	Cost of charity care (line 21 minus line 22)		4, 298, 14	47 2, 551, 539	6, 849, 686	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patie	nt dave bave	nd a longth	of ctoy limit	1.00 N	24.00
24.00	imposed on patients covered by Medicaid or other indigent care		nu a renytn	of Stay filler	IN	24.00
25 00	If line 24 is yes, enter the charges for patient days beyond t		care program	's length of	0	25.00
	stay limit	gont		i i i i i i i i i i i i i i i i i i i	Ĭ	
26.00	Total bad debt expense for the entire hospital complex (see in	nstructions)			21, 441, 612	26.00
27.00	Medicare reimbursable bad debts for the entire hospital comple	ex (see instr			486, 353	27.00
	Medicare allowable bad debts for the entire hospital complex ((see instruct	i ons)		748, 236	
	Non-Medicare bad debt expense (see instructions)				20, 693, 376	
	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	kpense (see i	nstructions)		4, 401, 386	
	Cost of uncompensated care (line 23 column 3 plus line 29)				11, 251, 072	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			11, 251, 072	31.00

	Financial Systems	COMMUNITY HOSP				u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CC		Period: From 01/01/2019	Worksheet A	
					To 12/31/2019	Date/Time Pre 8/19/2020 1:5	
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		0		0 10, 458, 853	10, 458, 853	1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT		0		0 6, 658, 970		2.00
3.00	00300 OTHER CAP REL COSTS		0		0 0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 196	9, 417	11, 61		11, 588	4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	4, 248, 332	89, 516, 335 4, 382, 738	93, 764, 66 6, 021, 41		84, 134, 990	5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 638, 673 0	4, 362, 736 673, 742	673, 74		5, 929, 215 673, 742	8.00
9.00	00900 HOUSEKEEPING	1, 378, 711	1, 027, 804	2, 406, 51		2, 392, 672	
10.00	01000 DI ETARY	1, 213, 364	1, 760, 277	2, 973, 64		869, 833	
11.00		0	0		0 2, 027, 785	2, 027, 785	
13.00 16.00	01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	288, 151 276, 718	74, 391 87, 638	362, 54 364, 35		362, 542 364, 276	13.00 16.00
17.00	01700 SOCIAL SERVICE	1, 372, 074	347, 407	1, 719, 48		1, 717, 078	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0		0 0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	0		0 0	0	22.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS		0.500.7/0				
30.00 31.00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	22, 717, 672 2, 841, 571	9, 500, 762 1, 325, 309	32, 218, 43 4, 166, 88			
43.00	04300 NURSERY	2, 841, 571	1, 325, 309		0 674, 855	674, 855	
101 00	ANCI LLARY SERVICE COST CENTERS				0, 1, 000	0717000	101 00
50.00	05000 OPERATING ROOM	3, 561, 854	18, 371, 851	21, 933, 70			
51.00	05100 RECOVERY ROOM	2, 894, 582	1, 292, 395	4, 186, 97			51.00
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	605, 229 1, 940, 105	35, 036 1, 979, 850	640, 26 3, 919, 95		3, 875, 604 2, 688, 282	52.00 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	619, 700	1, 533, 918	2, 153, 61		1, 059, 642	
57.00	05700 CT SCAN	718, 900	1, 101, 114	1, 820, 01		1, 430, 123	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	311, 938	208, 345	520, 28	3 –18, 779	501, 504	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 476, 947	8, 456, 453	9, 933, 40		2, 890, 063	
60.00		0	7, 422, 470	7, 422, 47	0 -2,284 0 0	7, 420, 186	60.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	1, 830, 848	1,029,741	2, 860, 58	-	0 2, 475, 431	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	2, 794, 566	1, 378, 109	4, 172, 67		2, 716, 015	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 740, 187	740, 187	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 170, 711	170, 711	
69.00 70.00		873, 213	516, 226	1, 389, 43			
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	476, 083 0	376, 473 982, 249	852, 55 982, 24		796, 570 13, 659, 452	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	02, 247		0 10, 334, 651	10, 334, 651	
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 916, 927	8, 883, 034	11, 799, 96			
	07400 RENAL DI ALYSI S	0	466, 743	466, 74			
76.00	03950 ENDOSCOPY 03330 I MAGI NG CENTER	642, 866 866, 596	1, 243, 277	1, 886, 14			
	07697 CARDIAC REHABILITATION	282, 394	1, 037, 690 102, 543	1, 904, 28 384, 93		1, 461, 651 367, 486	
	OUTPATIENT SERVICE COST CENTERS	202, 074					
90.00	09000 CLI NI C	0	0		0 0	0	90.00
90.01	04950 DI ABETI C CARE CENTER	0	0		0 0	0	90.01
90. 02 90. 03	04951 ANTI -COAGULATI ON CLI NI C 04952 PALLI ATI VE CARE	506, 389	174, 345	680, 73	4 -15, 801	664, 933	90. 02 90. 03
90.03 90.04	04953 SPINE CENTER	125, 168	137, 558	262, 72	6 -68, 458	194, 268	
91.00	09100 EMERGENCY	5, 299, 060	2, 822, 219	8, 121, 27			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	64, 720, 827	168, 257, 459	232, 978, 28	6 8, 813	232, 987, 099	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191.00	19100 RESEARCH	0	0		0 0	0	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	319	192, 615	192, 93	4 0	192, 934	
	19300 NONPALD WORKERS	0	0		0 0		193.00
	07950 HOME OFFICE 07956 LEASED OFFICE SPACE	0	0				194. 00 194. 06
	07958 MISC NONRELMBURSABLE COST CENTERS	489, 836	341, 289	831, 12	5 -8, 813		
200.00		65, 210, 982	168, 791, 363				

CLASSI	FICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO	CN: 15-012	From C	01/01/2019	Worksheet A	
						2/31/2019	Date/Time Pr 8/19/2020 1	
	Cost Center Description	Adjustments	Net Expenses				0/17/2020 1	
		(See A-8)	For Allocation					
		6.00	7.00					_
	ENERAL SERVICE COST CENTERS	0.4/7.505	7 001 040					_
	0100 CAP REL COSTS-BLDG & FIXT	-3, 167, 505						1.
	0200 CAP REL COSTS-MVBLE EQUIP	3, 532, 060						2.
	0300 OTHER CAP REL COSTS	0 701 107	u u					3.
	0400 EMPLOYEE BENEFITS DEPARTMENT	2, 721, 137						4.
	0500 ADMI NI STRATI VE & GENERAL	-44, 286, 252						5.
	0700 OPERATION OF PLANT	-353, 919						7.
	0800 LAUNDRY & LINEN SERVICE	0						8.
	0900 HOUSEKEEPING	0						9.
		-38, 901						10.
		-1, 465, 834						11.
		2,736,136						13.
	1600 MEDICAL RECORDS & LIBRARY	1, 684, 384						16.
	1700 SOCIAL SERVICE	0						17.
	2100 I &R SERVICES-SALARY & FRINGES APPRVD	608, 162						21.
	2200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	808, 192	808, 192					22.
	IPATI ENT ROUTI NE SERVI CE COST CENTERS	1 700 400	20 207 202					- 20
	3000 ADULTS & PEDIATRICS	1, 732, 438						30.
	3100 I NTENSI VE CARE UNI T	0						31.
	1300 NURSERY	0	674, 855					43.
	ICI LLARY SERVICE COST CENTERS	0	(700 505					
	5000 OPERATING ROOM	0						50.
	5100 RECOVERY ROOM	0						51.
	5200 DELIVERY ROOM & LABOR ROOM	0	0,0,0,001					52.
	5400 RADI OLOGY-DI AGNOSTI C	-185, 775						54.
	5500 RADI OLOGY-THERAPEUTI C	0	.,					55.
	5700 CT SCAN	0	.,					57.
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0						58.
	5900 CARDI AC CATHETERI ZATI ON	0	2,0,0,000					59.
		-829, 984						60.
	5400 I NTRAVENOUS THERAPY	0						64.
	5500 RESPI RATORY THERAPY	0	2/ 1/0/ 101					65.
		-19, 037						66.
	5700 OCCUPATIONAL THERAPY	0						67.
		0						68.
		51, 166						69.
	7000 ELECTROENCEPHALOGRAPHY	113, 313						70.
	7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	831, 225						71.
	7200 I MPL. DEV. CHARGED TO PATIENTS	0						72.
	7300 DRUGS CHARGED TO PATIENTS	220, 537						73.
1	7400 RENAL DIALYSIS	0						74.
	3950 ENDOSCOPY	0						76.
	3330 I MAGI NG CENTER	0						76.
	7697 CARDI AC REHABI LI TATI ON	-9, 351	358, 135					76
	JTPATI ENT SERVICE COST CENTERS							
		0	0					90.
	1950 DI ABETI C CARE CENTER	0	0					90
	4951 ANTI - COAGULATI ON CLI NI C	-323, 865	341, 068					90.
	1952 PALLIATIVE CARE	0	0					90
	1953 SPINE CENTER	0						90
	9100 EMERGENCY	0	7, 765, 800					91
	9200 OBSERVATION BEDS (NON-DISTINCT PART)							92.
	PECIAL PURPOSE COST CENTERS	05 (11 (55	407.015.(-)					-
B. 00	SUBTOTALS (SUM OF LINES 1 through 117)	-35, 641, 673	197, 345, 426					118
	NREIMBURSABLE COST CENTERS	-						-
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0					190
	P100 RESEARCH	0	u u					191
	200 PHYSI CLANS' PRI VATE OFFI CES	0	192, 934					192
	2300 NONPAID WORKERS	0	0					193
	7950 HOME OFFICE	0	0					194
	7956 LEASED OFFICE SPACE	0	0					194
4.0807	7958 MISC NONREIMBURSABLE COST CENTERS	0	022,012					194
0.00	TOTAL (SUM OF LINES 118 through 199)	-35, 641, 673	198, 360, 672					200

n Financial Systems SSIFICATIONS		COMMUNITY HOS	PITAL SOUTH Provider CCN: 15-01		
				From 01/01/2019 To 12/31/2019 Date/Tin	ne Prepareo
	Increases			8/19/202	20 1:53 pm
Cost Center	Line #	Salary	Other		
2.00 A - Chargeable Medical Supplie	3.00	4.00	5.00		
MEDICAL SUPPLIES CHARGED TO	71.00	0	13, 907, 107		1.
PATI ENTS					
	0.00	0	0		2.
	0.00 0.00	0	0		3. 4.
	0.00	0	0		4. 5.
	0.00	0	0		6.
	0.00	0	0		7.
	0.00 0.00	0	0		8.
	0.00	0	0		9. 10.
	0.00	0	ő		11.
	0.00	0	0		12.
	0.00	0	0		13.
	0.00	0	0		14.
	0.00 0.00	0	0 0		15. 16.
	0.00	0	0		17.
	0.00	o	0		18.
	0.00	О	0		19.
	0.00	0	0		20.
	0.00 0.00	0	0		21.
	0.00	0	0		22.
	0.00	0	õ		24.
	0.00	О	0		25.
	0.00	0	0		26.
	0.00	0	0000000		27.
TOTALS B - Implantable Device Reclass		0	13,907,107		
IMPL. DEV. CHARGED TO	72.00	0	10, 334, 651		1.
PATI ENTS	0.00	0	0		2.
	0.00	0	0		3.
	0.00	0	0		4.
TOTALS		0	10, 334, 651		
C - Drugs Charges to Pat MEDICAL SUPPLIES CHARGED TO	71.00		457		1.
PATI ENTS	71.00		457		1.
DRUGS CHARGED TO PATIENTS	73.00		443, 141		2.
					3.
					4.
					5.
					7.
					8.
					9.
					10.
					11
					13
					14
					15
					16
					17.
					18. 19.
					20.
		0	443, 598		
D - Depreciation Expense CAP REL COSTS-MVBLE EQUIP	2.00	0	9, 220, 661		1.
	0.00	0	0		2.
	0.00	О	0		3.
	0.00	0	0		4.
	0.00 0.00	0	0		5.
	0.00	0	0		7.
	0.00	0	0		8.
	0.00	О	0		9.
	0.00	О	0		10.
1	0.00	0	0		11.
	I	_1	~		1
	0.00 0.00	0 0	0 0		12

COMMUNITY HOSPITAL SOUTH Provider CCN: 15-0128 Period:

In Lieu of Form CMS-2552-10 Worksheet A-6

ECLAS	SIFICATIONS			Provider CCN: 15-0128	Period: From 01/01/2019	Worksheet A-6
					To 12/31/2019	Date/Time Prepared: 8/19/2020 1:53 pm
	Cost Center	Li ne #	Salary	Other		
	2.00	3.00	4.00	5.00		
4.00		0.00	0	0		14.0
5.00		0.00	0	0		15.0
6.00 7.00		0.00 0.00	0	0		16. 0 17. 0
7.00 8.00		0.00	0	0		17.0
9.00		0.00	0	0		10.0
0.00		0.00	Ō	0		20.0
1.00		0.00	0	0		21.0
2.00		0.00	0	0		22.0
3.00		0.00	0	0		23.0
4.00 5.00		0.00 0.00	o	0		24. 0 25. 0
26.00		0.00	0	ő		26.0
7.00		0.00	0	0		27.0
8.00	L	0.00	o	<u>0</u>		28.0
	TOTALS		0	9, 220, 661		
00	E - Interest Expense	1.00	0	E E E E 100		1.0
. 00	CAP_REL_COSTS-BLDG_&_FIXT TOTALS		— — — 0	<u>5, 565, 108</u> 5, 565, 108		1.0
	F - Other Capital Rental	<u> </u>	0	3, 303, 100		
. 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2, 203, 193		1.0
2.00	MISC NONREIMBURSABLE COST	194.08	0	1, 279		2.0
	CENTERS					
. 00		0.00 0.00	0	0		3.0
. 00 . 00		0.00	0	0		4.0 5.0
. 00		0.00	0	0		6.0
. 00		0.00	0	ő		7.0
. 00		0.00	0	o		8.0
. 00		0.00	0	0		9.0
0.00		0.00	0	0		10. C
1.00		0.00	0	0		11.0
2.00		0.00	0	0		12.0
3.00		0.00	0	0		13.0
4.00 5.00		0.00 0.00	0	0		14. 0 15. 0
6.00		0.00	0	0		16.0
7.00		0.00	0	ő		17.0
8.00		0.00	0	0		18.0
9.00		0.00	0	0		19. 0
0.00		0.00	0	0		20.0
1.00		0.00	0	0		21.0
2.00		0.00	0	0		22.0
3.00 4.00		0.00 0.00	0	0 0		23. C 24. C
5.00		0.00	0	0		24.0
6.00		0.00	o	ő		26.0
	TOTALS		0	2,204,472		
	G - STD BENEFIT	, r				
. 00	ADMINISTRATIVE & GENERAL	5.00	0	3, 481		1.0
. 00 . 00	OPERATION OF PLANT	7.00 9.00	0	3, 831 3, 635		2.0
00	HOUSEKEEPI NG DI ETARY	9.00	0	3, 635		3.0
00	MEDICAL RECORDS & LIBRARY	16.00	0	1, 519		4.0
00	SOCI AL SERVI CE	17.00	0	3, 750		6.0
00	ADULTS & PEDIATRICS	30.00	Ő	145, 086		7.0
00	INTENSIVE CARE UNIT	31.00	Ō	23, 340		8.0
00	OPERATING ROOM	50.00	О	4, 310		9. (
0. 00	RECOVERY ROOM	51.00	0	21, 615		10.0
. 00	RADI OLOGY-THERAPEUTI C	55.00	0	1, 280		11. (
2.00	CARDIAC CATHETERIZATION	59.00	0	4, 403		12. (
3.00 1.00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00	0	9, 627 25, 812		13. 0
4.00 5.00	ELECTROCARDI OLOGY	69.00	0	25, 812 6, 079		14.0
5.00 5.00	ELECTROEARDTOLOGY	70.00	0	2, 225		15.0
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	35, 169		17.0
3.00	ENDOSCOPY	76.00	0	403		18.0
9.00	I MAGI NG CENTER	76.06	Ö	3, 216		19. (
0. 00	CARDI AC REHABI LI TATI ON	76.97	0	594		20.0
1.00	ANTI-COAGULATION CLINIC	90.02	о	2, 670		21.0
	EMERGENCY	91.00	0	28, 208		22.0
2.00	TOTALS	<u> </u>	<u>_</u>	332, 459		

Heal th	Financial Systems		COMMUNITY HOSP	ITAL SOUTH		In Lie	u of Form CMS-2	552-10
RECLAS	SIFICATIONS			Provider C	CN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet A-6 Date/Time Prep	ared.
						10 12/01/2017	8/19/2020 1:53	
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	H - Labor and Delivery							
1.00	NURSERY	43.00	484, 125	190, 730				1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	2, 320, 957	914, 382				2.00
	TOTALS	T	2, 805, 082	1, 105, 112				
	I - Cafeteria							
1.00	CAFETERI A	11.00	849, 009	1, 178, 776				1.00
	TOTALS		849,009	1, 178, 776				
	J - Therapy							
1.00	OCCUPATI ONAL THERAPY	67.00	563, 360	176, 827				1.00
2.00	SPEECH PATHOLOGY	68.00	129, 929	40, 782				2.00
	TOTALS		693, 289	217, 609				
	K - Building Depreciation							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4, 764, 884				1.00
	TOTALS	+		4, 764, 884				
	L - Capital Insurance Costs	I	-1	.,				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	128, 861				1.00
	TOTALS			128, 861				
	M - Radiology Support Staff	I	-	,				
1.00	RADI OLOGY-THERAPEUTI C	55.00	56, 234	29, 612				1.00
2.00	CT SCAN	57.00	154, 940	81, 590				2.00
3.00	MAGNETIC RESONANCE I MAGING	58.00	27, 795	14,636				3.00
0.00	(MRI)	50.00	21,115	14, 000				0.00
	TOTALS	+	238, 969	125, 838				
500 00	Grand Total: Increases		4, 586, 349	49, 529, 136			F	500.00
000.00		I	1, 000, 047	17, 527, 150				

COMMUNITY HOSPITAL SOUTH

RECLOSITIONIDIS Provider CDL 15 - 0.2 P	Heal th	Financial Systems		COMMUNI TY HOS	PITAL SOUTH		In Lieu	of Form CMS-2552-10
Decreases Intervent Decreases Decreases <thdecreases< th=""> <thdecreases< th=""> <thd< td=""><td>RECLASS</td><td>SEFECATIONS</td><td></td><td></td><td>Provi der</td><td></td><td></td><td>Worksheet A-6</td></thd<></thdecreases<></thdecreases<>	RECLASS	SEFECATIONS			Provi der			Worksheet A-6
Image: Control Optimized States Other Other Other Other A : Overgedire Related Supplices 0.00 9.00							To 12/31/2019	Date/Time Prepared:
Cost Center Line # Stary Other Next Next <td></td> <td></td> <td>Decreases</td> <td></td> <td></td> <td></td> <td></td> <td>8/19/2020 1:53 pm</td>			Decreases					8/19/2020 1:53 pm
A Chargenetic effectives Col C So So C So		Cost Center		Salary	Other	Wkst. A-7 Ref.		
1.00 ADMINISTRATURY A CREEAU 5.00 0 14.352 0 1.00 2.00 DEPERTURY OF PLANT 7.00 0 2.20 0 4.00 4.00 SCIAL SERVICE 17.00 0 2.20 0 4.00 4.00 SCIAL SERVICE 17.00 0 2.22 0 4.00 4.00 SCIAL SERVICE 17.00 0 2.22 0 4.00 6.00 ILESSINGCE 17.01 0 2.22 0 4.00 6.00 ILESSINGCE INGUEDEY ON ARCONTE 5.00 0 7.03 0 10.00 7.00 DERIVAC CATHERARY 50.00 0 7.13.31 0 11.00 12.00 11.00 DERIVAC CATHERARY 60.00 0 33.870 0 12.00 14.00 12.00 DERIVAC CATHERARY 60.00 0 33.870 0 12.00 14.00 12.00 13.00 14.00 12.00 14.00 12.00				8.00	9.00	10.00		
2.00 DEFERTION OF PLANT 7.00 0 1.6 0 2.00 2.00 DELAS ALTONO TONO 1.00 0 2.00 3.00 4.00 DELAS ALTONO TONO 1.24.25 0 4.00 4.00 DESATIS ALTONO TONO 2.12.475 0 0 0.00 7.00 DESATIS ANDING 51.00 0 2.12.475 0 0 0.00 0.00 DESATIS RADING 51.00 0 7.14.379 0 10.00 11.00 1	1 00			0	1/ 252			1.00
3.00 DLE LARY 10.00 0 395 0 3.00 5.00 MATES & PEAL FUEL 17.00 0 122.20 0 4.00 5.00 MATES & PEAL FUEL 31.00 0 122.202 0 4.00 5.00 MATES & PEAL FUEL 31.00 0 122.202 0 4.00 6.00 MATES & PEAL FUEL 31.00 0 4.00 4.00 4.00 0.00 MATES ALL SERVICE 51.00 0 4.00 4.00 4.00 4.00 110 OC T SCAL MATES ALL SERVICE 52.00 0 177.631 0 12.00 12.00 MATES RESIMARCE HARINO 52.00 0 177.631 0 12.00 <td< td=""><td></td><td></td><td></td><td>°,</td><td></td><td></td><td></td><td></td></td<>				°,				
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13.00 ELECTROCARDIOLOGY 69.00 237 13.00 14.00 ELECTROENCEPHALOGRAPHY 70.00 397 14.00 15.00 RENAL DI ALVSI S 74.00 554 15.00 16.00 ENDOSCOPY 76.00 895 16.00 17.00 IMAGING CENTER 76.06 19.909 17.00 18.00 CARDIAC REHABILITATION 76.97 57 18.00 19.00 ANTI-COAGULATION CLINIC 90.02 11 19.00 20.00 EMERGENCY 91.00 18.960 20.00 20.00 OPERATION OF PLANT 7.00 86.236 0 20.00 1.00 OPERATION OF PLANT 7.00 86.236 0 2.00 3.00 HOUSEKEEPING 9.00 0 5.174 0 3.00 4.00 DIETARY 10.00 0 18.805 0 5.00 5.00 5.00 SOCIAL SERVICE 17.00 0 18.805 0 5.00 5.00 6.00 ADULTS & PEDIATRICS 30.00 0 18.977								
14.00 ELECTROENCEPHALOGRAPHY 70.00 397 14.00 15.00 RENAL DI ALYSI S 74.00 554 15.00 16.00 ENDOSCOPY 76.00 895 16.00 17.00 IMAGI NG CENTER 76.06 19,909 17.00 18.00 CARDI AC REHABI LI TATI ON 76.97 57 18.00 19.00 ANTI - COAGULATI ON CLI NI C 90.02 11 19.00 20.00 EMERGENCY								
16.00 ENDOSCOPY 76.00 895 16.00 17.00 IMAGI NG CENTER 76.06 19,909 17.00 18.00 CARDI AC REHABI LI TATI ON 76.97 57 18.00 19.00 ANTI - COAGULATI ON CLI NI C 90.02 11 19.00 20.00 EMERGENCY 91.00 18.960 20.00 0 - - 0 443,598 20.00 0 OPERATION OF PLANT 7.00 0 86,236 0 2.00 3.00 HOUSEKEEPI NG 9.00 0 5,174 0 3.00 4.00 D I ETARY 10.00 0 1,805 0 5.00 5.00 0 1,805 0 3.00 4.00 5.00 5.00 5.00 SOCI AL SERVI CE 17.00 0 18,977 0 6.00 7.00 INTENSI VE CARE UNI T 31.00 0 189,170 0 7.00 8.00 OPERATING ROOM 50.00 0 1,636,105 0 8.00 9.00 RECOVERY ROOM<								
17.00 IMAGING CENTER 76.06 19,909 17.00 18.00 CARDIAC REHABILITATION 76.97 57 18.00 19.00 ANTI-COAGULATION CLINIC 90.02 11 19.00 20.00 EMERGENCY 91.00 18.960 20.00 D - Depreciation Expense 0 443.598 20.00 1.00 ADMINISTRATIVE & GENERAL 5.00 0 3,920,144 9 1.00 2.00 OPERATION OF PLANT 7.00 0 86,236 0 2.00 3.00 HOUSEKEEPING 9.00 0 5,174 0 3.00 4.00 DI ETARY 10.00 0 71,610 40 4.00 5.00 SOCI AL SERVICE 17.00 1,805 0 5.00 6.00 6.00 ADULTS & PEDIATRICS 30.00 0 418,377 0 6.00 7.00 INTENSIVE CARE UNIT 31.00 0 189,170 0 7.00 8.00 OPERATING ROOM 50.00 0 26,955 0 9.00 9.00 <								
18.00 CARDI AC REHABI LI TATI ON 76.97 57 18.00 19.00 ANTI - COAGULATI ON CLI NI C 90.02 11 19.00 20.00 EMERGENCY 91.00 18.960 20.00 D - Depreciation Expense 0 443.598 20.00 D - Depreciation Expense 0 3.920,144 9 1.00 2.00 OPERATI ON OF PLANT 7.00 0 86,236 0 2.00 3.00 HOUSEKEEPI NG 9.00 0 5,174 0 3.00 4.00 DI ETARY 10.00 0 71,610 0 4.00 5.00 0 189,170 0 5.00 5.00 6.00 7.00 189,170 0 189,170 0 7.00 8.00 9.00 0 1636,105 0 8.00 9.00 7.00 1.636,105 0 7.00 8.00 OPERATI NG ROOM 50.00 0 1636,105 0 8.00 9.00 7.00 1.00 7.00 1.00 1.00 1.00 1.000 1.00								
19.00 ANTI-COAGULATION CLINIC 90.02 11 19.00 20.00 20.00 EMERGENCY 91.00 0 18.960 20.00 D Depreciation Expense 0 443.598 10.00 20.00 1.00 ADMINI STRATIVE & GENERAL 5.00 0 3.920,144 9 1.00 2.00 OPERATION OF PLANT 7.00 0 86,236 0 2.00 3.00 HOUSEKEEPING 9.00 0 5,174 0 3.00 4.00 DI ETARY 10.00 0 71,610 0 4.00 5.00 SOCI AL SERVI CE 17.00 0 189,170 0 5.00 6.00 ADULTS & PEDIATRICS 30.00 0 189,170 0 7.00 8.00 OPERATING ROOM 51.00 0 26,955 0 8.00 9.00 9.00 RECOVERY ROOM 51.00 0 3.848 0 10.00 10.00 RADI LOGY-DI AGNOSTI C 55.00 0 26,955 0 10.00 11.00								
D Depreciation Expense 1.00 ADMINISTRATIVE & GENERAL 5.00 0 3,920,144 9 1.00 2.00 OPERATION OF PLANT 7.00 0 86,236 0 2.00 3.00 HOUSEKEEPING 9.00 0 5,174 0 3.00 4.00 Dil ETARY 10.00 0 71,610 0 4.00 5.00 SOCIAL SERVICE 17.00 0 1,805 0 5.00 6.00 ADULTS & PEDIATRICS 30.00 0 418,377 0 6.00 7.00 INTENSIVE CARE UNIT 31.00 0 189,170 0 7.00 8.00 OPERATING ROOM 51.00 0 26,955 0 9.00 9.00 RECOVERY ROOM 51.00 0 308,488 0 10.00 11.00 RADIOLOGY-THERAPEUTIC 55.00 0 261,446 0 11.00			90.02					
D - Depreciation Expense 1.00 ADMI NI STRATI VE & GENERAL 5.00 0 3,920,144 9 1.00 2.00 OPERATI ON OF PLANT 7.00 0 86,236 0 2.00 3.00 HOUSEKEEPI NG 9.00 0 5,174 0 3.00 4.00 DI ETARY 10.00 0 71,610 0 4.00 5.00 SOCI AL SERVI CE 17.00 0 1,805 0 5.00 6.00 ADULTS & PEDI ATRI CS 30.00 0 418,377 0 6.00 7.00 INTENSI VE CARE UNI T 31.00 0 189,170 7.00 7.00 8.00 OPERATI NG ROOM 50.00 0 1,636,105 0 8.00 9.00 9.00 RECOVERY ROOM 51.00 0 308,488 0 10.00 10.00 10.00 RADI OLOGY-THERAPEUTI C 55.00 0 261,446 0 11.00	20.00	EMERGENCY	<u>91.</u> 00				_	20.00
1.00 ADMI NI STRATI VE & GENERAL 5.00 0 3,920,144 9 1.00 2.00 OPERATI ON OF PLANT 7.00 0 86,236 0 2.00 3.00 HOUSEKEEPI NG 9.00 0 5,174 0 3.00 4.00 DI ETARY 10.00 0 71,610 0 4.00 5.00 SOCI AL SERVI CE 17.00 0 1,805 0 5.00 6.00 ADULTS & PEDI ATRI CS 30.00 0 418,377 0 6.00 7.00 INTENSI VE CARE UNI T 31.00 0 189,170 0 7.00 8.00 OPERATI NG ROOM 50.00 0 1,636,105 0 8.00 9.00 RECOVERY ROOM 51.00 0 26,955 0 9.00 10.00 RADI OLOGY-DI AGNOSTI C 54.00 0 308,488 0 10.00 11.00 RADI OLOGY-THERAPEUTI C 55.00 0 261,446 0 11.00		D - Depreciation Expense		0	443, 398			
3.00 HOUSEKEEPING 9.00 0 5,174 0 3.00 4.00 DI ETARY 10.00 0 71,610 0 4.00 5.00 SOCI AL SERVI CE 17.00 0 1,805 0 5.00 6.00 ADULTS & PEDI ATRI CS 30.00 0 418,377 0 6.00 7.00 INTENSI VE CARE UNIT 31.00 0 189,170 0 7.00 8.00 OPERATI NG ROOM 50.00 0 1,636,105 0 8.00 9.00 RECOVERY ROOM 51.00 0 26,955 0 9.00 10.00 RADI OLOGY-THERAPEUTI C 55.00 0 261,446 0 11.00	1.00		5.00	0	3, 920, 144	l ç		1.00
4.00 DI ETARY 10.00 0 71,610 0 4.00 5.00 SOCI AL SERVI CE 17.00 0 1,805 0 5.00 6.00 ADULTS & PEDI ATRI CS 30.00 0 418,377 0 6.00 7.00 INTENSI VE CARE UNI T 31.00 0 189,170 0 7.00 8.00 OPERATI NG ROOM 50.00 0 1,636,105 0 8.00 9.00 RECOVERY ROOM 51.00 0 26,955 0 9.00 10.00 RADI OLOGY-DI AGNOSTI C 54.00 0 308,488 0 10.00 11.00 RADI OLOGY-THERAPEUTI C 55.00 0 261,446 0 11.00				-				
5.00 SOCI AL SERVICE 17.00 0 1,805 0 5.00 6.00 ADULTS & PEDIATRICS 30.00 0 418,377 0 6.00 7.00 INTENSIVE CARE UNIT 31.00 0 189,170 0 7.00 8.00 OPERATING ROOM 50.00 0 1,636,105 0 8.00 9.00 RECOVERY ROOM 51.00 0 26,955 0 9.00 10.00 RADIOLOGY-DIAGNOSTIC 54.00 0 308,488 0 10.00 11.00 RADIOLOGY-THERAPEUTIC 55.00 0 261,446 0 11.00				-				
6.00 ADULTS & PEDIATRICS 30.00 0 418,377 0 6.00 7.00 INTENSIVE CARE UNIT 31.00 0 189,170 0 7.00 8.00 OPERATING ROOM 50.00 0 1,636,105 0 8.00 9.00 RECOVERY ROOM 51.00 0 26,955 0 9.00 10.00 RADI OLOGY-DI AGNOSTIC 54.00 0 308,488 0 10.00 11.00 RADI OLOGY-THERAPEUTIC 55.00 0 261,446 0 11.00				-				
8.00 OPERATING ROOM 50.00 0 1,636,105 0 8.00 9.00 RECOVERY ROOM 51.00 0 26,955 0 9.00 10.00 RADI OLOGY-DI AGNOSTI C 54.00 0 308,488 0 10.00 11.00 RADI OLOGY-THERAPEUTI C 55.00 0 261,446 0 11.00	6.00	ADULTS & PEDIATRICS	30.00	-	418, 377	· (6.00
9.00 RECOVERY ROOM 51.00 0 26,955 0 9.00 10.00 RADI OLOGY-DI AGNOSTI C 54.00 0 308,488 0 10.00 11.00 RADI OLOGY-THERAPEUTI C 55.00 0 261,446 0 11.00				0				
10.00 RADI OLOGY-DI AGNOSTI C 54.00 0 308, 488 0 10.00 11.00 RADI OLOGY-THERAPEUTI C 55.00 0 261, 446 0 11.00				0				
			54.00	-		3 0		10.00
12.00 UI SCANI 57.00 UI 275,542 UI 12.00								
	12.00	UT SUAN	J 57.00	O	275, 542	<u>-</u>	'	12.00

COMMUNITY HOSPITAL SOUTH

Provider CCN: 15-0128

In Lieu of Form CMS-2552-10

Period: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared: 8/19/2020 1:53 pm

					'	0 12/31/2019 Date/11me F 8/19/2020 1	
		Decreases		÷			
	Cost Center	Line #	Sal ary		Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
13.00	MAGNETIC RESONANCE IMAGING	58.00	0	49, 086	0		13.00
14.00	(MRI) CARDIAC CATHETERIZATION	59.00	0	953, 849	0		14.00
14.00	LABORATORY	60.00	0	2, 173	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	27, 775	0		16.00
17.00	PHYSI CAL THERAPY	66.00	0	139, 324	0		17.00
18.00	ELECTROCARDI OLOGY	69.00	0	86, 864	0		18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	22, 995	0		19.00
20.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	34, 727	0		20.00
01 00	PATIENTS	70.00	0	(7 500			01.00
21. 00 22. 00	DRUGS CHARGED TO PATIENTS ENDOSCOPY	73.00 76.00	0	67, 533 329, 858	0		21.00
22.00	I MAGI NG CENTER	76.06	0	175, 654	0		22.00
24.00	CARDI AC REHABI LI TATI ON	76.97	0	8, 555	0		24.00
25.00	ANTI-COAGULATION CLINIC	90.02	0	15, 385	0		25.00
26.00	SPINE CENTER	90.04	0	14, 082	0		26.00
27.00	EMERGENCY	91.00	0	87, 451	0		27.00
28.00	MISC NONREIMBURSABLE COST	194.08	0	4, 298	0		28.00
	<u>CENTERS</u>						
	TOTALS		0	9, 220, 661			_
1.00	E - Interest Expense ADMINISTRATIVE & GENERAL	5.00	0	5, 565, 108	11		1.00
1.00	TOTALS		0	<u>5, 565, 108</u> 5, 565, 108			1.00
	F - Other Capital Rental	l I		0,000,100	I		_
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	25	10		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	1, 212	0		2.00
3.00	OPERATION OF PLANT	7.00	0	5, 919	0		3.00
4.00	HOUSEKEEPING	9.00	0	8, 669	0		4.00
5.00		10.00	0	4, 018	0		5.00
6.00 7.00	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	16.00 17.00	0	80 576	0		6.00 7.00
8.00	ADULTS & PEDIATRICS	30.00	0	15, 628	0		8.00
9.00	OPERATING ROOM	50.00	0	182, 320	0		9.00
10.00	RECOVERY ROOM	51.00	0	4, 655	0		10.00
11.00	RADI OLOGY-DI AGNOSTI C	54.00	0	759	0		11.00
12.00	RADI OLOGY-THERAPEUTI C	55.00	0	387	0		12.00
13.00	CARDI AC CATHETERI ZATI ON	59.00	0	2, 243	0		13.00
14.00	LABORATORY	60.00	0	80	0		14.00
15.00		65.00	0	1, 715	0		15.00
16. 00 17. 00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66.00 69.00	0	361, 629 418	0		16.00 17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	12, 734	0		17.00
19.00	MEDI CAL SUPPLI ES CHARGED TO	70.00	0	1, 195, 634	0		19.00
	PATIENTS		-	.,,	-		
20.00	DRUGS CHARGED TO PATIENTS	73.00	0	350, 083	0		20.00
21.00	RENAL DI ALYSI S	74.00	0	104	0		21.00
22.00	ENDOSCOPY	76.00	0	764	0		22.00
23.00	I MAGI NG CENTER	76.06 90.02	0	423			23.00
24.00 25.00	ANTI-COAGULATION CLINIC SPINE CENTER	90.02 90.04	0	13 54, 304	0 0		24.00 25.00
26.00	EMERGENCY	90.04	0	34, 304 80			26.00
	TOTALS		— — — ō	2, 204, 472			
	G - STD BENEFIT						
1.00	ADMI NI STRATI VE & GENERAL	5.00	3, 481	0			1.00
2.00	OPERATION OF PLANT	7.00	3, 831	0			2.00
3.00	HOUSEKEEPI NG	9.00	3, 635	0	0		3.00
4.00		10.00	2,206	0			4.00
5.00 6.00	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	16.00 17.00	1, 519 3, 750	0	0		5.00 6.00
7.00	ADULTS & PEDIATRICS	30.00	145, 086	0	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	23, 340	0	-		8.00
9.00	OPERATING ROOM	50.00	4, 310	0	0		9.00
10.00	RECOVERY ROOM	51.00	21, 615	0	0		10.00
11.00	RADI OLOGY-THERAPEUTI C	55.00	1, 280	0	0		11.00
12.00	CARDI AC CATHETERI ZATI ON	59.00	4,403	0	0		12.00
13.00		65.00	9,627	0			13.00
14.00 15.00	PHYSICAL THERAPY	66.00	25, 812	0	0		14.00
15. 00 16. 00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	69.00 70.00	6, 079 2, 225	0	0		15.00 16.00
17.00	DRUGS CHARGED TO PATIENTS	70.00	2, 225 35, 169	0	0		17.00
18.00	ENDOSCOPY	75.00	403	0	0		18.00
19.00	I MAGI NG CENTER	76.06	3, 216	0	0		19.00
20.00	CARDI AC REHABI LI TATI ON	76.97	594	0			20.00
21.00	ANTI-COAGULATION CLINIC	90.02	2, 670	0	0		21.00

leal th	Financial Systems		COMMUNITY HOSP	ITAL SOUTH			u of Form CMS-2	2552-10
RECLAS	SEFECATIONS			Provider (CCN: 15-0128	Period:	Worksheet A-6	
						From 01/01/2019 To 12/31/2019	Date/Time Pre 8/19/2020 1:5	
		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	<u>.</u>		
	6.00	7.00	8.00	9.00	10.00			
22.00	EMERGENCY	91.00	2 <u>8, 2</u> 08	Q		Q		22.00
	TOTALS		332, 459	C				
	H - Labor and Delivery							
1.00	ADULTS & PEDIATRICS	30.00	2, 805, 082	1, 105, 112		0		1.00
2.00		0.00	0	0		Q		2.00
	TOTALS		2, 805, 082	1, 105, 112				
	I - Cafeteria				1			
1.00	DI ETARY	10.00	<u>849, 0</u> 09	<u>1, 178, 7</u> 76		0		1.00
	TOTALS		849, 009	1, 178, 776				
	J - Therapy				1	- 1		
1.00	PHYSI CAL THERAPY	66.00	693, 289	217, 609		0		1.00
2.00		0.00	0	0		Q		2.00
	TOTALS		693, 289	217, 609				
	K - Building Depreciation							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4, 764, 884		2		1.00
	TOTALS		0	4, 764, 884				
	L - Capital Insurance Costs							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	12 <u>8, 8</u> 61		12		1.00
	TOTALS		0	128, 861				
	M - Radiology Support Staff					-		
1.00	RADI OLOGY-DI AGNOSTI C	54.00	238, 969	125, 838		0		1.00
2.00		0.00	0	C		0		2.00
3.00		0.00	0	C		0		3.00
	TOTALS		238, 969	125, 838				
500 00	Grand Total: Decreases		4, 918, 808	49, 196, 677				500.00

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH			In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0128		iod: m 01/01/2019	Worksheet A-7 Part I	
				То	12/31/2019	Date/Time Pre 8/19/2020 1:5	pared:
			Acqui si ti on	s		0/19/2020 1. 5	5 pili
	Begi nni ng	Purchases	Donati on		Total	Disposals and	
	Bal ances					Retirements	
	1.00	2.00	3.00		4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES		_				
1.00 Land	1, 254, 312	0		0	0	0	1.00
2.00 Land Improvements	2, 722, 362	0		0	0	0	2.00
3.00 Buildings and Fixtures	177, 055, 544	19, 253, 731		0	19, 253, 731	13, 174, 431	3.00
4.00 Building Improvements	1, 737, 035	0		0	0	0	4.00
5.00 Fixed Equipment	0	0		0	0	0	5.00
6.00 Movable Equipment	76, 878, 740	5, 687, 903		0	5, 687, 903	-29, 020	6.00
7.00 HIT designated Assets	0	0		0	0	0	7.00
8.00 Subtotal (sum of lines 1-7)	259, 647, 993	24, 941, 634		0	24, 941, 634	13, 145, 411	8.00
9.00 Reconciling Items	0	0		0	0	0	9.00
10.00 Total (line 8 minus line 9)	259, 647, 993	24, 941, 634		0	24, 941, 634	13, 145, 411	10.00
	Endi ng Bal ance						
		Depreci ated					
		Assets					
	6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00 Land	1, 254, 312	0					1.00
2.00 Land Improvements	2, 722, 362	0					2.00
3.00 Buildings and Fixtures	183, 134, 844	0					3.00
4.00 Building Improvements	1, 737, 035	0					4.00
5.00 Fixed Equipment	0	0					5.00
6.00 Movable Equipment	82, 595, 663	0					6.00
7.00 HIT designated Assets	0	0					7.00
8.00 Subtotal (sum of lines 1-7)	271, 444, 216	0					8.00
9.00 Reconciling Items	0	0					9.00
10.00 Total (line 8 minus line 9)	271, 444, 216	0					10.00

Heal th	Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0128	Peri od:	Worksheet A-7	
					From 01/01/2019 To 12/31/2019		pared:
						8/19/2020 1:5	3 pm
			SL	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	•	
		0.00	10.00	44.00		instructions)	
	DADT LL DECONCLULATION OF ANOUNTS FROM WORL	9.00	10.00	11.00	12.00	13.00	
4 00	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES I a	na 2			1 00
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3.00
		SUMMARY O	- CAPITAL				
		0.11	T + + (4) (-			
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	45.00	-			
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORE	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2019 Fo 12/31/2019	Worksheet A-7 Part III Date/Time Prep 8/19/2020 1:53	
	COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	188, 848, 552 82, 537, 623 271, 386, 175	0	188, 848, 552 82, 537, 62 271, 386, 175	3 0. 304133	0	1.00 2.00 3.00
			-		-	
Cost Center Description	Taxes	Other Capi tal -Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		-	r			
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0		0 4, 764, 884 0 7, 987, 837 0 12, 752, 721		1.00 2.00 3.00
	0	SI	JMMARY OF CAPI		2, 203, 173	3.00
Cost Center Description		Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE			ı .	-1 -		
1.00 CAP REL COSTS-BLDG & FLXT 2.00 CAP REL COSTS-MVBLE EQUIP	2, 397, 603	128, 861			7, 291, 348 10, 191, 030	1.00 2.00
3.00 Total (sum of lines 1-2)	2, 397, 603	128, 861			17, 482, 378	2.00 3.00

	Financial Systems MENTS TO EXPENSES		COMMUNITY HOS	Provider CCN: 15-0128	Period: From 01/01/2019	u of Form CMS-2 Worksheet A-8	
					To 12/31/2019		
				Expense Classification or		8/19/2020 1:5	3 pili
				To/From Which the Amount is	to be adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	
5.00	di scounts (chapter 8) Refunds and rebates of	В	11 707	ADMI NI STRATI VE & GENERAL	5.00	0	
	expenses (chapter 8)	D		ADMINISTRATIVE & GENERAL		0	
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	
7.00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7.00
8.00	21) Tel evi si on and radi o servi ce		0		0.00	0	8. 00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	
10. 00	Provider-based physician adjustment	A-8-2	-234, 476			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	2, 654, 944			0	12.00
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	0 -1, 357, 812	CAFETERI A	0.00 11.00	0	
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17.00	patients Sale of drugs to other than		0		0.00	0	17.00
18.00	patients Sale of medical records and		0		0.00	0	
	abstracts		0				
19.00	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
20.00	books, etc.) Vending machines		0		0.00	0	
21.00	Income from imposition of interest, finance or penalty		0		0.00	0	21.00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
26. 00	(chapter 21) Depreciation - CAP REL		Ω	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL			CAP REL COSTS-MVBLE EQUIP	2.00	0	
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist			*** Cost Center Deleted ***		0	28.00
29.00	Physicians' assistant		0		0.00		29.00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of limitation (chapter 14)						
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

Health Financial Systems		COMMUNITY HOS	SPITAL SOUTH	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0128 F	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8	pared:
			Expense Classification on To/From Which the Amount is			
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		C		0.00	0	
33.01 Misc Revenue	В		OPERATION OF PLANT	7.00	0	33. 01
33.02 Misc Revenue	В		DI ETARY	10.00	0	
33.03 Misc Revenue	В		RADI OLOGY-DI AGNOSTI C	54.00	0	
33.04 Misc Revenue	В		LABORATORY	60.00	0	00101
33.05 Misc Revenue	В		PHYSICAL THERAPY	66.00	0	00.00
33.06 Misc Revenue	В		MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.06
33.07 Misc Revenue	В	-46,800	DRUGS CHARGED TO PATIENTS	73.00	0	33.07
33.08 Misc Revenue	В		CARDIAC REHABILITATION	76.97	0	33.08
33.09 Space Rental Income	В		ADMI NI STRATI VE & GENERAL	5.00	0	33.09
33.10 Space Rental Income	В		OPERATION OF PLANT	7.00	0	33.10
33.11 Investment Income	В		LABORATORY	60.00	0	
34.00 HAF Tax Offset	A		ADMI NI STRATI VE & GENERAL	5.00	0	
34.01 LOC Non-Allow Interest Expens			CAP REL COSTS-BLDG & FIXT	1.00	11	34.01
34.02 Non-Allowable Interest Expens	e A	-921, 968	CAP REL COSTS-BLDG & FIXT	1.00	11	34. 02
34.03 2012B Non- Allow Interest Expense	A	-96, 191	CAP REL COSTS-BLDG & FIXT	1.00	11	34.03
34.04 50M BMO Non- Allow Interest Expense	А	-32,067	CAP REL COSTS-BLDG & FIXT	1.00	11	34.04
34.05 12B Non-Allow Interest Expens	e A	-392, 391	CAP REL COSTS-BLDG & FIXT	1.00	11	34.05
34.06 50 BMO Loan Non- Allow Interest Expense	A		CAP REL COSTS-BLDG & FIXT	1.00	11	
34. 07 Non-Allowable Interest Expens	e A	-1, 720, 019	CAP REL COSTS-BLDG & FIXT	1.00	11	34. 07
35.00 Bad Debt	А	-16, 752, 404	ADMI NI STRATI VE & GENERAL	5.00	0	35,00
36.00 Meals of Wheels Cost	A		CAFETERIA	11.00	0	
36.01 Nurse Practitioner Offset	A		ANTI-COAGULATION CLINIC	90.02	0	36.01
50.00 TOTAL (sum of lines 1 thru 49		-35, 641, 673			_	50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Heal th	Financial Systems	COMMUNI TY HO	SPITAL SOUTH	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 01/01/2019 To 12/31/2019		narod
				10 12/31/2019	8/19/2020 1:5	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
	1.00	2.00	3, 00	4,00	5 5.00	
	A. COSTS INCURRED AND ADJUST					
	HOME OFFICE COSTS:			KGANIZATIONS OK	CLATWED	
1.00		ADMINISTRATIVE & GENERAL	1550 COUNTY LN RD	89, 772	67, 057	1.00
2.00		ADULTS & PEDIATRICS	1550 COUNTY LN RD	52, 772	39, 420	2.00
3.00		CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	3, 532, 060	0	3.00
3.01		EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2, 721, 137	0	3.01
3.02		ADMINISTRATIVE & GENERAL	HOME OFFICE	32, 250, 536	45, 251, 762	3.02
3.03		OPERATION OF PLANT	HOME OFFICE	407, 736	0	3.03
3.04		NURSING ADMINISTRATION	HOME OFFICE	2, 736, 136	0	3.04
3.05		MEDICAL RECORDS & LIBRARY	HOME OFFICE	1, 684, 384	0	3.05
3.06		ADULTS & PEDIATRICS	HOME OFFICE	437, 348	0	3.06
3.07		ADULTS & PEDIATRICS	HOME OFFICE	1, 281, 738	0	3.07
3.08		RADI OLOGY-DI AGNOSTI C	HOME OFFICE	42, 017	0	3.08
3.09		ELECTROCARDI OLOGY	HOME OFFICE	51, 166	0	3.09
3.10		ELECTROENCEPHALOGRAPHY	HOME OFFICE	113, 313	0	3.10
3.11		MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	839, 449	0	3. 11
3.12		DRUGS CHARGED TO PATIENTS	HOME OFFICE	267, 337	0	3. 12
4.00		I&R SERVICES-SALARY & FRINGE		608, 162	0	4.00
4.01		I&R SERVICES-OTHER PRGM. COS		808, 192	0	4.01
4.02		ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR AND CAL		0	4.02
5.00	TOTALS (sum of lines 1-4).			48, 013, 183	45, 358, 239	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.				<i>i</i>	

* 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.

1103 110	been posted to norksheet A,				or 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 RELATED ORGANIZATION(S) AND/OR HOME OFFICE:									

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

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

Ter libur se					
6.00	С	CHNW	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00 G.	Other (financial or	OTHER			100.00
nc	on-financial) specify:				
pro	Sil Tinanerary Speerry.				

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

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

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

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

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

organization.

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

Health Financial Systems	Financial Systems COMMUNITY HOSPITA			In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FR OFFICE COSTS	ROM RELATED ORGANIZATIONS AN	ND HOME	Provider CCN: 15-0128	From 01/01/2019		
				10 12/31/2019	Date/Time Prepared:	

							8/19/2020	1:53 pm
	Net	Wkst. A-7 Ref.						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6.00	7.00						
			TS REQUIRED AS A RESULT (OF TRANSAC	CTIONS W	TH RELATED (ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO							
1.00	22, 715							1.00
2.00	13, 352							2.00
3.00	3, 532, 060							3.00
3.01	2, 721, 137	0						3. 01
3.02	-13, 001, 226	0						3. 02
3.03	407, 736	0						3. 03
3.04	2, 736, 136	0						3.04
3.05	1, 684, 384	0						3. 05
3.06	437, 348	0						3.06
3.07	1, 281, 738	0						3.07
3.08	42,017	0						3. 08
3.09	51, 166	0						3.09
3.10	113, 313	0						3. 10
3.11	839, 449	0						3. 11
3.12	267, 337	0						3. 12
4.00	608, 162	0						4.00
4.01	808, 192	0						4. 01
4.02	89, 928	0						4. 02
5.00	2, 654, 944							5.00
* The	amounts on lin	es 1-4 (and subsc	rints as appropriate) are	transfer	red in c	letail to Wor	ksheet A column 6 lines a	<u> </u>

* 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.

nus not	been posted to norkaneet n,									
	Related Organization(s)									
	and/or Home Office									
	Type of Business									
	6. 00									

 B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

reimbursement under title XVIII.	
6.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10. 00	10.00
6.00 7.00 8.00 9.00 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 organization.

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

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

Heal th	Financial Syste	ems	COMMUNITY HO	SPITAL SOUTH		In Li	eu of Form CMS-	2552-10
PROVIDER BASED PHYSICIAN ADJUSTMENT				Provider CCN: 15-0128		Period: Worksheet A-8-2		
						From 01/01/2019 To 12/31/2019		epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identi fi er	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	AGGREGATE-ADMI NI STRATI VE &	444, 349	96, 568	347, 78	1 211, 500	2,064	1.00
		GENERAL						
2.00	0.00		0			0 0		
3.00	0.00		0	-		0 0	-	
4.00	0.00		0	-		0 0	, s	
5.00	0.00		0	0		0 0	0	
6.00	0.00		0	°,		0 0	, °	
7.00	0.00		0	0		0 0	0	
8.00	0.00		0	0		0	0	8.00
9.00	0.00		0	°,			0	,
10.00	0.00		0	0		0 0	0	10.00
200.00			444, 349					200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng Educati on	Share of col.	Insurance	
	1.00	2.00	8.00	9.00	12.00	12 13.00	14.00	
1.00		AGGREGATE-ADMI NI STRATI VE &	209, 873			0 0		1.00
1.00	5.00	GENERAL	207,073	10, 474			0	1.00
2.00	0.00	-	0	o		o l	0	2.00
3.00	0.00		0				-	
4.00	0.00		0					
5.00	0.00		0	-			-	
6.00	0.00		0	0			0	
7.00	0.00		0	0			0	
8.00	0.00		0	0				
9.00	0.00		0	0			0	
10.00	0.00		0	0			0	
200.00			209, 873	10, 494				
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	AGGREGATE-ADMI NI STRATI VE &	0	209, 873	137, 90	3 234, 476		1.00
		GENERAL						
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 0		5.00
6.00	0.00		0			0 0		6.00
7.00	0.00		0			0 0		7.00
8.00	0.00		0	-		0 0		8.00
9.00	0.00		0			0 0		9.00
10.00	0.00		0					10.00
200.00	I		0	209, 873	137, 90	3 234, 476		200. 00

Health Financial Systems	COMMUNI TY HOSI	PITAL SOUTH		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eri od:	Worksheet B	
				rom 01/01/2019 0 12/31/2019	Part I Date/Time Pre	pared:
					8/19/2020 1:5	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost			BENEFI TS		
	Allocation			DEPARTMENT		
	(from Wkst A col. 7)					
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS	I			1		
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP	7, 291, 348 10, 191, 030	7, 291, 348	10, 191, 030			1.00 2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 732, 725	0	25			4.00
5.00 00500 ADMINI STRATI VE & GENERAL	39, 848, 738	410, 760	3, 927, 269		44, 365, 569	5.00
7.00 00700 OPERATION OF PLANT	5, 575, 296	1, 370, 457	45, 391		7, 060, 007	7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	673, 742 2, 392, 672	19, 882 42, 693	0 13, 666		693, 624 2, 506, 952	8.00 9.00
10. 00 01000 DI ETARY	830, 932	42, 093 71, 252	27, 199		2, 508, 952 944, 637	
11. 00 01100 CAFETERI A	561, 951	166, 025	44, 893		808, 631	11.00
13.00 01300 NURSING ADMINISTRATION	3, 098, 678	0	0		3, 110, 815	13.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	2,048,660	0	79		2,060,331	16.00
17.00 01700 SOCIAL SERVICE 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	1, 717, 078 608, 162	19, 973 0	2, 351 0		1, 797, 039 608, 162	17.00 21.00
22. 00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	808, 192	11, 733			819, 925	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			r			
30. 00 03000 ADULTS & PEDI ATRI CS	28, 307, 303	1, 815, 959			31, 166, 527	30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	3, 737, 018 674, 855	551, 410 49, 606			4, 593, 891 754, 140	
ANCI LLARY SERVICE COST CENTERS	074,000	47,000	7,207	20, 372	734, 140	+3.00
50. 00 05000 OPERATI NG ROOM	6, 738, 525	661, 299			8, 709, 853	50.00
51.00 05100 RECOVERY ROOM	3, 933, 731	154, 692	30, 715		4, 240, 153	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 875, 604 2, 502, 507	237, 805 222, 925	44, 520 272, 177		4, 281, 186 3, 069, 264	
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 059, 642	222, 723	256, 765		1, 344, 825	55.00
57.00 05700 CT SCAN	1, 430, 123	27, 377	254, 361		1, 748, 669	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	501, 504	30, 633	17, 001		563, 448	
59. 00 05900 CARDIAC CATHETERIZATION 60. 00 06000 LABORATORY	2, 890, 063	201, 733	724, 403		3, 878, 225	59.00
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	6, 590, 202 0	93, 645 0	79		6, 683, 926 0	60.00 64.00
65. 00 06500 RESPI RATORY THERAPY	2, 475, 431	46, 786	27, 157	76, 713	2, 626, 087	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 696, 978	16, 190	597, 974		3, 398, 565	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	740, 187	4, 348			795, 993	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	170, 711 1, 339, 481	1, 000 113, 509	6, 395 58, 278		183, 579 1, 547, 793	
70. 00 07000 ELECTROENCEPHALOGRAPHY	909, 883	45, 513			1, 010, 629	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 490, 677	211, 865	1, 214, 617		15, 917, 159	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	10, 334, 651	0	0		10, 334, 651	
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	11, 924, 030 462, 809	115, 201 22, 047	389, 186 103		12, 549, 802 484, 959	
76. 00 03950 ENDOSCOPY	1, 059, 385	0	284, 566		1, 371, 013	
76.06 03330 I MAGI NG CENTER	1, 461, 651	0	173, 827		1, 671, 845	
76. 97 O7697 CARDI AC REHABI LI TATI ON	358, 135	0	6, 739	11, 870	376, 744	76. 97
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0	0	0		0	90.00
90. 01 04950 DI ABETI C CARE CENTER	0	0	0		0	90.00
90. 02 04951 ANTI-COAGULATION CLINIC	341, 068	0	2, 168	21, 218	364, 454	
90. 03 04952 PALLI ATI VE CARE	0	0	0	0	0	90.03
90. 04 04953 SPI NE CENTER 91. 00 09100 EMERGENCY	194, 268	0 E44 252	67, 428		266, 968	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 765, 800	544, 352	68, 911	222,019	8, 601, 082 0	
SPECIAL PURPOSE COST CENTERS					-	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	197, 345, 426	7, 280, 670	10, 188, 050	2, 712, 104	197, 311, 122	118.00
NONREI MBURSABLE COST CENTERS		0	0		0	100.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH	0	0	0			190. 00 191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	192, 934	0	0	-	192, 947	
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
194.0007950 HOME OFFICE	0	0	0	Ŭ		194.00
194.0607956 LEASED OFFICE SPACE 194.0807958 MISC NONREI MBURSABLE COST CENTERS	0 822, 312	0 10, 678	0 2, 980		0 856, 603	194.06 194.08
200.00 Cross Foot Adjustments	022,012	10, 078	2,700	20,000		200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	198, 360, 672	7, 291, 348	10, 191, 030	2, 732, 750	198, 360, 672	202.00

Heal th	Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2019 To 12/31/2019		pared: 3 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	1		1			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	44, 365, 569					5.00
7.00	00700 OPERATION OF PLANT	2,033,967	9, 093, 974		~		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	199, 831	32, 814				8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	722, 245 272, 147	70, 461 117, 596		0 3, 299, 658 0 43, 158		9.00 10.00
11.00	01100 CAFETERI A	232, 964	274,009		0 43, 158 0 100, 564		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	896, 216	274,009		0 100, 504	0	13.00
16.00	01600 MEDICAL RECORDS & LI BRARY	593, 575	0		0 0	0	16.00
17.00	01700 SOCIAL SERVICE	517, 722	32, 964		0 12,098	0	17.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	175, 210			0 12,070	0	21.00
	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	236, 218	19, 364		0 7, 107	0	22.00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	200,210	17,001	1	,,,,,,,	<u> </u>	22.00
30.00	03000 ADULTS & PEDIATRICS	8, 979, 024	2, 997, 081	423, 08	9 1, 099, 951	1, 261, 595	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 323, 486	910, 052				31.00
43.00	04300 NURSERY	217, 265	81, 870	9, 94	0 30, 047	0	43.00
	ANCILLARY SERVICE COST CENTERS	÷					
50.00	05000 OPERATI NG ROOM	2, 509, 283	1, 091, 414		0 400, 558	0	50.00
51.00	05100 RECOVERY ROOM	1, 221, 575	255, 306	139, 60	8 93, 699	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 233, 397	392, 475				52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	884, 246	367, 918	16, 91	1 135, 029		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	387, 440	0		0 0	0	55.00
57.00	05700 CT SCAN	503, 786	45, 183			0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	162, 328	50, 557	1	0 18, 555	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 117, 305	332, 942				59.00
60.00	06000 LABORATORY	1, 925, 619	154, 552		0 56, 722	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	756, 568 979, 116	77, 216		0 28, 339 0 9, 806		65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	229, 323	26, 719 7, 175		0 9,808		67.00
68.00	06800 SPEECH PATHOLOGY	52, 889	1, 651		0 2,033		68.00
69.00	06900 ELECTROCARDI OLOGY	445, 915	187, 336		0 68, 754		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	291, 159			0 27, 568		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 585, 686	349, 664	1	0 128, 330	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 977, 382	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 615, 560	190, 128		0 69,779	0	73.00
74.00	07400 RENAL DIALYSIS	139, 715	36, 386		0 13, 354	0	74.00
76.00	03950 ENDOSCOPY	394, 985	0)	0 0	0	76.00
76.06	03330 I MAGI NG CENTER	481, 654	0		0 0	0	76.06
76.97	07697 CARDI AC REHABI LI TATI ON	108, 539	0		0 0	0	76.97
	OUTPATIENT SERVICE COST CENTERS	-	-	1	-1 -	-	
90.00	09000 CLINIC	0	0		0 0	0	90.00
90.01	04950 DI ABETI C CARE CENTER	104 000	0		0 0	0	90.01
90.02	04951 ANTI-COAGULATION CLINIC	104, 998	0		0 0	0	90.02 90.03
	04952 PALLI ATI VE CARE 04953 SPI NE CENTER	74 012	0			0	90.03 90.04
90. 04 91. 00	09100 EMERGENCY	76, 913 2, 477, 946		173, 29	0 329, 721	0	90.04 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,477,940	090, 403	1/3,29	0 329,721	0	91.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		44, 063, 197	9, 076, 351	926, 26	9 3, 293, 190	1, 377, 538	118 00
	NONREI MBURSABLE COST CENTERS		.,	,		.,	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191.00	19100 RESEARCH	0	0		o o		191.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	55, 587	0		0 0	0	192.00
	19300 NONPAI D WORKERS	0	0		0 0		193.00
	07950 HOME OFFICE	0	0		0 0		194.00
	07956 LEASED OFFICE SPACE	0	0		0 0		194.06
	07958 MISC NONREI MBURSABLE COST CENTERS	246, 785	17, 623		0 6, 468	0	194.08
200.00	5						200.00
201.00		0	0		0		201.00
202.00	TOTAL (sum lines 118 through 201)	44, 365, 569	9, 093, 974	926, 26	9 3, 299, 658	1, 377, 538	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	COMMUNI TY HOS	Provi der CC	F	Period: From 01/01/2019 Fo 12/31/2019	u of Form CMS- Worksheet B Part I Date/Time Pre 8/19/2020 1:5	epared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS &	SOCI AL SERVI CE	I NTERNS & RESI DENTS SERVI CES-SALAR Y & FRI NGES	
		11.00	13.00	LI BRARY 16.00	17.00	21.00	
	GENERAL SERVICE COST CENTERS				1		
11.00 13.00 16.00 17.00 21.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 01004 CATE DOUTING CEDUCE	1, 416, 168 17, 826 5, 942 31, 690 0	4, 024, 857 0 0 0 0	2, 659, 848 ((2, 391, 513 0 0	783, 372	1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 16.00 17.00 21.00 22.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	554, 582	2, 867, 583	317, 792	2 2, 049, 205	610, 080	30.00
31.00	03100 I NTENSI VE CARE UNI T	59, 420		30, 93	1 176, 061	25, 533	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	11, 884	61, 448	10, 725	5 166, 247	0	43.00
50.00	05000 OPERATING ROOM	102, 994	0	312, 184	4 0	33, 848	50.00
51.00	05100 RECOVERY ROOM	65, 362	0	105, 403	3 0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	61, 400		51, 417		0	
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	45, 555 17, 826		94, 081 57, 503		0	
	05700 CT SCAN	23, 768		175, 137		0	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	7,923		31, 547	-	0	
	05900 CARDI AC CATHETERI ZATI ON	35, 652		218, 104		0	59.00
60.00	06000 LABORATORY	C		220, 118		0	60.00
	06400 I NTRAVENOUS THERAPY	47.52	-	(24 F2)	-	0	64.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	47, 536 21, 787		36, 533 32, 717		0 12, 630	65.00 66.00
	06700 OCCUPATI ONAL THERAPY	13, 865		9, 100		12,030	
	06800 SPEECH PATHOLOGY	3, 961		2, 098		0	
	06900 ELECTROCARDI OLOGY	33, 671		75, 889		0	
	07000 ELECTROENCEPHALOGRAPHY	11, 884		13, 304		8, 325	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS			124, 743 93, 437		0	
	07300 DRUGS CHARGED TO PATIENTS	63, 381	-	183, 368	-	0	
	07400 RENAL DI ALYSI S	C		4, 016		0	
	03950 ENDOSCOPY	13, 865		33, 442		0	
	03330 I MAGI NG CENTER	1, 981		39, 798		0	
	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	9, 903	8 0	4, 765	5 0	0	76.97
	09000 CLINIC	C	0	(0 0	0	90.00
90.01	04950 DI ABETI C CARE CENTER	C	0		0 0	0	90.01
	04951 ANTI-COAGULATION CLINIC	C	0	2, 979	9 0	0	
	04952 PALLIATIVE CARE 04953 SPINE CENTER			(784		0	
	09100 EMERGENCY	152, 510	788, 585	377, 933		68, 264	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 416, 168	4, 024, 857	2, 659, 848	3 2, 391, 513	758, 680	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	(0 0		190. 00
	19100 RESEARCH	C	0	(0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(192.00
	19300 NONPALD WORKERS 07950 HOME OFFICE		0	(193.00 194.00
	07956 LEASED OFFICE SPACE			(194.00
	07958 MISC NONREI MBURSABLE COST CENTERS		0	(o o		194.08
200.00	Cross Foot Adjustments					0	200.00
201.00		0	0	(201.00
202.00	TOTAL (sum lines 118 through 201)	1, 416, 168	4, 024, 857	2, 659, 848	2, 391, 513	783, 372	202.0

Heal th	Financial Systems	COMMUNI TY HOSF	PITAL SOUTH		In Lie	u of Form CMS-2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Peri od:	Worksheet B
					From 01/01/2019 To 12/31/2019	Part I Date/Time Prepared:
						8/19/2020 1:53 pm
		I NTERNS & RESI DENTS				
	Cost Center Description	SERVI CES-OTHER	Subtotal	Intern &	Total	
		PRGM. COSTS	1	Residents Cos	st	
				& Post Stepdown		
				Adjustments		
		22.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS					1 00
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP					1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMINI STRATI VE & GENERAL					5.00
	00700 OPERATION OF PLANT					7.00
	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG					8.00 9.00
	01000 DI ETARY					10.00
	01100 CAFETERI A					11.00
	01300 NURSI NG ADMI NI STRATI ON					13.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE					16.00 17.00
	02100 I &R SERVICES-SALARY & FRINGES APPRVD					21.00
	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	1, 082, 614				22.00
	INPATIENT ROUTINE SERVICE COST CENTERS	042 124	F2 1/0 /22	1 452 20	E1 71/ 400	20.00
	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T	843, 124 35, 287	53, 169, 633 7, 966, 075	-1, 453, 20 -60, 82		30.00 31.00
	04300 NURSERY	0	1, 343, 566		0 1, 343, 566	43.00
	ANCI LLARY SERVI CE COST CENTERS					
	05000 OPERATING ROOM	46, 778	13, 206, 912	-80, 62		50.00
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	6, 121, 106 6, 211, 559		0 6, 121, 106 0 6, 211, 559	51.00 52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	4, 613, 004		0 4, 613, 004	54.00
	05500 RADI OLOGY-THERAPEUTI C	0	1, 807, 594		0 1, 807, 594	55.00
	05700 CT SCAN	0	2, 563, 818		0 2, 563, 818	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	834, 358 5, 715, 282		0 834, 358 0 5, 715, 282	58.00 59.00
	06000 LABORATORY	0	9, 040, 937		0 9, 040, 937	60.00
	06400 I NTRAVENOUS THERAPY	0	0		0 0	64.00
	06500 RESPIRATORY THERAPY	0	3, 572, 279		0 3, 572, 279	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	17, 454	4, 498, 794 1, 058, 089	-30, 08	4, 468, 710 0 1, 058, 089	66.00 67.00
	06800 SPEECH PATHOLOGY	0	244, 784		0 244, 784	68.00
69.00	06900 ELECTROCARDI OLOGY	0	2, 359, 358		0 2, 359, 358	69.00
	07000 ELECTROENCEPHALOGRAPHY	11, 506	1, 449, 490	-19, 83		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	21, 105, 582 13, 405, 470		0 21, 105, 582 0 13, 405, 470	71.00
	07300 DRUGS CHARGED TO PATIENTS	0	16, 672, 018		0 16, 672, 018	73.00
74.00	07400 RENAL DI ALYSI S	0	678, 430		0 678, 430	74.00
	03950 ENDOSCOPY	0	1,813,305		0 1, 813, 305	76.00
	03330 I MAGI NG CENTER 07697 CARDI AC REHABI LI TATI ON	0	2, 195, 278 499, 951		0 2, 195, 278 0 499, 951	76.06 76.97
	OUTPATIENT SERVICE COST CENTERS	<u> </u>	477,731		<u> </u>	10. 77
	09000 CLI NI C	0	0		0 0	90.00
	04950 DI ABETI C CARE CENTER	0	0		0 0	90.01
	04951 ANTI-COAGULATION CLINIC 04952 PALLIATIVE CARE	0	472, 431		0 472, 431	90. 02 90. 03
	04953 SPINE CENTER	0	344, 665		0 344, 665	90.04
	09100 EMERGENCY	94, 340	13, 962, 074	-162, 60	13, 799, 470	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	1,048,489	196, 925, 842	-1, 807, 16	9 195, 118, 673	118.00
	NONREIMBURSABLE COST CENTERS	1,040,409	190, 923, 842	-1, 807, 10	195, 116, 075	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	190. 00
	19100 RESEARCH	0	0		0 0	191.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0	248, 534		0 248, 534	192.00 193.00
	07950 HOME OFFICE	0	0		0 0	193.00
	07956 LEASED OFFICE SPACE	0	0		0 0	194.06
	07958 MISC NONREI MBURSABLE COST CENTERS	34, 125	1, 186, 296	-58, 81	7 1, 127, 479	194. 08
200.00 201.00		0	0		0 0	200. 00 201. 00
201.00		1, 082, 614	0 198, 360, 672	-1, 865, 98	196, 494, 686	201.00
202.00		., 302, 014		., 000, 70		1202.00

Heal th	Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS		Worksheet B Part II				
				T	rom 01/01/2019 o 12/31/2019	Date/Time Pre	
			CAPI TAL REI	LATED COSTS		8/19/2020 1:5	3 pm
	Cast Castas Description	Discontinu			Culture		
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	,	1.00	2.00	20	1.00	
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
	00200 CAP REL COSTS-MUBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	o	25	25	25	2.00 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	0	410, 760			0	5.00
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	1, 370, 457 19, 882		1, 415, 848 19, 882	0	7.00 8.00
	00900 HOUSEKEEPING	0	42, 693			0	9.00
	01000 DI ETARY	0	71, 252			0	10.00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	166, 025 0		210, 918 0	0	11.00 13.00
	01600 MEDICAL RECORDS & LIBRARY	0	0	79	-	0	16.00
	01700 SOCIAL SERVICE	0	19, 973		22, 324	0	17.00
	02100 I &R SERVI CES-SALARY & FRINGES APPRVD 02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	0	0 11, 733	0	0 11, 733	0	21.00 22.00
	INPATIENT ROUTINE SERVICE COST CENTERS	0	11,733	0	11,735	0	22.00
	03000 ADULTS & PEDIATRICS	0	1, 815, 959			25	30.00
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	0	551, 410 49, 606			0	31.00 43.00
	ANCI LLARY SERVICE COST CENTERS	0	47,000	7,207	30, 073	0	+3.00
	05000 OPERATING ROOM	0	661, 299			0	50.00
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	154, 692 237, 805			0	51.00 52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	222, 925			0	54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0	256, 765		0	55.00
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	27, 377 30, 633		281, 738 47, 634	0	57.00 58.00
	05900 CARDI AC CATHETERI ZATI ON	0	201, 733			0	59.00
	06000 LABORATORY	0	93, 645			0	60.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0 46, 786	-	0 73, 943	0	64.00 65.00
	06600 PHYSI CAL THERAPY	0	16, 190			0	66.00
	06700 OCCUPATI ONAL THERAPY	0	4, 348			0	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	1, 000 113, 509			0	68.00 69.00
	07000 ELECTROEACH OLOGT	0	45, 513			0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	211, 865			0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	115 201	-	0 E04 297	0	72.00 73.00
	07400 RENAL DIALYSIS	0	115, 201 22, 047			0	
76.00	03950 ENDOSCOPY	0	0	284, 566	284, 566	0	76.00
	03330 I MAGI NG CENTER 07697 CARDI AC REHABI LI TATI ON	0	0			0	76.06 76.97
	OUTPATIENT SERVICE COST CENTERS	0	0	0,737	0,737	0	/0. //
	09000 CLINIC	0	0	0	0	0	90.00
	04950 DI ABETI C CARE CENTER 04951 ANTI - COAGULATI ON CLI NI C	0	0	0 2, 168	0 2, 168	0	90. 01 90. 02
	04952 PALLI ATI VE CARE	0	0	0	2,100	0	90.03
	04953 SPINE CENTER	0	0	67, 428		0	90.04
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	544, 352	68, 911	613, 263	0	91.00 92.00
	SPECIAL PURPOSE COST CENTERS				0		72.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	7, 280, 670	10, 188, 050	17, 468, 720	25	118.00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19100 RESEARCH	0	0	0	0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
	19300 NONPALD WORKERS 07950 HOME OFFICE				0		193.00 194.00
	07956 LEASED OFFICE SPACE	0	0	0	0		194.00
	07958 MISC NONREI MBURSABLE COST CENTERS	0	10, 678	2, 980	13, 658	0	194.08
200.00 201.00	Cross Foot Adjustments Negative Cost Centers		Λ	0	0	Ο	200. 00 201. 00
201.00	TOTAL (sum lines 118 through 201)	0	7, 291, 348	10, 191, 030	17, 482, 378		201.00

Heal th	Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Pre 8/19/2020 1:5	pared: 3 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
1 00	GENERAL SERVICE COST CENTERS			1			1 4 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	4, 338, 029					5.00
7.00	00700 OPERATION OF PLANT	198, 880	1, 614, 728				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	19, 539					8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	70, 621	12, 511		0 139, 491 0 1, 824	147 746	9.00 10.00
11.00	01100 CAFETERIA	26, 610 22, 779			0 1,824 0 4,251	147, 765 0	1
13.00	01300 NURSI NG ADMI NI STRATI ON	87,632	0	1	0 0	0	1
16.00	01600 MEDICAL RECORDS & LIBRARY	58,040	0		0 0	0	16.00
17.00	01700 SOCIAL SERVICE	50, 623			0 511	0	17.00
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	17, 132			0 0 0 300	0	
22.00	02200 I & SERVICES-OTHER PRGM. COSTS APPRVD I NPATI ENT ROUTI NE SERVICE COST CENTERS	23, 097	3, 438		0 300	0	22.00
30.00	03000 ADULTS & PEDIATRICS	877, 950	532, 164	20, 66	7 46, 502	135, 328	30.00
31.00	03100 I NTENSI VE CARE UNI T	129, 410		2, 64	9 14, 119	12, 437	31.00
43.00	04300 NURSERY	21, 244	14, 537	48	6 1, 270	0	43.00
50, 00	ANCILLARY SERVICE COST CENTERS	245, 357	193, 792		0 16, 933	0	50.00
51.00	05100 RECOVERY ROOM	119, 445				0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	120, 601	69, 688			0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	86, 461	65, 328			0	
55.00	05500 RADI OLOGY-THERAPEUTI C	37, 884	0		0 0	0	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	49, 260 15, 872			6 701 0 784	0	1
59.00	05900 CARDI AC CATHETERI ZATI ON	109, 250		1		0	
60.00	06000 LABORATORY	188, 286		1	0 2, 398	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	1
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	73, 977 95, 738	13, 711 4, 744		0 1, 198 0 415	0	
67.00	06700 OCCUPATIONAL THERAPY	22, 423			0 415	0	1
68.00	06800 SPEECH PATHOLOGY	5, 171	293		0 26	0	1
69.00	06900 ELECTROCARDI OLOGY	43, 601	33, 263		0 2, 907	0	1
70.00	07000 ELECTROENCEPHALOGRAPHY	28, 469			0 1, 165	0	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	448, 386	62, 086 0		0 5,425 0 0	0	1
	07300 DRUGS CHARGED TO PATIENTS	353, 528			0 2.950	0	
74.00	07400 RENAL DI ALYSI S	13, 661	6, 461		0 565	0	
	03950 ENDOSCOPY	38, 621	0		0 0	0	
76. 06 76. 97	03330 I MAGI NG CENTER 07697 CARDI AC REHABI LI TATI ON	47,096			0 0 0 0	0	
70.97	OUTPATIENT SERVICE COST CENTERS	10, 613	0	1	0 0	0	10.97
90.00	09000 CLI NI C	0	0		0 0	0	90.00
	04950 DI ABETI C CARE CENTER	0	-		0 0	0	
	04951 ANTI-COAGULATION CLINIC 04952 PALLIATIVE CARE	10, 267	0		0 0	0	
	04953 SPINE CENTER	7, 520				0	1
	09100 EMERGENCY	242, 292		8, 46	5 13, 939	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1					92.00
118.00	SPECIAL PURPOSE COST CENTERS	4 200 462	1 (11 500	45.04	7 120 210	147, 765	110.00
116.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	4, 308, 463	1, 611, 599	45, 24	7 139, 218	147,703	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0) (0 0	0	190.00
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	5, 435	0		0 0		192.00
	19300 NONPAI D WORKERS 07950 HOME OFFI CE	0					193.00 194.00
	07956 LEASED OFFICE SPACE	0	0		0 0	0	194.06
	07958 MISC NONREI MBURSABLE COST CENTERS	24, 131	3, 129	1	0 273	0	194. 08
200.00 201.00					0 0	0	200. 00 201. 00
201.00		4, 338, 029	1, 614, 728	45, 24		0 147, 765	
			==				

	Financial Systems	COMMUNITY HOS				u of Form CMS-	2552-10
ALLOCA	TI ON OF CAPITAL RELATED COSTS		Provi der CC	F	eriod: rom 01/01/2019 o 12/31/2019	Worksheet B Part II Date/Time Pre 8/19/2020 1:5 INTERNS &	epared: 3 pm
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	RESI DENTS SERVI CES-SALAR Y & FRI NGES	
		11.00	13.00	16.00	17.00	21.00	
	GENERAL SERVICE COST CENTERS	l	I				
1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 16.00 17.00 21.00 22.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LINEN SERVI CE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMINI STRATI ON 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 02100 I &R SERVI CES-SALARY & FRINGES APPRVD 02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD INPATI ENT ROUTI NE SERVI CE COST CENTERS	286, 601 3, 608 1, 203 6, 413 0 0	0	59, 322 0 0 0	85, 724 0 0	17, 132	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 16.\ 00\\ 17.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}$
30.00	03000 ADULTS & PEDI ATRI CS	112, 235	65, 005	7, 109	73, 454		30.00
31.00 43.00	03100 NTENSI VE CARE UNI T 04300 NURSERY	12, 025 2, 405		692 240	6, 311 5, 959		31.00 43.00
50.00 51.00 52.00 55.00 55.00 57.00 58.00 64.00 64.00 65.00 66.00 67.00 68.00 69.00 71.00 72.00 73.00 74.00 74.00 76.00 76.00 76.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06400 LABORATORY 06400 I NTRAVENOUS THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 OCCUPATI ONAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03950 ENDOSCOPY 03330 I MAGI NG CENTER 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS	20, 844 13, 228 12, 426 9, 219 3, 608 4, 810 1, 603 7, 215 0 9, 620 4, 409 2, 806 802 6, 814 2, 405 0 12, 827 0 2, 806 401 2, 004		6, 983 2, 358 1, 150 2, 104 1, 286 4, 879 4, 924 0 817 732 204 47 1, 698 298 2, 790 2, 090 4, 102 90 748 890 107			$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 67.\ 00\\ 68.\ 00\\ 70.\ 00\\ 71.\ 00\\ 71.\ 00\\ 71.\ 00\\ 74.\ 00\\ 74.\ 00\\ 74.\ 00\\ 76.\ 06\\ 76.\ 97\\ \end{array}$
90. 01 90. 02 90. 03 90. 04	09000 CLINIC 04950 DIABETIC CARE CENTER 04951 ANTI-COAGULATION CLINIC 04952 PALLIATIVE CARE 04953 SPINE CENTER 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0 0 30, 865	0 0 0 17, 877	0 0 67 0 18 8, 275	0 0 0		90.00 90.01 90.02 90.03 90.04 91.00 92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	286, 601	91, 240	59, 322	85, 724	0	118.00
191.00 192.00 193.00 194.00 194.06	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSICLANS' PRIVATE OFFICES 19300 NONPALD WORKERS 07950 HOME OFFICE 07956 LEASED OFFICE SPACE 07958 MISC NONREIMBURSABLE COST CENTERS Cross Foot Adjustments Negative Cost Centers	0 0 0 0 0 0 286, 601	0 0 0 0 0 0 91, 240	0 0 0 0 0 0 59, 322	0 0 0 0 0 0 85, 724	0	190.00 191.00 192.00 193.00 194.00 194.06 194.08 200.00 201.00 202.00

Health Financial Systems	COMMUNI TY HOSE	PLTAL SOUTH		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0128	Peri od:	Worksheet B
				From 01/01/2019 To 12/31/2019	Part II Date/Time Prepared:
					8/19/2020 1:53 pm
	I NTERNS & RESI DENTS				
Cost Center Description	SERVI CES-OTHER	Subtotal	Intern &	Total	
	PRGM. COSTS		Residents Cos		
			& Post		
			Stepdown		
	22.00	24.00	Adjustments 25.00	26.00	
GENERAL SERVICE COST CENTERS	22100	21100	20100	20100	
1.00 00100 CAP REL COSTS-BLDG & FLXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT					5.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9.00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION					11.00
13. 00 01300 NURSING ADMINISTRATION 16. 00 01600 MEDICAL RECORDS & LIBRARY					13.00
17. 00 01700 SOCIAL SERVICE					17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES AP	PRVD				21.00
22.00 02200 I &R SERVICES-OTHER PRGM. COSTS A					22.00
INPATIENT ROUTINE SERVICE COST CENTERS	5	2 00/ 00/	1		
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T		3, 896, 986 1, 084, 360		0 3, 896, 986 0 1, 084, 360	30.00 31.00
43. 00 04300 NURSERY		106, 427		0 106, 427	43.00
ANCI LLARY SERVICE COST CENTERS	I		1		
50. 00 05000 OPERATI NG ROOM		2, 305, 386		0 2, 305, 386	50.00
51.00 05100 RECOVERY ROOM		376, 551		0 376, 551	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC		494, 606 664, 748		0 494, 606 0 664, 748	52.00 54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		299, 543		0 299, 543	55.00
57. 00 05700 CT SCAN		350, 926		0 350, 926	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		75, 576		0 75, 576	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		1, 112, 294		0 1, 112, 294	59.00
		316, 774		0 316, 774 0 0	60.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY		173, 266		0 173, 266	64.00 65.00
66. 00 06600 PHYSI CAL THERAPY		720, 202		0 720, 202	66.00
67.00 06700 OCCUPATI ONAL THERAPY		58, 894		0 58, 894	67.00
68.00 06800 SPEECH PATHOLOGY		13, 734		0 13, 734	68.00
		260, 070		0 260, 070	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI	FNTS	126, 460 1, 945, 169		0 126, 460 0 1, 945, 169	70.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	LITTO	293, 217		0 293, 217	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		911, 553		0 911, 553	73.00
74.00 07400 RENAL DI ALYSI S		42, 927		0 42, 927	74.00
76.00 03950 ENDOSCOPY 76.06 03330 I MAGI NG CENTER		326, 741		0 326, 741	76.00
76. 97 07697 CARDIAC REHABILITATION		222, 214 19, 463		0 222, 214 0 19, 463	76.06 76.97
OUTPATIENT SERVICE COST CENTERS		17,100		17,100	/0.//
90. 00 09000 CLI NI C		0		0 0	90.00
90. 01 04950 DI ABETI C CARE CENTER		0		0 0	90.01
90. 02 04951 ANTI - COAGULATI ON CLINIC 90. 03 04952 PALLI ATI VE CARE		12, 502		0 12, 502	90. 02 90. 03
90. 03 04952 PALLIATIVE CARE 90. 04 04953 SPI NE CENTER		74, 966		0 74,966	90.03
91. 00 09100 EMERGENCY		1, 094, 497		0 1, 094, 497	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT P	ART)			0	92.00
SPECIAL PURPOSE COST CENTERS			1		
118.00 SUBTOTALS (SUM OF LINES 1 throug	h 117) 0	17, 380, 052		0 17, 380, 052	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANT	TEN	0		0 0	190.00
190.00 19000 GTFT, FLOWER, COFFEE SHOP & CANT 191.00 19100 RESEARCH		0		0 0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		5, 435		0 5, 435	192.00
193.00 19300 NONPALD WORKERS		0		0 0	193.00
194.00 07950 HOME OFFICE		0		0 0	194.00
194. 06 07956 LEASED OFFICE SPACE	ic l	0		0 1 101	194.06
194.08 07958 MISC NONREIMBURSABLE COST CENTER 200.00 Cross Foot Adjustments	38, 568	41, 191 55, 700		0 41, 191 0 55, 700	194. 08 200. 00
201.00 Negative Cost Centers	0	0		0 0	201.00
202.00 TOTAL (sum lines 118 through 201) 38, 568	17, 482, 378		0 17, 482, 378	202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	COMMUNITY HOS	SPITAL SOUTH Provider CC		Period:	u of Form CMS- Worksheet B-1	
					rom 01/01/2019 o 12/31/2019		
		CAPI TAL RE	LATED COSTS			8/19/2020 1:5	
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconci l i ati on	ADMI NI STRATI VE	
			(DOLLAR VALUE)	BENEFITS		& GENERAL	
				DEPARTMENT (GROSS		(ACCUM. COST)	
		1.00	2.00	SALARI ES) 4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	54	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	400, 832					1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	10, 322, 919	64, 876, 327	,		2.00 4.00
5.00	00500 ADMINI STRATI VE & GENERAL	22, 581	3, 978, 097	4, 244, 851		153, 995, 103	5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	75, 339		1, 634, 842		7, 060, 007 693, 624	7.00 8.00
9.00	00900 HOUSEKEEPING	2, 347		1, 375, 076	-	2, 506, 952	
10.00	01000 DI ETARY	3, 917		362, 149		944, 637	1
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	9, 127 C		849, 009 288, 151		808, 631 3, 110, 815	
16.00	01600 MEDICAL RECORDS & LIBRARY	C C	-	275, 199		2, 060, 331	
17.00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD	1,098	2, 381 0	1, 368, 324		1, 797, 039 608, 162	
21.00 22.00	02200 I &R SERVICES-SALARY & FRINGES APPRVD	645	-		-	819, 925	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	99, 830 30, 313				31, 166, 527 4, 593, 891	
43.00	04300 NURSERY	2, 727		484, 125		754, 140	
F0 00	ANCI LLARY SERVI CE COST CENTERS	24.254	1 175 100			0 700 053	
50. 00 51. 00	05100 RECOVERY ROOM	36, 354 8, 504		3, 557, 544 2, 872, 967		8, 709, 853 4, 240, 153	
52.00	05200 DELIVERY ROOM & LABOR ROOM	13, 073	45, 096	2, 926, 186	0	4, 281, 186	52.00
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	12, 255		1, 701, 136 674, 654		3, 069, 264 1, 344, 825	
55.00 57.00	05700 CT SCAN	1,505		873, 840		1, 344, 625	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 684		339, 733		563, 448	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	11, 090 5, 148		1, 472, 544 C		3, 878, 225 6, 683, 926	1
64.00	06400 I NTRAVENOUS THERAPY	0, 140			0	0, 003, 720	64.00
65.00	06500 RESPI RATORY THERAPY	2, 572		1, 821, 221		2, 626, 087	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	890 239		2, 075, 465 563, 360		3, 398, 565 795, 993	
68.00	06800 SPEECH PATHOLOGY	55	6, 478	129, 929	0	183, 579	68.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	6, 240 2, 502		867, 134 473, 858		1, 547, 793 1, 010, 629	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 647		473,850		15, 917, 159	
	07200 I MPL. DEV. CHARGED TO PATIENTS	C	-	C	0	10, 334, 651	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	6, 333 1, 212			B 0	12, 549, 802 484, 959	•
76.00	03950 ENDOSCOPY	C		642, 463	0	1, 371, 013	
	03330 I MAGI NG CENTER			863, 380		1, 671, 845	
/0.9/	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS		6, 826	281, 800	<u> </u>	376, 744	76.97
	09000 CLI NI C	C	0	0	0	0	
	04950 DI ABETI C CARE CENTER 04951 ANTI - COAGULATI ON CLI NI C		0 2, 196	503, 719		0 364, 454	90. 01 90. 02
	04952 PALLI ATI VE CARE	C	0	(0	0	90.03
	04953 SPI NE CENTER	0	68, 301	125, 168		266, 968	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	29, 925	69, 803	5, 270, 852	0	8, 601, 082	91.00 92.00
	SPECIAL PURPOSE COST CENTERS	I					
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	400, 245	10, 319, 900	64, 386, 172	-44, 365, 569	152, 945, 553	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	C	0	0	190.00
191.00	19100 RESEARCH	C	0	C	-	0	191.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES 19300 NONPAI D WORKERS		0	319	0	192, 947	192.00 193.00
	07950 HOME OFFICE		0	0	0		194.00
	07956 LEASED OFFICE SPACE	0	0	(0		194.06
194.08 200.00	07958 MISC NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	587	3, 019	489, 836		856, 603	194.08 200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	7, 291, 348	10, 191, 030	2, 732, 750		44, 365, 569	202.00
203.00		18. 190534	0. 987224	0. 042122		0. 288097	203. 00
204.00	Cost to be allocated (per Wkst. B,			25		4, 338, 029	204.00
	Part II)	I	1	I	1	I	I

Health Financial Systems	COMMUNITY HOSPITAL SOUTH			In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provider CO	CN: 15-0128	Period: From 01/01/2019	Worksheet B-1	
				To 12/31/2019		
	CAPI TAL REI	LATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
	1.00	2.00	4.00	5A	5.00	
205.00 Unit cost multiplier (Wkst. B, Part			0.0000	00	0. 028170	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems	COMMUNITY HOS				u of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2019 o 12/31/2019	Worksheet B-1 Date/Time Pre	
Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPING	DIETARY	8/19/2020 1:5 CAFETERI A	
cost center bescription	PLANT (SQUARE FEET)	LI NEN SERVICE (POUNDS OF LAUNDRY)		(PATIENT DAYS)		
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT	1					1 1.00
2.00 00200 CAP REL COSTS-BLOG & FIAT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL						2.00 4.00 5.00
7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG	302, 912 1, 093 2, 347	158, 784 C	299, 472			7.00 8.00 9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	3, 917 9, 127 0	0	3, 917 9, 127 0	35, 596 0 0	715 9	1
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	3	1
17. 00 01700 SOCIAL SERVICE 21. 00 02100 I &R SERVICES-SALARY & FRINGES APPRVD	1,098		.,	0	16 0	1
22.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	645	C	645	0	0	1
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	99, 830	72, 527	99, 830	32, 600	280	30.00
31. 00 03100 I NTENSI VE CARE UNI T	30, 313	9, 297		2, 996	30	1
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	2,727	1, 704	2, 727	0	6	43.00
50. 00 05000 OPERATING ROOM	36, 354	C	36, 354	0	52	50.00
51.00 05100 RECOVERY ROOM	8, 504	23, 932	8, 504	0	33	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	13, 073 12, 255			0	31 23	
55. 00 05500 RADI OLOGY - THERAPEUTI C	0			0	9	
57.00 05700 CT SCAN	1, 505			0	12	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION	1, 684		1, 684 11, 090	0	4 18	58.00 59.00
60. 00 06000 LABORATORY	5, 148			0	0	1
64.00 06400 INTRAVENOUS THERAPY	0	-		0	0	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	2, 572		_, _, _	0	24 11	1
67. 00 06700 OCCUPATI ONAL THERAPY	239			0	7	1
68.00 06800 SPEECH PATHOLOGY	55			0	2	1
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	6, 240 2, 502		6, 240 2, 502	0	17 6	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 647		11, 647	0	0	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	6, 333		6, 333	0	32	1
74. 00 07400 RENAL DIALYSIS 76. 00 03950 ENDOSCOPY	1, 212			0	0 7	
76. 06 03330 I MAGI NG CENTER	0	C	0	0	1	76.06
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C	0	0	5	76.97
0UTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC	0	0	0	0	0	90.00
90. 01 04950 DI ABETI C CARE CENTER	0	C	0	0	0	1
90. 02 04951 ANTI - COAGULATI ON CLINIC	0	0	0	0	0	1
90. 03 04952 PALLI ATI VE CARE 90. 04 04953 SPI NE CENTER	0		0	0	0	
91. 00 09100 EMERGENCY	29, 925	29, 706	29, 925	0	77	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	302, 325	158, 784	298, 885	35, 596	715	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0		0	0		191.00 192.00
193. 00 19300 NONPAI D WORKERS	0	0	0	0	0	193.00
194. 00 07950 HOME OFFICE 194. 06 07956 LEASED OFFICE SPACE	0		0	0		194.00 194.06
194. 08 07958 MISC NONREIMBURSABLE COST CENTERS	587		587	0		194.08
200.00 Cross Foot Adjustments					-	200.00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I)	9, 093, 974	926, 269	3, 299, 658	1, 377, 538	1, 416, 168	201.00 202.00
203.00Unit cost multiplier (Wkst. B, Part I)204.00Cost to be allocated (per Wkst. B,	30. 021835 1, 614, 728			38. 699236 147, 765	1, 980. 654545 286, 601	
Part II) 205.00 Unit cost multiplier (Wkst. B, Part II)	5. 330683	0. 284959	0. 465790	4. 151169	400.840559	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

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CAFETERIA	
ALS SERVED)	
11.00	
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	inancial Systems	COMMUNITY HOSE				u of Form CMS-2	
COST AL	LOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2019	Worksheet B-1	
				Т	o 12/31/2019	Date/Time Pre 8/19/2020 1:5	
					INTERNS &		
	Cost Center Description	NURSI NG		SOCIAL SERVICE	SERVI CES-SALAR		
		ADMI NI STRATI ON	RECORDS &		Y & FRINGES	PRGM. COSTS	
		(DI RECT NURS.	LI BRARY (GROSS	(TOTAL PATIENT DAYS)	(ASSIGNED TIME)	(ASSIGNED TIME)	
		HRS.)	CHARGES)	5,110)			
		13.00	16.00	17.00	21.00	22.00	
	ENERAL SERVICE COST CENTERS						1 1 00
	00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
	0400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
	0500 ADMINI STRATI VE & GENERAL						5.00
	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPING						9.00
	01000 DI ETARY 01100 CAFETERI A						10.00
	1300 NURSING ADMINI STRATI ON	393					13.00
	1600 MEDI CAL RECORDS & LI BRARY	0	975, 399, 358				16.00
17.00 0	1700 SOCIAL SERVICE	0	0	40, 696			17.00
	2100 I & R SERVICES-SALARY & FRINGES APPRVD	0	0	C			21.00
	2200 I & SERVICES-OTHER PRGM. COSTS APPRVD	0	0	C)	77, 346	22.00
	NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	280	116, 535, 240	34, 871	60, 236	60, 236	30.00
	3100 I NTENSI VE CARE UNI T	30	11, 342, 527	2, 996		2, 521	
	04300 NURSERY	6	3, 932, 921	2, 829		0	1
	NCILLARY SERVICE COST CENTERS						1
	05000 OPERATING ROOM	0	114, 478, 882			3, 342	•
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	38,651,555			0	
	05400 RADI OLOGY-DI AGNOSTI C	0	18, 854, 904 34, 499, 662		-	0	
	05500 RADI OLOGY-THERAPEUTI C	0	21, 086, 673	-	-	0	55.00
	5700 CT SCAN	0	64, 223, 374		0	0	
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	11, 568, 422	C	0 0	0	58.00
	5900 CARDI AC CATHETERI ZATI ON	0	79, 979, 434		-	0	
	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	0	80, 717, 854		-	0	60.00
	06500 RESPIRATORY THERAPY	0	13, 396, 698	-	-	0	64.00 65.00
	06600 PHYSI CAL THERAPY	0	11, 997, 527		-	1, 247	
	06700 OCCUPATIONAL THERAPY	0	3, 337, 172	C		0	
	06800 SPEECH PATHOLOGY	0	769, 399		-	0	
	06900 ELECTROCARDI OLOGY	0	27, 828, 885		-	0	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	4, 878, 782 45, 743, 653		022	822	•
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	34, 263, 581		-	0	
	07300 DRUGS CHARGED TO PATIENTS	0	67, 241, 793			0	
	7400 RENAL DIALYSIS	0	1, 472, 859		0	0	74.00
	3950 ENDOSCOPY	0	12, 263, 369		, i	0	
		0	14, 593, 895			0	
	07697 CARDI AC REHABI LI TATI ON UTPATI ENT SERVI CE COST CENTERS	0	1, 747, 302	C	0 0	0	76.97
	99000 CLINIC	0	0	C	0	0	90.00
90.01 0	04950 DIABETIC CARE CENTER	0	0	C	0	0	90.01
	04951 ANTI-COAGULATION CLINIC	0	1, 092, 331	c	0	0	
	04952 PALLI ATI VE CARE	0	0	C	0	0	
	04953 SPI NE CENTER 09100 EMERGENCY	0 77	287, 410 138, 613, 254		-	0	90.04 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		130, 013, 234		0,740	0, 740	91.00
	PECIAL PURPOSE COST CENTERS						/2.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	393	975, 399, 358	40, 696	74, 908	74, 908	118.00
	ONREIMBURSABLE COST CENTERS	· · · · ·					
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	-		190.00
	9100 RESEARCH 9200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		191.00 192.00
	9300 NONPALD WORKERS	0	0				192.00
	17950 HOME OFFICE	0	0		0		194.00
	7956 LEASED OFFICE SPACE	0	0	C	0		194.06
	07958 MISC NONREI MBURSABLE COST CENTERS	0	0	C	2, 438	2, 438	194.08
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	4 004 057	2 KEO 040	0 001 E10		1 000 414	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	4, 024, 857	2, 659, 848	2, 391, 513	783, 372	1, 082, 614	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10, 241. 366412	0.002727	58. 765309	10. 128151	13. 997026	203.00
204.00	Cost to be allocated (per Wkst. B,	91, 240	59, 322				204.00
	Part II)						I

Health Financial Systems	COMMUNI TY HOSI	PITAL SOUTH		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 01/01/2019 To 12/31/2019		
				INTERNS &	RESI DENTS	
Cost Center Description	NURSI NG	MEDI CAL	SOCIAL SERVIC	ESERVI CES-SALAR		
	ADMI NI STRATI ON	RECORDS &		Y & FRINGES	PRGM. COSTS	
		LI BRARY	(TOTAL PATIEN	T (ASSI GNED	(ASSI GNED	
	(DI RECT NURS.	(GROSS	DAYS)	TIME)	TIME)	
	HRS.)	CHARGES)				
	13.00	16.00	17.00	21.00	22.00	
205.00 Unit cost multiplier (Wkst. B, Part	232. 162850	0. 000061	2. 10644	8 0. 221498	0. 498642	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 8/19/2020 1:5	pared: 3 pm
		Title	XVIII	Hospi tal	PPS	
				Costs	•	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	51, 716, 429		51, 716, 42	29 0	51, 716, 429	30.00
31.00 03100 I NTENSI VE CARE UNI T	7, 905, 255		7, 905, 2		7, 905, 255	•
43. 00 04300 NURSERY	1, 343, 566		1, 343, 50		1, 343, 566	•
ANCI LLARY SERVICE COST CENTERS	.,		.,		.,	
50. 00 05000 OPERATI NG ROOM	13, 126, 286		13, 126, 28	36 0	13, 126, 286	50.00
51.00 05100 RECOVERY ROOM	6, 121, 106		6, 121, 10		6, 121, 106	
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 211, 559		6, 211, 5		6, 211, 559	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 613, 004		4, 613, 00		4, 613, 004	
55. 00 05500 RADI OLOGY-THERAPEUTI C	1,807,594		1, 807, 59		1, 807, 594	•
57. 00 05700 CT SCAN	2, 563, 818		2, 563, 8		2, 563, 818	•
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	834, 358		834, 3		834, 358	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 715, 282		5, 715, 28		5, 715, 282	•
60. 00 06000 LABORATORY	9,040,937		9, 040, 93		9,040,937	
64. 00 06400 I NTRAVENOUS THERAPY	0		.,,	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	3, 572, 279	0	3, 572, 2	79 0	3, 572, 279	
66. 00 06600 PHYSI CAL THERAPY	4, 468, 710	0			4, 468, 710	
67.00 06700 OCCUPATI ONAL THERAPY	1,058,089	0	1, 058, 08		1, 058, 089	
68.00 06800 SPEECH PATHOLOGY	244, 784	0	244, 78		244, 784	•
69. 00 06900 ELECTROCARDI OLOGY	2, 359, 358	-	2, 359, 3		2, 359, 358	
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 429, 659		1, 429, 65		1, 429, 659	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 105, 582		21, 105, 58		21, 105, 582	•
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	13, 405, 470		13, 405, 4		13, 405, 470	•
73.00 07300 DRUGS CHARGED TO PATIENTS	16, 672, 018		16, 672, 0		16, 672, 018	•
74.00 07400 RENAL DI ALYSI S	678, 430		678, 43		678, 430	
76.00 03950 ENDOSCOPY	1, 813, 305		1, 813, 30		1, 813, 305	•
76.06 03330 I MAGI NG CENTER	2, 195, 278		2, 195, 2		2, 195, 278	
76. 97 07697 CARDI AC REHABI LI TATI ON	499, 951		499, 95		499, 951	76.97
OUTPATIENT SERVICE COST CENTERS	1,					1
90. 00 09000 CLINIC	0			0 0	0	90.00
90. 01 04950 DI ABETI C CARE CENTER	0			0 0	0	90.01
90. 02 04951 ANTI-COAGULATION CLINIC	472, 431		472, 43	31 0	472, 431	
90. 03 04952 PALLIATIVE CARE	0			0 0	0	90.03
90. 04 04953 SPI NE CENTER	344,665		344, 60	55 0	344, 665	90.04
91.00 09100 EMERGENCY	13, 799, 470		13, 799, 4		13, 799, 470	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 994, 700		6, 994, 70		6, 994, 700	•
200.00 Subtotal (see instructions)	202, 113, 373				202, 113, 373	
201.00 Less Observation Beds	6, 994, 700		6, 994, 70		6, 994, 700	
202.00 Total (see instructions)	195, 118, 673				195, 118, 673	
		-		-1		

Health Financial Systems	COMMUNI TY HOSE	PITAL SOUTH		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 8/19/2020 1:5	epared: 53 pm
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpatient	Total (col.	6 Cost or Other	TEFRA	
·			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS			_			
30. 00 03000 ADULTS & PEDI ATRI CS	107, 791, 681		107, 791, 6	81		30.00
31.00 03100 INTENSIVE CARE UNIT	11, 342, 527		11, 342, 5	27		31.00
43. 00 04300 NURSERY	3, 932, 921		3, 932, 9	21		43.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	64, 529, 733	49, 949, 149	114, 478, 8	82 0. 114661	0.00000	50.00
51.00 05100 RECOVERY ROOM	15, 031, 486	23, 620, 069			0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	18, 854, 904	0			0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	7, 098, 630	27, 401, 032			0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	6, 552, 551	14, 534, 122			0. 000000	
57.00 05700 CT SCAN	16, 583, 761	47, 639, 613			0. 000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 244, 034	8, 324, 388			0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	33, 758, 431	46, 221, 003	79, 979, 4	34 0. 071459	0. 000000	
60. 00 06000 LABORATORY	46, 624, 519	34, 093, 335	80, 717, 8		0. 000000	
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0. 000000	0.00000	
65. 00 06500 RESPI RATORY THERAPY	11, 510, 429	1, 886, 269			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	3, 782, 460	8, 215, 067			0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	2, 303, 730	1, 033, 442			0. 000000	
68.00 06800 SPEECH PATHOLOGY	581, 989	187, 410			0.00000	
69. 00 06900 ELECTROCARDI OLOGY	8, 526, 947	19, 301, 938			0.00000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	301, 424	4, 577, 358			0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 301, 150	20, 442, 503			0.00000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	20, 484, 702	13, 778, 879			0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	42, 841, 125	24, 400, 668			0.00000	
74.00 07400 RENAL DI ALYSI S	1, 472, 859	0	.,, .		0.00000	
76.00 03950 ENDOSCOPY	2, 303, 523	9, 959, 846			0.00000	
76.06 03330 I MAGI NG CENTER	172, 342	14, 421, 553			0.00000	
76. 97 07697 CARDIAC REHABILITATION	3, 890	1, 743, 412	1, 747, 3	0. 286127	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS	1 1		1			
90. 00 09000 CLINIC	0	0		0 0. 000000	0.00000	
90. 01 04950 DI ABETI C CARE CENTER	0	0		0 0.000000	0.00000	
90. 02 04951 ANTI - COAGULATI ON CLINIC	10, 655	1, 081, 676			0.00000	
90. 03 04952 PALLI ATI VE CARE	0	0		0 0.000000	0.00000	
90. 04 04953 SPI NE CENTER	0	287, 410			0.00000	
91.00 09100 EMERGENCY	29, 019, 808	109, 593, 446			0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 933, 881	5, 809, 678			0.00000	
200.00 Subtotal (see instructions)	486, 896, 092	488, 503, 266	975, 399, 3	58		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	486, 896, 092	488, 503, 266	975, 399, 3	58		202.00

	Financial Systems	COMMUNITY HOSPI			u of Form CMS-	-2552-1
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Peri od: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 8/19/2020 1:5	epared: 53 pm
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30.00	03000 ADULTS & PEDIATRICS					T 30. 0
31.00	03100 I NTENSI VE CARE UNI T					31.0
43.00	04300 NURSERY					43.0
	ANCI LLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 114661				50.0
51.00	05100 RECOVERY ROOM	0. 158366				51.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 329440				52.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 133712				54.0
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 085722				55.0
57.00	05700 CT SCAN	0. 039920				57.0
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 072124				58.0
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 071459				59.0
60.00	06000 LABORATORY	0. 112007				60.0
64.00	06400 I NTRAVENOUS THERAPY	0. 000000				64.0
65.00	06500 RESPI RATORY THERAPY	0. 266654				65.0
66.00	06600 PHYSI CAL THERAPY	0. 372469				66.0
67.00	06700 OCCUPATI ONAL THERAPY	0. 317062				67.0
68. 00	06800 SPEECH PATHOLOGY	0. 318150				68.0
69.00	06900 ELECTROCARDI OLOGY	0. 084781				69.0
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 293036				70. C
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 461388				71. C
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 391245				72.0
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 247941				73.0
	07400 RENAL DI ALYSI S	0. 460621				74.0
76.00	03950 ENDOSCOPY	0. 147864				76.0
76.06	03330 I MAGI NG CENTER	0. 150424				76.0
76. 97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0. 286127				76.9
90.00	09000 CLINIC	0. 000000				90.0
	04950 DI ABETI C CARE CENTER	0. 000000				90.0
90.01	04950 DTABETTC CARE CENTER	0. 432498				90.0
90.02 90.03	04952 PALLIATIVE CARE	0. 432498				90.0
90.03	04953 SPINE CENTER	1. 199210				90.0
	09100 EMERGENCY	0. 099554				91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 799983				92.0
200.00		0. 177703				200.0
200.00						200.0
201.00	Total (see instructions)					201.0

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 8/19/2020 1:5	epared: 53 pm
		Titl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	53, 169, 633		53, 169, 63	33 0	53, 169, 633	30.00
31.00 03100 INTENSIVE CARE UNIT	7, 966, 075		7, 966, 0	75 0	7, 966, 075	31.00
43. 00 04300 NURSERY	1, 343, 566		1, 343, 50	66 0	1, 343, 566	43.00
ANCI LLARY SERVI CE COST CENTERS	1					
50.00 05000 OPERATING ROOM	13, 206, 912		13, 206, 9		13, 206, 912	
51.00 05100 RECOVERY ROOM	6, 121, 106		6, 121, 10		6, 121, 106	
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 211, 559		6, 211, 5		6, 211, 559	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 613, 004		4, 613, 00		4, 613, 004	
55. 00 05500 RADI OLOGY - THERAPEUTI C	1, 807, 594		1, 807, 59		1, 807, 594	
57.00 05700 CT SCAN	2, 563, 818		2, 563, 8		2, 563, 818	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	834, 358		834, 3		834, 358	
59.00 05900 CARDI AC CATHETERI ZATI ON	5, 715, 282		5, 715, 28		5, 715, 282	
60. 00 06000 LABORATORY	9, 040, 937		9, 040, 93		9, 040, 937	
64.00 06400 INTRAVENOUS THERAPY	0			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	3, 572, 279				3, 572, 279	
66.00 06600 PHYSI CAL THERAPY	4, 498, 794		.,		4, 498, 794	
67.00 06700 OCCUPATIONAL THERAPY	1, 058, 089		1, 058, 08		1, 058, 089	1
68. 00 06800 SPEECH PATHOLOGY	244, 784		244, 78		244, 784	
69. 00 06900 ELECTROCARDI OLOGY	2, 359, 358		2, 359, 3		2, 359, 358	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 449, 490		1, 449, 49		1, 449, 490	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	21, 105, 582		21, 105, 58		21, 105, 582	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	13, 405, 470		13, 405, 4		13, 405, 470	
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	16, 672, 018		16, 672, 0		16, 672, 018	
76. 00 03950 ENDOSCOPY	678, 430 1, 813, 305		678, 43 1, 813, 30		678, 430 1, 813, 305	
76. 06 03330 I MAGI NG CENTER 76. 97 07697 CARDI AC REHABI LI TATI ON	2, 195, 278 499, 951		2, 195, 2 499, 9		2, 195, 278 499, 951	
OUTPATIENT SERVICE COST CENTERS	499,931		499, 93	0	499, 931	/0.9/
90. 00 09000 CLINIC	0			0 0	0	90.00
90. 01 04950 DIABETIC CARE CENTER	0			0 0	0	
90. 02 04951 ANTI - COAGULATI ON CLINIC	472, 431		472, 43	-	472, 431	
90. 03 04952 PALLI ATI VE_CARE	4/2, 431 0		+/2,4		472, 431	1
90. 04 04953 SPI NE CENTER	344, 665		344, 60	-	344, 665	
91. 00 09100 EMERGENCY	13, 962, 074		13, 962, 0		13, 962, 074	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 994, 700		6, 994, 70		6, 994, 700	
200.00 Subtotal (see instructions)	203, 920, 542				203, 920, 542	
201.00 Less Observation Beds	6, 994, 700		6, 994, 70		6, 994, 700	
202.00 Total (see instructions)	196, 925, 842				196, 925, 842	
	1, , 20, 012	. 0	, , 20, 0	9	, ,20,012	1

Health Financial Systems	COMMUNI TY HOSE				u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 8/19/2020 1:5	epared:
		Titl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpatient	Total (col.	6 Cost or Other	TEFRA	
		·	+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	107, 791, 681		107, 791, 6	81		30.00
31.00 03100 INTENSIVE CARE UNIT	11, 342, 527		11, 342, 53			31.00
43. 00 04300 NURSERY	3, 932, 921		3, 932, 93	21		43.00
ANCI LLARY SERVI CE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
50.00 05000 OPERATING ROOM	64, 529, 733	49, 949, 149				
51.00 05100 RECOVERY ROOM	15, 031, 486	23, 620, 069				
52.00 05200 DELIVERY ROOM & LABOR ROOM	18, 854, 904	0				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	7, 098, 630	27, 401, 032			0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	6, 552, 551	14, 534, 122			0. 000000	
57.00 05700 CT SCAN	16, 583, 761	47, 639, 613				
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 244, 034	8, 324, 388			0. 000000	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	33, 758, 431	46, 221, 003	79, 979, 4	34 0. 071459	0. 000000	•
60. 00 06000 LABORATORY	46, 624, 519	34, 093, 335	80, 717, 8		0. 000000	•
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0.000000	0. 000000	•
65. 00 06500 RESPI RATORY THERAPY	11, 510, 429	1, 886, 269			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	3, 782, 460	8, 215, 067			0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	2, 303, 730	1, 033, 442				
68.00 06800 SPEECH PATHOLOGY	581, 989	187, 410				
69. 00 06900 ELECTROCARDI OLOGY	8, 526, 947	19, 301, 938			0. 000000	
70.00 07000 ELECTROENCEPHALOGRAPHY	301, 424	4, 577, 358			0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 301, 150	20, 442, 503				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	20, 484, 702	13, 778, 879			0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	42, 841, 125	24, 400, 668			0. 000000	
74.00 07400 RENAL DIALYSIS	1, 472, 859	0	.,		0. 000000	
76.00 03950 ENDOSCOPY	2, 303, 523	9, 959, 846				
76.06 03330 I MAGI NG CENTER	172, 342	14, 421, 553			0. 000000	
76. 97 07697 CARDI AC REHABILI TATI ON	3, 890	1, 743, 412	1, 747, 30	0. 286127	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS	· · · · · ·					
90. 00 09000 CLINIC	0	0		0 0.000000		
90. 01 04950 DI ABETI C CARE CENTER	0	0		0 0.000000		
90. 02 04951 ANTI-COAGULATION CLINIC	10, 655	1, 081, 676	1, 092, 3			
90. 03 04952 PALLI ATI VE CARE	0	0		0 0.000000		
90. 04 04953 SPI NE CENTER	0	287, 410				
91.00 09100 EMERGENCY	29, 019, 808	109, 593, 446			0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 933, 881	5, 809, 678			0.00000	
200.00 Subtotal (see instructions)	486, 896, 092	488, 503, 266	975, 399, 3	58		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	486, 896, 092	488, 503, 266	975, 399, 3	58		202.00

Heal th	Financial Systems	COMMUNI TY HOSPI	TAL SOUTH	In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 8/19/2020 1:5	epared: 53 pm
			Title XIX	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
43.00	04300 NURSERY					43.00
	ANCI LLARY SERVICE COST CENTERS	· ·				
50.00	05000 OPERATING ROOM	0. 115365				50.00
51.00	05100 RECOVERY ROOM	0. 158366				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 329440				52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 133712				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 085722				55.00
57.00	05700 CT SCAN	0. 039920				57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 072124				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0.071459				59.00
60.00	06000 LABORATORY	0. 112007				60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000				64.00
65.00	06500 RESPI RATORY THERAPY	0. 266654				65.00
66.00		0. 374977				66.00
67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0. 374977				67.00
68.00	06800 SPEECH PATHOLOGY	1				
		0. 318150				68.00
69.00		0. 084781				69.00
70.00		0. 297101				70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 461388				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 391245				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 247941				73.00
74.00	07400 RENAL DI ALYSI S	0. 460621				74.00
76.00	03950 ENDOSCOPY	0. 147864				76.00
76.06	03330 I MAGI NG CENTER	0. 150424				76.06
76.97	07697 CARDI AC REHABI LI TATI ON	0. 286127				76.97
	OUTPATIENT SERVICE COST CENTERS					_
90.00	09000 CLI NI C	0. 000000				90.00
	04950 DI ABETI C CARE CENTER	0. 000000				90.01
90.02	04951 ANTI-COAGULATION CLINIC	0. 432498				90.02
	04952 PALLI ATI VE CARE	0. 000000				90.03
90.04	04953 SPI NE CENTER	1. 199210				90.04
91.00	09100 EMERGENCY	0. 100727				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 799983				92.00
200.00	Subtotal (see instructions)					200.00
201.00						201.00
202.00						202.00

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-:	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE F REDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF	Provider C	CN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part II Date/Time Pre 8/19/2020 1:5	pared: 3 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating Cos	st Capital	Operating Cost	
	(Wkst. B, Part				Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1		1			-
50.00 05000 OPERATING ROOM	13, 206, 912					
51.00 05100 RECOVERY ROOM	6, 121, 106				-	
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 211, 559				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 613, 004			56 0	0	
55. 00 05500 RADI OLOGY - THERAPEUTI C	1, 807, 594	299, 543	1, 508, 0	51 0	0	
57.00 05700 CT SCAN	2, 563, 818	350, 926	2, 212, 8	92 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	834, 358	75, 576	758, 7	32 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 715, 282	1, 112, 294	4, 602, 9	38 0	0	59.00
60. 00 06000 LABORATORY	9, 040, 937	316, 774	8, 724, 10	53 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	C		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	3, 572, 279	173, 266	3, 399, 0	13 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	4, 498, 794				0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	1,058,089	58, 894	999, 1	95 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	244, 784				0	68.00
69. 00 06900 ELECTROCARDI OLOGY	2, 359, 358				0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 449, 490				0	•
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 105, 582				0	•
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	13, 405, 470				0	•
73. 00 07300 DRUGS CHARGED TO PATIENTS	16, 672, 018				0	
74. 00 07400 RENAL DIALYSIS	678, 430				0	
76. 00 03950 ENDOSCOPY	1, 813, 305				0	
76. 06 03330 I MAGI NG CENTER	2, 195, 278				•	
76. 97 07697 CARDI AC REHABI LI TATI ON	499, 951				-	
OUTPATIENT SERVICE COST CENTERS	477, 751	17, 403	400,40		0	/0. 7/
90. 00 09000 CLINIC	0	C	1	0 0	0	90.00
90. 01 04950 DI ABETI C CARE CENTER	0			0 0	0	
90. 01 04950 DTABETTC CARE CENTER 90. 02 04951 ANTI - COAGULATION CLINIC	472, 431	12, 502			0	1 10.01
	472,431	12, 502		0 0	0	
	244.445				0	
	344, 665				-	
91.00 09100 EMERGENCY	13, 962, 074				0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 994, 700				0	
200.00 Subtotal (sum of lines 50 thru 199)	141, 441, 268					200.00
201.00 Less Observation Beds	6, 994, 700					201.00
202.00 Total (line 200 minus line 201)	134, 446, 568	12, 292, 279	122, 154, 2	39 0	0	202.00

ealth Financial Systems ALCULATION OF OUTPATIENT SERVICE COST TO CHA	COMMUNITY HOSP	Provi der C	NI 15 0100	Peri od:	u of Form CMS Worksheet C	-2002-
EDUCTIONS FOR MEDICALD ONLY	RGE RATIOS NET OF	Provider co	JN. 13-0120	From 01/01/2019	Part II	
				To 12/31/2019		epared
					8/19/2020 1:	53 pm
Cost Conton Description			e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of Capital and	Total Charges (Worksheet C,	Outpatient	70		
	Operating CostP	wurksneet C,		je 6		
	Reduction	8)	/ col. 7)	0		
	6.00	7.00	8.00			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	0.00			_
0. 00 05000 OPERATING ROOM	13, 206, 912	114, 478, 882	0. 1153	45		50.0
1. 00 05100 RECOVERY ROOM	6, 121, 106	38, 651, 555				51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	6, 211, 559	18, 854, 904				52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 613, 004	34, 499, 662				54.0
5. 00 05500 RADI OLOGY - THERAPEUTI C	1, 807, 594	21, 086, 673				55.0
7. 00 05700 CT SCAN	2, 563, 818	64, 223, 374				57.
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 503, 818	11, 568, 422				57.
						58.
	5, 715, 282	79, 979, 434				
	9, 040, 937	80, 717, 854				60.
4.00 06400 I NTRAVENOUS THERAPY	0	0				64.
5. 00 06500 RESPI RATORY THERAPY	3, 572, 279	13, 396, 698				65.
6. 00 06600 PHYSI CAL THERAPY	4, 498, 794	11, 997, 527				66.
7.00 06700 OCCUPATIONAL THERAPY	1,058,089	3, 337, 172				67.
8.00 06800 SPEECH PATHOLOGY	244, 784	769, 399				68.
9.00 06900 ELECTROCARDI OLOGY	2, 359, 358	27, 828, 885				69.
0. 00 07000 ELECTROENCEPHALOGRAPHY	1, 449, 490	4, 878, 782				70.
1.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIE		45, 743, 653				71.
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS	13, 405, 470	34, 263, 581	0. 3912			72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	16, 672, 018	67, 241, 793				73.
4. 00 07400 RENAL DIALYSIS	678, 430	1, 472, 859				74.
6.00 03950 ENDOSCOPY	1, 813, 305	12, 263, 369				76.
6.06 03330 I MAGI NG CENTER	2, 195, 278	14, 593, 895				76.
6. 97 07697 CARDIAC REHABILITATION	499, 951	1, 747, 302	0. 2861	27		76.
OUTPATIENT SERVICE COST CENTERS			1			
0. 00 09000 CLINIC	0	0				90.
0. 01 04950 DI ABETI C CARE CENTER	0	0	0.0000			90.
0. 02 04951 ANTI-COAGULATION CLINIC	472, 431	1, 092, 331	0. 4324			90.
0. 03 04952 PALLIATIVE CARE	0	0	0.0000			90.
0. 04 04953 SPI NE CENTER	344, 665	287, 410		10		90.
1. 00 09100 EMERGENCY	13, 962, 074	138, 613, 254		27		91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PA		8, 743, 559		83		92.
00.00 Subtotal (sum of lines 50 thru 19	9) 141, 441, 268	852, 332, 229				200.
01.00 Less Observation Beds	6, 994, 700	0				201.
02.00 Total (line 200 minus line 201)	134, 446, 568	852, 332, 229				202.

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider (CCN: 15-0128	Peri od:	Worksheet D	
				From 01/01/2019	Part I	
				To 12/31/2019	Date/Time Pre 8/19/2020 1:5	pared:
		Ti †I	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cos			
	Part II, col.		(col. 1 - co			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	3, 896, 986		0 3, 896, 9	36 40, 325	96.64	30.00
31.00 INTENSIVE CARE UNIT	1,084,360		1, 084, 3	50 2, 996	361.94	31.00
43.00 NURSERY	106, 427		106, 4	27 2, 829	37.62	43.00
200.00 Total (lines 30 through 199)	5,087,773		5, 087, 7	73 46, 150		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	11, 942					30.00
31. 00 INTENSIVE CARE UNIT	1, 139	412, 25	o			31.00
43.00 NURSERY	0		ol			43.00
200.00 Total (lines 30 through 199)	13, 081	1, 566, 32	5			200. 00

Health Financial Systems	COMMUNITY HOS				u of Form CMS-	2552-1
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT,	AL COSTS	Provider C	CN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Pre 8/19/2020 1:5	pared: 3 pm
			XVIII	Hospi tal	PPS	
Cost Center Description		Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 305, 386			38 22, 935, 152	461, 868	50.0
51.00 05100 RECOVERY ROOM	376, 551	38, 651, 555	0.00974	42 4, 871, 016	47, 453	51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	494, 606	18, 854, 904	0. 02623	32 0	0	52.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	664, 748	34, 499, 662			53, 237	54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	299, 543	21, 086, 673	0.01420	3, 212, 198	45, 629	55.0
57.00 05700 CT SCAN	350, 926	64, 223, 374	0.00546	6, 446, 818	35, 225	57.0
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	75, 576				7, 833	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 112, 294					
50. 00 06000 LABORATORY	316, 774					
54.00 06400 INTRAVENOUS THERAPY	0					
55. 00 06500 RESPIRATORY THERAPY	173, 266	-			50, 953	
56. 00 06600 PHYSI CAL THERAPY	720, 202				101, 255	
57. 00 06700 OCCUPATI ONAL THERAPY	58, 894				19, 359	
58. 00 06800 SPEECH PATHOLOGY	13, 734					
59. 00 06900 ELECTROCARDI OLOGY	260, 070					
70. 00 07000 ELECTROEARD OLOGT	126, 460					
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 945, 169					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	293, 217					
73. 00 07300 DRUGS CHARGED TO PATIENTS	911, 553					
74.00 07400 RENAL DIALYSIS	42, 927					
76. 00 03950 ENDOSCOPY	326, 741					
76. 06 03330 I MAGI NG CENTER	222, 214					
	19, 463					
76. 97 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	19, 463	1, 747, 302	0.01113	39 586	/	/6.9
	0	0	0.0000	20 0	0	
	0	-			-	
20. 01 04950 DI ABETI C CARE CENTER	0	1 000 001	0.0000		0	
20. 02 04951 ANTI-COAGULATION CLINIC	12, 502				0	
PO. 03 04952 PALLI ATI VE CARE	0	0	0.0000		0	
PO. 04 04953 SPINE CENTER	74, 966				0	
91. 00 09100 EMERGENCY	1, 094, 497					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	527,072					
200.00 Total (lines 50 through 199)	12, 819, 351	852, 332, 229		125, 484, 933	1, 908, 773	200.0

Health Financial Systems	COMMUNI TY HOSP	ITAL SOUTH		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COSTS			Period: From 01/01/2019 To 12/31/2019		
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School N Post-Stepdown Adjustments 1A	ursing School	Allied Health Post-Stepdown Adjustments 2A		All Other Medical Education Cost 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA	1.00	ZA	2.00	3.00	
INFATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY 200. 00 Total (Lines 30 through 199)	0 0 0	0 0 0 0			0 0 0 0	31.00
Cost Center Description	Adjustment (Amount (see instructions) m	Total Costs (sum of cols. 1 through 3, minus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS30.00O3000 ADULTS & PEDIATRICS31.00O3100 INTENSIVE CARE UNIT43.00O4300 NURSERY200.00Total (lines 30 through 199)	0	0 0 0 0	40, 32 2, 99 2, 82 46, 15	6 0.00 9 0.00	1, 139 0	31.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 INTENSI VE CARE UNI T 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0 0 0					30.00 31.00 43.00 200.00

Health Financial Systems	COMMUNI TY HOSF	PITAL SOUTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provider C	CN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Pre 8/19/2020 1:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Jursing School	Nursing Scho	Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS			_			
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
76. 00 03950 ENDOSCOPY	0	0		0 0	0	76.00
76.06 03330 I MAGI NG CENTER	0	0		0 0	0	76.06
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 04950 DI ABETI C CARE CENTER	0	0		0 0	0	90. 01
90. 02 04951 ANTI - COAGULATI ON CLINIC	0	0		0 0	0	90.02
90. 03 04952 PALLI ATI VE CARE	0	0		0 0	0	90. 03
90. 04 04953 SPI NE CENTER	0	0		0 0	0	90.04
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0	l	0 0	0	200. 00

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	PITAL SOUTH S Provider C	CN· 15-0128	Peri od:	Worksheet D	2552-1
	H COSTS	NOT OF OTHER TAS		SN. 15 0120	From 01/01/2019	Part IV	
milliouc	11 66515				To 12/31/2019	Date/Time Pre	pared
						8/19/2020 1:5	3 pm
		_		XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent		to Charges	
		Education Cost	1, 2, 3, and	Cost (sum o		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 114, 478, 882		
1.00	05100 RECOVERY ROOM	0	C		0 38, 651, 555	0.00000	51.(
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 18, 854, 904	0.00000	52.0
4.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 34, 499, 662	0.000000	54.0
5.00	05500 RADI OLOGY-THERAPEUTI C	0	C		0 21, 086, 673	0.000000	55.0
7.00	05700 CT SCAN	0	C		0 64, 223, 374	0.000000	57.
8.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 11, 568, 422	0, 000000	58.
9.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 79, 979, 434	0. 000000	
0.00	06000 LABORATORY	0	0		0 80, 717, 854	0. 000000	
4.00	06400 I NTRAVENOUS THERAPY	0	C C		0 0	0.000000	
5.00	06500 RESPI RATORY THERAPY	0			0 13, 396, 698	0.000000	
6.00	06600 PHYSI CAL THERAPY	0			0 11, 997, 527	0.000000	
7.00	06700 OCCUPATI ONAL THERAPY	0			0 3, 337, 172	0.000000	
8.00	06800 SPEECH PATHOLOGY	0			0 769, 399		
9.00	06900 ELECTROCARDI OLOGY	0			0 27, 828, 885	0.000000	
9.00	07000 ELECTROCARDIOLOGI	0			0 4, 878, 782	0.000000	
1.00		0					
2.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0				0.000000 0.000000	
		0					
3.00	07300 DRUGS CHARGED TO PATIENTS	0	U		0 67, 241, 793	0.00000	
4.00	07400 RENAL DI ALYSI S	0	0		0 1, 472, 859		
6.00	03950 ENDOSCOPY	0	0		0 12, 263, 369		
6.06	03330 I MAGI NG CENTER	0	0		0 14, 593, 895		
6. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 1, 747, 302	0.00000	76.
	OUTPATIENT SERVICE COST CENTERS	-	-	1			
0.00	09000 CLINIC	0	0		0 0	0.00000	
0. 01	04950 DIABETIC CARE CENTER	0	0		0 0	0.00000	
0. 02	04951 ANTI-COAGULATION CLINIC	0	C		0 1, 092, 331	0.00000	
0. 03	04952 PALLIATIVE CARE	0	0		0 0	0. 000000	
0. 04	04953 SPINE CENTER	0	0		0 287, 410		
1.00	09100 EMERGENCY	0	0		0 138, 613, 254	0.00000	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0 8, 743, 559	0.00000	92.
200.00	Total (lines 50 through 199)	0	C		0 852, 332, 229		200.

Health Financial Systems	COMMUNI TY HOSPI	Provi der CCN: 15-0128			u of Form CMS-2552-1	
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0128	Period: From 01/01/2019	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2019		pared:
					8/19/2020 1:5	3 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges		Charges before		
	(col. 6 ÷ col.		Costs (col.		on/after Geo	
	7)		x col. 10)	Recl assi fi cati		
	9,00	10.00	11.00	0n 12.00	on 12.01	
ANCI LLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	12.01	
50. 00 05000 OPERATING ROOM	0. 000000	22, 935, 152		0 9, 789, 446	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	4, 871, 016		0 5, 331, 922		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	4, 871, 010		0 5, 331, 422		51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 762, 968		6, 337, 169	-	54.00
55. 00 05500 RADI OLOGY THERAPEUTI C	0. 000000	3, 212, 198		0 7, 154, 105		55.00
57. 00 05700 CT SCAN	0. 000000	6, 446, 818		0 10, 203, 190		57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	1, 198, 991		0 1, 960, 927		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	11, 874, 750		0 16, 368, 900		59.00
60. 00 06000 LABORATORY	0. 000000	17, 094, 129		0 6, 295, 928	-	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0		64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	3, 939, 792		0 303, 606	-	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	1, 686, 774		0 89, 255		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0.000000	1, 096, 961		0 23, 232		67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	272, 429		0 3, 341	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3, 601, 082		0 5, 686, 095	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	112, 740		0 926, 441	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	8, 200, 719		0 5, 447, 105	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	8, 132, 140		0 5, 128, 890	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	14, 208, 684		0 6, 799, 944	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	822, 006		0 0	0	74.00
76.00 03950 ENDOSCOPY	0. 000000	25, 216		0 2, 925, 798	0	76.00
76.06 03330 I MAGI NG CENTER	0.000000	50, 448		0 3, 127, 076	0	76.06
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	586		0 703, 670	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	-	
90. 01 04950 DIABETIC CARE CENTER	0. 000000	0		0 0	-	90.01
90. 02 04951 ANTI - COAGULATION CLINIC	0. 000000	0		0 642, 806		90.02
90. 03 04952 PALLI ATI VE CARE	0. 000000	0		0 0	0	90.03
90. 04 04953 SPI NE CENTER	0. 000000	0		0 389		90.04
91.00 09100 EMERGENCY	0. 000000	11, 530, 431		0 14, 497, 695		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	1, 408, 903		0 3, 466, 665		
200.00 Total (lines 50 through 199)		125, 484, 933		0 113, 213, 595	0	200.00

	Financial Systems	COMMUNITY HOSE				u of Form CMS-2552-10	
	I ONMENT OF I NPATI ENT/OUTPATI ENT ANCI LLARY SEI H COSTS	RVICE OTHER PASS	Provider C	CN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Pr 8/19/2020 1:	epared: 53 pm
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpatient	Outpati ent		· · · · · · · · · · · · · · · · · · ·		
		Program	Program				
		Pass-Through	Pass-Through				
		Costs (col. 9	Costs (col. 9				
		x col. 12)	x col. 12)				
		before Geo	on/after Geo				
		Recl assi fi cati I	Recl assi fi cati				
		on	on				
		13.00	13.01				
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0				50.0
51.00	05100 RECOVERY ROOM	0	0				51.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54. C
5.00	05500 RADI OLOGY-THERAPEUTI C	0	0				55.0
7.00	05700 CT SCAN	0	0				57.0
8.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.0
9.00	05900 CARDI AC CATHETERI ZATI ON	0	0				59.0
60.00	06000 LABORATORY	0	0				60.0
64.00	06400 INTRAVENOUS THERAPY	0	0				64.0
5.00	06500 RESPI RATORY THERAPY	0	0				65.0
56.00	06600 PHYSI CAL THERAPY	0	0				66.0
57.00	06700 OCCUPATI ONAL THERAPY	0	0				67.0
8.00	06800 SPEECH PATHOLOGY	0	0				68.0
9.00	06900 ELECTROCARDI OLOGY	0	0				69. (
0. 00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.0
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. (
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. (
3.00	07300 DRUGS CHARGED TO PATIENTS	0	0				73.0
4.00	07400 RENAL DIALYSIS	0	0				74. (
6.00	03950 ENDOSCOPY	0	0				76. (
6.06	03330 I MAGI NG CENTER	0	0				76.0
6.97	07697 CARDI AC REHABI LI TATI ON	0	0				76. 9
	OUTPATIENT SERVICE COST CENTERS						
0.00	09000 CLI NI C	0	0				90. (
0. 01	04950 DI ABETI C CARE CENTER	0	0				90. (
0. 02	04951 ANTI-COAGULATION CLINIC	0	0				90.0
0.03	04952 PALLI ATI VE CARE	0	0				90. (
0.04	04953 SPI NE CENTER	0	0				90. (
1.00	09100 EMERGENCY	0	0				91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.0
200.00		0	0				200.0

APPORTI ONMENT OF	MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider C	CN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 8/19/2020 1:5	
			Title	e XVIII	Hospi tal	PPS	
				Charges		Costs	
Cost	Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed		(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To			
				Ded. & Coins			
		1.00	0.00	(see inst.)		F 00	
		1.00	2.00	3.00	4.00	5.00	
	SERVICE COST CENTERS	0 114//1	0 700 444	1	0	1 100 4/0	50.00
50.00 05000 OPERA		0. 114661			0 0 0 0	1, 122, 468	
51.00 05100 RECOV		0. 158366			0 0	844, 395	
	/ERY_ROOM_&_LABOR_ROOM DLOGY-DIAGNOSTIC	0. 329440			0 0	047.254	
	DLOGY-DHAGNOSTIC	0. 133712			0 0	847, 356	
					0 0	613, 264	
	TIC RESONANCE IMAGING (MRI)	0. 039920			0 0	407, 311	
	AC CATHETERIZATION	0. 072124			0 0	141, 430	
60.00 06000 LABOR		0. 112007			0 0	1, 169, 705 705, 188	
	VENOUS THERAPY	0. 000000		1	0 0	05, 188	
	RATORY THERAPY	0. 266654			0 0	80, 958	
	CAL THERAPY	0. 372469			0 0	33, 245	
	PATIONAL THERAPY	0. 372409			0 0	7, 366	
	CH PATHOLOGY	0. 318150			0 0	1, 063	
	FROCARDI OLOGY	0. 084781			0 0	482, 073	
70.00 07000 ELECT	ROENCEPHALOGRAPHY	0. 293036			0 0	271, 481	
	CAL SUPPLIES CHARGED TO PATIENTS	0. 461388			0 0	2, 513, 229	
	DEV. CHARGED TO PATIENTS	0. 391245			0 0	2,006,653	
	CHARGED TO PATIENTS	0. 247941	6, 799, 944		0 101, 815	1, 685, 985	•
74.00 07400 RENAL		0. 460621)	0 0	0	
76.00 03950 ENDOS	SCOPY	0. 147864	2, 925, 798		0 0	432, 620	76.00
76.06 03330 I MAGI	NG CENTER	0. 150424			0 0	470, 387	76.06
76. 97 07697 CARDI	AC REHABILITATION	0. 286127	703, 670)	0 0	201, 339	76.97
OUTPATI ENT	SERVICE COST CENTERS						
90.00 09000 CLI NI	С	0. 000000	C		0 0	0	90.00
90. 01 04950 DI ABE	TIC CARE CENTER	0. 000000	0		0 0	0	90.01
90.02 04951 ANTI -	COAGULATION CLINIC	0. 432498	642, 806	,	0 0	278, 012	90.02
90. 03 04952 PALLI		0. 000000	0		0 0	0	90.03
90. 04 04953 SPI NE		1. 199210			0 0	466	
91.00 09100 EMERG		0. 099554			0 89	1, 443, 304	
	VATION BEDS (NON-DISTINCT PART)	0. 799983	3, 466, 665		0 25	2, 773, 273	92.00
	otal (see instructions)		113, 213, 595		0 101, 929	18, 532, 571	
	PBP Clinic Lab. Services-Program				0 0		201.00
	Charges						
202.00 Net C	Charges (line 200 - line 201)	1	113, 213, 595	1	0 101, 929	18, 532, 571	1202.00

Health Financial Systems	COMMUNITY HOS				u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pro	
		Ti tl o	XVIII	Hospi tal	8/19/2020 1: PPS	53 pili
	Cos			nospitai	FFJ	
Cost Center Description	Cost	Cost	-			
cost center beschiption	Reimbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	25, 244	1			73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76.00 03950 ENDOSCOPY	0	0				76.00
76. 06 03330 I MAGI NG CENTER	0	0				76.06
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
0UTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0	0				
90. 01 04950 DI ABETI C CARE CENTER	0					90.00 90.01
90. 01 04950 DTABETTC CARE CENTER 90. 02 04951 ANTI -COAGULATION CLINIC	0	0				90.01
90. 02 04951 ANTI-COAGULATION CLINIC 90. 03 04952 PALLI ATI VE CARE						90.02
90. 04 04952 PALLIATIVE CARE 90. 04 04953 SPINE CENTER		0				90.03
91. 00 09100 EMERGENCY		9				90.04
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		20				91.00
200.00 Subtotal (see instructions)		25, 273				200.00
201.00 Less PBP Clinic Lab. Services-Program		25,275				200.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)	0	25, 273				202.00
	0	1 20,270	I			1202.00

Health Financial Systems	COMMUNITY HOS	SPI TAL	SOUTH		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Pr	rovider C		Peri od:	Worksheet D	
					From 01/01/2019		
					To 12/31/2019		
			T; +1	e XIX	Hospi tal	8/19/2020 1:5 PPS	<u>3 pili</u>
Cost Center Description	Capi tal	Curi	ng Bed	Reduced	Total Patient	· · · · · ·	
COST Center Description	Related Cost			Capi tal		3 / col. 4)	
	(from Wkst. B,	Auji	ustment	Related Cost	Days	3 / COL 4)	
	Part II, col.			(col. 1 - 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	5.00	
30. 00 ADULTS & PEDIATRICS	3, 896, 986		0	3, 896, 98	40, 325	96.64	30.00
31.00 INTENSIVE CARE UNIT	1, 084, 360		0				•
				1, 084, 36			•
43. 00 NURSERY	106, 427			106, 42			•
200.00 Total (lines 30 through 199)	5,087,773			5, 087, 77	46, 150		200.00
Cost Center Description	Inpati ent		oati ent				
	Program days		rogram				
			tal Cost				
		(COL.	5 x col.				
	6,00		<u>6)</u> 7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00		7.00				
30. 00 ADULTS & PEDIATRICS	1, 554		150, 179				30.00
30. 00 JADOLIS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT	1, 554		150, 179				30.00
	1 710	1	0				
43. 00 NURSERY	1,718	1	64, 631	1			43.00
200.00 Total (lines 30 through 199)	3, 272	1	214, 810	1			200.00

Health Financial Systems	COMMUNI TY HOS	PITAL SOUTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0128	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Pre 8/19/2020 1:5	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	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	
ANCI LLARY SERVI CE COST CENTERS	÷		•			
50. 00 05000 OPERATI NG ROOM	2, 305, 386	114, 478, 882	0. 02013	38 1, 117, 535	22, 505	50.00
51.00 05100 RECOVERY ROOM	376, 551	38, 651, 555	0.00974	42 384, 023	3, 741	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	494, 606	18, 854, 904	0. 02623	32 219, 802	5, 766	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	664, 748	34, 499, 662	0.01920	304, 100	5, 859	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	299, 543	21, 086, 673	0.01420	164, 499	2, 337	55.00
57.00 05700 CT SCAN	350, 926	64, 223, 374	0.00546	666, 590	3, 642	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	75, 576	11, 568, 422				
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 112, 294	79, 979, 434				•
60. 00 06000 LABORATORY	316, 774	80, 717, 854			8, 418	
64. 00 06400 I NTRAVENOUS THERAPY	0	00,717,007			0	•
65. 00 06500 RESPI RATORY THERAPY	173, 266	13, 396, 698			5, 146	•
66. 00 06600 PHYSI CAL THERAPY	720, 202	11, 997, 527			6, 367	
67. 00 06700 OCCUPATI ONAL THERAPY	58, 894	3, 337, 172				•
68. 00 06800 SPEECH PATHOLOGY	13, 734	769, 399			401	
69. 00 06900 ELECTROCARDI OLOGY	260, 070	27, 828, 885			2, 845	
70. 00 07000 ELECTROENCEPHALOGRAPHY	126, 460	4, 878, 782			2, 045	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 945, 169	45, 743, 653			46, 578	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	293, 217				2, 159	
73. 00 07200 DRUGS CHARGED TO PATIENTS	911, 553					
		67, 241, 793				•
	42, 927	1, 472, 859			1, 511	
	326, 741	12, 263, 369			1, 818	•
76. 06 03330 I MAGI NG CENTER	222, 214	14, 593, 895			144	
76. 97 O7697 CARDI AC REHABI LI TATI ON	19, 463	1, 747, 302	0.01113	39 0	0	76.97
OUTPATIENT SERVICE COST CENTERS		0	0.0000			
90. 00 09000 CLINIC	0	0			0	
90. 01 04950 DI ABETI C CARE CENTER	0	0			0	
90. 02 04951 ANTI - COAGULATI ON CLINIC	12, 502	1, 092, 331			3	
90. 03 04952 PALLI ATI VE CARE	0	0	0.0000		0	
90. 04 04953 SPI NE CENTER	74, 966				0	
91.00 09100 EMERGENCY	1, 094, 497	138, 613, 254			9, 174	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	527,069		0. 06028	31 22, 273	1, 343	92.00
200.00 Total (lines 50 through 199)	12, 819, 348	852, 332, 229		11, 851, 240	175, 071	

Health Financial Systems	COMMUNI TY HOSPI	TAL SOUTH		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COSTS			Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 8/19/2020 1:5	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Nu Post-Stepdown Adjustments 1A	1.00	Allied Health Post-Stepdowr Adjustments 2A	Cost	All Other Medical Education Cost 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2/1	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY 200. 00 Total (Lines 30 through 199)	0 0 0	0 0 0 0		0 0 0 0 0 0 0 0	0 0 0 0	31.00
Cost Center Description	Adjustment (s Amount (see 1 instructions) mi	Total Costs sum of cols. through 3, inus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATI ENT ROUTI NE SERVI CE COST CENTERS30. 0003000ADULTS & PEDI ATRI CS31. 0003100INTENSI VE CARE UNI T43. 0004300NURSERY200. 00Total (Lines 30 through 199)	0	0 0 0 0	40, 32 2, 99 2, 82 46, 15	6 0.00 9 0.00	0 1, 718	•
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T 43. 00 04300 NURSERY 200. 00 Total (lines 30 through 199)						30.00 31.00 43.00 200.00

APPORT IOMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0128 Period: From 0/172019 To 12/31/201 Worksheet D Prot / V Date/Time Prepared: To 12/31/201 TITUE XIX Hospital PPS Title XIX Hospital PPS Title XIX Hospital PPS Title XIX Hospital Non Physician Nursing School	Health Financial Systems	COMMUNI TY HOSE	PITAL SOUTH		In Lie	u of Form CMS-:	2552-10
Cost Center Description Non Physic Lian Nursi ng School Nursi ng Schoo		RVICE OTHER PASS	Provider C	CN: 15-0128	From 01/01/2019	Part IV Date/Time Pre	
Anesthetist Post-Stepdown Post-Stepdown Adjustments Adjustments Adjustments 50.00 05000 OPERATING ROOM 0			Titl	e XIX	Hospi tal		•
Anesthetist Post-Stepdown Post-Stepdown Adjustments Adjustments Adjustments 50.00 05000 OPERATING ROOM 0	Cost Center Description	Non Physician	Nursing School	Nursina Scho	Allied Health	Allied Health	
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROM 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
ANCI LLARY SERVICE COST CENTERS 0 <t< td=""><td></td><td>Cost</td><td>Adjustments</td><td></td><td></td><td></td><td></td></t<>		Cost	Adjustments				
50. 00 0 <td></td> <td>1.00</td> <td>2A</td> <td>2.00</td> <td>3A</td> <td>3.00</td> <td></td>		1.00	2A	2.00	3A	3.00	
51.00 IST00 RECOVERY ROOM 0	ANCI LLARY SERVI CE COST CENTERS						
52:00 05200 DELIVERY ROOM & LABOR ROOM 0	50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
54.00 05400 RADI OLOGY-DI ACNOSTI C 0 0 0 0 0 0 0 0 0 0 55.00 0 55.00 0 <td>51.00 05100 RECOVERY ROOM</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>51.00</td>	51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
55.00 0500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 55.00 57.00 05700 CT SCAN 0 0 0 0 0 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MR1) 0 <	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)	0 0	0	52.00
57.00 05700 CT SCAN 0 0 0 0 0 0 57.00 58.00 05500 CARDIAC CATHETERIZATION 0 0 0 0 0 58.00 60.00 CARDIAC CATHETERIZATION 0	54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0 0	0	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 0 0 58.00 59.00 CARDIA C CATHETERI ZATION 0 <td>55. 00 05500 RADI OLOGY - THERAPEUTI C</td> <td>0</td> <td>0</td> <td>)</td> <td>0 0</td> <td>0</td> <td>55.00</td>	55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0)	0 0	0	55.00
59.00 05900 CARDI AC CATHETERI ZATI ON 0	57.00 05700 CT SCAN	0	0)	0 0	0	57.00
60.00 06000 LABORATORY 0	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0)	0 0	0	58.00
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 06700 0CUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 71.00 72.00 07200 INPL. DEV. CHARGED TO PATI ENTS 0 0 0 72.00 73.00 07400 RENAL DI ALYSIS 0 0 0 74.00 76.00 03300 INAGI NG CENTER 0 0 0 76.06 76.97 CAR	59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0)	0 0	0	59.00
65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 0CUPATI ONAL THERAPY 0 0 0 0 66.00 67.00 0CUPATI ONAL THERAPY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 70.00 OTOO ELECTROCARDI OLOGY 0 0 0 0 0 69.00 71.00 0700 ELECTROCARDE OLAGRAPHY 0 0 0 0 70.00 72.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 73.00 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 74.00 74.00 74.00 74.00 OTAOL RENAL DI ALYSI S 0 0 0 0 0 74.00 76.97 CARDI AC REHABI LI TATI ON 0 0 0 0	60. 00 06000 LABORATORY	0	0)	0 0	0	60.00
66.00 06600 PHYSICAL THERAPY 0 </td <td>64.00 06400 I NTRAVENOUS THERAPY</td> <td>0</td> <td>0</td> <td>)</td> <td>0 0</td> <td>0</td> <td>64.00</td>	64.00 06400 I NTRAVENOUS THERAPY	0	0)	0 0	0	64.00
67.00 06700 0CCUPATIONAL THERAPY 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 CELECTROCARDIOLOGY 0 0 0 0 69.00 70.00 FLECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 74.00 7400 RENAL DI ALYSI S 0 0 0 0 74.00 76.00 03301 IAGI NG CENTER 0 0 0 0 76.00 76.00 76.07 CARDI AC REHABILITATION 0 0 0 0 0 76.00 76.07 CARDI AC REHABILITATION 0 0 0 0 0 0 0 <t< td=""><td>65. 00 06500 RESPI RATORY THERAPY</td><td>0</td><td>0</td><td>)</td><td>0 0</td><td>0</td><td>65.00</td></t<>	65. 00 06500 RESPI RATORY THERAPY	0	0)	0 0	0	65.00
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 70.00 O7000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 REUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 76.00 03300 IMAGI NG CENTER 0 0 0 0 76.06 76.06 03330 IMAGI NG CENTER 0 0 0 0 76.07 0000 CLETTROENCE 0 0 0 0 0 90.00 00.00 00000 CLINI C 0 0 0 0 0 90.	66. 00 06600 PHYSI CAL THERAPY	0	0)	0 0	0	66.00
69.00 06900 ELECTROCARDIOLOGY 0<	67.00 06700 OCCUPATI ONAL THERAPY	0	0)	0 0	0	67.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 76.00 0 0 0 0 0 76.00	68.00 06800 SPEECH PATHOLOGY	0	0)	0 0	0	68.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 76.00 03950 ENDOSCOPY 0 0 0 0 0 76.00 76.00 03330 IMAGI NG CENTER 0 0 0 0 0 76.00 76.767 76797 CARDI AC REHABI LI TATI ON 0 0 0 0 0 76.97 00100 014950 DI ABETI C CARE CENTER 0 0 0 0 90.00 90.01 90.00 04950 DI ABETI C CARE CENTER 0 0 0 0 90.02 90.01 04950 DI ABETI C CARE CENTER 0 0 0 0 90.02 90.02 04951 NTI - COAGU	69. 00 06900 ELECTROCARDI OLOGY	0	0)	0 0	0	69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 74.00 76.00 03950 ENDOSCOPY 0 0 0 0 0 76.00 76.00 03330 IMAGING CENTER 0 0 0 0 0 76.00 76.07 76.97 CARDIAC REHABILITATION 0 0 0 0 0 76.97 0.00 09000 CLINIC 0 0 0 0 0 90.00 90.00 09000 CLINIC 0 0 0 0 90.01 90.01 04950 DI ABETIC CARE CENTER 0 0 0 0 90.02 90.02 04951 ANTI-COAGULATION CLINIC 0 0 0 0 90.02 90.03 04952 PALLIATIVE CARE 0 0	70.00 07000 ELECTROENCEPHALOGRAPHY	0	0)	0 0	0	70.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 74.00 76.00 03950 ENDOSCOPY 0 0 0 0 0 0 76.00 76.00 03330 IMAGI NG CENTER 0 0 0 0 0 76.00 76.07 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 76.06 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 76.06 76.97 04950 DI ABETI C CARE CENTERS 0 0 0 0 90.00 90.00 09000 CLINIC 0 0 0 0 90.00 90.01 90.01 04950 DI ABETI C CARE CENTER 0 0 0 0 90.02 90.02 04951 ANTI - COAGULATI ON CLI NI C 0 0 0 0 90.02 90	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
74.00 07400 RENAL DIALYSIS 0 0 0 0 74.00 76.00 03950 ENDOSCOPY 0 0 0 0 0 76.00 76.00 03330 IMAGING CENTER 0 0 0 0 0 76.00 76.00 03330 IMAGING CENTER 0 0 0 0 0 76.06 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 0 76.06 70.00 09000 CLINIC 0 0 0 0 0 90.00 90.00 09000 CLINIC 0 0 0 0 90.00 90.01 04950 IABETIC CARE CENTER 0 0 0 90.01 90.02 04951 ANTI-COAGULATION CLINIC 0 0 0 90.02 90.03 04952 PALLIATIVE CARE 0 0 0 0 90.02 90.04 04953 SPINE CENTER 0 0 0 90.04 9	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
76.00 03950 ENDOSCOPY 0 0 0 0 0 76.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.06 03330 IMAGING CENTER 0 0 0 0 0 0 0 0 76.06 70.06 70.06 <th< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>74.00</td></th<>		0	0		0 0	0	74.00
76.97 07697 CARDI AC REHABILITATION 0 0 0 0 0 0 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 0<		0	0		0 0	0	76.00
OUTPATI ENT SERVICE COST CENTERS 90.00 O9000 CLINIC 0 0 0 0 0 0 90.00 90.10 04950 DLABETIC CARE CENTER 0 0 0 0 0 0 90.01 90.20 04951 ANTI-COAGULATION CLINIC 0 0 0 0 0 90.02 90.30 04952 PALLIATIVE CARE 0 0 0 0 90.03 90.4953 PINE CENTER 0 0 0 90.03 90.04 99.02 90.03 90.04 90.03 91.00 90.03 90.04 90.03 91.00 90.03 91.00 90.04 92.00 0 0 0 0 90.04 92.00 92.00 0 92.00 0 92.00 0 92.00	76.06 03330 I MAGI NG CENTER	0	0		0 0	0	76.06
90.00 09000 CLINIC 0 0 0 0 0 90.00 90.01 04950 DIABETIC CARE CENTER 0 0 0 0 0 90.01 90.02 04951 ANTI-COAGULATION CLINIC 0 0 0 0 0 90.02 90.03 04952 PALLIATIVE CARE 0 0 0 0 90.03 90.04 04953 SPINE CENTER 0 0 0 90.04 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00		0	0		0 0	0	76.97
90.01 04950 DI ABETI C CARE CENTER 0 0 0 0 90.01 90.02 04951 ANTI - COAGULATI ON CLINIC 0 0 0 0 90.02 90.03 04952 PALLI ATI VE CARE 0 0 0 0 90.03 90.04 04953 SPI NE CENTER 0 0 0 0 90.04 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92.00							
90. 02 04951 ANTI-COAGULATION CLINIC 0 0 0 90. 02 90. 03 04952 PALLIATIVE CARE 0 0 0 0 90. 03 90. 04 04953 SPINE CENTER 0 0 0 0 90. 04 91. 00 09100 EMERGENCY 0 0 0 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00		0	0		0 0	-	
90.03 04952 PALLIATIVE CARE 0 0 0 0 90.03 90.04 04953 SPINE CENTER 0 0 0 0 90.04 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00		0	0		0 0	0	
90. 04 04953 SPINE CENTER 0 0 0 0 90. 04 91. 00 09100 EMERGENCY 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92. 00		0	0		0 0	0	
91.00 09100 EMERGENCY 0 0 0 91.00 91.00 92.00 0 92.00 0 0 0 0 92.00 0 92.00 0 0 0 0 0 92.00 0 92.00 0 0 0 0 0 0 0 92.00		0	0		0 0	0	90.03
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 92. 00	90. 04 04953 SPI NE CENTER	0	0		0 0	0	90.04
		0	0		0 0	-	
200 001 Total (Lines 50 through 199) 01 01 01 01 01 01 01200 00		0			0	-	
	200.00 Total (lines 50 through 199)	0	0	1	0 0	0	200. 00

	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		PITAL SOUTH	°N- 15_0128	Peri od:	eu of Form CMS-2 Worksheet D	2552-1
	H COSTS	VICE UTIER FAS.	FIOVICEIC		From 01/01/2019		
INKUUG	H C0313				To 12/31/2019	Date/Time Pre	pared:
						8/19/2020 1:5	3 pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	F 00	(00	7.00	instructions)	
	ANCILLADY SEDVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
50.00	ANCILLARY SERVICE COST CENTERS	0	C	1	0 114, 478, 882	0.000000	50.00
50.00	05100 RECOVERY ROOM	0	-		0 114, 478, 882 0 38, 651, 555		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0					
		0					
54.00	05400 RADI OLOGY-DI AGNOSTI C	0			0 34, 499, 662		
55.00	05500 RADI OLOGY-THERAPEUTI C	0			0 21, 086, 673		
57.00	05700 CT SCAN	0			0 64, 223, 374		
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 11, 568, 422		
9.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 79, 979, 434		
50.00	06000 LABORATORY	0	0		0 80, 717, 854		
54.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	01000000	
55.00	06500 RESPI RATORY THERAPY	0	C		0 13, 396, 698		
6. 00	06600 PHYSI CAL THERAPY	0	0		0 11, 997, 527		
57.00	06700 OCCUPATI ONAL THERAPY	0	C		0 3, 337, 172		
68.00	06800 SPEECH PATHOLOGY	0	0		0 769, 399		
9.00	06900 ELECTROCARDI OLOGY	0	0		0 27, 828, 885		
0.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 4, 878, 782		
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 45, 743, 653		
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 34, 263, 581		
3.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 67, 241, 793		
4.00	07400 RENAL DIALYSIS	0	0		0 1, 472, 859		
6. 00	03950 ENDOSCOPY	0	0		0 12, 263, 369		
6. 06	03330 I MAGI NG CENTER	0	-		0 14, 593, 895		
6. 97	07697 CARDIAC REHABILITATION	0	0		0 1, 747, 302	0.00000	76.9
	OUTPATIENT SERVICE COST CENTERS	_					
0.00	09000 CLI NI C	0			0 0		
0. 01	04950 DI ABETI C CARE CENTER	0			0 0	0. 000000	
0. 02	04951 ANTI-COAGULATION CLINIC	0	0		0 1, 092, 331	0. 000000	
0. 03	04952 PALLI ATI VE CARE	0	0		0 0		
0.04	04953 SPI NE CENTER	0	0		0 287, 410		
1.00	09100 EMERGENCY	0	0		0 138, 613, 254		
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0 8, 743, 559	0.000000	92.0
200.00	Total (lines 50 through 199)	0	0		0 852, 332, 229		200. 0

Health Financial Systems	COMMUNI TY HOSP	ITAL SOUTH		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA	RVICE OTHER PASS	Provider C	CN: 15-0128	Period: From 01/01/2019	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2019	Date/Time Pre	pared:
					8/19/2020 1:5	3 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Outpatient	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Costs (col.	n Charges before 8 Geo	Charges on/after Geo	
	(col. 6 ÷ col. 7)		x col 10)		Reclassi fi cati	
	/)			on	on	
	9.00	10.00	11.00	12.00	12.01	
ANCI LLARY SERVI CE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10100	11100	12100	1 12101	
50. 00 05000 OPERATI NG ROOM	0.000000	1, 117, 535		0 0	0 0	50.00
51.00 05100 RECOVERY ROOM	0.000000	384, 023		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	219, 802		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	304, 100		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.000000	164, 499		0 0	0	55.00
57.00 05700 CT SCAN	0. 000000	666, 590		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	158, 319		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 269, 439		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	2, 145, 335		0 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	397, 917		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	106, 060		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	50, 948		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	22, 478		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	304, 440		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	21, 378		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 095, 357		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	252, 225		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 856, 934		0 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0. 000000	51, 837		0 0	0	74.00
76.00 03950 ENDOSCOPY	0. 000000	68, 220		0 0	0	76.00
76.06 03330 I MAGI NG CENTER	0. 000000	9, 443		0 0		76.06
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0. 000000	0		0 0	0 0	76.97
90. 00 09000 CLINIC	0, 000000	0		0 0	0	90.00
90. 01 04950 DI ABETI C CARE CENTER	0. 000000	0			-	90.00
90. 02 04951 ANTI -COAGULATI ON CLINIC	0. 000000	242			0	90.01
90. 03 04952 PALLI ATI VE CARE	0. 000000	242			0	90.02
90. 04 04953 SPINE CENTER	0. 000000	0		0 0	0	90.04
91. 00 09100 EMERGENCY	0. 000000	1, 161, 846		0 0		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	22, 273		0 0	-	
200.00 Total (lines 50 through 199)		11, 851, 240		0 0		200.00
				1		

DRORT	Financial Systems	COMMUNITY HOSPITAL SOUTH RVICE OTHER PASS Provider CCN: 15-0128			In Lieu of Form CMS-2		
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEN H COSTS	RVICE OTHER PASS	Provider CC	CN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Pr 8/19/2020 1:	epared: 53 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before Geo Recl assi fi cati f	x col. 12) on/after Geo				
		on	on				
		13.00	13.01				
	ANCI LLARY SERVICE COST CENTERS						-
	05000 OPERATING ROOM	0	0				50.0
	05100 RECOVERY ROOM	0	0				51.0
	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.0
1	05400 RADI OLOGY -DI AGNOSTI C	0	0				54.0
	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	0	0				55. C
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.0
	05900 CARDI AC CATHETERI ZATI ON	0	0				59.0
	06000 LABORATORY	0	0				60.0
1	06400 I NTRAVENOUS THERAPY	0	0				64.0
1	06500 RESPI RATORY THERAPY	0	0				65.0
1	06600 PHYSI CAL THERAPY	0	0				66.0
	06700 OCCUPATI ONAL THERAPY	0	0				67.0
	06800 SPEECH PATHOLOGY	0	0				68.0
9.00	06900 ELECTROCARDI OLOGY	0	0				69.0
0. 00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.0
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. (
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.0
	07300 DRUGS CHARGED TO PATIENTS	0	0				73.
	07400 RENAL DIALYSIS	0	0				74.
6.00	03950 ENDOSCOPY	0	0				76.
1	03330 I MAGI NG CENTER	0	0				76.
- F	07697 CARDI AC REHABI LI TATI ON	0	0				76.
	OUTPATIENT SERVICE COST CENTERS	1 1					_
	09000 CLINIC	0	0				90.
	04950 DI ABETI C CARE CENTER	0	0				90.
	04951 ANTI-COAGULATION CLINIC	0	0				90.
	04952 PALLIATIVE CARE	0	0				90.
	04953 SPINE CENTER	0	0				90.
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				91.0
	UYZUUIUDJERVAITUN BEDJ (NUN-DISTINUT PART)	0	0				92.0

APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider C	CN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 8/19/2020 1:5	
			Titl	e XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins	. Ded. & Coins.		
				(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATING ROOM	0. 115365				0	
51.00	05100 RECOVERY ROOM	0. 158366	C	479, 21	10 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 329440	0		0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 133712	C	1, 071, 74	42 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 085722	C	455, 58	39 0	0	55.00
57.00	05700 CT SCAN	0. 039920	0	2, 431, 13	30 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 072124	0	222, 73	34 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 071459	0	390, 10	0 80	0	59.00
60.00	06000 LABORATORY	0. 112007	0	2,002,50	68 0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	C		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 266654		65, 9	71 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 374977	0	95, 02	21 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 317062				0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 318150				0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 084781				0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 297101		29, 7		0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0, 461388				0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 391245	0			0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 247941				0	73.00
74.00	07400 RENAL DIALYSIS	0. 460621			0 0	0	
76.00	03950 ENDOSCOPY	0. 147864				0	
76.06	03330 I MAGI NG CENTER	0. 150424				0	
76.97	07697 CARDI AC REHABI LI TATI ON	0. 286127			05 0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	C		0 0	0	90.00
90.01	04950 DIABETIC CARE CENTER	0. 000000			0 0	0	
90.02	04951 ANTI - COAGULATI ON CLINIC	0. 432498		14, 3		0	
90.03	04952 PALLIATIVE CARE	0. 000000			0 0	0	
90.04	04953 SPI NE CENTER	1. 199210			0 0	0	
91.00	09100 EMERGENCY	0. 100727				0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 799983		-,,		0	
200.00		0. , , , , , , , , 0.5					200.00
200.00				10, 072, 00	0 0	0	201.00
201.00	Only Charges						201.00

Health Financial Systems	COMMUNITY HOS	SPITAL SOUTH		In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pro 8/19/2020 1:5	
		Ti †I	e XIX	Hospi tal	PPS	
	Co	sts		incopri tur		
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS		1	1			
50.00 O5000 OPERATING ROOM	100, 793					50.00
51.00 05100 RECOVERY ROOM	75, 891					51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	-				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	143, 305					54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	39,054					55.00
57. 00 05700 CT SCAN	97, 051					57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	16, 064					58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	27,877					59.00 60.00
64.00 06400 INTRAVENOUS THERAPY	224, 302					64.00
65. 00 06500 RESPIRATORY THERAPY	17, 591					65.00
66. 00 06600 PHYSI CAL THERAPY	35, 631					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	4, 312					67.00
68. 00 06800 SPEECH PATHOLOGY	2, 321					68.00
69. 00 06900 ELECTROCARDI OLOGY	19, 735					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	8, 830					70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	305, 228					71.00
72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS	76, 316					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	92,044					73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76.00 03950 ENDOSCOPY	18, 111	0				76.00
76.06 03330 I MAGI NG CENTER	25, 079	0				76.06
76. 97 07697 CARDI AC REHABI LI TATI ON	173	0				76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0					90.00
90. 01 04950 DI ABETI C CARE CENTER	0					90.01
90.02 04951 ANTI-COAGULATION CLINIC	6, 215					90.02
90. 03 04952 PALLI ATI VE CARE	0					90.03
90. 04 04953 SPI NE CENTER	0	l o				90.04
91. 00 09100 EMERGENCY	869, 694					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 210					92.00
200.00 Subtotal (see instructions)	2, 209, 827					200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
0nl y Charges 202.00 Net Charges (line 200 - line 201)	2, 209, 827	0				202.00
	2,207,027	1 0	I			1202.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre	
		Title XVIII	Hospi tal	8/19/2020 1:5 PPS	
	Cost Center Description			FF3	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed day			40, 325	
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room days	40, 325 0	
00	do not complete this line.	iys). Thi you have only pr	rvate room days,	0	J .
00	Semi-private room days (excluding swing-bed and observation b			34, 871	
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decembe	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			_	_
00	Total swing-bed NF type inpatient days (including private roo reporting period	om days) through December	- 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private roo	m davs) after December 3	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)	-			
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	the Program (excluding	g swing-bed and	11, 942	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	room days)	0	10
	through December 31 of the cost reporting period (see instruc	tions)	5 1		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
	through December 31 of the cost reporting period				
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
00	Medically necessary private room days applicable to the Progr			0	14
00	Total nursery days (title V or XIX only)			0	15
. 00	Nursery days (title V or XIX only)			0	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost	0.00	17
	reporting period	Ū.			
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	the cost	0.00	20
	reporting period	,			
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting pariod (line	51, 716, 429 0	
. 00	5 x line 17)	ier st of the cost report	ing period (inte	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	n period (line 8	0	25
. 00	x line 20)			0	25
	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		51, 716, 429	27
. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	28
	Private room charges (excluding swing-bed charges)		5.07	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ line 28)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 20 ÷ line 3)			0.00	
	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 51, 716, 429	
. 50	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			1 202 40	1 20
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 282. 49 15, 315, 496	
	Medically necessary private room cost applicable to the Progr			13, 313, 470	
	Total Program general inpatient routine service cost (line 39			15, 315, 496	1 11

	- Financial Systems TION OF INPATIENT OPERATING COST	COMMUNI TY HOSP	ITAL SOUTH Provider CO	CN: 15-0128	In Lie Period:	u of Form CMS- Worksheet D-1	
					From 01/01/2019 To 12/31/2019		epared:
	Cost Center Description	Total Inpatient Costli 1.00	Total	XVIII Average Per Diem (col. 1 col. 2) 3.00	Hospital Program Days ÷ 4.00	PPS Program Cost (col. 3 x col. 4) 5.00	
42.00 N	NURSERY (title V & XIX only)	0	0				42.00
	ntensive Care Type Inpatient Hospital Units	7 005 055	0.00/	0 (00 (1 1 2 2	0.005.0/5	1 40 00
44.00 C 45.00 B 46.00 S	NTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT DTHER SPECIAL CARE (SPECIFY) Cost Center Description	7, 905, 255	2, 996	2, 638. 6	0 1, 139	3, 005, 365	43.00 44.00 45.00 46.00 47.00
	•					1.00	
	Program inpatient ancillary service cost (Wks					22, 758, 076	
	<u>Fotal Program inpatient costs (sum of lines 4</u> ASS THROUGH COST ADJUSTMENTS	1 through 48)(s	ee instructio	ns)		41, 078, 937	49.00
	Pass through costs applicable to Program inpa	ntient routine s	ervices (from	Wkst. D. sum	of Parts L and	1, 566, 325	50.00
	II)					.,,	
	Pass through costs applicable to Program inpa	ntient ancillary	services (fr	om Wkst. D, s	um of Parts II	1, 908, 773	51.00
	and IV) Fotal Program excludable cost (sum of lines 5	(0, and, 51)				3, 475, 098	52.00
53.00 T	Fotal Program inpatient operating cost excluc nedical education costs (line 49 minus line 5	ling capital rela	ated, non-phy	sician anesth	etist, and	37, 603, 839	
	ARGET AMOUNT AND LIMIT COMPUTATION					0	1 54 00
	Program discharges Farget amount per discharge					0 0.00	
	Farget amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	ine 56 minus	line 53)	0	57.00
1	Bonus payment (see instructions)					0	
m	Lesser of lines 53/54 or 55 from the cost rep narket basket	0.1	0		mpounded by the		
61.00 I w	Lesser of lines 53/54 or 55 from prior year of fline 53/54 is less than the lower of lines which operating costs (line 53) are less thar amount (line 56), otherwise enter zero (see i	55, 59 or 60 e expected costs	nter the less	er of 50% of		0. 00 0	
62.00 R	Allowable Inpatient cost plus incentive payment		tions)			0	
	ROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	s through Decem	ber 31 of the	cost reporti	ng period (See	0	64.00
i	nstructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost					0	
66.00 T	nstructions)(title XVIII only) Fotal Medicare swing-bed SNF inpatient routir	ne costs (line 6	4 plus line 6	5)(title XVII	l only). For	0	66.00
67.00 T	CAH (see instructions) Fitle V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost re	porting period	0	67.00
68.00 T	(line 12 x line 19) Fitle V or XIX swing-bed NF inpatient routine	e costs after De	cember 31 of	the cost repo	rting period	0	68.00
69.00 T	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient r			,		0	69.00
	ART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70.00
	Adjusted general inpatient routine service co						71.00
	Program routine service cost (line 9 x line 7			,			72.00
	Medically necessary private room cost applica	0	•				73.00
75.00 C	Fotal Program general inpatient routine servi Capital-related cost allocated to inpatient r				art II, column		74.00 75.00
	26, line 45) Per diem capital-related costs (line 75 ÷ lir	ne 2)					76.00
	Program capital -related costs (line 9 x line						77.00
1	npatient routine service cost (line 74 minus						78.00
1	Aggregate charges to beneficiaries for excess				uc line 70		79.00
	Fotal Program routine service costs for compa npatient routine service cost per diem limit		st inmitation	(IINE /8 MIN	us ITTIE /9)		80.00 81.00
	npatient routine service cost per drem rimit						82.00
	Reasonable inpatient routine service costs (s						83.00
	Program inpatient ancillary services (see ins						84.00
	Jtilization review - physician compensation (85.00 86.00
85.00 U							1 00.UU
85.00 U 86.00 T	Total Program inpatient operating costs (sum		ougn 85)				
85.00 U 86.00 T P.		THROUGH COST	ough 85)			5, 454	
85.00 U 86.00 T 87.00 T 88.00 A	Fotal Program inpatient operating costs (sum ART IV - COMPUTATION OF OBSERVATION BED PASS	Iiem (line 27 ÷				5, 454 1, 282. 49 6, 994, 700	87.00 88.00

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1		
				From 01/01/2019 To 12/31/2019			
		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	3, 896, 986	51, 716, 429	0. 07535	3 6, 994, 700	527, 072	90.00	
91.00 Nursing School cost	0	51, 716, 429	0.00000	0 6, 994, 700	0	91.00	
92.00 Allied health cost	0	51, 716, 429	0.00000	0 6, 994, 700	0	92.00	
93.00 All other Medical Education	0	51, 716, 429	0. 00000			93.00	

OMPUT	Financial Systems COMMUNITY HOSE ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1	
		Title XIX	Hospi tal	Date/Time Pre 8/19/2020 1:5 PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	ays, excluding newborn)		40, 325	1 1
00 00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed	g-bed and newborn days)	ivate room days,	40, 325 0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation			34, 871	4
00	Total swing-bed SNF type inpatient days (including private reporting period			0	5
00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	5.		0	
00	Total swing-bed NF type inpatient days (including private reporting period	oom days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	oom days) after December 3	1 of the cost	0	8
00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the Program (excluding	swing-bed and	1, 554	9
00	Swing-bed SNF type inpatient days applicable to title XVIII through December 31 of the cost reporting period (see instru		oom days)	0	10
00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,	only (including private r	oom days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or 3 through December 31 of the cost reporting period		e room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or 3 after December 31 of the cost reporting period (if calendar			0	13
00	Medically necessary private room days applicable to the Pro Total nursery days (title V or XIX only)			0 2, 829	14
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			1, 718	
. 00	Medicare rate for swing-bed SNF services applicable to servi	ices through December 31 c	f the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to servi	ices after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	ces through December 31 of	the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service reporting period	ces after December 31 of t	he cost	0.00	20
. 00 . 00	Total general inpatient routine service cost (see instructi Swing-bed cost applicable to SNF type services through Dece		ing pariod (line)	53, 169, 633 0	
	5 x line 17) Swing-bed cost applicable to SNF type services after Decemb		51 (0	
	x line 18)				
	Swing-bed cost applicable to NF type services through Decemi 7 x line 19)		0 1 1		24
	Swing-bed cost applicable to NF type services after December x line 20)	i si oi the cost reporting	period (Tine 8		25
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	t (line 21 minus line 26)		0 53, 169, 633	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-	bed and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 2)	$7 \cdot 100 28$		0 0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)	· · · · · · · · · · · · · · · · · · ·		0.000000	1
	Average semi-private room per diem charge (line 30 ÷ line 4))		0.00	
00	Average per diem private room charge differential (line 32 i		tions)	0.00	
00	Average per diem private room cost differential (line 34 x			0.00	
00 00	Private room cost differential adjustment (line 3 x line 35 General inpatient routine service cost net of swing-bed cos		fferential (line	0 53, 169, 633	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST A				1
. 00	Adjusted general inpatient routine service cost per diem (se			1, 318. 53	
	Drogram general inpatient routing convice cost (line 0 v li	ng 38)		2, 048, 996	39
. 00 . 00	Program general inpatient routine service cost (line 9 x lin Medically necessary private room cost applicable to the Prov	-		2,048,990	1

OMPUT	Financial Systems FATION OF INPATIENT OPERATING COST		PITAL SOUTH Provider CO	CN: 15-0128	Peri od:	eu of Form CMS- Worksheet D-1	
					From 01/01/2019 To 12/31/2019		
				e XIX	Hospi tal	8/19/2020 1:5 PPS	53 pm
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Costl	npatient Days		÷	(col. 3 x col.	
		1.00	2.00	<u>col. 2)</u> 3.00	4.00	4)	
2.00	NURSERY (title V & XIX only)	1, 343, 566	2, 829	474.9) 42.
	Intensive Care Type Inpatient Hospital Units						
3.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	7, 966, 075	2, 996	2, 658.9	90 0	C	
1.00 5.00	BURN INTENSIVE CARE UNIT						44.
5.00							46.
. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			2, 122, 106	5 48.
. 00	Total Program inpatient costs (sum of lines			ns)		4, 987, 032	
	PASS THROUGH COST ADJUSTMENTS						
0. 00	Pass through costs applicable to Program inp	atient routine s	services (trom	WKST. D, SUR	n of Parts I and	214, 810	50.
I. 00	Pass through costs applicable to Program inp	atient ancillary	/ services (fr	om Wkst. D, s	sum of Parts II	175, 071	1 51.
	and IV)						
2.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		atod non ator		notict and	389, 881 4, 597, 151	
3.00	medical education costs (line 49 minus line	5 1	ated, non-phy	si ci an anesti	ietist, and	4, 597, 151	1 53.
	TARGET AMOUNT AND LIMIT COMPUTATION						
. 00	5					C	
. 00 . 00	5					0.00	
. 00	Difference between adjusted inpatient operat	ing cost and tar	rget amount (l	ine 56 minus	line 53)		
. 00	Bonus payment (see instructions)	ing obse and tar	got amount (i		11110 00)	C	
9.00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ending 1996, u	pdated and co	ompounded by the	0.00	59.
). 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report und	lated by the m	arkat haskat		0.00	60.
1.00	If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less that	n expected costs					
	amount (line 56), otherwise enter zero (see	instructions)					
2.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)) 62.) 63.
	PROGRAM INPATIENT ROUTINE SWING BED COST						
1.00	5	ts through Decem	nber 31 of the	cost reporti	ng period (See	C	64.
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decombo	or 21 of the c	ost roporting	n pariod (Saa	(65.
5. 00	instructions) (title XVIII only)	ts after becenbe		σειτεροιτιτή	j period (see		05.
5.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line é	64 plus line 6	5)(title XVII	l only). For	C	66.
7 00	CAH (see instructions)	a agata through	December 21 a	f the east m	norting pariod		
7.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 0	r the cost re	eporting period		67.
3. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost repo	orting period	C	68.
	(line 13 x line 20)						
₽.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					C) 69.
0. 00	Skilled nursing facility/other nursing facil						70.
. 00	Adjusted general inpatient routine service c	2					71.
2.00	Program routine service cost (line 9 x line		()	25)			72.
3. 00 1. 00	Medically necessary private room cost applic Total Program general inpatient routine serv	0	•	ne 35)			73.
5.00	Capital -related cost allocated to inpatient	•		orksheet B, A	Part II, column		75.
	26, line 45)						
00	Per diem capital -related costs (line 75 ÷ li					ł	76.
. 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu					1	77
. 00	Aggregate charges to beneficiaries for exces		rovi der record	s)		1	79
. 00	Total Program routine service costs for comp	arison to the co		,	nus line 79)	1	80
. 00	Inpatient routine service cost per diem limi						81
. 00 . 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (ł	82
. 00	Program inpatient ancillary services (see in		»)			1	83
	Utilization review - physician compensation		ıs)			l	85
6. 00			ough 85)			L	86.
7.00	PART IV - COMPUTATION OF OBSERVATION BED PAS: Total observation bed days (see instructions					5, 454	1 87.
B. 00	Adjusted general inpatient routine cost per		line 2)			1, 318. 53	
5.00							

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019	Date/Time Pre 8/19/2020 1:5	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	3, 896, 986	53, 169, 633	0. 07329	3 7, 191, 263	527, 069	90.00
91.00 Nursing School cost	0	53, 169, 633	0.00000	7, 191, 263	0	91.00
92.00 Allied health cost	0	53, 169, 633	0.00000	7, 191, 263	0	92.00
93.00 All other Medical Education	0	53, 169, 633	0.00000	7, 191, 263	0	93.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0128	Period:	Worksheet D-3	5
			From 01/01/2019		
			To 12/31/2019	Date/Time Pre 8/19/2020 1:5	
	Title	e XVIII	Hospi tal	PPS	is pili
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
		J		(col. 1 x col.	
			5	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
D. 00 03000 ADULTS & PEDIATRICS			25, 852, 546		30.0
1.00 03100 INTENSIVE CARE UNIT			4, 032, 163		31.0
3. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS					
D. 00 05000 OPERATI NG ROOM		0. 11466			
1.00 05100 RECOVERY ROOM		0. 15836		771, 403	
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 32944		-	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1337			54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C		0.08572	3, 212, 198	275, 356	55.0
7.00 05700 CT SCAN		0. 03992	20 6, 446, 818	257, 357	57.0
B. OO 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 07212	24 1, 198, 991	86, 476	58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.07145	59 11, 874, 750	848, 558	59.0
D. 00 06000 LABORATORY		0. 11200	07 17, 094, 129	1, 914, 662	60.0
4. 00 06400 I NTRAVENOUS THERAPY		0.0000	0 0	0	64.0
5. 00 06500 RESPI RATORY THERAPY		0. 26665	54 3, 939, 792	1, 050, 561	65.0
5. 00 06600 PHYSI CAL THERAPY		0. 37246	59 1, 686, 774	628, 271	66.0
7. 00 06700 OCCUPATI ONAL THERAPY		0. 31706	52 1, 096, 961	347, 805	67.0
3. 00 06800 SPEECH PATHOLOGY		0. 31815	50 272, 429	86, 673	68.0
9. 00 06900 ELECTROCARDI OLOGY		0. 08478	3, 601, 082	305, 303	69.0
D. 00 07000 ELECTROENCEPHALOGRAPHY		0. 29303	36 112, 740	33, 037	70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 46138	8, 200, 719	3, 783, 713	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 39124	45 8, 132, 140	3, 181, 659	72.0
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 24794	14, 208, 684	3, 522, 915	73.0
4. 00 07400 RENAL DIALYSIS		0. 46062	822, 006	378, 633	74.0
5. 00 03950 ENDOSCOPY		0. 14786	54 25, 216	3, 729	76.0
5. 06 03330 I MAGI NG CENTER		0. 15042	24 50, 448	7, 589	76.0
5. 97 07697 CARDI AC REHABI LI TATI ON		0. 28612	27 586	168	76.9
OUTPATIENT SERVICE COST CENTERS					
D. 00 09000 CLINIC		0.00000	0 0	0	90.0
D. 01 04950 DI ABETI C CARE CENTER		0.00000	0 0	0	90.0
D. 02 04951 ANTI-COAGULATION CLINIC		0. 43249	98 0	0	90.0
D. 03 04952 PALLI ATI VE CARE		0.0000	0 00	0	90.0
D. 04 04953 SPI NE CENTER		1. 1992	10 0	0	90.0
1. 00 09100 EMERGENCY		0.09955	54 11, 530, 431	1, 147, 901	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 79998	33 1, 408, 903	1, 127, 098	92.0
DO.00 Total (sum of lines 50 through 94 and 96 through 98)			125, 484, 933	22, 758, 076	200. 0
01.00 Less PBP Clinic Laboratory Services-Program only char	ges (line 61)		0		201.0
02.00 Net charges (line 200 minus line 201)			125, 484, 933		202.0

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0128	Peri od:	Worksheet D-3	;
			From 01/01/2019		
			To 12/31/2019	Date/Time Pre	
	T: +1	e XIX	Hospi tal	8/19/2020 1:5 PPS	o3 pm
Cost Center Description	1111	Ratio of Cos		Inpatient	
Cost center bescription		To Charges	Program	Program Costs	
		10 charges	Charges	$(col \cdot 1 \times col \cdot 1)$	
			onar ges	2)	
		1.00	2.00	3.00	<u> </u>
INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00 03000 ADULTS & PEDIATRICS			5, 394, 764		30.0
. 00 03100 INTENSIVE CARE UNIT			517, 528		31.0
3. 00 04300 NURSERY			256, 603		43.0
ANCI LLARY SERVI CE COST CENTERS					
0. 00 05000 OPERATING ROOM		0. 11536		128, 924	
00 05100 RECOVERY ROOM		0. 15836			
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 32944		72, 412	
I. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1337		40, 662	
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 08572		14, 101	
7. 00 05700 CT SCAN		0. 03992		26, 610	
3. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 07212		11, 419	
2. 00 05900 CARDI AC CATHETERI ZATI ON		0.0714			
0. 00 06000 LABORATORY		0. 11200		240, 293	
I. 00 06400 INTRAVENOUS THERAPY		0.0000		0	
5. 00 06500 RESPI RATORY THERAPY		0. 2666		106, 106	
5. 00 06600 PHYSI CAL THERAPY		0. 3749		39, 770	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 3170		16, 154	
3. 00 06800 SPEECH PATHOLOGY		0. 3181		7, 151	
2. 00 06900 ELECTROCARDI OLOGY		0.08478		25, 811	
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 29710			
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.46138		505, 385	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 39124		98, 682	
8. 00 07300 DRUGS CHARGED TO PATIENTS		0. 24794		460, 410	
I. 00 07400 RENAL DI ALYSI S 5. 00 03950 ENDOSCOPY		0.46062		23, 877	
		0. 14780		10, 087	
 b. 06 03330 I MAGI NG CENTER b. 97 07697 CARDI AC REHABI LI TATI ON 		0. 15042 0. 28612		1, 420 0	
OUTPATIENT SERVICE COST CENTERS		0.2801.	27 0	0	/0.9
0. 00 09000 CLINIC		0.0000	0 00	0	90.0
0. 01 04950 DI ABETI C CARE CENTER		0.00000		0	
). 02 04951 ANTI-COAGULATION CLINIC		0. 43249		105	
0. 03 04952 PALLI ATI VE CARE		0. 00000		0	
0. 04 04953 SPINE CENTER		1. 1992		0	
00 09100 EMERGENCY		0. 10072		117, 029	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 79998		17,818	
00.00 Total (sum of lines 50 through 94 and 96 through 98			11, 851, 240		
01.00 Less PBP Clinic Laboratory Services-Program only ch			n, 001, 240	2, 122, 100	200.0
22.00 Net charges (line 200 minus line 201)	300 (1110 01)	1	11, 851, 240		202. 0

	Financial Systems COMMUNITY HOSPIT	AL SOUTH Provider CCN: 15-0128	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
CALCUL			From 01/01/2019 To 12/31/2019	Part A Date/Time Prep 8/19/2020 1:53	
		Title XVIII	Hospi tal	PPS	
			Before GEO Reclass	On/After GEO Reclass	
			1.00	1.01	
1.00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments		0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurri	ng prior to October 1	21, 779, 931	0	1.01
1.02	(see instructions) DRG amounts other than outlier payments for discharges occurri	ng on or after October	1 0	6, 974, 605	1.02
1 02	(see instructions)	r di cohorgoo coourri ra		0	1 02
1.03	DRG for federal specific operating payment for Model 4 BPCI fo prior to October 1 (see instructions)	r discharges occurring	0	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI fo on or after October 1 (see instructions)	r di scharges occurri ng	0	0	1.04
2.00	Outlier payments for discharges. (see instructions)				2.00
2.01	Outlier reconciliation amount	onc)	0	0	2.01
2.02 2.03	Outlier payment for discharges for Model 4 BPCI (see instructi Outlier payments for discharges occurring prior to October 1 (-	562, 143	0	2.02 2.03
2.04	Outlier payments for discharges occurring on or after October	1 (see instructions)	0	99, 435	2.04
3.00 4.00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repor	ting period (see	9, 288, 571 153. 04	3, 506, 011	3.00 4.00
	instructions)				
5.00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent cost reporting	0.00		5.00
	period ending on or before 12/31/1996. (see instructions)				
6.00	FTE count for allopathic and osteopathic programs that meet th to the cap for new programs in accordance with 42 CFR 413.79(e		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified u	nder 42 CFR	0.00		7.00
7.01	<pre>\$412.105(f)(1)(iv)(B)(1) ACA § 5503 reduction amount to the IME cap as specified under</pre>	42 CFR	0.00		7.01
	412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1,	2011 then see			
8.00	instructions. Adjustment (increase or decrease) to the FTE count for allopat	hic and osteopathic	6. 21		8.00
	programs for affiliated programs in accordance with 42 CFR 413				
8.01	413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 The amount of increase if the hospital was awarded FTE cap slo		0.00		8. 01
8. 02	ACA. If the cost report straddles July 1, 2011, see instructio The amount of increase if the hospital was awarded FTE cap slo		0.00		8. 02
0.02	teaching hospital under § 5506 of ACA. (see instructions)	ts from a crosed	0.00		0.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line (see instructions)	s (8, 8,01 and 8,02)	6. 21		9.00
10. 00	FTE count for all opathic and osteopathic programs in the curre	nt year from your	6.38		10.00
11.00	records FTE count for residents in dental and podiatric programs.		1.36		11.00
12.00	Current year allowable FTE (see instructions)		7.57		12.00
13.00 14.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that yea	r ended on or after	7.54 6.88		13.00 14.00
14.00	September 30, 1997, otherwise enter zero.				
15.00 16.00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program		7.33 0.00		15.00 16.00
17.00	Adjustment for residents displaced by program or hospital clos	ure	0.00		17.00
18. 00 19. 00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4)		7. 33 0. 047896		18.00 19.00
20.00	Prior year resident to bed ratio (see instructions)		0. 048601		20.00
21.00 22.00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)		0. 047896 562, 423	180, 105	21.00 22.00
22.00	IME payment adjustment - Managed Care (see instructions)		239, 859	90, 536	
22.00	Indirect Medical Education Adjustment for the Add-on for § 422		0.00		
23.00	Number of additional allopathic and osteopathic IME FTE reside CFR 412.105 (f)(1)(iv)(C).	nt cap slots under 42	0.00		23.00
24.00 25.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the L	ower of line 22 or line	0. 17 0. 00		24.00 25.00
25.00	24 (see instructions)	ower of the 23 of the	0.00		25.00
26.00 27.00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)		0. 000000 0. 000000		26.00 27.00
27.00	IME add-on adjustment amount (see instructions)		0.000000	0	
28. 01 29. 00	IME add-on adjustment amount - Managed Care (see instructions)		0 540 400	190, 105	28.01
29.00 29.01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	562, 423 239, 859	180, 105 90, 536	
20.00	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A pa instructions)	trent days (see	2.64		30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.71		31.00
32.00 33.00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)		25.35 10.13	10. 13	32.00 33.00
	Disproportionate share adjustment (see instructions)		551, 577		

Heal th	Financial Systems COMMUNITY HOSPITAL SOUTH	In	Lieu of Form CMS-	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-01		Worksheet E	2002 10
CALCOL		From 01/01/2 To 12/31/2	019 Part A	pared:
			8/19/2020 1:5	3 pm
		Hospital	PPS	
			0/1 On/After 10/1	
	Uncomponented Core Adjustment	1.00	2.00	
35.00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)	8, 272, 872,	447 8, 350, 599, 096	35.00
35.00	Factor 3 (see instructions)	0. 000193		
35.01	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line)			
33. UZ	instructions)	(See 1,000,	102 1,407,133	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instruction	s) 1, 196,	788 353, 705	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1, 550,		36.00
00.00	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 t		170	00.00
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DF		0	40.00
.0.00	652, 682, 683, 684 and 685 (see instructions)			101.00
		Before GE	0 On/After GEO	
		Recl ass	Recl ass	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see		0 0	41.00
	instructions)			
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683,	684	0 0	41.01
	an 685. (see instructions)			
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0. 00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685.	(see	0	43.00
44.00	instructions)	7 0.000		44.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by	y 7 0.000	0000	44.00
45 00	days)			45.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)	24 452		46.00
47.00 48.00	Subtotal (see instructions)	24, 652,	862 7, 784, 482	
46.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0 0	48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		32, 767, 739	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applica	ble)	2, 529, 697	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instruction	ns)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instruction	ns).	200, 153	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		36, 425	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines	υ,	0	
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	
59.00	Total (sum of amounts on lines 49 through 58)		35, 534, 014	
60.00	Primary payer payments		7, 193	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		35, 526, 821	
62.00	Deductibles billed to program beneficiaries		3, 103, 696	1
63.00	Coinsurance billed to program beneficiaries		49, 104	
64.00	Allowable bad debts (see instructions)		263, 811	1
65.00	Adjusted reimbursable bad debts (see instructions)		171, 477	
66.00 67.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		42, 587	1
67.00 68.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for applicable to MS-DRG	e (coo instructio	ns) 32, 545, 498	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instruc		0	1
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	G 01137	0	1
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	1
70.87	Demonstration payment adjustment amount before sequestration		0	1
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	1
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	1
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	1
70.92			0	
70.93	HVBP payment adjustment amount (see instructions)		-84, 614	1
	HRR adjustment amount (see instructions)		-203, 467	
	Recovery of accel erated depreciation			70.95
	· · ·			•

	ATION OF REIMBURSEMENT SETTLEMENT	TAL SOUTH Provider C	CN: 15-0128	Peri od:	Worksheet E	2552-
				From 01/01/2019 To 12/31/2019	Date/Time Pre	
					8/19/2020 1:5	3 pm
		litle	EXVIII	Hospital	PPS	
				<u>(yyyy)</u> 0	Amount 1.00	
0.96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70.
	the corresponding federal year for the period prior to 10/1)					
D. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70.
	the corresponding federal year for the period ending on or af	fter 10/1)				
	Low Volume Payment-3				0	
	HAC adjustment amount (see instructions)	(0 % 70)			82, 369	
	Amount due provider (line 67 minus lines 68 plus/minus lines Sequestration adjustment (see instructions)	69 & 70)			32, 175, 048 643, 501	
	Demonstration payment adjustment amount after sequestration				043, 501	
	Sequestration adjustment-PARHM pass-throughs				0	71.
	Interim payments				30, 951, 540	
	Interim payments-PARHM					72.
3.00	Tentative settlement (for contractor use only)				0	73.
3. 01	Tentative settlement-PARHM (for contractor use only)					73.
4.00	Balance due provider/program (line 71 minus lines 71.01, 71.0)2, 72, and			580, 007	74.
	73)					
	Balance due provider/program-PARHM (see instructions)				71/ 51/	74.
5.00	Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	ance with			716, 516	75.
ł	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1		1	
	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.
	plus 2.04 (see instructions)				_	
1.00	Capital outlier from Wkst. Ĺ, Pt. I, line 2				0	91.
	Operating outlier reconciliation adjustment amount (see instr				0	92.
	Capital outlier reconciliation adjustment amount (see instruc	,			0	
	The rate used to calculate the time value of money (see instr				0.00	
	Time value of money for operating expenses (see instructions)				0	
6.00	Time value of money for capital related expenses (see instruc	ctions)			0	96.
				Prior to 10/1	0n/Aftor 10/1	
					0n/After 10/1 2 00	
	HSP Bonus Pavment Amount		·	Prior to 10/1 1.00	0n/After 10/1 2.00	
	HSP Bonus Payment Amount HSP bonus amount (see instructions)				2.00	100.
00.00			·	1.00	2.00	100.
00.00	HSP bonus amount (see instructions)			1.00	2.00	
00.00 01.00 02.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction	ns)		1.00	2.00 0 0.000000000	101.
00.00 01.00 02.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	ns)		1.00 0.00000000000000000000000000000000	2.00 0.0000000000 0	102.
00.00 01.00 02.00 03.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			1.00 0.0000000000 0.0000000000000000000	2.00 0.000000000 0 0.0000	101. 102. 103.
00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions	5)		1.00 0.00000000000000000000000000000000	2.00 0.000000000 0 0.0000	101. 102. 103.
00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst	s) rration) Adju		1.00 0.0000000000 0.0000000000000000000	2.00 0.000000000 0 0.0000	101. 102. 103. 104.
00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe	s) rration) Adju		1.00 0.0000000000 0.0000000000000000000	2.00 0.000000000 0 0.0000	101. 102. 103. 104.
00.00 01.00 02.00 03.00 04.00 00.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	s) rration) Adju		1.00 0.0000000000 0.0000000000000000000	2.00 0.000000000 0 0.0000	101. 102.
00.00 01.00 02.00 03.00 04.00 00.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe	s) rration) Adju eriod under 1		1.00 0.0000000000 0.0000000000000000000	2.00 0.000000000 0 0.0000	101. 102. 103. 104. 200.
 D0. 00 D1. 00 D2. 00 D3. 00 D4. 00 D0. 00 D0. 00 D1. 00 	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	s) rration) Adju eriod under 1		1.00 0.0000000000 0.0000000000000000000	2.00 0.000000000 0 0.0000	101. 102. 103. 104.
D0.00 D1.00 D2.00 D3.00 D4.00 D0.00 D1.00 D2.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	s) ration) Adju eriod under t ne 49)	the 21st	1.00 0.000000000 0.0000 0.0000 0.0000	2.00 0.0000000000 0.0000 0.0000 0	101. 102. 103. 104. 200. 201.
D0.00 D1.00 D2.00 D3.00 D4.00 D0.00 D1.00 D2.00 D3.00 D4.00 D5.00 D0.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	s) ration) Adju eriod under t ne 49)	the 21st	1.00 0.000000000 0.0000 0.0000 0.0000	2.00 0.0000000000 0.0000 0.0000 0	101. 102. 103. 104. 200. 201. 202.
DO. 00 D1. 00 D2. 00 D3. 00 D4. 00 D0. 00 D1. 00 D2. 00 D3. 00 D4. 00 D5. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	s) ration) Adju eriod under t ne 49)	the 21st	1.00 0.000000000 0.0000 0.0000 0.0000	2.00 0.0000000000 0.0000 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203.
>0.00 >1.00 >2.00 >3.00 >4.00 >0.00 >00.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	s) ration) Adju eriod under t ne 49)	the 21st	1.00 0.000000000 0.0000 0.0000 0.0000	2.00 0.0000000000 0.0000 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204.
00.00 01.00 02.00 03.00 04.00 01.00 02.00 03.00 03.00 04.00 05.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	s) rration) Adju eriod under 1 ne 49) n first year	the 21st	1.00 0.000000000 0.0000 0.0000 0.0000	2.00 0.0000000000 0.0000 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 204. 205.
0.00 1.00 2.00 3.00 4.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	s) rration) Adju eriod under 1 ne 49) n first year	the 21st	1.00 0.000000000 0.0000 0.0000 0.0000	2.00 0.0000000000 0.0000 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 204. 205.
0.00 1.00 2.00 13.00 14.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	s) rration) Adju eriod under 1 ne 49) n first year	the 21st	1.00 0.000000000 0.0000 0.0000 0.0000	2.00 0.0000000000 0.0000 0.0000 0	101. 102. 103. 200. 200. 201. 202. 203. 204. 205. 206.
0.00 1.00 2.00 3.00 4.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	s) rration) Adju eriod under t ne 49) n first year	the 21st	1.00 0.000000000 0.0000 0.0000 0.0000	2.00 0.0000000000 0.0000 0.0000 0	101. 102. 103. 200. 200. 201. 202. 203. 204. 205. 206. 206.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	s) rration) Adju eriod under t ne 49) n first year	the 21st	1.00 0.000000000 0.0000 0.0000 0.0000	2.00 0.0000000000 0.0000 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 203. 204. 205. 206. 206. 207. 208.
00.00 11.00 12.00 13.00 14.00 10.00 11.00 12.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	s) rration) Adju eriod under t ne 49) n first year	the 21st	1.00 0.000000000 0.0000 0.0000 0.0000	2.00 0.0000000000 0.0000 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 203. 204. 205. 206. 206. 207. 208. 209.
00.00 01.00 02.00 03.00 04.00 04.00 01.00 02.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 06.00 07.00 06.00 07.00 06.00 06.00 07.00 06.00 07.00 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	s) rration) Adju eriod under 1 ne 49) n first year first year cructions) line 59)	the 21st	1.00 0.000000000 0.0000 0.0000 0.0000	2.00 0.0000000000 0.0000 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203.
00.00 01.00 02.00 03.00 04.00 04.00 05.00 05.00 05.00 05.00 06.00 07.00 08.00 09.00 10.00 11.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	s) rration) Adju eriod under 1 ne 49) n first year ructions) line 59)	the 21st	1.00 0.000000000 0.0000 0.0000 0.0000	2.00 0.0000000000 0.0000 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208. 209. 200. 211.
00.00 11.00 12.00 13.00 14.00 14.00 10.00 11.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 10.00 11.00 12.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line	s) rration) Adju eriod under 1 ne 49) n first year ructions) line 59)	the 21st	1.00 0.000000000 0.0000 0.0000 0.0000	2.00 0.0000000000 0.0000 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 204. 205. 206. 207. 208. 209. 210. 211. 211.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 05.00 05.00 05.00 06.00 07.00 08.00 09.00 11.00 11.00 12.00 13.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	s) rration) Adju eriod under t ne 49) first year first year line 59) 211)	of the curre	1.00 0.000000000 0.0000 0.0000 0.0000	2.00 0.0000000000 0.0000 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208. 209. 209. 210.

	Financial Systems COMMUNITY HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT Pr	SOUTH rovider CCN: 15-0128	In Lie Period: From 01/01/2019 To 12/31/2019		pared:
		Title XVIII	Hospi tal	PPS	<u> </u>
				4.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruction OPPS payments	ns)		25, 273 18, 532, 571 16, 215, 806	2.00
3.00 4.00 4.01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			56, 306 0	4.00 4.01
5.00 6.00 7.00	Enter the hospital specific payment to cost ratio (see instruction Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6	ons)		0. 000 0 0. 00	6.00
8.00 9.00 10.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, Organ acquisitions	col. 13, line 200		0 0 0	
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges			25, 273	11.00
12.00	Ancillary service charges			101, 929	12.00
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line Total reasonable charges (sum of lines 12 and 13) Customary charges	69)		0 101, 929	
15. 00 16. 00	Aggregate amount actually collected from patients liable for pay Amounts that would have been realized from patients liable for pa had such payment been made in accordance with 42 CFR §413.13(e)			0 0	15.00 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only i instructions)	ifline 18 exceeds li	ne 11) (see	101, 929 76, 656	1
20.00 21.00	Excess of reasonable cost over customary charges (complete only i instructions) Lesser of cost or charges (see instructions)	ne 18) (see	0 25, 273		
22.00	Interns and residents (see instructions)			0	22.00
23.00 24.00	Cost of physicians' services in a teaching hospital (see instruct Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT	tions)		0 16, 272, 112	
25. 00 26. 00 27. 00	 Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 				25.00 26.00 27.00
28.00 29.00	instructions) Direct graduate medical education payments (from Wkst. E-4, line ESRD direct medical education costs (from Wkst. E-4, line 36)	50)		90, 374 0	29.00
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			13, 561, 020 13, 074	31.00
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES))		13, 547, 946	32.00
33.00 34.00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 484, 425	33.00 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			314, 876	
36.00	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)		308, 265	
37.00 38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			13, 862, 822 -51	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	39.50 39.97
39.97 39.98	Partial or full credits received from manufacturers for replaced	devices (see instruc	tions)	40, 425	
39.99	RECOVERY OF ACCELERATED DEPRECIATION		·	0	39.99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			13, 862, 873 277, 257	
40.01	Demonstration payment adjustment amount after sequestration			0	
40.03	Sequestration adjustment-PARHM pass-throughs				40. 03
41.00 41.01	Interim payments Interim payments-PARHM			13, 420, 696	41.00
41.01	Tentative settlement (for contractors use only)			0	1
42.01	Tentative settlement-PARHM (for contractor use only)				42.01
43.00 43.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			164, 920	43.00 43.01
44.00	Protested amounts (nonallowable cost report items) in accordance §115.2 TO BE COMPLETED BY CONTRACTOR	with CMS Pub. 15-2,	chapter 1,	0	
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00 93.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)				94.00

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0128	Period: From 01/01/2019 To 12/31/2019		pare 3 pm
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		30, 951, 54	40	13, 420, 696	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
~~	write "NONE" or enter a zero					~
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER			0	0	3
02				0	0	3
03				0	0	3
04				0	0	3
05				0	0	3
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52 53				0	0	3
53 54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3
	3. 50-3. 98)			0	Ű	
00	Total interim payments (sum of lines 1, 2, and 3.99)		30, 951, 54	40	13, 420, 696	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					_
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVI DER			0	0	5
02				0	0	5
03				0	0	5
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on					6
00	the cost report. (1)					0
01	SETTLEMENT TO PROVIDER		580, 00	07	164, 920	6
02	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		31, 531, 54	47	13, 585, 616	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
)	1.00	2.00	

Heal th	Financial Systems COMMUN	NETY HOSPITAL SOUTH	In Lie	u of Form CMS	-2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0128 Period: W From 01/01/2019 F To 12/31/2019 C				
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST F	REPORTS			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CA	ALCULATION			
1.00	Total hospital discharges as defined in AARA §4102	from Wkst. S-3, Pt. I col. 15 line	e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of I	lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. li	ne 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of I	lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 li	i ne 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10,	, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the pure line 168	chase of certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instru	uctions)			8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after seque	estration (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instruc	tions)			30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line	e 30 and line 31) (see instruction	ns)		32.00

	Financial Systems COMMUNITY HOSPI GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der C		Peri od:	u of Form CMS-2 Worksheet E-4	
IEDI CAL	EDUCATION COSTS			From 01/01/2019 To 12/31/2019	Date/Time Pre 8/19/2020 1:53	
		Title	XVIII	Hospi tal	PPS	s pili
					1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
	Unweighted resident FTE count for allopathic and osteopathic	programs for	cost reporti	ng periods	0.00	1.0
	ending on or before December 31, 1996. Unweighted FTE resident cap add-on for new programs per 42 CF	R 413.79(e)(1) (see instr	uctions)	0.00	2.
00	Amount of reduction to Direct GME cap under section 422 of MM	IA	, ,		0.00	
	Direct GME cap reduction amount under ACA §5503 in accordance	with 42 CFR	§413.79 (m).	(see	0.00	3.
00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and		programs due	to a Medicare	6. 21	4.
01	GME affiliation agreement (42 CFR $$413.75(b)$ and $$413.79(f)$ ACA Section 5503 increase to the Direct GME FTE Cap (see inst		cost reporti	ng periods	0.00	4.
	straddling 7/1/2011) ACA Section FEO(number of additional direct CNE FTE can alst	a (and inst	ruations for	anat reporting	0.00	
	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (see inst	ructions for	cost reporting	0.00	4.
00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	line 4 plus l	ines 4.01 and	6. 21	5.
00	Unweighted resident FTE count for allopathic and osteopathic	programs for	the current	year from your	6.38	6.
	records (see instructions) Enter the lesser of line 5 or line 6				6. 21	7.
			Primary Care		Total	
00	Weighted FTE count for physicians in an allopathic and osteop	athi c	1.00 5.7	2.00 1 0.67	3.00	8.
	program for the current year.					
	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6.		5.5	6 0.65	6. 21	9.
	Weighted dental and podiatric resident FTE count for the curr	ent year		1.36		10.
	Unweighted dental and podiatric resident FTE count for the cu	irrent year		0.00		10.
	Total weighted FTE count Total weighted resident FTE count for the prior cost reportin	a voar (soo	5.5 5.4			11. 12.
	instructions)	iy year (see	5.4	.0.04		12.
	Total weighted resident FTE count for the penultimate cost re year (see instructions)	porting	5. C	0.74		13.
	Rolling average FTE count (sum of lines 11 through 13 divided	l by 3).	5.3	4 1.13		14.
	Adjustment for residents in initial years of new programs		0.0			15.
	Unweighted adjustment for residents in initial years of new p		0.0			15.
	Adjustment for residents displaced by program or hospital clo Unweighted adjustment for residents displaced by program or h		0. C 0. C			16. 16.
	closure	iospi tai	0.0	0.00		10.
	Adjusted rolling average FTE count		5.3			17.
	Per resident amount		91, 900. 4			18.
9.00	Approved amount for resident costs		490, 74	8 103, 847	594, 595	19.
					1.00	
	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots rec	eived under 42	0.00	20.
	Direct GME FTE unweighted resident count over cap (see instru	ictions)			0. 17	21
2.00	Allowable additional direct GME FTE Resident Count (see instr	uctions)			0.00	22
3.00	Enter the locality adjustment national average per resident a	mount (see i	nstructions)		0.00	23.
	Multiply line 22 time line 23				0	
6.00	Total direct GME amount (sum of lines 19 and 24)		Innationt Par	t Managed Care	594, 595 Total	25.
			А	Ũ		
0	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00	
	Inpatient Days (see instructions)		13, 08	6, 162		26.
	Total Inpatient Days (see instructions)		38, 50			27.
	Ratio of inpatient days to total inpatient days		0. 33976			28.
9.00	Program direct GME amount		202, 02	3 95, 166	297, 189	29.
	Percent reduction for MA DGME			7.00		29.
	Reduction for direct GME payments for Medicare Advantage			6, 662	6, 662	30.
	Net Program direct GME amount				290, 527	

Heal th	Financial Systems	COMMUNITY HOSPIT	AL SOUTH	In Lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPAT	FIENT DIRECT	Provider CCN: 15-0128	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS			From 01/01/2019 To 12/31/2019	Date/Time Pre	arad
				10 12/31/2019	8/19/2020 1:53	
			Title XVIII	Hospi tal	PPS	
			•			
					1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOS	ITE RATE - TITLE	E XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL	
	EDUCATION COSTS)					
32.00	Renal dialysis direct medical education costs	(from Wkst. B, F	Pt. I, sum of col. 20 an	d 23, lines 74	0	32.00
	and 94)			74 1 040	4 470 050	00.00
33.00	Renal dialysis and home dialysis total charges			/4 and 94)	1, 472, 859	
34.00 35.00	Ratio of direct medical education costs to tot Medicare outpatient ESRD charges (see instruct		e 32 ÷ 11 ne 33)		0.000000	34.00 35.00
35.00	Medicare outpatient ESRD direct medical educat		24 x Lino 25)		0	35.00
30.00	APPORTIONMENT BASED ON MEDICARE REASONABLE COS				0	30.00
	Part A Reasonable Cost		UNET			
37.00	Reasonable cost (see instructions)				41, 078, 937	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, c	ol 1 line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hos		ructions)		0	39.00
40,00	Primary payer payments (see instructions)				7, 193	
41.00	Total Part A reasonable cost (sum of lines 37	through 39 minus	s line 40)		41, 071, 744	
	Part B Reasonable Cost	Q				
42.00	Reasonable cost (see instructions)				18, 557, 844	42.00
43.00	Primary payer payments (see instructions)				13, 074	43.00
44.00	Total Part B reasonable cost (line 42 minus li	,			18, 544, 770	
45.00	Total reasonable cost (sum of lines 41 and 44)				59, 616, 514	
46.00	Ratio of Part A reasonable cost to total reaso	•	,		0. 688932	46.00
47.00	Ratio of Part B reasonable cost to total reaso	· · ·	,		0. 311068	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEE	N PART A AND PAF	RT B			
48.00					290, 527	
49.00	Part A Medicare GME payment (line 46 x 48) (ti				200, 153	
50.00	50.00 Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions) 90,374					

	inancial Systems COMMUNITY HOS SHEET (If you are nonproprietary and do not maintain be accounting records, complete the General Fund column	Provider C		Period: From 01/01/2019	u of Form CMS- Worksheet G	
nly)				To 12/31/2019	Date/Time Pre 8/19/2020 1:5	
		General Fund	Specific Purpose Fund		Plant Fund	
CI	JRRENT ASSETS	1.00	2.00	3.00	4.00	-
	ash on hand in banks	5, 849	(0 0	0	1 1
	emporary investments	0		0 0	0	
	otes receivable	0		o o	0	3
00 A	ccounts receivable	183, 566, 569		o c	0	4
0 00	ther receivable	-144, 164, 341		0 0	0	5
	llowances for uncollectible notes and accounts receivable	529, 743		0 0	0	
	nventory	3, 673, 051		0 0	0	
	repaid expenses ther current assets	130,000			0	
	ue from other funds	49, 666			0	
	otal current assets (sum of lines 1-10)	43, 790, 537			0	
	IXED ASSETS	43, 170, 337	· · · · · · · · · · · · · · · · · · ·	<u> </u>	0	1
	and	1, 254, 312		0 0	0	12
	and improvements	2, 722, 362		o o	0	13
. 00 A	ccumulated depreciation	0		o c	0	14
	ui I di ngs	183, 134, 843		0 0	0	15
	ccumulated depreciation	0		0 0	0	
	easehold improvements	1, 737, 035		0 0	0	
	ccumulated depreciation	02 420 201			0	
	ixed equipment ccumulated depreciation	82, 420, 201			0	
	utomobiles and trucks	59, 805			0	
	ccumul ated depreciation	0,000		0 0	0	
	ajor movable equipment	0		0 0	0	
	ccumulated depreciation	-136, 432, 656	(0 0	0	
	inor equipment depreciable	0	(o c	0	25
	ccumul ated depreciation	0		0 0	0	
	IT designated Assets	0		0 C	0	
	ccumulated depreciation	0		0 0	0	
	i nor equipment-nondepreciable	115, 657		0 0	0	
	otal fixed assets (sum of lines 12-29) THER ASSETS	135, 011, 559	(0 0	0	30
	nvestments	0		0 0	0	31
	eposits on leases	0		0 0	0	
	ue from owners/officers	0		0 0	0	
. 00 0	ther assets	426, 604, 547		o c	0	34
. 00 T	otal other assets (sum of lines 31-34)	426, 604, 547		0 C	0	35
	otal assets (sum of lines 11, 30, and 35)	605, 406, 643		0 0	0	36
	JRRENT LI ABI LI TI ES			-1 -1		
	ccounts payable	972, 604		0 0	0	
	alaries, wages, and fees payable ayroll taxes payable	0			0	
	otes and Loans payable (short term)	0			0	
	eferred income	0		0 0	0	
	ccelerated payments	0			0	42
	ue to other funds	0		o o	0	
00 0	ther current liabilities	1, 491, 595		o c	0	44
	otal current liabilities (sum of lines 37 thru 44)	2, 464, 199		0 0	0	45
	DNG TERM LIABILITIES			1		
	ortgage payable	0		0 0	0	
	otes payable	0		0 0	0	1
	nsecured loans ther long term liabilities	753, 787			0	
	otal long term liabilities (sum of lines 46 thru 49)	753, 787			0	
	otal liabilities (sum of lines 45 and 50)	3, 217, 986		0 0	0	
	APITAL ACCOUNTS	-, ,				
00 G	eneral fund balance	602, 188, 657				52
	pecific purpose fund		(C		53
	onor created - endowment fund balance - restricted			0		54
	onor created - endowment fund balance - unrestricted			0		55
	overning body created - endowment fund balance			0		56
	lant fund balance - invested in plant				0	
	lant fund balance - reserve for plant improvement,				0	58
	eplacement, and expansion otal fund balances (sum of lines 52 thru 58)	602, 188, 657		0 0	0	59
	otal liabilities and fund balances (sum of lines 51 and	605, 406, 643			0	
		000, 100, 040		- U	0	1 00

Heal th	Financial Systems	COMMUNI TY HOSE	PITAL SOUTH			In Lie	u of Form CMS	5-2	552-10
	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0128		eriod: com 01/01/2019	Worksheet G	-1 rep	ared:
		General	Fund	Speci al	Pur	pose Fund	Endowment Fur	nd	
1.00	Fund balances at beginning of period	1.00	2.00 538,142,909	3.00		4.00	5.00		1.00
2.00 3.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		64, 045, 748 602, 188, 657			0			2.00 3.00
4.00	Additions (credit adjustments) (specify)	0	,,		0	-		0	4.00
5.00 6.00		0			0 0			0	5.00 6.00
7.00		0			0			0	7.00
8.00		0			0			0	8.00
9.00		0			0	0		0	9.00
10.00 11.00	Total additions (sum of line 4–9) Subtotal (line 3 plus line 10)		0 602, 188, 657			0			10. 00 11. 00
12.00	Deductions (debit adjustments) (specify)	0	002, 100, 00,		0	0		0	12.00
13.00		0			0			0	13.00
14.00 15.00		0			0				14. 00 15. 00
16.00		0			0			0	16.00
17.00		0			0			0	17.00
	Total deductions (sum of lines 12-17)		0			0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		602, 188, 657			0			19. 00
		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 4.00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0		0				3.00 4.00
5.00			0						5.00
6.00			0						6.00
7.00 8.00			0						7.00 8.00
9.00			0						9.00
10.00	Total additions (sum of line 4–9)	0			0				10.00
11.00	Subtotal (line 3 plus line 10)	0			0				11.00
12.00 13.00	Deductions (debit adjustments) (specify)		0						12.00 13.00
14.00			0						14.00
15.00			0						15.00
16.00 17.00			0						16.00 17.00
17.00	Total deductions (sum of lines 12-17)	0	0		0				17.00
19.00	Fund balance at end of period per balance	0			0				19.00
	sheet (line 11 minus line 18)		I					1	

CTATE	Financial Systems COMMUNITY HOSPI IENT OF PATIENT REVENUES AND OPERATING EXPENSES		N. 1E 0100		u of Form CMS-2	
STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-0128	Period: From 01/01/2019	Worksheet G-2 Parts I & II	
				To 12/31/2019	Date/Time Pre	
	Cast Castar Description		1	Outratiant	8/19/2020 1:5	3 pm
	Cost Center Description	-	Inpatient 1.00	Outpatient 2.00	<u> </u>	
	PART I - PATIENT REVENUES	I	1.00	2.00	3.00	
	General Inpatient Routine Services					1
1.00	Hospi tal		115, 664, 6	51	115, 664, 651	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE		115 /// /	F 1	115 /// /51	9.00
10.00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services	I	115, 664, 6		115, 664, 651	10.00
11.00	INTENSIVE CARE UNIT		11, 290, 6	40	11, 290, 640	11.00
12.00	CORONARY CARE UNIT		11, 270, 0	-0	11, 270, 040	12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	11, 290, 6	40	11, 290, 640	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16))	126, 955, 2	91	126, 955, 291	17.00
18.00	Ancillary services		345, 102, 9	69 517, 515, 936	862, 618, 905	•
19.00	Outpatient services			0 0	0	
20.00	RURAL HEALTH CLINIC			0 0	0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
22.00	HOME HEALTH AGENCY					22.00
23.00 24.00	AMBULANCE SERVICES CMHC					23.00
24.00 25.00	AMBULATORY SURGICAL CENTER (D. P.)					24.00
26.00	HOSPICE					26.00
27.00	OTHER (SPECIFY)			0 75, 636	75, 636	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	472, 058, 2		989, 649, 832	
	G-3, line 1)		,, _			
	PART II - OPERATING EXPENSES					1
29.00	Operating expenses (per Wkst. A, column 3, line 200)			234, 002, 345		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00 38.00	DEDUCT (SPECIFY)			0		37.00 38.00
38.00				0		38.00
40.00				0		40.00
40.00				0		40.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		234, 002, 345		43.00
	to Wkst. G-3, line 4)					

Heal th	Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0128	Peri od:	Worksheet G-3	
			From 01/01/2019 To 12/31/2019	Date/Time Pre	narod
			10 12/31/2017	8/19/2020 1:5	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part			989, 649, 832	1.00
2.00	Less contractual allowances and discounts on	patients' accounts		695, 230, 056	2.00
3.00	Net patient revenues (line 1 minus line 2)			294, 419, 776	3.00
4.00	Less total operating expenses (from Wkst. G-			234, 002, 345	4.00
5.00	Net income from service to patients (line 3	minus line 4)		60, 417, 431	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			166, 726	
7.00	Income from investments			829, 321	7.00
8.00	Revenues from telephone and other miscellane	ous communication services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			11, 797	
11.00	Rebates and refunds of expenses			0	
12.00	Parking lot receipts			0	
13.00	Revenue from laundry and linen service			0	
14.00	Revenue from meals sold to employees and gue	sts		1, 357, 812	
15.00	Revenue from rental of living quarters			0	
16.00	Revenue from sale of medical and surgical su			0	16.00
17.00	Revenue from sale of drugs to other than pat			0	
18.00	Revenue from sale of medical records and abs			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms,			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, a	nd canteen		0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			797, 642	
23.00	Governmental appropriations			0	23.00
24.00	MI SC REVENUE			508, 519	
25.00	Total other income (sum of lines 6-24)			3, 671, 817	
26.00	Total (line 5 plus line 25)			64, 089, 248	
27.00	TAXES			43, 500	
28.00	Total other expenses (sum of line 27 and sub			43, 500	
29.00	Net income (or loss) for the period (line 26	minus line 28)		64, 045, 748	29.00

Health Financial Systems COMMUNI CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0128	Period: From 01/01/2019 To 12/31/2019	u of Form CMS-2552 Worksheet L Parts I-III Date/Time Prepare 8/19/2020 1:53 pm	
		Title XVIII	Hospi tal	PPS	5 pin
			Urban	Rural	
			1.00	1.01	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				1
. 00	Capital DRG other than outlier		1, 772, 087	555, 331	1 1.
. 01	Model 4 BPCI Capital DRG other than outlier		0	0	1.
. 00	Capital DRG outlier payments		63, 682		2.
. 01	Model 4 BPCI Capital DRG outlier payments		0		2.
. 00	Total inpatient days divided by number of days in the c	ost reporting period (see	107.10		3.
	instructions)	ost i sporting por ou (oso			
. 00	Number of interns & residents (see instructions)		7.33		4.
. 00	Indirect medical education percentage (see instructions)	1.95		5.
. 00	Indirect medical education adjustment (multiply line 5				6.
	columns 1 and 1.01) (see instructions)				.
. 00	Percentage of SSI recipient patient days to Medicare Pa	rt A patient davs (Worksheet	E, 2.64		7
	part A line 30) (see instructions)				
. 00	Percentage of Medicaid patient days to total days (see	instructions)	22. 71		8
. 00	Sum of lines 7 and 8	,	25.35		9
0.00	Allowable disproportionate share percentage (see instru	ctions)	5.26		10
1.00	Disproportionate share adjustment (see instructions)		93, 212		11
	Total prospective capital payments (see instructions)		2, 529, 697		12
2.00	Total prospective capital payments (see mistractions)		2, 327, 077		12
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
. 00	Program inpatient routine capital cost (see instruction	s)		0	1 1.
. 00	Program inpatient ancillary capital cost (see instructi			0	
. 00	Total inpatient program capital cost (line 1 plus line			0	
. 00	Capital cost payment factor (see instructions)	2)		0	
. 00	Total inpatient program capital cost (line 3 x line 4)			0	
. 00	Total inpatient program capital cost (The 5 x The 4)			0	5
				1, 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
00	Program inpatient capital costs (see instructions)			0	1 1
. 00	Program inpatient capital costs (see instructions)	metaneos (soo instructions)		0	
. 00	Net program inpatient capital costs (line 1 minus line			0	
. 00	Applicable exception percentage (see instructions)	2)		0.00	
00	Capital cost for comparison to payments (line 3 x line	4)		0.00	
. 00	Percentage adjustment for extraordinary circumstances (0.00	
	5 5	,	v line ()		
. 00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)			0	
00	Capital minimum payment level (line 5 plus line 7)			0	
. 00	Current year capital payments (from Part I, line 12, as applicable)			0	
0.00				0	
1.00	Carryover of accumulated capital minimum payment level	over capital payment (from pr	ior year	0	11
	Worksheet L, Part III, line 14)			_	
2.00				0	
	0 Current year exception payment (if line 12 is positive, enter the amount on this line)				
4.00	Carryover of accumulated capital minimum payment level	over capital payment for the	following period	0	14
	(if line 12 is negative, enter the amount on this line)				
				0	15
5.00	Current year allowable operating and capital payment (s				
5. 00	Current year allowable operating and capital payment (s Current year operating and capital costs (see instructi Current year exception offset amount (see instructions)			0	16