payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050 EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0074 Period: From 01/01/2018 To 12/31/2018 Parts I-III Date/Time Prepared: 5/29/2019 3:09 pm

PART I - CO	OST REPORT	STATUS				
Provi der	1. [X] Electronically filed	cost report	Date: 5/29/2019	Ti me:	3: 09 p
use only	2. [] Manually submitted co	st report			
	3. [0 4. [F] If this is an amended] Medicare Utilization.	report enter the number of times the providenter "F" for full or "L" for low.	der resubmitted this cost	report	
Contractor use only	(1) (2) (3) (4)]Cost Report Status As Submitted Settled without Audit Settled with Audit Reopened Amended		10. NPR Date: 11. Contractor's Vendor Co 12. [0]Ifline 5, columr number of times r	1 is 4:	

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HEALTH NETWORK, INC. (15-0074) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[X]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) HOLLY MILLARD

Officer or Administrator of Provider(s)

NETWORK SENIOR VICE PRESIDENT OF FIN

Title

(Dated when report is electronically signed.)

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-526, 464	-447, 183	0	0	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200.00	Total Total	0	-526, 464	-447, 183	0	0	200.00
Thook	and amounts represent "due to" or "due from"	the engliceble	nroarom for th	a alamant of t	ha abaya aamal	av indiaatad	

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-MEDI CARE.

HOSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENIIFICATION DA	ATA	Provi d	er CCI	N: 15-0074	Period: From 01/0 To 12/3	1/2018 1/2018	Workshee Part I Date/Time 5/29/2019	e Pre	
	1.00	2.	. 00		3. 00			4. 00			
	Hospital and Hospital Health Care Co	mplex Address:									
1. 00	Street: 1500 NORTH RITTER AVENUE	PO Box:									1.00
2.00	City: INDIANAPOLIS	State:	IN Zi	ip Code	e: 462	19 Cou	nty: MARION				2. 00
		Component Na	ame	CCN	CBS	SA Provi de	er Date	Payme	ent System	n (P,	
			Nu	umber	Numb	per Type	Certi fi e	d T	, 0, or N)	
								V	XVIII	XI X	
		1.00	2	2. 00	3. 0	00 4.00	5. 00	6. 00	7.00	8. 00	
	Hospital and Hospital-Based Componer	t Identification				<u> </u>					
3. 00	Hospi tal	COMMUNITY HEALTH		50074	2690	00 1	07/01/196	56 N	Р	Р	3.00
		NETWORK, INC.							'		
1. 00	Subprovider - IPF						İ		1 1		4.00
5. 00	Subprovider - IRF										5. 00
. 00	Subprovider - (Other)								1		6.00
. 00	Swing Beds - SNF										7. 00
							ŀ	-			
. 00	Swing Beds - NF						l .	-			8.00
. 00	Hospi tal -Based SNF										9.00
0. 00	Hospi tal -Based NF										10.00
1. 00	Hospi tal -Based OLTC										11.00
2. 00	Hospital-Based HHA										12.00
3.00	Separately Certified ASC										13.00
4.00	Hospi tal -Based Hospi ce										14.00
5.00	Hospital-Based Health Clinic - RHC										15.00
6.00	Hospital - Based Health Clinic - FOHC							ı			16.00
7. 00	Hospital-Based (CMHC) I						İ		i i		17. 00
8. 00	Renal Dialysis						İ		i i		18.00
	Other						İ		i i		19.00
	12.5			-			Fro	m·	To:		
							1. (2. 00		
20 00	Cost Reporting Period (mm/dd/yyyy)						01/01/		12/31/2		20.00
	Type of Control (see instructions)						2		12, 01, 2	0.0	21.00
. 1. 00	Type or control (see this true trons)										21.00
					ı	1. 00	2. (20	3. 00		
	Inpatient PPS Information					1.00	2. (50	0.00		
22. 00	•	currently receiv	vi na navmen	ts for	Т	Υ	N				22. 00
22.00	disproportionate share hospital adju					Į.	IN IN				22.00
	§412. 106? In column 1, enter "Y" fo										
	facility subject to 42 CFR Section §			ienτ							
00 01	hospital?) In column 2, enter "Y" fo	•			_	V		,			22 01
22. 01	Did this hospital receive interim un					Υ	Y				22. 01
	cost reporting period? Enter in colu										
	the portion of the cost reporting pe										
	Enter in column 2, "Y" for yes or "N				ost						
	reporting period occurring on or aft										00.00
2. 02	Is this a newly merged hospital that	•				N	N				22. 02
	payments to be determined at cost re				S)						
	Enter in column 1, "Y" for yes or "N										
	cost reporting period prior to Octob										
	or "N" for no, for the portion of th	e cost reporting	period on	or aft	er						
	October 1.										
2. 03	Did this hospital receive a geograph					N	N		N		22. 03
	rural as a result of the OMB standar										
	adopted by CMS in FY2015? Enter in c										
	for the portion of the cost reportin				r						
	in column 2, "Y" for yes or "N" for										
	reporting period occurring on or aft										
	Does this hospital contain at least										
	counted in accordance with 42 CFR 41	2.105)? Enter in	column 3,	"Y" fo	r						
	yes or "N" for no.										
23. 00	Which method is used to determine Me						3 N				23.00
	below? In column 1, enter 1 if date										
	if date of discharge. Is the method				ost						
	reporting period different from the										
	reporting period? In column 2, ente	r "Y" for yes or									
			In-State	In-St	tate	Out-of	Out-of	Medi ca	iid Oth	er	
			Medi cai d	Medic	cai d	State	State	HMO da	ys Medio	cai d	
			paid days	eligi	ble	Medicaid	Medi cai d		day	ys	
				unpa	aid	paid days	eligible				
				day	/S		unpai d				
			1.00	2. 0		3. 00	4. 00	5. 00	6.0	00	
4. 00	If this provider is an IPPS hospital	, enter the	3, 224		724		102		556	27	24.00
	in-state Medicaid paid days in colum					''		_5,			
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in co										
	out-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in										
			1	1	- 1				1		

Health Financial Systems COMMUNITY HEALTH NETWORK, INC.	n Lieu	ı of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0074 Period: From 01/01	/2018	Workshe Part I	et S-2	
	/2018	Date/Ti 5/29/20		
	Medi ca	id 0	ther	у ріп
Medicaid Medicaid State State paid days eligible Medicaid Medicaid	HMO da	·	li cai d lays	
unpaid paid days eligible				
days unpai d 1.00 2.00 3.00 4.00	5. 00	6	0. 00	
25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 Medicaid paid days in column 1, the in-state		0		25. 00
Medicald 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.	1			
Urban/Ru		Date of 2.0		
26.00 Enter your standard geographic classification (not wage) status at the beginning of the	1			26. 00
cost reporting period. Enter "1" for urban or "2" for rural. 27.00 Enter your standard geographic classification (not wage) status at the end of the cost	1			27. 00
reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.				
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in	0			35. 00
effect in the cost reporting period. Beginn	i na:	Endi	na:	
1.0		2. 0		24.00
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36. 00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0			37. 00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in				37. 01
accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)				
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is				38. 00
greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.				
Y/N		Y/		
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume N	J	2. C N		39. 00
hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in				
accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes				
or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or N		Υ		40. 00
"N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for				
no in column 2, for discharges on or after October 1. (see instructions)	V	XVIII	XI X	
Prospective Payment System (PPS)-Capital	1.00	2. 00	3.00	
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance	N	Y	N	45. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances	N	N	N I	46. 00
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through	"		"	10.00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47. 00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48. 00
Teaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes	Υ			56. 00
or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved	N			57. 00
GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1	'`			07.00
is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is				
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as	N			58. 00
	l IV			
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				59. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N et A	Pass_Th	rough I	
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. Ď-5.	et A	Pass-Th Qualifi	cation	
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I. NAHE 413.85 Worksheet	et A		cation	
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I. NAHE 413.85 Y/N Line 1.00 2.0	eet A #	Qualifi	cation on Code	
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I. NAHE 413.85 Worksheet A: NAHE 413.85 Vine NAHE 4	eet A #	Qualifi Criterio	cation on Code	60. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I. NAHE 413.85 Y/N Line 1.00 2.0 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions) 60.01 If line 60 is yes, complete columns 2 and 3 for each program. (see	eet A #	Qualifi Criterio	cation on Code	
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I. NAHE 413.85 Y/N Line 1.00 2.0 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	eet A #	Qualifi Criteric 3.0	cation on Code	60. 00

Health Financial Systems	COMMUNITY	нелі ти	NETWORK, INC.		In Lie	eu of Form CMS-2	2552_10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF				CN: 15-0074	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I	pared:
		Y/N	I ME	Direct GME	IME	Direct GME	7 DIII
		1. 00	2. 00	3. 00	4.00	5. 00	
 61.00 Did your hospital receive FTE slots under A section 5503? Enter "Y" for yes or "N" for column 1. (see instructions) 61.01 Enter the average number of unweighted prim FTEs from the hospital's 3 most recent cost ending and submitted before March 23, 2010. 	no in mary care t reports	Y			32.8	5 29. 67	61. 00
instructions) 61.02 Enter the current year total unweighted pri FTE count (excluding OB/GYN, general surger and primary care FTEs added under section 5 ACA). (see instructions)	ry FTEs,						61. 02
61.03 Enter the base line FTE count for primary of and/or general surgery residents, which is determining compliance with the 75% test. (instructions)	used for						61. 03
61.04 Enter the number of unweighted primary care surgery allopathic and/or osteopathic FTEs current cost reporting period. (see instruct 61.05 Enter the difference between the baseline page 1.05 Enter the number of unweighted primary care surgery and th	in the tions).						61. 04 61. 05
and/or general surgery FTEs and the current primary care and/or general surgery FTE cou 61.04 minus line 61.03). (see instructions)	t year's unts (line)						
61.06 Enter the amount of ACA §5503 award that is used for cap relief and/or FTEs that are no care or general surgery. (see instructions)	onpri mary						61. 06
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2. 00	3.00	4. 00	
 61.10 Of the FTEs in line 61.05, specify each new special ty, if any, and the number of FTE refor each new program. (see instructions) Ercolumn 1, the program name. Enter in column program code. Enter in column 3, the IME FI unweighted count. Enter in column 4, the diffE unweighted count. 61.20 Of the FTEs in line 61.05, specify each exprogram special ty, if any, and the number of residents for each expanded program. (see instructions) Enter in column 1, the program special ty. The program code. Enter 3, the IME FTE unweighted count. Enter in column 2. 	esidents nter in n 2, the TE rect GME coanded of FTE am name. in column	FAMI LY	MEDI CI NE	1350	5. 60		61. 10
the direct GME FTE unweighted count.							
						1.00	
ACA Provisions Affecting the Health Resource 62.00 Enter the number of FTE residents that your					ind for which	0.00	62. 00
your hospital received HRSA PCRE funding (s 62.01 Enter the number of FTE residents that rota during in this cost reporting period of HRS	see instruc ated from a SA THC proc	ctions) a Teachi gram. (s	ng Health Cer ee instructio	nter (THC) into			62. 01
Teaching Hospitals that Claim Residents in 63.00 Has your facility trained residents in none	provi der se	ettings	during this c			Y	63. 00
"Y" for yes or "N" for no in column 1. If y	yes, comple	ete line	s 64 through	67. (see insti	ructions) Unweighted	Ratio (col. 1/	
				FTEs Nonprovi der Si te	FTEs in	(col. 1 + col. 2))	
				1 00	2.00	2 00	

) Si te			
		1. 00	2.00	3. 00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	This base year	is your cost r	eporting	
1	period that begins on or after July 1, 2009 and before June 30, 2010.				
64. 00 l	Enter in column 1, if line 63 is yes, or your facility trained residents	0. 17	3. 25	0. 049708	64.00
ļi	in the base year period, the number of unweighted non-primary care				
ı	resident FTEs attributable to rotations occurring in all nonprovider				
9	settings. Enter in column 2 the number of unweighted non-primary care				
l l	resident FTEs that trained in your hospital. Enter in column 3 the ratio				
	of (column 1 divided by (column 1 + column 2)). (see instructions)				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0074 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 3:09 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 FAMILY MEDICINE 3. 92 25. 07 0. 135219 65. 00 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0. 98 9. 06 0. 097610 66. 00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 2.00 3. 00 1.00 4.00 5.00 67.00 Enter in column 1, the program FAMILY PRACTICE 0. 201630 67. 00 1350 6.68 26.45 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 | If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most N O N 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 Ν subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Health Financial Systems COMMUNITY HEALTH		N 45 0074		u of Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	JN: 15-0074	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Pre 5/29/2019 3:0	epared:
				1. 00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for ye				N	80.00
81.00 Is this a LTCH co-located within another hospital for part "Y" for yes and "N" for no. TEFRA Providers	or all of the o	cost reportin	g period? Enter	N	81.00
Is this a new hospital under 42 CFR Section §413.40(f)(1)(i B6.00 Did this facility establish a new Other subprovider (exclud §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
87.00 Is this hospital an extended neoplastic disease care hospit 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	al classified u	under section		N	87. 00
			V	XI X	
			1. 00	2. 00	
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospit	al services? Er	nter "Y" for	N	Υ	90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through			N	N	91.00
full or in part? Enter "Y" for yes or "N" for no in the app 92.00 Are title XIX NF patients occupying title XVIII SNF beds (d instructions) Enter "Y" for yes or "N" for no in the applic	lual certificati			N	92. 00
93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N	N	93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for no	o in the	N	N	94. 00
25.00 Filine 94 is "Y", enter the reduction percentage in the ap 26.00 Does title V or XIX reduce operating cost? Enter "Y" for ye			0. 00 N	0. 00 N	95. 00 96. 00
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the ap 98.00 Does title V or XIX follow Medicare (title XVIII) for the i			0. 00 Y	0. 00 N	97.00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.			'	IN IN	70.00
Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.				Y	98. 01
Does title V or XIX follow Medicare (title XVIII) for the c bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.			Y	Y	98. 02
Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.				N	98. 03
Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.			N	N	98. 04
08.05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.				Y	98. 05
P8.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			Y	Y	98. 06
Rural Providers 105.00 Does this hospital qualify as a CAH?			N		105. 00
106.00 f this facility qualifies as a CAH, for outpatient services? (see instructions)	-inclusive meth	nod of paymen	1		106. 00
107.00 f this facility qualifies as a CAH, is it eligible for costraining programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col	ın 1. (see instr	ructions) If	N		107. 00
reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sched	dul e? See 42	. N		108. 00
N. N. Section 3412. 113(c). Litter 1 101 yes of N 101 110.	Physi cal 1.00	Occupationa 2.00	Speech 3.00	Respiratory 4.00	
109.00 f this hospital qualifies as a CAH or a cost provider, are		2.00 N	3.00 N	4.00 N	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				,,,	

110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.

1.00

N

110. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0074	Peri od: From 01/01	/2010	Worksheet S- Part I	-2552-1 -2
			/2018	Date/Time Pr 5/29/2019 3:	
		1. 00	າ	2. 00	\perp
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this community for yes or "N" for no in column 1. If the response to column tegration prong of the FCHIP demo in which this CAH is participated all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	st reporting period? Ento lumn 1 is Y, enter the ticipating in column 2.	er N		2.00	111.00
			1. 00	2.00 3.00)
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208.1.	If column 2 is "E", ento t for long term care (inc s) based on the definition	er in column cludes		0	115. 0
16.00 Is this facility classified as a referral center? Enter "Y" 17.00 Is this facility legally-required to carry malpractice insurance.	ance? Enter "Y" for yes (N Y		116. 00
18.00 Is the mal practice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 if the polic	cy is	1		118. 0
	Premi ums	s Losse	es	Insurance	
	1. 00	2.00		3. 00	
18.01 List amounts of malpractice premiums and paid losses:	1, 320,	557	С		0 118. 0
		1. 00)	2. 00	
18.02 Are mal practice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein. 19.00 DO NOT USE THIS LINE		N			118. 0
20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" for yes on alifies for the Outpatien	-		N	120. 0
21.00 Did this facility incur and report costs for high cost implai patients? Enter "Y" for yes or "N" for no.	ntable devices charged to	y Y			121. 0
22.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.					122. 0
<u>Transplant Center Information</u> 25.00 Does this facility operate a transplant center? Enter "Y" for	r yes and "N" for no. If	N			125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, en		te			126. 0
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, ento in column 1 and termination date, if applicable, in column 2.	er the certification date	e			127. 0
28.00 f this is a Medicare certified liver transplant center, enti in column 1 and termination date, if applicable, in column 2.	er the certification date	e			128. 0
29.00 f this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		in			129. 0
30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column					130. 0
31.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column	umn 2.				131. 0
32.00 If this is a Medicare certified islet transplant center, ento in column 1 and termination date, if applicable, in column 2.					132. 0
33.00 f this is a Medicare certified other transplant center, ent- in column 1 and termination date, if applicable, in column 2.		9			133. 0
34.00 f this is an organ procurement organization (0P0), enter the and termination date, if applicable, in column 2.	e uru number in column 1				134. 0
All Providers 40.00 Are there any related organization or home office costs as do	ofined in CMC Dub. 1E 1	Y		HB0720	140. 0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Ą	Provider CC	:N: 15-0074			/01/2018 2/31/2018	Worksheet S- Part I Date/Time Pr 5/29/2019 3:	epared:
1.00		2. 00					3. 00	0/27/2017 3.	O 7 DIII
If this facility is part of a cha home office and enter the home of	fice contractor name	er on lir and cont	ractor numbe	er.			address		
141. 00 Name: COMMUNITY HEALTH NETWORK	Contractor's Na PO Box:			IAN Contr	actor's	s Nun	nber: 0810)1	141. 00
142.00 Street: 1500 N RITTER 143.00 City: INDIANAPOLIS	State:	SERVI I N	CES	Zi p C	ode:		4621	9-3095	142. 00 143. 00
								1.00	_
44.00 Are provider based physicians' co	sts included in Works	heet A?						Y Y	144. 0
AF OOLE agota for rand, convices and a	aimad an Wkat A Li	no 74 o	ro the costs	· for			1. 00 Y	2.00	145. 0
 45.00 f costs for renal services are cipatient services only? Enter "Y" no, does the dialysis facility in period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodologenter "Y" for yes or "N" for no in yes, enter the approval date (mm/g) 	'for yes or "N" for clude Medicare utiliz for no in column 2. gy changed from the p n column 1. (See CMS	no in co ation fo reviousl Pub. 15-	lumn 1. If our this cost y filed cost	column 1 i reporting report?	,		N		146. 0
lyes, errer the approval date (iiiii)	dayyyy) iii coranii 2.								
47 00 Was thorse a share in the state of the	and booke? Fatara "Y"	for	on "N" 6-	20				1.00	147.0
47.00 Was there a change in the statist 48.00 Was there a change in the order o								N N	147. 0 148. 0
49.00 Was there a change to the simplifi					for no			N	149. 0
			Part A	Part			tle V	Title XIX	
Does this facility contain a prov	idor that qualifies f	for an ov	1.00	2.00			3.00	4. 00	
or charges? Enter "Y" for yes or									
55.00 Hospi tal			N	N			N	N	155. (
56.00 Subprovi der - IPF			N	N			N	N	156. (
57. 00 Subprovi der – I RF 58. 00 SUBPROVI DER			N	N			N	N	157. (158. (
58. 00 S0BPR0VI DER 59. 00 SNF			N	l N	-		N	N	159. (
60.00 HOME HEALTH AGENCY			N	N N			N	N N	160. 0
61.00 CMHC				N			N	N	161. 0
								1.00	
Multicampus 65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that h	as one o	r more campu	ıses in di	fferen	t CBS	SAs?	N	165. 0
	Name		County	State	Zip Co		CBSA	FTE/Campus	
((, 00 6) ; 4/5 ; 6	0		1. 00	2. 00	3.00	0	4. 00	5. 00	0111
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.0	0 166. (
								1.00	
Health Information Technology (HI						ct			
67.00 s this provider a meaningful use 68.00 f this provider is a CAH (line 10 reasonable cost incurred for the	05 is "Y") and is a m	eani ngfu	l user (line			nter	the	Y	167. (0168. (
68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user ? Enter "Y" for yes o	, does t r "N" fo	his provider r no. (see i	nstructio	ns)		•		168.
69.00 If this provider is a meaningful transition factor. (see instruction) and is	not a CAH (line 105	is "N"				0169. (
							gi nni ng 1. 00	Endi ng 2. 00	
70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and en	di ng dat	e for the re	eporting			01/2015	12/31/2015	170. 0
							1. 00	2.00	-
171.00 If line 167 is "Y", does this pro section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3 umn 1. If column 1 is	, Pt. I,	line 2, col	. 6? Ente			N N		0 171. 0

	Financial Systems COMMUNITY HEALTH AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 01/01/2018 To 12/31/2018		2
					5/29/2019 3:0	
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	esponses. Ente	1.00 er all dates in t	2. 00 the	
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
1.00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in co		instructions)			
			1. 00	2. 00	V/I 3. 00	
2.00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in column	9	N N	2.00	3.00	2. 00
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	Y			3. 00
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
4. 00 5. 00	Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differ	or Compiled, ilable in	Y	A		4. 00
	those on the filed financial statements? If yes, submit reco					
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
6. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?		ne provider is			6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in: Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.		I during the	Y N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved		al education	Υ		9. 00
10. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		he current	Υ		10. 00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. 00
					Y/N 1. 00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po			ost reporting	Y N	12. 00 13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payment Bed Complement	nts waived? If	yes, see ins	structi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost reporti		yes, see inst t A	ructions. Par	N + R	15. 00
		Y/N	Date	Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16. 00
17. 00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Υ	02/23/2017	Y	02/23/2017	17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

Heal th	Financial Systems COMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CM	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0074	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S Part II Date/Time P 5/29/2019 3	repared:
			i pti on	Y/N	Y/N	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20. 00
20.00	Report data for Other? Describe the other adjustments:			IN	14	20.00
		Y/N	Date	Y/N	Date	
21 00	West has seek assessed and a second and a second and a	1.00	2.00	3.00	4. 00	21.00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS I	HOSPI TALS)			
00.00	Capital Related Cost					
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		sals made dur	ring the cost		22. 00
23.00	reporting period? If yes, see instructions.	due to apprais	sar s made dui	Tilg the cost		23.00
24. 00	Were new leases and/or amendments to existing leases entere	ed into during	this cost re	eporting period?		24. 00
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repor	rting period?	'If yes, see		25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost renorti	na neriod2 l	f ves see		26. 00
	instructions.	·	0.			
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportii	ng period? If	yes, submit		27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	ntered into du	ring the cost	reporting		28. 00
	period? If yes, see instructions.		o .			
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr		ebt Service F	Reserve Fund)		29. 00
30. 00	Has existing debt been replaced prior to its scheduled matuinstructions.		debt? If yes	s, see		30. 00
31. 00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes	s, see		31. 00
	instructions. Purchased Services					
32. 00	Have changes or new agreements occurred in patient care ser	vices furnishe	ed through co	ntractual		32. 00
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to competi	tive bidding? If		33. 00
	no, see instructions. Provider-Based Physicians					
34. 00	Are services furnished at the provider facility under an ar	rangement with	n provi der-ba	sed physicians?		34.00
	If yes, see instructions.	Ü	•	. ,		
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		nts with the	provi der-based		35. 00
				Y/N 1. 00	2. 00	
	Home Office Costs			1.00	2.00	
36. 00	Were home office costs claimed on the cost report?					36. 00
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the	home office?			37. 00
38. 00	If line 36 is yes , was the fiscal year end of the home off			-		38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			5,		39. 00
40. 00	see instructions.	homo offico?	If you soo			40. 00
40.00	If line 36 is yes, did the provider render services to the instructions.	nome office?	ii yes, see			40.00
		1.	2.	00		
	Cost Report Preparer Contact Information					
41. 00	held by the cost report preparer in columns 1, 2, and 3,	SHI RLEY		BI SHOP		41.00
42. 00	respectively. Enter the employer/company name of the cost report	COMMUNITY HEAL	_TH NETWORK			42. 00
	preparer.			CDI CHODATOOMANI	UITV COM	
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-4135		SBI SHOP@ECOMMUI	NLLY, CUM	43. 00

Heal th	Financial Systems COMMUNITY HEALTH	H NETWORK, INC.	In Lie	In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-0074	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Pre 5/29/2019 3:0	pared:		
		3.00		0,2,,201, 0.0	<i>y</i>		
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	NETWORK DIRECTOR OF REIMBURSEMENT			41. 00		
42.00	Enter the employer/company name of the cost report				42. 00		
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43. 00		

| Period: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Heal th Fi nancialSystemsCOMMUNITYHOSPITALANDHOSPITAL HEALTH CARE COMPLEXSTATISTICAL DATA Provider CCN: 15-0074

				Т	o 12/31/2018	Date/Time Prep 5/29/2019 3:09	
						I/P Days / 0/P	7 DIII
						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	254	92, 710	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		254	92, 710	0.00	0	7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	31. 00	28			0	8. 00
9. 00	CORONARY CARE UNIT	32. 00	23	8, 395	0. 00	0	9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGI CAL INTENSI 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)		305	111, 325	0. 00	0	14. 00
15. 00	CAH visits					0	15. 00
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPICE	20.00					24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10 25. 00
25. 00 26. 00	CMHC - CMHC	88. 00				0	25. 00 26. 00
	RURAL HEALTH CLINIC					0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00	305			U	26. 25 27. 00
27. 00 28. 00	Total (sum of lines 14-26)		305)		0	28. 00
29. 00	Observation Bed Days					U	28.00
30.00	Ambulance Trips						29. 00 30. 00
30.00	Employee discount days (see instruction)						30.00
	Employee discount days - IRF		_	,			
32. 00 32. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room		0	O			32. 00 32. 01
32. UI	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days						33. 00
	LTCH site neutral days and discharges						33. 00
55.01	Eron or to houtrar days and droundinges	ı		1	1		55.01

 Heal th Financial
 Systems
 COMMUNITY

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-0074

						5/29/2019 3:0	9 pm
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns		
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	15, 743	3, 070	65, 033			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	8, 964	26, 017				2. 00
3.00	HMO IPF Subprovider	0, 704	20, 017				3.00
4. 00	HMO IRF Subprovider	0	0	ł			4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	ł			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	·			6.00
7. 00	Total Adults and Peds. (exclude observation	15, 743	3, 070				7. 00
7.00	beds) (see instructions)	10,710	0,070	00,000			/. 00
8.00	INTENSIVE CARE UNIT	2, 276	0	6, 047			8. 00
9.00	CORONARY CARE UNIT	2, 260	0	5, 645			9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1, 533				13. 00
14.00	Total (see instructions)	20, 279	4, 603	78, 578	43. 16	2, 753. 70	•
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVIDER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19. 00
20. 00 21. 00	NURSING FACILITY					•	20. 00 21. 00
21.00	OTHER LONG TERM CARE HOME HEALTH AGENCY						21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPICE						24. 00
24. 10	HOSPICE (non-distinct part)			523			24. 10
25. 00	CMHC - CMHC			020			25. 00
26. 00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		l .	ł
27. 00	Total (sum of lines 14-26)				43. 16	2, 753. 70	27. 00
28. 00	Observation Bed Days		2, 002	5, 890			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			643			30. 00
31.00	Employee discount days - IRF			0			31. 00
32. 00	Labor & delivery days (see instructions)	0	27	324			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
22.00	outpatient days (see instructions)						22.00
33. 00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	ا ا				1	33. 01

 Heal th Financial
 Systems
 COMMUNITY

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-0074

				To	12/31/2018	Date/Time Pre 5/29/2019 3:0	
		Full Time		Di scha	arges		
		Equi val ents					
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	4, 786	582	17, 767	1. 00
2.00	HMO and other (see instructions)			1, 958	5, 117		2. 00
3. 00	HMO IPF Subprovider			1 .,	0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				Ĭ.		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGI CAL INTENSI 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	4, 786	582	17, 767	14. 00
15. 00	CAH visits			.,		,	15. 00
16. 00	SUBPROVIDER - IPF	ľ					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	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27.00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance 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
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | Part II | P Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0074

					To	12/31/2018	Date/Time Prep 5/29/2019 3:09	
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst.	Sal ari es (col. 2 ± col.	Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3.00	3) 4.00	<u>col . 4</u> 5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	177, 514, 842	-1, 050, 565	176, 464, 277	5, 353, 291. 00	32. 96	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0.00	2. 00
3. 00	A Non-physician anesthetist Part		0	0	0	0.00	0. 00	3. 00
4. 00	B Physician-Part A -		298, 690	0	298, 690	1, 858. 00	160. 76	4. 00
4. 01	Administrative Physicians - Part A - Teaching		812, 920			6, 641. 00		4. 01
5.00	Physician and Non Physician-Part B		8, 029, 678		5, 527, 575	91, 206. 00		
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0. 00	0.00	6. 00
7. 00	Interns & residents (in an approved program)	21. 00	0	3, 521, 215	3, 521, 215	119, 292. 00	29. 52	7. 00
7. 01	Contracted interns and residents (in an approved programs)		0	o	О	0.00	0. 00	7. 01
8.00	Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 3, 736, 466	-21, 407	0 3, 715, 059	0. 00 175, 035. 00		
	instructions) OTHER WAGES & RELATED COSTS					·		
11. 00	Contract Labor: Direct Patient Care		3, 200, 063	0	3, 200, 063	30, 026. 00	106. 58	11. 00
12. 00	Contract labor: Top level management and other management and administrative		1, 766, 924	0	1, 766, 924	14, 217. 00	124. 28	12. 00
13. 00	services Contract Labor: Physician-Part		4, 659, 470	0	4, 659, 470	41, 352. 00	112. 68	13. 00
14. 00	A - Administrative Home office and/or related organization salaries and		0	0	0	0.00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		55, 145, 402	0	55, 145, 402	1, 305, 917. 00	42. 23	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00		14. 02 15. 00
16. 00	- Administrative Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 00
	WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		45, 186, 231	0	45, 186, 231			17. 00
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		1, 454, 623 0	0	1, 454, 623 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	B Physician Part A - Administrative		20, 739	0	20, 739			22. 00
22. 01	Physician Part A - Teaching		74, 127					22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		1, 018, 046 0	0	1, 018, 046 0			23. 00 24. 00
25. 00	Interns & residents (in an approved program)		790, 965	0	790, 965			25. 00
25. 50	Home office wage-related (core)		12, 603, 957	0	12, 603, 957			25. 50
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative -		0	0	0			25. 52
25. 53	wage-related (core) Home office & Contract		0	0	0			25. 53
	Physicians Part A - Teaching - wage-related (core)	C						
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4.00	199, 480	0	199, 480	4, 168. 00	47. 86	26. 00
	Administrative & General	5. 00	10, 970, 148	-25, 545	10, 944, 603	276, 635. 00		27. 00

Medical Records & Medical

Records Library

Social Service

43.00 Other General Service

41.00

42.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0074

-1, 294

-10, 647

750, 376

2, 153, 582

20, 128. 00

56, 055. 00

0.00

Peri od:

37. 28

41.00

38. 42 42. 00

0.00 43.00

From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 5/29/2019 3:09 pm Wkst. A Line Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Number on of Salaries Sal ari es Related to Wage (col. 4 Reported col . 5) (from Wkst. $(col.2 \pm col.$ Salaries in col. 4 A-6)3) 1.00 4.00 5.00 2.00 6.00 3.00 28.00 Administrative & General under 17, 564, 603 17, 564, 603 176, 174. 00 99. 70 28.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 29.00 0.00 0.00 Operation of Plant 30.00 7.00 2, 670, 256 -24, 093 110, 541. 00 23. 94 30.00 2, 646, 163 31.00 0.00 Laundry & Linen Service 8.00 0.00 31.00 32.00 Housekeepi ng 9.00 2, 652, 633 -28, 769 2, 623, 864 164, 483. 00 15. 95 32.00 33.00 Housekeeping under contract 561, 298 561, 298 13, 253. 00 42. 35 33.00 (see instructions) 16. 52 34.00 10.00 2, 444, 412 -1, 748, 753 695, 659 42, 106. 00 34.00 Di etary 35.00 Di etary under contract (see 0.00 0.00 35.00 instructions) Cafeteri a 11.00 102, 467. 00 16. 89 36.00 1, 730, 216 1, 730, 216 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 38.00 Nursing Administration 13.00 3, 175, 432 -9, 871 3, 165, 561 91, 588. 00 34. 56 38.00 39.00 Central Services and Supply 14.00 0.00 0.00 39.00 Pharmacy 40.00 15.00 5, 804, 413 -18, 460 5, 785, 953 95, 434. 00 60.63 40.00

751, 670

2, 164, 229

16.00

17.00

18.00

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0074 Worksheet S-3 Peri od: From 01/01/2018 To 12/31/2018 Part III Date/Time Prepared: 5/29/2019 3:09 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . (from Salaries in col . 5) Works<u>heet A-6)</u> 3) col. 4 1.00 2.00 5.00 6.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 186, 798, 145 -4, 571, 780 182, 226, 365 5, 325, 579. 00 1.00 34. 22 instructions) 2.00 Excluded area salaries (see 3, 736, 466 -21, 407 3, 715, 059 175, 035. 00 21. 22 2.00 instructions) 3.00 Subtotal salaries (line 1 183, 061, 679 -4, 550, 373 178, 511, 306 5, 150, 544. 00 34.66 3.00 minus line 2) 4.00 Subtotal other wages & related 64, 771, 859 64, 771, 859 1, 391, 512. 00 46.55 4.00 costs (see inst.)

C

-4, 550, 373

-137, 216

57, 810, 927

301, 094, 092

48, 821, 358

0.00

6, 542, 056. 00

1, 153, 032. 00

32. 39

46 02

42.34

5.00

6.00

7.00

57, 810, 927

305, 644, 465

48, 958, 574

Subtotal wage-related costs

Total overhead cost (see

Total (sum of lines 3 thru 5)

(see inst.)

instructions)

5.00

6.00

7.00

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0074	Period: Worksheet S-3 From 01/01/2018 Part IV

	To 12/31/2018	Date/Time Prep 5/29/2019 3:09	pared: 9 pm
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		1
1.00	401K Employer Contributions	5, 615, 004	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	6, 085, 662	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	17, 383, 956	8. 02
8. 03	Health Insurance (Purchased)	0	
9.00	Prescription Drug Plan	4, 928, 112	9. 00
10.00	Dental, Hearing and Vision Plan	184, 269	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	100, 073	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	1, 530, 246	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	284, 342	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		l
	TAXES		l
	FICA-Employers Portion Only	12, 242, 203	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		1
	Day Care Cost and Allowances	190, 864	•
	Tuition Reimbursement	0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	48, 544, 731	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0074	Peri od: From 01/01/2018 To 12/31/2018		pared:
Cost Center Description		Contract Labor	Benefit Cost	

			5/29/2019 3:09	9 pm
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	3, 200, 063	48, 544, 731	1.00
2.00	Hospi tal	3, 200, 063	45, 186, 231	2.00
3.00	Subprovi der - I PF			3.00
4.00	Subprovi der - I RF			4.00
5.00	Subprovi der - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospi tal -Based SNF			8.00
9.00	Hospi tal -Based NF			9.00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -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	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Di al ysi s	0	0	17.00
18. 00	Other	0	3, 358, 500	18. 00

Heal th	Financial Systems COMMUNITY HEALTH NET	WORK, INC.	In Lie	eu of Form CMS-2	2552-10		
		Provider CCN: 15-0074	Peri od:	Worksheet S-1	0		
			From 01/01/2018 To 12/31/2018		nared:		
			10 12/31/2010	5/29/2019 3:0			
				1. 00			
	Uncompensated and indigent care cost computation						
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	rided by line 202 colum	n 8)	0. 231666	1.00		
2. 00	Medicaid (see instructions for each line) Net revenue from Medicaid			116, 625, 873	2.00		
3. 00	Did you receive DSH or supplemental payments from Medicaid?			Υ	3. 00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	al payments from Medic	ai d?	N	4. 00		
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicaid		18, 969, 026			
6. 00	Medi cai d charges			452, 818, 847			
7. 00 8. 00	Medicaid cost (line 1 times line 6)	line 7 minus sum of li	noc 2 and E. if	104, 902, 731			
0.00	Difference between net revenue and costs for Medicaid program (< zero then enter zero)	TITIE / IIITIUS SUII OT TI	nes 2 and 5, 11	0	8.00		
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line)					
9.00	Net revenue from stand-alone CHIP			0			
10.00	Stand-alone CHIP charges			0			
11. 00 12. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (line 11 minus line O	if a zoro thon	0	1		
12.00	lenter zero)	ithe it minus tine 9;	ii < zero then	0	12.00		
	Other state or local government indigent care program (see inst	ructions for each line)				
13. 00	Net revenue from state or local indigent care program (Not incl			1	13. 00		
14. 00	Charges for patients covered under state or local indigent care	program (Not included	in lines 6 or	0	14. 00		
15. 00	10) State or local indigent care program cost (line 1 times line 14)		0	15. 00		
16. 00	Difference between net revenue and costs for state or local ind	•	ne 15 minus line				
	13; if < zero then enter zero)						
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	P and state/local indi	gent care progran	ms (see			
17. 00	Private grants, donations, or endowment income restricted to fu	ınding charity care		0	17. 00		
18. 00	Government grants, appropriations or transfers for support of h			0			
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent care program	s (sum of lines	0	19. 00		
		Uni nsured	Insured	Total (col. 1			
		patients	pati ents	+ col . 2)			
	Uncompared Care (see instructions for each line)	1.00	2. 00	3. 00			
20. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fac	ility 42,908,4	76 3, 287, 029	46, 195, 505	20.00		
	(see instructions)		3, 231, 321	,,			
21. 00	Cost of patients approved for charity care and uninsured discou	ints (see 9,940,4	35 3, 287, 029	13, 227, 464	21. 00		
22.00	instructions) Design to receive from notions for amounts proviously written	off oc	0		22. 00		
22. 00	Payments received from patients for amounts previously written charity care	orr as	0	0	22.00		
23. 00	Cost of charity care (line 21 minus line 22)	9, 940, 4	35 3, 287, 029	13, 227, 464	23. 00		
				1.00			
24 00	Does the amount on line 20 column 2 include charges for nation	ut days beyond a Length	of stay limit	1. 00 N	24. 00		
	4.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?						
25. 00	If line 24 is yes, enter the charges for patient days beyond the stay limit	0	25. 00				
26. 00							
27. 00	Medicare reimbursable bad debts for the entire hospital complex	,		888, 287	ı		
27. 01	Medicare allowable bad debts for the entire hospital complex (s	see instructions)		1, 366, 595	1		
28. 00 29. 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt exp	nanca (caa instructions)	4, 088, 493	ı		
	Cost of uncompensated care (line 23 column 3 plus line 29)	rense (see 1115t1 UCT1 OHS	,	1, 425, 473 14, 652, 937	1		
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)		14, 652, 937	1		
	14, 032, 337 31. 00						

DOST Center Description		Financial Systems C SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	COMMUNITY HEALTH OF EXPENSES	NETWORK, INC. Provider Co	CN: 15-0074	In Lie Period:	u of Form CMS-2 Worksheet A	2552-10
Control Cont	RECEAS	STITICATION AND ADSOSTIMENTS OF TRIAL DALANCE V	OI EXIENSES	Trovider co	1	From 01/01/2018	Date/Time Pre	
THE PRINT STREAM CONTROL CONTROL 1,000 2,000 3,000 4,00 5,00		Cost Center Description	Sal ari es	Other			Reclassified Trial Balance (col. 3 +-	
1.00 001001 CAP REL COSSS-BLUS & FIRX			1.00	2. 00	3.00	4. 00		
2.00	4 00					04 070 000	04 070 000	1 00
0.0000 OTHER CARP REL COSTS 109,400 100,200 0 0 0 0 0 0 0 0 0				0	•			
0.0000 CAMAN ISTRATIVE A GENERAL 10, 770, 1481 170, 379, 4897 1811, 349, 630 27, 951, 877 159, 977, 733 5.00 0.0000 CAMANOY ELINEN SERVICE 2, 625, 64 1, 025, 783 1, 025, 78				Ö		0		3. 00
0.00000 LUBRITOR OF PIANT 2,707,256 14,251,864 16,932,120 -96,432 19,965,688 70,900 0.00000		1 1	1					4.00
0.00 0.000 AUNIONY & LI NEN SERVICE 0 1,005,763 1,025,763 1,025,763 1,025,763 1,005,763 1,001 1,001 1,001 1,000 1,								1
10.00 01000 DETARY 2, 444, 472 4, 098, 903 6, 543, 315 -4, 660, 007 1, 883, 308 100 13000 30000 ARESTRIC AREA SERVICES & SUPPLY 5, 904, 473 7, 473 1, 973, 735 4, 723, 737 4, 723,		1 1	1 1					1
11.00 0 1100 (CAFETRIA) 0 0 0 4, 299, 691 1, 299, 691 1, 14.00 0 1, 299, 691 1, 200, 691 1			1					9.00
13.00 01300 NIRSH NG AMIN HISTRATION 3,775,437 1,077,315 4,257,721 -39,045 4,213,702 13.00 15.00 01500 PHARMACY 5,804,133 96,965,565 101,769,793 -22,354,419 9,415,559 15.00 15.00 01500 PHARMACY 1,000 15.00 15.00 PHARMACY 1,000 15.00 PHARMACY 1,000 15.00 PHARMACY 1,000 15.00 PHARMACY 1,000 1,00		1 1	2, 444, 412	4, 098, 903 0				
15.00 0 10500 [MIANMARY] 17.00 0 10700 [DICLAL, ERCORDS & LIBRARY] 17.00 0 10700 [DICLAL SERVICE] 17.00 0 10700 [DICLAL SERVICE] 17.00 0 10700 [DICLAL SERVICE] 18.00 0 10700 [DICLAL SERV		1 1	3, 175, 432	1, 077, 315	4, 252, 74			1
16.00 01000 MEDICAL RECORDS & LIBRARY 751, 670 010, 971 1, 367, 641 -0.00 1, 307, 561 16.00 12.10 02100 187 SERVICES-SALARY & FRINCES APPRIVD 0 0 0 0 0 4, 272, 237 4, 272, 237 21.00 22200 02200 187 SERVICES-SALARY & FRINCES APPRIVD 8, 662, 630 2, 456, 110 11, 118, 740 -4, 255, 047 6, 793, 693 22.00 02200 188 SERVICES-SALARY & FRINCES APPRIVD 8, 662, 630 2, 456, 110 11, 118, 740 -4, 255, 047 6, 793, 693 22.00 223000 22300 22300 22300 22300 22300 22300			0					
17.00 01700 SOZIAL SERVICES 2,164,229 572,010 2,736,839 -1,050 2,735,789 17.00 22.00 02200 IAS SERVICES-SALARY & FRINGES APPRVD 8,662,630 2,456,110 11,118,740 -4,325,047 6,793,693 22.00 02300			1					
22.00 02200 LAR SERVICES-OTHER PREM COSTS APPRIVO 8, 662, 630 2, 456, 110 11, 118, 740 -4, 325, 047 6, 793, 693 22 00 02301 RADIOLOGY SCHOOL-ALLED HEALTH 0 0 0 0 0 0 0 0 0	17. 00	01700 SOCIAL SERVICE	1			-1, 050	2, 735, 789	17. 00
23.00 0.3200 EMS TRAIN ING-ALLIED HEALTH 0 0 0 0 0 0 0 0 0			0 442 430	0	11 110 74			
23.01 03201 RADI CLORY SCHOOL-ALLED HEALTH 0 0 0 0 0 0 0 0 0		1 1	0, 002, 030	2, 430, 110	11, 110, 74	0 -4, 323, 047		23. 00
23.0 02300 PHARMACY RESIDUECY-BTH ALLIED HEALTH 0 0 0 0 0 0 23.0	23. 01	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH	0	0		0	0	23. 01
INPATI ENT ROUTINE SERVICE COST CENTERS 37,404,086 13,543,132 50,947,218 -3,629,078 47,318,140 30.00 3100 AUNTS & PEDIATRICS 37,404,086 13,543,132 50,947,218 -3,629,078 47,318,140 31.00 32.00 3200 AUNTS & PEDIATRICS 37,404,086 13,543,132 50,947,218 -3,629,078 47,318,140 31.00 31.00 INTENSIVE CARE UNIT 5,179,969 2,996,603 7,576,572 674,586 6,901,986 31.00 32.00			0	0		0		
31 00 03100 INTENSI VE CARE UNIT 2, 945, 788 1, 512, 688 4, 458, 446 -156, 504 4, 301, 910 32, 00 3200 CRONARY CARE UNIT 2, 945, 788 1, 512, 688 4, 458, 446 -156, 504 4, 301, 910 32, 00 3200 CRONARY CARE UNIT 2, 945, 788 1, 512, 688 4, 458, 446 -156, 504 4, 301, 910 32, 00 3200 CRONARY CARE UNIT 2, 945, 788 1, 512, 688 4, 458, 446 -156, 504 4, 301, 910 32, 0	23. 03		J 0			5 0	0	23.03
32 00 032000 COROMARY CARE UNIT 2,945,788 1,512,658 4,458,446 -156,536 4,301,910 32 00		1 1	1					1
A3. 00 043000 MURSERY COST CENTERS			1					1
50.00 050000 050000 050000 050000 050000 05000			2, 710, 700	0	1, 100, 11			•
51 00 OSTOO RECOVERY ROOM & LABOR ROOM	EO 00		4 OE2 141	24 047 250	29 100 20	10 041 221	0 120 140	E0 00
54. 00 OS400 RADI OLOCY-DI AGNOSTIC 3, 933, 212 2, 562, 453 6, 495, 665 -2, 702, 220 3, 793, 445 54. 055 00 5500 OS500 RADI OLOCY-THERAPEUTIC 325, 726 1, 239, 457 1, 565, 185 -513, 000 1, 052, 185 55. 00 OS500 RADI OLOCY-THERAPEUTIC 33, 93, 212 2, 234, 465 1, 239, 457 1, 565, 185 -513, 000 1, 052, 185 55. 00 OS500 CT SCAN 831, 607 1, 300, 298 2, 131, 905 376, 103 2, 508, 008 58. 00 OS500 MGCMETI C RESONANCE I IMAGI NG (MRI) 414, 338 596, 940 1, 011, 278 -269, 225 742, 063 58. 00 OS500 MGCMETI C RESONANCE I IMAGI NG (MRI) 3, 011, 106 27, 363, 439 30, 314, 545 -26, 327, 419 4, 047, 126 59. 00 0.000 LABORATORY 311, 793 311, 793 311, 793 311, 793 311, 793 319, 477 421, 263 -28, 119 333, 144 64. 00 0.000 0.000 NIRAVENDUS THERAPY 3, 287, 226 1, 587, 350 4, 874, 56 -577, 560 4, 297, 1016 65. 00 0.000 PhYSI CAL THERAPY 5, 693, 593 3, 305, 758 4, 874, 56 -577, 560 4, 297, 1016 65. 00 0.000 0.		1 1	1					1
55.00								1
57.00 05700 CT SCAN S31, 607 1,300, 298 2,131, 905 376, 103 2,508, 008 57.00 59.00 05900 CARDITIC RESONANCE I MAGI NC (MRI) 3,011, 106 27,363, 439 30,374, 545 -26,327, 419 4,047, 126 59.00 69000 CARDIA C CATHETERI ZATI ON 3,011, 106 27,363, 439 30,374, 545 -26,327, 419 4,047, 126 59.00 69000 LABORATORY 311, 793 109, 470 421, 203 -28, 119 393, 144 64.00 66.00 06000 HISTRAVENOUS THERAPY 3,287, 226 1,587, 350 4,874, 576 -577, 560 4,297, 016 65.00 660.00 66000 PHYSI CAIL HERAPY 5,693, 593 3,305, 758 8,999, 351 -3,057, 114 5,942, 237 66.00 66000 PHYSI CAIL HERAPY 5,693, 593 3,305, 758 8,999, 351 -3,057, 114 5,942, 237 66.00 66000 66000 SEECH PATHOLOGY 0 0 0 0 0 5,597, 359, 773 68.00 68000 68000 SEECH PATHOLOGY 0 0 0 0 0 5,597, 359, 773 68.00 69.00 69000 ELECTROCARDI OLOGY 2,435, 573 420, 476 2,856, 649 -424, 869 2,431, 180 69.00 71.00 07000 ELECTROCARDI OLOGY 2,435, 573 420, 476 2,856, 649 -424, 869 2,431, 180 69.00 71.00 07000 ELECTROCARDI OLOGY 2,435, 573 458, 712 797, 785 1.99, 488 778, 297 70.00 70.00 07000 ELECTROCARDI OLOGY 2,435, 573 458, 712 797, 785 1.99, 488 778, 297 70.00 70.00 07000 ELECTROCARDI OLOGY 2,435, 573 459, 714, 714 70.00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 2,5,639, 613 25,632, 231 71.00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1					1
59.00 05900 CARDIAC CATHETERIZATION 3,011,106 27,363,499 30,374,545 -26,327,419 4,047,126 59,00 60.00 06000 LABDRATIORY 0 13,283,466 13,283,466 -176,317 13,107,149 60.00 60.00 06400 INTRAVENOUS THERAPY 311,793 109,470 421,263 -28,119 393,144 64.00 06600 PHYSI CAL THERAPY 3,287,226 1,587,350 4,874,576 -577,550 4,297,106 65.00 06600 PHYSI CAL THERAPY 5,693,593 3,305,758 8,999,351 -3,057,114 5,942,237 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 1,530,202 1,530,202 67.00 0700			1					1
60.0 0 66000 LABORATORY			1					1
64.00 06400 INTRAVERIOUS THERAPY 311, 793 109, 470 421, 263 -28, 119 393, 144 64, 05 65.00 06500 RESPI RATORY THERAPY 5, 693, 503 3, 305, 758 8, 999, 351 -3, 577, 114 5, 942, 237 66.00 06600 PHYSI CAL THERAPY 5, 693, 503 3, 305, 758 8, 999, 351 -3, 057, 114 5, 942, 237 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 559, 773 68.00 06600 SPECCH PATHOLOGY 0 0 0 0 559, 773 68.00 06600 SPECCH PATHOLOGY 0 0 0 0 559, 773 68.00 06600 SPECCH PATHOLOGY 0 0 0 0 0 0 0 0 0 0			1					
66.00 06600 PHYSI CAL THERAPY 5, 693, 593 3, 305, 758 8, 999, 351 -3, 057, 114 5, 942, 237 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 559, 773 559, 773 68. 00 68. 00 06800 SPEECH PATHOLOGY 2, 435, 573 420, 476 2, 856, 049 -424, 869 2, 431, 180 69. 00 69. 00 06900 ELECTROCARDI OLOGY 2, 435, 573 420, 476 2, 856, 049 -424, 869 2, 431, 180 69. 00 71. 00 07000 ELECTROCREPHALOGRAPHY 519, 073 458, 712 977, 785 -199, 488 778, 297 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 25, 362, 231 25, 362, 231 71. 00 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 107, 914, 334 107, 914, 334 73. 00 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 107, 914, 334 107, 914, 334 73. 00 71. 00 07400 RENAL DI ALYSI S 0 1, 424, 395 -2, 392 1, 422, 003 74. 00 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 1, 424, 395 -2, 392 1, 422, 003 74. 00 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 1, 424, 395 -2, 392 1, 422, 003 74. 00 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 1, 424, 395 -2, 392 1, 422, 003 74. 00 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 1, 424, 395 -2, 392 1, 422, 003 74. 00 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 1, 424, 395 -2, 392 1, 422, 003 74. 00 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 1, 424, 395 -2, 392 1, 422, 003 74. 00 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 71. 00 07300 07300 07300 07300 07300 07300 07300 07300 07300 07300 07300 07300 07300			311, 793			· ·	393, 144	64. 00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 1,530,202 1,530,202 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 559,773 559,773 68. 00 69. 00 06900 ELECTROCARDI OLOGY 2,435,573 420,476 2,856,049 -424,869 2,431,180 69. 00 70. 00 07000 ELECTROCARDI OLOGY 2,435,573 458,712 977,785 -199,488 778,297 70. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 25,362,231 25,639,613 72. 00 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 107,914,334 107,914,334 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 107,914,334 107,914,334 73. 00 74. 00 07400 RENAL DI ALYSIS 399,843 496,221 896,064 -346,956 549,108 76. 00 76. 01 03350 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 28,012,702 11,358,413 39,371,115 -1,880,705 37,490,410 76. 00 76. 04 03952 WOUND CARE CENTER 7,749,938 5,391,471 13,141,409 -1,304,134 11,837,275 76. 03 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 9,821,771 2,692,102 3,595,879 -942,353 2,653,526 76. 03 76. 06 03953 IMAGI NG CENTERS 9,821,771 2,692,102 3,595,879 -942,353 2,653,526 76. 03 76. 07 07697 CARDI AG REHABI LI TATI ON 690,295 355,495 1,045,790 -140,543 905,247 76. 90 76. 90 07698 MYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 90. 00 09000 CLINIC 0 0 0 0 0 0 0 90. 01 04950 IHEERIST 0 0 0 0 0 0 0 90. 02 04951 HEALTHY CLARE 0 0 0 0 0 0 0 90. 03 09001 CLINIC 0 0 0 0 0 0 90. 04 04953 SPHE CENTER 1,753,418 852,854 2,606,272 -186,840 2,419,432 90.00 90. 07 09003 KNEE CENTER 1,634,030 1,960,001 3,594,031 -202,916 3,391,115 90.00 90. 00 09000 WORK SITE CLINICS 0 0 0 0 0 0 90. 01 09006 WORK SITE CLINICS 0 0 0 0 0 0 90. 01 09006 WORK SITE CLINICS 0 0 0 0 0 0 90. 01 09006 WORK SITE CLINIC			1					ı
68. 00 06800 SPECH PATHOLOGY 0 0 559, 773 559, 773 68. 069. 00 06900 ELECTROCARDI OLOGY 2, 435, 573 420, 476 2, 856, 049 -424, 869 2, 431, 180 69. 00 07000 ELECTROCROEPHALOGRAPHY 519, 073 458, 712 977, 785 -199, 488 778, 297 70. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 519, 073 458, 712 977, 785 -199, 488 778, 297 70. 00 70. 00 0 25, 362, 231 25, 362, 231 71. 00 72. 00 10			1	3, 305, 758				
70. 00 07000 CLECTROENCEPHALGGRAPHY 519, 073 458, 712 977, 785 -199, 488 778, 297 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 25, 639, 613 25, 362, 231 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 25, 639, 613 25, 362, 231 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 107, 914, 334 107, 914, 334 73. 00 73. 00 73. 00 73. 00 07400 RENAL DI ALYSI S 0 0 1, 424, 395 1, 424, 395 -2, 392 1, 422, 003 74. 00 74.		06800 SPEECH PATHOLOGY	0	0			559, 773	68. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 25, 362, 231 25, 362, 231 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 25, 363, 613 25, 363, 613 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0107, 914, 334 107, 914, 334 73. 00 74. 00								
73. 00 07300 DRUGS CHARGED TO PATIENTS		1 1	0	430, 712	977, 70.			
74. 00 07400 RENAL DI ALYSI S 76. 00 03330 ENDOSCOPY 399, 843 496, 221 896, 064 -346, 956 549, 108 76. 00 30350 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 28, 012, 702 11, 358, 413 39, 371, 115 -1, 880, 705 37, 490, 410 76. 01 30550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 28, 012, 702 11, 358, 413 39, 371, 115 -1, 880, 705 37, 490, 410 76. 01 76. 00 30951 LUTHERWOOD PARTNERSHI P 7, 749, 938 5, 391, 471 13, 141, 409 -1, 304, 134 11, 837, 275 76. 03 76. 05 3480 [NOCLOGY-CANCER CARE CENTER 903, 777 2, 692, 102 3, 595, 879 -942, 353 2, 653, 526 76. 04 76. 05 03480 [NOCLOGY-CANCER CARE CENTER 9, 821, 711 24, 801, 965 34, 623, 676 -4, 988, 149 29, 635, 527 76. 05 76. 05 03480 [NOCLOGY-CANCER CARE CENTER 9, 821, 711 24, 801, 965 34, 623, 676 -4, 988, 149 29, 635, 527 76. 05 76. 07 03954 [BREAST DI AGNOSTI C CENTER 0, 2, 630, 168 4, 339, 626 6, 969, 794 -2, 303, 232 4, 666, 562 76. 07 03954 [BREAST DI AGNOSTI C CENTER 0, 2, 175, 408 2, 175, 408 2, 175, 408 465, 681 905, 200, 200 00 00 00 00 00 00 00 00 00 00 00 00		1 1	0	0				
76. 00 03330 ENDOSCOPY 399, 843 496, 221 896, 064 -346, 956 549, 108 76. 00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 28, 012, 702 11, 358, 413 39, 371, 115 -1, 806, 705 37, 490, 410 76. 01 76. 03 03951 LUTHERWOOD PARTMERSHI P 7, 749, 938 5, 391, 471 13, 141, 409 -1, 304, 134 11, 837, 275 76. 03 03951 LUTHERWOOD PARTMERSHI P 903, 777 2, 692, 102 3, 595, 879 -942, 353 2, 653, 526 76. 04 76. 05 03480 0NCOLOGY-CANCER CARE CENTER 903, 777 2, 692, 102 3, 595, 879 -942, 353 2, 653, 526 76. 04 76. 06 03951 IMAGI NG CENTERS 2, 630, 168 4, 339, 626 6, 969, 794 -2, 303, 232 4, 666, 562 76. 06 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 2, 175, 408 2, 175, 408 2, 175, 408 -46, 152 2, 129, 256 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 2, 175, 408 2, 175, 408 465, 681 465, 681 76. 97 07697 CARDI AC REHABI LI TATI ON 690, 295 355, 495 1, 045, 790 -140, 543 905, 247 76. 97 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	0	0 1 424 395	1 424 39			1
76. 03 03951 LUTHERWOOD PARTNERSHIP			399, 843					
76. 04 03952 WOUND CARE CENTER 903,777 2,692,102 3,595,879 -942,353 2,653,526 76.04 76.05 03480 ONCOLOGY-CANCER CARE CENTER 9,821,711 24,801,965 34,623,676 -4,988,149 29,635,527 76.06 76.06 03953 IMAGING CENTERS 2,630,168 4,339,626 6,969,794 -2,303,232 4,666,562 76.06 76.07 03954 BREAST DI AGNOSTIC CENTER 0 2,175,408 2,175,408 -46,152 2,129,256 76.07 76.97 07697 CARDI AC REHABI LITATI ON 690,295 355,495 1,045,790 -140,543 905,247 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 465,681 465,681 76.97 0UTPATI ENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 88.00 09000 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 0 90.00 90.00 90.00 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1					1
76. 05		1 1						
76. 07 03954 BREAST DIAGNOSTIC CENTER 0 2, 175, 408 2, 175, 408 -46, 152 2, 129, 256 76. 07 76. 97 07697 CARDI AC REHABILITATI ON 690, 295 355, 495 1, 045, 790 -140, 543 905, 247 76. 97 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 465, 681 465, 681 465, 681 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	76. 05	03480 ONCOLOGY-CANCER CARE CENTER	9, 821, 711	24, 801, 965	34, 623, 67	-4, 988, 149	29, 635, 527	76. 05
76. 97			2, 630, 168					
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 465, 681 465, 681 76. 98		1 1	690, 295					
88. 00	76. 98		1	0			465, 681	76. 98
89. 00	88. 00		0	0		0	0	88.00
90. 01 04950 DI ABETI C CARE CENTER 0 0 0 0 0 0 90. 01 90. 02 04951 HEALTHY HEARTS CENTER 1,753,418 852,854 2,606,272 -186,840 2,419,432 90. 02 90. 03 09001 CLI NI C 0 0 0 0 0 0 0 90. 04 04953 SPI NE CENTER 0 46 46 0 46 90. 04 90. 05 04954 INFUSI ON CENTERS 426,303 15,659,853 16,086,156 -15,405,197 680,959 90. 05 90. 06 09002 MEDCHECK CLI NI CS 0 0 0 0 0 0 90. 08 09004 PALLI ATI VE CARE 0 0 0 0 0 0 90. 08 09006 WORK SI TE CLI NI CS 0 0 0 0 0 90. 08 09006 WORK SI TE CLI NI CS 0 0 0 0 90. 08 09006 WORK SI TE CLI NI CS 0 0 0 0 90. 08 09006 WORK SI TE CLI NI CS 0 0 0 0 90. 08 09006 WORK SI TE CLI NI CS 0 0 0 0 90. 08 09006 WORK SI TE CLI NI CS 0 0 0 0 90. 08 09006 WORK SI TE CLI NI CS 0 0 0 0 90. 08 09006 WORK SI TE CLI NI CS 0 0 0 0 90. 08 09006 WORK SI TE CLI NI CS 0 0 0 0 90. 08 09006 WORK SI TE CLI NI CS 0 0 0 0 90. 08 09006 WORK SI TE CLI NI CS 0 0 0 0 90. 08 09006 WORK SI TE CLI NI CS 0 0 0 0 90. 08 09006 WORK SI TE CLI NI CS 0 0 0 0 90. 08 09007 09008	89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	_	89. 00
90. 02			0	0		0	_	1
90. 04 04953 SPI NE CENTER 0 46 46 0 46 90. 04 90. 05 90. 05 90. 06 90. 05 90. 06 90. 06 90. 07 90. 08 90. 08 90. 08 90. 08 90. 10 90. 06 9		1 1	1, 753, 418	852, 854	2, 606, 27	-186, 840	_	ı
90. 05 04954 INFUSION CENTERS 426, 303 15, 659, 853 16, 086, 156 -15, 405, 197 680, 959 90. 05 90. 06 90. 07 90. 08			0	0		0	_	
90. 06 09002 MEDCHECK CLINICS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			426 303					ı
90. 08 09004 PALLI ATI VE CARE		09002 MEDCHECK CLINICS	0	0		0		1
90. 10 09006 WORK SITE CLINICS 0 0 0 0 90. 10			1, 634, 030	1, 960, 001	3, 594, 03	-202, 916		
			0	0				90. 08
	90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	0	0	45	0	0	90. 12
91. 00 09100 EMERGENCY 8, 465, 291 7, 181, 063 15, 646, 354 -676, 577 14, 969, 777 91. 00	91.00	OA LOO EWEKGENCA	8, 465, 291	7, 181, 063	15, 646, 35	-6/6, 577	14, 969, 777	91.00

Health Financial Systems CC	OMMUNITY HEALTH	NETWORK, INC.		In Lie	eu of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		eri od:	Worksheet A	
				rom 01/01/2018 o 12/31/2018	Date/Time Pre 5/29/2019 3:0	
Cost Center Description	Sal ari es	0ther		Recl assi fi cati		
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00	0.00			col . 4)	
as as assess another than pena (way by at year pant)	1.00	2. 00	3. 00	4. 00	5. 00	00.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS		ام				00.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0	98. 00
SPECIAL PURPOSE COST CENTERS	170 770 07/	4/7 141 202	(40,010,750	1 (21 720	(40 551 470	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	173, 778, 376	467, 141, 383	640, 919, 759	1, 631, 720	642, 551, 479	1118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	٥	٥			0	190. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0		0	l e	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		90, 633	90, 633	-27, 829		
194. 00 07950 HOME OFFICE		7 0, 033	70, 033	-21,029		194. 00
194.01 07951 OCCUPATIONAL HEALTH ONSITE SVCS		0				194. 00
194. 03 07953 SCHOOL BASED CLINICS	1, 302	36	1, 338	0		194. 01
194. 04 07954 SMO-NON PROVI DER BASED	477, 778	148, 746			626, 524	1
194. 05 07955 FAMILY PRACTICE MEDICINE	2, 351, 463	2, 382, 540			3, 265, 339	
194. 07 07957 LIFECHECK	2, 331, 403	2, 302, 340	٠, ١٥٠, ٥٥٥	1, 400, 004		194. 07
194. 08 07958 GROUP HOMES AND MISC. N_R CTRS	905, 923	535, 892	1, 441, 815	-135, 227		
194. 09 07959 SURGERY CENTER EAST	705, 725	033, 072	1, 441, 010	133, 227		194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	177, 514, 842	470, 299, 230	647, 814, 072	0	647, 814, 072	
255. 55	, 511, 612	, 277, 200	31.,011,072	.1	0,011,072	

неат тг	n Financial Systems	COMMUNITY HEALTH	I NETWORK, INC.		In Lie	u of Form CMS-25	552-10
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANC		Provi der CCN	: 15-0074	Peri od:	Worksheet A	
					From 01/01/2018 To 12/31/2018	Date/Time Prepa	ared:
						5/29/2019 3:09	
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation				
		6. 00	7.00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	-6, 566, 956					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	9, 967, 294					2. 00
3.00	00300 OTHER CAP REL COSTS	0	0				3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	8, 791, 400					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-43, 250, 837					5.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	-145, 815 0					7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10.00		-65, 227					10.00
11. 00		-2, 109, 707	2, 189, 984				11. 00
13.00		4, 359, 991	1 1				13.00
14.00	l l	3, 929, 603	1				14.00
15.00	01500 PHARMACY	-508, 163	8, 907, 396				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	4, 499, 336	5, 866, 897				16.00
17.00		0	_,				17.00
21. 00							21.00
22. 00	l l						22. 00
23.00		0	1				23.00
23. 01	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH	0				•	23. 01
23. 02 23. 03		0				1	23. 02 23. 03
23. 03	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH INPATIENT ROUTINE SERVICE COST CENTERS		U U				23. 03
30. 00		-174, 178	47, 143, 962				30. 00
31.00		171,170	1				31.00
32. 00		0				l l	32. 00
43.00		0	1			-	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00		-289, 022				l l	50.00
51.00		0				l l	51.00
52. 00		-827, 725					52.00
54.00		-36, 018					54.00
55.00		0				l l	55.00
57. 00 58. 00		0				l l	57. 00 58. 00
59. 00		-166, 858					59.00
60.00		-990, 925				I	60.00
64. 00	l l	770, 725					64. 00
65. 00			1			<u> </u>	65. 00
66.00	l l	176, 924	1			<u> </u>	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	1, 530, 202				67.00
68.00	06800 SPEECH PATHOLOGY	0	559, 773				68.00
69. 00		543, 686	1				69.00
70. 00	l l	144, 450	1			l l	70. 00
71.00							71.00
72.00		2 000 (03	,,			•	72.00
73. 00 74. 00	l l	2, 090, 602				1	73. 00 74. 00
76.00			549, 108			I	76. 00
76. 01		-24, 023, 388	1			•	76. 01
76. 03	l l	-9, 158, 584				I	76. 03
76.04	03952 WOUND CARE CENTER	0	2, 653, 526			-	76.04
76.05	03480 ONCOLOGY-CANCER CARE CENTER	-7, 794, 488	21, 841, 039			-	76.05
76.06		0	4, 666, 562			-	76.06
76. 07		0	2, 129, 256			l l	76. 07
76. 97		-27, 133					76. 97
76. 98		0	465, 681				76. 98
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	O				88. 00
89.00			1			I	89.00
90.00							90.00
90. 01		n	0			I	90. 01
90. 02	l l	-660, 856	1, 758, 576				90. 02
90. 03		0	0			<u> </u>	90. 03
90. 04		0	46			•	90. 04
90. 05	l l	0	680, 959			<u> </u>	90.05
90.06	l l	0				I	90.06
90.07	l l	0	3, 391, 115			I	90.07
90.08	1	0	0			•	90.08
90. 10	l l		0			•	90. 10
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE 09100 EMERGENCY	147 227	14 022 550			1	90. 12 91. 00
7 I. UU	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-147, 227	14, 822, 550			1	91.00
92 00							

Health FinancialSystemsCOMMUNITY HEADRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES COMMUNITY HEALTH NETWORK, INC. In Lieu of Form CMS-2552-10 Provider CCN: 15-0074

			5/29/2019 3:	09 pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7.00		
OTHER REIMBURSABLE COST CENTERS				
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-65, 119, 407	577, 432, 072		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
191. 00 19100 RESEARCH	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	62, 804		192. 00
194.00 07950 HOME OFFICE	0	0		194. 00
194.01 07951 OCCUPATIONAL HEALTH ONSITE SVCS	0	0		194. 01
194.03 07953 SCHOOL BASED CLINICS	0	1, 338		194. 03
194.04 07954 SMO-NON PROVIDER BASED	0	626, 524		194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	0	3, 265, 339		194. 05
194. 07 07957 LI FECHECK	0	o		194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	0	1, 306, 588		194. 08
194. 09 07959 SURGERY CENTER EAST	0	0		194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	-65, 119, 407	582, 694, 665		200. 00

Health Financial Systems		CO	MMUNITY HEALTH	H NETWORK, INC.		In Lieu of Form CMS-2552-1		
RECLAS	SIFICATIONS			Provi der C	CCN: 15-0074	Peri od: From 01/01/2018	Worksheet A-	6
						To 12/31/2018	Date/Time Pr	epared:
		Increases					5/29/2019 3:	09 pm
	Cost Center	Increases Line #	Sal ary	Other				
	2. 00	3.00	4.00	5. 00				
	A - Chargeable Medical Supplie							
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	25, 362, 231				1. 00
2. 00	FATTENTS	0.00	0	0				2. 00
3.00		0.00	0	0				3. 00
4.00		0.00	0	0				4. 00
5. 00 6. 00		0. 00 0. 00	0	0				5. 00 6. 00
7. 00		0.00	0	o				7. 00
8.00		0. 00	0	0				8. 00
9.00		0.00	0	0				9. 00
10. 00 11. 00		0. 00 0. 00	0	0				10. 00 11. 00
12. 00		0.00	0	0				12. 00
13.00		0. 00	О	0				13. 00
14.00		0.00	0	0				14. 00
15. 00 16. 00		0. 00 0. 00	0	0				15. 00 16. 00
17. 00		0.00	0	0				17. 00
18. 00		0. 00	О	0				18. 00
19. 00		0.00	0	0				19. 00
20. 00 21. 00	+	0. 00 0. 00	0	0				20. 00 21. 00
22. 00		0.00	0	0				22. 00
23. 00		0. 00	О	0				23. 00
24. 00		0.00	0	0				24. 00
25. 00 26. 00		0. 00 0. 00	0	0				25. 00 26. 00
27. 00		0.00	0	0				27. 00
28. 00		0. 00	0	0				28. 00
29. 00		0.00	0	0				29. 00
30. 00 31. 00		0. 00 0. 00	0	0				30. 00 31. 00
32. 00		0.00	0	0				32. 00
33. 00		0. 00	0	0				33. 00
34. 00		0.00	0	0				34. 00
35. 00 36. 00		0. 00 0. 00	0	0				35. 00 36. 00
37. 00		0.00	0	0				37. 00
38. 00		0.00	O	Ō				38. 00
39. 00			•	0				39. 00
	B - Implantable Device Reclass		0	25, 362, 231				
1.00	I MPL. DEV. CHARGED TO	72.00	0	25, 639, 613				1.00
	PATI ENTS							
2.00		0.00	0	0				2. 00
3. 00 4. 00		0. 00 0. 00	0	0				3. 00 4. 00
5. 00		0.00	Ö	0				5. 00
	0		0	25, 639, 613				
1. 00	C - Drugs Charges to Pat DRUGS CHARGED TO PATIENTS	73. 00	0	107, 914, 334				1. 00
2.00	DROGS CHARGED TO PATTENTS	0.00	0	107, 914, 334				2.00
3.00		0. 00	0	0				3. 00
4.00		0.00	0	0				4.00
5. 00 6. 00		0. 00 0. 00	0	0				5. 00 6. 00
7. 00		0.00	0	0				7. 00
8.00		0.00	О	0				8. 00
9.00		0.00	0	0				9. 00
10. 00 11. 00		0. 00 0. 00	0	0				10. 00 11. 00
12. 00		0.00	0	0				12. 00
13.00		0.00	О	0				13. 00
14.00		0.00	0	0				14.00
15. 00 16. 00		0. 00 0. 00	0	0				15. 00 16. 00
17. 00		0.00	0	0				17. 00
18. 00		0. 00	0	0				18. 00
19. 00		0.00	0	0				19.00
20.00		0. 00 0. 00	0	0				20. 00 21. 00
21. 00 22. 00		0.00	0	0				21.00
23. 00		0.00	Ö	Ö				23. 00
	<u>'</u>	·						

Health Financial Systems RECLASSIFICATIONS | Period: | Worksheet A-6 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: 5/29/2019 3:09 pm Provider CCN: 15-0074

					5/29/2019 3:	
		Increases		·		
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4.00	5. 00		
24.00		0.00	0	0		24. 00
25. 00		0.00	0	0		25. 00
26. 00		0.00	0	0		26. 00
27.00		0.00	0	0		27. 00
28.00		0.00	0	0		28. 00
29.00		0.00	0	0		29. 00
30.00		0.00	0	0		30. 00
31.00		0.00	O	0		31. 00
32.00		0.00	o	0		32.00
	0 — — — — — —			107, 914, 334		İ
	D - Depreciation Expense			· · · · ·		1
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	20, 008, 754		1. 00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	o		12. 00
13. 00		0.00	0	o		13. 00
14. 00		0.00	0	0		14. 00
15. 00		0.00	o	Ö		15. 00
16. 00		0.00	0	Ö		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18.00
19. 00		0.00	0	0		19. 00
			•			20.00
20.00		0.00	0	0		4
21. 00		0.00	0	0		21. 00
22. 00		0.00	0	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00		0.00	0	0		25. 00
26. 00		0.00	0	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	0	0		29. 00
30. 00		0.00	0	0		30. 00
31.00		0.00	0	0		31. 00
32.00		0.00	0	0		32. 00
33.00		0.00	0	0		33. 00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35. 00
36.00		0.00	0	0		36. 00
37.00		0.00	0	0		37. 00
38.00		0.00	0	0		38. 00
39.00		0.00	0	0		39. 00
40.00		0.00	0	0		40.00
41.00		0.00	0	0		41. 00
	$\frac{1}{0} = \frac{1}{0} = \frac{1}{0} = \frac{1}{0}$		0	20, 008, 754		
	E - Interest Expense					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	<u>11, 136, 0</u> 40		1. 00
	0			11, 136, 040		
	F - Other Capital Rental	,				
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	10, 853, 643		1. 00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10. 00		0.00	o	Ö		10.00
11. 00		0.00	Ö	Ö		11. 00
12. 00		0.00	o	Ö		12. 00
13. 00		0.00	0	Ö		13. 00
14. 00		0.00	o	Ö		14. 00
15. 00		0.00	0	Ö		15. 00
16. 00		0.00	0	o		16. 00
17. 00		0.00	0	0		17. 00
17.00	I	0.00	υĮ	U _I		17.00

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

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 3:09 pm

		Increases			5/29/2019 3:	U4 piii
	Cost Center	Li ne #	Sal ary	Other		1
	2.00	3.00	4.00	5. 00		
18. 00	21.00	0.00	0	0.00		18. 00
19. 00		0.00	o	0		19. 00
20. 00		0.00	o	0		20. 00
21. 00		0.00	o	0		21. 00
22. 00		0.00	o	0		22. 00
23. 00		0.00	o	0		23. 00
		•	o	0		1
24. 00		0.00	•	0		24. 00
25. 00		0.00	0	0		25. 00
26. 00		0.00	0	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	0	0		29. 00
30. 00		0.00	0	0		30. 00
31. 00		0.00	0	0		31. 00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33. 00
34.00		0.00	o	0		34. 00
35.00		0.00	0	0		35. 00
36.00		0.00	O	0		36. 00
37. 00		0.00	Ö	0		37. 00
38. 00		0.00	o	0		38. 00
39. 00		0.00	o	0		39. 00
		· · · · · · · · · · · · · · · · · · ·	0	0		1
40.00		0.00	-	0		40.00
41. 00		0.00	0	0		41. 00
42. 00		0.00	0	0		42. 00
43. 00		0.00	0	0		43. 00
	0		0	10, 853, 643		_
	G - STD BENEFITS		_1			4
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	25, 545		1.00
2.00	OPERATION OF PLANT	7.00	0	24, 093		2. 00
3. 00	HOUSEKEEPI NG	9. 00	0	28, 769		3. 00
4.00	DI ETARY	10.00	0	18, 537		4. 00
5.00	NURSING ADMINISTRATION	13. 00	0	9, 871		5. 00
6.00	PHARMACY	15. 00	0	18, 460		6. 00
7.00	MEDICAL RECORDS & LIBRARY	16. 00	0	1, 294		7. 00
8.00	SOCI AL SERVI CE	17. 00	o	10, 647		8. 00
9.00	I&R SERVICES-OTHER PRGM	22. 00	o	60, 339		9. 00
	COSTS APPRVD					
10.00	ADULTS & PEDIATRICS	30.00	o	261, 108		10.00
11. 00	INTENSIVE CARE UNIT	31.00	O	33, 182		11. 00
12. 00	CORONARY CARE UNIT	32.00	Ö	25, 455		12. 00
13. 00	OPERATING ROOM	50.00	o	12, 729		13. 00
14. 00	RECOVERY ROOM	51.00	o	3, 365		14. 00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	Ö	20, 645		15. 00
16. 00	RADI OLOGY-THERAPEUTI C	55. 00	o	20, 043		16. 00
	CT SCAN	•	o			1
17. 00	MAGNETIC RESONANCE I MAGING	57.00		2, 477		17. 00
18. 00		58. 00	0	3, 446		18. 00
10.00	(MRI)	F0 00	0	10 440		10.00
	CARDI AC CATHETERI ZATI ON	59.00	۰	12, 442		19. 00
	I NTRAVENOUS THERAPY	64.00	0	4, 969		20. 00
21. 00	RESPIRATORY THERAPY	65.00	0	23, 970		21. 00
	PHYSI CAL THERAPY	66.00	0	39, 188		22. 00
	ELECTROCARDI OLOGY	69. 00	0	9, 557		23. 00
	ELECTROENCEPHALOGRAPHY	70. 00	0	2, 264		24. 00
25.00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0	205, 272		25. 00
	SERVI CES					
26.00	LUTHERWOOD PARTNERSHIP	76. 03	0	57, 575		26. 00
27.00	WOUND CARE CENTER	76. 04	o	2, 226		27. 00
28. 00	ONCOLOGY-CANCER CARE CENTER	76. 05	o	35, 756		28. 00
29. 00	I MAGING CENTERS	76.06	О	12, 508		29. 00
30.00	CARDIAC REHABILITATION	76. 97	o	9, 472		30.00
31.00	HEALTHY HEARTS CENTER	90. 02	O	17, 064		31.00
32. 00	INFUSION CENTERS	90. 05	n	177		32. 00
33. 00	KNEE CENTER	90. 07	o	10, 849		33. 00
34. 00	EMERGENCY	91.00	0	25, 702		34. 00
35. 00	FAMILY PRACTICE MEDICINE	194. 05	o	20, 670		35. 00
36. 00	GROUP HOMES AND MISC. N_R	194. 08	0	737		36. 00
30.00	CTRS	174.00	٩	131		30.00
	0	$\vdash \vdash +$	— — — _d	1, 050, 565	1	1
	H - Labor and Delivery		U _I	1, 030, 303		1
1.00	NURSERY	43.00	382, 204	170, 328		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	944, 655	420, 983		2. 00
2.00	0	— — 32.00 +	1, 326, 859			2.00
	lo l		1, 320, 039	371, 311	I	1

RECLASS	SIFICATIONS			Provi der C	CCN: 15-0074	Period: From 01/01/2018		
						To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
		Increases		,				
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	I - Cafeteria							
1 00	CAFETEDIA	11 00	1 720 217	0				1 00

					3/24/2014 3. 04 pill
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	
	I - Cafeteria				
1.00	CAFETERI A	11, 00	1, 730, 216	0	1. 0
2.00	CAFETERI A	11.00	0	2, 569, 475	2.00
	0	— — ····+	1, 730, 216	2, 569, 475	
	J - Therapy Reclass		1, 700, 210	2,007,170	
1.00	OCCUPATI ONAL THERAPY	67.00	1, 079, 768	450, 434	1.0
2.00	SPEECH PATHOLOGY	68.00	394, 997	164, 776	2.0
2.00	0	00.00	1, 474, 765	615, 210	2.0
	U Duillidiaa Damaai ati aa		1, 4/4, /00	013, 210	
4 00	K - Builiding Depreciation	1 00	ام	0.000.540	4.0
1.00	CAP REL COSTS-BLDG & FIXT	1.00		9, 998, 543	1.00
	0		0	9, 998, 543	
	L - Capital Insurance Costs	,			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0_	23 <u>5, 4</u> 39	1. 0
	0		0	235, 439	
	M - Radi ol ogy Support				
1.00	RADI OLOGY-THERAPEUTI C	55.00	380, 777	125, 133	1. 0
2.00	CT SCAN	57.00	165, 378	54, 347	2. 0
3.00	MAGNETIC RESONANCE I MAGING	58.00	28, 208	9, 270	3.00
	(MRI)		.,		
4.00	I MAGING CENTERS	76.06	113, 274	37, 225	4.00
00	0		687, 637	225, 975	
	N - Hyperbaric Oxygen Therapy	/	007,007	220, 710	
1.00	HYPERBARI C OXYGEN THERAPY	76. 98	129, 137	336, 544	1.0
1.00	O TITEL CONTINUE THE RAFT	70.70	129, 137	336, 544	1.0
	0 - IHH Cat Scan		129, 137	330, 344	
1 00		F7.00	F07 FF7	0	1.0
1.00	CT SCAN	57.00	587, 557	0	1.0
2.00	CT_SCAN	57.00	0	137, 535	2.00
	0		587, 557	137, 535	
	P - Residents Costs	, ,			
1.00	I&R SERVICES-SALARY &	21.00	3, 521, 215	751, 022	1.00
	FRI_NGES_ APPRVD				
	0		3, 521, 215	751, 022	
	S - CBI Allocation to Gallahu	ue			
1.00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0	2, 304	1. 0
	SERVI CES				
	0 — — — — — —			2, 304	
500.00	Grand Total: Increases		9, 457, 386	217, 428, 538	500. 0
	1	1			1

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

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 3:09 pm

		Decreases				5/29/2019 3:0	J9 pm
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8.00	9. 00	10.00		
	A - Chargeable Medical Suppli	es					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	56	0		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	36, 075			2. 00
3.00	OPERATION OF PLANT	7. 00	0	161, 883	1		3. 00
4.00	HOUSEKEEPI NG	9.00	0	1, 134			4. 00
5.00	DI ETARY	10.00	0	1, 011	0		5. 00
6. 00 7. 00	NURSING ADMINISTRATION PHARMACY	13. 00 15. 00	0	14, 283 228, 327	1		6. 00 7. 00
8. 00	I &R SERVICES-OTHER PRGM	22. 00	0	1, 033			8.00
0.00	COSTS APPRVD	22.00	Ĭ	1, 000	Ĭ		0.00
9.00	ADULTS & PEDIATRICS	30.00	О	956, 730	0		9. 00
10.00	INTENSIVE CARE UNIT	31.00	0	409, 514	0		10.00
11. 00	CORONARY CARE UNIT	32.00	0	114, 884			11. 00
12. 00	OPERATING ROOM	50.00	0	7, 540, 868			12. 00
13.00	RECOVERY ROOM	51.00	0	101, 741	0		13.00
14.00	RADI OLOGY TUEDADELITIC	54.00	0	448, 267	0		14. 00
15. 00 16. 00	RADI OLOGY-THERAPEUTI C CT SCAN	55. 00 57. 00	0	556, 134 206, 819			15. 00 16. 00
17. 00	MAGNETIC RESONANCE I MAGING	58.00	0	8, 098	1		17. 00
17.00	(MRI)	30.00	Ĭ	0,070	١		17.00
18. 00	CARDIAC CATHETERIZATION	59.00	О	11, 275, 309	o		18. 00
19. 00	LABORATORY	60.00	О	58, 219	0		19. 00
20. 00	INTRAVENOUS THERAPY	64.00	0	25, 115			20. 00
21. 00	RESPI RATORY THERAPY	65. 00	0	424, 367	0		21. 00
22. 00	PHYSI CAL THERAPY	66. 00	0	31, 393			22. 00
23. 00	ELECTROCARDI OLOGY	69.00	0	34, 083	1		23. 00
24. 00	ELECTROENCEPHALOGRAPHY	70.00	0	34, 215			24. 00
25. 00	RENAL DI ALYSI S ENDOSCOPY	74.00	0	1, 518			25. 00
26. 00 27. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 00 76. 01	0	241, 899 27, 268	1		26. 00 27. 00
27.00	SERVICES	70.01		27, 200			27.00
28. 00	WOUND CARE CENTER	76. 04	О	289, 492	o		28. 00
29. 00	ONCOLOGY-CANCER CARE CENTER	76. 05	О	521, 528	0		29. 00
30.00	I MAGING CENTERS	76.06	0	976, 151	0		30.00
31. 00	BREAST DIAGNOSTIC CENTER	76. 07	0	750			31. 00
32. 00	CARDIAC REHABILITATION	76. 97	0	14, 926			32. 00
33. 00	HEALTHY HEARTS CENTER	90. 02	0	29, 937			33. 00
34. 00	I NFUSI ON CENTERS	90. 05	0	4, 931	0		34.00
35. 00	KNEE CENTER	90. 07	0	17, 620			35. 00
36. 00 37. 00	EMERGENCY PHYSICIANS' PRIVATE OFFICES	91. 00 192. 00	0	531, 989 272	0		36. 00 37. 00
38. 00	FAMILY PRACTICE MEDICINE	194. 05	0	30, 813			38.00
39. 00	GROUP HOMES AND MISC. N R	194. 08	Ö	3, 579			39.00
07.00	CTRS	.,		0, 0, ,			07.00
	0 — — — — —			25, 362, 231]
	B - Implantable Device Reclas						
1. 00	OPERATING ROOM	50.00	0	11, 298, 687			1. 00
2.00	RADI OLOGY-THERAPEUTI C	55.00	0	196, 444			2. 00
3.00	CARDI AC CATHETERI ZATI ON	59.00	0	13, 970, 977			3.00
4. 00 5. 00	ENDOSCOPY WOUND CARE CENTER	76.00	0	33, 354 140, 151			4. 00 5. 00
5.00	0	76.04		140, 131 25, 639, 613			3.00
	C - Drugs Charges to Pat		U _I	25, 059, 013	<u> </u>		1
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	63	0		1.00
2. 00	OPERATION OF PLANT	7. 00	Ö	1, 508			2. 00
3.00	DI ETARY	10.00	O	369			3. 00
4.00	NURSING ADMINISTRATION	13.00	0	14, 112	0		4. 00
5.00	CENTRAL SERVICES & SUPPLY	14. 00	0	3, 877	1		5. 00
6. 00	PHARMACY	15. 00	0	91, 376, 471	0		6. 00
7.00	ADULTS & PEDIATRICS	30.00	0	71, 888	1		7. 00
8.00	INTENSIVE CARE UNIT	31.00	0	20, 412			8.00
9.00	CORONARY CARE UNIT	32.00	0	12, 966			9.00
10. 00 11. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0	90, 574 1, 215			10.00
12. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 215 50, 769			12.00
13. 00	RADI OLOGY-THERAPEUTI C	55.00	ol	4, 799			13. 00
14. 00	CT SCAN	57.00	o	154, 903			14. 00
15. 00	MAGNETIC RESONANCE IMAGING	58. 00	O	59, 129			15. 00
	(MRI)		1	,			
16. 00	CARDI AC CATHETERI ZATI ON	59.00	О	123, 257			16. 00
17. 00	INTRAVENOUS THERAPY	64.00	0	39			17. 00
18.00	RESPIRATORY THERAPY	65.00	0	6, 464	1		18.00
19.00	PHYSI CAL THERAPY	66.00	0	1, 065	1		19.00
20. 00	ELECTROCARDI OLOGY	69.00	0	4, 602	0		20. 00

Provider CCN: 15-0074

| Peri od: | Worksheet A-6 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: 5/29/2019 3:09 pm

						5/29/2019 3:	09 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
21. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	2			21. 00
22. 00	RENAL DIALYSIS	74. 00	0	96			22. 00
23. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0	35, 071	0		23. 00
	SERVI CES		_		_		1
24. 00	LUTHERWOOD PARTNERSHIP	76. 03	0	14, 224			24. 00
25. 00	WOUND CARE CENTER	76. 04	0	39, 266			25. 00
26. 00	ONCOLOGY-CANCER CARE CENTER	76. 05	0	282, 597			26. 00
27. 00	I MAGING CENTERS	76. 06	0	94, 567			27. 00
28. 00	HEALTHY HEARTS CENTER	90. 02	0	90			28. 00
29. 00	INFUSION CENTERS	90. 05	0	15, 084, 507	0		29. 00
30.00	EMERGENCY	91.00	0	24, 519	0		30.00
31.00	FAMILY PRACTICE MEDICINE	194. 05	0	340, 893	0		31. 00
32.00	GROUP HOMES AND MISC. N_R	194. 08	0	20	0		32. 00
	CTRS						
	0		0	107, 914, 334			
	D - Depreciation Expense						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1, 394	9		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	9, 016, 048	o		2. 00
3.00	OPERATION OF PLANT	7.00	0	528, 278	o		3. 00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	83	o		4. 00
5.00	HOUSEKEEPI NG	9.00	0	6, 276			5. 00
6.00	DI ETARY	10.00	o	84, 648			6. 00
7. 00	NURSING ADMINISTRATION	13. 00	0	8, 832			7. 00
8. 00	CENTRAL SERVICES & SUPPLY	14. 00	o	20, 661			8. 00
9. 00	PHARMACY	15. 00	o	77, 533			9. 00
10. 00	I&R SERVICES-OTHER PRGM	22. 00	0	32, 154			10.00
10.00	COSTS APPRVD	22.00	٥	32, 134	١		10.00
11. 00	ADULTS & PEDIATRICS	30.00	0	656, 616	0		11. 00
12. 00	INTENSIVE CARE UNIT	31.00	o	227, 839			12. 00
13. 00	CORONARY CARE UNIT	32.00	0	28, 606			13. 00
14. 00	OPERATING ROOM	50.00	0	794, 783			14. 00
15. 00	RECOVERY ROOM		o				15. 00
	1	51.00	- 1	1, 400			1
16.00	RADI OLOGY-DI AGNOSTI C	54.00	0	518, 244			16.00
17. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	261, 247			17. 00
18. 00	CT SCAN	57. 00	0	206, 832			18. 00
19. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	239, 157	0		19. 00
	(MRI)		_		_		1
20. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	953, 938			20.00
21. 00	LABORATORY	60.00	0	64, 654			21. 00
22. 00	I NTRAVENOUS THERAPY	64. 00	0	2, 769			22. 00
23. 00	RESPI RATORY THERAPY	65. 00	0	135, 111			23. 00
24. 00	PHYSI CAL THERAPY	66. 00	0	94, 029			24. 00
25. 00	ELECTROCARDI OLOGY	69. 00	0	249, 892			25. 00
26. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	122, 541	0		26. 00
27. 00	RENAL DIALYSIS	74.00	0	503	0		27. 00
28. 00	ENDOSCOPY	76. 00	0	71, 073	0		28. 00
29. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0	176, 922	0		29. 00
	SERVI CES						
30.00	LUTHERWOOD PARTNERSHIP	76. 03	0	76, 250	0		30.00
31.00	WOUND CARE CENTER	76. 04	0	7, 683	0		31.00
32.00	ONCOLOGY-CANCER CARE CENTER	76. 05	0	3, 692, 534	0		32. 00
33.00	I MAGING CENTERS	76. 06	0	1, 034, 162			33. 00
34.00	CARDIAC REHABILITATION	76. 97	0	20, 689	o		34.00
35. 00	HEALTHY HEARTS CENTER	90. 02	0	32, 248			35. 00
36.00	INFUSION CENTERS	90. 05	o	60, 025			36.00
37. 00	KNEE CENTER	90. 07	Ö	184, 298			37. 00
38. 00	EMERGENCY	91.00	o o	77, 573			38. 00
39. 00	PHYSICIANS' PRIVATE OFFICES	192.00	o	7, 104			39. 00
40. 00	FAMILY PRACTICE MEDICINE	194. 05	o	182, 921			40.00
41. 00	GROUP HOMES AND MISC. N_R	194. 08	Ö	51, 204			41. 00
11.00	CTRS	171.00	Ĭ	01, 201	١		11.00
	0 — — — —		— — ₀	20, 008, 754			
	E - Interest Expense		<u> </u>	_3, 330, 734			
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	11, 136, 040	11		1.00
50	0		— — o	11, 136, 040			1.00
	F - Other Capital Rental		<u> </u>	11, 130, 040			1
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	24, 752	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 525, 908			2. 00
3.00	OPERATION OF PLANT	7. 00	o o	274, 763			3. 00
	HOUSEKEEPI NG	7.00 9.00	0				4. 00
4.00			-	2, 449			
5.00	DI ETARY	10.00	0	274, 288			5. 00
6.00	NURSING ADMINISTRATION	13.00	0	1, 818			6. 00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	1, 353, 337			7. 00
8.00	PHARMACY	15. 00	0	672, 088	0		8. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Provider CCN: 15-0074

					'	o 12/31/2018 Date/lime Pr 5/29/2019 3:	
		Decreases		<u>'</u>			
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
0.00	6. 00	7.00	8. 00	9. 00	10.00		0.00
9. 00 10. 00	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	16. 00 17. 00	0	80 1, 050			9. 00 10. 00
11. 00	I &R SERVICES-OTHER PRGM	22.00	0	19, 623			11.00
	COSTS APPRVD			,			
12.00	ADULTS & PEDIATRICS	30.00	0	25, 674			12. 00
13.00	INTENSIVE CARE UNIT	31.00	0	16, 821	0		13.00
14.00	CORONARY CARE UNIT	32.00	0	80			14.00
15. 00 16. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0	236, 319 951	0		15. 00 16. 00
17. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	46, 236	_		17. 00
18. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	286	-		18. 00
19.00	CT SCAN	57. 00	0	160	0		19. 00
20.00	MAGNETIC RESONANCE IMAGING	58.00	0	319	0		20.00
	(MRI)						
21. 00	CARDI AC CATHETERI ZATI ON LABORATORY	59. 00 60. 00	0	3, 938	0		21. 00 22. 00
22. 00 23. 00	I NTRAVENOUS THERAPY	64.00	0	53, 444 196	-		23. 00
24. 00	RESPIRATORY THERAPY	65.00	0	11, 618	-		24. 00
25. 00	PHYSI CAL THERAPY	66.00	0	840, 652			25. 00
26.00	ELECTROCARDI OLOGY	69.00	0	136, 292			26. 00
27. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	42, 730			27. 00
28. 00	RENAL DI ALYSI S	74.00	0	275			28. 00
29. 00 30. 00	ENDOSCOPY PSYCHI ATRI C/PSYCHOLOGI CAL	76. 00 76. 01	0	630 1, 643, 748			29. 00 30. 00
30.00	SERVICES	70.01		1,043,740	J		30.00
31.00	LUTHERWOOD PARTNERSHIP	76. 03	0	1, 213, 660	0		31.00
32.00	WOUND CARE CENTER	76. 04	0	80	0		32. 00
33. 00	ONCOLOGY-CANCER CARE CENTER	76. 05	0	491, 490			33. 00
34. 00 35. 00	I MAGING CENTERS	76. 06 76. 07	0	348, 851 45, 402	0		34. 00 35. 00
36. 00	BREAST DIAGNOSTIC CENTER CARDIAC REHABILITATION	76. 97	0	104, 928	-		36.00
37. 00	HEALTHY HEARTS CENTER	90. 02	0	124, 565			37. 00
38. 00	INFUSION CENTERS	90. 05	O	255, 734	-		38. 00
39. 00	KNEE CENTER	90. 07	0	998	0		39. 00
40.00	EMERGENCY	91.00	0	42, 496			40. 00
41.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	20, 453			41.00
42. 00 43. 00	FAMILY PRACTICE MEDICINE GROUP HOMES AND MISC. N_R	194. 05 194. 08	0	914, 037 80, 424	0		42. 00 43. 00
43.00	CTRS	174.00	٩	00, 424	J		43.00
	0		0	10, 853, 643			
1 00	G - STD BENEFITS ADMINISTRATIVE & GENERAL	F 00	25 545		0		1 00
1. 00 2. 00	OPERATION OF PLANT	5. 00 7. 00	25, 545 24, 093	0			1. 00 2. 00
3. 00	HOUSEKEEPI NG	9.00	28, 769	0			3. 00
4.00	DI ETARY	10.00	18, 537	0	0		4. 00
5.00	NURSING ADMINISTRATION	13. 00	9, 871	0	0		5. 00
6. 00	PHARMACY	15.00	18, 460	0			6. 00
7. 00 8. 00	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	16. 00 17. 00	1, 294	0	-		7. 00 8. 00
9. 00	I &R SERVICES-OTHER PRGM	22. 00	10, 647 60, 339	0			9. 00
7. 00	COSTS APPRVD	22.00	00,007	· ·			7.00
10.00	ADULTS & PEDIATRICS	30.00	261, 108	0			10. 00
11.00	INTENSIVE CARE UNIT	31.00	33, 182	0			11.00
12. 00 13. 00	CORONARY CARE UNIT	32. 00 50. 00	25, 455 12, 729	0			12. 00 13. 00
14. 00	RECOVERY ROOM	51.00	3, 365	0	0		14. 00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	20, 645	0	-		15. 00
16.00	RADI OLOGY-THERAPEUTI C	55.00	205	0	0		16. 00
17.00	CT SCAN	57.00	2, 477	0	-		17. 00
18. 00	MAGNETIC RESONANCE I MAGING	58. 00	3, 446	0	0		18. 00
19. 00	(MRI) CARDIAC CATHETERIZATION	59.00	12, 442	0	0		19. 00
20. 00	I NTRAVENOUS THERAPY	64.00	4, 969	0	0		20.00
21. 00	RESPI RATORY THERAPY	65. 00	23, 970	Ō	0		21. 00
22. 00	PHYSI CAL THERAPY	66.00	39, 188	0	0		22. 00
23. 00	ELECTROCARDI OLOGY	69.00	9, 557	0			23. 00
24. 00	ELECTROENCEPHALOGRAPHY	70.00	2, 264	0	-		24. 00
25. 00	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	76. 01	205, 272	0	0		25. 00
26. 00	LUTHERWOOD PARTNERSHIP	76. 03	57, 575	0	0		26. 00
27. 00	WOUND CARE CENTER	76. 04	2, 226	0	0		27. 00
28. 00	ONCOLOGY-CANCER CARE CENTER	76. 05	35, 756	0			28. 00
29. 00 30. 00	I MAGING CENTERS CARDIAC REHABILITATION	76. 06 76. 97	12, 508	0			29. 00 30. 00
30.00	OUT OF VEHABLEL LATION	10.97	9, 472	0	ı U		1 30.00

Provider CCN: 15-0074

1.00 NPUSION CENTERS 90.05 177 0 0 33.00 33.00 MERCENTER 90.07 10.849 0 0 0 33.00 33.00 MERCENTER 90.07 10.849 0 0 0 33.00 33.00 MERCENTER 90.07 91.00 25.702 0 0 0 0 34.00 35.00 MERCENTER 194.05 20.670 0 0 0 0 0 35.00 36.00 MERCENTER 194.05 20.670 0 0 0 0 0 0 0 0 0						10	2/11 me Prepared: 2/2019 3:09 pm
Color			Decreases		·		
31 .00							
1.00 1.00					9. 00	10. 00	
33.00 KNEE CENTER	31.00			17, 064	0	0	31.00
34.00 EMERGENCY 91.00 25,702 0 0 34.05 35.00 FAMILY PRACTICE MEDICINE 194.05 20,670 0 0 0 36.00 GROUP HOMES AND MISC. N_R 194.08 737 0 0 0 1.00 ADULTS & PEDIATRICS 30.00 1,326,859 591,311 0 0 1.00 O					0	0	32.00
35.00 FAMILY PRACTICE MEDICINE 194.05 20,670 0 0 35.0 36.00 GROUP HOMES AND MISC. N_R 194.08 737 0 0 0 0 CTRS 0 1.050,565 0 0 1 1.050,565 0 0 1 1.050,565 0 0 1 1.050,565 0 0 1 1.050,565 0 0 1 1.050,565 0 0 1 1.050,565 0 0 1 1.050,565 0 0 1 1.050,565 0 0 1 1.050,565 0 0 1 1.050,565 0 0 1 1.050,565 0 0 1 1.050,565 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33.00			10, 849	0	0	33.00
36. 00 GROUP HOMES AND MISC. N_R CTRS	34.00	EMERGENCY	91.00	25, 702	0	0	34.00
CTRS	35.00	FAMILY PRACTICE MEDICINE	194. 05	20, 670	0	0	35.00
Note	36.00		194. 08	737	0	0	36. 00
H - Labor and Del ivery ADULTS & PEDIATRICS		CTRS					
1. 00		0		1, 050, 565	0		
2.00							
1.00 DIETARY 10.00 1,730,216 0 0 0 2,569,475 0 0 0 0 0 0 0 0 0		ADULTS & PEDIATRICS		1, 326, 859	591, 311		1. 00
Cafeteria	2.00		0.00	0_	0		2. 00
1. 00 DI ETARY 10. 00 1, 730, 216 0 0 2.569, 475 0 0 2.00 DI ETARY 10. 00 1, 730, 216 2, 569, 475 0 0 2.00		0		1, 326, 859	591, 311		
2. 00 DIETARY 10. 00 0 2,569,475 0 0 0 1,730,216 2,569,475 0 0 1,730,216 2,569,475 0 0 0 0 0 0 0 0 0							
1,730,216 2,569,475		DI ETARY		1, 730, 216			1. 00
1.00	2.00	DI ETARY	<u>10.</u> 00	0_			2. 00
1.00 PHYSICAL THERAPY 66.00 1, 474, 765 615, 210 0 2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0		1, 730, 216	2, 569, 475		
2.00 0							
1.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 9,998,543 9 0 1.00		PHYSI CAL THERAPY		1, 474, 765	615, 210		1.00
1.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 9,998,543 9 1.00	2.00		0.00	0_	0		2. 00
1. 00		0		1, 474, 765	615, 210		
Column C							
L - Capi tal Insurance Costs 1.00 ADMINISTRATI VE & GENERAL 5.00 0 235, 439 12 1.00 M - Radi ol ogy Support 1.00 RADI OLOGY-DI AGNOSTI C 54.00 687, 637 225, 975 0 1.00 3.00 0 0 0 0 0 0 2.00 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00	CAP REL COSTS-MVBLE EQUIP		0_			1. 00
1. 00 ADMINISTRATIVE & GENERAL 5. 00 0 235, 439 12 0 1. 00 235, 439 12 0 1. 00 235, 439 12 0 1. 00 235, 439 12 0 1. 00 235, 439 12 0 1. 00 235, 439 12 12 1. 00 RADIOLOGY-DI AGNOSTI C 54. 00 687, 637 225, 975 0 1. 00 2. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0		0	9, 998, 543		
0							
M - Radi ol ogy Support 1. 00 RADI OLOGY-DI AGNOSTI C 54. 00 687, 637 225, 975 0 1. 0 2. 00 0. 00 0 0 0 0 3. 00 0 0 0 0 4. 00 0 0 0 0 0 0 0 0 0 0 0 1. 00 0 0 0 0 1. 00 0 0 0 0 1. 00 0 0 0 0 1. 00 0 0 0 0 1. 00 0 0 0 0 1. 00 0 0 0 0 1. 00 0 0 0 0 1. 00 0 0 0 0 1. 00 0 0 0 0 1. 00 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 1. 00 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 1. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00	ADMI NI STRATI VE & GENERAL		+			1.00
1. 00 RADI OLOGY-DI AGNOSTI C 54. 00 687, 637 225, 975 0 2. 00 3. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0		0	235, 439		
2. 00 3. 00 4. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
3. 00 4. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		RADI OLOGY-DI AGNOSTI C		687, 637	225, 975		1.00
4. 00				0	0	0	2. 00
0 687, 637 225, 975 N - Hyperbari c Oxygen Therapy 1. 00 WOUND CARE CENTER 76. 04 129, 137 336, 544 0 1. 0 0 129, 137 336, 544 0 1. 0 0 - I HH Cat Scan 1. 00 RADI OLOGY-DI AGNOSTI C 54. 00 587, 557 0 0 0 1. 0 2. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 137, 535 0 2. 0				0	0	0	3. 00
N - Hyperbari c Oxygen Therapy 1.00 WOUND CARE CENTER 76.04 129.137 336.544 0 1.00	4.00		0.00	0_	0	0	4. 00
1. 00 WOUND CARE CENTER 76. 04 129, 137 336, 544 0 1. 0 0 129, 137 336, 544 0 1. 0 0 - I HH Cat Scan 1. 00 RADI OLOGY-DI AGNOSTI C 54. 00 587, 557 0 0 1. 0 2. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 137, 535 0 2. 0		0		687, 637	225, 975		
0 129, 137 336, 544 0 0 - 1 HH Cat Scan 1.00 RADI OLOGY-DI AGNOSTI C 54.00 587, 557 0 0 1.00 RADI OLOGY-DI AGNOSTI C 54.00 0 137, 535 0 2.00							
0 - I HH Cat Scan 1. 00 RADI OLOGY-DI AGNOSTI C 54. 00 587, 557 0 0 2. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 137, 535 0	1. 00	WOUND CARE CENTER	76. 04	12 <u>9, 1</u> 37			1.00
1. 00 RADI OLOGY-DI AGNOSTI C 54. 00 587, 557 0 0 1. 0 2. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 137, 535 0 0		0		129, 137	336, 544		
2. 00 RADI <u>OLOGY-DI AGNOSTI C 54. 00 0137, 535</u> 0 0							
				587, 557			1. 00
0 597 557 127 525	2.00	RADI OLOGY-DI AGNOSTI C	54.00	0_			2. 00
		0		587, 557	137, 535		
P - Residents Costs							
	1.00		22. 00	3, 521, 215	751, 022	0	1. 00
COSTS_APPRVD		COSTS_APPRVD					
0 3, 521, 215 751, 022		0		3, 521, 215	751, 022		
S - CBI Allocation to Gallahue							
	1.00	ADMI NI STRATI VE & GENERAL		•_	<u>2, 3</u> 04	0	1.00
0 2, 304		0		0			
500.00 Grand Total: Decreases 10, 507, 951 216, 377, 973 500.00	500.00	Grand Total: Decreases		10, 507, 951	216, 377, 973		500. 00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0074 Peri od: Worksheet A-7 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 3:09 pm Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 4, 453, 049 1, 710, 000 1.00 0 4, 335, 982 2.00 Land Improvements 126, 439 2.00 3.00 400, 805, 410 85, 106, 043 85, 106, 043 23, 702, 749 3.00 Buildings and Fixtures 0 4.00 Building Improvements 10, 439, 956 1, 294, 642 1, 294, 642 31, 661 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 179, 369, 290 11, 497, 385 11, 497, 385 2, 632, 178 6.00 0 7.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 599, 403, 687 97, 898, 070 97, 898, 070 28, 203, 027 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 5<u>99, 403, 687</u> 97, 898, 070 97, 898, 070 28, 203, 027 10.00 0 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2, 743, 049 0 1.00 2.00 Land Improvements 4, 209, 543 0 2.00 3.00 Buildings and Fixtures 462, 208, 704 0 3.00 0 4.00 Building Improvements 11, 702, 937 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 6.00 188, 234, 497 0 6.00

669, 098, 730

669, 098, 730

0

0

0

7. 00

8.00

9.00

10.00

7.00

8.00

9.00

HIT designated Assets

10.00 Total (line 8 minus line 9)

Reconciling Items

Subtotal (sum of lines 1-7)

Heal th	Financial Systems CO	OMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0074	Peri od: From 01/01/2018 To 12/31/2018		
			SL	JMMARY OF CAP	PITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	,	
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2			
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	ol	2. 00
3.00	Total (sum of lines 1-2)	0	0		0 0	ol	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORL	KSHEET A, COLUM	IN 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
0 00	T 1 1 (C 1: 4 0)			1			2 22

0 0 0

0 0 0

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems C	OMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS			Period: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part III Date/Time Prep 5/29/2019 3:00	pared:	
		COM	COMPUTATION OF RATIOS			OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	DADT III DECONOLILATION OF CARLTAL COCTO	1. 00	2.00	3. 00	4. 00	5. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C	420, 034, 397		420, 034, 39	7 0. 700754	0	1. 00
2.00	CAP REL COSTS-BEDG & TTAT	179, 369, 290	l e	179, 369, 29		0	2.00
3.00	Total (sum of lines 1-2)	599, 403, 687		599, 403, 68		0	3. 00
0.00			TION OF OTHER (F CAPITAL	3. 33
	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 C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0	•	0 10, 035, 294		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 19, 977, 505		2. 00
3.00	Total (sum of lines 1-2)	0	0	L JMMARY OF CAPI	0 30, 012, 799	10, 853, 643	3. 00
			50	JIVIIVIARY OF CAPT	TAL		
	Cost Center Description	Interest	Insurance (see instructions)		Capi tal -Relate		
					d Costs (see instructions)	through 14)	
		11.00	12.00	13.00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C					.0.00	
1.00	CAP REL COSTS-BLDG & FLXT	4, 532, 333	235, 439		0 0	14, 803, 066	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	30, 831, 148	2. 00
3.00	Total (sum of lines 1-2)	4, 532, 333	235, 439		0 0	45, 634, 214	3. 00

| Period: | Worksheet A-8 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0074

				T	o 12/31/2018	Date/Time Prep 5/29/2019 3:09	
				Expense Classification on		3/29/2019 3.09	9 DIII
	To/From Which the Amount is to be Adjusted						
	Cost Center Description		Amount 2.00	Cost Center 3.00		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00 0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
	COSTS-MVBLE EQUIP (chapter 2)		-	NEE GOOTS MVDEE EGOTT			
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	О	4. 00
5.00	Refunds and rebates of	В	-19, 685	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7. 00
7.00	stations excluded) (chapter		O		0.00	o o	7.00
8. 00	21) Television and radio service		0		0. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provi der-based physician	A-8-2	-328, 418		0.00	0	10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	4, 115, 970			0	12. 00
	transactions (chapter 10)	A-0-1	4, 113, 770				
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В В	0 1, 980, 373-	CAFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee	1	0		0. 00	O	15. 00
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and		0		0. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00	Vending machines		0		0.00	0	20. 00
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
22.00	overpayments and borrowings to		O		0.00	J	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL 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
0.4	(chapter 21)			OAD DEL COCTO DI DC : TITT	ا ا		0/ 5-
26. 00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00	_	28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	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		0		0. 00	0	32. 00
33. 00	Depreciation and Interest EMS PARAMED ED TUITION	В	-181, 043	EMERGENCY	91. 00	o	33. 00
			• • •			-1	

Health Financial Systems ADJUSTMENTS TO EXPENSES Provider CCN: 15-0074 Peri od: Worksheet A-8 From 01/01/2018 | To 12/31/2018 | Date/Time Prepared:

					o 12/31/2018	Date/lime Pre 5/29/2019 3:0	
				Expense Classification on	Worksheet A	0,27,2017 0.0) piii
				To/From Which the Amount is			
	C+ C+	D: - (01- (2)	A	0+ 0+	1: "	WI+ A 7 D-£	
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
33. 01	Mi sc Revenue	1. 00 B	2.00	3.00 EMPLOYEE BENEFITS DEPARTMENT	4.00	5. 00 0	33. 01
33. 01	Mi sc Revenue	В		ADMINISTRATIVE & GENERAL	5. 00	0	•
33. 02	Mi sc Revenue	В		OPERATION OF PLANT	7.00	0	1
33. 04	Mi sc Revenue	В		DIETARY	10.00	0	1
33. 04	Misc Revenue	В		PHARMACY	15. 00	0	1
33. 06	Mi sc Revenue	B		MEDICAL RECORDS & LIBRARY	16.00	0	
33. 07	Mi sc Revenue	B		I &R SERVICES-OTHER PRGM	22.00	0	33. 07
33.07	Wil 3C Revenue		-30, 700	COSTS APPRVD	22.00	0	33.07
33. 08	Mi sc Revenue	В	-138 991	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 08
33. 09	Mi sc Revenue	B		LABORATORY	60.00	0	33. 09
33. 10	Mi sc Revenue	B		PHYSI CAL THERAPY	66.00	0	33. 10
33. 11	Mi sc Revenue	В		BELECTROCARDI OLOGY	69.00	0	
33. 12	Mi sc Revenue	B		CARDI AC REHABI LI TATI ON	76. 97	0	ı
33. 13	Mi sc Revenue	B		EMERGENCY	91.00	0	33. 13
33. 14	Space Rental Income	В		OPERATION OF PLANT	7. 00	0	
34. 00	50 BMO Loan Non- Allow	A		ADMI NI STRATI VE & GENERAL	5.00	0	34. 00
01.00	Interest Expense		77,007	Control of the cont	0.00	Ĭ	01.00
34. 01	LOC Non-Allow Interest Expense	A	-66, 760	CAP REL COSTS-BLDG & FIXT	1.00	11	34. 01
34. 02	12A Non-Allow Interest Expense			CAP REL COSTS-BLDG & FIXT	1.00	11	
34. 03	12B Non-Allow Interest Expense			CAP REL COSTS-BLDG & FIXT	1.00	11	•
34. 04	50 BMO Loan Non- Allow	A		CAP REL COSTS-BLDG & FIXT	1.00	11	
	Interest Expense		,				
34. 05	12B Non-Allow Interest Expense	A I	-911, 673	CAP REL COSTS-BLDG & FIXT	1.00	11	34. 05
34.06	00 Non-Allow Interest Expense	A I		CAP REL COSTS-BLDG & FIXT	1.00	11	34. 06
34. 07	Loss on Assets	A		ADMINISTRATIVE & GENERAL	5. 00	0	•
34. 08	Loss on Assets	A I		ELECTROENCEPHALOGRAPHY	70.00	0	1
34. 09	Loss on Assets	A I		PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0	1
				SERVI CES			
34. 10	HAF Tax Offset	A	-18, 572, 562	ADMINISTRATIVE & GENERAL	5. 00	0	34. 10
36.00	CARDIAC CATH SHARED SERVICES	A	-127, 131	CARDIAC CATHETERIZATION	59. 00	0	36. 00
36. 01	CARDIAC MONITORING SHARED	A	294, 258	ELECTROCARDI OLOGY	69. 00	0	36. 01
	SERVI CES						
36. 02	Non Allow Marketing Expense	A		ADMINISTRATIVE & GENERAL	5. 00	0	36. 02
36. 03	Depreciation Carryforward	A		CAP REL COSTS-BLDG & FIXT	1.00	9	36. 03
36. 04	Depreciation Carryforward	A	265, 422	CAP REL COSTS-MVBLE EQUIP	2. 00	9	36. 04
36. 05	Meals on Wheels Cost	A	-129, 334	CAFETERI A	11. 00	0	36. 05
36.06	Pavillions	A		ADMINISTRATIVE & GENERAL	5. 00	0	36. 06
36. 07	Physician Assistant Offset	A		ADULTS & PEDIATRICS	30.00	0	36. 07
36. 08	Nurse Practitioner Offset	A		ADULTS & PEDIATRICS	30.00	9	36. 08
36. 09	Nurse Practitioner Offset	A		OPERATING ROOM	50.00	0	
36. 10	Nurse Practitioner Offset	A		CARDIAC CATHETERIZATION	59. 00	9	00
36. 11	Nurse Practitioner Offset	A		HEALTHY HEARTS CENTER	90. 02	9	
36. 12	OB Laborist Loss	A		DELIVERY ROOM & LABOR ROOM	52.00	0	
36. 13	Gallahue Professional Fee	A	-24, 039, 897	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0	36. 13
		[SERVI CES			
36. 14	Gallahue Professional Fee	A		LUTHERWOOD PARTNERSHIP	76. 03	0	36. 14
36. 15	SPONSORSHI P	A	-	ADMINISTRATIVE & GENERAL	5. 00	0	36. 15
50. 00	TOTAL (sum of lines 1 thru 49)		-65, 119, 407	[50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						<u> </u>

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME
OFFICE COSTS

Provider CCN: 15-0074
From 01/01/2018
To 12/31/2018
Date/Time Prepared 5/29/2019 3:09 pm

				To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	•
			'	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1.00		I&R SERVICES-SALARY & FRINGE		3, 254, 460	4, 272, 237	1. 00
2.00		I&R SERVICES-OTHER PRGM COST		5, 215, 460	6, 846, 503	2.00
3.00			1400 N RITTER	182, 736	143, 466	
3. 01	II	l .	1400 N RITTER	195, 331	153, 354	3. 01
3.02			1400 N RITTER	59, 710	46, 878	
3.03			1400 N RITTER	106, 995	84, 001	3. 03
3.04			1400 N RITTER	67, 779	53, 213	3. 04
3. 05	II	PSYCHI ATRI C/PSYCHOLOGI CAL SE	7250 CLEARVI STA	25, 769	4, 346	3. 05
4.00			CHNW - HOME OFFICE	9, 701, 872	0	4.00
4. 01			CHNW - HOME OFFICE	8, 844, 235	0	4. 01
4.02			CHNW - HOME OFFICE	90, 453, 112	113, 961, 793	4. 02
4.03			CHNW - HOME OFFICE	987, 675	0	4. 03
4.04			CHNW - HOME OFFICE	4, 359, 991	0	4. 04
4.05	14.00	CENTRAL SERVICES & SUPPLY	CHNW - HOME OFFICE	3, 929, 603	0	4. 05
4.06	16. 00	MEDICAL RECORDS & LIBRARY	CHNW - HOME OFFICE	4, 531, 724	0	4.06
4.07	30.00	ADULTS & PEDIATRICS	CHNW - HOME OFFICE	657, 136	0	4. 07
4.08			CHNW - HOME OFFICE	102, 973	0	4. 08
4.09	66.00	PHYSI CAL THERAPY	CHNW - HOME OFFICE	239, 242	0	4. 09
4. 10	69.00	ELECTROCARDI OLOGY	CHNW - HOME OFFICE	249, 536	0	4. 10
4. 11	70.00	ELECTROENCEPHALOGRAPHY	CHNW - HOME OFFICE	144, 085	0	4. 11
4. 12	73. 00	DRUGS CHARGED TO PATIENTS	CHNW - HOME OFFICE	2, 090, 602	0	4. 12
4. 13	76. 05	ONCOLOGY-CANCER CARE CENTER	CHNW - HOME OFFICE	4, 506, 668	0	4. 13
4. 14	90. 02	HEALTHY HEARTS CENTER	CHNW - HOME OFFICE	289, 802	0	4. 14
4. 15	91.00	EMERGENCY	CHNW - HOME OFFICE	40, 329	0	4. 15
4. 16	76. 05	ONCOLOGY-CANCER CARE CENTER	ANDERSON CANCER CENTER	o	12, 343, 133	4. 16
4. 17	5. 00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR AND CAL	1, 788, 069	O	4. 17
	TOTALS (sum of lines 1-4).			142, 024, 894	137, 908, 924	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/	or Home Office		
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.

6.00	В	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				100.00
	non-financial) specify:				

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

			5/29/2019 3:0	
		Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
			MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE COS			1 00
1.00	-1, 017, 777			1.00
2.00	-1, 631, 043	0		2.00
3.00	39, 270	0		3.00
3. 01	41, 977	0		3. 01
3. 02 3. 03	12, 832 22, 994	0		3. 02
3. 04	22, 994 14, 566			3. 04
3. 05	21, 423			3. 05
4.00	9, 701, 872			4. 00
4. 00	8, 844, 235	7		4. 01
4. 02	-23, 508, 681	0		4. 02
4. 03	987, 675	0		4. 03
4. 04	4, 359, 991	0		4. 04
4. 05	3, 929, 603	0		4. 05
4. 06	4, 531, 724	0		4. 06
4. 07	657, 136			4. 07
4. 08	102, 973			4. 08
4. 09	239, 242	0		4. 09
4. 10	249, 536	0		4. 10
4. 11	144, 085	0		4. 11
4. 12	2, 090, 602	0		4. 12
4. 13	4, 506, 668	0		4. 13
4. 14	289, 802	0		4. 14
4. 15	40, 329	0		4. 15
4. 16	-12, 343, 133			4. 16
4. 17	1, 788, 069			4. 17
5. 00	4, 115, 970			5. 00

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

 	cordinate i dilaret 27 the dimedite difference of cordinate of the cordinate in cordinate in the partit	
Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00		6. 00
7.00		7. 00
8.00		8. 00 9. 00
9.00		
10.00		10. 00 100. 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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2
From 01/01/2018
To 12/21/2018 Date/Time Prepar Provider CCN: 15-0074

						To 12/31/2018		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der		Physi ci an/Prov	, , , , , , , , , , , , , , , , , , ,
		I denti fi er	Remuneration	Component	Component		ider Component Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1.00		AGGREGATE-ADMI NI STRATI VE &	525, 682	224, 334	301, 348	211, 500	1, 940	1. 00
2.00	0. 00	GENERAL	0	0	0	0	0	2. 00
3. 00	0.00		l o			Ö	l o	3. 00
4.00	0.00		0	0	0	0	0	
5.00	0.00		0	0	0	0	0	5. 00
6.00	0. 00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10.00
200.00	WI+ A I : "	C+ C+ (Dh.:	525, 682				1, 940	200. 00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	Unadjusted RCE	Cost of		Physician Cost of Malpractice	
		rdentrirei	LIIIII	Limit	Continuing	Share of col.	Insurance	
				Er iiii t	Education	12	Trisur direc	
	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14. 00	
1. 00		AGGREGATE-ADMINISTRATIVE & GENERAL	197, 264	9, 863	0	0	0	1. 00
2.00	0.00		0	0	0	О	0	2. 00
3.00	0.00		0	0	0	0	0	3. 00
4.00	0.00		0	0	0	0	0	4. 00
5.00	0.00		0	0	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7. 00	0.00		0	0	0	0	0	
8.00	0. 00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0. 00		107.074	0 0/3	0	0	1	10.00
200.00	Wkst. A Line #	Cost Center/Physician	197, 264 Provi der	9,863 Adjusted RCE	RCE	Adjustment	0	200. 00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Auj us tillerit		
		ruentiffei	Share of col.	Li iiii t	Di Sai i Owanee			
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		AGGREGATE-ADMINISTRATIVE & GENERAL	0	197, 264	104, 084	328, 418		1. 00
2.00	0.00		0	0	0	0		2. 00
3.00	0.00		0	0	0	0		3. 00
4.00	0. 00		0	0	0	0		4. 00
5.00	0. 00		0	0	0	0		5. 00
6. 00	0. 00		0	0	0	0		6. 00
7.00	0.00		0	0	0	0		7. 00
8.00	0.00		0	0	0	0		8. 00
9. 00 10. 00	0. 00 0. 00		0		0	0		9. 00 10. 00
200.00	0.00				104, 084	-		200.00
200.00	1		1	177, 204	104,004	320,410	I	200.00

Health Financial Systems		COMMUNITY HEALTH NETWORK, INC. In Lieu of Form					
COST /	ALLOCATION - GENERAL SERVICE COSTS		F		Period: From 01/01/2018 To 12/31/2018		pared: 9 pm
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL REI	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	, p
		0	1. 00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS	1 44 000 044	44.000.044	1			
1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 14.00 15.00 16.00 17.00 22.00	01100 CAFETERIA 01300 NURSI NG ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	14, 803, 066 30, 831, 148 9, 066, 938 116, 146, 916 15, 819, 873 1, 025, 700 4, 611, 742 1, 818, 081 2, 189, 984 8, 573, 693 3, 449, 914 8, 907, 396 5, 866, 897 2, 735, 789 3, 254, 460 5, 131, 884	14, 803, 066 171, 255 746, 021 2, 203, 542 0 247, 684 189, 589 522, 332 168, 035 292, 224 39, 172 36, 015 60, 179 0 5, 662	30, 831, 14 15, 415, 57 6, 339, 35 175, 52 4 3, 66 38, 61 128, 31 5, 36 692, 50 361, 79 4	2 24, 653, 765 1, 530, 800 370, 114 0 4 366, 995 5 97, 300 242, 002 442, 761 3 0 809, 270 104, 954 901, 217 492, 505	5, 874, 322	7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 21. 00 22. 00
23. 00 23. 01	02300 EMS TRAINING-ALLIED HEALTH 02301 RADIOLOGY SCHOOL-ALLIED HEALTH	0	0		0 0	0	23. 00 23. 01
23. 02		o	0	1		0	23. 02
23. 03		0	0		0 0	0	23. 03
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	47, 143, 962	3, 962, 760	178, 54	5, 009, 491	56, 294, 759	30.00
31. 00	03100 INTENSIVE CARE UNIT	6, 901, 986	620, 863	123, 09		8, 365, 815	31. 00
32.00		4, 301, 910	359, 770			5, 084, 599	1
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	552, 532	59, 106	6, 32	2 53, 458	671, 418	43.00
67. 00 68. 00 69. 00 70. 00 71. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05100 RECOVERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05500 CAT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 OCCUPATI ONAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03330 ENDOSCOPY 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03951 LUTHERWOOD PARTNERSHI P 03952 WOUND CARE CENTER 03480 ONCOLOGY-CANCER CARE CENTER 03953 I MAGI NG CENTERS 03954 BREAST DI AGNOSTI C CENTER	7, 850, 146 1, 329, 886 1, 854, 067 3, 757, 427 1, 052, 185 2, 508, 008 742, 053 3, 880, 268 12, 116, 224 393, 144 4, 297, 016 6, 119, 161 1, 530, 202 559, 773 2, 974, 866 922, 747 25, 362, 231 25, 639, 613 110, 004, 936 1, 422, 003 549, 108 13, 467, 022 2, 678, 691 2, 653, 526 21, 841, 039 4, 666, 562 2, 129, 256 878, 114 465, 681	988, 337 201, 313 146, 102 570, 093 165, 088 88, 153 107, 561 417, 298 93, 289 8, 756 44, 266 69, 336 17, 744 6, 483 20, 270 0 6, 841 0 111, 749 0 107, 792 373, 516 2, 547 53, 949 152, 606 17, 976	1, 18 15, 62 271, 50 123, 78 104, 35. 120, 83 404, 67. 55, 35 1, 49 73, 84 458, 81 8, 98 3, 28 191, 41 78, 56 13 36, 13 915, 87, 649, 19 3, 35 1, 710, 38 692, 21 22, 88 61, 20	4 135, 995 5 198, 381 368, 884 98, 789 4 221, 280 4 61, 416 8 419, 417 5 0 4 42, 915 4 456, 425 584, 598 7 151, 025 55, 247 339, 322 72, 285 0 0 0 0 9 0 55, 925 3, 889, 370 1, 075, 915 108, 036 1, 368, 742 381, 970 3 0 95, 225	1, 707, 958 624, 791 3, 525, 876 1, 073, 597 25, 362, 231 25, 639, 613 110, 004, 936 1, 428, 983 641, 172 18, 384, 017 4, 403, 799 2, 872, 713 25, 293, 680 5, 743, 289 2, 206, 088 1, 187, 148	51. 00 52. 00 54. 00 55. 00 57. 00 58. 00 59. 00 60. 00 64. 00 67. 00 68. 00 69. 00 70. 00 71. 00 73. 00 74. 00 76. 01 76. 03 76. 04 76. 05 76. 07 76. 97
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 04950 DIABETIC CARE CENTER 04951 HEALTHY HEARTS CENTER 09001 CLINIC 04953 SPINE CENTER 04954 INFUSION CENTERS 09002 MEDCHECK CLINICS	0 0 0 0 1, 758, 576 0 46 680, 959 0 3, 391, 115 0	0 0 0 88, 301 0 0 0 262, 334	157, 28	0 0 0 8 59, 601 0		89. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06

Heal	th Finan	cial Systems CC	OMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-	2552-10
		TION - GENERAL SERVICE COSTS		Provi der CC	F	eriod: rom 01/01/2018	Worksheet B Part I Date/Time Pre 5/29/2019 3:0	pared:
				CAPITAL REL	ATED COSTS			
		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2. 00	4. 00	4A	
90. 1 91. 0 92. 0	09100	FAMILY PRACTICE AND MATERNITY CARE EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	0 14, 822, 550	0 951, 249	0 51, 389	0 1, 180, 428	0 17, 005, 616 0	91. 00
72. 0		REI MBURSABLE COST CENTERS						72.00
98. 0		OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
70. 0		AL PURPOSE COST CENTERS		<u> </u>		<u> </u>		70.00
118.	00	SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	577, 432, 072	14, 757, 158	30, 213, 116	24, 134, 147	576, 248, 514	118. 00
190.	00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
		RESEARCH	0	o	0	0	0	191. 00
192.	00 19200	PHYSICIANS' PRIVATE OFFICES	62, 804	45, 908	11, 325	0	120, 037	192. 00
194.	00 07950	HOME OFFICE	0	o	0	0	0	194. 00
194.	01 07951	OCCUPATIONAL HEALTH ONSITE SVCS	0	0	0	0	0	194. 01
194.	03 07953	SCHOOL BASED CLINICS	1, 338	0	0	182	1, 520	194. 03
194.	04 07954	SMO-NON PROVIDER BASED	626, 524	0	0	66, 826	693, 350	194. 04
	1	FAMILY PRACTICE MEDICINE	3, 265, 339	0	552, 873	326, 003	4, 144, 215	
		LI FECHECK	0	0	0	0		194. 07
		GROUP HOMES AND MISC. N_R CTRS	1, 306, 588	0	53, 834	126, 607	1, 487, 029	
		SURGERY CENTER EAST	0	0	0	0		194. 09
200.	1	Cross Foot Adjustments						200. 00
201.		Negative Cost Centers	582 694 665	0 14 803 066	0 30 831 148	0 24 653 765		201. 00
7(1)	[][]]	LILLAL ESUM LINAS LIX THYOUGH JULI	1 28/ 69/ 665	1 14 803 0661	KU 8 (I 1/18	1 /4 653 /651	587 AU/L AAS	17(17 ()()

582, 694, 665

14, 803, 066

30, 831, 148

24, 653, 765

582, 694, 665 202. 00

202.00

TOTAL (sum lines 118 through 201)

Provider CCN: 15-0074

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: | 5/29/2019 3:09 pm

				''	0 12/31/2010	5/29/2019 3:0	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	•	& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	124, 763, 096					5. 00
7. 00	00700 OPERATION OF PLANT	5, 059, 120	23, 628, 175				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	279, 462	23, 020, 179				8. 00
9. 00	00900 HOUSEKEEPING		-		7 000 570		9. 00
		1, 424, 931	500, 959		7, 808, 572	2 240 520	•
10.00	01000 DI ETARY	584, 018	383, 457		129, 469	3, 240, 529	10.00
11. 00	01100 CAFETERI A	839, 860	1, 056, 454		356, 697	1, 620, 264	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	2, 503, 767	339, 862		114, 750	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 208, 214	591, 044	0	199, 557	0	14. 00
15. 00	01500 PHARMACY	2, 756, 538	79, 229	0	26, 750	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 636, 848	72, 843	0	24, 594	0	16. 00
17. 00	01700 SOCIAL SERVICE	843, 969	121, 717	0	41, 096	0	17. 00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	1, 020, 857	0	0	0	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	1, 600, 453	11, 452	2, 696	3, 867	0	22. 00
23. 00	02300 EMS TRAINING-ALLIED HEALTH	0	0	_,	0	0	23. 00
23. 01	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH	0	0	Ŏ	0	0	23. 01
23. 02	02302 PHARMACY RESIDENCY-ALLIED HEALTH	0	0		0	0	23. 02
23. 02	l l	0	0	0	0	0	
23. 03	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	l v	0	l 0	υ	0	23. 03
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	45 007 454	0.044.040	000 500	0.704.407	4 070 577	
30. 00	03000 ADULTS & PEDI ATRI CS	15, 337, 451	8, 014, 960			1, 372, 577	30. 00
31. 00	03100 INTENSIVE CARE UNIT	2, 279, 258	1, 255, 739	25, 489		128, 102	31. 00
32. 00	03200 CORONARY CARE UNIT	1, 385, 294	727, 661	0	245, 684	119, 586	32. 00
43.00	04300 NURSERY	182, 927	119, 546	3, 087	40, 363	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 673, 930	1, 998, 983	29, 877	674, 928	0	50.00
51.00	05100 RECOVERY ROOM	454, 548	407, 170		137, 475	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	603, 250	295, 501	7, 623	99, 772	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 353, 502	1, 153, 053			0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	392, 284	333, 902			0	55. 00
	05700 CT SCAN					0	•
57. 00		796, 040	178, 297				57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	281, 130	217, 549			0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 395, 391	844, 014		284, 969	0	59. 00
60. 00	06000 LABORATORY	3, 341, 551	188, 684		63, 707	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	121, 596	17, 710		5, 980	0	64. 00
65.00	06500 RESPI RATORY THERAPY	1, 327, 249	89, 531	24, 950	30, 229	0	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 970, 325	140, 236	0	47, 349	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	465, 331	35, 889	0	12, 117	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	170, 224	13, 113		4, 427	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	960, 621	40, 998		13, 842	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	292, 500	10, 7,0	1, 332	.0,012	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 909, 914	0	1, 332	0	0	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6, 985, 487	0		0	0	72.00
			0	0	0		
73. 00	07300 DRUGS CHARGED TO PATIENTS	29, 970, 835	40.004	0	4 (70	0	73.00
74. 00	07400 RENAL DI ALYSI S	389, 325	13, 836		4, 672	0	74. 00
76. 00	03330 ENDOSCOPY	174, 687	0	2, 326		0	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	5, 008, 707	226, 021	0	76, 313	0	76. 01
76. 03	03951 LUTHERWOOD PARTNERSHIP	1, 199, 811	0	0	0	0	76. 03
76. 04	03952 WOUND CARE CENTER	782, 668	218, 017	10, 022	73, 610	0	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	6, 891, 238	755, 462	14, 949	255, 071	0	76. 05
76.06	03953 I MAGI NG CENTERS	1, 564, 753	5, 151	0	1, 739	0	76. 06
76. 07	03954 BREAST DIAGNOSTIC CENTER	601, 046	109, 115	0	36, 841	0	76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	323, 437	308, 656		104, 213	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	136, 844	36, 358		12, 276	0	76. 98
70. 70	OUTPATIENT SERVICE COST CENTERS	130, 044	30, 330		12, 270		70.70
88. 00	08800 RURAL HEALTH CLINIC	0		0		0	88. 00
		0	0	0	0		•
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
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 HEALTHY HEARTS CENTER	587, 873	178, 595	13, 649	60, 300	0	90. 02
90. 03	09001 CLI NI C	0	0	0	0	0	90. 03
90.04	04953 SPI NE CENTER	13	0	0	0	0	90. 04
90. 05	04954 I NFUSI ON CENTERS	244, 618	0	O	О	0	90. 05
90.06	09002 MEDCHECK CLINICS	0	0	0	0	0	90.06
90. 07	09003 KNEE CENTER	1, 059, 990	530, 590	l n	179, 146	0	90. 07
90. 08	09004 PALLIATIVE CARE	1 ., 557, 770	000,070	ا م	,, . 10	0	90. 08
90. 10	09006 WORK SITE CLINICS		0		0	0	90. 10
90. 10	1 1		0		0	0	90. 10
	04961 FAMILY PRACTICE AND MATERNITY CARE	4 422 143	1 022 040	122 (24	440 400		1
91. 00	09100 EMERGENCY	4, 633, 163	1, 923, 969	123, 694	649, 600	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
0.5	OTHER REIMBURSABLE COST CENTERS			1	-1		
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00

| Peri od: | Worksheet B | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Part | Prepared: | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | P

				''	3 12/31/2016	5/29/2019 3:0	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	·	& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7.00	8. 00	9. 00	10.00	
SPECI	AL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	123, 006, 848	23, 535, 323	1, 305, 204	7, 777, 222	3, 240, 529	118. 00
NONRE	IMBURSABLE COST CENTERS						
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
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	32, 704	92, 852	0	31, 350	0	192. 00
194. 00 07950	HOME OFFICE	0	0	0	0	0	194. 00
194. 01 07951	OCCUPATIONAL HEALTH ONSITE SVCS	0	0	0	0	0	194. 01
194. 03 07953	SCHOOL BASED CLINICS	414	0	0	0	0	194. 03
194. 04 07954	SMO-NON PROVIDER BASED	188, 903	0	0	0	0	194. 04
194. 05 07955	FAMILY PRACTICE MEDICINE	1, 129, 087	0	0	0	0	194. 05
194. 07 07957	LI FECHECK	0	0	0	0	0	194. 07
194. 08 07958	GROUP HOMES AND MISC. N_R CTRS	405, 140	0	0	0	0	194. 08
194. 09 07959	SURGERY CENTER EAST	0	0	0	0	0	194. 09
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	124, 763, 096	23, 628, 175	1, 305, 204	7, 808, 572	3, 240, 529	202. 00

Provider CCN: 15-0074

			10	12/31/2018	Date/lime Prep 5/29/2019 3:09	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	<i>y</i> p
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11.00	13. 00	14. 00	15.00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUI P 4.00 00400 EMPLOYEE BENEFI TS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIBRARY 17.00 01700 SOCIAL SERVICE 21.00 02100 & RESERVICES-SALARY & FRINGES APPRVD	6, 955, 907 201, 355 0 324, 914 45, 763 123, 559 260, 847	12, 351, 473 6, 175, 735 0 0 0 0	12, 609, 191 6, 304, 564 73 129 0	19, 609, 625 9, 804, 812 0 0	17, 592, 839 0 0	1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 21. 00
22. 00 02200 1&R SERVI CES-OTHER PRGM COSTS APPRVD 23. 00 02300 EMS TRAINING-ALLIED HEALTH 23. 01 02301 RADIOLOGY SCHOOL-ALLIED HEALTH 23. 02 02302 PHARMACY RESIDENCY-ALLIED HEALTH	128, 135 0 0 0	0 0 0	1, 005 0 0 0	0 0 0	0 0 0 0	22. 00 23. 00 23. 01 23. 02
23. 03 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	O	0	0	23. 03
I NPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS	2, 031, 856	3, 680, 573	65, 802	ol	1, 344, 616	30. 00
31. 00 03100 INTENSIVE CARE UNIT	297, 457	538, 823	10, 187	0	210, 510	31. 00
32. 00 03200 CORONARY CARE UNIT	187, 626	339, 873	7, 574	0	129, 635	32.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	22, 881	41, 448	1, 277	0	18, 035	43. 00
50. 00 05000 OPERATI NG ROOM	260, 847	472, 506	450, 976	0	852, 236	50. 00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	54, 915 59, 491	0 107, 765	3, 741 3, 155	0	99, 368 44, 576	51. 00 52. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	118, 983	107, 765	1, 246	0	385, 349	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	45, 763	0	10, 027	0	139, 558	55.00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	141, 864	0	254 8	0	578, 091 99, 661	57. 00 58. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION	27, 458 169, 321	0	513, 376	0	1, 408, 676	59. 00
60. 00 06000 LABORATORY	0	Ö	96, 088	o	1, 159, 232	60.00
64. 00 06400 I NTRAVENOUS THERAPY	18, 305	0	161	0	4, 717	64. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	192, 203 105, 254	0	2, 469 3, 300	0	194, 132 183, 523	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	64, 068	0	853	o	47, 487	67. 00
68. 00 06800 SPEECH PATHOLOGY	22, 881	0	312	0	17, 402	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	187, 626 36, 610	0	4, 544 2, 209	0	390, 369 57, 269	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö	951, 464	o	650, 950	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	565, 942	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DIALYSIS	0	0	4, 048, 406 75	9, 804, 813 0	5, 019, 658 32, 422	
76. 00 03330 ENDOSCOPY	22, 881	0	2, 310	Ö	37, 578	
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	224, 236	0	13, 955	0	165, 848	76. 01
76. 03 03951 LUTHERWOOD PARTNERSHI P 76. 04 03952 WOUND CARE CENTER	64, 068	0	8, 406 8, 708	0	5, 720 95, 800	76. 03 76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	649, 828	0	36, 613	0	1, 600, 363	76. 05
76. 06 03953 I MAGI NG CENTERS 76. 07 03954 BREAST DI AGNOSTI C CENTER	4, 576 0	0	2, 629 0	0	393, 448 39, 054	76. 06 76. 07
76. 97 07697 CARDI AC REHABI LI TATI ON	59, 491	0	762	0	28, 407	76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	9, 153	0	852	0	18, 264	76. 98
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
90. 00 09000 CLI NI C	0	o	Ö	o	0	90.00
90. 01 04950 DI ABETI C CARE CENTER	100,030	0	0	0	0	90. 01
90. 02 04951 HEALTHY HEARTS CENTER 90. 03 09001 CLI NI C	109, 830	0	5, 284 0	0	33, 971 0	90. 02 90. 03
90. 04 04953 SPI NE CENTER	0	0	0	Ō	6	90. 04
90. 05 04954 INFUSION CENTERS	0	0	0	0	20, 564	90.05
90. 06 09002 MEDCHECK CLINICS 90. 07 09003 KNEE CENTER	0 132, 711	0	0 1, 997	0 0	0 36, 110	90. 06 90. 07
90. 08 09004 PALLI ATI VE CARE	0	Ö	0	ő	611	90. 08
90. 10 09006 WORK SITE CLINICS	0	O	0	О	0	90. 10
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 91. 00 09100 EMERGENCY	0 549, 151	0 994, 750	0 40, 628	0	0 1, 483, 681	90. 12 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	347, 131	774, 750	40, 020		1, 403, 001	92. 00
	'		'	'	,	

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0074	Peri od: Worksheet B

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Prepare 5/29/2019 3:09 pm	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16. 00	
OTHER REIMBURSABLE COST CENTERS						
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0 98.	00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 955, 907	12, 351, 473	12, 605, 41	9 19, 609, 625	17, 592, 839 118.	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		0	0 191.	00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	3	9 0	0 192.	00
194. 00 07950 HOME OFFICE	0	o		0	0 194.	00
194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS	0	o		0 0	0 194.	01
194. 03 07953 SCHOOL BASED CLINICS	0	0		0 0	0 194.	03
194. 04 07954 SMO-NON PROVIDER BASED	0	0		0 0	0 194.	04
194.05 07955 FAMILY PRACTICE MEDICINE	0	o	9	0 0	0 194.	05
194. 07 07957 LI FECHECK	0	o		0 0	0 194.	07
194.08 07958 GROUP HOMES AND MISC. N R CTRS	0	o	3, 64	3 0	0 194.	08
194. 09 07959 SURGERY CENTER EAST	0	o		0 0	0 194.	09
200.00 Cross Foot Adjustments					200.	
201.00 Negative Cost Centers	0	l o		ol o	0 201.	
202.00 TOTAL (sum lines 118 through 201)	6, 955, 907	12, 351, 473	12, 609, 19	1 19, 609, 625		
, , , , , , , , , , , , , , , , , , ,	-,,	, , , , , , , , , , , , ,	,,			

| Peri od: | Worksheet B | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Part | Prepared: | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | P Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0074

				T	o 12/31/2018	Date/Time Pre 5/29/2019 3:0	
			INTERNS &	RESI DENTS		372772017 3.0) piii
	Cost Contor Doscription	SOCIAL SERVICES	SEDVICES SALAD	SEDVICES OTHER	EMS	RADI OLOGY	
	Cost Center Description	SOCIAL SERVICE	Y & FRINGES		TRAI NI NG-ALLI E		
		17.00		00.00	D HEALTH	HEALTH	
	GENERAL SERVICE COST CENTERS	17. 00	21. 00	22. 00	23. 00	23. 01	
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						5. 00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00	01700 SOCIAL SERVICE	4, 228, 184					17. 00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	5, 028, 669				21. 00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0		7, 621, 930			22. 00
23. 00	02300 EMS TRAINING-ALLIED HEALTH	0			0		23. 00
23. 01 23. 02	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 02302 PHARMACY RESI DENCY-ALLI ED HEALTH	0				0	23. 01 23. 02
23. 02	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH						23. 02
	INPATIENT ROUTINE SERVICE COST CENTERS	-					
30.00	03000 ADULTS & PEDIATRICS	3, 499, 344	2, 577, 197		0	0	30. 00
31. 00	03100 NTENSI VE CARE UNI T	325, 382	405, 509		0	1	31.00
32. 00 43. 00	03200 CORONARY CARE UNIT 04300 NURSERY	303, 750 99, 708	0	0	0	1	32. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	77, 708	U	0	0	0	43.00
50.00	05000 OPERATI NG ROOM	0	94, 352	143, 009	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	· ·	52. 00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	54. 00 55. 00
57. 00	05700 CT SCAN		0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	Ö	Ö	ő	0	Ö	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	0	10, 368	15, 715	0	0	60.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0	0	0	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY		40, 813	61, 861	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	Ö	0	0 ., 00 .	0	Ö	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 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	o	35, 465	53, 753	0	ő	73. 00
	07400 RENAL DIALYSIS	O	0	0	0	0	74. 00
	03330 ENDOSCOPY	0	0	0	0	0	76. 00
	03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES	0	123, 124	186, 619	0	0	76. 01
	03951 LUTHERWOOD PARTNERSHI P 03952 WOUND CARE CENTER		30, 116	45, 646	0	0	76. 03 76. 04
	03480 ONCOLOGY-CANCER CARE CENTER	o	00, 110	0	0	Ö	76. 05
	03953 I MAGI NG CENTERS	o	0	0	0	0	76. 06
	03954 BREAST DIAGNOSTIC CENTER	0	0	0	0	0	76. 07
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	0	U	0	0	0	76. 98
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
	09000 CLI NI C		0	0	0	0	90. 00
	04950 DI ABETI C CARE CENTER	0	0	0	0	0	90. 01
	04951 HEALTHY HEARTS CENTER 09001 CLI NI C		0	0	0	0	90. 02 90. 03
	04953 SPI NE CENTER		0	0	0	0	90.03
	04954 I NFUSI ON CENTERS	0	o	0	0	0	90. 05
	09002 MEDCHECK CLINICS	0	0	0	0	0	90. 06
	09003 KNEE CENTER	0	41, 485	62, 879	0	0	90. 07
	09004 PALLIATIVE CARE 09006 WORK SITE CLINICS	0	0	0	0	0	90. 08 90. 10
	04961 FAMILY PRACTICE AND MATERNITY CARE		0	0	0	0	90. 10
	09100 EMERGENCY	o	108, 409	164, 314	0	1	

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0074	Peri od: Worksheet B

From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: 5/29/2019 3:09 pm INTERNS & RESIDENTS SOCI AL SERVI CESERVI CES-SALAR SERVI CES-OTHER EMS RADI OLOGY Cost Center Description Y & FRINGES PRGM COSTS TRAI NI NG-ALLI E SCHOOL-ALLI ED D HEALTH HEALTH 17.00 21.00 22.00 23.00 23.01 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 0 0 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 4, 228, 184 3, 466, 838 5, 254, 671 0 0 118. 00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190, 00 0 0 0 0 0 0 0 0 0 0 0 0 191. 00 19100 RESEARCH 0 0 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 0 60, 561 91, 792 0 192.00 194.00 07950 HOME OFFICE 0 194. 00 0 194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS 0 0 194. 01 C 194. 03 07953 SCHOOL BASED CLINICS 0 194. 03 194. 04 07954 SMO-NON PROVIDER BASED 0 194. 04 194.05 07955 FAMILY PRACTICE MEDICINE 0 194. 05 1, 480, 863 2, 244, 537 0 194. 07 194. 07 07957 LI FECHECK 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 0 20, 407 30, 930 0 194. 08 194. 09 07959 SURGERY CENTER EAST 0 194, 09 0 0 200. 00 200.00 Cross Foot Adjustments 0 201.00 Negative Cost Centers 0 0 201.00 202.00 0 202.00 TOTAL (sum lines 118 through 201) 4, 228, 184 5, 028, 669 7, 621, 930

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0074 Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 3:09 pm Cost Center Description **PHARMACY** PHARMACY Subtotal Intern & Total RESIDENCY-ALLI RESIDNECY-BTH Residents Cost ED HEALTH ALLI ED HEALTH & Post Stepdown Adjustments 23. 03 23.02 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17.00 01700 SOCIAL SERVICE 17.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22 00 22 00 23.00 02300 EMS TRAINING-ALLIED HEALTH 23.00 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 23.01 23.01 23.02 02302 PHARMACY RESIDENCY-ALLIED HEALTH 23.02 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH 23.03 23 03 INPATIENT ROUTINE SERVICE COST CENTERS 94, 671, 603 30.00 03000 ADULTS & PEDIATRICS 0 101, 155, 047 -6, 483, 444 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 14, 880, 881 -1, 020, 137 13, 860, 744 31.00 0 03200 CORONARY CARE UNIT Ω 8 531 282 8.531.282 32 00 32 00 43.00 04300 NURSERY 1, 200, 690 1, 200, 690 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 17, 466, 067 17, 228, 706 50.00 -237, 361 50.00 2, 825, 595 2, 825, 595 05100 RECOVERY ROOM 0 51.00 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 00000000000000000000000000000000 0 3, 435, 308 0 3, 435, 308 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 8, 382, 527 8, 382, 527 54.00 2, 482, 510 2, 482, 510 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 57 00 05700 CT SCAN 4, 703, 013 0 4, 703, 013 57 00 1, 739, 548 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 739, 548 58.00 58.00 05900 CARDIAC CATHETERIZATION 59.00 9, 748, 445 9, 748, 445 59 00 06000 LABORATORY 17, 140, 213 -26, 083 60.00 17, 114, 130 60.00 64.00 06400 I NTRAVENOUS THERAPY 614, 778 614, 778 64.00 65.00 06500 RESPIRATORY THERAPY 6, 732, 314 6, 732, 314 65.00 06600 PHYSI CAL THERAPY 9, 784, 566 -102, 674 66.00 9, 681, 892 66.00 06700 OCCUPATIONAL THERAPY 2, 333, 703 2, 333, 703 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 853, 150 853, 150 68.00 69.00 06900 ELECTROCARDI OLOGY 5, 123, 876 0 5, 123, 876 69.00 07000 ELECTROENCEPHALOGRAPHY 0 1, 463, 517 0 70.00 1, 463, 517 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 33, 874, 559 0 33, 874, 559 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 33, 191, 042 33, 191, 042 72.00 07300 DRUGS CHARGED TO PATIENTS 158, 937, 866 -89, 218 158, 848, 648 73.00 73.00 07400 RENAL DIALYSIS 1, 869, 313 1, 869, 313 0 74 00 74 00 76.00 03330 ENDOSCOPY 880, 954 880, 954 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 24, 099, 097 76.01 24, 408, 840 -309, 743 76.01 76.03 03951 LUTHERWOOD PARTNERSHIP 5, 617, 736 5, 617, 736 76.03 4, 201, 368 76.04 03952 WOUND CARE CENTER -75, 762 4, 125, 606 76.04 76.05 03480 ONCOLOGY-CANCER CARE CENTER 0 35, 497, 204 35, 497, 204 76.05 76.06 03953 I MAGING CENTERS 0 7, 715, 585 0 7, 715, 585 76.06 2, 992, 144 o 2, 992, 144 76 07 03954 BREAST DIAGNOSTIC CENTER 0 76 07 07697 CARDIAC REHABILITATION 76.97 0 2, 012, 114 0 2, 012, 114 76.97 07698 HYPERBARI C OXYGEN THERAPY 716, 019 76. 98 76.98 716, 019 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 88 00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 00000000000 0 0 0 0 89.00 09000 CLI NI C 0 0 90.00 90.00 0 0 90.01 04950 DIABETIC CARE CENTER 0 90.01 04951 HEALTHY HEARTS CENTER 0 3, 147, 239 3, 147, 239 90 02 90.02 90.03 09001 CLI NI C 0 90.03 C 0 04953 SPINE CENTER 0 90.04 65 65 90.04 0 90.05 04954 INFUSION CENTERS 0 1, 163, 030 1, 163, 030 90.05 90.06 09002 MEDCHECK CLINICS 90.06 C 0 5, 831, 144 09003 KNEE CENTER 5, 935, 508 -104, 364 90.07 90.07 90.08 09004 PALLIATIVE CARE 0 611 0 611 90.08 09006 WORK SITE CLINICS 90.10 90 10 0 C 0 0 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 90.12 91. 00 09100 EMERGENCY 27, 676, 975 -272, 723 27, 404, 252 91.00

Health Financial Systems CO	OMMUNITY HEALTH	I NETWORK INC		In Lio	u of Form CMS-2552	10
COST ALLOCATION - GENERAL SERVICE COSTS	JUNIONI II HEALIII	Provi der CCI	<u> </u>	Peri od: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Prepare 5/29/2019 3:09 pm	ed:
Cost Center Description	PHARMACY RESI DENCY-ALLI ED HEALTH	ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	23. 02	23. 03	24. 00	25. 00	26. 00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	92.	. 00
OTHER REIMBURSABLE COST CENTERS		, ,				
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0 98	. 00
SPECIAL PURPOSE COST CENTERS	1 _					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	570, 435, 20	2 -8, 721, 509	561, 713, 693 118	. 00
NONREI MBURSABLE COST CENTERS					0 400	00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0 190	
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	429, 33	0 150 252	0 191. 276, 982 192.	
194. 00 07950 HOME OFFICE	0		429, 33	5 -152, 353	276, 982 192	
194. 01 07950 HOME OFFICE 194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS	0				0 194	
194. 03 07953 SCHOOL BASED CLINICS	0		1, 93		1, 934 194	
194. 04 07954 SMO-NON PROVIDER BASED	0		882, 25		882, 253 194	
194. 05 07955 FAMILY PRACTICE MEDICINE			8, 998, 79		5, 273, 392 194	
194. 07 07957 LI FECHECK			0, 770, 77	-3, 723, 400	0 194	
194. 08 07958 GROUP HOMES AND MISC. N R CTRS	0		1, 947, 14	9 -51, 337	1, 895, 812 194	
194. 09 07938 GROOF HOMES AND WISC. N_R CTRS			1, 747, 14	-51, 557	0 194	
200.00 Cross Foot Adjustments					0 200	
201.00 Negative Cost Centers					0 200	
202.00 TOTAL (sum lines 118 through 201)			582, 694, 66	5 -12, 650, 599	570, 044, 066 202	
202.00 TOTAL (Suil Titles TTO till ough 201)	1	١	302, 074, 00	o ₁ -12,000,099	370, 044, 000 202	. 50

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Part | Prepared: | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0074

					То	12/31/2018	Date/Time Pre 5/29/2019 3:0	
				CAPI TAL REI	LATED COSTS		372772017 3.0	y pili
			6	DI DO A FLYT	MANUE FOLLID		EMDL OVEE	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs					
	CENED	AL CEDVICE COCT CENTEDS	0	1. 00	2.00	2A	4. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1.00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	171, 255		15, 586, 827	15, 586, 827	4. 00
5.00		ADMINISTRATIVE & GENERAL	0	746, 021		7, 085, 380	967, 809	5.00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	0	2, 203, 542 0		2, 379, 068 42	233, 995 0	7. 00 8. 00
9. 00		HOUSEKEEPI NG	0	247, 684		251, 348	232, 023	9. 00
10.00	01000	DI ETARY	0	189, 589	38, 615	228, 204	61, 516	10. 00
11.00		CAFETERI A	0	522, 332		650, 646	153, 000	1
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	0	168, 035 292, 224		173, 403 984, 727	279, 924 0	13. 00 14. 00
15. 00	1	PHARMACY	0	39, 172		400, 964	511, 640	1
16. 00		MEDICAL RECORDS & LIBRARY	0	36, 015		36, 055	66, 354	•
17. 00		SOCIAL SERVICE	0	60, 179		60, 708	190, 437	•
21. 00		I &R SERVICES-SALARY & FRINGES APPRVD	0	0	-	0	311, 374	1
22. 00 23. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRVD EMS TRAINING-ALLIED HEALTH	0	5, 662 0	26, 096	31, 758 0	449, 309 0	22. 00 23. 00
23. 01		RADI OLOGY SCHOOL-ALLI ED HEALTH	0	0		ő	0	23. 01
23. 02		PHARMACY RESIDENCY-ALLIED HEALTH	0	0	0	O	0	23. 02
23. 03		PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	0	0	0	23. 03
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	0	3, 962, 760	178, 546	4, 141, 306	3, 167, 232	30.00
31. 00	1	INTENSIVE CARE UNIT	0	620, 863		743, 958	455, 120	1
32. 00		CORONARY CARE UNIT	0	359, 770		374, 228	258, 239	1
43.00		NURSERY	0	59, 106	6, 322	65, 428	33, 798	43. 00
EO 00	ANCI L	LARY SERVICE COST CENTERS		000 227	410.01/	1 200 152	257 207	FO 00
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	0	988, 337 201, 313		1, 399, 153 202, 497	357, 286 85, 980	
52. 00		DELIVERY ROOM & LABOR ROOM	0	146, 102		161, 727	125, 421	
54.00		RADI OLOGY-DI AGNOSTI C	0	570, 093	271, 505	841, 598	233, 218	54. 00
55. 00		RADI OLOGY-THERAPEUTI C	0	165, 088		288, 871	62, 457	
57. 00 58. 00	1	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	0	88, 153 107, 561		192, 507 228, 395	139, 899 38, 829	1
59.00		CARDIAC CATHETERIZATION	0	417, 298		821, 976	265, 166	•
60.00		LABORATORY	0	93, 289		148, 644	0	60.00
64. 00	1	INTRAVENOUS THERAPY	0	8, 756		10, 250	27, 132	•
65. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	0	44, 266		118, 110	288, 563	•
66. 00 67. 00		OCCUPATIONAL THERAPY	0	69, 336 17, 744		528, 146 26, 731	369, 597 95, 482	•
68. 00		SPEECH PATHOLOGY	Ö	6, 483		9, 771	34, 929	
69. 00		ELECTROCARDI OLOGY	0	20, 270		211, 688	214, 528	
70.00		ELECTROENCEPHALOGRAPHY	0	0		78, 565	45, 700	
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0) 0		0	0	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATIENTS	0	0		ő	0	ı
74. 00	1	RENAL DIALYSIS	0	6, 841	139	6, 980	0	1
76.00		ENDOSCOPY	0	0	36, 139	36, 139	35, 357	1
76. 01 76. 03	1	PSYCHIATRIC/PSYCHOLOGICAL SERVICES LUTHERWOOD PARTNERSHIP	0	111, 749 0		1, 027, 625 649, 193	2, 458, 955 680, 220	
76. 03	1	WOUND CARE CENTER		107, 792		111, 151	68, 303	1
76. 05	03480	ONCOLOGY-CANCER CARE CENTER	0	373, 516	1, 710, 383	2, 083, 899	865, 352	76. 05
	1	I MAGING CENTERS	0	2, 547		694, 757	241, 491	
76. 07 76. 97	1	BREAST DIAGNOSTIC CENTER CARDIAC REHABILITATION	0	53, 949 152, 606		76, 832 213, 809	0 60, 204	
	1	HYPERBARIC OXYGEN THERAPY	0	17, 976		18, 529	11, 419	1
. 5. 75		TIENT SERVICE COST CENTERS		.,,,,,		.5, 527	. 1, 177	1 3. 70
88. 00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	ł
89.00		FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90. 00 90. 01	1	CLINIC DIABETIC CARE CENTER	0	0		0	0	90. 00 90. 01
90. 01	1	HEALTHY HEARTS CENTER		88, 301	68, 000	156, 301	153, 542	•
90. 03	1	CLI NI C	0	0	0	0	0	1
90. 04	1	SPI NE CENTER	0	0	0		0	
90. 05 90. 06	1	INFUSION CENTERS MEDCHECK CLINICS	0	0	157, 288	157, 288	37, 681 0	1
90.06	1	KNEE CENTER		262, 334	-	272, 454	143, 535	1
90. 08		PALLI ATI VE CARE	O	0	0	0	0	90. 08
90. 10	1	WORK SITE CLINICS	0	0	0	o	0	1
90. 12	04961	FAMILY PRACTICE AND MATERNITY CARE	0	0	0	이	0	90. 12

Health Financial Systems CO	DMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2018 To 12/31/2018		
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2.00	2A	4. 00	
91. 00 09100 EMERGENCY	0	951, 249	51, 38	1, 002, 638	746, 296	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
OTHER REIMBURSABLE COST CENTERS		_				
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98. 00
SPECIAL PURPOSE COST CENTERS		44 757 450	00 040 44	44.070.074	45 050 040	440.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	14, 757, 158	30, 213, 11	6 44, 970, 274	15, 258, 312	1118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0			0	190. 00
191. 00 19100 RESEARCH	0	0		0	-	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	45, 908	11, 32	25 57, 233		191.00
194. 00 07950 HOME OFFICE	0	45, 700	11, 32	0 0 0		194. 00
194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS	0	0			-	194. 00
194. 03 07953 SCHOOL BASED CLINICS	0	0			-	194. 03
194. 04 07954 SMO-NON PROVI DER BASED	0	0			42, 249	
194. 05 07955 FAMILY PRACTICE MEDICINE	0	0	552, 87	552, 873		1
194. 07 07957 LI FECHECK	0	0	002,0	0 002,0.0		194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	0	0	53, 83	53, 834	80, 044	194. 08
194. 09 07959 SURGERY CENTER EAST	0	0		0 0	· ·	194, 09
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0 0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	14, 803, 066	30, 831, 14	45, 634, 214	15, 586, 827	202. 00

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Part | Prepared: | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HEALTH NETWORK, INC. Provider CCN: 15-0074

				T	0 12/31/2018	Date/Time Pre 5/29/2019 3:0	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	7. 00	LI NEN SERVI CE 8. 00	9. 00	10.00	
1 00	GENERAL SERVICE COST CENTERS						1 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 ADMINISTRATIVE & GENERAL	8, 053, 189					5. 00
7.00	00700 OPERATION OF PLANT	326, 555	2, 939, 618				7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	18, 039	42 225	18, 081 9, 040	444 712		8. 00 9. 00
10.00	01000 DI ETARY	91, 976 37, 697	62, 325 47, 706		646, 712 10, 723	385, 846	
11. 00	01100 CAFETERI A	54, 211	131, 435	0	29, 542	192, 923	
13.00	01300 NURSING ADMINISTRATION	161, 613	42, 283	26		0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	77, 988	73, 533		16, 528	0	14. 00
15. 00	01500 PHARMACY	177, 929	9, 857	0	2, 215	0	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	105, 655 54, 476	9, 062 15, 143		2, 037 3, 404	0	16. 00 17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	65, 894	15, 143	0	3, 404	0	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	103, 306	1, 425	37	320	0	22. 00
23. 00	02300 EMS TRAINING-ALLIED HEALTH	0	0	0	0	0	23. 00
23. 01	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH	0	0	0	0	0	23. 01
23. 02 23. 03	02302 PHARMACY RESIDENCY-ALLIED HEALTH 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	0	0	0	23. 02 23. 03
23. 03	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0		U _I	0	23.03
30. 00	03000 ADULTS & PEDIATRICS	990, 000	997, 154	4, 482	224, 125	163, 431	30. 00
31.00	03100 INTENSIVE CARE UNIT	147, 121	156, 228	353	35, 115	15, 253	
32. 00	03200 CORONARY CARE UNIT	89, 418	90, 529		20, 348	14, 239	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	11, 808	14, 873	43	3, 343	0	43.00
50. 00	05000 OPERATING ROOM	172, 596	248, 697	414	55, 898	0	50.00
51. 00	05100 RECOVERY ROOM	29, 340	50, 657	0	11, 386	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	38, 938	36, 764	106		0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	87, 366	143, 453	182	32, 243	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	25, 321	41, 541	116		0	55. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	51, 383 18, 146	22, 182 27, 066	367 117	4, 986 6, 083	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	90, 070	105, 005	153		0	59.00
60.00	06000 LABORATORY	215, 690	23, 475	0	5, 276	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	7, 849	2, 203	0	495	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	85, 671	11, 139			0	65. 00
66. 00	06600 PHYSI CAL THERAPY	127, 180	17, 447	0	3, 921	0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	30, 036 10, 988	4, 465 1, 631	0	1, 004 367	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	62, 006	5, 101	Ö	1, 146	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	18, 880	0	18	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	446, 020	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	450, 898	0	0	0	0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	1, 934, 551 25, 130	1, 721	0	387	0	73. 00 74. 00
	03330 ENDOSCOPY	11, 276	1, 721	32	0	0	
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	323, 301	28, 120		6, 320	0	76. 01
76. 03	03951 LUTHERWOOD PARTNERSHIP	77, 445	0	0	0	0	76. 03
76. 04	03952 WOUND CARE CENTER	50, 520	27, 124			0	76. 04
76. 05 76. 06	03480 ONCOLOGY-CANCER CARE CENTER 03953 I MAGI NG CENTERS	444, 815 101, 001	93, 988 641	207	21, 125 144	0	76. 05 76. 06
76. 07	03954 BREAST DI AGNOSTI C CENTER	38, 796	13, 575	0	3, 051	0	76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	20, 877	38, 400	Ö		0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	8, 833	4, 523	0	1, 017	0	76. 98
	OUTPATIENT SERVICE COST CENTERS	1 -		_	ام		
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90. 01	04950 DI ABETI C CARE CENTER		0	0	ő	0	
90. 02	04951 HEALTHY HEARTS CENTER	37, 946	22, 219	189	4, 994	0	90. 02
90. 03	09001 CLI NI C	0	0	0	0	0	90. 03
90. 04	04953 SPI NE CENTER	1 1	0	0	0	0	90. 04
90. 05 90. 06	04954 I NFUSION CENTERS 09002 MEDCHECK CLINICS	15, 790	0	0	0	0	90. 05 90. 06
90.00	09003 KNEE CENTER	68, 420	66, 012] 0 0	14, 837	0	90.08
90. 08	09004 PALLIATIVE CARE	0	0	0	0	0	90. 08
90. 10	09006 WORK SITE CLINICS	0	0	0	O	0	90. 10
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	0	0	0	_ 0	0	
91.00	09100 EMERGENCY	299, 061	239, 364	1, 714	53, 800	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	. 9			٠		

Provider CCN: 15-0074

					5/29/2019 3:0	9 pm
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5. 00	7. 00	8. 00	9. 00	10.00	
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through	117) 7, 939, 827	2, 928, 066	18, 081	644, 116	385, 846	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEE	EN O	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	2, 111	11, 552	0	2, 596	0	192. 00
194.00 07950 HOME OFFICE	0	0	0	0	0	194. 00
194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS	0	0	0	0	0	194. 01
194. 03 07953 SCHOOL BASED CLINICS	27	0	0	0	0	194. 03
194.04 07954 SMO-NON PROVIDER BASED	12, 193	0	0	0	0	194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	72, 880	0	0	0	0	194. 05
194. 07 07957 LI FECHECK	0	0	0	0	0	194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	26, 151	0	0	0	0	194. 08
194.09 07959 SURGERY CENTER EAST	0	0	0	0	0	194. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	8, 053, 189	2, 939, 618	18, 081	646, 712	385, 846	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0074

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Ti

			10	12/31/2010	Date/lime Pre 5/29/2019 3:0	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	<i>y</i> p
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11.00	13. 00	14. 00	15. 00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	1, 211, 757 35, 077 0 56, 602 7, 972 21, 525 45, 441 22, 322 0 0	701, 830 350, 915 0 0 0 0 0 0 0	1, 503, 691 751, 804 9 15 0 120 0	1, 911, 011 955, 505 0 0 0 0 0	1, 182, 649 0 0 0 0 0 0	1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 14. 00 15. 00 16. 00 17. 00 21. 00 22. 00 23. 00 23. 01 23. 02
23. 03 O2303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	0	0	0	23. 03
I NPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS	353, 958	209, 136	7, 848	ol	90, 432	30. 00
31. 00 03100 NTENSI VE CARE UNI T	51, 819	30, 617	1, 215	0	14, 158	31. 00
32. 00 03200 CORONARY CARE UNIT	32, 686	19, 312	903	0	8, 719	32. 00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	3, 986	2, 355	152	0	1, 213	43. 00
50. 00 05000 OPERATING ROOM	45, 441	26, 849	53, 783	0	57, 317	50. 00
51.00 05100 RECOVERY ROOM	9, 567	0	446	0	6, 683	51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	10, 364	6, 123	376	0	2, 998	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	20, 727 7, 972	0	149 1, 196	0	25, 917 9, 386	54. 00 55. 00
57. 00 05700 CT SCAN	24, 713	0	30	0	38, 879	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	4, 783	0	1	0	6, 703	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	29, 497	0	61, 225	0	94, 740	59. 00
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	0 3, 189	0	11, 459 19	0	77, 964 317	60. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY	33, 483	0	295	0	13, 056	65. 00
66. 00 06600 PHYSI CAL THERAPY	18, 336	0	394	0	12, 343	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	11, 161	0	102	0	3, 194	67. 00
68. 00 06800 SPEECH PATHOLOGY	3, 986	0	37	0	1, 170	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	32, 686 6, 378	0	542 263	0	26, 254 3, 852	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0, 3, 5	Ö	113, 471	Ö	43, 779	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	38, 062	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	482, 809	955, 506	337, 043	
74. 00 07400 RENAL DI ALYSI S 76. 00 03330 ENDOSCOPY	0 3, 986	0	276	0	2, 181 2, 527	74. 00 76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	39, 063	0	1, 664	0	11, 154	76. 01
76. 03 03951 LUTHERWOOD PARTNERSHIP	0	0	1, 003	0	385	76. 03
76. 04 03952 WOUND CARE CENTER	11, 161	0	1, 039	0	6, 443	76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER 76. 06 03953 I MAGING CENTERS	113, 204 797	0	4, 366 314	0	107, 632 26, 461	76. 05 76. 06
76. 07 03954 BREAST DI AGNOSTI C CENTER	0	0	0	o	2, 627	
76. 97 07697 CARDI AC REHABI LI TATI ON	10, 364	0	91	0	1, 910	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1, 594	0	102	0	1, 228	76. 98
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	O	0	O	O	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o	o	0	o	0	89. 00
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 04951 HEALTHY HEARTS CENTER	19, 133	0	630	0	2, 285	90. 02
90. 03 09001 CLI NI C 90. 04 04953 SPI NE CENTER	0	0	0	0	0	90. 03 90. 04
90. 05 04954 NFUSION CENTERS		ol	o	ol	1, 383	90. 05
90. 06 09002 MEDCHECK CLINICS	0	o	Ō	o	0	90. 06
90. 07 09003 KNEE CENTER	23, 119	0	238	0	2, 429	90. 07
90. 08 09004 PALLIATIVE CARE	0	0	0	0	41	90. 08
90.10 09006 WORK SITE CLINICS 90.12 04961 FAMILY PRACTICE AND MATERNITY CARE		0	0	O O	0	90. 10 90. 12
91. 00 09100 EMERGENCY	95, 665	56, 523	4, 845	ol	99, 784	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0074	Peri od:	Worksheet B

From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/29/2019 3:09 pm Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL ADMI NI STRATI ON SERVICES & RECORDS & SUPPLY LI BRARY 11.00 13.00 15.00 16.00 14.00 OTHER REIMBURSABLE COST CENTERS 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 0 98.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 1, 182, 649 118. 00 118.00 1, 211, 757 701, 830 1, 503, 240 1, 911, 011 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 191. 00 19100 RESEARCH 0 191.00 0 0 0 0 0 0 0 0 0 5 0 0 0 0 0 0 0 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192, 00 0 194.00 07950 HOME OFFICE 0 194.00 0 194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS 0 0 0 194. 01 0 194. 03 07953 SCHOOL BASED CLINICS 0 0 194. 03 194. 04 07954 SMO-NON PROVI DER BASED 0 194. 04 194.05 07955 FAMILY PRACTICE MEDICINE 0 11 0 194. 05 194. 07 07957 LI FECHECK 0 0 194. 07 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 0 194. 08 0 435 194. 09 07959 SURGERY CENTER EAST 0 194. 09 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 TOTAL (sum lines 118 through 201) 1, 911, 011 202.00 1, 211, 757 701, 830 1, 503, 691 1, 182, 649 202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/29/2019 3:09 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0074

Cost Center Bescription Cost Center Bescription					'	0 12/31/2018	5/29/2019 3:0	
CENTRAL SERVICE COST CENTRES 17.00 21.00 22.00 23.00 23.00 23.00 20.01				INTERNS &	RESI DENTS			
CENTRAL SERVICE COST CENTRES 17.00 21.00 22.00 23.00 23.00 23.00 20.01		Coot Conton Decemintion	COCLAL CEDVICE	CEDVI CEC CALAD	CEDVI CEC OTHER	EMC	DADLOLOCV	
D. HEATTH STATE D. HEATTH STATE D. HEATTH D. D. D. D. D. D. D. D. D. D. D. D. D.		cost center bescription	SUCIAL SERVICE					
DIRECTION STANLED CONTINUES HAVE 10				I W THINGES	1110111 00010			
1.00			17. 00	21. 00	22. 00		23. 01	
2.00							1	
4.00		1						1
5.00		1						1
0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000		1					•	1
8 00 00 000000000000000000000000000000		1						
0.00 0.000		1					•	1
10.00 01000 DETARY								1
13.00 0.300 MURS HAS ABMIN STRATION 13.00 15.00 10-500 FIABMACY 15.00 15.00 10-500 FIABMACY 15.00 17.00 10-500 FIABMACY 18.00 10-500 FIABMACY								1
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 15.00 10.00 1	11. 00							1
15.00 10500 PHASMACY	13.00	01300 NURSING ADMINISTRATION						13. 00
16. 00 1600 MEDICAL RECORDS & LIBRARY 17.00 1700, 00 17								1
17.00 17.00 2001 AL SERVICE 345, 708 17.00 22.00								1
21.00			245 700					1
22.00				l				1
23.00 02300 EMS TRAIN NO-ALLIED HEALTH		1		422, 709				1
23.01 2320 PARIBACY RESIDENCY—ALLE DE HEALTH 0 23.02 23.02 230.02 230.02 PARIBARCY RESIDENCY—ALLE DE HEALTH 0 23.02 23.03 PARIBARCY RESIDENCY—BERNEY—BE					000, 577	0		1
23.02 02302 PHARBACY RESIDENCY-BIT LALED HALTH 0			0				•	
12.3 0. 20.303 PARABARCY RESIDINECY - BITH ALLIED HEALTH 0			o o				Ĭ	1
30.00 30000 ADULTS & PEDIATRICS 286, 117 26, 604 31, 00 32.00 32.00 03200 CORDIARRY CARE UNIT 24, 835 32.00 32.00 03200 CORDIARRY CARE UNIT 24, 835 32.00 32.00 32.00 MINSERY 34.00 32.00 MINSERY 34.00 32.00 MINSERY 34.00 32.00 MINSERY 34.00 35.00 MINSERY 34.00 35.00			0					1
31.00		INPATIENT ROUTINE SERVICE COST CENTERS						
32.00 03200C CORONARY CARE LIMIT 2.4 8.35 8.152 3.2 0.00 4300 0XESERY 8.152 3.5 0.00 5000 0XESERY 8.152 3.5 0.00 5000 0XESERY CORON 0.0			286, 117					30. 00
43. 00 A300 NURSERY		1	1	ł				
ANCILLARY SERVICE COST CENTERS		1	1					1
50.00 05000 0FECRATI NG ROOM 0 51.00 52.00 05200 0FECUPERY ROOM 0 0 052.00 05200 0FECUPERY ROOM 0 0 0 052.00 05200 0FECUPERY ROOM 0 0 0 0 0 0 0 0 0	43. 00		8, 152					43.00
51.00 G5100 RECOVERY ROOM & LABOR ROOM 52.00 52.00 52.00 63.00 BELI VERY ROOM & LABOR ROOM 52.00 55.00 6	EO 00						I	E0 00
S2.00 05200 DELIVERY ROOM & LABOR ROOM		1						1
54.00 05400 RADI DLOGY-DI AGNOSTIC 0 55.00 55.00 55.00 05500 RADI DLOGY-THERAPEUTIC 0 55.00 05500 RADI DLOGY-THERAPEUTIC 0 55.00 05900 RADI DLOGY-THERAPEUTIC 0 55.00 05900 RADI DLOGY-THERAPEUTIC 0 55.00 05900 MARNETIC RESONANCE IMAGI NG (MRI) 0 59.00 05900 CARDI JAC CATHETERI JATI ON 0 59.00 05900 CARDI JAC CATHETERI JATI ON 0 0.00 0.000 0.0000 ABORATORY 0 0.00 0.000 0.0000 ABORATORY 0 0.00 0.000 0.0000 ABORATORY 0 0.00 0.000 0.0000 ABORATORY 0 0.00 0.000 0.0000 ABORATORY 0 0.00 0.0000 0.0000 ABORATORY 0 0.00 0.00000 0.00000 0.00000 0.00000 0.0000000 0.00000000		1	1	l e				ı
55.00 05500 RADIOLOGY-THERAPEUTIC 0 55.00 57.00 570 0570 07500 075				l				1
SB 00 OSBOO MAGNETIC RESONANCE I MAGI NG (MRI) 0 59 00 0590 OSBOO CARDIAC CATHETERIZATION 0 59 00 0500 CARDIAC CATHETERIZATION 0 0.00 0.00 0.0000 0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000		1	0					1
59.00 05900 CARDIAC CATHETERI ZATION 0 0 0 0 0 0 0 0 0	57.00	05700 CT SCAN	0					57. 00
60.00 06000 LABORATORY 0 60.00 60.	58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0					58. 00
64.00 06400 INTRAVENOUS THERAPY 0 65.00 65.00 65.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 66.00 67.00 67.00 67.00 66.00 67.00 67.00 67.00 68.00 69			0					1
65. 00 06500 RESPI RATORY THERAPY 0 0 0 66. 00 06. 00 06600 PHYSI CAL THERAPY 0 0 0 0 66. 00 07. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 08. 00 06600 SPECH PATHOLOGY 0 0 0 0 08. 00 06600 ELECTROCARDI OLOGY 0 0 0 0 09. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 09. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 09. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 09. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 09. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 09. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 09. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 09. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 09. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 09. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 09. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 09. 01 07000 DRUGS CHARGED TO PATIENTS 0 0 0 0 09. 01 07400 REMAL DI ALYSI S 0 0 0 0 0 09. 01 07400 REMAL DI ALYSI S 0 0 0 0 09. 01 07400 REMAL DI ALYSI S 0 0 0 0 09. 01 07400 REMAL DI ALYSI S 0 0 0 0 09. 01 07400 REMAL DI ALYSI S 0 0 0 0 09. 01 07400 REMAL DI ALYSI S 0 0 0 0 09. 01 07400 REMAL DI ALYSI S 0 0 0 0 09. 01 07400 REMAL DI ALYSI S 0 0 0 0 09. 01 07400 REMAL DI ALYSI S 0 0 0 0 09. 01 07400 REMAL DI ALYSI S 0 0 0 0 09. 01 07400 REMAL DI ALYSI S 0 0 0 0 09. 01 07400 07400 REMAL DI ALYSI S 0 0 0 09. 01 07400 07400 0 0 0 0 09. 01 07400 07400 0 0 0 0 09. 01 07400 07400 0 0 0 0 09. 01 07400 07400 0 0 0 0 09. 01 07400 07400 0 0 0 0 09. 01 07400 07400 0 0 0 0 09. 01 07400 07400 0 0 0 0 09. 01 07400 07400 0 0 0 0 09. 01 07400 07400 0 0 0 0 09. 01 07400 07400 0 0 0 09. 01 07400 07400 0 0 0 0 09. 01 07400 07400 0			0					1
66. 00 06500 06500 06500 06500 06700 06700 06700 06700 06700 06700 06700 06700 06700 06800 07200			0					1
67. 00 06700 06700 06700 06700 06800								1
68. 00 06800 SPEECH PATHOLOGY 0 06900			-	l				1
69.00 06900 ELECTROCARDI OLOGY 0 70.00 70.		1 1						1
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 71. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 75. 00 74. 00 76			0					1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 73. 00 73.00 DRUGS CHARGED TO PATIENTS 0 73. 00 73.00 DRUGS CHARGED TO PATIENTS 0 73. 00 74.00 DRUGS CHARGED TO PATIENTS 0 73. 00 74.00 DRUGS CHARGED TO PATIENTS 0 75. 00 75. 00 75. 00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 76. 03 03951 LUTHERWOOD PARTNERSHI P 0 76. 03 76. 04 03952 WOUND CARE CENTER 0 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 76. 05 03953 I MAGI NG CENTERS 0 76. 05 03953 I MAGI NG CENTERS 0 76. 05 03954 BREAST DI AGNOSTI C CENTER 0 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 90. 00 03900 CLI NI C 0 90. 00 0000 CLI NI C 0 90. 00 0	70.00	07000 ELECTROENCEPHALOGRAPHY	0					1
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 75. 01 03350 RENAL DI ALYSI S 76. 00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 76. 01 03952 WOUND CARE CENTER 0 76. 04 76. 05 76. 04 76. 05 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 76. 05 76. 06 03952 MOUND CARE CENTER 0 76. 07 76	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					
74. 00 76				l				
76. 00 03330 ENDOSCOPY			1	l e				1
76. 01			1	l e				
76. 03 03951 LUTHERWOOD PARTNERSHIP 0 76. 03 03952 WOUND CARE CENTER 0 76. 04 03952 WOUND CARE CENTER 0 76. 05 76. 05 03953 I MAGI NG CENTERS 0 76. 06 76. 06 03953 I MAGI NG CENTERS 0 76. 06 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 76. 07 07697 CARDI AC REHABI LI TATI ON 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0 76. 98 0011 PATI ENT SERVI CE COST CENTERS 0 0 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 90. 00 09000 CLI NI C 0 90. 00 09000 CLI NI C 0 90. 00 09000 CLI NI C 0 90. 01 04950 DI ABETI C CARE CENTER 0 90. 01 04950 DI ABETI C CARE CENTER 0 90. 01 04951 HEALTHY HEARTS CENTER 0 90. 02 04951 HEALTHY HEARTS CENTER 0 90. 02 04951 HEALTHY HEARTS CENTER 0 90. 03 09001 CLI NI C 0 90. 03 09001 CLI NI C 0 90. 03 09001 CLI NI C 0 90. 05 04954 I NFUSI ON CENTERS 0 90. 05 090. 05 04954 I NFUSI ON CENTERS 0 90. 05 090. 05 09002 MEDCHECK CLI NI CS 0 90. 05 090. 06 09002 MEDCHECK CLI NI CS 0 90. 05 090. 07 09003 KNEE CENTER 0 90. 06 90. 07 09003 KNEE CENTER 0 90. 07 090. 08 09004 PALLI ATI VE CARE 0 90. 08 0900		1	-					1
76. 04 03952 WOUND CARE CENTER 0 76. 04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 76. 05 76. 06 03953 I MAGI NG CENTERS 0 76. 06 76. 07 03954 BREAST DI AGNOSTIC CENTER 0 76. 07 76. 97 07697 CARDI AC REHABILITATION 0 76. 97 76. 98 0000 HYPERBARIC OXYGEN THERAPY 0 76. 98 0000 UNIPATIENT SERVICE COST CENTER 0 88. 00 88. 00 08800 RURAL HEALTH CLINIC 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 90. 01 90. 01 04950 DI ABETIC CARE CENTER 0 90. 01 90. 02 04951 HEALTHY HEARTS CENTER 0 90. 01 90. 03 09001 CLINIC 0 90. 02 90. 04953 SPINE CENTER 0 90. 03 90. 04 04953 SPINE CENTER 0 90. 03 90. 04 04953 SPINE CENTER 0 90. 05 90. 05 04954 INFUSION CENTERS 0 90. 05 90. 06 09002 MEDCHECK CLINICS 0 90. 06 90. 07 09003 KNEE CENTER 0 90. 07 90. 08 09004 PALLIATIVE CARE 0 90. 07 90. 08 09004 FAMILY PRACTICE AND MATERNITY CARE 0 90. 08 90. 10 09006 WORK SITE CLINICS 0 90. 08 90. 10 09006 WORK SITE CLINICS 0 90. 08 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE		1						
76. 05 03480 0NCOLOGY-CANCER CARE CENTER 0 76. 05 76. 06 03953 IMAGI NG CENTERS 0 0 76. 06 76. 06 76. 07 03954 BREAST DI AGNOSTIC CENTER 0 76. 07 76. 07 07697 CARDI AC REHABI LITATI ON 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 00 00 00 00 00 00 00		1	0				•	
76. 06			0					
76. 07			0					
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 88. 00 0 89. 00 0 89. 00	76. 07	03954 BREAST DIAGNOSTIC CENTER	0					76. 07
SECTION SERVICE COST CENTERS	76. 97	07697 CARDI AC REHABI LI TATI ON	1	l e				
88. 00	76. 98		0					76. 98
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 90. 00 90. 00 09000 CLINIC 0 90. 00 90. 01 04950 DI ABETIC CARE CENTER 0 90. 01 90. 02 04951 HEALTHY HEARTS CENTER 0 90. 02 90. 03 09001 CLINIC 0 90. 03 90. 04 04953 SPINE CENTER 0 90. 03 90. 04 04954 INFUSION CENTERS 0 90. 05 04954 INFUSION CENTERS 0 90. 06 09002 MEDCHECK CLINICS 0 90. 05 90. 07 09003 KNEE CENTER 0 90. 06 90. 07 09003 KNEE CENTER 0 90. 07 90. 08 09004 PALLIATIVE CARE 0 90. 08 90. 10 09006 WORK SITE CLINICS 0 90. 10 09006 WORK SITE CLINICS 0 90. 10 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0				Г	Г		1	
90. 00 09000 CLINIC 00 90. 00 90. 01 90. 00 90. 01 90. 01 90. 01 90. 01 90. 01 90. 02 90. 03 90. 01 10. 02 90. 03 90. 01 90. 04 90. 03 90. 04 90. 05 90. 05 90. 05 90. 06 90. 02 90. 05 90. 06 90. 07 90. 08 90. 07 90. 08 90. 04 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08 90. 07 90. 08				ŀ				
90. 01								1
90. 02								1
90. 03								1
90. 04			0					1
90. 05			0					
90. 07 09003 KNEE CENTER 0 90. 07 90. 08 09004 PALLI ATI VE CARE 0 90. 10 90. 10 90. 12 04961 FAMI LY PRACTI CE AND MATERNI TY CARE 0 90. 12 90. 12 90. 12 90. 12 90. 12 90. 12 90. 10 90. 12 90. 10 9			0					1
90. 08 09004 PALLIATIVE CARE 0 90. 08 90. 10 09006 WORK SITE CLINICS 0 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 90. 12	90.06	09002 MEDCHECK CLINICS	0					90.06
90. 10 09006 WORK SITE CLINICS 0 90. 10 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 90. 12			0					1
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 90. 12			0					
		1						1
41. OU DATOO EMERGEING)				ŀ				1
	91.00	U7 I UU EMEKGENU Y	1 0	l	l	1	<u> </u>	91.00

Health Financial Systems	COMMUNITY HEALTH				2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0074	Peri od: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prep 5/29/2019 3:00	
		INTERNS & RESIDENTS			

				o 12/31/2018		
		INTERNS &	RESI DENTS		,	
Cost Center Description	SOCIAL SERVICE				RADI OLOGY	
		Y & FRINGES	PRGM COSTS	TRAI NI NG-ALLI E		
	47.00	04.00	20.00	D HEALTH	HEALTH	
	17. 00	21. 00	22. 00	23. 00	23. 01	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						00.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0					98. 00
SPECIAL PURPOSE COST CENTERS	245 700				0	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	345, 708	0	0	0	0	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190. 00
190.00/1900/GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
192. 00 19100 RESEARCH 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES						191.00
194. 00 07950 HOME OFFICE	0					194. 00
194. 01 07951 OCCUPATI ONAL HEALTH ONSI TE SVCS						194. 00
194. 03 07953 SCHOOL BASED CLINICS						194. 03
194. 04 07954 SMO-NON PROVI DER BASED	0					194. 04
194. 05 07955 FAMILY PRACTICE MEDICINE	0					194. 05
194. 07 07957 LI FECHECK	0					194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	0					194. 08
194. 09 07959 SURGERY CENTER EAST						194. 09
200.00 Cross Foot Adjustments		422, 709	608, 597	o	0	200. 00
201.00 Negative Cost Centers	0	0	0	o		201. 00
202.00 TOTAL (sum lines 118 through 201)	345, 708	422, 709	608, 597	0	0	202. 00

Provider City 15 OOA Per total City 17 OO		Financial Systems	COMMUNITY HEALTI	H NETWORK, INC.		In Lie	u of Form CMS-	<u> 2552-10</u>
The control of the	ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der CC		From 01/01/2018	Part II Date/Time Pre	pared:
DEBIND SERVICE ODST CENTERS		Cost Center Description	RESI DENCY-ALLI	RESI DNECY-BTH	Subtotal	Residents Cost & Post Stepdown	•	
1.00		Joseph Ospinos Coot Ospitspo	23. 02	23. 03	24. 00	25. 00	26. 00	
2.00 0000000000000000000000000000000000	1 00		<u> </u>	T T		1		1 00
30.00 3000 ADULT'S & PEDIATRICS 10, 635, 221 0 10, 635, 221 30, 00 3000 3000 INTENSIVE CASE INIT 933, 456 0 933, 456 32. 00 3300 MINSERY 933, 456 0 933, 456 32. 00 3300 MINSERY 1515, 151 0 1161, 151 43. 00 3300 MINSERY 8000	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 14. 00 15. 00 16. 00 17. 00 21. 00 22. 00 23. 00 23. 01 23. 02	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 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 02301 RADIOLOGY SCHOOL-ALLIED HEALTH 02302 PHARMACY RESIDNECY-BTH ALLIED HEALTH		1				2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 22. 00 23. 00 23. 01 23. 02
31.00 03100 NTENSI VE CARE UNIT 1, 677, 561 31.00 32.00 03200 CRONARY CARE UNIT 933, 456 0 933, 456 32.00 32.00 03200 CRONARY CARE UNIT 145, 151	20 00				10 625 22	1 0	10 625 221	20 00
50.00 G05000 OPERATI NG ROOM 2, 417, 434 50. 2, 417, 434 50. 0 50. 0 50. 0 50.00 BELOWERY ROOM 396, 556 51. 00 52. 00 05200 DELI VERY ROOM 8.06, 556 51. 00 52. 00 05200 DELI VERY ROOM 8.06, 556 51. 00 52. 00 05200 DELI VERY ROOM 8.06, 556 51. 00 52. 00 05500 RADI DLOGY-THERAPEUTI C 1,384, 853 54. 00 0.5500 RADI DLOGY-THERAPEUTI C 446, 197 0. 446, 197 55. 00 05500 RADI DLOGY-THERAPEUTI C 446, 197 0. 446, 197 55. 00 05500 RADI DLOGY-THERAPEUTI C 446, 197 0. 444, 196 57. 00 57.00 07500 C T SCAM 446, 197 0. 444, 196 0. 474, 196 59. 00 05900 C T SCAM 446, 197 0. 444, 197 55. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 330, 123 0. 330, 123 59. 00 05900 CARDI ACC AFTIETER I ZATI ON 1,491, 433 0. 1,491, 433 59. 00 06000 LARDIAGO LA	31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 04300 NURSERY			1, 677, 56 933, 45	0 6 0	1, 677, 561 933, 456	31. 00 32. 00
51 DO 05100 RECOVERY ROOM & LABOR ROOM 396, 556 0, 396, 555 51, 00 52, 00 0520 0ELIVERY ROOM & LABOR ROOM 0391, 080 52, 00 05400 RADI LOGY-DI AGNOSTI C 1, 384, 853 0, 1, 384, 853 0, 1, 384, 853 0, 1, 384, 853 0, 1, 384, 853 0, 10 346, 197 57, 00 05700 CT SCAN 474, 946 0 474, 946 57, 00 380, 00 380, 00 ARDI ALOGY-THERAPEUTI C 346, 197 57, 00 390, 020 CT SCAN 347, 946 0 474, 946 57, 00 380, 00 3	50. 00				2, 417, 43	4 0	2, 417, 434	50.00
54. 00 05400 RADIOLOGY-DIAGNOSTIC 1,384,853 54. 00 1,384,857 55. 00 55. 00 05500 CRDIOLOGY-THERAPEUTIC 446,197 0 446,197 55. 00 05700 CT SCAN 474,946 0 474,946 57. 00 0.5700 CT SCAN 474,946 0 474,946 57. 00 0.5900 CARDIOLOGY-THERAPEUTIC 33. 01,123 0 330,123 58. 00 0.5900 CARDIOLOGY-THERAPEUTIC 482,508 0 482,508 0 482,508 0 0.5900 CARDIOLOGY-THERAPEUTIC 482,508 0 482,508 0 0.5900 CARDIOLOGY-THERAPEUTIC 482,508 0 0.5900 CARDIOLOGY-THERAPEUTIC 51,454 0 51,454 0 0.513,454 0 0.513,454 0 0.5900 0.6400 INTRAVENOUS THERAPY 553,167 0 553,167 0 0.553,167 0 0.6500 0.6500 RESPIRATORY THERAPEY 10,77,364 0 1,077,364 0 0.707,364 0		05100 RECOVERY ROOM			396, 55	6 0	396, 556	51.00
55.00 05500 ASDI OLOGY-THERAPEUTIC 446, 197 0 446, 197 55.00 57.00 05700 CT SCAN 474, 946 0 474, 946 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 330, 123 0 330, 123 58.00 05900 CARDI ACC CATHETERI ZATI ON 1, 491, 433 59.00 0500 CARDI ACC CATHETERI ZATI ON 482, 508 0 482, 508 0 60.00 06000 LABORATORY 482, 508 0 482, 508 0 60.00 06000 LABORATORY 51, 454 0 51, 454 0 51, 454 0 60.00 06000 INTRAVENOUS THERAPPY 53, 457 0 553, 167 0 053, 167 0 00.00 00.								
57.00 05700 CT SCAN 347, 946 0 474, 946 0 347, 946 0 370, 203 0 330, 123 50, 00 59.00 05900 CARPITE RESONANCE IMAGING (MRI) 1,491,433 0 1,491,433 59.00 05900 CARPILA C CATHETERIZATION 482,508 0 482,508 0 0.00 06000 LABORATORY 482,508 0 482,508 0 0.00 06000 LABORATORY 51,454 0 51,454 0 51,454 0 61.00 06000 06000 NESPIRATORY THERAPY 553,167 0 553,167 0 553,167 0 05000 070,000								
59 00 OSPOOI CARDIAC CATHETER ZATION 1, 491, 433 50, 00 00 00 00 00 00 00 00 00 00 00						1		
0.000 0.0000 LABORATORY	58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)			330, 12		330, 123	58. 00
64.00 06400 INTRAVENDUS THERAPY 51, 454 0 51, 454 64.00								
65.00 0.6500 RESPI RATORY THERAPY 1.077, 364 65.00						1		
66.00 06600 PKYSI CAL THERAPY 1,077,364 0 1,077,364 66.00								1
68. 00 06900 SPEECH PATHOLOGY 62, 879 0 62, 879 68. 00						1		
69-00 06900 06900 05000 05000 0553, 951 0 0553, 951 0 070.00 0								
70.00 07000 ELECTROENCEPHALOGRAPHY 153, 656 0 153, 656 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 603, 270 0 603, 270 71.00 072.00 170.00						1		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS						1	•	
72.00 07200 IMPL DEV. CHARGED TO PATIENTS 488,960 0 488,960 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3,709,909 0 3,709,909 73.00 07400 RENAL DIALYSIS 36,408 0 36,408 74.00 07400 RENAL DIALYSIS 36,408 0 36,408 74.00 07400 RENAL DIALYSIS 89,593 0 89,593 76.00 089,593 76.00 089,593 76.00 089,593 76.00 089,593 76.00 089,593 76.00 089,593 76.00 089,593 0 089,593 76.00 089,593 76.00 089,593 76.00 089,593 76.00 089,593 76.00 089,593 76.00 089,593 76.00 089,593 76.00 089,593 76.00 089,593 76.00 089,593 76.00 089,593 76.00 089,593 76.00 089,593 76.00 089,593 76.00 089,593 76.00 089,593 76.00 089,593 089,593 76.00 089,593 089,593 76.00 089,593 089,593 76.00 089,593 089,593 089,593 76.00 089,593								
74.00 07400 RENAL DI ALYSIS 36, 408 0 36, 408 74. 00 76. 00 03330 ENDOSCOPY 89, 593 0 89, 593 76. 00 03530 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 3, 896, 202 0 2, 81, 91, 91, 91, 91, 91, 91, 91, 91, 91, 9					488, 960	o o		
76. 00 0330 ENDOSCOPY 89, 593 0 89, 593 76. 00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 3, 896, 202 0 3, 896, 202 76. 01 76. 03 3, 896, 202 76. 01 76. 03 3, 896, 202 76. 01 76. 03 76. 04 03952 WOUND CARE CENTER 281, 976 0 281, 976 76. 04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 3, 734, 588 0 3, 734, 588 76. 05 76. 06 76. 06 76. 06 76. 06 76. 06 76. 07 76.						1		
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 3, 896, 202 0 3, 896, 202 76. 01 76. 03 03951 LUTHERWOOD PARTNERSHI P 1, 408, 246 0 1, 408, 246 76. 03 76. 04 03952 WOUND CARE CENTER 281, 976 0 281, 976 76. 04 76. 03 76. 04 76. 03 76. 04 76. 03 76. 04 76. 03 76. 04 76. 05 76. 04 76. 05 76. 04 76. 05 76. 06 76. 07 76. 04 76. 05 76. 06 76. 07 76. 04 76. 07 76. 06 76. 07						1		
76. 04 03952 WOUND CARE CENTER 281, 976 0 281, 976 76. 04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 3,734,588 0 3,734,588 76. 05 76. 06 03953 IMAGI NG CENTERS 1,065,606 0 1,065,606 10 1,065,606 76. 06 76. 07 03954 BREAST DI AGNOSTI C CENTER 134,881 0 134,881 76. 07 76. 97 07697 CARDI AC REHABI LI TATI ON 354,286 0 354,286 76. 97 76. 98 OT698 HYPERBARI C OXYGEN THERAPY 0 47,245 76. 98 OT698 HYPERBARI C OXYGEN THERAPY 0 47,245 76. 98 OT698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							•	
76. 05 03480 0NCOLOGY-CANCER CARE CENTER 3, 734, 588 0 3, 734, 588 76. 05 76. 06 03953 IMAGI NG CENTERS 1, 065, 606 0 1, 065, 606 76. 06 76. 07 07697 07697 CARDI AC REHABI LI TATI ON 354, 286 0 354, 286 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 47, 245 0 47, 245 0UTPATI ENT SERVI CE COST CENTERS 0 0 0 0 88. 00 08800 RURAL HEALTH CLI NI C 0 0 0 0 90. 00 09000 CLI NI C 0 0 0 0 90. 01 04950 DI ABETI C CARE CENTER 0 0 0 0 90. 02 04951 HEALTHY HEARTS CENTER 397, 239 0 397, 239 90. 02 90. 03 09001 CLI NI C 0 0 0 0 90. 04953 SPI NE CENTER 1 0 1 90. 04 90. 05 04954 INFUSION CENTERS 212, 142 0 212, 142 90. 05 90. 06 09002 MEDCHECK CLI NI CS 0 0 0 0 90. 07 09003 NEE CENTER 591, 044 0 591, 044 90. 07 90. 08 09004 PALLI ATIVE CARE 0 0 0 0 0 90. 12 04961 FAMILY PRACTI CE AND MATERNI TY CARE 0 0 0 0 0 90. 12 04961 FAMILY PRACTI CE AND MATERNI TY CARE 0 0 0 0 0 90. 12 04961 FAMILY PRACTI CE AND MATERNI TY CARE 0 0 0 0 0 90. 12 04961 FAMILY PRACTI CE AND MATERNI TY CARE 0 0 0 0 90. 12 04961 FAMILY PRACTI CE AND MATERNI TY CARE 0 0 0 0 90. 12 04961 FAMILY PRACTI CE AND MATERNI TY CARE 0 0 0 0 90. 12 04961 PAMILY PRACTI CE AND MATERNI TY CARE 0 0 0 0 90. 12 04961 PAMILY PRACTI CE AND MATERNI TY CARE 0 0 0 0 90. 12 04961 PAMILY PRACTI CE AND MATERNI TY CARE 0 0 0 0 90. 12 04961 PAMILY PRACTI CE AND MATERNI TY CARE 0 0 0 0 90. 12 04961 PAMILY PRACTI CE AND MATERNI TY CARE 0 0 0 0 90. 12 04961 PAMILY PRACTI CE AND MATERNI TY CARE 0 0 0 0 90. 12 04961 PAMILY PRACTI CE AND MATERNI TY CARE 0 0 0 0 90. 12 04961 PAMILY PACTI CE AND MATERNI TY CARE 0								
76. 06 03953 IMAGING CENTERS 1, 065, 606 0 1, 065, 606 76. 06 76. 06 76. 07 03954 BREAST DI AGNOSTIC CENTER 134, 881 0 134, 881 76. 07 76. 97 07697 CARDI AC REHABI LI TATI ON 354, 286 0 354, 286 76. 97 76. 98								
76. 07 03954 BREAST DI AGNOSTI C CENTER 134, 881 0 134, 881 76. 07 76. 97 76. 97 76. 97 76. 97 76. 97 76. 98 76. 97 76. 98 7								
76. 98 O7698 HYPERBARIC OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC O O O O S89. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER O O O O O O O O O O O O O O O O O O O								
SECTION SERVICE COST CENTERS SERVICE COST CENTERS SERVICE COST CENTERS SERVICE COST CENTERS SERVICE COST CENTERS SERVICE COST CENTERS SERVICE CENTER SERVICE C						1		
88. 00 08800 RURAL HEALTH CLINI C 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 90. 00 09000 CLINI C 0 0 0 90. 01 04950 DI ABETI C CARE CENTER 0 0 0 0 90. 02 04951 HEALTHY HEARTS CENTER 397, 239 0 397, 239 90. 02 90. 03 09001 CLINI C 0 0 0 0 90. 04 04953 SPINE CENTER 1 0 1 90. 04 90. 05 04954 INFUSION CENTERS 212, 142 0 212, 142 90. 06 09002 MEDCHECK CLINI CS 0 0 0 0 90. 07 09003 KNEE CENTER 591, 044 0 591, 044 90. 08 09004 PALLI ATI VE CARE 41 0 41 90. 07 90. 10 09006 WORK SITE CLINI CS 0 0 0 0 90. 10 09006 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 90. 12	76. 98				47, 24	5 0	47, 245	76. 98
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 90. 00 90. 00 90. 00 90. 00 04950 04950 04951 04950 04951 04950 04951 04950 04951 04950 04951 04950 04951 0	88 00						0	88 00
90. 01								
90. 02					(1
90. 03 09001 CLINI C 0 0 90. 03 90. 04 04953 SPI NE CENTER 1 0 1 90. 04 90. 05 04954 INFUSI ON CENTERS 212, 142 0 212, 142 90. 05 90. 06 90002 MEDCHECK CLINI CS 0 0 0 0 90. 06 90. 07 90903 KNEE CENTER 591, 044 0 591, 044 0 591, 044 0 90. 07 90. 08 09004 PALLI ATI VE CARE 41 0 41 90. 08 90. 10 90. 12 04961 FAMI LY PRACTI CE AND MATERNI TY CARE 0 0 0 90. 12					207 220			1
90. 04 04953 SPI NE CENTER 1 0 1 90. 04 90. 05 04954 INFUSION CENTERS 212, 142 0 212, 142 90. 05 90. 06 09002 MEDCHECK CLINICS 0 0 0 0 0 0 0 0 0						1		
90. 06 09002 MEDCHECK CLINICS 0 0 0 0 90. 06 90. 07 09003 KNEE CENTER 591, 044 0 591, 044 90. 07 90. 08 09004 PALLIATIVE CARE 41 0 41 90. 08 90. 10 09006 WORK SITE CLINICS 0 0 0 90. 10 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 90. 12						1 0	1	
90. 07 09003 KNEE CENTER 591, 044 0 591, 044 90. 07 90. 08 09004 PALLI ATI VE CARE 41 0 41 90. 08 90. 10 09006 WORK SI TE CLINICS 0 0 0 90. 10 90. 12 04961 FAMI LY PRACTI CE AND MATERNITY CARE 0 0 0 90. 12					212, 14			
90. 08 09004 PALLI ATI VE CARE					501 O4			1
90. 10 09006 WORK SITE CLINICS 0 0 90. 10 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 90. 12								1
	90. 10	09006 WORK SITE CLINICS			(o o	0	90. 10
71. 00 07100 LWLKGENCT 2, 599, 690 91. 00								
	91.00	O 7 1 O O EMERGENCT	<u> </u>	1	2, 544, 64	ام الح	2, 544, 690	J 91. UU

Health Financial Systems C	OMMUNITY HEALTH	I NETWORK INC		In lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	OWNINGTOFF	Provi der CC		Peri od: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/29/2019 3:09 pm
Cost Center Description	PHARMACY RESI DENCY-ALLI ED HEALTH	ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
	23. 02	23. 03	24. 00	25. 00	26. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	92. 00
OTHER REIMBURSABLE COST CENTERS		,			
98. 00 09850 OTHER REIMBURSABLE COST CENTERS				0 0	0 98.00
SPECIAL PURPOSE COST CENTERS		I al	10 100 10	ما ما	10 100 100
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	43, 482, 49	2 0	43, 482, 492 118. 00
NONREI MBURSABLE COST CENTERS					0 100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH					0 190. 00 0 191. 00
191.00 19100 RESEARCH 192.00 19200 PHYSICIANS' PRIVATE OFFICES			73, 49	0	73, 497 192. 00
194. 00 07950 HOME OFFICE			73, 49	7	73, 497 192. 00
194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS					0 194.00
194. 03 07953 SCHOOL BASED CLINICS			14	0	142 194. 03
194. 04 07954 SMO-NON PROVI DER BASED			54, 44		54, 442 194, 04
194. 05 07955 FAMILY PRACTICE MEDICINE			831, 87		831, 871 194. 05
194. 07 07957 LI FECHECK			031, 07		0194.07
194. 08 07958 GROUP HOMES AND MISC. N R CTRS			160, 46	4	160, 464 194, 08
194. 09 07959 SURGERY CENTER EAST			100, 40		0 194. 09
200.00 Cross Foot Adjustments	0	0	1, 031, 30	6	1, 031, 306 200. 00
201.00 Negative Cost Centers	0		1,001,00		0 201. 00
202. 00 TOTAL (sum lines 118 through 201)	0	Ö	45, 634, 21	4 0	45, 634, 214 202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0074 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/29/2019 3:09 pm CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (DOLLAR VALUE) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 703 265 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 61, 172, 201 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 8, 136 30, 586, 101 176, 264, 797 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 35 442 12, 577, 943 10 944 603 -124, 763, 096 457 931 569 5 00 7.00 00700 OPERATION OF PLANT 104,686 348, 261 2, 646, 163 18, 569, 055 7.00 1, 025, 742 8.00 00800 LAUNDRY & LINEN SERVICE 83 8.00 00900 HOUSEKEEPI NG 11, 767 7, 269 2, 623, 864 0 5, 230, 085 9.00 9.00 01000 DI ETARY 0 695, 659 10 00 9 007 76, 616 2, 143, 585 10 00 11.00 01100 CAFETERI A 24, 815 254, 588 1, 730, 216 0 3, 082, 632 11.00 01300 NURSING ADMINISTRATION 7, 983 9, 189, 857 13.00 10,650 3, 165, 561 0 13.00 01400 CENTRAL SERVICES & SUPPLY 1, 373, 998 14.00 13.883 4. 434. 641 14.00 1, 861 15.00 01500 PHARMACY 717, 833 5.785.953 10, 117, 630 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 1,711 80 750, 376 0 0 0 6,007,906 16.00 01700 SOCIAL SERVICE 3, 097, 714 17.00 2,859 1,050 2, 153, 582 17.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 3, 521, 215 3, 746, 965 21.00 21.00 22 00 02200 L&R SERVICES-OTHER PRGM COSTS APPRVD 269 51, 778 5, 081, 076 5, 874, 322 22 00 02300 EMS TRAINING-ALLIED HEALTH 0 0 23.00 23.00 23. 01 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 0 Ω 0 0 0 23.01 02302 PHARMACY RESIDENCY-ALLIED HEALTH 0 23.02 0 0 23.02 0 0 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH O 23.03 0 23.03 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 188, 263 354, 254 35, 816, 119 56, 294, 759 30.00 31.00 03100 INTENSIVE CARE UNIT 29, 496 244, 233 5, 146, 787 0 8, 365, 815 31.00 32.00 03200 CORONARY CARE UNIT 17,092 28, 686 2, 920, 333 0 5, 084, 599 32.00 04300 NURSERY 43.00 2,808 12, 543 382, 204 0 671, 418 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 46, 954 815, 101 4.040.412 9, 814, 423 50.00 972, 313 05100 RECOVERY ROOM 9,564 51.00 2, 350 1,668,378 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 6, 941 31, 001 1, 418, 341 0 2, 214, 175 52.00 4, 967, 909 05400 RADI OLOGY-DI AGNOSTI C 27.084 54 00 538, 694 2, 637, 373 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 7,843 245, 599 706, 300 1, 439, 845 55.00 57.00 05700 CT SCAN 4, 188 207, 050 1, 582, 065 0 2, 921, 795 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 239, 748 439, 100 1, 031, 864 58.00 5.110 58.00 05900 CARDIAC CATHETERIZATION 802, 923 2, 998, 664 59.00 19,825 5, 121, 661 59 00 0 60.00 06000 LABORATORY 4, 432 109, 830 12, 264, 868 60.00 64.00 06400 INTRAVENOUS THERAPY 416 2, 964 306, 824 0 0 0 446, 309 64.00 06500 RESPIRATORY THERAPY 4, 871, 551 65 00 2 103 146, 515 3 263 256 65 00 06600 PHYSI CAL THERAPY 66.00 3, 294 910, 326 4, 179, 640 7, 231, 905 66.00 67.00 06700 OCCUPATIONAL THERAPY 843 17, 832 1, 079, 768 1, 707, 958 67.00 68.00 06800 SPEECH PATHOLOGY 308 6, 523 394, 997 0 0 0 0 0 0 624, 791 68.00 06900 ELECTROCARDI OLOGY 379, 793 3, 525, 876 69 00 963 2, 426, 016 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 155, 881 516, 809 1,073,597 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 25, 362, 231 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 25, 639, 613 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS O 0 C 110, 004, 936 73 00 74.00 07400 RENAL DIALYSIS 325 275 0 1, 428, 983 74.00 399, 843 03330 ENDOSCOPY 71, 703 0 76.00 641, 172 76.00 5, 309 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 1, 817, 192 27, 807, 430 0 18, 384, 017 76.01 76.01 03951 LUTHERWOOD PARTNERSHIP 7, 692, 363 76.03 1, 288, 066 4, 403, 799 76.03 03952 WOUND CARE CENTER 5, 121 6, 665 772, 414 2, 872, 713 76.04 76.04 9, 785, 955 0 03480 ONCOLOGY-CANCER CARE CENTER 76 05 17,745 3, 393, 577 25, 293, 680 76.05 03953 I MAGING CENTERS 1, 373, 416 5.743.289 76 06 121 2, 730, 934 76 06 0 76.07 03954 BREAST DIAGNOSTIC CENTER 2,563 45, 402 2, 206, 088 76.07 07697 CARDIAC REHABILITATION 0 1, 187, 148 76.97 7, 250 121, 434 680, 823 76.97 07698 HYPERBARI C OXYGEN THERAPY 502, 272 76.98 854 1,098 129, 137 76. 98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 0 C 0 0 0 89 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89 00 0 90.00 09000 CLINIC 90.00 0 0 0 04950 DIABETIC CARE CENTER 0 90.01 Λ Λ Λ 90 01 1, 736, 354 2, 157, 737 04951 HEALTHY HEARTS CENTER 90.02 4, 195 134, 919 90.02 0 90.03 09001 CLI NI C C 0 90.03 04953 SPINE CENTER 0 90.04 0 0 46 90.04 0 90.05 04954 INFUSION CENTERS 0 312, 075 426, 126 897, 848 90.05 90.06 09002 MEDCHECK CLINICS C 0 0 90.06 09003 KNEE CENTER 20,080 3, 890, 600 90.07 90.07 12, 463 1, 623, 181 09004 PALLIATIVE CARE 0 90 08 90.08 Ω Λ 90.10 09006 WORK SITE CLINICS 0 0 0 90.10

	COMMUNITY HEALTH			In Lie	u of Form CMS-:	<u> 2552-10</u>
COST ALLOCATION - STATISTICAL BASIS		Provi der CC		Period: From 01/01/2018 Fo 12/31/2018	Worksheet B-1 Date/Time Pre 5/29/2019 3:0	pared:
	CAPITAL RE	LATED COSTS			1 0, 2 3, 20 1 7 0. 0) piii
Cost Center Description		MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	& GENERAL (ACCUM. COST)	
	1.00	2.00	4.00	5A	5. 00	
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0	١	•	0	0	70
91. 00 09100 EMERGENCY	45, 192	101, 962	8, 439, 589	0	17, 005, 616	
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	ol		0	0	98. 00
SPECIAL PURPOSE COST CENTERS		ı u		<u> </u>	U	96.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	701, 084	59, 945, 960	172, 549, 738	-124, 763, 096	451, 485, 418	118 00
NONREI MBURSABLE COST CENTERS	7017001	0777107700	1727017770	, , , , , , , , , , , , , , , , , , , ,	1017 1007 110	1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	0	190. 00
191. 00 19100 RESEARCH	0	o	(0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	2, 181	22, 470	(0	120, 037	192. 00
194.00 07950 HOME OFFICE	0	0	(0	0	194. 00
194.01 07951 OCCUPATIONAL HEALTH ONSITE SVCS	0	0	(0		194. 01
194. 03 07953 SCHOOL BASED CLINICS	0	0	1, 302			194. 03
194.04 07954 SMO-NON PROVIDER BASED	0	0	477, 778		693, 350	
194.05 07955 FAMILY PRACTICE MEDICINE	0	1, 096, 958	2, 330, 793	0	4, 144, 215	
194. 07 07957 LI FECHECK	0	0	(0		194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	0	106, 813	905, 186	6 0	1, 487, 029	
194. 09 07959 SURGERY CENTER EAST	0	이	(0	0	194. 09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	14 000 044	20 021 140	24 /52 7/1	_	124 7/2 22/	201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	14, 803, 066				124, 763, 096	
203.00 Unit cost multiplier (Wkst. B, Part I)	21. 049058	0. 504006			0. 272449	
204.00 Cost to be allocated (per Wkst. B,			15, 586, 82	7	8, 053, 189	204. 00

0.088428

0. 017586 205. 00

206. 00 207. 00

205.00

206.00

207.00

Part II)

11)

Unit cost multiplier (Wkst. B, Part

NAHE adjustment amount to be allocated (per Wkst. B-2)
NAHE unit cost multiplier (Wkst. D, Parts III and IV)

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HEALTH NETWORK, INC. COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0074 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/29/2019 3:09 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A (SQUARE FEET) (PATIENT DAYS) (MEALS SERVED) PLANT LINEN SERVICE (SQUARE FEET) (POUNDS OF LAUNDRY) 7.00 9.00 10.00 11.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 555,001 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 123, 457 8.00 00900 HOUSEKEEPI NG 9.00 11,767 61, 728 543, 234 9.00 10.00 01000 DI ETARY 9,007 9,007 152, 968 10.00 11.00 01100 CAFETERI A 24, 815 24, 815 1,520 76.484 11.00 01300 NURSING ADMINISTRATION 7, 983 7, 983 44 13.00 13.00 178 14.00 01400 CENTRAL SERVICES & SUPPLY 13,883 C 13,883 0 0 14.00 15.00 01500 PHARMACY 1,861 1,861 0 71 15.00 01600 MEDICAL RECORDS & LIBRARY 0 1,711 0 16.00 1.711 10 16.00 01700 SOCIAL SERVICE 27 17.00 2,859 C 2,859 17.00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD C 57 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 269 255 269 0 28 22.00 02300 EMS TRAINING-ALLIED HEALTH 23 00 0 C 0 23 00 C 23.01 02301 RADIOLOGY SCHOOL-ALLIED HEALTH 0 C 0 0 23.01 02302 PHARMACY RESIDENCY-ALLIED HEALTH 0 C 0 0 0 23.02 23.02 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH 0 0 23.03 23.03 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 188, 263 30, 602 188, 263 64, 792 444 30.00 03100 INTENSIVE CARE UNIT 31.00 29, 496 2, 411 29, 496 6,047 31.00 65 32 00 03200 CORONARY CARE UNIT 17.092 17.092 41 32 00 5.645 04300 NURSERY 43.00 2,808 292 2,808 5 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 46, 954 46, 954 57 50.00 2,826 0 0 05100 RECOVERY ROOM 51 00 9 564 9 564 12 51 00 C 52.00 05200 DELIVERY ROOM & LABOR ROOM 6,941 721 6, 941 13 52.00 05400 RADI OLOGY-DI AGNOSTI C 27, 084 27, 084 26 54.00 1, 246 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 7,843 794 7,843 10 55.00 57.00 05700 CT SCAN 4, 188 2, 504 57.00 4.188 31 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 5, 110 797 5, 110 6 58.00 05900 CARDIAC CATHETERIZATION 37 59.00 19.825 1,044 19, 825 59.00 60.00 06000 LABORATORY 4, 432 4, 432 0 60.00 C 06400 I NTRAVENOUS THERAPY 64.00 416 416 4 64.00 2, 360 65.00 06500 RESPIRATORY THERAPY 2, 103 2, 103 42 65.00 66.00 06600 PHYSI CAL THERAPY 3, 294 3, 294 23 66.00 06700 OCCUPATIONAL THERAPY 67.00 843 843 14 67.00 C 06800 SPEECH PATHOLOGY 5 68.00 308 r 308 68.00 69.00 06900 ELECTROCARDI OLOGY 963 963 41 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 8 70.00 126 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 C 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 07400 RENAL DIALYSIS 325 C 325 0 74.00 74.00 03330 ENDOSCOPY 76.00 0 220 Γ 5 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 49 76.01 5, 309 5, 309 76.01 03951 LUTHERWOOD PARTNERSHIP 76.03 C 0 76.03 03952 WOUND CARE CENTER 76.04 5.121 948 5. 121 14 76.04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 17, 745 1, 414 17, 745 142 76.05 76.06 03953 I MAGING CENTERS 121 C 121 1 76.06 0 03954 BREAST DIAGNOSTIC CENTER 2,563 2, 563 0 76.07 76.07 0 07697 CARDIAC REHABILITATION 7, 250 76.97 7, 250 0 13 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 854 0 854 0 2 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 0 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 C 0 0 0 0 0 0 0 0 0 89.00 90.00 09000 CLI NI C 0 C 0 0 90.00 04950 DIABETIC CARE CENTER 90. 01 C 0 90.01 90 02 04951 HEALTHY HEARTS CENTER 1, 291 4 195 24 90 02 4 195 90.03 09001 CLI NI C C 0 90.03 04953 SPINE CENTER 0 0 0 90.04 90.04 C 04954 INFUSION CENTERS 90.05 0 0 0 0 90.05 09002 MEDCHECK CLINICS 90.06 0 Ω 0 90.06 0 90.07 09003 KNEE CENTER 12, 463 C 12, 463 29 90.07 09004 PALLIATIVE CARE 90.08 0 90.08 0 90.10 09006 WORK SITE CLINICS C 0 0 90. 10 0 04961 FAMILY PRACTICE AND MATERNITY CARE 90.12

45, 192

11,700

0

45, 192

0

91.00

92.00

120

09100 EMERGENCY

09200 OBSERVATION BEDS (NON-DISTINCT PART)

90 12

91.00

Health Financial Systems CC	DMMUNITY HEALTH	NETWORK INC		In lie	u of Form CMS-:	2552 10
COST ALLOCATION - STATISTICAL BASIS	DIVINIONI II IILALIII	Provi der Co		Peri od:	Worksheet B-1	
				From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	(SQUARE FEET)	(PATIENT DAYS)	(MEALS SERVED)	
	(SQUARE FEET)	(POUNDS OF				
		LAUNDRY)				
	7. 00	8. 00	9. 00	10. 00	11. 00	
OTHER REIMBURSABLE COST CENTERS						1
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	0	98. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	552, 820	123, 457	541, 05	3 152, 968	1, 520	118. 00
NONREI MBURSABLE COST CENTERS	1					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
191. 00 19100 RESEARCH	0	0		0		191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	2, 181	0	2, 18	1 0		192. 00
194.00 07950 HOME OFFICE	0	0		0		194. 00
194.01 07951 OCCUPATIONAL HEALTH ONSITE SVCS	0	0		0		194. 01
194. 03 07953 SCHOOL BASED CLINICS	0	0		0		194. 03
194.04 07954 SMO-NON PROVIDER BASED	0	0		0		194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	0	0		0		194. 05
194. 07 07957 LI FECHECK	0	0	,	0		194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	0	0	,	0		194. 08
194.09 07959 SURGERY CENTER EAST	0	0	,	0	0	194. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	23, 628, 175	1, 305, 204	7, 808, 57	2 3, 240, 529	6, 955, 907	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	42. 573212					1
204.00 Cost to be allocated (per Wkst. B,	2, 939, 618	18, 081	646, 71	2 385, 846	1, 211, 757	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	5. 296599	0. 146456	1. 19048	2. 522397	797. 208553	205. 00

206. 00

207. 00

206.00

207.00

11)

NAHE adjustment amount to be allocated

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

Property Property		FINANCIAI SYSTEMS	COMMUNITY HEALTH		N 45 0074		eu of Form CMS-2	
Control Cont	COST	ALLOCATION - STATISTICAL BASIS		Provider CC			Date/Time Pre	pared:
		Cost Center Description	ADMI NI STRATI ON (DI RECT NURS.	SERVI CES & SUPPLY (COSTED	(COSTED	RECORDS & LI BRARY (GROSS	SOCIAL SERVICE (TOTAL PATIENT	
DEBLEMENT SERVICE COST CENTERS 1 0 0 00000 APRIL COSTS-MARILE EQUIDATION 2 0 0 00000 APRIL COSTS-MARILE EQUIDATION 2 0 0 0 00000 APRIL MINISTRATIVE & CORPORATE 3 0 0 00000 APRIL MINISTRATIVE & CORPORATE 3 0 0 00000 APRIL MINISTRATIVE & CORPORATE 3 0 0 00000 APRIL MINISTRATIVE & CORPORATE 3 0 0 00000 APRIL MINISTRATIVE & CORPORATE 3 0 0 00000 APRIL MINISTRATIVE & CORPORATE 3 0 0 00000 APRIL MINISTRATIVE & CORPORATE 3 0 0 00000 APRIL MINISTRATIVE & CORPORATE 3 0 0 0 00000 APRIL MINISTRATIVE & CORPORATE 3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					15. 00		17. 00	
2.00 DOCTOOL OR PRIL CUSTS-WASEL EQUIP		GENERAL SERVICE COST CENTERS						
30.00	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 17. 00 21. 00 22. 00 23. 00 23. 01 23. 02	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 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 02301 RADIOLOGY SCHOOL-ALLIED HEALTH 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	745 0 0 0 0 0 0 0	168, 056, 250 1, 945 3, 447 0 26, 790 0 0	10	2, 424, 668, 959 0 0 0 0 0 0 0 0 0 0	78, 578 0 0 0 0 0 0	1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 21. 00 22. 00 23. 00 23. 01 23. 02 23. 03
31.00 03100 NTEINS VE CARE UNIT	30. 00		444	1, 754, 024		185, 310, 889	65, 033	30.00
43.00 0.4300 NURSERY 5 34.031 0 2,486,560 1,853 43.05	31. 00	03100 INTENSIVE CARE UNIT	65	271, 548		29, 011, 855	6, 047	31. 00
MICLILARY SERVICE COST CENTERS			1				l	
50.00	43.00		ا ا	34, 031]		2, 485, 560	1, 853	43.00
55.00 05500 ASDIOLOGY-THERAPEUTIC 0 267, 278 0 19, 233, 433 0 55, 00 58.00 05800 MAGNETIC, RESONANCE IMAGING (MRI) 0 210 0 13, 734, 924 0 58, 00 59.00 DSSOO ASDOO, CARDIA, CCARHITERIZATION 0 13, 684, 546 0 194, 139, 514 0 59, 00 60.00 CORDO, CARDIA, CCARHITERIZATION 0 13, 684, 546 0 194, 139, 514 0 59, 00 60.00 CORDO, CARDIA, CCARHITERIZATION 0 13, 684, 546 0 150, 718, 1810 0 60, 00 64.00 CORDO, CARDIA, CCARHITERIZATION 0 4, 304 0 650, 128 0 66, 00 660, 00 660, 00 660, 00 660, 00 660, 00 660, 00 660, 00 660, 00 660, 00 660, 00 660, 00 660, 00 660, 00 670, 00 660, 00 660, 00 660, 00 670, 00 660, 00 660, 00 660, 00 670, 00 660, 00 670, 00 660, 00<	51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0 13	99, 722 84, 112		13, 694, 666 6, 143, 307	0	51. 00 52. 00
57. 00 05700 CT SCAN 0 6.770 0 79,670,808 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 210 0 13,734,924 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 210 0 13,734,924 0 58. 00 69. 00 05900 CARDI AC CATHETERIZATI ON 0 21,561,334 0 159,761,810 0 60. 00 60.			1				l	
58. 00 05800 MAGNETI C RESONANCE I MIGLING (MRI) 0 2.10 0 13, 734, 924 0 58. 00 05900 CARDIAC CATHETERIZATION 0 13, 684, 5846 0 194, 139, 514 0 59. 00 05900 CARDIAC CATHETERIZATION 0 2, 561, 334 0 159, 761, 810 0 60. 00 60			1					
59. DO 0.05900 CARDIAC CATHETERI ZATION 0 13,684,546 0 194,139,514 0 59,06 64. DO 0.0600 LABORATORY 0 2,561,334 0 159,761,810 0 60.00 64. DO 0.06400 INTRAVENOUS THERAPY 0 4,304 0 26,754,634 0 65.0128 0 64.00 65. DO 0.06500 RESPI RATORY THERAPY 0 83,772 0 25,722,567 0 66.00 67. DO 0.0700 OCCUPATI ONAL THERAPY 0 22,747 0 6,544,546 0 67.00 69. DO 0.0900 SEECER PATHOLOGY 0 8.321 0 2,398,243 0 68.00 69. DO 0.0900 ELECTROCARDI OLLOGY 0 121,134 0 53,799,522 0 69.00 71. DO 0.00 TOO,000 ELECTROCARDI OLLOGY 0 121,134 0 53,799,522 0 69.00 71. DO 0.00 TOO,000 ELECTROCARDI OLLOGY 0 121,134 0 7.00 7.00 7.00		1	- 1				l e	58.00
64. 00 06.400 INTRAVENDUS THERAPY 0 4 304 0 6.50 128 0 64. 00			o	•			l	59. 00
65. 00 06500 RESPI RATORY THERAPY 0 65,826 0 26,754,634 0 65,066 06600 PHYSI CAL THERAPY 0 87,772 0 25,292,567 0 66,00 67,00 06600 PHYSI CAL THERAPY 0 22,747 0 6,544,546 0 67,00 68,00 06600 SPEECH PATHOLOGY 0 8,321 0 2,398,243 0 68,00 06900 ELECTROCARDIOLOGY 0 13,134 0 53,799,522 0 69,00 06900 ELECTROCARDIOLOGY 0 25,8891 0 7,892,638 0 70,00 00 0600 ELECTROCARDIOLOGY 0 58,891 0 7,892,638 0 70,00 07,00 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0			1				l	60.00
66.00 06600 PHYSI CAL THERAPY 0 87, 972 0 25, 292, 567 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 22, 747 0 6, 544, 546 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 83, 321 0 2, 398, 243 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 121, 134 0 53, 799, 522 0 69.00 71.00 07000 ELECTROCREPHALOGRAPHY 0 0 121, 134 0 53, 799, 522 0 69.00 71.00 07000 ELECTROCREPHALOGRAPHY 0 0 121, 134 0 0 78, 892, 638 0 70.00 71.00 07000 ELECTROCREPHALOGRAPHY 0 0 0 0 0 77, 996, 411 0 72.00 72.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 77, 996, 411 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 107, 914, 337 100 691, 871, 039 0 73.00 74.00 07400 RENAL DIALYSIS 0 107, 914, 337 100 691, 871, 039 0 73.00 74.00 07400 RENAL DIALYSIS 0 107, 914, 337 100 691, 871, 039 0 73.00 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 371, 994 0 22, 856, 664 0 76.01 76.03 03951 LUTHERROODO PARTINERSHI P 0 224, 077 0 788, 292 0 76.03 76.03 03951 LUTHERROODO PARTINERSHI P 0 224, 077 0 788, 292 0 76.03 76.04 03952 WOUND CARE CENTER 0 975, 943 0 220, 557, 245 0 76.05 76.07 03954 BREAST DIAGNOSTI CENTER 0 975, 943 0 220, 557, 245 0 76.05 76.07 03954 BREAST DIAGNOSTI CENTER 0 0 0 0 5, 382, 335 0 76.07 76.97 07697 CARDIAR CHABILLITATION 0 20, 302 0 3, 914, 932 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 22, 713 0 2, 517, 150 0 90.00 70.01 04950 DIABETI C CARE CENTER 0 0 0 0 0 0 0 0 70.02 04951 HEALTH CLINIC 0 0 0 0 0 0 0 70.03 09001 CLINIC C CENTER 0 0 0 0 0 0 0 70.04 04953 SPINE CENTER 0 0 0 0 0 0 0 0 70.05 04950 HAGRING C CENTER 0 0 0 0 0 0 70.00 04950 HAGRING C CENTER 0 0 0 0 0 0 0 7			-1					
67. 00 06700 0CCUPATI ONAL THERAPY 0 22, 747 0 6, 544, 546 0 67. 0C 68. 00 06800 SPEECH PATHOLOGY 0 8, 321 0 2, 398, 243 0 68. 0C 69. 00 06900 ELECTROCARDIOLOGY 0 121, 134 0 53, 799, 522 0 69. 0C 70. 00 07000 ELECTROCARDIOLOGY 0 58, 891 0 7, 892, 638 0 70. 0C 70. 00 07000 ELECTROCROCEPHALOGRAPHY 0 58, 891 0 7, 892, 638 0 70. 0C 71. 00 07000 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 25, 362, 230 0 89, 712, 030 0 71. 0C 72. 00 07200 MPL DEV. CHARGED TO PATIENTS 0 107, 914, 337 100 691, 871. 039 0 73. 0C 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 107, 914, 337 100 691, 871. 039 0 73. 0C 76. 00 03330 ENDOSCOPY 0 61, 583 0 5, 178, 873 0 76. 0C 76. 01 03350 PSYCHI ATRI CZPSYCHOLOGI CAL SERVI CES 0 371, 994 0 22, 856, 664 0 76. 0T 76. 03 03951 LUTHERWOOD PARTNERSHI P 0 224, 077 0 788, 292 0 76. 03 76. 06 03952 WOUND CARE CENTER 0 232, 123 0 13, 202, 822 0 76. 04 76. 07 03954 BRAST I DIAGNOSTI C CENTER 0 70, 086 0 54, 223, 816 0 76. 06 76. 07 03954 BRAST I DIAGNOSTI C CENTER 0 70, 086 0 54, 223, 816 0 76. 06 76. 07 03954 BRAST I DIAGNOSTI C CENTER 0 0 0 0 0 0 0 76. 90 07697 CARDIA C REHABILITATION 0 20, 302 0 3, 914, 932 0 76. 90 76. 90 07699 HYPERBARI C DXYGEN THERAPY 0 22, 713 0 2, 517, 150 0 76. 90 76. 90 07699 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 76. 90 076 04, 681, 838 0 90. 02 77. 90 07690 04, 681, 838 0 90. 02 78. 90 076 076, 076 076, 076 076, 076 076, 076 78. 90 076 076, 076 076, 076 076, 076 076 076 78. 90 076 076, 076 076 076 076 076 78. 90 076 076, 076 076 076 076 076 076 076 78. 90 076 076 076 076 076 076 076 076 076 79. 90 076 076 076 076 076 076 076 076 076 076							l	
68. 00 06900 DEECTR PATHOLOGY 0 8, 321 0 2, 398, 243 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 121, 134 0 53, 799, 522 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 58, 891 0 7, 892, 638 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 25, 362, 230 0 89, 712, 030 0 71. 00 72. 00 07200 IMPL. DE IV. CHARGED TO PATIENTS 0 0 0 0 77, 996, 411 0 72. 00 73. 00 07300 INPL. DE IV. CHARGED TO PATIENTS 0 107, 914, 337 100 691, 871, 039 0 73. 00 74. 00 07300 RUISC CHARGED TO PATIENTS 0 107, 914, 337 100 691, 871, 039 0 73. 00 74. 00 07300 RUISC CHARGED TO PATIENTS 0 107, 914, 337 100 691, 871, 039 0 73. 00 76. 01 07330 ENDOSCOPY 0 61, 583 0 5, 178, 873 0 76. 00 76. 03 03951 LUTHERWOOD PARTINERSHI P 0 0 224, 077 0 788, 292 0 76. 04 76. 04 03952 WOUND CARE CENTER 0 232, 123 0 13, 202, 822 0 76. 04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 975, 943 0 220, 557, 245 0 76. 04 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 0 0 5, 382, 335 0 76. 07 76. 97 07697 CARDI AC REHABILITATION 0 22, 713 0 2, 517, 150 0 76. 96 76. 97 07699 Hyperrabari C Oxygen Theraphy 0 22, 713 0 2, 517, 150 0 76. 96 76. 98 07699 Hyperrabari C Oxygen Theraphy 0 22, 713 0 2, 517, 150 0 76. 96 79. 076 04950 DIABETIC CARE CENTER 0 0 0 0 0 0 0 79. 0. 00 0900 CLINIC C 0 0 0 0 0 0 79. 0. 00 0900 CLINIC C 0 0 0 0 0 0 79. 0. 00 0900 CLINIC C 0 0 0 0 0 0 79. 0. 00 0900 CLINIC C 0 0 0 0 0 0 79. 0. 00 0900 CLINIC C 0 0 0 0 0 0 79. 0. 00 0900 PRODENTIAL CONTRACT CENTER 0 0 0 0 0 79. 0. 00 0900 CLINIC C 0 0 0 0 0 79. 0. 00 0900 CLINIC C 0 0 0 0 0 79. 0. 00 0900 0900 0900 0900 0900 0900 79. 0. 00 0900								67. 00
70. 00 07000 CLECTROENCEPHALOGRAPHY 0 58,891 0 7,892,638 0 70.00			O	8, 321			0	68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 25, 362, 230 0 89, 712, 030 0 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 10, 71. 00 07300 DRUGS CHARGED TO PATIENTS 0 107, 914, 337 100 691, 871, 039 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 107, 914, 337 100 691, 871, 039 0 73. 00 07400 RENAL DIALYSIS 0 107, 914, 337 100 691, 871, 039 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 107, 914, 337 100 691, 871, 039 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 107, 914, 337 100 691, 871, 039 0 74. 00 07400 RENAL DIALYSIS 0 1, 986 0 4, 468, 277 0 74. 00 074, 00 07								
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 77, 996, 411 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 107, 914, 337 100 691, 871, 039 0.73. 00 73. 00 74. 00 74. 00 07400 RENAL DI ALYSIS 0 1, 986 0 4, 468, 277 0.74. 00 74. 00 07400 RENAL DI ALYSIS 0 1, 986 0 4, 468, 277 0.74. 00 76. 00 0.3330 ENDOSCOPY 0 61, 583 0 5, 178, 873 0.76. 00 0.3330 ENDOSCOPY 0 61, 583 0 5, 178, 873 0.76. 00 0.3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 371, 994 0 22, 856, 664 0.76. 00 0.			1					1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 107, 914, 337 100 691, 871, 039 0 73. 00 74. 00 07400 RENAL DI IALYSIS 0 1,986 0 4,468, 277 0 74. 00 76. 00 03301 ENDOSCOPY 0 61,583 0 5,178, 873 0 76. 00 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 371, 994 0 22,856, 664 0 76. 01 76. 01 03951 LUTHERWOOD PARTMERSHI P 0 224, 077 0 788, 292 0 76. 03 76. 03 03951 LUTHERWOOD PARTMERSHI P 0 224, 077 0 788, 292 0 76. 03 76. 03 03952 WOND CARE CENTER 0 232, 123 0 13, 202, 822 0 76. 03 76. 05 76. 06 03952 WOND CARE CENTER 0 975, 943 0 220, 557, 245 0 76. 05 76. 06 03953 IMAGI NG CENTERS 0 70, 086 0 54, 223, 816 0 76. 06 76. 07 03954 BREST DI AGNOSTI C CENTER 0 0 0 0 5, 382, 335 0 76. 07 76. 97 07697 CARDI AC REHABI LI TATI ON 0 20, 302 0 3, 914, 932 0 76. 97 76. 98 07698 HYPERSARI C OXYGEN THERAPY 0 22, 713 0 2, 517, 150 0 76. 98 0700000 0 0 0 0 0 0 0		l l	1	25, 362, 230			l e	
76. 00 03330 ENDOSCOPY 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 371, 994 0 22, 856, 664 0 76. 01 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 371, 994 0 22, 856, 664 0 76. 01 76. 02 76. 03 03951 LUTHERWOOD PARTNERSHI P 0 224, 077 0 788, 292 0 76. 03 76. 04 03952 WOUND CARE CENTER 0 232, 123 0 13, 202, 822 0 76. 04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 975, 943 0 220, 557, 245 0 76. 05 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 0 70, 086 0 54, 223, 816 0 76. 07 76. 97 76. 97 07697 CARDI AC REHABI LI TATI ON 0 20, 302 0 3, 914, 932 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 22, 713 0 2, 517, 150 0 76. 98 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			- 1	107, 914, 337			l e	73. 00
76. 01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0 371, 994 0 22, 856, 664 0 76. 01 76. 03 03951 LUTHERWOOD PARTNERSHI P 0 224, 077 0 788, 292 0 76. 03 03951 UUTHERWOOD PARTNERSHI P 0 224, 077 0 788, 292 0 76. 03 03951 WOUND CARE CENTER 0 232, 123 0 13, 202, 822 0 76. 03 03480 ONCOLOGY-CANCER CARE CENTER 0 975, 943 0 220, 557, 245 0 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 975, 943 0 220, 557, 245 0 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 70, 086 0 54, 223, 816 0 76. 06 03953 IMAGING CENTERS 0 70, 086 0 54, 223, 816 0 76. 06 03953 IMAGING CENTERS 0 0 70, 086 0 54, 223, 816 0 76. 07 03954 BREAST DI AGNOSTIC CENTER 0 0 0 5, 382, 335 0 76. 07 076. 97 CARDI AC REHABI LI TATI ON 0 20, 302 0 3, 914, 932 0 76. 97 076. 98 07698 HYPERBARI C OXYGEN THERAPY 0 22, 713 0 2, 517, 150 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 22, 713 0 2, 517, 150 0 76. 98 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l l	0				l e	74. 00
76. 03 03951 LUTHERWOOD PARTNERSHIP 0 224,077 0 788,292 0 76. 03 76. 04 03952 WOUND CARE CENTER 0 232,123 0 13,202,822 0 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 975,943 0 220,557,245 0 76. 05 03953 IMAGING CENTERS 0 70,086 0 54,223,816 0 76. 05 03953 IMAGING CENTERS 0 70,086 0 54,223,816 0 76. 05 03953 IMAGING CENTERS 0 70,086 0 54,223,816 0 76. 05 03954 BREAST DI AGNOSTI C CENTER 0 0 0 0 5,382,335 0 76. 97 076.97 CARDI AC REHABILITATION 0 20,302 0 3,914,932 0 76. 97 076.98 HYPERBARI C OXYGEN THERAPY 0 22,713 0 2,517,150 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 22,713 0 2,517,150 0 76. 98 000 FROM CONTROL OXYGEN THERAPY 0 0 22,713 0 2,517,150 0 76. 98 000 FROM CONTROL OXYGEN THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l l	0					
76. 04 03952 WOUND CARE CENTER 0 232, 123 0 13, 202, 822 0 76. 04 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 0 975, 943 0 220, 557, 245 0 76. 05		l l					l e	76. 03
76. 06 03953 IMAGING CENTERS 0 70,086 0 54,223,816 0 76.0676.07 03954 BREAST DI AGNOSTIC CENTER 0 0 0 0 5,382,335 0 76.076.97 07697 CARDI AC REHABILITATI ON 0 20,302 0 3,914,932 0 76.97 076.98 PREAST DI AGNOSTIC CENTER 0 0 20,302 0 3,914,932 0 76.97 076.98 PREAST COMPANDED CONTROL OF CARDI AC REHABILITATI ON 0 22,713 0 2,517,150 0 76.98 PREAST COMPANDED CONTROL OF CARDI AC REHABILITATI ON 0 22,713 0 2,517,150 0 76.98 PREAST COMPANDED CONTROL OF CARDI AC REHABILITATI ON 0 22,713 0 2,517,150 0 76.98 PREAST COMPANDED CONTROL OF CARDINA OF CARDI			O				0	76. 04
76. 07		• • • • • • • • • • • • • • • • • • •	0				i e	76. 05
76. 97			0	70, 086			i e	
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 22, 713 0 2, 517, 150 0 76. 98 000			- 1	20, 302			l e	76. 97
88. 00	76. 98	1 1	O		1		l	76. 98
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 90. 00 90. 00 90. 00 0 0 0				-1				
90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0			0	0		0	•	1
90. 01 04950 DI ABETI C CARE CENTER 0 0 0 0 0 0 0 90. 01 90. 02 04951 HEALTHY HEARTS CENTER 0 140, 854 0 4, 681, 838 0 90. 02 90. 03 09001 CLI NI C 0 0 0 0 0 0 0 0 90. 03 90. 04 04953 SPI NE CENTER 0 0 0 0 0 820 0 90. 04 90. 05 04954 I NFUSION CENTERS 0 0 0 0 2, 834, 012 0 90. 05 90. 06 09002 MEDCHECK CLI NI CS 0 0 0 0 0 0 90. 06 90. 07 09003 KNEE CENTER 0 53, 233 0 4, 976, 511 0 90. 07 90. 08 09004 PALLI ATI VE CARE 0 0 0 0 84, 215 0 90. 07 90. 10 09006 WORK SI TE CLI NI CS 0 0 0 0 0 0 90. 12 90. 12 04961 FAMI LY PRACTI CE AND MATERNI TY CARE 0 0 0 0 0 0 0 0 0 90. 12			0	0				
90. 03		l l	ō	O		0		90. 01
90. 04 04953 SPI NE CENTER 0 0 0 0 0 820 0 90. 04 90. 05 90. 05 90. 05 90. 06 90. 05 90. 06 90. 06 90. 05 90. 06 90. 07 90. 07 90. 08			0	140, 854		4, 681, 838	l	
90. 05 04954 INFUSION CENTERS 0 0 0 0 2,834,012 0 90. 05 90. 06 09002 MEDCHECK CLINICS 0 0 0 0 0 0 0 0 90. 06 090. 07 09003 KNEE CENTER 0 53,233 0 4,976,511 0 90. 07 09004 PALLIATIVE CARE 0 0 0 0 84,215 0 90. 08 09004 PALLIATIVE CARE 0 0 0 0 0 0 0 0 90. 10 090. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 0 0 0 0 0 0 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 0 0 0 0 0 0 90. 12 04961 0			0	0		0	l	
90. 06			0	0				
90. 07 09003 KNEE CENTER 0 53, 233 0 4, 976, 511 0 90. 07 90. 08 09004 PALLI ATI VE CARE 0 0 0 0 84, 215 0 90. 18 90. 10 90. 12 04961 FAMI LY PRACTI CE AND MATERNI TY CARE 0 0 0 0 0 0 90. 12 04961 FAMI LY PRACTI CE AND MATERNI TY CARE 0 0 0 0 0 0 90. 12 04961 04		l l	0	O		0	l .	90.06
90. 10 09006 WORK SITE CLINICS 0 0 0 0 90. 10 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 0 0 0 90. 12		09003 KNEE CENTER	0	53, 233			l e	90. 07
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 0 90. 12			0	0		84, 215		90. 08
		1	0	0				
			- 1	1, 082, 992		٥	l	
			"			· · · · · · · · · · · · · · · · · · ·		

Health Financial Systems	COMMUNITY HEALTH	NETWORK, INC.		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider Co		Period: From 01/01/2018 To 12/31/2018	Worksheet B-1 Date/Time Pre 5/29/2019 3:0	pared:
Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.)	SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	RECORDS & LI BRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
OO OO OOOOO ODGEDWATHON DEDG (MON DIGTINOT	13.00	14.00	15. 00	16. 00	17. 00	00.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT	PART)					92. 00
OTHER REIMBURSABLE COST CENTERS		1	ı		_	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	5 0	0		0 0	0	98. 00
SPECIAL PURPOSE COST CENTERS	1 447)	00/ 044 040		0 0 404 ((0 050	70 570	140 00
118.00 SUBTOTALS (SUM OF LINES 1 throu	igh 117) 1, 490	336, 011, 948	20	0 2, 424, 668, 959	78, 578]118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CAN	ITFFN O			0 0	0	190. 00
191. 00 19100 RESEARCH	n en	_		0 0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES		1, 047		0 0		192. 00
194. 00 07950 HOME OFFICE		0		0 0		194. 00
194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS	, l o	Ō		o o		194. 01
194. 03 07953 SCHOOL BASED CLINICS		0		0		194. 03
194. 04 07954 SMO-NON PROVIDER BASED	0	0		0 0	0	194. 04
194.05 07955 FAMILY PRACTICE MEDICINE	0	2, 386		0	0	194. 05
194. 07 07957 LI FECHECK	0	0		0	0	194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	0	97, 118		0	0	194. 08
194.09 07959 SURGERY CENTER EAST	0	0		0 0	0	194. 09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. Part I)	B, 12, 351, 473	12, 609, 191	19, 609, 62	5 17, 592, 839	4, 228, 184	202. 00
203.00 Unit cost multiplier (Wkst. B,	Part I) 8, 289. 579195	0. 037515	98, 048. 12500	0. 007256	53. 808751	203.00
204.00 Cost to be allocated (per Wkst. Part II)	B, 701, 830	1, 503, 691	1, 911, 01	1, 182, 649	345, 708	204. 00
205.00 Unit cost multiplier (Wkst. B,	Part 471. 026846	0. 004474	9, 555. 05500	0. 000488	4. 399552	205. 00
206 00 NAHE adjustment amount to be al	Located					206 00

206. 00 207. 00

206.00

207.00

NAHE adjustment amount to be allocated (per Wkst. B-2)
NAHE unit cost multiplier (Wkst. D, Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provider CCN: 15-0074

				1	To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
		INTERNS &	RESI DENTS			, 0, 2, 7, 20 1, 7 0. 0	, p
	Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	EMS	RADI OLOGY	PHARMACY	
		Y & FRINGES			SCHOOL-ALLI ED		
		(ASSI GNED TI ME)	(ASSI GNED TIME)	D HEALTH (ASSI GNED	HEALTH (ASSI GNED	ED HEALTH (ASSIGNED	
		21.00	22.00	TIME)	TIME)	TIME)	
	GENERAL SERVICE COST CENTERS	21.00	22. 00	23. 00	23. 01	23. 02	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON						11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE			•			16. 00 17. 00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD	411, 771					21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD		411, 771	1			22. 00
23. 00 23. 01	02300 EMS TRAINING-ALLIED HEALTH 02301 RADIOLOGY SCHOOL-ALLIED HEALTH				0		23. 00 23. 01
23. 02	02302 PHARMACY RESIDENCY-ALLIED HEALTH					0	23. 02
23. 03	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH						23. 03
30. 00	O3000 ADULTS & PEDIATRICS	211, 033	211, 033		0	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	33, 205	33, 205	1		0	31.00
32. 00 43. 00	03200 CORONARY CARE UNIT 04300 NURSERY	0	0			0	32. 00 43. 00
43.00	ANCI LLARY SERVICE COST CENTERS	0	0) 0	0	43.00
50.00	05000 OPERATI NG ROOM	7, 726	7, 726	1		0	50.00
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELI VERY ROOM & LABOR ROOM	0	0			0	51. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		o o	0	54. 00
55. 00	O5500 RADI OLOGY-THERAPEUTI C O5700 CT SCAN	0	0		0	0	55.00
57. 00 58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0	59. 00
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	849	849		0	0	60. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	0	0		o o	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 342	3, 342		0	0	66.00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0			0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	i i	o o	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 904	2, 904		0	0	73. 00
74. 00 76. 00	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	0	0	(0	0	74. 00 76. 00
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	10, 082	10, 082			0	76.00
76. 03	03951 LUTHERWOOD PARTNERSHIP	0	0	(0	0	76. 03
76. 04 76. 05	03952 WOUND CARE CENTER 03480 ONCOLOGY-CANCER CARE CENTER	2, 466	2, 466		0	0	76. 04 76. 05
76. 06	03953 I MAGING CENTERS	0	0		o o	0	76. 06
	03954 BREAST DIAGNOSTIC CENTER	0	0		0	0	76. 07
76. 97 76. 98	O7697 CARDI AC REHABI LI TATI ON O7698 HYPERBARI C OXYGEN THERAPY	0	0			0	76. 97 76. 98
	OUTPATIENT SERVICE COST CENTERS		Ü		,		
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0	0	88. 00
90.00	09000 CLINIC	0	0			0	89. 00 90. 00
90. 01	04950 DI ABETI C CARE CENTER	0	0	C	0	0	90. 01
90. 02 90. 03	04951 HEALTHY HEARTS CENTER 09001 CLI NI C	0	0		0	0	90. 02 90. 03
90. 04	04953 SPI NE CENTER		0			0	90. 04
	04954 INFUSION CENTERS	0	0	(o o	0	90.05
90. 06 90. 07	O9002 MEDCHECK CLINICS O9003 KNEE CENTER	3, 397	0 3, 397		0 ار	0	90. 06 90. 07
90. 08	09004 PALLI ATI VE CARE	0	0,077		o o	0	90. 08
90. 10	09006 WORK SITE CLINICS	0	0	(0	0	90. 10

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0074	Peri od: Worksheet B-1

COST ALLOCAT	TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
		_				5/29/2019 3:0	
		INTERNS & F	RESI DENTS				
	Cost Center Description	SERVI CES-SALARIS	EDVICES OTHER	l EMS	RADI OLOGY	PHARMACY	
	cost center bescription	Y & FRINGES			SCHOOL-ALLIED		
		(ASSI GNED	(ASSI GNED	D HEALTH	HEALTH	ED HEALTH	
		TIME)	TIME)	(ASSI GNED	(ASSI GNED	(ASSI GNED	
				TIME)	TIME)	TIME)	
		21.00	22. 00	23. 00	23. 01	23. 02	
90. 12 04961	FAMILY PRACTICE AND MATERNITY CARE	0	0	C	0	0	90. 12
91.00 09100	EMERGENCY	8, 877	8, 877	[c	o	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	REIMBURSABLE COST CENTERS						
98. 00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0	98. 00
	AL PURPOSE COST CENTERS						
	SUBTOTALS (SUM OF LINES 1 through 117)	283, 881	283, 881	C	0	0	118. 00
	MBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
191. 00 19100		0	0	C	0		191. 00
	PHYSICIANS' PRIVATE OFFICES	4, 959	4, 959	(0		192. 00
194. 00 07950		0	0	C	0		194. 00
	OCCUPATIONAL HEALTH ONSITE SVCS	0	0	C	0		194. 01
	SCHOOL BASED CLINICS	0	0	C	0		194. 03
	SMO-NON PROVIDER BASED	0	0	C	0		194. 04
	FAMILY PRACTICE MEDICINE	121, 260	121, 260	C	0		194. 05
194. 07 07957		0	0	C	0		194. 07
	GROUP HOMES AND MISC. N_R CTRS	1, 671	1, 671	C	이		194. 08
	SURGERY CENTER EAST	0	0	C	이		194. 09
200.00	Cross Foot Adjustments						200. 00
	Negative Cost Centers			_	_		201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	5, 028, 669	7, 621, 930	C	0	0	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	12. 212295	18. 510118	0. 000000	0. 000000	0.000000	203. 00
204.00	Cost to be allocated (per Wkst. B, Part II)	422, 709	608, 597	С	0	0	204. 00
	Unit cost multiplier (Wkst. B, Part	1. 026563	1. 477999	0. 000000	0. 000000	0. 000000	205. 00
	NAHE adjustment amount to be allocated (per Wkst. B-2)			C	0	0	206. 00
207. 00	NAHE unit cost multiplier (Wkst. D,			0. 000000	0. 000000	0. 000000	207. 00

Health Financial Systems COMMUNITY HEALTH NETWORK, INC. In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0074 Period: Worksheet B-1

From 01/01/2018 12/31/2018 Date/Time Prepared: 5/29/2019 3:09 pm Cost Center Description PHARMACY RESIDNECY-BTH ALLIED HEALTH (ASSI GNED TIME) 23.03 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17. 00 | 01700 | SOCIAL SERVICE 17.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22 00 22 00 02300 EMS TRAINING-ALLIED HEALTH 23.00 23.00 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 23.01 23.01 23. 02 02302 PHARMACY RESIDENCY-ALLIED HEALTH 23.02 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH 23. 03 23 03 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 0 31.00 03100 INTENSIVE CARE UNIT 31.00 03200 CORONARY CARE UNIT 32 00 32 00 04300 NURSERY 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 0 50.00 05000 OPERATING ROOM 50.00 51. 00 05100 RECOVERY ROOM 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 00000000000000000000000000000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 57 00 05700 CT SCAN 57 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 06000 LABORATORY 60.00 60.00 06400 INTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 07400 RENAL DIALYSIS 74 00 74 00 76. 00 03330 ENDOSCOPY 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.01 76.01 03951 LUTHERWOOD PARTNERSHIP 76.03 76.03 03952 WOUND CARE CENTER 76.04 76.04 76.05 03480 ONCOLOGY-CANCER CARE CENTER 76.05 03953 I MAGING CENTERS 76.06 76.06 76 07 03954 BREAST DIAGNOSTIC CENTER 76 07 07697 CARDIAC REHABILITATION 76.97 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 76. 98 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 00000000000000 88 00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 09000 CLI NI C 90.00 90.00 90. 01 04950 DIABETIC CARE CENTER 90.01 04951 HEALTHY HEARTS CENTER 90.02 90 02 90.03 09001 CLI NI C 90.03 04953 SPINE CENTER 90.04 90.04 90.05 04954 INFUSION CENTERS 90.05 90.06 09002 MEDCHECK CLINICS 90.06 90. 07 09003 KNEE CENTER 90.07 90. 08 09004 PALLIATIVE CARE 90.08 09006 WORK SITE CLINICS 90 10 90.10 90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 90.12 91. 00 09100 EMERGENCY 91.00

Health Financial Systems CO		OMMUNITY HEALTH N	Provider CCN: 15-0074	Period:	u of Form CMS-2552-10 Worksheet B-1
COST ALLUCA	ITON - STATISTICAL BASIS		Provider CCN. 15-0074	From 01/01/2018	WOLKSHEEL D-1
				To 12/31/2018	Date/Time Prepared:
	Cost Center Description	PHARMACY			5/29/2019 3: 09 pm
	cost center bescriptron	RESI DNECY-BTH			
		ALLI ED HEALTH			
		(ASSI GNED			
		TIME)			
		23. 03			
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	REIMBURSABLE COST CENTERS				
	OTHER REIMBURSABLE COST CENTERS	0			98. 00
	AL PURPOSE COST CENTERS				
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0			118. 00
	I MBURSABLE COST CENTERS				
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190. 00
191. 00 19100		0			191.00
	PHYSICIANS' PRIVATE OFFICES	0			192. 00
	HOME OFFICE OCCUPATIONAL HEALTH ONSITE SVCS	0			194. 00 194. 01
	SCHOOL BASED CLINICS	0			194. 01
		0			194. 03
194. 04 07954 SMO-NON PROVIDER BASED 194. 05 07955 FAMILY PRACTICE MEDICINE		0			194. 05
194. 07 07957 LI FECHECK					194. 07
	GROUP HOMES AND MISC. N_R CTRS				194. 08
	SURGERY CENTER EAST				194. 09
200.00	Cross Foot Adjustments				200. 00
201. 00	Negative Cost Centers				201. 00
202. 00	Cost to be allocated (per Wkst. B,	O			202. 00
	Part I)				
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000			203. 00
204. 00	Cost to be allocated (per Wkst. B,	0			204. 00
	Part II)				
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000			205. 00
206. 00	NAHE adjustment amount to be allocated	0			206. 00
207.00	(per Wkst. B-2)	0.000000			007 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0. 000000			207. 00
•		,			•

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0074 Peri od: Worksheet C From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 3:09 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30 00 03000 ADULTS & PEDIATRICS 94, 671, 603 94, 671, 603 94.671.603 03100 INTENSIVE CARE UNIT 13, 860, 744 13, 860, 744 0 13, 860, 744 31.00 31.00 03200 CORONARY CARE UNIT o 32.00 8, 531, 282 8, 531, 282 8, 531, 282 32.00 04300 NURSERY 43.00 1, 200, 690 1, 200, 690 1, 200, 690 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 17, 228, 706 17, 228, 706 17, 228, 706 50.00 51.00 05100 RECOVERY ROOM 2, 825, 595 2, 825, 595 0 2, 825, 595 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 3, 435, 308 3, 435, 308 52 00 3, 435, 308 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 8, 382, 527 8, 382, 527 0 8, 382, 527 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 2, 482, 510 2, 482, 510 0 0 0 2, 482, 510 55.00 05700 CT SCAN 4, 703, 013 4, 703, 013 4, 703, 013 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 739, 548 58.00 1.739.548 1, 739, 548 58.00 59.00 05900 CARDIAC CATHETERIZATION 9, 748, 445 9, 748, 445 9, 748, 445 59.00 06000 LABORATORY 17, 114, 130 60.00 17, 114, 130 17, 114, 130 0 60.00 06400 INTRAVENOUS THERAPY 614.778 614.778 614, 778 64 00 64 00 65.00 06500 RESPIRATORY THERAPY 6, 732, 314 6, 732, 314 6, 732, 314 65.00 06600 PHYSI CAL THERAPY 9, 681, 892 9, 681, 892 9, 681, 892 66.00 66.00 0 0 0 06700 OCCUPATIONAL THERAPY 67.00 2, 333, 703 2, 333, 703 2, 333, 703 67.00 06800 SPEECH PATHOLOGY 853, 150 68 00 68 00 853 150 853 150 69.00 06900 ELECTROCARDI OLOGY 5, 123, 876 5, 123, 876 5, 123, 876 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 463, 517 1, 463, 517 0 0 0 1, 463, 517 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 33 874 559 33, 874, 559 33 874 559 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 33, 191, 042 33, 191, 042 72.00 33, 191, 042 72.00 158, 848, 648 07300 DRUGS CHARGED TO PATIENTS 158, 848, 648 158, 848, 648 73.00 73.00 07400 RENAL DIALYSIS 74.00 1, 869, 313 1, 869, 313 0 1, 869, 313 74.00 03330 ENDOSCOPY 76 00 880 954 880 954 880, 954 76 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.01 24, 099, 097 24, 099, 097 24, 099, 097 76.01 03951 LUTHERWOOD PARTNERSHIP 5, 617, 736 5, 617, 736 5, 617, 736 76.03 0 76.03 76.04 03952 WOUND CARE CENTER 4, 125, 606 4, 125, 606 4, 125, 606 76.04 76.05 03480 ONCOLOGY-CANCER CARE CENTER 35, 497, 204 35, 497, 204 35, 497, 204 76 05 0 76.06 03953 I MAGING CENTERS 7, 715, 585 7, 715, 585 7, 715, 585 76.06 2, 992, 144 03954 BREAST DIAGNOSTIC CENTER 2, 992, 144 0 2, 992, 144 76.07 76.07 0 76. 97 07697 CARDIAC REHABILITATION 2,012,114 2, 012, 114 2, 012, 114 76. 97 07698 HYPERBARIC OXYGEN THERAPY 716, 019 76.98 716, 019 716, 019 0 76.98 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 O 0 88 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 89.00 0 0 O 90.00 09000 CLI NI C 0 Λ 90 00 90.01 04950 DIABETIC CARE CENTER 0 0 90.01 0 90.02 04951 HEALTHY HEARTS CENTER 3, 147, 239 3, 147, 239 3, 147, 239 90.02 09001 CLINIC 90.03 90.03 0 0 0 04953 SPINE CENTER 0 90.04 65 65 65 90.04 90.05 04954 INFUSION CENTERS 1, 163, 030 1, 163, 030 1, 163, 030 90.05 0 09002 MEDCHECK CLINICS 90.06 90.06 C 0 90 07 09003 KNEE CENTER 5, 831, 144 5, 831, 144 5, 831, 144 90 07 09004 PALLIATIVE CARE 0 90.08 90.08 611 611 611 0 90. 10 09006 WORK SITE CLINICS 0 0 Ω 90.10 04961 FAMILY PRACTICE AND MATERNITY CARE 90.12 0 0 0 90.12 91.00 09100 EMERGENCY 27, 404, 252 27, 404, 252 27, 404, 252 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 7, 862, 267 7, 862, 267 7, 862, 267 92.00 OTHER REIMBURSABLE COST CENTERS 98.00 09850 OTHER REIMBURSABLE COST CENTERS Ω 98 00 200.00 Subtotal (see instructions) 569, 575, 960 0 569, 575, 960 0 569, 575, 960 200. 00 7, 862, 267 201. 00 201.00 Less Observation Beds 7, 862, 267 7, 862, 267

561, 713, 693

561, 713, 693

561, 713, 693 202. 00

202.00

Total (see instructions)

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Worksheet C Part I Date/Time Prepared: 5/29/2019 3:09 pm Provider CCN: 15-0074 Peri od: From 01/01/2018 To 12/31/2018 Title XVIII Hospi tal PPS Charges Outpatient Total (col. 6 + col. 7) Cost or Other TEFRA Inpatient Cost Center Description I npati ent Ratio 8. 00 9. 00 6.00 7.00 10.00 INPATIENT POLITIME SERVICE COST CENTERS

	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	176, 452, 043		176, 452, 043			30.00	
31.00	03100 INTENSIVE CARE UNIT	29, 011, 855		29, 011, 855			31. 00	
32.00	03200 CORONARY CARE UNIT	17, 865, 916		17, 865, 916			32. 00	
43.00	04300 NURSERY	2, 485, 560		2, 485, 560			43.00	
.0. 00	ANCI LLARY SERVI CE COST CENTERS	27 1007 000		27 1007 000			10.00	
50. 00	05000 OPERATING ROOM	97, 277, 956	20, 174, 699	117, 452, 655	0. 146686	0. 000000	50. 00	
51. 00	05100 RECOVERY ROOM	7, 678, 782	6, 015, 884	13, 694, 666	0. 206328	0. 000000	51. 00	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	6, 143, 307	0,013,004	6, 143, 307	0. 559195	0. 000000	52. 00	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	10, 222, 965	42, 884, 674	53, 107, 639	0. 157840	0. 000000	54. 00	
55. 00	05500 RADI OLOGY-THERAPEUTI C	6, 764, 380	12, 469, 053	19, 233, 433	0. 137640	0. 000000	55. 00	
57. 00	05700 CT SCAN				•			
58. 00		19, 559, 243	60, 111, 565	79, 670, 808	0. 059031	0.000000	57. 00	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 628, 704	10, 106, 220	13, 734, 924	0. 126651	0.000000	58. 00	
59.00	05900 CARDI AC CATHETERI ZATI ON	75, 737, 969	118, 401, 545	194, 139, 514	0.050214	0.000000	59. 00	
60.00	06000 LABORATORY	73, 902, 316	85, 859, 494	159, 761, 810	0. 107123	0.000000	60.00	
64. 00	06400 I NTRAVENOUS THERAPY	624, 722	25, 406	650, 128	0. 945626	0.000000	64.00	
65. 00	06500 RESPI RATORY THERAPY	24, 091, 692	2, 662, 942	26, 754, 634	0. 251632	0.000000	65.00	
66. 00	06600 PHYSI CAL THERAPY	3, 365, 847	21, 926, 720	25, 292, 567	0. 382796	0. 000000	66. 00	
67. 00	06700 OCCUPATI ONAL THERAPY	2, 697, 624	3, 846, 922	6, 544, 546	0. 356587	0. 000000	67. 00	
68. 00	06800 SPEECH PATHOLOGY	930, 194	1, 468, 049	2, 398, 243	0. 355740	0. 000000		
69. 00	06900 ELECTROCARDI OLOGY	13, 369, 308	40, 430, 214	53, 799, 522	0. 095240	0. 000000	69. 00	
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 011, 108	6, 881, 530	7, 892, 638	0. 185428	0. 000000	70. 00	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	48, 068, 058	41, 643, 972	89, 712, 030	0. 377592	0.000000		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	48, 464, 259	29, 532, 152	77, 996, 411	0. 425546	0.000000	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	67, 783, 149	624, 087, 890	691, 871, 039	0. 229593	0.000000	73.00	
74.00	07400 RENAL DIALYSIS	4, 468, 277	0	4, 468, 277	0. 418352	0.000000	74.00	
76.00	03330 ENDOSCOPY	1, 938, 025	3, 240, 848	5, 178, 873	0. 170105	0.000000	76.00	
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	O	22, 856, 664	22, 856, 664	1. 054358	0.000000	76. 01	
76. 03	03951 LUTHERWOOD PARTNERSHIP	o	788, 292	788, 292	7. 126466	0.000000	76. 03	
76. 04	03952 WOUND CARE CENTER	98, 280	13, 104, 542	13, 202, 822	0. 312479	0.000000	76. 04	
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	2, 053, 860	218, 503, 385	220, 557, 245	0. 160943	0.000000	76. 05	
76. 06	03953 I MAGI NG CENTERS	137, 523	54, 086, 293	54, 223, 816	0. 142291	0.000000	76. 06	
76. 07	03954 BREAST DIAGNOSTIC CENTER	13, 637	5, 368, 698	5, 382, 335	0. 555919	0. 000000	76. 07	
76. 97	07697 CARDI AC REHABI LI TATI ON	77, 512	3, 837, 420	3, 914, 932	0. 513959	0. 000000	76. 97	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	2, 517, 150	2, 517, 150	0. 284456	0. 000000	76. 98	
70. 70	OUTPATIENT SERVICE COST CENTERS	<u> </u>	2,017,100	2,017,100	0. 201100	0.00000	70.70	
88. 00	08800 RURAL HEALTH CLINIC	0	0	0			88. 00	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	l ő	0	0			89. 00	
90. 00	09000 CLINIC	i o	0	0	0. 000000	0. 000000	90.00	
90. 01	04950 DI ABETI C CARE CENTER		0	0	0. 000000	0. 000000	90. 00	
90. 01	04951 HEALTHY HEARTS CENTER	31, 340	4, 650, 498	4, 681, 838	0. 672223	0. 000000	90.01	
90. 02	09001 CLINIC	31, 340	4, 000, 490	4, 001, 030	0. 000000	0. 000000	90. 02	
90. 03	04953 SPI NE CENTER		820	820	•	0. 000000	90.03	
		٩			0. 079268			
90. 05	04954 I NFUSION CENTERS	16, 816	2, 817, 196	2, 834, 012	0. 410383	0.000000	90. 05	
90. 06	09002 MEDCHECK CLINICS	0		0	0.000000	0.000000	90. 06	
90. 07	09003 KNEE CENTER	974	4, 975, 537	4, 976, 511	1. 171733	0. 000000	90. 07	
90. 08	09004 PALLI ATI VE CARE	186	84, 029	84, 215	0. 007255	0. 000000	90. 08	
90. 10	09006 WORK SITE CLINICS	0	0	0	0. 000000	0. 000000	90. 10	
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	0	0	0	0. 000000	0. 000000	90. 12	
91.00	09100 EMERGENCY	38, 999, 394	165, 477, 029	204, 476, 423	0. 134022	0. 000000	91. 00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 269, 551	7, 589, 295	8, 858, 846	0. 887505	0. 000000	92. 00	
	OTHER REIMBURSABLE COST CENTERS							
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0. 000000	0.000000		
200.00	, ,	786, 242, 332	1, 638, 426, 627	2, 424, 668, 959			200. 00	
201.00	1						201. 00	
202.00	Total (see instructions)	786, 242, 332	1, 638, 426, 627	2, 424, 668, 959			202. 00	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | 5/29/2019 3:09 pm

		Title XVIII	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 INTENSIVE CARE UNIT				31.00
32. 00 03200 CORONARY CARE UNIT				32. 00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS	<u> </u>			
50. 00 05000 OPERATING ROOM	0. 146686			50.00
51. 00 05100 RECOVERY ROOM	0. 206328			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 559195			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 157840			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 129073			55. 00
57. 00 05700 CT SCAN	0. 059031			57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 126651			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 050214			59. 00
60. 00 06000 LABORATORY	0. 107123			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 945626			64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 943626			65. 00
66. 00 06600 PHYSI CAL THERAPY	1 1			66. 00
	0. 382796			
67. 00 06700 OCCUPATI ONAL THERAPY	0. 356587			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 355740			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 095240			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 185428			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 377592			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 425546			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 229593			73. 00
74. 00 07400 RENAL DI ALYSI S	0. 418352			74. 00
76. 00 03330 ENDOSCOPY	0. 170105			76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1. 054358			76. 01
76. 03 03951 LUTHERWOOD PARTNERSHIP	7. 126466			76. 03
76. 04 03952 WOUND CARE CENTER	0. 312479			76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	0. 160943			76. 05
76. 06 03953 I MAGI NG CENTERS	0. 142291			76. 06
76. 07 03954 BREAST DI AGNOSTI C CENTER	0. 555919			76. 07
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 513959			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 284456			76. 98
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89. 00
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 04950 DIABETIC CARE CENTER	0. 000000			90. 01
90. 02 04951 HEALTHY HEARTS CENTER	0. 672223			90. 02
90. 03 09001 CLI NI C	0. 000000			90. 03
90. 04 04953 SPI NE CENTER	0. 079268			90. 04
90. 05 04954 NFUSION CENTERS	0. 410383			90. 05
90. 06 09002 MEDCHECK CLINICS	0. 000000			90.06
90. 07 09003 KNEE CENTER	1. 171733			90. 07
90. 08 09004 PALLI ATI VE CARE	0. 007255			90. 08
90. 10 09006 WORK SITE CLINICS	0. 000000			90. 10
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0. 000000			90. 12
91. 00 09100 EMERGENCY	0. 134022			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 134022			92.00
OTHER REIMBURSABLE COST CENTERS	3. 007 303			72.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98. 00
200.00 Subtotal (see instructions)	3. 000000			200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	1			1202.00

Provider CCN: 15-0074 Peri od: Worksheet C From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 3:09 pm Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30 00 03000 ADULTS & PEDIATRICS 101, 155, 047 101, 155, 047 101, 155, 047 14, 880, 881 03100 INTENSIVE CARE UNIT 14, 880, 881 14, 880, 881 0 31.00 31.00 03200 CORONARY CARE UNIT o 32.00 8, 531, 282 8, 531, 282 8, 531, 282 32.00 04300 NURSERY 43.00 1, 200, 690 1, 200, 690 1, 200, 690 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 17, 466, 067 17, 466, 067 17, 466, 067 50.00 51.00 05100 RECOVERY ROOM 2, 825, 595 2, 825, 595 0 2, 825, 595 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 3, 435, 308 3, 435, 308 52 00 3, 435, 308 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 8, 382, 527 8, 382, 527 0 8, 382, 527 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 2, 482, 510 2, 482, 510 0 0 0 2, 482, 510 55.00 05700 CT SCAN 4, 703, 013 4, 703, 013 4, 703, 013 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 739, 548 58.00 1.739.548 1, 739, 548 58.00 59.00 05900 CARDIAC CATHETERIZATION 9, 748, 445 9, 748, 445 9, 748, 445 59.00 06000 LABORATORY 60.00 17, 140, 213 17, 140, 213 0 17, 140, 213 60.00 06400 INTRAVENOUS THERAPY 614.778 614, 778 64 00 614 778 64 00 65.00 06500 RESPIRATORY THERAPY 6, 732, 314 6, 732, 314 6, 732, 314 65.00 06600 PHYSI CAL THERAPY 9, 784, 566 9, 784, 566 9, 784, 566 66.00 66.00 0 0 0 06700 OCCUPATIONAL THERAPY 67.00 2, 333, 703 2, 333, 703 2, 333, 703 67.00 06800 SPEECH PATHOLOGY 853, 150 853, 150 68 00 68 00 853 150 69.00 06900 ELECTROCARDI OLOGY 5, 123, 876 5, 123, 876 5, 123, 876 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 463, 517 1, 463, 517 0 0 0 1, 463, 517 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 33 874 559 33, 874, 559 33 874 559 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 33, 191, 042 33, 191, 042 72.00 33, 191, 042 72.00 07300 DRUGS CHARGED TO PATIENTS 158, 937, 866 158, 937, 866 158, 937, 866 73.00 73.00 07400 RENAL DIALYSIS 74.00 1, 869, 313 1, 869, 313 0 1, 869, 313 74.00 03330 ENDOSCOPY 76 00 880 954 880 954 880, 954 76 00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.01 24, 408, 840 24, 408, 840 24, 408, 840 76.01 03951 LUTHERWOOD PARTNERSHIP 5, 617, 736 5, 617, 736 5, 617, 736 76.03 0 76.03 76.04 03952 WOUND CARE CENTER 4, 201, 368 4, 201, 368 4, 201, 368 76.04 76.05 03480 ONCOLOGY-CANCER CARE CENTER 35, 497, 204 35, 497, 204 35, 497, 204 76 05 0 76.06 03953 I MAGING CENTERS 7, 715, 585 7, 715, 585 7, 715, 585 76.06 2, 992, 144 03954 BREAST DIAGNOSTIC CENTER 2, 992, 144 0 2, 992, 144 76.07 76.07 0 76. 97 07697 CARDIAC REHABILITATION 2,012,114 2, 012, 114 2, 012, 114 76. 97 07698 HYPERBARIC OXYGEN THERAPY 716, 019 76.98 716, 019 716, 019 0 76.98 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 O 0 88 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 89.00 0 0 O 90.00 09000 CLI NI C 0 Λ 90 00 90.01 04950 DIABETIC CARE CENTER 0 0 90.01 0 90.02 04951 HEALTHY HEARTS CENTER 3, 147, 239 3, 147, 239 3, 147, 239 90.02 09001 CLINIC 90.03 90.03 0 0 0 04953 SPINE CENTER 0 90.04 65 65 65 90.04 90.05 04954 INFUSION CENTERS 1, 163, 030 1, 163, 030 1, 163, 030 90.05 0 09002 MEDCHECK CLINICS 90.06 90.06 C 0 5, 935, 508 90 07 09003 KNEE CENTER 5, 935, 508 5. 935. 508 90.07 09004 PALLIATIVE CARE 0 90.08 90.08 611 611 611 0 90. 10 09006 WORK SITE CLINICS 0 0 Ω 90.10 04961 FAMILY PRACTICE AND MATERNITY CARE 90.12 0 0 0 90.12 91.00 09100 EMERGENCY 27, 676, 975 27, 676, 975 27, 676, 975 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 7, 862, 267 7, 862, 267 7, 862, 267 92.00 OTHER REIMBURSABLE COST CENTERS 98.00 09850 OTHER REIMBURSABLE COST CENTERS Ω 98 00 200.00 Subtotal (see instructions) 578, 297, 469 0 578, 297, 469 0 578, 297, 469 200. 00

7, 862, 267

570, 435, 202

7, 862, 267

570, 435, 202

7, 862, 267 201. 00

570, 435, 202 202. 00

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems COMMUNITY HEALTH NETWORK, INC. In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0074 Peri od: Worksheet C From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 3:09 pm Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 176, 452, 043 03000 ADULTS & PEDIATRICS 176, 452, 043 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 29, 011, 855 29, 011, 855 31.00 03200 CORONARY CARE UNIT 32.00 17, 865, 916 17, 865, 916 32.00 43.00 04300 NURSERY 2, 485, 560 2, 485, 560 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 97, 277, 956 20, 174, 699 117, 452, 655 0.148707 0.000000 50.00 51.00 05100 RECOVERY ROOM 7, 678, 782 6,015,884 13, 694, 666 0. 206328 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 6, 143, 307 0. 559195 6.143.307 0.000000 52.00 52.00 42, 884, 674 53, 107, 639 05400 RADI OLOGY-DI AGNOSTI C 0. 157840 0.000000 54.00 10, 222, 965 54 00 6, 764, 380 55.00 05500 RADI OLOGY-THERAPEUTI C 12, 469, 053 19, 233, 433 0.129073 0.000000 55.00 57.00 05700 CT SCAN 19, 559, 243 60, 111, 565 79, 670, 808 0.059031 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 13, 734, 924 3, 628, 704 10, 106, 220 0.000000 58.00 0.126651 58.00 05900 CARDIAC CATHETERIZATION 59.00 75, 737, 969 118, 401, 545 194, 139, 514 0.050214 0.000000 59.00 06000 LABORATORY 73, 902, 316 85, 859, 494 159, 761, 810 0.107286 0.000000 60.00 60.00 64.00 06400 INTRAVENOUS THERAPY 624, 722 25, 406 650, 128 0. 945626 0.000000 64.00 06500 RESPIRATORY THERAPY 26, 754, 634 24.091.692 2, 662, 942 0.251632 0.000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 3, 365, 847 21, 926, 720 25, 292, 567 0.386855 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 2, 697, 624 3, 846, 922 6, 544, 546 0. 356587 0.000000 67.00 67.00 06800 SPEECH PATHOLOGY 930, 194 2, 398, 243 0. 355740 0.000000 68.00 1, 468, 049 68.00 06900 ELECTROCARDI OLOGY 53, 799, 522 69.00 13, 369, 308 40, 430, 214 0.095240 0.000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 1,011,108 6,881,530 7, 892, 638 0. 185428 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 48, 068, 058 41, 643, 972 89, 712, 030 0.377592 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 48. 464. 259 29, 532, 152 77, 996, 411 0 425546 0.000000 72 00 07300 DRUGS CHARGED TO PATIENTS 691, 871, 039 73.00 67, 783, 149 624, 087, 890 0.229722 0.000000 73.00 74.00 07400 RENAL DIALYSIS 4, 468, 277 4, 468, 277 0.418352 0.000000 74.00 76.00 03330 ENDOSCOPY 1, 938, 025 3, 240, 848 5, 178, 873 0.170105 0.000000 76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 22, 856, 664 22, 856, 664 1.067909 0.000000 76.01 0 76.01 76.03 03951 LUTHERWOOD PARTNERSHIP 788, 292 788, 292 7. 126466 0.000000 76.03 03952 WOUND CARE CENTER 76.04 98, 280 13, 104, 542 13, 202, 822 0.318217 0.000000 76.04 76 05 03480 ONCOLOGY-CANCER CARE CENTER 2.053.860 218, 503, 385 220 557 245 0 160943 0 000000 76 05 03953 I MAGING CENTERS 54, 086, 293 0.000000 76.06 137, 523 54, 223, 816 0.142291 76.06 76. 07 03954 BREAST DIAGNOSTIC CENTER 13, 637 5, 368, 698 5, 382, 335 0.555919 0.000000 76.07 76.97 07697 CARDIAC REHABILITATION 77, 512 3, 837, 420 3, 914, 932 0.513959 0.000000 76.97 76.98 07698 HYPERBARIC OXYGEN THERAPY 2, 517, 150 2, 517, 150 0.000000 76. 98 0 0.284456

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | 5/29/2019 3:09 pm

		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient		<u> </u>	
'	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
32. 00 03200 CORONARY CARE UNIT				32.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS	•			
50. 00 05000 OPERATING ROOM	0. 148707			50.00
51. 00 05100 RECOVERY ROOM	0. 206328			51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0. 559195			52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 157840			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 129073			55. 00
57. 00 05700 CT SCAN	0. 059031			57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 126651			58.00
	0. 050214			59.00
• • • • • • • • • • • • • • • • • • •				
• • • • • • • • • • • • • • • • • • •	0. 107286			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 945626			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 251632			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 386855			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 356587			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 355740			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 095240			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 185428			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 377592			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 425546			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 229722			73. 00
74.00 07400 RENAL DIALYSIS	0. 418352			74. 00
76. 00 03330 ENDOSCOPY	0. 170105			76.00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1. 067909			76. 01
76. 03 03951 LUTHERWOOD PARTNERSHIP	7. 126466			76. 03
76. 04 03952 WOUND CARE CENTER	0. 318217			76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	0. 160943			76. 05
76. 06 03953 I MAGI NG CENTERS	0. 142291			76. 06
76. 07 03954 BREAST DIAGNOSTIC CENTER	0. 555919			76. 07
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 513959			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 284456			76. 98
OUTPATIENT SERVICE COST CENTERS	0. 204430			70. 70
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
	1 1			
	0.000000			89.00
90. 00 09000 CLI NI C	0.000000			90.00
90. 01 04950 DI ABETI C CARE CENTER	0.000000			90. 01
90. 02 04951 HEALTHY HEARTS CENTER	0. 672223			90. 02
90. 03 09001 CLI NI C	0.000000			90. 03
90. 04 04953 SPI NE CENTER	0. 079268			90. 04
90. 05 04954 I NFUSI ON CENTERS	0. 410383			90. 05
90. 06 09002 MEDCHECK CLI NI CS	0. 000000			90. 06
90. 07 09003 KNEE CENTER	1. 192705			90. 07
90. 08 09004 PALLI ATI VE CARE	0. 007255			90. 08
90. 10 09006 WORK SITE CLINICS	0. 000000			90. 10
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0. 000000			90. 12
91. 00 09100 EMERGENCY	0. 135355			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 887505			92. 00
OTHER REIMBURSABLE COST CENTERS				
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
1.222. (222.1.100.400.010)	1			1232.00

Health Financial Systems COMMUNITY HEACLCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF | Peri od: | Worksheet C | From 01/01/2018 | Part II | To 12/31/2018 | Date/Ti me Prepared: 5/29/2019 3:09 pm Provider CCN: 15-0074 REDUCTIONS FOR MEDICALD ONLY

						5/29/2019 3:0	9 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
			(Wkst. B, Part			Reduction	
		I, col. 26)		Cost (col. 1 -		Amount	
		1, 551. 25)	1. 00 20)	col . 2)		7 0 1	
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00	05000 OPERATING ROOM	17, 466, 067	2, 417, 434	15, 048, 633	0	0	50.00
51. 00	05100 RECOVERY ROOM	2, 825, 595					
							1
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 435, 308					
54.00	05400 RADI OLOGY - DI AGNOSTI C	8, 382, 527					54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 482, 510					
57. 00	05700 CT SCAN	4, 703, 013					
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 739, 548					
59. 00	05900 CARDI AC CATHETERI ZATI ON	9, 748, 445					
60.00	06000 LABORATORY	17, 140, 213					60.00
64.00	06400 I NTRAVENOUS THERAPY	614, 778					
65.00	06500 RESPI RATORY THERAPY	6, 732, 314	553, 167	6, 179, 147	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	9, 784, 566	1, 077, 364	8, 707, 202	2	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	2, 333, 703	172, 175	2, 161, 528	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	853, 150	62, 879	790, 271	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	5, 123, 876				0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 463, 517					1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	33, 874, 559					
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	33, 191, 042					1
73. 00	07300 DRUGS CHARGED TO PATIENTS	158, 937, 866					
74. 00	07400 RENAL DIALYSIS	1, 869, 313					74.00
76. 00	03330 ENDOSCOPY						
		880, 954					
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	24, 408, 840					
76. 03	03951 LUTHERWOOD PARTNERSHIP	5, 617, 736					76. 03
76. 04	03952 WOUND CARE CENTER	4, 201, 368					
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	35, 497, 204					
76. 06	03953 I MAGI NG CENTERS	7, 715, 585				1	
76. 07	03954 BREAST DIAGNOSTIC CENTER	2, 992, 144				0	76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	2, 012, 114					
76. 98	07698 HYPERBARI C OXYGEN THERAPY	716, 019	47, 245	668, 774	0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 RURAL HEALTH CLINIC	0	0	(0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0	0	89. 00
90.00	09000 CLI NI C	0	0		0	0	90.00
90. 01	04950 DIABETIC CARE CENTER	0	0	C	0	0	90. 01
90. 02	04951 HEALTHY HEARTS CENTER	3, 147, 239	397, 239	2, 750, 000	0	0	90. 02
90. 03	09001 CLI NI C	0	0	· C	0	0	90. 03
90. 04	04953 SPI NE CENTER	65	1	64	. 0	0	90. 04
90. 05	04954 INFUSION CENTERS	1, 163, 030	212, 142	950, 888	3	0	90. 05
90.06	09002 MEDCHECK CLINICS	0		(0	1
90. 07	09003 KNEE CENTER	5, 935, 508	591, 044	5, 344, 464	-	0	
90. 08	09004 PALLI ATI VE CARE	611	41	1		l o	90. 08
90. 10	09006 WORK SITE CLINICS	0				0	
90. 10	04961 FAMILY PRACTICE AND MATERNITY CARE				_	0	90. 10
91.00	09100 EMERGENCY	27, 676, 975	_		_	-	1
91.00							1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 862, 267	883, 231	6, 979, 036	0	10	92.00
00.00	OTHER REIMBURSABLE COST CENTERS		_			_	00.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0					98. 00
200.00	1 1 ,	452, 529, 569					200. 00
201.00		7, 862, 267					201. 00
202.00	Total (line 200 minus line 201)	444, 667, 302	30, 091, 103	414, 576, 199	0	1 0	202. 00

Peri od: Worksheet C From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared: 5/29/2019 3:09 pm REDUCTIONS FOR MEDICALD ONLY

						5/29/2019 3:09	9 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to Charge			
		Operating Cost	Part I, column				
		Reducti on	8)	/ col. 7)			
		6. 00	7.00	8.00			
	ANCILLARY SERVICE COST CENTERS	0.00	7.00	0.00			
50. 00	05000 OPERATI NG ROOM	17, 466, 067	117, 452, 655	0. 148707	,		50.00
51. 00	05100 RECOVERY ROOM	2, 825, 595					51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 435, 308					52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 382, 527					54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 482, 510			3		55. 00
57.00	05700 CT SCAN	4, 703, 013	79, 670, 808	0. 059031			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 739, 548	13, 734, 924	0. 126651			58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	9, 748, 445		0. 050214			59. 00
60.00	06000 LABORATORY	17, 140, 213					60.00
64.00	06400 I NTRAVENOUS THERAPY	614, 778					64.00
65. 00	06500 RESPI RATORY THERAPY	6, 732, 314					65. 00
66. 00	06600 PHYSI CAL THERAPY	9, 784, 566					66.00
67. 00							
	06700 OCCUPATI ONAL THERAPY	2, 333, 703					67. 00
68. 00	06800 SPEECH PATHOLOGY	853, 150					68. 00
69. 00	06900 ELECTROCARDI OLOGY	5, 123, 876					69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 463, 517					70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	33, 874, 559	89, 712, 030	0. 377592	2		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	33, 191, 042	77, 996, 411	0. 425546			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	158, 937, 866	691, 871, 039	0. 229722	2		73. 00
74.00	07400 RENAL DIALYSIS	1, 869, 313	4, 468, 277	0. 418352	2		74.00
76. 00	03330 ENDOSCOPY	880, 954		l .			76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	24, 408, 840					76. 01
76. 03	03951 LUTHERWOOD PARTNERSHIP	5, 617, 736					76. 03
76. 03	03952 WOUND CARE CENTER	4, 201, 368					76. 03
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	35, 497, 204					76. 05
76. 06	03953 I MAGI NG CENTERS	7, 715, 585					76. 06
76. 07	03954 BREAST DIAGNOSTIC CENTER	2, 992, 144					76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	2, 012, 114					76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	716, 019	2, 517, 150	0. 284456)		76. 98
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000			88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 000000)		89. 00
90.00	09000 CLI NI C	0		0.000000			90.00
90. 01	04950 DI ABETI C CARE CENTER	0	0	i			90. 01
90. 02	04951 HEALTHY HEARTS CENTER	3, 147, 239	4, 681, 838				90. 02
90. 03	09001 CLINI C	0,117,207	1,001,000	0. 000000			90. 03
90. 03	04953 SPI NE CENTER	65	820				90.03
90. 05	04954 I NFUSI ON CENTERS	1	l e	l .			90.04
	1	1, 163, 030	2, 834, 012	1			
90. 06	09002 MEDCHECK CLINICS	0		0.000000			90. 06
90. 07	09003 KNEE CENTER	5, 935, 508		l .			90. 07
90. 08	09004 PALLI ATI VE CARE	611	84, 215				90. 08
90. 10	09006 WORK SITE CLINICS	0	0				90. 10
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	0	0	0.000000)		90. 12
91.00	09100 EMERGENCY	27, 676, 975	204, 476, 423	0. 135355	5		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 862, 267					92.00
	OTHER REIMBURSABLE COST CENTERS				<u> </u>		
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000			98. 00
200.00			2, 198, 853, 585				200.00
200.00		7, 862, 267		j			200.00
201.00			2, 198, 853, 585				201.00
202. UL	Trotal (Time 200 IIII lius Time 201)	1 444, 007, 302	2, 170, 000, 080	1	T		202.00

Health Financial Systems	COMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2018 To 12/31/2018		pared: 9 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	10, 635, 221		10,000,22			
31.00 INTENSIVE CARE UNIT	1, 677, 561	l .	1, 677, 56			
32. 00 CORONARY CARE UNIT	933, 456		933, 45	5, 645		
43. 00 NURSERY	145, 151		145, 15	1, 853	78. 33	43. 00
200.00 Total (lines 30 through 199)	13, 391, 389		13, 391, 38	9 84, 468		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	15, 743					30. 00
31.00 INTENSIVE CARE UNIT	2, 276	631, 408	3			31. 00
32. 00 CORONARY CARE UNIT	2, 260	373, 714				32. 00
43. 00 NURSERY	0	C)			43.00
200.00 Total (lines 30 through 199)	20, 279	3, 365, 785	i			200. 00

Heal th	Financial Systems C	OMMUNITY HEALTH	NETWORK, INC.		In Lie	eu of Form CMS-	2552-10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C		Peri od:	Worksheet D	
					From 01/01/2018	Part II	
					To 12/31/2018	Date/Time Pre 5/29/2019 3:0	pared:
			Ti tl e	e XVIII	Hospi tal	PPS	9 рііі
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
	5051 5011101 50501 Ft. 611	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,		(col . 1 ÷ col		column 4)	
		Part II, col.	8)	2)	3		
		26)	,	, i			
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCI LLARY SERVI CE COST CENTERS						
50. 00	05000 OPERATING ROOM	2, 417, 434				751, 431	1
51. 00	05100 RECOVERY ROOM	396, 556				62, 401	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	391, 080				1	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 384, 853					•
55. 00	05500 RADI OLOGY-THERAPEUTI C	446, 197					•
57. 00	05700 CT SCAN	474, 946					•
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	330, 123	13, 734, 924	0. 02403			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 491, 433	194, 139, 514	0.00768	2 30, 037, 814	230, 750	59. 00
60.00	06000 LABORATORY	482, 508	159, 761, 810	0.00302	0 26, 247, 584	79, 268	60.00
64.00	06400 I NTRAVENOUS THERAPY	51, 454	650, 128	0. 07914	4 159, 859	12, 652	64.00
65.00	06500 RESPIRATORY THERAPY	553, 167	26, 754, 634	0. 02067	6 8, 266, 434	170, 917	65.00
66.00	06600 PHYSI CAL THERAPY	1, 077, 364	25, 292, 567	0. 04259	6 1, 394, 109	59, 383	
67.00	06700 OCCUPATI ONAL THERAPY	172, 175		•	1, 161, 659		•
68. 00	06800 SPEECH PATHOLOGY	62, 879					•
69. 00	06900 ELECTROCARDI OLOGY	553, 951					1
70. 00	07000 ELECTROENCEPHALOGRAPHY	153, 656					1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	603, 270		1			1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	488, 960		•			
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 709, 909					1
74. 00	07400 RENAL DIALYSIS	36, 408					1
76. 00	03330 ENDOSCOPY	89, 593		1			1
76. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 896, 202		1		l	
76. 01	03951 LUTHERWOOD PARTNERSHIP	1				l	1
76. 03	03952 WOUND CARE CENTER	1, 408, 246					1
		281, 976				l .	1
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	3, 734, 588					1
76. 06	03953 I MAGI NG CENTERS	1, 065, 606				l e	
76. 07	03954 BREAST DI AGNOSTI C CENTER	134, 881				l e	
76. 97	07697 CARDI AC REHABI LI TATI ON	354, 286		1		l e	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	47, 245	2, 517, 150	0. 01876	9 0	0	76. 98
00.00	OUTPATIENT SERVICE COST CENTERS	0	1 0	0 00000	0	0	00.00
88. 00	08800 RURAL HEALTH CLINIC			0.00000			
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	-		0.00000			
90.00	09000 CLINIC	0		0.00000			
90. 01	04950 DI ABETI C CARE CENTER	0		0.00000		0	
90. 02	04951 HEALTHY HEARTS CENTER	397, 239				l	
90. 03	09001 CLI NI C	0	C				
90. 04	04953 SPI NE CENTER	1	820				
90. 05	04954 I NFUSI ON CENTERS	212, 142	2, 834, 012	•		0	
90. 06	09002 MEDCHECK CLINICS	0					
90. 07	09003 KNEE CENTER	591, 044			7 0	0	90. 07
	09004 PALLI ATI VE CARE	41	84, 215			0	
90. 10	09006 WORK SITE CLINICS	0	C	0.00000	0 0	0	90. 10
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	0	C	0.00000	0	0	90. 12
91. 00	09100 EMERGENCY	2, 599, 690	204, 476, 423	0. 01271	4 15, 656, 428	199, 056	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	883, 231	8, 858, 846	0. 09970	0 486, 093	48, 463	92.00
	OTHER REIMBURSABLE COST CENTERS						1
	09850 OTHER REIMBURSABLE COST CENTERS	0	C	0.00000		0	
200.00	Total (lines 50 through 199)	30, 974, 334	2, 198, 853, 585	i	209, 144, 007	2, 382, 233	200. 00

Health Financial Systems (COMMUNITY HEALTH	NETWORK, INC.		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provider C		Peri od:	Worksheet D	
				From 01/01/2018 To 12/31/2018		narodi
				12/31/2010	5/29/2019 3:0	pareu. 19 nm
		Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	(0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0	(0	0	
32. 00 03200 CORONARY CARE UNIT	0	0	(0	0	
43. 00 04300 NURSERY	0	0	(0	0	
200.00 Total (lines 30 through 199)	0	0	(0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adj ustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,				
	instructions) 4.00	mi nus col . 4) 5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
30. 00 03000 ADULTS & PEDIATRICS	1 0		70, 923	0.00	15, 743	30.00
31. 00 03100 NTENSI VE CARE UNI T	0		6, 047			
32. 00 03200 CORONARY CARE UNIT			5, 645			
43. 00 04300 NURSERY			1, 853			
200.00 Total (lines 30 through 199)			84, 468		-	200.00
Cost Center Description	Inpati ent		04, 400	7	20,217	200.00
oost contor boson per on	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INDATI ENT DOUTINE CEDALCE COCT CENTEDO	•					

30. 00 31. 00

32. 00 43. 00 200. 00

30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 032. 00 04300 O4300 NURSERY Total (lines 30 through 199)

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2018 | Part IV | To 12/31/2018 | Date/Time Prepared: 5/29/2019 3:09 pm Provider CCN: 15-0074 THROUGH COSTS

					5/29/2019 3:0	9 pm
			XVIII	Hospi tal	PPS	
Cost Center Description			Nursing School	Allied Health	Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	(0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	(0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0	55. 00
57. 00 05700 CT SCAN	0	0		0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	O		0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	o o	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0		0	o o	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0			o o	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0			o o	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0			o o	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0			Ö	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	ĺ			Ö	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			Ö	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			Ö	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0			0	73.00
74. 00 07400 RENAL DIALYSIS	0	0			0	74.00
76. 00 03330 ENDOSCOPY	0				0	76.00
76. 00 03330 ENDOSCOFT 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0			0	76. 00
76. 03 03951 LUTHERWOOD PARTNERSHI P		0			0	76. 01
76. 04 03952 WOUND CARE CENTER	0	0			0	76. 03
76. 05 03480 ONCOLOGY-CANCER CARE CENTER		0			0	76. 04
76. 06 03953 I MAGING CENTERS	0	0			0	76.05
	0	0				76.00
	_	0				1
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0			0	76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0	0	1	0	0	76. 98
OUTPATIENT SERVICE COST CENTERS	1	0		0		00 00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	_	1	-		88. 00
	0	0		0		89. 00
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 HEALTHY HEARTS CENTER	0	0		0	0	90. 02
90. 03 09001 CLI NI C	0	0		0	0	90. 03
90. 04 04953 SPI NE CENTER	0	0		0	0	90. 04
90. 05 04954 INFUSION CENTERS	0	0		0	0	90. 05
90. 06 09002 MEDCHECK CLINICS	0	0	(0	0	90. 06
90. 07 09003 KNEE CENTER	0	0	(0	0	90. 07
90. 08 09004 PALLI ATI VE CARE	0	0	(و ا	0	90. 08
90. 10 09006 WORK SITE CLINICS	0	0	(0	0	90. 10
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0	0	(0	0	90. 12
91. 00 09100 EMERGENCY	0	0		0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92. 00
OTHER REIMBURSABLE COST CENTERS			1			
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	1			98. 00
200.00 Total (lines 50 through 199)	0	0	η (0	J 0	200. 00

| Peri od: | Worksheet D | From 01/01/2018 | Part IV | To 12/31/2018 | Date/Time Prepared: | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Par
 Heal th Financial
 Systems
 COMMUNITY
 HEALTH N

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN: 15-0074 THROUGH COSTS

				lo 12/31/2018	Date/lime Prep 5/29/2019 3:0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
·	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
ANOULL ADV. CEDVLOE COST CENTEDS	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	1	0	J	117 450 455	0.000000	FO 00
50. 00 05000 OPERATI NG ROOM	0	0	1	117, 452, 655	0.000000	50.00
51. 00 05100 RECOVERY ROOM	0	0	1	13, 694, 666		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0			0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		00, 10, 100,	0. 000000 0. 000000	54. 00 55. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C 57. 00 05700 CT SCAN		0		17/200/ 100		
	0	0			0. 000000 0. 000000	57. 00 58. 00
58.00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59.00 05900 CARDI AC CATHETERI ZATI ON	0	0			0. 000000	59. 00
60. 00 06000 LABORATORY		0	1	, ,	0. 000000	60.00
	0	0		159, 761, 810 650, 128	0. 000000	64. 00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	0			0. 000000	65. 00
	0	0				
	1	0			0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		-, ,	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	1	2,070,210	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		00////022	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	1	.,,	0.000000	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	89, 712, 030	0.000000	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0			0.000000	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	•	691, 871, 039	0.000000	73.00
74. 00 07400 RENAL DI ALYSI S	0	0		.,,	0. 000000	74.00
76. 00 03330 ENDOSCOPY	0	0		0, 170, 070	0.000000	76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		22, 000, 001	0.000000	76. 01
76. 03 03951 LUTHERWOOD PARTNERSHIP	0	0			0.000000	76. 03
76. 04 03952 WOUND CARE CENTER	0	0	1	13, 202, 822	0.000000	76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	_	0		,	0.000000	76. 05
76. 06 03953 IMAGING CENTERS 76. 07 03954 BREAST DIAGNOSTIC CENTER	0	0		54, 223, 816	0. 000000 0. 000000	76. 06 76. 07
76. 07 03954 BREAST DI AGNOSTI C CENTER 76. 97 07697 CARDI AC REHABI LI TATI ON		0		5, 382, 335 3, 914, 932	0. 000000	76. 07 76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0			0. 000000	76. 97 76. 98
OUTPATIENT SERVICE COST CENTERS	0	0	1	2, 517, 150	0.000000	70. 90
88. 00 08800 RURAL HEALTH CLINIC	1 0	0		0	0. 000000	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.000000	89. 00
90. 00 09000 CLI NI C	0	0		0	0. 000000	90.00
90. 01 04950 DI ABETI C CARE CENTER	0	0		0	0.000000	90. 01
90. 02 04951 HEALTHY HEARTS CENTER	0	0		4, 681, 838	0. 000000	90. 02
90. 03 09001 CLI NI C	0	0) (0	0.000000	90. 03
90. 04 04953 SPI NE CENTER	0	0)	820	0.000000	90. 04
90. 05 04954 I NFUSI ON CENTERS	0	0)	2, 834, 012	0.000000	90. 05
90. 06 09002 MEDCHECK CLINICS	0	0		0	0. 000000	90.06
90. 07 09003 KNEE CENTER	0	0		4, 976, 511	0. 000000	90. 07
90. 08 09004 PALLI ATI VE CARE	0	0) (84, 215	0.000000	90. 08
90. 10 09006 WORK SITE CLINICS	0	0)	0	0.000000	90. 10
90.12 04961 FAMILY PRACTICE AND MATERNITY CARE	0	0)	0	0.000000	90. 12
91. 00 09100 EMERGENCY	0	0		204, 476, 423	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		8, 858, 846	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0		1	0	0. 000000	98. 00
200.00 Total (lines 50 through 199)	0	0	(2, 198, 853, 585		200. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet D | From 01/01/2018 Part IV | To 12/31/2018 Date/Time Prepared: 5/29/2019 3:09 pm
 Heal th Financial
 Systems
 COMMUNITY
 HEALTH N

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN: 15-0074 THROUGH COSTS

						5/29/2019 3:0	9 pm
			Title	xVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	36, 509, 151		5, 399, 294	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	2, 154, 944	0	5, 773, 208	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 980, 263	0	11, 087, 901	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	3, 299, 895	l o	8, 143, 059	0	55.00
57.00	05700 CT SCAN	0. 000000	7, 475, 408	l o	13, 031, 635	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	1, 309, 539		2, 544, 049	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	30, 037, 814		41, 024, 323	0	59. 00
60.00	06000 LABORATORY	0. 000000	26, 247, 584		20, 620, 589	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	159, 859		0.020,007	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	8, 266, 434		403, 976	Ö	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	1, 394, 109		49, 401	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 161, 659		29, 338	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	365, 070		2, 822	0	68. 00
69. 00	1 1						69.00
	06900 ELECTROCARDI OLOGY	0. 000000	5, 826, 534		11, 731, 099	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	376, 781	0	1, 380, 112	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	17, 803, 385		11, 133, 006	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	21, 408, 004		11, 643, 622	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	22, 205, 190		218, 397, 705	0	73. 00
74.00	07400 RENAL DI ALYSI S	0. 000000	2, 405, 904		0	0	74.00
76. 00	03330 ENDOSCOPY	0. 000000	153, 717		757, 054	0	76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		803, 336	0	76. 01
76. 03	03951 LUTHERWOOD PARTNERSHIP	0. 000000	0		0	0	76. 03
76. 04	03952 WOUND CARE CENTER	0. 000000	40, 937		5, 182, 884	0	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	0. 000000	399, 970		68, 722, 735	0	76. 05
76. 06	03953 I MAGI NG CENTERS	0. 000000	5, 709		14, 451, 721	0	76. 06
76. 07	03954 BREAST DIAGNOSTIC CENTER	0. 000000	1, 842		174, 014	0	76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	578		1, 649, 324	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
00.00	OUTPATIENT SERVICE COST CENTERS	0.00000				0	00.00
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	-	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0	89. 00
90.00	09000 CLINIC	0. 000000	0		0	0	90.00
90. 01	04950 DIABETIC CARE CENTER	0. 000000	0		0	0	90. 01
90. 02	04951 HEALTHY HEARTS CENTER	0. 000000	11, 206		2, 153, 294	0	90. 02
90. 03	09001 CLI NI C	0. 000000	0	-	0	0	90. 03
90. 04	04953 SPINE CENTER	0. 000000	0	-	0	0	90. 04
90. 05	04954 INFUSION CENTERS	0. 000000	0		964, 999	0	90. 05
90.06	09002 MEDCHECK CLINICS	0. 000000	0	_	0	0	90. 06
90. 07	09003 KNEE CENTER	0. 000000	0	0	0	0	90. 07
90. 08	09004 PALLI ATI VE CARE	0. 000000	0	-	939	0	90. 08
90. 10	09006 WORK SITE CLINICS	0. 000000	0		0	0	90. 10
90. 12	04961 FAMILY PRACTICE AND MATERNITY CARE	0. 000000	0	-	0	0	90. 12
91.00	09100 EMERGENCY	0. 000000	15, 656, 428		22, 916, 482	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	486, 093	0	3, 366, 587	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0	0	98. 00
200.00	Total (lines 50 through 199)		209, 144, 007	0	483, 538, 508	0	200. 00

	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	OWNIGHT THEALTH		CN: 15-0074	Period: From 01/01/2018	Worksheet D Part V Date/Time Pre 5/29/2019 3:0	pared:
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		1 00	2.00	(see inst.)	(see inst.)	F 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3. 00	4. 00	5. 00	
50. 00	05000 OPERATING ROOM	0. 146686	5, 399, 294		0 0	792, 001	50.00
51. 00	05100 RECOVERY ROOM	0. 206328			0 0	l	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 559195			0 0		1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 157840		Ί		1, 750, 114	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 129073			0 0	l	1
57. 00	05700 CT SCAN	0. 059031	13, 031, 635		0 0	769, 270	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 126651	2, 544, 049		0 0	322, 206	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 050214			0 0	1	
60. 00	06000 LABORATORY	0. 107123			0 0	2, 208, 939	
64. 00	06400 I NTRAVENOUS THERAPY	0. 107123			0 0	2, 200, 737	1
65. 00	06500 RESPI RATORY THERAPY	0. 251632				101, 653	1
66. 00	06600 PHYSI CAL THERAPY	0. 382796		1			
67. 00	06700 OCCUPATI ONAL THERAPY	0. 356587		1		10, 462	1
68. 00	06800 SPEECH PATHOLOGY	0. 355740			0 0	1	
69. 00	06900 ELECTROCARDI OLOGY	0. 095240			0 0	1, 117, 270	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 185428			0 0	255, 911	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 377592			0 0	4, 203, 734	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 425546		1	0 0	4, 954, 897	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 229593		1	341, 968		
74. 00	07400 RENAL DI ALYSI S	0. 418352		,	0 0	0	74.00
76. 00	03330 ENDOSCOPY	0. 170105			0 0	128, 779	1
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1. 054358		1	0 0	847, 004	
76. 03	03951 LUTHERWOOD PARTNERSHIP	7. 126466	0	1	0 0	0	76. 03
76. 04	03952 WOUND CARE CENTER	0. 312479	5, 182, 884		0 0	1, 619, 542	76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	0. 160943			0 1, 381	11, 060, 443	76. 05
76.06	03953 I MAGI NG CENTERS	0. 142291	14, 451, 721		0	2, 056, 350	76. 06
76. 07	03954 BREAST DIAGNOSTIC CENTER	0. 555919	174, 014		0	96, 738	76. 07
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 513959	1, 649, 324		0	847, 685	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 284456	0		0 0	0	76. 98
	OUTPATIENT SERVICE COST CENTERS	_					
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90. 00	09000 CLI NI C	0. 000000			0	0	
90. 01	04950 DI ABETI C CARE CENTER	0. 000000)	0	0	
90. 02	04951 HEALTHY HEARTS CENTER	0. 672223			0		1
90. 03	09001 CLI NI C	0. 000000		1	0	0	
90. 04	04953 SPI NE CENTER	0. 079268		1	0		
	04954 I NFUSI ON CENTERS	0. 410383			0	396, 019	
	09002 MEDCHECK CLINICS	0. 000000		1	0	0	90. 06
	09003 KNEE CENTER	1. 171733		1	0	0	
90. 08	09004 PALLI ATI VE CARE	0. 007255		1	0	/	90. 08
90. 10	09006 WORK SITE CLINICS	0. 000000		1	0	0	
	04961 FAMILY PRACTICE AND MATERNITY CARE	0. 000000		1	0 0	0	
91.00	09100 EMERGENCY	0. 134022			0 929	1	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 887505	3, 366, 587		0 345	2, 987, 863	92. 00
00.00	OTHER REIMBURSABLE COST CENTERS	0.000000			0 0	_	00.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			0 0		
200. 00 201. 00			483, 538, 508	1, 88	344, 623	95, 510, 411	200.00
201.00	Only Charges				ا		201.00
202.00			483, 538, 508	1, 88	344, 623	95, 510, 411	202. 00
		•				•	•

Provider CCN: 15-0074

						5/29/2019 3:0)9 pm
			Ti tl e	XVIII	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
	•	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)	-			
	I	6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATI NG 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	l o				54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	1			55. 00
57. 00	05700 CT SCAN		0				57. 00
				1			1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	1			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	1			59. 00
60.00	06000 LABORATORY	0	0	1			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	l o)			67. 00
68. 00	06800 SPEECH PATHOLOGY	0	1				68. 00
69. 00	06900 ELECTROCARDI OLOGY		Ö				69. 00
	1						
70.00	07000 ELECTROENCEPHALOGRAPHY	0		1			70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	432	78, 513				73. 00
74.00	07400 RENAL DI ALYSI S	0	0				74.00
76.00	03330 ENDOSCOPY	0	0				76. 00
76. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				76. 01
76. 03	03951 LUTHERWOOD PARTNERSHIP	0	0				76. 03
76. 04	03952 WOUND CARE CENTER	0	l o	,			76. 04
76. 05	03480 ONCOLOGY-CANCER CARE CENTER	0	222				76. 05
	03953 I MAGI NG CENTERS	0	0	1			76. 06
76. 07	03954 BREAST DIAGNOSTIC CENTER		ĺ	1			76. 07
	07697 CARDI AC REHABI LI TATI ON		Ö	1			76. 97
	07698 HYPERBARI C OXYGEN THERAPY		•				76. 98
70. 90	OUTDATIENT CEDVICE COCT CENTERS			1			70. 90
00 00	OUTPATIENT SERVICE COST CENTERS		1				00.00
88. 00	08800 RURAL HEALTH CLINIC	0		1			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90. 00	09000 CLI NI C	0	0	1			90.00
90. 01	04950 DIABETIC CARE CENTER	0	0	1			90. 01
90. 02	04951 HEALTHY HEARTS CENTER	0	0)			90. 02
90. 03	09001 CLI NI C	0	0				90. 03
90. 04	04953 SPI NE CENTER	0	0)			90. 04
90.05	04954 I NFUSI ON CENTERS	0	0				90. 05
90.06	09002 MEDCHECK CLINICS	0	l o	,			90.06
90. 07	09003 KNEE CENTER	0	0				90. 07
	09004 PALLI ATI VE CARE	0	ĺ				90. 08
			Ö	1			90. 10
	04961 FAMILY PRACTICE AND MATERNITY CARE						90. 10
				1			
	l l	0					91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	306	1			92. 00
	OTHER REIMBURSABLE COST CENTERS		<u> </u>				4
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0		1			98. 00
200.00		432	79, 166	1			200. 00
201.00		0					201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	432	79, 166				202. 00

Health Financial Systems	COMMUNITY HEALTH	I NETWORK, INC.		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE C	APITAL COSTS		F	Period: From 01/01/2018 Fo 12/31/2018	Date/Time Pre 5/29/2019 3:0	pared: 9 pm
			e XIX	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 Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	5					
30. 00 ADULTS & PEDIATRICS	10, 635, 221	0	10, 635, 22	70, 923	149. 95	30.00
31.00 INTENSIVE CARE UNIT	1, 677, 561		1, 677, 56	6, 047	277. 42	31.00
32.00 CORONARY CARE UNIT	933, 456		933, 456	5, 645	165. 36	32.00
43. 00 NURSERY	145, 151		145, 151	1, 853	78. 33	43.00
200.00 Total (lines 30 through 199)	13, 391, 389		13, 391, 389	84, 468		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	6					
30. 00 ADULTS & PEDI ATRI CS	3, 070	460, 347	'			30. 00
31.00 INTENSIVE CARE UNIT	0	0				31.00
32.00 CORONARY CARE UNIT	0	0				32.00
43. 00 NURSERY	1, 533	120, 080				43.00
200.00 Total (lines 30 through 199)	4, 603					200.00
	•	•	•			•

Health Financial Systems C	OMMUNITY HEALTH	H NETWORK, INC.		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C	CN: 15-0074	Peri od:	Worksheet D	
				From 01/01/2018	Part II	
				To 12/31/2018	Date/Time Pre	pared:
		T: +1	. VIV	Hooni tal	5/29/2019 3: 0 PPS	9 pili
Coat Contar Deparintion	Coni tol		e XIX	Hospi tal		
Cost Center Description	Capital Related Cost	Total Charges		t Inpatient Program	Capital Costs	
		(from Wkst. C,		9	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2.00	2.00	4.00	F 00	
ANCLLIADY CEDVICE COCT CENTERS	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	2 417 424	117 450 /55	0.00050	111 000	0.477	F0 00
50. 00 05000 OPERATING ROOM	2, 417, 434		1			
51. 00 05100 RECOVERY ROOM	396, 556					
52. 00 05200 DELIVERY ROOM & LABOR ROOM	391, 080		1			52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	1, 384, 853	•	1		l	
55. 00 05500 RADI OLOGY-THERAPEUTI C	446, 197					
57. 00 05700 CT SCAN	474, 946				1	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	330, 123				1	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 491, 433				l	1
60. 00 06000 LABORATORY	482, 508				l	1
64.00 06400 I NTRAVENOUS THERAPY	51, 454					
65. 00 06500 RESPIRATORY THERAPY	553, 167	26, 754, 634	0. 02067	76 505, 778	10, 457	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 077, 364	25, 292, 567	0. 04259	80, 191	3, 416	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	172, 175	6, 544, 546	0. 02630	08 68, 068	1, 791	67. 00
68.00 06800 SPEECH PATHOLOGY	62, 879	2, 398, 243	0. 02621	9 24, 605	645	68. 00
69. 00 06900 ELECTROCARDI OLOGY	553, 951	53, 799, 522	0. 01029	262, 116	2, 699	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	153, 656	7, 892, 638	0. 01946	42, 808	833	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	603, 270	1	1		7, 084	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	488, 960					
73. 00 07300 DRUGS CHARGED TO PATIENTS	3, 709, 909	1				
74. 00 07400 RENAL DIALYSIS	36, 408		1		l	1
76. 00 03330 ENDOSCOPY	89, 593		1		l	1
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	3, 896, 202		1		0	76. 01
76. 03 03951 LUTHERWOOD PARTNERSHI P	1, 408, 246		1		Ö	76. 03
76. 04 03952 WOUND CARE CENTER	281, 976	1	1			76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	3, 734, 588		1		i e	1
76. 06 03953 I MAGI NG CENTERS	1, 065, 606				110	
76. 07 03954 BREAST DIAGNOSTIC CENTER	134, 881		1		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	354, 286	•	1		l	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	1	•	1		l	1
OUTPATIENT SERVICE COST CENTERS	47, 245	2, 517, 150	0.01676	09 0	0	70.90
88. 00 08800 RURAL HEALTH CLINIC	0		0.00000	00	0	88. 00
					l e	
					l	1
	0	1				90.00
90. 01 04950 DI ABETI C CARE CENTER	0	1	0.00000		0	90. 01
90. 02 04951 HEALTHY HEARTS CENTER	397, 239	4, 681, 838				90. 02
90. 03 09001 CLI NI C	0	0	0.00000		0	90. 03
90. 04 04953 SPI NE CENTER	1	820	1		0	90. 04
90. 05 04954 I NFUSI ON CENTERS	212, 142	2, 834, 012	1		0	90. 05
90. 06 09002 MEDCHECK CLINICS	0	0	0.00000			90. 06
90. 07 09003 KNEE CENTER	591, 044	4, 976, 511	0. 11876	0 0	0	90. 07
90. 08 09004 PALLI ATI VE CARE	41	84, 215	0. 00048	0 0	0	90. 08
90. 10 09006 WORK SITE CLINICS	0	0	0. 00000	0 0	0	90. 10
90.12 04961 FAMILY PRACTICE AND MATERNITY CARE	0	0	0. 00000	0 0	0	90. 12
91. 00 09100 EMERGENCY	2, 599, 690	204, 476, 423	1		14, 107	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	883, 236	1			l	1
OTHER REIMBURSABLE COST CENTERS						1
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0		0.00000	00	0	98. 00
200.00 Total (lines 50 through 199)	30, 974, 339	2, 198, 853, 585		10, 718, 483		
1	, 50 ,			., ,		

Weelth Financial Contains	OMMUNICAL TU	NETWORK INC		1-1:-	6 F ONC :	2552 40
Health Financial Systems CO APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	OMMUNITY HEALTH SS THROUGH COS		CN: 15-0074	Period:	u of Form CMS-2 Worksheet D	2552-10
THE SERVICE STREET				rom 01/01/2018	Part III	
			-	Γο 12/31/2018		pared:
		Ti +l	e XIX	Hospi tal	5/29/2019 3: 0 PPS	9 piii
Cost Center Description	Nursing School			Allied Health	All Other	
oust defined beschiptron	Post-Stepdown		Post-Stepdown		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0)	0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0)	0	0	31. 00
32. 00 03200 CORONARY CARE UNIT	0	0)	0	0	32. 00
43. 00 04300 NURSERY	0	0)	0	0	1 .0.00
200.00 Total (lines 30 through 199)	0	0	(0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see instructions)	1 through 3, minus col. 4)				
	4.00	5.00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	70, 92	0.00	3, 070	30.00
31. 00 03100 NTENSI VE CARE UNI T		0	6, 04			31.00
32. 00 03200 CORONARY CARE UNIT		Ö	5, 64!		0	32.00
43. 00 04300 NURSERY		Ö	1, 85		1, 533	
200.00 Total (lines 30 through 199)		o	84, 46		· ·	200. 00
Cost Center Description	I npati ent			*		
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
INDATIENT POUTINE CEDVICE COCT CENTEDO	9. 00					

30. 00 31. 00

32. 00 43. 00 200. 00

30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 032. 00 04300 O4300 NURSERY Total (lines 30 through 199)

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2018 | Part IV | To 12/31/2018 | Date/Time Prepared: 5/29/2019 3:09 pm Provider CCN: 15-0074 THROUGH COSTS

					5/29/2019 3:0	9 pm
			e XIX	Hospi tal	PPS	
Cost Center Description			Nursing School	Allied Health	Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0)	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	(0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0) (0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0) (0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0) (0	0	55. 00
57. 00 05700 CT SCAN	0) (0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0) (0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	l 0		0	0	59.00
60. 00 06000 LABORATORY	0	0	,	0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	i o		0	o o	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0		0	o o	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	Ö			o o	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	Ĭ			Ö	67.00
68. 00 06800 SPEECH PATHOLOGY	0	Ĭ			Ö	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	Ĭ			Ö	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	l o			Ö	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l o			Ö	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	٥			Ö	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	٥			Ö	73.00
74. 00 07400 RENAL DIALYSIS	0				0	74.00
76. 00 03330 ENDOSCOPY	0)		0	76.00
76. 00 03330 ENDOSCOFT 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES)		0	76. 00
76. 03 03951 LUTHERWOOD PARTNERSHI P)		0	76. 01
76. 04 03952 WOUND CARE CENTER	0)		0	76. 03
76. 05 03480 ONCOLOGY-CANCER CARE CENTER)		0	76.04
76. 06 03953 I MAGI NG CENTERS)		0	76.05
76. 07 03954 BREAST DIAGNOSTIC CENTER	0				0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0				0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY					0	76. 97
OUTPATIENT SERVICE COST CENTERS	0		1) 0	0	70.98
88. 00 08800 RURAL HEALTH CLINIC	0	0	J	0	0	00 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER			1			88. 00 89. 00
	0					•
	0					90. 00 90. 01
	0					90.01
	0	0		0	0	
90. 03 09001 CLI NI C	0	0				90. 03
90. 04 04953 SPI NE CENTER	0	0				90.04
90. 05 04954 INFUSION CENTERS	0	0			0	90.05
90. 06 09002 MEDCHECK CLINICS	0				0	90.06
90. 07 09003 KNEE CENTER	0				1	90. 07
90. 08 09004 PALLIATIVE CARE	0]	0	0	90.08
90. 10 09006 WORK SITE CLINICS]	0	0	90. 10
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0]	0	0	90. 12
91. 00 09100 EMERGENCY	0		1	0	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	1 0		1		<u> </u>	92. 00
OTHER REIMBURSABLE COST CENTERS			J			00.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	l .	1	0		98.00
200.00 Total (lines 50 through 199)	0	0	'l	0	l 0	200. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2018 | Part IV | To 12/31/2018 | Date/Time Prepared: 5/29/2019 3:09 pm
 Heal th Financial
 Systems
 COMMUNITY
 HEALTH N

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN: 15-0074 THROUGH COSTS

					5/29/2019 3:0	9 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
		·	and 4)			
	4. 00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	C	117, 452, 655	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	ıl c	13, 694, 666	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	l o			0. 000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	d		0. 000000	55. 00
57. 00 05700 CT SCAN	0	0	l c		0. 000000	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	١			0. 000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0				0. 000000	59.00
60. 00 06000 LABORATORY					0. 000000	60.00
64. 00 06400 I NTRAVENOUS THERAPY						64.00
65. 00 06500 RESPIRATORY THERAPY					0.000000	65.00
	0	0	C	-, -, -, -		•
66. 00 06600 PHYSI CAL THERAPY	0	0		25, 292, 567	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	9	-, ,		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	1		0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0) c	, ,	0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	l c	7, 892, 638		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1		0. 000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C		0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	691, 871, 039	0.000000	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	C	4, 468, 277	0.000000	74. 00
76. 00 03330 ENDOSCOPY	0	0	C	5, 178, 873	0.000000	76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	C	22, 856, 664	0.000000	76. 01
76. 03 03951 LUTHERWOOD PARTNERSHIP	0	0) c	788, 292	0.000000	76. 03
76. 04 03952 WOUND CARE CENTER	0	0) c	13, 202, 822	0.000000	76. 04
76.05 03480 ONCOLOGY-CANCER CARE CENTER	0	0	ol c	220, 557, 245	0.000000	76. 05
76.06 03953 I MAGING CENTERS	0	0	ol c		0.000000	76. 06
76. 07 03954 BREAST DIAGNOSTIC CENTER	0	0		5, 382, 335	0.000000	76. 07
76. 97 07697 CARDI AC REHABI LI TATI ON	0	l o			0.000000	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	l c	0	0. 000000	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	l e	l .		0. 000000	89. 00
90. 00 09000 CLI NI C	0	0		-	0. 000000	90.00
90. 01 04950 DI ABETI C CARE CENTER	0	0		_	0. 000000	90. 01
90. 02 04951 HEALTHY HEARTS CENTER	0			_	0. 000000	90. 02
90. 03 09001 CLI NI C					0. 000000	90. 03
90. 04 04953 SPI NE CENTER				ή	0. 000000	90.03
90. 05 04954 NFUSION CENTERS					0. 000000	90.04
	0	0				•
90. 06 09002 MEDCHECK CLINICS	0	0	C		0.000000	90.06
90. 07 09003 KNEE CENTER	0	0	C		0.000000	90. 07
90. 08 09004 PALLI ATI VE CARE	0	0	C		0.000000	90.08
90. 10 09006 WORK SITE CLINICS	0	0		_	0. 000000	90. 10
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0	0	C		0. 000000	90. 12
91. 00 09100 EMERGENCY	0	0	1			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	<u> </u>	8, 858, 846	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS		i				
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0					1
200.00 Total (lines 50 through 199)	0	0	() C	2, 198, 853, 585		200. 00

| Peri od: | Worksheet D | From 01/01/2018 | Part IV | To 12/31/2018 | Date/Time Prepared: | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Par
 Heal th Financial
 Systems
 COMMUNITY
 HEALTH N

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN: 15-0074 THROUGH COSTS

			10	12/31/2018	Date/lime Pre 5/29/2019 3:0	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
·	Ratio of Cost	Program	Program	Program	Program Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.	J	Costs (col. 8	J	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11.00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	411, 882	0	0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	111, 423	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	404, 282	0	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	221, 544	0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	172, 840	o	0	0	55. 00
57. 00 05700 CT SCAN	0. 000000	535, 298	o	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	85, 265	o	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	415, 278	o	0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	2, 121, 848	1	0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	16, 812	d ol	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	505, 778	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	80, 191	l o	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	68, 068		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	24, 605		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	262, 116	1	0	0	69.00
70. 00 07000 ELECTROCARD OLOGT	0. 000000	42, 808	1	0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 053, 317	0	0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	1			0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	544, 419	1	0	0	72.00
	0.000000	2, 124, 462	0	0	0	•
74. 00 07400 RENAL DI ALYSI S 76. 00 03330 ENDOSCOPY	0.000000	135, 750	1	0	0	74.00
	0.000000	27, 520 0	0	0	-	76.00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0.000000	0		Ŭ	0	76. 01
76. 03 03951 LUTHERWOOD PARTNERSHIP	0.000000	0.000	0	0	0	76. 03
76. 04 03952 WOUND CARE CENTER	0.000000	9, 920		0	0	76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	0.000000	192, 268	1	0	0	76. 05
76. 06 03953 I MAGI NG CENTERS	0. 000000	5, 617	1	0	0	76. 06
76. 07 03954 BREAST DIAGNOSTIC CENTER	0. 000000	0		0	0	76. 07
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 000000	139	1	0	0	76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
OUTPATIENT SERVICE COST CENTERS	0.000000		ı ol	0	0	00.00
88. 00 08800 RURAL HEALTH CLINIC	0.000000	0		0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0		0		89.00
90. 00 09000 CLI NI C	0.000000	0		0	0	90.00
90. 01 04950 DI ABETI C CARE CENTER	0.000000	0	1	0	0	90. 01
90. 02 04951 HEALTHY HEARTS CENTER	0.000000	860	1	0	0	90. 02
90. 03 09001 CLI NI C	0. 000000	0		0	0	90. 03
90. 04 04953 SPI NE CENTER	0. 000000	0		0	0	90. 04
90. 05 04954 I NFUSI ON CENTERS	0. 000000	0	1	0	0	90. 05
90. 06 09002 MEDCHECK CLINICS	0. 000000	0	1	0	0	90. 06
90. 07 09003 KNEE CENTER	0. 000000	0	0	0	0	90. 07
90. 08 09004 PALLI ATI VE CARE	0. 000000	0	0	0	0	90. 08
90. 10 09006 WORK SITE CLINICS	0. 000000	0	0	0	0	90. 10
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0. 000000	0	0	0	0	90. 12
91. 00 09100 EMERGENCY	0. 000000	1, 109, 558	1	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	34, 615	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS			1			
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0	0	98. 00
200.00 Total (lines 50 through 199)	1	10, 718, 483	0	0	0	200. 00

APP0R1	TONMENT OF MED	ICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provi der C	CN: 15-0074	Peri od: From 01/01/2018	Worksheet D Part V	
						To 12/31/2018		pared:
							5/29/2019 3:0	9 pm
				Ti tl	e XIX	Hospi tal	PPS	
				200 0 1 1	Charges		Costs	
	Cost Cen	nter Description	Cost to Charge			Cost	PPS Services	
				Services (see		Rei mbursed	(see inst.)	
			Worksheet C, Part I, col. 9	inst.)	Services Subject To	Services Not Subject To		
			rait i, coi. 9		Ded. & Coins			
					(see inst.)	(see inst.)		
			1.00	2. 00	3.00	4.00	5. 00	
	ANCI LLARY SERV	/ICE COST CENTERS			,			
50.00	05000 OPERATI N		0. 148707	0		0 371, 938	0	50.00
51.00	05100 RECOVERY	' ROOM	0. 206328	0)	0 151, 315	0	51.00
52.00		ROOM & LABOR ROOM	0. 559195	0	1	0	0	52. 00
54.00	05400 RADI OLOG		0. 157840	0)	0 706, 010		54. 00
55. 00	05500 RADI OLOG	SY-THERAPEUTI C	0. 129073	0)	0 521, 719	0	55. 00
57. 00	05700 CT SCAN		0. 059031	0)	0 1, 402, 368	0	57. 00
58. 00		RESONANCE IMAGING (MRI)	0. 126651	0)	0 208, 644	0	
59. 00		CATHETERI ZATI ON	0. 050214	0)	0 478, 891	0	
60. 00	06000 LABORATO		0. 107286	0	1	0 1, 787, 494		
64. 00	06400 I NTRAVEN		0. 945626	0	•	0 118		
65. 00	06500 RESPI RAT		0. 251632	0	1	0 60, 630		
66. 00	06600 PHYSI CAL		0. 386855	0	1	0 244, 367	0	
67. 00	06700 OCCUPATI		0. 356587	0	1	0 78, 890		
68. 00	06800 SPEECH P		0. 355740	0		0 41, 835	0	
69.00	06900 ELECTROC		0. 095240	0		0 266, 801	0	69.00
70.00		NCEPHALOGRAPHY	0. 185428	0		0 43, 729		
71. 00 72. 00	1 1	SUPPLIES CHARGED TO PATIENTS	0. 377592	0		0 301, 031 0 537, 204	0	
		EV. CHARGED TO PATIENTS HARGED TO PATIENTS	0. 425546 0. 229722	0	1			1
73. 00 74. 00	07400 RENAL DI		0. 229722	0	1	0 12, 832, 156 0 0	0	i
76.00	03330 ENDOSCOP		0. 416352	0	1	0 32, 872	0	1
76. 00		RIC/PSYCHOLOGICAL SERVICES	1. 067909	0	•	0 5, 717, 411	0	76. 00
76. 03	1 1	OD PARTNERSHIP	7. 126466	0	1	0 488, 323		1
76. 04	03952 WOUND CA		0. 318217	0		0 1, 464, 665		76. 04
76. 05		'-CANCER CARE CENTER	0. 160943	0		0 3, 331, 455		1
76. 06	03953 I MAGI NG		0. 142291	0		0 372, 708		
76. 07		DIAGNOSTIC CENTER	0. 555919	0	,	0 32, 963		1
76. 97		REHABI LI TATI ON	0. 513959	0)	0 0		
76. 98		RIC OXYGEN THERAPY	0. 284456	0		0 0	0	1
	OUTPATIENT SEF	RVICE COST CENTERS						
88. 00	08800 RURAL HE	ALTH CLINIC	0. 000000				0	88. 00
89. 00	08900 FEDERALL	Y QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90. 00	09000 CLI NI C		0. 000000	0)	0	0	
90. 01	04950 DI ABETI C		0. 000000	0	1	0	0	
90. 02	04951 HEALTHY	HEARTS CENTER	0. 672223	0	1	0 30, 829		
90. 03	09001 CLI NI C	W.T.E.D.	0.000000	0	1	0	0	
90. 04	04953 SPI NE CE		0. 079268	Ü		0	0	
90.05	04954 I NFUSI ON		0. 410383	0		0 19, 246		
	09002 MEDCHECK		0.000000	0		0 0	1	
90. 07 90. 08	09003 KNEE CEN		1. 192705 0. 007255	0		0 336 0 5. 114		
90. 06	09004 PALLI ATI 09006 WORK SIT		0. 007255	0		0 5, 114	0	
	1 1	PRACTICE AND MATERNITY CARE	0. 000000	0		0 0	0	
91. 00	09100 EMERGENC		0. 135355	0		0 4, 852, 158	-	
		TION BEDS (NON-DISTINCT PART)	0. 887505	0	1	0 259, 954		
,2.00		SABLE COST CENTERS	3. 007303		1	207, 704	0	/2.00
98. 00		I MBURSABLE COST CENTERS	0. 000000	C		0 0	0	98. 00
200.00	1 1	(see instructions)		0		0 36, 643, 174	0	200. 00
201.00		Clinic Lab. Services-Program				0 0		201. 00
	Only Cha							1
202.00	Net Char	ges (line 200 - line 201)		0	1	0 36, 643, 174	0	202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0074 Peri od: Worksheet D From 01/01/2018 Part V Date/Time Prepared: 12/31/2018 5/29/2019 3:09 pm Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 55, 310 50.00 51.00 05100 RECOVERY ROOM 0 0 0 31, 221 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 52 00 C 05400 RADI OLOGY-DI AGNOSTI C 54.00 111, 437 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 67, 340 55.00 57.00 05700 CT SCAN 00000000000000000000000000 82.783 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 26, 425 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 24, 047 59.00 06000 LABORATORY 60.00 191, 773 60.00 06400 I NTRAVENOUS THERAPY 64 00 64 00 112 65.00 06500 RESPIRATORY THERAPY 15, 256 65.00 06600 PHYSI CAL THERAPY 94, 535 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 28, 131 67.00 68.00 06800 SPEECH PATHOLOGY 14, 882 68 00 69.00 06900 ELECTROCARDI OLOGY 25, 410 69.00 07000 ELECTROENCEPHALOGRAPHY 8, 109 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 113, 667 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 228, 605 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 947, 829 73.00 07400 RENAL DIALYSIS 74.00 74.00 03330 ENDOSCOPY 76.00 5, 592 76.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 6, 105, 675 76.01 76.01 76.03 03951 LUTHERWOOD PARTNERSHIP 3, 480, 017 76.03 03952 WOUND CARE CENTER 76. 04 466, 081 76.04 03480 ONCOLOGY-CANCER CARE CENTER 76.05 536, 174 76.05 03953 I MAGING CENTERS 76.06 53, 033 76.06 03954 BREAST DIAGNOSTIC CENTER 76.07 18, 325 76.07 07697 CARDIAC REHABILITATION 76. 97 Ω 76. 97 07698 HYPERBARIC OXYGEN THERAPY 76. 98 76. 98 0 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0000000000000 89.00 0 90.00 09000 CLI NI C 0 90.00 90.01 04950 DIABETIC CARE CENTER 90.01 90. 02 04951 HEALTHY HEARTS CENTER 20, 724 90.02 90.03 09001 CLI NI C 90.03 C 90.04 04953 SPINE CENTER C 90.04 90.05 04954 INFUSION CENTERS 7,898 90.05 09002 MEDCHECK CLINICS 90.06 90.06 C 09003 KNEE CENTER 90 07 401 90 07 90.08 09004 PALLIATIVE CARE 37 90.08 09006 WORK SITE CLINICS 90. 10 0 90.10 90 12 04961 FAMILY PRACTICE AND MATERNITY CARE 90 12 Ω 91.00 09100 EMERGENCY 656, 764 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 230, 710 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 98 00 09850 OTHER REIMBURSABLE COST CENTERS 98 00 0 0 200.00 Subtotal (see instructions) 15, 648, 303 200.00 201.00 Less PBP Clinic Lab. Services-Program 201. 00

0

15, 648, 303

202.00

202.00

Only Charges

Net Charges (line 200 - line 201)

Health Financial Systems	COMMUNITY HEALTH NET	In Lie	eu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0074	Peri od: From 01/01/2018	Worksheet D-1	
				Date/Time Pre 5/29/2019 3:0	pared: 9 pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1 00	

		Title XVIII	Hospi tal	PPS	7 PIII
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1 00	I NPATI ENT DAYS			70.000	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			70, 923 70, 923	
3.00	Private room days (excluding swing-bed and observation bed day		vate room days,	0	
4. 00	do not complete this line.	ad daya)		/F 022	4. 00
5.00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room		31 of the cost	65, 033 0	1
	reporting period	3 ,			
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	m davs) after December 3	of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 ,		45 740	
9. 00	Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	swing-bed and	15, 743	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruc		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	nly (including private r	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	V only (including private	room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this line	e)	_	
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
17.00	SWING BED ADJUSTMENT	+b	C 41 4	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services reporting period	0. 00	19. 00		
20. 00					
21. 00	Total general inpatient routine service cost (see instructions	s)		94, 671, 603	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7×1 ine 19) Swing-bed cost applicable to NF type services after December :	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		94, 671, 603	
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed)	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi -private room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	aus lino 22)/soo instance	tions)	0.00	
	Average per diem private room charge differential (line 32 mil		LI UIIS)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x line Reivate room cost differential adjustment (line 3 x line 35)	IC 31)		0.00	1
36.00	Private room cost differential adjustment (line 3 x line 35)	and private reem seet di	Eforontial (11 ==	04 471 402	
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	anu private room cost di	rerential (IINe	94, 671, 603	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		,		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				ļ
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 334. 85	
39. 00	Program general inpatient routine service cost (line 9 x line			21, 014, 544	
	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		0 21, 014, 544	
- 1. 00	Trotal Trogiam general Impatrent routine service cost (IIIIe 37	11110 40)		21,014,044	1 -1.00

Heal th	Financial Systems C	OMMUNITY HEALTH I	NETWORK, INC.		In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co		Period: From 01/01/2018	Worksheet D-1	
					Γο 12/31/2018		
			Title	: XVIII	Hospi tal	5/29/2019 3: 09 PPS	9 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost I	npatient Days		÷	(col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	0		_		42. 00
42.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	13, 860, 744	4 047	2, 292. 1	2 274	F 21/ 070	43. 00
43. 00 44. 00	CORONARY CARE UNIT	8, 531, 282	6, 047 5, 645		-		44. 00
45. 00		0,001,202	0,010	.,	2,200	0, 110, 000	45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1. 00	
48. 00	Program inpatient ancillary service cost (Wk			ma)		40, 295, 035	48. 00
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(S	ee instructio	ins)		69, 942, 096	49. 00
50.00	Pass through costs applicable to Program inp	atient routine s	ervices (from	Wkst. D, sum	of Parts I and	3, 365, 785	50.00
51. 00		ationt ancillary	convices (fr	om Wkst D si	ım of Dorto II	2, 382, 233	51. 00
31.00	and IV)	atrent ancirrary	services (II	OIII WKSt. D, St	un or Parts II	2, 302, 233	31.00
52. 00	Total Program excludable cost (sum of lines	,				5, 748, 018	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-phy	sician anesthe	etist, and	64, 194, 078	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	54.00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	, ,	ing cost and tar	get amount (I	ine 56 minus I	ine 53)	o o	57. 00
58. 00	Bonus payment (see instructions)					0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period e	nding 1996, u	pdated and cor	npounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	60.00
61. 00	If line 53/54 is less than the lower of line					0	61. 00
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)							62.00
63. 00	0	63. 00					
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reportir	ng period (See	0	64. 00
/ F 00	instructions)(title XVIII only)		04 6 11		1 1 6		/F 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	r 31 of the c	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVIII	only). For	0	66.00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	o costs through	Docombor 21 o	f the cost ror	porting ported	ol	67. 00
07.00	(line 12 x line 19)	e costs through	becember 31 0	Title Cost Tep	on tring period		07.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost repor	rting period	0	68. 00
69 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (L	ine 67 + line	68)		ol	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N					-	
70.00	Skilled nursing facility/other nursing facil	•					70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ne /U ÷ IIIIe	۷)			71. 00 72. 00
73. 00	Medically necessary private room cost applic	able to Program					73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				art II column		74. 00 75. 00
75.00	26, line 45)	routine service	COSTS (110III W	OI KSHEEL B, FA	art II, Corumii		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li	,					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		ovi der record	s)			79. 00
80.00	Total Program routine service costs for comp		st limitation	(line 78 minu	us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (see instructions)				83. 00
84.00	Program inpatient ancillary services (see in		6)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	J/				
87.00	Total observation bed days (see instructions	•	Line 2)			5, 890 1 224 95	87.00
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	11110 2)			1, 334. 85 7, 862, 267	
	, , , , , , , , , , , , , , , , , , , ,	/					

Health Financial Systems CO	OMMUNITY HEALTH	I NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Period: From 01/01/2018	Worksheet D-1	
				To 12/31/2018		pared: 9 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	10, 635, 221	94, 671, 603	0. 11233	7, 862, 267	883, 231	90.00
91.00 Nursing School cost	0	94, 671, 603	0.00000	7, 862, 267	0	91.00
92.00 Allied health cost	0	94, 671, 603	0.00000	7, 862, 267	0	92.00
93.00 All other Medical Education	0	94, 671, 603	0. 000000	7, 862, 267	0	93. 00

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	u of Form CMS-	2552-10	
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0074	Peri od: From 01/01/2018	Worksheet D-1	
		To 12/31/2018	Date/Time Pre 5/29/2019 3:0	pared: 9 pm
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				

		Title XIX	Hospi tal	PPS	
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, ex	cluding newborn)		70, 923	1.00
2.00	Inpatient days (including private room days, excluding swing-bed a	nd newborn days)		70, 923	2. 00
3.00	Private room days (excluding swing-bed and observation bed days).	If you have only priv	vate room days,	0	3. 00
4 00	do not complete this line.	>		/F 022	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed day		21 of the cost	65, 033 0	4. 00 5. 00
5.00	Total swing-bed SNF type inpatient days (including private room day reporting period	ys) through becember	31 of the cost	U	5.00
6.00	Total swing-bed SNF type inpatient days (including private room day	vs) after December 3	1 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	, , ,			
7.00	Total swing-bed NF type inpatient days (including private room days	s) through December	31 of the cost	0	7. 00
	reporting period) () () ()			
8. 00	Total swing-bed NF type inpatient days (including private room day reporting period (if calendar year, enter 0 on this line)	s) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to the	Program (excluding	swing-bed and	3, 070	9. 00
7. 00	newborn days)	Trogram (exeruating .	Swillig bed did	0,070	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (om days)	0	10.00
	through December 31 of the cost reporting period (see instructions				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (om days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter Swing-bed NF type inpatient days applicable to titles V or XIX only		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	y (Therading private	1 doin days)	O	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only	y (including private	room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year,				
14. 00	Medically necessary private room days applicable to the Program (e.	xcluding swing-bed da	ays)	0	14. 00
15.00	Total nursery days (title V or XIX only)			1, 853	
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		ļ	1, 533	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services th	rough December 31 of	the cost	0.00	17. 00
.,, 00	reporting period	ough boombon or or	1110 0001	0.00	''''
18.00	Medicare rate for swing-bed SNF services applicable to services af	ter December 31 of t	he cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services through	ough December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services aft	er December 31 of th	e cost	0.00	20.00
20.00	reporting period	51 2000m201 01 01 tm		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			101, 155, 047	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31	of the cost reporti	ng period (line	0	22. 00
22.00	5 x line 17)	f the cost monanting	noried (line (0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 o x line 18)	The cost reporting	perrod (Trie 6	U	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31	of the cost reportin	a period (line	0	24. 00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December 31 of	the cost reporting	period (line 8	0	25. 00
27 00	x line 20)			0	24 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line	21 minus lina 26)		0 101, 155, 047	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	21 11111103 11116 20)	l	101, 133, 047	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and	observation bed cha	rges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)		,	0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line	e 28)		0. 000000	1
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
34. 00	Average per diem private room charge differential (line 32 minus l		ons)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x line 31))		0.00	ł
36.00	Private room cost differential adjustment (line 3 x line 35)		6	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and p	rivate room cost dif	rerential (line	101, 155, 047	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMEN	NTS			1
38. 00	Adjusted general inpatient routine service cost per diem (see inst			1, 426. 27	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	,		4, 378, 649	
40. 00	Medically necessary private room cost applicable to the Program (I			0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 + li	ne 40)		4, 378, 649	41.00

Heal th	Financial Systems CO	MMUNITY HEALTH N	IETWORK, INC.		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CO		Peri od: From 01/01/2018	Worksheet D-1	
					To 12/31/2018	Date/Time Prep 5/29/2019 3:09	pared:
				e XIX	Hospi tal	PPS	7 piii
	Cost Center Description	Total Inpatient Costlr	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
		impatrent costin		col . 2)		4)	
42.00	MUDSERV (+i +l o V & VIV only)	1. 00 1, 200, 690	2. 00 1, 853	3. 00 647. 9	4. 00 7 1, 533	5. 00 993, 338	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	1, 200, 690	1, 000	047. 9	1, 555	993, 330	42.00
43.00	INTENSIVE CARE UNIT	14, 880, 881	6, 047	2, 460. 8		0	43. 00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	8, 531, 282	5, 645	1, 511. 3	0 0	0	44. 00 45. 00
46. 00	SURGI CAL I NTENSI VE CARE UNI T						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
						1. 00	
48.00	Program inpatient ancillary service cost (Wks			no)		2, 293, 964	
49.00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	i through 48) (Se	ee mstructro	115)		7, 665, 951	49.00
50.00	Pass through costs applicable to Program inpa	itient routine se	ervices (from	Wkst. D, sum	of Parts I and	580, 427	50. 00
51. 00	<pre> Pass through costs applicable to Program inpa</pre>	itient ancillary	services (fr	om Wkst. D. s	um of Parts II	127, 929	51. 00
	and IV)	,		, .		·	
52. 00 53. 00	Total Program excludable cost (sum of lines 5 Total Program inpatient operating cost exclud		ated non-phy	sician anesth	etist and	708, 356 6, 957, 595	
33. 00	medical education costs (line 49 minus line 5	9 1	Trea, non priy		etrst, and	0, 737, 373	33.00
54 OO	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00							55. 00
56.00	Target amount (line 54 x line 55)			!	11 52)	0	56.00
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and targ	get amount (i	ine 56 minus	11 ne 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost rep	orting period er	ndi ng 1996, u	pdated and co	mpounded by the	0. 00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year of	ost report, upda	ated by the m	arket basket		0. 00	60. 00
61.00	If line 53/54 is less than the lower of lines	55, 59 or 60 er	nter the Less	er of 50% of		0	61. 00
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		(lines 54 x	60), or 1% of	the target		
62. 00	Relief payment (see instructions)	,				0	
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruct	tions)			0	63. 00
64.00	Medicare swing-bed SNF inpatient routine cost	s through Decemb	per 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost</pre>	s after Necember	31 of the c	ost renortina	neriod (See	0	65. 00
	instructions) (title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	e costs (line 64	1 plus line 6	5)(title XVII	I only). For	0	66. 00
67.00	,	costs through [December 31 o	f the cost re	porting period	0	67. 00
68. 00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine</pre>	costs after Dec	rember 31 of	the cost reno	rting period	0	68. 00
00.00	(line 13 x line 20)	costs arter bec	Schiber 31 01	the cost repo	rting perrou		
69. 00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facili	·					70. 00
71. 00 72. 00	Adjusted general inpatient routine service co		ne 70 ÷ line	2)			71.00
73. 00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica		(line 14 x li	ne 35)			72. 00 73. 00
74.00	Total Program general inpatient routine servi	•					74.00
75. 00	Capital-related cost allocated to inpatient r 26, line 45)	outine service o	costs (from W	orksheet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ lin	. *					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess		ovi der record	s)			79. 00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		st limitation	(line 78 min	us line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost per drem frim t						82. 00
83.00	Reasonable inpatient routine service costs (s)				83.00
84. 00 85. 00	Program inpatient ancillary services (see ins Utilization review - physician compensation (s)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thro					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					5, 890	87. 00
88. 00	Adjusted general inpatient routine cost per d	liem (line 27 ÷ l	ine 2)			1, 426. 27	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				8, 400, 730	89.00

Health Financial Systems C	OMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018	Date/Time Prep 5/29/2019 3:00	oared: 9 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	10, 635, 221	101, 155, 047	0. 10513	8, 400, 730	883, 236	90.00
91.00 Nursing School cost	0	101, 155, 047	0.00000	0 8, 400, 730	0	91.00
92.00 Allied health cost	0	101, 155, 047	0.00000	0 8, 400, 730	0	92.00
93.00 All other Medical Education	0	101, 155, 047	0. 00000	8, 400, 730	0	93. 00

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lieu	of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0074	Peri od: From 01/01/2018	Worksheet D-3
		To 12/31/2018	Date/Time Prepared:

THE ATTENT AND LEARLY SERVICE SOST ALTORITORINE.	Trovider ex		From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 3:0	pared:
	Title	XVIII	Hospi tal	PPS	7 PIII
Cost Center Description		Ratio of Cost		Inpati ent	
		To Charges	Program	Program Costs	
		l ro onal goo	Charges	(col. 1 x col.	
			orial ges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			32, 526, 407		30.00
31. 00 03100 INTENSIVE CARE UNIT			10, 485, 700		31.00
32. 00 03200 CORONARY CARE UNIT			6, 353, 888		32. 00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 14668	6 36, 509, 151	5, 355, 381	50.00
51. 00 05100 RECOVERY ROOM		0. 20632	8 2, 154, 944	444, 625	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 55919	5 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 15784	0 3, 980, 263	628, 245	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 12907	3, 299, 895	425, 927	55. 00
57. 00 05700 CT SCAN		0. 05903	1 7, 475, 408	441, 281	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 12665	1, 309, 539	165, 854	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 05021	4 30, 037, 814	1, 508, 319	59. 00
60. 00 06000 LABORATORY		0. 10712	3 26, 247, 584	2, 811, 720	60.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 94562	6 159, 859	151, 167	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 25163	2 8, 266, 434	2, 080, 099	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 38279	6 1, 394, 109	533, 659	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 35658	7 1, 161, 659	414, 232	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 35574	0 365, 070	129, 870	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 09524	0 5, 826, 534	554, 919	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 18542	8 376, 781	69, 866	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 37759	2 17, 803, 385	6, 722, 416	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 42554	6 21, 408, 004	9, 110, 090	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 22959	3 22, 205, 190	5, 098, 156	73. 00
74. 00 07400 RENAL DIALYSIS		0. 41835	2, 405, 904	1, 006, 515	74. 00
76. 00 03330 ENDOSCOPY		0. 17010	5 153, 717	26, 148	76. 00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		1. 05435	8 0	0	76. 01
76. 03 03951 LUTHERWOOD PARTNERSHIP		7. 12646	6 0	0	76. 03
76. 04 03952 WOUND CARE CENTER		0. 31247	9 40, 937	12, 792	76. 04
76. 05 03480 ONCOLOGY-CANCER CARE CENTER		0. 16094	399, 970	64, 372	76. 05
76. 06 03953 I MAGI NG CENTERS		0. 14229	1 5, 709	812	76. 06
76. 07 03954 BREAST DI AGNOSTI C CENTER		0. 55591	9 1, 842	1, 024	76. 07
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 51395			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 28445	6 0	0	76. 98
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0. 00000		0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	89. 00
90. 00 09000 CLI NI C		0. 00000		0	90. 00
90. 01 04950 DI ABETI C CARE CENTER		0.00000		0	90. 01
90. 02 04951 HEALTHY HEARTS CENTER		0. 67222			90. 02
90. 03 09001 CLI NI C		0. 00000		0	90. 03
90. 04 04953 SPI NE CENTER		0. 07926		_	90. 04
90. 05 04954 I NFUSI ON CENTERS		0. 41038		0	90. 05
90. 06 09002 MEDCHECK CLI NI CS		0. 00000		0	90. 06
90. 07 09003 KNEE CENTER		1. 17173		0	90. 07
90. 08 09004 PALLI ATI VE CARE		0.00725		0	90. 08
90. 10 09006 WORK SITE CLINICS		0. 00000		0	90. 10
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE		0.00000		0	90. 12
91. 00 09100 EMERGENCY		0. 13402			91.00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 88750	5 486, 093	431, 410	92. 00
OTHER REI MBURSABLE COST CENTERS			ol -	=	00.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0. 00000		0	98. 00
Total (sum of lines 50 through 94 and 96 through 98)	(1)		209, 144, 007	40, 295, 035	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(IIne 61)		200 144 007		201.00
202.00 Net charges (line 200 minus line 201)		I	209, 144, 007	I	202. 00

Health Financial Systems	COMMUNITY HEALTH NET	TWORK, INC.	In L	ieu of Form CMS-2552-10
INDATIENT ANGLE ADVICEDURGE COCT ADDODTI ONMENT		D CON 15 0074	D!I	W

Heal th F	Financial Systems COMMUNITY HEALTH NE	TWORK, INC.		In Lie	eu of Form CMS-2	2552-10
I NPATI EN	NT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-0074	Peri od:	Worksheet D-3	
				From 01/01/2018		
				To 12/31/2018		
					5/29/2019 3:0	9 pm
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
	sect senter recent per en		To Charges	Program	Program Costs	
			10 charges			
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
I	NPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS			7, 051, 621		30.00
1	03100 INTENSIVE CARE UNIT					31.00
				460, 910		1
1	03200 CORONARY CARE UNIT			582, 551		32. 00
43.00 0	04300 NURSERY			181, 721		43. 00
Α	NCILLARY SERVICE COST CENTERS					
50.00 0	05000 OPERATING ROOM		0. 14870	7 411, 882	61, 250	50.00
1	05100 RECOVERY ROOM		0. 20632		l	1
	l e e e e e e e e e e e e e e e e e e e		1		•	1
	05200 DELIVERY ROOM & LABOR ROOM		0. 55919		•	1
54.00 0	05400 RADI OLOGY-DI AGNOSTI C		0. 15784	0 221, 544	34, 969	54. 00
55. 00 0	05500 RADI OLOGY-THERAPEUTI C		0. 12907	[3] 172, 840	22, 309	55. 00
57.00 0	05700 CT SCAN		0.05903	1 535, 298	31, 599	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 12665		•	1
					•	1
	05900 CARDI AC CATHETERI ZATI ON		0. 05021		•	1
60.00 0	06000 LABORATORY		0. 10728	6 2, 121, 848	227, 645	60.00
64.00 0	06400 INTRAVENOUS THERAPY		0. 94562	16, 812	15, 898	64. 00
65.00 0	06500 RESPI RATORY THERAPY		0. 25163	2 505, 778	127, 270	65. 00
1					•	1
	06600 PHYSI CAL THERAPY		0. 38685			1
	06700 OCCUPATI ONAL THERAPY		0. 35658	68, 068	24, 272	67. 00
68. 00 0	06800 SPEECH PATHOLOGY		0. 35574	0 24, 605	8, 753	68. 00
69.00 0	06900 ELECTROCARDI OLOGY		0. 09524	0 262, 116	24, 964	69. 00
1	07000 ELECTROENCEPHALOGRAPHY		0. 18542			1
					1	1
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 37759			1
72. 00 0	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 42554	6 544, 419	231, 675	72. 00
73.00 0	07300 DRUGS CHARGED TO PATIENTS		0. 22972	2, 124, 462	488, 036	73. 00
1	07400 RENAL DIALYSIS		0. 41835		1	74. 00
	3330 ENDOSCOPY		1		1	1
1			0. 17010		1	1
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		1. 06790		0	
76. 03 0	03951 LUTHERWOOD PARTNERSHIP		7. 12646	6 0	0	76. 03
76. 04 0	03952 WOUND CARE CENTER		0. 31821	7 9, 920	3, 157	76. 04
76. 05 0	03480 ONCOLOGY-CANCER CARE CENTER		0. 16094	3 192, 268	30, 944	76. 05
	03953 I MAGI NG CENTERS		0. 14229		•	1
1	l e e e e e e e e e e e e e e e e e e e		1		l	1
1	3954 BREAST DI AGNOSTI C CENTER		0. 55591			76. 07
76. 97 0	07697 CARDI AC REHABI LI TATI ON		0. 51395	9 139	71	76. 97
76. 98 0	07698 HYPERBARIC OXYGEN THERAPY		0. 28445	6 0	0	76. 98
0	UTPATIENT SERVICE COST CENTERS					
88. 00 0	08800 RURAL HEALTH CLINIC		0.00000	0 0	0	88. 00
1	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		1	
						1
	99000 CLINIC		0.00000			
	04950 DIABETIC CARE CENTER		0.00000	0 0	0	90. 01
	04951 HEALTHY HEARTS CENTER		0. 67222	3 860	578	90. 02
	99001 CLI NI C		0.00000		1	90. 03
1	04953 SPI NE CENTER		0. 07926			
	14954 INFUSION CENTERS		0. 41038		-	
	19002 MEDCHECK CLINICS		0. 00000		1	
90. 07 0	99003 KNEE CENTER		1. 19270	5 0	0	90. 07
	99004 PALLIATIVE CARE		0.00725		0	90. 08
	19006 WORK SITE CLINICS		0. 00000		-	1
]	
	14961 FAMILY PRACTICE AND MATERNITY CARE		0.00000		1	90. 12
91.00 0	9100 EMERGENCY		0. 13535	5 1, 109, 558	150, 184	91.00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 88750	34, 615	30, 721	92.00
	THER REIMBURSABLE COST CENTERS					1
	19850 OTHER REIMBURSABLE COST CENTERS		0.00000	in n	0	98. 00
] 0.00000	10, 718, 483	1	
200.00	Total (sum of lines 50 through 94 and 96 through 98)	(1)		10, /18, 483	2, 293, 964	1
201.00	Less PBP Clinic Laboratory Services-Program only charges	(IIne 61)		0	1	201. 00
202.00	Net charges (line 200 minus line 201)			10, 718, 483		202. 00
·						

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0074		Worksheet E Part A Date/Time Prepared: 5/29/2019 3:09 pm

NAME A - IMPAILENT HOSPITAL SERVICES UNDER IPPS 1.00			T: +1 o V/////	Hooni tol	5/29/2019 3:0	9 pm
ART A - INPATIBIT MOSPITAL SERVICES UNDER IPPS 0.0 1.00 1			Title XVIII	Hospi tal	PPS	
1.00 DRG Amounts other than outlier payments for discharges occurring prior to October 1 (see 37,181,322 1.01					1. 00	
1.00 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 37,518,321 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 1.594,322 1.02 1.03 DRG amounts other than outlier payment for Model 4 BPCI for discharges occurring prior to October 1 (see 1.594,322 1.02 1.03 DRG for frederal spacelfic operating payment for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for federal spacelfic operating payment for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for federal spacelfic operating payment for discharges occurring on or after 0 1.04 DRG for federal spacelfic operating payment for discharges occurring on or after 0 1.04 DRG for federal spacelfic operating payment for discharges occurring on or after 0 1.04 DRG for federal spacelfic operating payment for discharges occurring on or after 0 1.04 DRG for federal spacelfic operating payment for discharges occurring on or after 0 1.04 DRG for federal spacelfic operating payment for discharges occurring on or after 0 1.04 DRG for federal spacelfic operating payment for discharges occurring on or after 0 1.04 DRG for federal spacelfic operating payment for discharges occurring on or after 0 1.04 DRG for federal spacelfic operating payment for discharges occurring on or after 0 1.04 DRG for federal spacelfic operating payment for discharges occurring on or after 0 1.04 DRG for federal spacelfic operating payment for discharges occurring on or after 0 1.04 DRG for federal spacelfic operating payment for discharges occurring on or after 0 1.04 DRG for federal spacelfic operating payment for discharges occurring on or after 0 1.04 DRG for federal spacelfic operating payment for discharges occurring on or after 0 1.04 DRG for federal spacelfic operating payment for discharges occurring on or after 0 1.04 DRG for federal spacelfic operating payment of 0 1.04 DRG for feder	1 00				0	1 00
1.03 DRG assounts other than outlife payments for discharges occurring on or after October 1,594,399 1,09		DRG amounts other than outlier payments for discharges occurring	-			
1.03 100 1.03 100 1.03 100 1.03 100 1.03 100 1.03 100 1.03 100 1.03 100 1.03 100 1.03 100 1.03 100 1.03 100 1.03	1. 02	DRG amounts other than outlier payments for discharges occurring	ng on or after October	(see	12, 594, 329	1. 02
1.04 Oktober 1 (see instructions) 0.1 0.4	1. 03	DRG for federal specific operating payment for Model 4 BPCI for	r discharges occurring p	orior to October	0	1. 03
2.01 Outlier reconcilitation amount 0 2.01	1. 04	DRG for federal specific operating payment for Model 4 BPCI for	r discharges occurring o	on or after	0	1. 04
Managed Care Simulated Payments 21,218,289 3.00						
Red days available divided by number of days in the cost reporting period (see instructions) 287.43 4.00		Outlier payment for discharges for Model 4 BPCI (see instruction	ons)		0	2. 02
Indirect Medical Education Adjustment 5.00 FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996, (see Instructions) 6.00 FTE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00 MA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) 2.69 7.00 7.01 7		· · · · · · · · · · · · · · · · · · ·				
or before 12/31/1996, (see instructions) or before 12/31/1996 (see instructions) 10 MA Section 422 reduction amount to the lME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) 10 MA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost cost report straddles July 1, 2011 then see instructions) 10 May United the Cost of the Section 422 reference of the Sectio		Indirect Medical Education Adjustment				
new programs in accordance with 42 CFR 413.79(e) 2.69 7.00 MACA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the composition of the Composition of		or before 12/31/1996. (see instructions)		J.		
ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(1)(8)(2) if the cost report straddles July 1, 2011 then see instructions. Adjustment (Increase or decrease) to the FTE count for all lopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). But a mount of linercase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. But a mount of linercase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) But a mount of linercase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) But a mount of linercase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) But a mount of linerase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) But a mount of linerase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) But a mount of linerase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) But a mount of linerase from the long from the program of lines (see instructions) But a mount of line But a mount of lines (see instructions) But a mount of lines (see instructions) But a mount of line But a mount of lines (see instructions) But a mount of lines (see instructions) But a mount of lines (see instructions) But a mount of lines (see instructions) But a mount of lines (see instructions) But a mount of lines (see instructions) But a mount of lines (see instructions) But a mount of lines (see instructions) But a mount of lines (see instructions) But a mount of lines (see instructions) But a mount of lines		new programs in accordance with 42 CFR 413.79(e)				
Agl Justment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413. 75(b), 413. 79(c)(2) (iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). B. 01		ACA \S 5503 reduction amount to the IME cap as specified under				
8. 01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradies July 1, 2011, see instructions. 0.00 8. 02	8. 00	Adjustment (increase or decrease) to the FTE count for allopatlaffiliated programs in accordance with 42 CFR 413.75(b), 413.75			-9. 34	8. 00
8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	8. 01	The amount of increase if the hospital was awarded FTE cap slo	ts under § 5503 of the A	ACA. If the cost	10. 40	8. 01
Instructions	8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital				8. 02
11.00 FTE count for residents in dental and podiatric programs. 2 77 11.00 12.00 Current year allowable FTE (see instructions) 26.15 12.00 13.00 Total allowable FTE count for the prior year. 26.77 13.00 14.00 Total allowable FTE count for the penult mate year if that year ended on or after September 30, 1997, 31.00 15.00 Sum of lines 12 through 14 divided by 3. 27.97 15.00 16.00 Adjustment for residents in initial years of the program 0.00 10.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Current year resident to bed ratio (line 18 divided by line 4). 0.097311 19.00 19.00 Current year resident to bed ratio (see instructions) 0.092697 20.00 19.00 Prior year resident to bed ratio (see instructions) 0.092697 20.00 19.00 IME payment adjustment (see instructions) 0.092697 20.00 10.00 IME payment adjustment - Managed Care (see instructions) 0.092697 20.00 10.01 Indirect Medical Education Adjustment for the Add-on for \$ 422 of the MMA 10.01 Indirect Medical Education Adjustment for the Add-on for \$ 422 of the MMA 10.00 IME FTE Resident Count Over Cap (see instructions) 17.01 24.00 10.00 IME FTE Resident Count Over Cap (see instructions) 17.01 24.00 10.00 IME FTE count on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.000000 26.00 10.00 IME add-on adjustment amount (see instructions) 0.000000 27.00 10.00 IME gard-on adjustment factor. (see instructions) 0.000000 27.00 10.00 IME add-on adjustment amount (see instructions) 0.000000 27.00 10.00 IME add-on adjustment amount (see instructions) 0.000000 27.00 10.00 IME add-on adjustment amount (see inst	9. 00		s (8, 8,01 and 8,02) (s	see	23. 38	9. 00
13.00 Total allowable FTE count for the prior year. 13.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 31.00 14.0	11. 00	FTE count for residents in dental and podiatric programs.	nt year from your record	ds	2. 77	11. 00
14.00		· · · · · · · · · · · · · · · · · · ·				
15.00 Sum of lines 12 through 14 divided by 3. 27.97 15.00 16.00 Adjustment for residents in initial years of the program 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for line 3 divided by line 4). 0.09731 19.00		Total allowable FTE count for the penultimate year if that year	r ended on or after Sep	cember 30, 1997,		
17.00	15. 00				27. 97	15. 00
18.00 Adjusted rolling average FTE count 27.97 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.097311 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.092697 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.092697 21.00 22.00 IME payment adjustment (see instructions) 2,473,009 22.00 1 IME payment adjustment - Managed Care (see instructions) 1,047,101 22.01 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 1,047,101 22.01 24.00 IME FTE Resident Count Over Cap (see instructions) 17.01 24.00 25.00 IME FTE Resident Count Over Cap (see instructions) 17.01 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27.00 28.01 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.2000 28.01 29.00 Total I						
19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.097311 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.092697 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.092697 21.00 22.00 IME payment adjustment (see instructions) 2,473,009 22.00 1 IME payment adjustment - Managed Care (see instructions) 1,047,101 22.01 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.00 23.00 23.00 (f)(1)(iv)(C). 0.00 23.00 24.00 IME FTE Resident Count Over Cap (see instructions) 17.01 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 17.01 24.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 25.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.000000 27.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.00 29.01 Total IME payment - Managed Care (sum		, , , ,	ure			
20.00 Prior year resident to bed ratio (see instructions) 0.092697 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.092697 21.00 22.00 IME payment adjustment (see instructions) 1,047,101 22.01 IME payment adjustment — Managed Care (see instructions) 1,047,101 22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(v)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 17.01 24.00 25.00 Ime amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME add-on adjustment amount (see instructions) 0.28.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 29.00 Total IME payment (sum of lines 22 and 28) 2,473,009 29.00		,				
21.00 Enter the lesser of lines 19 or 20 (see instructions) 22.00 IME payment adjustment (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment amount (see instructions) 29.01 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (see instructions) 20.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 41.00 Allowable disproportionate share percentage (see instructions) 30.00 Allowable disproportionate share percentage (see instructions) 31.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions)			•			
22.00 IME payment adjustment (see instructions) 22.473,009 22.00 IME payment adjustment - Managed Care (see instructions) 1,047,101 22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 17.01 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount (see instructions) 0.28.00 Total IME payment (sum of lines 22 and 28) 2.473,009 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 10 isproportionate Share Adjustment 30.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 10 isproportionate Share Adjustment 30.00 Sum of lines 30 and 31 49.40 32.00 Sum of lines 30 and 31 49.40 32.00 Sum of lines 30 and 31 49.40 32.00 Allowable disproportionate share percentage (see instructions) 29.97 33.00		· · · · · · · · · · · · · · · · · · ·				
22. 01 IME payment adjustment - Managed Care (see instructions) 1, 047, 101 22. 01 1ndi rect Medical Education Adjustment for the Add-on for § 422 of the MMA 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105 0. 00 23. 00 (f)(1)(iv)(C). 24. 00 IME FTE Resident Count Over Cap (see instructions) 17. 01 24. 00 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0. 00 25. 00 instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 0. 000000 26. 00 27. 00 IME payments adjustment factor. (see instructions) 0. 000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0. 28. 00 29. 00 1ME payment (sum of lines 22 and 28) 2, 473, 009 29. 00 1041 IME payment - Managed Care (sum of lines 22. 01 and 28. 01) 1. 047, 101 29. 01 1. 047, 101						
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 23.00 (f) (1) (iv) (C) 24.00 IME FTE Resident Count Over Cap (see instructions) 17.01 24.00 18.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 18.00 IME payments adjustment amount (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment amount - Managed Care (see instructions) 10.00 28.00 29.01 Total IME payment (sum of lines 22 and 28) 20.02 IT Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 20.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 49.40 32.00 33.00 Allowable disproportionate share percentage (see instructions) 29.97 33.00						
(f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 17.01 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions) 24.00 25.00 25.00 0.00 26.00 0.000000 27.00 26.00 27.00 0.000000 27.00 28.00 0.000000 27.00 29.00 0.000000 27.00 29.00 0.000000 27.00 29.00 0.000000 27.00 29.00 0.000000 0.000000 27.00 20.00 0.000000 0.000000 27.00 20.00 0.000000 0.000000 27.00 20.00 0.000000 0.000000 0.000000 27.00 20.00 0.000000 0.000000 0.000000 0.000000	22.00			-D 412 10F	0.00	22.00
25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0. 00 instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 18. 00 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29. 01 Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30. 00 Sum of lines 30 and 31 31. 00 Allowable disproportionate share percentage (see instructions) 29. 01 Allowable disproportionate share percentage (see instructions) 29. 02 Double Care (sum of lines 22.01 and 28.01) 29. 01 Disproportionate Share Adjustment 29. 01 Disproportionate Share Adjustment 29. 01 Disproportionate Share Adjustment 29. 01 Disproportionate Share Adjustment days to Medicare Part A patient days (see instructions) 20. 00 Sum of lines 30 and 31 20. 01 Disproportionate Share percentage (see instructions)		(f)(1)(iv)(C).	nt cap slots under 42 G	-R 412. 105		
26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 2, 473, 009 29. 00 29. 01 Disproportionate Share Adjustment 29. 01 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 10. 87 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 38. 53 31. 00 32. 00 Sum of lines 30 and 31 49. 40 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 29. 97 33. 00		If the amount on line 24 is greater than -O-, then enter the Lo	ower of line 23 or line	24 (see		
27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 2, 473, 009 29. 00 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 1, 047, 101 29. 01 Disproportionate Share Adjustment 9ercentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 10. 87 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 38. 53 31. 00 32. 00 Sum of lines 30 and 31 49. 40 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 29. 97 33. 00	26 00				0.000000	26 00
28. 00 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30. 00 Percentage of Medicaid patient days (see instructions) 30. 00 Sum of lines 30 and 31 30. 00 Allowable disproportionate share percentage (see instructions) 30. 00 Allowable disproportionate share percentage (see instructions) 30. 00 Allowable disproportionate share percentage (see instructions) 30. 00 Allowable disproportionate share percentage (see instructions) 30. 00 Allowable disproportionate share percentage (see instructions)						
28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 2, 473, 009 29. 00 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 1, 047, 101 29. 01 Disproportionate Share Adjustment 9 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 10. 87 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 38. 53 31. 00 32. 00 Sum of lines 30 and 31 49. 40 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 29. 97 33. 00		· · · · · · · · · · · · · · · · · · ·			_	
29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 29.00 29.00 29.01 29.00 29.01 29		· · · · · · · · · · · · · · · · · · ·			-	
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 1, 047, 101 1, 047, 101 29. 01 30. 00 31. 00 32. 00 32. 00 33. 00 34. lowable disproportionate share percentage (see instructions) 29. 01					-	
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 10.87 30.00 38.53 31.00 49.40 32.00 29.97 33.00		Total IME payment - Managed Care (sum of lines 22.01 and 28.01))			
31.00Percentage of Medicaid patient days (see instructions)38.5331.0032.00Sum of lines 30 and 3149.4032.0033.00Allowable disproportionate share percentage (see instructions)29.9733.00	30.00	Percentage of SSI recipient patient days to Medicare Part A pa	tient days (see instruct	i ons)	10. 87	30.00
32.00 Sum of Lines 30 and 31 49.40 32.00 33.00 Allowable disproportionate share percentage (see instructions) 29.97 33.00				•		
		Sum of lines 30 and 31			49. 40	32. 00
34.00 Disproportionate share adjustment (see instructions) 3,754,690 34.00						
	34. 00	Disproportionate share adjustment (see instructions)		l	3, 754, 690	34. 00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0074	Peri od: From 01/01/2018	Worksheet E Part A	
			To 12/31/2018	Date/Time Prep 5/29/2019 3:09	pared:
		Title XVIII	Hospi tal	PPS	, p
			Prior to 10/1		
	Uncompensated Care Adjustment		1. 00	2. 00	
35. 00	Total uncompensated care amount (see instructions)		6, 766, 695, 164	8, 272, 872, 447	35. 00
35. 01	Factor 3 (see instructions)		0. 000641030	0. 000683862	
35. 02	Hospital uncompensated care payment (If line 34 is zero, enter instructions)	r zero on this line) (se	e 4, 337, 653	5, 657, 507	35. 02
35. 03	Pro rata share of the hospital uncompensated care payment amou	unt (see instructions)	3, 244, 326	1, 426, 003	35. 03
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.03	3)	4, 670, 329	.,,	36. 00
	Additional payment for high percentage of ESRD beneficiary dis				
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding (discharges for MS-DRGs	0		40. 00
41. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	83. 684 an 685. (see	0		41.00
	instructions)	, (
41. 01	Total ESRD Medicare covered and paid discharges excluding MS-	DRGs 652, 682, 683, 684	0		41. 01
42. 00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qualit	fy for adjustment)	0.00		42. 00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682				43. 00
	instructions)	•			
44. 00	Ratio of average length of stay to one week (line 43 divided below)	by line 41 divided by 7	0. 000000		44. 00
45. 00	days) Average weekly cost for dialysis treatments (see instructions))	0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 41.		0		46. 00
47. 00	Subtotal (see instructions) 65, 384, 184				47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, sr only. (see instructions)	mall rural hospitals	0		48. 00
	John y. (See This tructions)			Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instructions)			66, 431, 285	
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt.			4, 757, 576 0	50. 00 51. 00
52. 00	Direct graduate medical education payment (from Wkst. E-4, lin			383, 257	52.00
53. 00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	9)		0	54. 01 55. 00
56. 00	Cost of physicians' services in a teaching hospital (see intru	•		0	56.00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. II		hrough 35).	0	57.00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 11 line 200)		0	58.00
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			71, 572, 118 24, 906	
61. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		71, 547, 212	
62. 00	Deductibles billed to program beneficiaries			4, 253, 636	62. 00
63. 00	Coinsurance billed to program beneficiaries			155, 775	1
64.00				478, 751	1
65. 00 66. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		311, 188 367, 688	•
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	ructions)		67, 448, 989	67.00
68. 00	Credits received from manufacturers for replaced devices for a	applicable to MS-DRGs (s	ee instructions)	07, 440, 707	68. 00
	Outlier payments reconciliation (sum of lines 93, 95 and 96).		′	0	69.00
69. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	_	•	0	70.00
69. 00 70. 00	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) adjustment (see	instructions)	0	70. 50
70. 00 70. 50				0	70.87
70. 00 70. 50 70. 87	Demonstration payment adjustment amount before sequestration			0	70.88
70. 00 70. 50 70. 87 70. 88	SCH or MDH volume decrease adjustment (contractor use only)				70.89
70. 00 70. 50 70. 87 70. 88 70. 89	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see insti	ructions)		^	
70. 00 70. 50 70. 87 70. 88 70. 89 70. 90	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instr HSP bonus payment HVBP adjustment amount (see instructions)	ructions)		0	70. 90
70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	ructions)		0	70. 90 70. 91
70. 00 70. 50 70. 87 70. 88 70. 89 70. 90	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	ructions)			70. 90 70. 91 70. 92
70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92 70. 93	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	ructions)		0	70. 90 70. 91 70. 92 70. 93

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC		In lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		 CCN: 15-0074	Peri od: From 01/01/2018	Worksheet E	pared:
	Ti t	e XVIII	Hospi tal	PPS	
		FFY	· (yyyy)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal ye			0	0	70. 96

		Title	XVIII	Hospi tal	PPS	
			FFY ((уууу)	Amount	
			(0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70. 97
	the corresponding federal year for the period ending on or afte	^ 10/1)				
70. 98	Low Volume Payment-3				0	70. 98
70. 99	HAC adjustment amount (see instructions)				169, 221	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69	& 70)			67, 081, 389	71. 00
71. 01	Seguestration adjustment (see instructions)	ĺ			1, 341, 628	71. 01
71. 02	Demonstration payment adjustment amount after sequestration				0	
72. 00	Interim payments				66, 266, 225	
73. 00	Tentative settlement (for contractor use only)				0	73.00
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02,	72 and			-526, 464	•
7 1. 00	73)	, z, and			020, 101	' ' ' ' ' '
75. 00	Protested amounts (nonallowable cost report items) in accordance	∍ with			1, 964, 419	75. 00
73.00	CMS Pub. 15-2, chapter 1, §115.2	, wi tii			1, 704, 417	73.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	2 03			0	90.00
70. 00	plus 2.04 (see instructions)	2.03			0	70.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91. 00
92. 00	Operating outlier reconciliation adjustment amount (see instruc	tions)			0	92.00
93. 00	Capital outlier reconciliation adjustment amount (see instruction)	· / I			0	
	'	· · · · · · · · · · · · · · · · · · ·			_	
94.00	The rate used to calculate the time value of money (see instruc	tions)			0.00	
95. 00	Time value of money for operating expenses (see instructions)	,			0	
96. 00	Time value of money for capital related expenses (see instruction	ons)		5	0	96. 00
				Prior to 10/1		
				1. 00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0. 0000000000	0.0000000000	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	0	102. 00
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0. 0000	0.0000	103. 00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	0	104. 00
	Rural Community Hospital Demonstration Project (§410A Demonstra	tion) Adjus	stment			
200.00	Is this the first year of the current 5-year demonstration period	od under t	he 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					
	Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	19)				201. 00
202.00	Medicare discharges (see instructions)					202. 00
203.00	Case-mix adjustment factor (see instructions)					203. 00
	Computation of Demonstration Target Amount Limitation (N/A in fi	rst year o	of the current	5-year demonst	ration	
	peri od)	•		•		
204.00	Medicare target amount					204. 00
	Case-mix adjusted target amount (line 203 times line 204)					205. 00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instru	ctions)				207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I					208. 00
	Adjustment to Medicare IPPS payments (see instructions)	0,,				209. 00
	Reserved for future use					210. 00
	Total adjustment to Medicare IPPS payments (see instructions)					211. 00
Z 1 1. UU	Comparision of PPS versus Cost Reimbursement					<u> </u>
212 00	Total adjustment to Medicare Part A IPPS payments (from line 21	1)				212. 00
	Low-volume adjustment (see instructions)	1)				212.00
	Net Medicare Part A IPPS adjustment (difference between PPS and	cost roim	hurcomon+1			218. 00
∠10.UL	(line 212 minus line 213) (see instructions)	COST LEIIII	bui Scilicitt)			2 10.00
	(TITIC 212 IIII IIIG 3 ITTIC 213) (See TITS (LUCTIONS)			1	I	I

Health Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0074		Worksheet E Part B Date/Time Prepared: 5/29/2019 3:09 pm

			10 12/31/2018	5/29/2019 3:0	
		Title XVIII	Hospi tal	PPS	7 piii
			•		
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			70 500	1 1 0
1	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	tions)		79, 598 95, 510, 411	
1	OPPS payments	11 0113)		80, 196, 132	
	Outlier payment (see instructions)			1, 322, 033	
	Outlier reconciliation amount (see instructions)			0	1
5. 00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5.0
4	Line 2 times line 5			0	
	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	1
	Transitional corridor payment (see instructions)	V and 12 lime 200		0	
	Ancillary service other pass through costs from Wkst. D, Pt. I Organ acquisitions	v, coi. 13, line 200		0	
	Total cost (sum of lines 1 and 10) (see instructions)			79, 598	
- +	COMPUTATION OF LESSER OF COST OR CHARGES			17,070	1 0
	Reasonable charges				1
2.00	Ancillary service charges			346, 504	12. 0
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	
	Total reasonable charges (sum of lines 12 and 13)			346, 504	14.0
	Customary charges	normant for convices on	a charge backs	0] 15. 0
	Aggregate amount actually collected from patients liable for μ Amounts that would have been realized from patients liable for				
	had such payment been made in accordance with 42 CFR §413.13(e		i a chargebasi s		10.0
1	Ratio of line 15 to line 16 (not to exceed 1.000000)	-,		0.000000	17.0
	Total customary charges (see instructions)			346, 504	18.0
	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	266, 906	19.0
	instructions)	: € : 11	10) (20.0
	Excess of reasonable cost over customary charges (complete onlinstructions)	y IT Time II exceeds II	ne 18) (See	0	20.0
	Lesser of cost or charges (see instructions)			79, 598	21.0
1	Interns and residents (see instructions)		ļ	0	
23. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)	ļ	0	23.0
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			81, 518, 165	24.0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1 25 6
	Deductibles and coinsurance amounts (for CAH, see instructions Deductibles and Coinsurance amounts relating to amount on line	•	uctions)	0 13, 919, 074	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			67, 678, 689	1
	instructions)		, (.,,	
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)	ļ	523, 869	28.0
1	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. (
1	Subtotal (sum of lines 27 through 29)			68, 202, 558	
	Primary payer payments Subtotal (line 30 minus line 31)			21, 130 68, 181, 428	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	`FS)		00, 101, 420	32.0
	Composite rate ESRD (from Wkst. I-5, line 11)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0	33. 0
1	Allowable bad debts (see instructions)			887, 844	34.0
35. 00	Adjusted reimbursable bad debts (see instructions)			577, 099	
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		825, 806	
	Subtotal (see instructions)			68, 758, 527	
	MSP-LCC reconciliation amount from PS&R			177	1
1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	=)		U	39.0
1	Demonstration payment adjustment amount before sequestration	3)		o	1
1	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	27, 846	1
	RECOVERY OF ACCELERATED DEPRECIATION	(0	
10.00	Subtotal (see instructions)		ļ	68, 758, 350	40. (
	Sequestration adjustment (see instructions)			1, 375, 167	
	Demonstration payment adjustment amount after sequestration			0	
4	Interim payments Tentative settlement (for contractors use only)			67, 830, 366	
- 1	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			-447, 183	1
1	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2.	chapter 1.	333, 258	
	§115. 2		- p] ' '' '
	TO BE COMPLETED BY CONTRACTOR				
20 00	Original outlier amount (see instructions)			0	
1	Outlier reconciliation adjustment amount (see instructions)		ļ	0	
91. 00			1		
91. 00 92. 00	Time Value of Money (see instructions)		1	0.00	1

Health Financial Systems COMMUNIANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2018 Part I
To 12/31/2018 Date/Ti me Prepared: 5/29/2019 3:09 pm Provider CCN: 15-0074

					5/29/2019 3: 09	9 pm
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A		⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		66, 266, 22		67, 830, 366	1. 00
2.00	Interim payments payable on individual bills, either		(0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider				•	
3. 01	ADJUSTMENTS TO PROVIDER		(0	3. 01
3.02			(D	0	3. 02
3.03			(0	3. 03
3.04					0	3. 04
3.05			(0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM				0	3. 50
3.51				D	0	3. 51
3. 52					0 0	3. 52
3. 53 3. 54						3. 53 3. 54
3. 54	Subtotal (sum of lines 3.01-3.49 minus sum of lines					3. 54
3. 77	3. 50-3. 98)		,			3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		66, 266, 22	5	67, 830, 366	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
E 01	Program to Provider TENTATIVE TO PROVIDER				1 0	5. 01
5. 01 5. 02	TENTATIVE TO PROVIDER					5. 01
5. 02						5. 02
3.03	Provider to Program		<u> </u>	21		3. 03
5. 50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51			(0	5. 51
5. 52			(0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)				_	
6. 01	SETTLEMENT TO PROVIDER		50/ 4/	1	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		526, 46		447, 183	6. 02
7. 00	Total Medicare program liability (see instructions)		65, 739, 76		67, 383, 183	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor				2.00	8. 00
				1		

Heal th	Financial Systems COMMUNITY HEALTH N	ETWORK, INC.	In Lie	u of Form CMS-	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0074	Peri od: From 01/01/2018	Worksheet E-1 Part II		
			To 12/31/2018			
		Title XVIII	Hospi tal	PPS	, p	
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	2 14		1.00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2. 00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	ertified HIT technology	Wkst. S-2, Pt. I		7. 00	
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9. 00	Sequestration adjustment amount (see instructions)				9. 00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00	
10.00	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH	(333 . 11311 4011 0113)			1 .0.00	
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
	Other Adjustment (specify)				31.00	
	30 Other Augustinent (Specify)					

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

30. 00 31. 00 32. 00

RECT (Financial Systems COMMUNITY HEALTH N GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider Co	CN: 15-0074	Peri od:	u of Form CMS-2 Worksheet E-4	
EDI CAL	EDUCATI ON COSTS			From 01/01/2018 To 12/31/2018		
		Title	: XVIII	Hospi tal	5/29/2019 3: 0 ^o	9 pm
		11 (10	,,,,,,	noop: tui		
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1. 00	
00 [Unweighted resident FTE count for allopathic and osteopathic	programs for	cost reporti	ng peri ods	26. 92	1.
	ending on or before December 31, 1996. Jnweighted FTE resident cap add-on for new programs per 42 CF	R 413.79(e)(1) (see instr	ructions)	0. 00	2.
01 [Amount of reduction to Direct GME cap under section 422 of MM Direct GME cap reduction amount under ACA §5503 in accordance		§413.79 (m).	(see	2. 82 0. 00	1
00	nstructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	-9. 34	4.
01 /	ACA Section 5503 increase to the Direct GME FTE Cap (see instacted ling 7/1/2011)		cost reporti	ng periods	9. 32	4.
02	ACA Section 5506 number of additional direct GME FTE cap slot beriods straddling 7/1/2011)	s (see inst	ructions for	cost reporting	0.00	4.
00 F	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	24. 08	5.
00 ι	Jnweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	40. 39	6.
00 E	Enter the lesser of line 5 or line 6		D=: 0	0+1	24. 08	7.
			Primary Care	0ther 2.00	Total 3.00	
	Weighted FTE count for physicians in an allopathic and osteop	athi c	33. 1		40. 39	8
00 i	orogram 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		19. 7	4. 33	24. 08	9
				2.77		10
	Weighted dental and podiatric resident FTE count for the curr Jnweighted dental and podiatric resident FTE count for the cu	,		2. 77 2. 77		10
.00 1	Total weighted FTE count	,	19. 7			11
	Total weighted resident FTE count for the prior cost reportin nstructions)	g year (see	21. 4	5. 64		12
. 00 1	Total weighted resident FTE count for the penultimate cost re year (see instructions)	porting	28. 6	4. 80		13
	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	23. 2			14
	Adjustment for residents in initial years of new programs Jnweighted adjustment for residents in initial years of new p	roarome	0. 0 0. 0			15
	Adjustment for residents displaced by program or hospital clo		0.0			16
.01 L	Jnweighted adjustment for residents displaced by program or h		0.0			16
. 00	Adjusted rolling average FTE count		23. 2			17
- 1	Per resident amount Approved amount for resident costs		85, 659. 7 1, 992, 44	· ·	2, 498, 289	18 19
					1. 00	
	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots red	eived under 42	0. 00	20
1	Direct GME FTE unweighted resident count over cap (see instru	ctions)			16. 31	21
- 1	Allowable additional direct GME FTE Resident Count (see instr				0.00	
- 1	Enter the locality adjustment national average per resident a Multiply line 22 time line 23	mount (see i	nstructions)		0. 00 0	
	Fotal direct GME amount (sum of lines 19 and 24)				2, 498, 289	
			Inpatient Par	t Managed care		
			1. 00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD			2.5.		
	Inpatient Days (see instructions) Fotal Inpatient Days (see instructions)		20, 27 77, 0 ²			26
	Ratio of inpatient days to total inpatient days		0. 26319			28
	Program direct GME amount		657, 54			29
	Reduction for direct GME payments for Medicare Advantage			41, 070		30
- 1	Net Program direct GME amount		i .	1	907, 126	

Heal th	Financial Systems COMMUNITY HEALTH N	ETWORK, INC.	In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0074	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLI EDUCATION COSTS)	•		CAL	
32.00	Renal dialysis direct medical education costs (from Wkst. B,	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00
	and 94)				
33. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.		74 and 94)	4, 468, 277	ı
34. 00	Ratio of direct medical education costs to total charges (lin	e 32 ÷ line 33)		0. 000000	1
	Medicare outpatient ESRD charges (see instructions)			0	
36. 00	Medicare outpatient ESRD direct medical education costs (line			0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
27.00	Part A Reasonable Cost		I	(0.042.00/	1 27 00
37. 00	Reasonable cost (see instructions)			69, 942, 096	1
38. 00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) Cost of physicians' services in a teaching hospital (see inst	ruoti ono)		0	38. 00 39. 00
40. 00	Primary payer payments (see instructions)	ructions)		24, 906	
	Total Part A reasonable cost (sum of lines 37 through 39 minu	s lino 40)		69, 917, 190	
41.00	Part B Reasonable Cost	s iiile 40)		07, 717, 170	41.00
42 00	Reasonable cost (see instructions)			95, 590, 009	42 00
43. 00	Primary payer payments (see instructions)			21, 130	1
44. 00	Total Part B reasonable cost (line 42 minus line 43)			95, 568, 879	1
	Total reasonable cost (sum of lines 41 and 44)			165, 486, 069	1
46. 00		e 41 ÷ line 45)		0. 422496	1
47.00	Ratio of Part B reasonable cost to total reasonable cost (line	e 44 ÷ line 45)		0. 577504	47. 00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAI	RT B			
48.00	Total program GME payment (line 31)			907, 126	48. 00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		383, 257	49. 00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		523, 869	50. 00

Health Financial Systems

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

Provider CCN: 15-0074

Offi y)					5/29/2019 3:0	9 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
1 00	CURRENT ASSETS	12 001				1 00
1. 00 2. 00	Cash on hand in banks Temporary investments	13, 801	0	_	1	1. 00 2. 00
3.00	Notes receivable	57, 500		_	0	3.00
4. 00	Accounts recei vabl e	2, 111, 404, 205		_	Ö	4. 00
5.00	Other recei vabl e	44, 844, 811	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	55, 749, 691	0	0	0	6. 00
7. 00	Inventory	8, 918, 713	1	0	0	7. 00
8.00	Prepai d expenses	6, 469, 519	1	0	0	8.00
9. 00 10. 00	Other current assets Due from other funds	60, 942	0	_	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	2, 227, 519, 182			•	11.00
11.00	FI XED ASSETS	2,227,317,102	-1			11.00
12. 00	Land	2, 743, 049	0	0	0	12. 00
13.00	Land improvements	4, 209, 543	0	0	0	13. 00
14. 00	Accumulated depreciation	0	0	0	1	14. 00
15. 00	Bui I di ngs	462, 208, 704	0	0	1	15. 00
16.00	Accumulated depreciation	11 702 027	0	0	0	16.00
17. 00 18. 00	Leasehold improvements Accumulated depreciation	11, 702, 937	0	_	0	17. 00 18. 00
19. 00	Fi xed equi pment	187, 960, 216	1	_	0	19.00
20. 00	Accumul ated depreciation	107, 700, 210		0	Ö	20.00
21. 00	Automobiles and trucks	215, 381	o o	o o	Ö	21.00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Maj or movable equipment	0	o	0	0	23. 00
24. 00	Accumulated depreciation	-330, 975, 365	0	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	_	0	25. 00
26. 00	Accumulated depreciation		0	0	0	26.00
27. 00 28. 00	HIT designated Assets Accumulated depreciation			0	0	27. 00 28. 00
29. 00	Mi nor equi pment-nondepreci abl e	58, 900	1	_		29.00
30. 00	Total fixed assets (sum of lines 12-29)	338, 123, 365		_	1	30.00
	OTHER ASSETS					
31. 00	Investments	C	0	0		31. 00
32. 00	Deposits on Leases	0	0	_		32. 00
33. 00	Due from owners/officers	0	0	_	0	33. 00
34. 00	Other assets	-1, 850, 592, 079	1		0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	-1, 850, 592, 079 715, 050, 468	1	_	1	35. 00 36. 00
30.00	CURRENT LIABILITIES	713,030,400	91 0			30.00
37. 00	Accounts payable	2, 889, 997	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	-141, 105	o o	0	0	38. 00
39. 00	Payroll taxes payable	-211	0	0	0	39. 00
40. 00	Notes and Loans payable (short term)	0	0	0	0	40. 00
41.00	Deferred income	0	0	0	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds			0	0	42. 00 43. 00
44. 00	Other current liabilities	9, 083, 210		0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	11, 831, 891	1	_		45. 00
	LONG TERM LIABILITIES	,,	-			
46.00	Mortgage payable	C	0	0	0	46. 00
47. 00	Notes payable	0	0	_	_	47. 00
48. 00	Unsecured Loans	0	0	_		48. 00
49. 00	Other long term liabilities	898, 263	1	_		49.00
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	898, 263 12, 730, 154	1		1	50. 00 51. 00
31.00	CAPITAL ACCOUNTS	12, 730, 134	<u> </u>	0	0	31.00
52. 00	General fund balance	702, 320, 314	ı			52. 00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant	1			0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	702, 320, 314		_	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	715, 050, 468	•	0	0	60.00
	59)					
		•	•			

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

					From 01/01/2018 To 12/31/2018		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	, join
		1.00	2. 00	3.00	4. 00	5. 00	
1. 00	Fund balances at beginning of period		493, 332, 692			0	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		208, 987, 622				2.00
3.00	Total (sum of line 1 and line 2)		702, 320, 314			0	3. 00
4.00	Additions (credit adjustments) (specify)	0			0	0	4. 00
5. 00 6. 00		0			0	0	5. 00 6. 00
7. 00		0			0		7. 00
8. 00					0		8. 00
9. 00		0			0	0	9. 00
10.00	Total additions (sum of line 4-9)		0		(0	10.00
11. 00	Subtotal (line 3 plus line 10)		702, 320, 314		(0	11.00
12. 00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13.00		0			0	0	13.00
14. 00 15. 00		0			0	0	14. 00 15. 00
16. 00		0			0		16. 00
17. 00					0		17. 00
18. 00	Total deductions (sum of lines 12-17)		0				18. 00
19. 00	Fund balance at end of period per balance		702, 320, 314		(o l	19.00
	sheet (line 11 minus line 18)		51	L			
		Endowment Fund	PI ant	Fund	_		
		6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0			0		3. 00
4. 00 5. 00	Additions (credit adjustments) (specify)		0				4. 00 5. 00
6. 00			0				6. 00
7. 00			0				7. 00
8.00			0				8. 00
9.00			0				9. 00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11. 00	Subtotal (line 3 plus line 10)	0			0		11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13. 00 14. 00			0				13. 00 14. 00
15. 00			0				15. 00
16. 00			0				16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0			0		18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19. 00

Health Financial Systems COMM STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0074

		Т	o 12/31/2018	Date/Time Prep 5/29/2019 3:00	
	Cost Center Description	Inpatient	Outpati ent	Total) piii
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>			
	General Inpatient Routine Services				
1.00	Hospi tal	54, 246, 185		54, 246, 185	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	C		0	5. 00
6.00	Swing bed - NF	C		0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	54, 246, 185		54, 246, 185	10. 00
	Intensive Care Type Inpatient Hospital Services		T		
11. 00	INTENSIVE CARE UNIT	11, 283, 879		11, 283, 879	11. 00
12.00	CORONARY CARE UNIT	16, 753, 776		16, 753, 776	
13.00	BURN INTENSIVE CARE UNIT				13. 00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)	00 007 /55		00 007 /55	15. 00
16. 00	31.	28, 037, 655		28, 037, 655	16. 00
17 00	11-15)	02 202 040		02 202 040	17 00
17. 00 18. 00	Total inpatient routine care services (sum of lines 10 and 16)	82, 283, 840		82, 283, 840	
19. 00	Ancillary services Outpatient services	0//, 93/, 3/5	1, 774, 613, 584	2, 452, 550, 959 0	18. 00 19. 00
20. 00	RURAL HEALTH CLINIC		J		20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0		21. 00
22. 00	HOME HEALTH AGENCY	-	0	U	22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	PROFESSI ONAL BILLI NG		19, 847, 156	19, 847, 156	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	760 221 215		2, 554, 681, 955	
	G-3, line 1)	, ===,	.,,,	_,,,,	
	PART II - OPERATING EXPENSES	'			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		647, 814, 072		29. 00
30.00	ADD (SPECIFY)	0			30. 00
31.00					31. 00
32.00		C			32. 00
33.00		C			33. 00
34.00		C			34. 00
35.00		C			35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	ADD (SPECIFY)	0			37. 00
38. 00		C			38. 00
39. 00		0			39. 00
40. 00		0			40. 00
41. 00		C			41. 00
42. 00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	er	647, 814, 072		43. 00
	to Wkst. G-3, line 4)	I	I	l l	l

					2552-10
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-0074	Peri od:	Worksheet G-3	
			From 01/01/2018 To 12/31/2018	Date/Time Pre	nanad.
			To 12/31/2018	5/29/2019 3:0	
				372772017 3.0) piii
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3	3. line 28)		2, 554, 681, 955	1. 00
2.00	Less contractual allowances and discounts on patients'			1, 721, 019, 465	1
3.00	Net patient revenues (line 1 minus line 2)			833, 662, 490	ı
4. 00	Less total operating expenses (from Wkst. G-2, Part II,	line 43)		647, 814, 072	
5.00	Net income from service to patients (line 3 minus line			185, 848, 418	
	OTHER INCOME	7			
6.00	Contributions, donations, bequests, etc			2, 379, 957	6.00
7.00	Income from investments			205, 970	7. 00
8.00	Revenues from telephone and other miscellaneous communic	cation services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			19, 685	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			1, 980, 373	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to or	ther than patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	MISC INCOME			18, 553, 219	24. 00

25. 00 26. 00

0 28.00 208, 987, 622 29.00

0 27.00

23, 139, 204 208, 987, 622

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

27. 00 OTHER

Heal th	Financial Systems COMMUNITY HEALTH	NETWORK, INC.	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0074	Peri od: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			4, 080, 955	1. 00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			93, 045	2. 00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost r	reporting period (see inst	tructions)	212. 85	3. 00
4.00	Number of interns & residents (see instructions)			27. 97	4. 00
5.00	Indirect medical education percentage (see instructions)			3. 78	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by th	ne sum of lines 1 and 1.01	I, columns 1 and	154, 260	6. 00
7. 00	1.01)(see instructions) Percentage of SSI recipient patient days to Medicare Part A	patient days (Worksheet E	E, part A line	10. 87	7. 00
	30) (see instructions)				
8. 00	Percentage of Medicaid patient days to total days (see instr	ructions)		38. 53	
9. 00	Sum of lines 7 and 8			49. 40	9. 00
10.00	Allowable disproportionate share percentage (see instruction	ns)		10. 52	
11. 00	Disproportionate share adjustment (see instructions)			429, 316	
12. 00	Total prospective capital payments (see instructions)			4, 757, 576	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1. 00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumstar	nces (see instructions)		0	2. 00
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3. 00
4.00	Applicable exception percentage (see instructions)			0.00	4. 00
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	6. 00
7.00	Adjustment to capital minimum payment level for extraordinar	ry circumstances (line 2 >	(line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)			0	
9.00	Current year capital payments (from Part I, line 12, as appl			0	
10.00	Current year comparison of capital minimum payment level to			0	
11. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	capital payment (from pri	or year	0	11. 00
12.00	Net comparison of capital minimum payment level to capital p	payments (line 10 plus lir	ne 11)	0	12. 00
13.00	Current year exception payment (if line 12 is positive, enter	er the amount on this line	e)	0	13. 00
14. 00	Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	capital payment for the 1	following period	0	14. 00

15.00 0 16.00 0 17.00

(if line 12 is negative, enter the amount on this line)

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)