AND SETTLEMENT	SUMMARY		From 01/01/2018 To 12/31/2018	Parts I-III Date/Time Prepared: 5/29/2019 3:00 pm
PART I - COST	REPORT STATUS			·
Provi der	1. [X] Electronically filed cost report		Date: 5/29/20	19 Time: 3:00 pm
use only	2. [] Manually submitted cost report			
	3. [0]If this is an amended report enter the number 4. [F]Medicare Utilization. Enter "F" for full or "L		resubmitted this co	ost report
Contractor use only	5. [1]Cost Report Status (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for (3) Settled with Audit 9. [N] Final Report for (4) Reopened (5) Amended	or this Provider CCN 12.		

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 HOSPITAL SOUTH (15-0128) 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.)

		Title XVIII				
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1.00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
Hospi tal	0	640, 098	40, 213	0	0	1.00
Subprovider - IPF	0	0	0		0	2.00
Subprovider - IRF	0	0	0		0	3. 00
Swing bed - SNF	0	0	0		0	5. 00
Swing bed - NF	0				0	6.00
Total	0	640, 098	40, 213	0	0	200. 00
	PART III - SETTLEMENT SUMMARY Hospi tal Subprovi der - IPF Subprovi der - IRF Swing bed - SNF Swing bed - NF	1.00	Cost Center Description	Cost Center Description	Cost Center Description	Cost Center Description

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

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

Health Financial Systems COMMUNITY HOSPITAL SOUTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0128 Peri od: Worksheet S-2 From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/29/2019 3:00 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1402 EAST COUNTY LINE ROAD SOUTH 1.00 1.00 PO Box: State: IN 2.00 City: INDIANAPOLIS Zip Code: 46227 County: MARION 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COMMUNITY HOSPITAL 150128 26900 07/01/1966 N 3.00 SOUTH Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovi der - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15 00 15 00 Hospital -Based Health Clinic - FQHC 16.00 Hospital-Based (CMHC) I 17.00 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 1. 00 2.00 01/01/2018 20.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2018 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22. 01 Did this hospital receive interim uncompensated care payments for this Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N N Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N 22.03 N Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 23.00 Ν below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State Out-of Out-of Medi cai d Other Medicaid | Medicaid State State HMO days Medi cai d

	paid days	el i gi bl e unpai d days	Medicaid paid days	Medicaid eligible unpaid		days	
	1.00		2.00	· '	F 00	/ 00	
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in	888	310	0	45	8, 085	17	24. 00
column 5, and other Medicaid days in column 6.							

	Financial Systems COMMUN TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	NITY HOSPITA ATA	L SUUTH Provider CC	N: 15-0128	Peri od:	ını			m CMS-2 et S-2	
					From 01 To 12	/31/20	18 Pa 18 Da 5,	art I ate/Ti /29/20	me Pre 119 3:0	pared
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	HMO	i cai d days	Med d	ther li cai d lays	
5 00	If this provider is an IRF, enter the in-state	1.00	2. 00	3. 00	4. 00	0 5	. 00	0 6	. 00	25. (
J. 00	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		0	U	Urban				Geogr	25.
						1. 00	3 00	2.0		t
7. 00	Enter your standard geographic classification (not v cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not v reporting period. Enter in column 1, "1" for urban center the effective date of the geographic reclassification is a sole community hospital (SCH), enter the	or rural. wage) status or "2" for r fication in	at the end ural. If ap column 2.	l of the cos oplicable,	t		1			26. (
3. 00	effect in the cost reporting period.	ie number or	perrous so	n Status in			0			35.
						nni ng:		Endi		
5. 00	Enter applicable beginning and ending dates of SCH s	status. Subs	cript line	36 for numb		1. 00		2.0	JU	36.
7 00	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), enter		r of portod	le MDU etatu			0			37.
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for 1	the MDH tran	sitional pa	nyment in	3					37.
. 00	accordance with FY 2016 OPPS final rule? Enter "Y" finstructions) If line 37 is 1, enter the beginning and ending date	es of MDH st	atus. If li	ne 37 is						38.
	greater than 1, subscript this line for the number of enter subsequent dates.	perioas i	n excess or	one and		Y/N		Y/	N	
						1.00		2.0		1
0. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent	er in colum nts in	n	N		N		39.
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octono in column 2, for discharges on or after October 1	ber 1. Ente	r "Y" for y			N		N		40.
						1		2. 00	XI X 3. 00	-
	Prospective Payment System (PPS)-Capital						. 00	2.00	3.00	
	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc	·	·			e	N N	Y N	N N	45. 46.
	pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					1				
	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymer Teaching Hospitals						N N	N N	N N	47. 48.
. 00	Is this a hospital involved in training residents in or "N" for no.	approved G	ME programs	? Enter "Y	" for yes	; <u> </u>	Y			56.
. 00	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mor for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	or yes or "N nth of this Y", complet	" for no in cost report e Worksheet	n column 1. ing period?	If columr Enter "	Y"	N			57.
	If line 56 is yes, did this facility elect cost rein defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. Ď-5.		s as		N			58.
. 00	Are costs claimed on line 100 of Worksheet A? If ye	⇒, complete	WKST. U-2,	NAHE 413.8 Y/N		sheet ne #	Qu	ıal i fi	rough cation on Code	59.
				1. 00		2. 00		3. 0	00	

Health Financial Systems COMMUNITY HOSPITAL SOUTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0128 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 3:00 pm Y/N IME Direct GME IME Direct GME 3. 00 1.00 2.00 4.00 5.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA 0 00 N section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA \$5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) N 63.00 Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs in FTEs Nonprovi der Hospi tal 2)) 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 reporting period that begins on or after July 1, 2009 and before June 30, 2010.

0.00

0.00

0.000000 64.00

64.00 Enter in column 1, if line 63 is yes, or your facility trained residents

in the base year period, the number of unweighted non-primary care resident 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)

From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 3:00 pm Program Code Unwei ghted Unwei ghted Program Name 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 is yes, or your facility 0.000000 65.00 0. 00 0. 00 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. 00 2. 13 0.000000 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 ahted Unwei ghted Ratio (col. 3/ Program Code 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 MEDICINE 0.000000 67.00 1350 0.00 5.08 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 O 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 N 75.00 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 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)

ealth Financial Systems COMMUNITY HOS HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	CN: 15-0128	Peri od: From 01/01/2018 To 12/31/2018	u of Form CMS- Worksheet S-2 Part I Date/Time Pre 5/29/2019 3:0	epared:
				1. 00	
Long Term Care Hospital PPS					
Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. TEFRA Providers			ng period? Enter	N N	80. 00 81. 00
Us this a new hospital under 42 CFR Section §413.40(f)(1)(i 16.00 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
17.00 Is this hospital an extended neoplastic disease care hospit 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	al classified	under sectio	n	N	87. 00
1000(d)(1)(b)(v1): Litter 1 101 yes of 14 101 flo.			V	XI X	
			1. 00	2. 00	
Title V and XIX Services 10.00 Does this facility have title V and/or XIX inpatient hospit	al services? F	nter "V" for	N	Υ	90.00
yes or "N" for no in the applicable column.			IN IN	ľ	90.00
11.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app			N	N	91. 00
22.00 Are title XIX NF patients occupying title XVIII SNF beds (dinstructions) Enter "Y" for yes or "N" for no in the applic		N	92. 00		
3.00 Does this facility operate an ICF/IID facility for purposes	N	N	93. 00		
"Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	N	N	94. 00		
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the ap	plicable colum	n.	0. 00	0.00	95. 00
16.00 Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.	00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the				
77.00 If line 96 is "Y", enter the reduction percentage in the ap	0. 00	0. 00	97. 00		
28.00 Does title V or XIX follow Medicare (title XVIII) for the i stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.	Y	N	98. 00		
28.01 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.		Υ	98. 01		
88.02 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	Υ	98. 02		
28.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y				N	98. 03
for title V, and in column 2 for title XIX. 18.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i			d N	N	98. 04
in column 2 for title XIX. 18.05 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				Υ	98. 05
column 2 for title XIX. 18.06 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	Υ	98. 06
Rural Providers			NI NI		105 00
05.00 Does this hospital qualify as a CAH? 06.00 f this facility qualifies as a CAH, has it elected the all	-inclusive met	hod of payme	nt N		105. 00 106. 00
for outpatient services? (see instructions) 07.00 If this facility qualifies as a CAH, is it eligible for cos training programs? Enter "Y" for yes or "N" for no in colum					107. 00
yes, the GME elimination is not made on Wkst. B, Pt. I, col reimbursed. If yes complete Wkst. D-2, Pt. II.					
08.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sche	dul e? See 4	2 N		108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati on		Respi ratory	
09.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00	2.00	3.00	4.00	109. 00
pror yes or in tor no for each therapy.					
			0.101	1.00	146
10.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no.	If yes,	N	110. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider	CCN: 15-0128	Peri od:	<u>ieu of Form CM</u> Worksheet S	
OSITIAL AND HOSITIAL HEALTH CARL COMMILEX TRENTITION DATA	CON. 13-0120	From 01/01/20 To 12/31/20	18 Part I	repare
		1. 00	2.00	
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating i Enter all that apply: "A" for Ambulance services; "B" for additional become for tele-health services.	period? Enter enter the n column 2.	N	2.00	111.
		1	. 00 2. 00 3. 0	0
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no is yes, enter the method used (A, B, or E only) in column 2. If column 2 either "93" percent for short term hospital or "98" percent for long to psychiatric, rehabilitation and long term hospitals providers) based on Pub. 15-1, chapter 22, §2208.1.	2 is "E", enter cerm care (incl the definition	in column udes	N O	
16.00 Is this facility classified as a referral center? Enter "Y" for yes or " 17.00 Is this facility legally-required to carry malpractice insurance? Enter no.		"N" for	N Y	116. 117.
18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 claim-made. Enter 2 if the policy is occurrence.	if the policy	is	1	118.
Cranin-made. Litter 2 11 the porrey 13 occurrence.	Premi ums	Losses	Insurance	
	1. 00	2.00	3.00	
8.01 List amounts of malpractice premiums and paid losses:	589, 3	137	0	0 118.
		1. 00	2.00	
Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pr §3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions)	cost centers Tovision in ACA Y" for yes or the Outpatient		N	118. 119. 120.
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable device	ŕ	Y		121.
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §190 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", ent the Worksheet A line number where these taxes are included.				122.
Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes and "N	l" for no. If	N		125.
yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, enter the cert in column 1 and termination date, if applicable, in column 2.	ification date	?		126.
7.00 f this is a Medicare certified heart transplant center, enter the certi in column 1 and termination date, if applicable, in column 2.	fication date			127.
8.00 If this is a Medicare certified liver transplant center, enter the certiin column 1 and termination date, if applicable, in column 2.				128
9.00 If this is a Medicare certified lung transplant center, enter the certificolumn 1 and termination date, if applicable, in column 2.		n		129
0.00 on this is a Medicare certified pancreas transplant center, enter the condate in column 1 and termination date, if applicable, in column 2. 1.00 of this is a Medicare certified intestinal transplant center, enter the				130
date in column 1 and termination date, if applicable, in column 2. 2.00 f this is a Medicare certified islet transplant center, enter the certi				131
in column 1 and termination date, if applicable, in column 2. 3.00 f this is a Medicare certified 13 applicable, in column 2.				133
in column 1 and termination date, if applicable, in column 2. 4.00 If this is an organ procurement organization (OPO), enter the OPO number and termination date, if applicable, in column 2.				134
All Providers				
10.00 Are there any related organization or home office costs as defined in CM chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and hom		Υ .	HB0720	140.

Health Financial Systems COMMUNITY HOSPITAL SOUTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0128 Peri od: Worksheet S-2 From 01/01/2018 Part I То 12/31/2018 Date/Time Prepared: 5/29/2019 3:00 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number
Name: COMMUNITY HEALTH NETWORK | Contractor's Name: WISCONSIN PHYSICIA Contractor's Name: WISCONSIN PHYSICIANS Contractor's Number: 08101 141 00 Name: 141 00 SERVI CES 142.00 Street: 1500 NORTH RITTER AVENUE PO Box: 142.00 143.00 City: INDIANAPOLIS 46219-3095 State: ΙN Zip Code: 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 2.00 1.00 145.00|| f costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is 145.00 Υ no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? N 146, 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147.00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1 00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal N Ν Ν N 155. 00 156.00 Subprovi der - IPF Ν 156. 00 Ν Ν Ν 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν Ν 161.00 1.00 Mul ti campus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. Ν 165.00 FTE/Campus Zip Code Name County State **CBSA** 3.00 5.00 0 1.00 2.00 4.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter transition factor. (see instructions) Beginn 1.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyyy) 1.00 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section	1. 00	
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter transition factor. (see instructions) Reginn 1.00		
reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a) (6) (ii)? Enter "Y" for yes or "N" for no. (see instructions) 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter transition factor. (see instructions) Beginn 1.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy) 1.00 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter	Y	167. 00
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter transition factor. (see instructions) Beginn 1.00		0168. 00
transition factor. (see instructions) Beginn 1.00		168. 01
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 01/01/2 period respectively (mm/dd/yyyy) 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter	:he 9.9	9169. 00
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 01/01/2 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 01/01/2 1.00 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter	g Endi ng	
period respectively (mm/dd/yyyy) 1.00 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in N section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter	15 12/31/2015	170. 00
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in N section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter		
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter	2. 00	
1876 Medicare days in column 2. (see instructions)		0 171. 00

	Financial Systems COMMUNITY HOS	SPITAL SOUTH		In Lie	eu of Form CMS-	2552-10
OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Peri od: From 01/01/2018		2
				To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
			'	Y/N	Date	J
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format.	N for all NO re	esponses. Ente	er all dates in	the	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the			N		1.00
	reporting period? If yes, enter the date of the change in o	corumn 2. (see	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare F		N			2. 00
	yes, enter in column 2 the date of termination and in colur voluntary or "I" for involuntary.	mn 3, "V" for				
00	Is the provider involved in business transactions, including	ng management	Y			3.00
	contracts, with individuals or entities (e.g., chain home of	offices, drug				
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of directors through ownership, control, or family and other					
	relationships? (see instructions)	er simirai				
			Y/N	Type	Date	
	Financial Data and Danarts		1.00	2. 00	3. 00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer-	tified Public	Υ	A		4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" 1	for Compiled,				"
	or "R" for Reviewed. Submit complete copy or enter date ava	ailable in				
00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	arent from	N			5.00
50	those on the filed financial statements? If yes, submit rec		IN IN			3.00
	, , , , , , , , , , , , , , , , , , , ,		1	Y/N	Legal Oper.	
				1. 00	2. 00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If was is th	ne nrovider is	N		6.00
,0	the legal operator of the program?	11 yes, 15 ti	ic provider 13	'		0.00
00	Are costs claimed for Allied Health Programs? If "Y" see in			N		7. 00
00	Were nursing school and/or allied health programs approved	and/or renewed	d during the	N		8. 00
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		9.00			
	program in the current cost report? If yes, see instruction			Y		
00	Was an approved Intern and Resident GME program initiated	or renewed in t	the current	N		10.00
00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	I & Pin an Λης	proved	N		11.00
. 00	Teaching Program on Worksheet A? If yes, see instructions.	i a k ili ali App	or oved	IN .		11.00
					Y/N	
	Dad Dahta				1. 00	
00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s. see instruct	tions.		Y	12.00
00	If line 12 is yes, did the provider's bad debt collection			st reporting	N	13.00
	period? If yes, submit copy.		_			
00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	tructi ons.	N	14.00
. 00	Did total beds available change from the prior cost reporti	ina period? If	ves. see inst	ructions.	N	15. 00
			t A	Par	t B	
		Y/N	Date	Y/N	Date	
	PS&R Data	1. 00	2.00	3. 00	4. 00	
00	Was the cost report prepared using the PS&R Report only?	l N		N		16. 00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 (see					
00	instructions) Was the cost report prepared using the PS&R Report for	Y	04/29/2014	Υ	04/29/2014	17. 00
00	totals and the provider's records for allocation? If	'	04/2//2014	'	04/2//2014	17.00
	either column 1 or 3 is yes, enter the paid-through date					
00	in columns 2 and 4. (see instructions)	N.		N.I		10.00
00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18.00
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
		1	1	1	l	1
	Report data for corrections of other PS&R Report information? If yes, see instructions.					

Heal th	Financial Systems COMMUNITY HOS	SPITAL SOUTH		In Lie	u of Form CMS	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co	CN: 15-0128	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S- Part II Date/Time Pr 5/29/2019 3:	epared:
		Descri	pti on	Y/N	Y/N	J piii
)	1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
		Y/N 1.00	Date 2.00	Y/N 3. 00	Date 4.00	
21. 00	Was the cost report prepared only using the provider's	N N	2.00	N N	4.00	21. 00
	records? If yes, see instructions.					
	COMPLETED DV COCT DELMDUDGED AND TEEDA HOODITAL C ONLY (EVON	EDT AULI DDENG II	00DL TAL (C)		1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	EPI CHILDRENS H	USPITALS)			
22. 00	Have assets been relifed for Medicare purposes? If yes, see	a instructions			N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost re	porting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	he cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportin	g period? If	yes, submit	N	27. 00
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit en	reporti ng	Υ	28. 00		
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	Υ	29. 00			
30. 00	treated as a funded depreciation account? If yes, see insti Has existing debt been replaced prior to its scheduled matu	N	30. 00			
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	N	31. 00			
32. 00	Purchased Services Have changes or new agreements occurred in patient care set arrangements with suppliers of services? If yes, see instru		d through co	ntractual	N	32. 00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 applies, see instructions.		g to competi	tive bidding? If	N	33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an allf yes, see instructions.	rrangement with	provi der-ba	sed physicians?	Υ	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		ts with the	provi der-based	N	35. 00
				Y/N	Date	
				1. 00	2. 00	
2/ 22	Home Office Costs					1 24 25
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been put	repared by the	home office?	N		36. 00 37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end			,		38. 00
39. 00	If line 36 is yes, did the provider render services to other see instructions.					39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00
		1.	00	2.	00	
	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,	RONALD		HELMS		41. 00
42. 00	respectively. Enter the employer/company name of the cost report	COMMUNITY HEAL	TH NETWORK			42. 00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-5501		RHELMS@ECOMMUNI	TY. COM	43. 00

Health Financial Systems COMMUNITY HOSPITAL SOUTH In Lieu of						u of Form CMS-	2552-10	
HOSPI TAL AN	D HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provider C			od: 01/01/2018 12/31/2018		pared:
			3.	00				
Cost	Report Preparer Contact Information	I			I			
hel d	r the first name, last name and the by the cost report preparer in colu ectively.		REI MBURSEMENT	MANAGER				41. 00
42.00 Enter	r the employer/company name of the c arer.	ost report						42. 00
43. 00 Enter	r the telephone number and email add rt preparer in columns 1 and 2, resp							43. 00

Health Financial Systems COMMUNI
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0128

					Т	o 12/31/2018	Date/Time Prep	
							5/29/2019 3:00 I/P Days / 0/P) piii
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	osiiiporierre	Line Number	1.0.	or beas	Avai I abl e	Oran nour s	"""	
		1. 00		2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		157	57, 305	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			157	57, 305	0.00	0	7. 00
	beds) (see instructions)							
8. 00	INTENSIVE CARE UNIT	31. 00		12	4, 380	0. 00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY	43. 00					0	13.00
14. 00	Total (see instructions)			169	61, 685	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	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC						_	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			169			_	27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			0	C			32.00
32. 01	Total ancillary labor & delivery room							32. 01
22.00	outpatient days (see instructions)							22.00
33.00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges		l		l		ı	33. 01

				'	0 12/31/2010	5/29/2019 3:0	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				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 8 exclude Swing Bed, Observation Bed and	12, 279	811	33, 892			1. 00
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	5, 643	6, 967				2. 00
3.00	HMO IPF Subprovider	o	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		O	0			6. 00
7.00	Total Adults and Peds. (exclude observation	12, 279	811	33, 892			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	945	0	2, 888			8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		1, 550	3, 184			13. 00
14.00	Total (see instructions)	13, 224	2, 361	39, 964	7. 87	877. 40	14. 00
15. 00	CAH visits	0	0	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							24. 00
24. 10	HOSPICE (non-distinct part)			527			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27. 00					7. 87	877. 40	
28. 00			931	4, 532			28. 00
29. 00		0					29. 00
30. 00	Employee discount days (see instruction)			496			30.00
31. 00				0			31. 00
32. 00	Labor & delivery days (see instructions)	0	17	623			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)	_					
33. 00		0					33.00
33. 01	LTCH site neutral days and discharges	0				l	33. 01

| Period: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared:
 Heal th Financial
 Systems
 COMMUNI

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-0128

				To	12/31/2018	Date/Time Prep 5/29/2019 3:00	
		Full Time	<u>'</u>	Di sch	arges		
	Component	Equi val ents Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	Component	Workers	ii tie v	I II LI E AVIII	II LIE XIX	Patients	
		11.00	12. 00	13.00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00		146	9, 954	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)			1, 251	1, 605		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00 12. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00 14. 00	NURSERY Total (see instructions)	0. 00	0	3, 315	146	9, 954	14. 00
15. 00	CAH visits	0.00	U	3, 313	140	9, 904	15. 00
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						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						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 Tri ps						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
22 00	outpatient days (see instructions)						22 00
	LTCH non-covered days			0			33. 00 33. 01
33.01	LTCH site neutral days and discharges	1		ı Y		l	33. UT

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | Part Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0128

					To	12/31/2018	Date/Time Prep 5/29/2019 3:00	
		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	col . 4 5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200. 00	61, 704, 432	-349, 182	61, 355, 250	1, 824, 988. 00	33. 62	1. 00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0.00	2. 00
3. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4.00	Physician-Part A - Administrative		401, 766	0	401, 766	1, 940. 00	207. 10	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0 254, 193	0	1	0. 00 4, 160. 00		4. 01 5. 00
6. 00	Physician-Part B 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	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved programs)		0	0	0	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 instructions)	44. 00	0 429, 538	0	-	0. 00 17, 344. 00		9. 00 10. 00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		529, 772	0	529, 772	6, 101. 00	86. 83	11. 00
12. 00	Care Contract labor: Top level		529, 772	0		0.00		12. 00
	management and other management and administrative services		_					
13. 00	Contract Labor: Physician-Part A - Administrative		1, 689, 538	0	1, 689, 538	19, 876. 00	85. 00	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		0	О	0	0.00	0. 00	14. 00
14. 01 14. 02	Home office salaries		19, 232, 360	0	19, 232, 360	443, 427. 00 0. 00		14. 01
15. 00	Related organization salaries Home office: Physician Part A		0	0	0	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
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		15, 013, 367	0	15, 013, 367			17. 00
18. 00	instructions) Wage-related costs (other)		0	0	0			18. 00
19. 00	(see instructions) Excluded areas		133, 543	0	133, 543			19. 00
20. 00	Non-physician anesthetist Part A		0	0	0			20. 00
21. 00	Non-physician anesthetist Part B		0	0	0			21. 00
22. 00	Physician Part A - Administrative		20, 055	0	20, 055			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0 42, 819	0	0 42, 819			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC)		0	0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related		441, 224	0	441, 224			25. 50
25. 51	(core) Rel ated organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	О	0			25. 52
25. 53	wage-related (core) Home office & Contract		0	0	0			25. 53
	Physicians Part A - Teaching - wage-related (core)							
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	5, 629	0	5, 629	143. 00	39. 36	26. 00
	Administrative & General	5. 00	4, 128, 200			87, 444. 00		27. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | Part | Part

							5/29/2019 3:00	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		5, 471, 408	0	5, 471, 408	59, 698. 00	91. 65	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00		
30.00	Operation of Plant	7. 00	1, 533, 473	-13, 702	1, 519, 771	67, 085. 00	22. 65	
31.00	Laundry & Linen Service	8. 00	0	0	0	0.00		31. 00
32.00	Housekeepi ng	9. 00	1, 266, 156	-5, 071	1, 261, 085	83, 743. 00	15. 06	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0.00	33.00
	(see instructions)							
34.00	Di etary	10. 00	1, 223, 272	-844, 424	378, 848	22, 421. 00	16. 90	34.00
35.00	Dietary under contract (see		0	0	0	0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	840, 809	840, 809	49, 290. 00	17. 06	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13. 00	266, 287	-319	265, 968	17, 333. 00	15. 34	38.00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15. 00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical	16. 00	253, 780	-287	253, 493	6, 222. 00	40. 74	41.00
	Records Li brary							
42.00	Social Service	17. 00	1, 247, 685	-8, 737	1, 238, 948	33, 047. 00	37. 49	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

					10	o 12/31/2018	Date/lime Prep 5/29/2019 3:00	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number		on of Salaries	,		Wage (col. 4 ÷	
			·	(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		66, 921, 647	-349, 182	66, 572, 465	1, 880, 526. 00	35. 40	1.00
	instructions)							
2.00	Excluded area salaries (see		429, 538	0	429, 538	17, 344. 00	24. 77	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		66, 492, 109	-349, 182	66, 142, 927	1, 863, 182. 00	35. 50	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		21, 451, 670	0	21, 451, 670	469, 404. 00	45. 70	4. 00
	costs (see inst.)							
5. 00	Subtotal wage-related costs		15, 474, 646	0	15, 474, 646	0. 00	23. 40	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		103, 418, 425					
7. 00	Total overhead cost (see		15, 395, 890	-43, 374	15, 352, 516	426, 426. 00	36. 00	7. 00
	instructions)						į l	

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0128	Peri od: Worksheet S-3 From 01/01/2018 Part IV To 12/31/2018 Date/Time Prepared:

		То	12/31/2018	Date/Time Prep 5/29/2019 3:00	
				Amount	
				Reported	
				1. 00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETI REMENT COST				
1.00	401K Employer Contributions			1, 937, 121	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)				
5.00	401K/TSA Plan Administration fees			0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan			252, 151	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)			6, 102, 239	8. 02
8.03	Heal th Insurance (Purchased)			0	8. 03
9.00	Prescription Drug Plan			1, 745, 305	9. 00
10.00	Dental, Hearing and Vision Plan			65, 259	10. 00
11.00	Life Insurance (If employee is owner or beneficiary)			35, 441	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)			519, 061	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0	14. 00
15.00	'Workers' Compensation Insurance			100, 700	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary	accrual required b	y FASB 106.	0	16. 00
	Non cumulative portion)	·	·		
	TAXES		,		
17.00	FICA-Employers Portion Only			4, 383, 553	17. 00
18.00	Medicare Taxes - Employers Portion Only			0	18. 00
19.00	Unemployment 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))	9	,		
22.00	Day Care Cost and Allowances			0	22. 00
23.00				68, 953	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)			15, 209, 783	24. 00
	Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0	25. 00
			,		

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lieu of Form CMS-2552-			
HOSPITAL CONTRACT LABOR AND BENEFIT COST	F	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part V Date/Time Prep 5/29/2019 3:00	pared:	
Cost Center Description		Contract Labor			
PART V - Contract Labor and Benefit Cost		1. 00	2. 00		

			3/2//2017 3.00	о ріп
	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	529, 772	15, 209, 783	1.00
2.00	Hospi tal	529, 772	15, 013, 367	2.00
3.00	Subprovi der - IPF			3.00
4.00	Subprovi der - I RF			4.00
5.00	Subprovi der - (0ther)	0	ol	5. 00
6.00	Swing Beds - SNF	0	ol	6.00
7.00	Swing Beds - NF	0	ol	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			14.00
15.00	Hospital-Based Health Clinic FQHC			15. 00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Dialysis	0	0	17. 00
18.00	Other	0	196, 416	18. 00
	•	•	'	

J3P1 17	AL UNCOMPENSATED AND INDIGENT CARE DATA	rovider CCN:	15-0128	Peri od: From 01/01/2018	Worksheet S-10	0
				To 12/31/2018	Date/Time Prep 5/29/2019 3:00	
					1. 00	
	Uncompensated and indigent care cost computation					
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by line	202 column	8)	0. 203454	1.
00	Medicaid (see instructions for each line) Net revenue from Medicaid				2, 014, 857	2.
00	Did you receive DSH or supplemental payments from Medicaid?				Υ Υ	3.
00	If line 3 is yes, does line 2 include all DSH and/or supplemental	l payments	from Medica	ıi d?	Y	4.
00	If line 4 is no, then enter DSH and/or supplemental payments from		0	5.		
00	Medicaid charges Medicaid cost (line 1 times line 6)				159, 334, 768	6. 7.
00	Difference between net revenue and costs for Medicaid program (li	ine 7 minus	sum of lir	ues 2 and 5 if	32, 417, 296 30, 402, 439	
00	<pre>< zero then enter zero)</pre>	THE 7 IIITHUS	3411 01 111	103 Z dila 3, 11	30, 402, 437	0.
	Children's Health Insurance Program (CHIP) (see instructions for	each line)				
	Net revenue from stand-alone CHIP				0	
	Stand-alone CHIP charges				0	10. 11.
	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (li	ine 11 minu	sline 9· i	f < zero then	-	
00	enter zero)	THE TI IIITIG	3 11110 7, 1	1 \ Zero then	J	'2.
	Other state or local government indigent care program (see instru					
. 00	Net revenue from state or local indigent care program (Not included in the control of the contro			<i>'</i>		13.
. 00	Charges for patients covered under state or local indigent care properties to the patients of the covered under state or local indigent care properties to the patients of the	program (No	t included	in lines 6 or	0	14.
. 00	State or local indigent care program cost (line 1 times line 14)				0	15.
	Difference between net revenue and costs for state or local indig	dent care n	rogram (lir	e 15 minus line		16
		gent care p	. 09. a (ic io illinus i inc p	· · · · · · · · · · · · · · · · · · ·	
	13; if < zero then enter zero)		<u> </u>			
	Grants, donations and total unreimbursed cost for Medicaid, CHIP		<u> </u>			
7. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func	and state/	local indig		ns (see	
7. 00 3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos	and state/ ding charit spital oper	local indig y care ations	ent care program	ns (see	17. 18.
7. 00 3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i	and state/ ding charit spital oper	local indig y care ations	ent care program	ns (see	17. 18.
7. 00 3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos	and state/ ding charit spital oper	local indig y care ations	ent care program	ns (see	17. 18.
. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i	and state/ ding charit spital oper	I ocal indig y care ations re programs Uninsured patients	ent care program (sum of lines Insured patients	0 0 30,402,439 Total (col. 1 + col. 2)	17. 18.
7. 00 8. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)	and state/ ding charit spital oper	I ocal indig y care ations re programs Uninsured	ent care program s (sum of lines	0 0 30,402,439 Total (col. 1	17. 18.
7. 00 3. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line)	and state/ ding charit spital oper indigent ca	y care ations re programs Uninsured patients 1.00	(sum of lines Insured patients 2.00	0 0 30,402,439 Total (col. 1 + col. 2) 3.00	17. 18. 19.
7. 00 3. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)	and state/ ding charit spital oper indigent ca	I ocal indig y care ations re programs Uninsured patients	(sum of lines Insured patients 2.00	0 0 30,402,439 Total (col. 1 + col. 2) 3.00	17. 18. 19.
7. 00 3. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount	and state/ ding charit spital oper indigent ca	y care ations re programs Uninsured patients 1.00	s (sum of lines Insured patients 2.00	Total (col. 1 + col. 2) 3.0, 269, 873	17. 18. 19.
7. 00 3. 00 0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions)	and state/ ding charit spital oper indigent ca	y care ations re programs Uni nsured pati ents 1.00	s (sum of lines Insured patients 2.00 9 1,757,554 1,757,554	0 0 30, 402, 439 Total (col. 1 + col. 2) 3.00 20, 269, 873 5, 523, 959	17. 18. 19. 20.
7. 00 3. 00 0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of	and state/ ding charit spital oper indigent ca	y care ations re programs Uni nsured pati ents 1.00	s (sum of lines Insured patients 2.00	0 0 30, 402, 439 Total (col. 1 + col. 2) 3.00 20, 269, 873 5, 523, 959	17. 18. 19. 20.
2. 00 3. 00 9. 00 9. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions)	and state/ ding charit spital oper indigent ca	y care ations re programs Uni nsured pati ents 1.00	Insured patients 2.00 1,757,554 0 0	0 0 30, 402, 439 Total (col. 1 + col. 2) 3.00 20, 269, 873 5, 523, 959	17. 18. 19. 20. 21.
2. 00 3. 00 9. 00 9. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	and state/ ding charit spital oper indigent ca	Jocal indig y care ations re programs Uninsured patients 1.00 18,512,31 3,766,40	Insured patients 2.00 1,757,554 0 0	Total (col. 1 + col. 2) 3.00 20, 269, 873 5, 523, 959 0 5, 523, 959	17. 18. 19. 20. 21.
2. 00 3. 00 2. 00 3. 00 4. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)	and state/ ding charit spital oper indigent ca	Jocal indig y care ations re programs Uninsured patients 1.00 18,512,31 3,766,40	Insured patients 2.00 1,757,554 0 0 0 1,757,554	Total (col. 1 + col. 2) 3.00 20, 269, 873 5, 523, 959 0 5, 523, 959 1.00	17. 18. 19. 20. 21. 22. 23.
2. 00 3. 00 2. 00 3. 00 4. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient	and state/ ding charit spital oper indigent ca lity ts (see ff as	Jocal indig y care ations re programs Uninsured patients 1.00 18,512,31 3,766,40	Insured patients 2.00 1,757,554 0 0 0 1,757,554	Total (col. 1 + col. 2) 3.00 20, 269, 873 5, 523, 959 0 5, 523, 959	17. 18. 19. 20. 21. 22.
0.00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)	and state/ ding charit spital oper indigent ca lity ts (see ff as days beyon rogram?	Jocal indig y care ations re programs Uninsured patients 1.00 18,512,31 3,766,40 3,766,40 d a Length	Insured patients 2.00 1,757,554 0 0 1,757,554 of stay limit	Total (col. 1 + col. 2) 3.00 20, 269, 873 5, 523, 959 0 5, 523, 959 1.00	17. 18. 19. 20. 21. 22. 23.
7, 00 3, 00 3, 00 0, 00 1, 00 2, 00 3, 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the	and state/ ding charit spital oper indigent ca lity ts (see ff as days beyon rogram? indigent c	Jocal indig y care ations re programs Uninsured patients 1.00 18,512,31 3,766,40 3,766,40 d a Length	Insured patients 2.00 1,757,554 0 0 1,757,554 of stay limit	Total (col. 1 + col. 2) 3.00 20, 269, 873 5, 523, 959 0 5, 523, 959	17. 18. 19. 20. 21. 22. 23.
7. 00 3. 00 9. 00 0. 00 1. 00 1. 00 3. 00 4. 00 5. 00 7. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instructions)	and state/ ding charit spital oper indigent ca lity ts (see ff as days beyon rogram? indigent c ructions) (see instru	Jocal indig y care ations re programs Uninsured patients 1.00 18,512,31 3,766,40 3,766,40 d a Length are program	Insured patients 2.00 1,757,554 0 0 1,757,554 of stay limit	0 0 0 30, 402, 439 Total (col. 1 + col. 2) 3.00 20, 269, 873 5, 523, 959 0 5, 523, 959 1.00 N 0 1, 241, 296 301, 385	20. 21. 22. 23. 24. 25. 26. 27.
7. 00 3. 00 9. 00 1. 00 1. 00 1. 00 1. 00 5. 00 7. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instructions Medicare reimbursable bad debts for the entire hospital complex (see	and state/ ding charit spital oper indigent ca lity ts (see ff as days beyon rogram? indigent c ructions) (see instru	Jocal indig y care ations re programs Uninsured patients 1.00 18,512,31 3,766,40 3,766,40 d a Length are program	Insured patients 2.00 1,757,554 0 0 1,757,554 of stay limit	Total (col. 1 + col. 2) 30, 402, 439 Total (col. 1 + col. 2) 3.00 20, 269, 873 5, 523, 959 0 5, 523, 959 1.00 N 0 1, 241, 296 301, 385 463, 668	20. 21. 22. 23. 24. 25. 26. 27. 27.
7. 00 3. 00 7. 00 0. 00 1. 00 2. 00 3. 00 4. 00 6. 00 7. 00 7. 01 3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit total bad debt expense for the entire hospital complex (see instructions lead to the complex (see instructions) expensed to the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	and state/ ding charit spital oper indigent ca lity ts (see ff as days beyon rogram? indigent c ructions) (see instructi	Jocal indig y care ations re programs Uninsured patients 1.00 18,512,31 3,766,40 3,766,40 d a Length are program ctions)	s (sum of lines Insured patients 2.00 9 1,757,554 0 0 1,757,554 of stay limit	Total (col. 1 + col. 2) 3.00 20, 269, 873 5, 523, 959 0 5, 523, 959 1.00 N 0 1, 241, 296 301, 385 463, 668 777, 628	20. 21. 22. 23. 24. 25. 26. 27. 27. 28.
7. 00 3. 00 9. 00 1. 00 2. 00 4. 00 7. 00 7. 00 7. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instructions Medicare reimbursable bad debts for the entire hospital complex (see	and state/ ding charit spital oper indigent ca lity ts (see ff as days beyon rogram? indigent c ructions) (see instructi	Jocal indig y care ations re programs Uninsured patients 1.00 18,512,31 3,766,40 3,766,40 d a Length are program ctions)	s (sum of lines Insured patients 2.00 9 1,757,554 0 0 1,757,554 of stay limit	Total (col. 1 + col. 2) 30, 402, 439 Total (col. 1 + col. 2) 3.00 20, 269, 873 5, 523, 959 0 5, 523, 959 1.00 N 0 1, 241, 296 301, 385 463, 668	20. 21. 22. 23. 24. 25. 26. 27. 27. 28. 29.

Heal th	Financial Systems	COMMUNITY HOSP	ITAL SOUTH		In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES Provider CCN: 15-0128			Peri od:	Worksheet A	
					rom 01/01/2018	Doto/Time Dro	norod.
				'	o 12/31/2018	Date/Time Pre 5/29/2019 3:0	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	D DIII
	oost center bescriptron	Sur di 1 CS	Other	+ col . 2)		Trial Balance	
				1 (01. 2)	0113 (300 / 0)	(col . 3 +-	
						col . 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT		0	(9, 557, 912	9, 557, 912	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		0	Č		6, 125, 630	
3.00	00300 OTHER CAP REL COSTS		0	Č	0	0, 120, 000	3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 629	6, 042	11, 671	1	11, 600	
5. 00	00500 ADMINISTRATIVE & GENERAL	4, 128, 200	67, 991, 186	72, 119, 386	I	63, 405, 605	5. 00
7. 00	00700 OPERATION OF PLANT	1, 533, 473	3, 798, 162	5, 331, 635		5, 474, 654	
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 555, 175	696, 382	696, 382		695, 769	
9. 00	00900 HOUSEKEEPI NG	1, 266, 156	936, 610	2, 202, 766		2, 183, 965	
10. 00	01000 DI ETARY	1, 223, 272	1, 802, 885	3, 026, 157		1, 013, 475	1
11. 00	01100 CAFETERI A	1, 223, 2, 2	0	0,020,107		1, 939, 854	
13. 00	01300 NURSI NG ADMI NI STRATI ON	266, 287	50, 098	316, 385		316, 385	
16. 00	01600 MEDICAL RECORDS & LIBRARY	253, 780	57, 266	311, 046	I I	310, 966	
17. 00	01700 SOCIAL SERVICE	1, 247, 685	328, 648	1, 576, 333		1, 574, 057	1
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	1, 247, 003	320, 040 0	1, 370, 330	2,270	1, 374, 037	1 .
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	0			0	1
22.00	I NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u>U</u>		<u>/ </u>	0	22.00
30. 00		21, 897, 972	8, 890, 068	30, 788, 040	-4, 967, 062	25, 820, 978	30.00
31. 00	03100 INTENSIVE CARE UNIT	2, 677, 648	1, 234, 004	3, 911, 652		3, 516, 790	
43. 00	04300 NURSERY	2,077,040	1, 234, 004	3, 711, 032		947, 054	
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>		747,034	747,034	43.00
50. 00	05000 OPERATING ROOM	3, 241, 744	16, 676, 222	19, 917, 966	-13, 876, 986	6, 040, 980	50.00
51. 00	05100 RECOVERY ROOM	2, 588, 380	1, 141, 322	3, 729, 702		3, 510, 252	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	573, 726	66, 072	639, 798		3, 102, 396	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 695, 970	1, 938, 240	3, 634, 210		2, 401, 139	
55. 00	05500 RADI OLOGY-THERAPEUTI C	556, 506	1, 326, 660	1, 883, 166		1, 009, 028	
57. 00	05700 CT SCAN	594, 348	1, 125, 442	1, 719, 790		1, 314, 218	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)						1
59. 00	05900 CARDI AC CATHETERI ZATI ON	238, 138	223, 321	461, 459		446, 961	
	06000 LABORATORY	1, 312, 056	8, 169, 171	9, 481, 227		2, 674, 601 6, 608, 311	59.00
60. 00 64. 00	1 1	0	6, 610, 564	6, 610, 564			
	06400 I NTRAVENOUS THERAPY	1 042 447	1 052 017		ή "	0 474 017	
65. 00	06500 RESPIRATORY THERAPY	1, 843, 447	1, 053, 817	2, 897, 264		2, 474, 017	
66.00	06600 PHYSI CAL THERAPY	2, 489, 578	1, 269, 766	3, 759, 344		2, 349, 870	
67. 00	06700 OCCUPATI ONAL THERAPY	O O	0	(734, 675	734, 675	
68. 00 69. 00	06800 SPEECH PATHOLOGY	040 100	F20 40F	1 270 (00	185, 711	185, 711	
	06900 ELECTROCARDI OLOGY	849, 198	529, 485	1, 378, 683		1, 276, 504	
70.00	07000 ELECTROENCEPHALOGRAPHY	427, 543	367, 255	794, 798		651, 472	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	906, 065 0	906, 065		11, 921, 402	
72.00	07200 DRUCS CHARGED TO PATIENTS	2 475 114	٥	11 217 252	, , [10, 287, 602	1
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 675, 114	8, 542, 138	11, 217, 252		11, 168, 866	
74.00	07400 RENAL DIALYSIS	(FO 204	419, 746	419, 746		415, 339	
	03950 ENDOSCOPY	658, 304	1, 196, 490	1, 854, 794		1, 057, 696	
	03330 I MAGING CENTER	798, 747	1, 109, 242				
76. 97	07697 CARDI AC REHABI LI TATI ON	241, 704	82, 634	324, 338	-13, 792	310, 546	76.97
00.00	OUTPATIENT SERVICE COST CENTERS		ما		y ol		00 00
	09000 CLI NI C 04950 DI ABETI C CARE CENTER	O O	0	(0	
90. 01		F24 7/7	1/1 100	(05.056	- 1	0	
90. 02	1 1	524, 767	161, 192	685, 959	-18, 275	667, 684	
90. 03	04952 PALLI ATI VE CARE	105 1//	124 074	2/0 1/0	14 710	212 422	90. 03
90. 04		125, 166	134, 974	260, 140		213, 422	
91.00	09100 EMERGENCY	5, 340, 356	2, 835, 955	8, 176, 311	-323, 004	7, 853, 307	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
110 00	SPECIAL PURPOSE COST CENTERS	(1.074.004	141 (77 104	202 052 016	1 704	202 052 012	110 00
118.00		61, 274, 894	141, 677, 124	202, 952, 018	1, 794	202, 953, 812	1118.00
100.00	NONREI MBURSABLE COST CENTERS	ما	ما		v ol		100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(190.00
191.00	19100 RESEARCH	0	10/ 405	127 425	′I "I		191.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	126, 425	126, 425		126, 425	
	19300 NONPALD WORKERS	0	0	(j j		193. 00
	07950 HOME OFFICE SPACE	0	0	(d o		194. 00
	07956 LEASED OFFICE SPACE	420 520	142 142	F70 (01	1 704		194.06
	07958 MISC NONREIMBURSABLE COST CENTERS	429, 538 61, 704, 432	143, 143	572, 681			
200.00	TOTAL (SUM OF LINES 118 through 199)	01, /04, 432	141, 946, 692	203, 651, 124	I 0	203, 651, 124	₁ 200.00

Heal th	Fi nan	ncial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-	2552-10
		ATION AND ADJUSTMENTS OF TRIAL BALANCE OF		Provi der CO	CN: 15-0128	Peri od:	Worksheet A	
						From 01/01/2018	Date/Time Pre	narodi
						To 12/31/2018	5/29/2019 3:0	
		Cost Center Description	Adjustments	Net Expenses		<u>'</u>		
		·		For Allocation				
			6. 00	7. 00				
4 00		AL SERVICE COST CENTERS	0.754.000		ı			4 00
1.00		CAP REL COSTS BLDG & FIXT	-2, 751, 909		1			1. 00 2. 00
2. 00 3. 00		CAP REL COSTS-MVBLE EQUIP OTHER CAP REL COSTS	3, 558, 420	9, 684, 050 0	1			3. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	3, 091, 568	3, 103, 168	1			4. 00
5. 00		ADMINISTRATIVE & GENERAL	-24, 073, 159	39, 332, 446	1			5. 00
7. 00		OPERATION OF PLANT	-194, 848	5, 279, 806				7. 00
8.00		LAUNDRY & LINEN SERVICE	0	695, 769	1			8. 00
9.00	00900	HOUSEKEEPI NG	0	2, 183, 965				9. 00
10.00	1	DI ETARY	-45, 650	967, 825	1			10. 00
11. 00		CAFETERI A	-1, 357, 919	581, 935	1			11. 00
13. 00		NURSING ADMINISTRATION	2, 637, 622	2, 954, 007	1			13. 00
16.00		MEDICAL RECORDS & LIBRARY	1, 656, 860	1, 967, 826	1			16.00
17. 00 21. 00		SOCIAL SERVICE I&R SERVICES-SALARY & FRINGES APPRVD	F02 01E	1, 574, 057	1			17. 00 21. 00
21.00		I &R SERVICES-SALARY & FRINGES APPRVD	593, 815 951, 622	593, 815 951, 622	1			22. 00
22.00		IENT ROUTINE SERVICE COST CENTERS	751, 022	751,022	l			22.00
30. 00		ADULTS & PEDIATRICS	2, 253, 668	28, 074, 646				30.00
31.00		INTENSIVE CARE UNIT	0	3, 516, 790				31.00
43.00	04300	NURSERY	0	947, 054				43.00
		LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	-7, 639	6, 033, 341	1			50.00
51.00		RECOVERY ROOM	0	3, 510, 252	1			51.00
52.00		DELIVERY ROOM & LABOR ROOM	474 007	3, 102, 396				52.00
54.00		RADI OLOGY THE PARELLE C	-471, 837	1, 929, 302	1			54.00
55. 00 57. 00	1	RADI OLOGY-THERAPEUTI C CT SCAN	0	1, 009, 028 1, 314, 218	1			55. 00 57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	446, 961				58. 00
59. 00	05900	CARDI AC CATHETERI ZATI ON	0	2, 674, 601	1			59. 00
60.00		LABORATORY	-770, 138	5, 838, 173	1			60.00
64.00		I NTRAVENOUS THERAPY	0	0	1			64.00
65.00	06500	RESPI RATORY THERAPY	0	2, 474, 017				65. 00
66. 00	06600	PHYSI CAL THERAPY	-31, 980	2, 317, 890				66. 00
67. 00	1	OCCUPATI ONAL THERAPY	0	734, 675	1			67. 00
68. 00		SPEECH PATHOLOGY	0	185, 711	1			68. 00
69. 00		ELECTROCARDI OLOGY	122, 689	1, 399, 193	1			69. 00
70.00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	138, 621	790, 093	1			70.00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	805, 311 0	12, 726, 713 10, 287, 602	1			71. 00 72. 00
73. 00		DRUGS CHARGED TO PATTENTS	234, 130		1			73. 00
74. 00	1	RENAL DIALYSIS	234, 130	415, 339				74.00
76. 00		ENDOSCOPY	o	1, 057, 696				76.00
76.06	1	I MAGING CENTER	0	1, 383, 119	1			76.06
76. 97	07697	CARDIAC REHABILITATION	-5, 870	304, 676				76. 97
		TIENT SERVICE COST CENTERS						4
90.00		CLINIC	0	0	1			90.00
90. 01	1	DI ABETI C CARE CENTER	0	0				90. 01
90. 02 90. 03	1	ANTI-COAGULATION CLINIC	-311, 672	356, 012 0	1			90. 02 90. 03
90. 03		PALLIATIVE CARE SPINE CENTER	0	213, 422				90.03
	1	EMERGENCY	-143	7, 853, 164				91. 00
92. 00	1	OBSERVATION BEDS (NON-DISTINCT PART)	143	7,055,104				92. 00
		AL PURPOSE COST CENTERS						1
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13, 978, 438	188, 975, 374				118. 00
		IMBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1			190. 00
		RESEARCH	0	0	•			191. 00
	1	PHYSICIANS' PRIVATE OFFICES	0	126, 425	1			192. 00
	1	NONPALD WORKERS	0	0	1			193. 00
	1	HOME OFFICE LEASED OFFICE SPACE	O	0	•			194. 00 194. 06
	1	MISC NONREIMBURSABLE COST CENTERS	0	570, 887	1			194. 08
200.00	1	TOTAL (SUM OF LINES 118 through 199)	-13, 978, 438		1			200. 00
		, , , , , , , , , , , , , , , , , , , ,		, , , , , , , , , , , , , , , , , , , ,	•			

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: 5/29/2019 3:00 pm Provider CCN: 15-0128

					5.	/29/2019 3:00 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00 A - Chargeable Medical Suppli	3.00	4. 00	5. 00		
1. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	12, 000, 645		1. 00
	PATI ENTS	, 66	ŭ	127 0007 010		11.00
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 8. 00		0. 00 0. 00	0	0		7. 00 8. 00
9. 00		0.00	0	0		9. 00
10. 00		0.00	0	Ö		10.00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14. 00		0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16.00		0.00	0	0		16.00
17. 00 18. 00		0. 00 0. 00	0	0		17. 00 18. 00
19. 00		0.00	0	o		19. 00
20. 00		0.00	0	Ö		20. 00
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	<u> </u>	0.00	0	0		24. 00
	O D. Land antable David as David		0	12, 000, 645		
1. 00	B - Implantable Device Reclas	72.00	0	10, 287, 602		1.00
1.00	PATIENTS	72.00	O	10, 267, 002		1.00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
	0 = = = = =			10, 287, 602		
	C - Drugs Charges to Pat					
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 790		1. 00
2. 00	PATIENTS DRUGS CHARGED TO PATIENTS	73. 00	0	413, 845		2. 00
3. 00	DRUGS CHARGED TO FATTENTS	0.00	0	413, 845		3.00
4. 00		0.00	0	Ö		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 11. 00		0. 00 0. 00	0	0		10. 00 11. 00
12. 00		0.00	0	0		12.00
13. 00		0.00	0			13. 00
14.00		0.00	0			14. 00
15.00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00 19. 00		0. 00 0. 00	0	0		18. 00 19. 00
19.00	TOTALS — — — — —		0	<u>0</u> 415, 635		19.00
	D - Depreciation Expense		0	413, 033		
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8, 878, 048		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 8. 00	•	0. 00 0. 00	0	0		7. 00 8. 00
9. 00		0.00	0	0		9.00
10. 00		0.00	0	o		10.00
11. 00		0.00	0	Ö		11. 00
12.00		0.00	0	0		12. 00
13. 00		0. 00	0	0		13. 00
14.00		0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16. 00 17. 00		0. 00 0. 00	0	0		16. 00 17. 00
18. 00		0.00	0			18.00
	1	3.30	<u>۷</u>	3		

| Peri od: | Worksheet A-6 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: 5/29/2019 3:00 pm

					5/29/2019 3:0	00 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
19. 00		0.00	0	0		19. 00
20. 00		0.00	0	0		20. 00
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	O		25. 00
26.00		0.00	0	O		26. 00
27.00		0.00	0	O		27. 00
28.00		0.00	o	0		28. 00
	0 — — — — —			8, 878, 048		1
	E - Interest Expense	•		<u> </u>		1
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4, 640, 464		1.00
				4, 640, 464		
	F - Other Capital Rental		-1	., ,		1
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 975, 409		1. 00
2.00	OPERATION OF PLANT	7.00	0	201, 428		2. 00
3.00	EMERGENCY	91.00	0	6, 586		3. 00
4.00	MISC NONREIMBURSABLE COST	194. 08	o	5, 760		4. 00
1. 00	CENTERS	171.00	Ĭ	3, 733		1.00
5.00		0.00	o	0		5. 00
6. 00		0.00	o	Ö		6. 00
7. 00		0.00	o	Ö		7. 00
8. 00		0.00	o	Ö		8.00
9. 00		0.00	0	Ö		9. 00
10. 00		0.00	o	0		10.00
11. 00		0.00	o	Ö		11.00
12. 00		0.00	o	Ö		12.00
13. 00		0.00	0	Ö		13. 00
14. 00	+		0	0		1
		0.00	0	0		14.00
15.00		0.00				15. 00
16.00		0.00	0	0		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	0		20. 00
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	L		0	0		25. 00
	0		0	2, 189, 183		
	G - STD BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	11, 643		1. 00
2.00	OPERATION OF PLANT	7. 00	0	13, 702		2. 00
3.00	HOUSEKEEPI NG	9.00	0	5, 071		3. 00
4.00	DI ETARY	10.00	0	3, 615		4. 00
5.00	NURSING ADMINISTRATION	13. 00	0	319		5. 00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	287		6. 00
7.00	SOCIAL SERVICE	17. 00	0	8, 737		7. 00
8.00	ADULTS & PEDIATRICS	30.00	0	157, 749		8. 00
9.00	INTENSIVE CARE UNIT	31.00	O	10, 491		9. 00
10.00	OPERATING ROOM	50.00	o	9, 771		10.00
11. 00	RECOVERY ROOM	51.00	o	29, 313		11. 00
12. 00	RADI OLOGY-DI AGNOSTI C	54.00	Ö	5, 226		12. 00
13. 00	CARDI AC CATHETERI ZATI ON	59.00	o	9, 765		13. 00
14. 00	RESPIRATORY THERAPY	65.00	o	14, 439		14. 00
15. 00	PHYSI CAL THERAPY	66.00	o	7, 221		15. 00
16. 00	ELECTROCARDI OLOGY	69.00	o	10, 216		16. 00
17. 00	ELECTROCARDIOLOGI	70.00	0	5, 726		17. 00
18. 00	DRUGS CHARGED TO PATIENTS	73.00	0	19, 826		18.00
19. 00	I MAGING CENTER	76.06	0	976		19.00
20. 00	CARDIAC REHABILITATION	76.06	ol Ol	976 1, 397		20.00
		91.00	-			1
21. 00	EMERGENCY	 		<u> 23, 692</u>		21. 00
	U Labor and Dolivery		U U	349, 182		1
1 00	H - Labor and Delivery	42.00	470 000			1 00
1.00	NURSERY	43.00	678, 823	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1, 765, 125	0		2.00
3.00	NURSERY	43.00		268, 231		3.00
4. 00	DELIVERY ROOM & LABOR ROOM _	52.00		69 <u>7, 4</u> 73		4. 00
	1		2, 443, 948	965, 704		I

Health Financial Systems COMMUNITY HOSPITAL SOUTH In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0128 Period: Worksheet A-6
From 01/01/2018 To 12/31/2018 Date/Time Prepared:

					Т	o 12/31/2018	Date/Time Pro 5/29/2019 3:0	epared:
		Increases					3/2//2017 3.	J pili
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3.00	4.00	5. 00				
	I - Cafeteria							
1.00	CAFETERI A	11. 00	840, 809	0)			1. 00
2.00	CAFETERI A	11. 00	O	1, 099, 045	5			2. 00
	0		840, 809	1, 099, 045	5			
	J - Therapy							
1.00	OCCUPATI ONAL THERAPY	67. 00	551, 540	0				1. 00
2.00	SPEECH PATHOLOGY	68. 00	139, 418	0				2. 00
3.00	OCCUPATI ONAL THERAPY	67. 00		183, 135	5			3. 00
4.00	SPEECH PATHOLOGY	68. 00		<u>46, 2</u> 93	В			4. 00
			690, 958	229, 428	3			
	K - Building Depreciation							
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0_	<u>4, 727, 827</u>				1. 00
	0		0	4, 727, 827	'			
	L - Capital Insurance Costs							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	•	18 <u>9, 6</u> 21				1. 00
	0		0	189, 621				
	M - Radiology Support Staff							
1.00	RADI OLOGY-THERAPEUTI C	55. 00	57, 854	0)			1. 00
2.00	CT SCAN	57. 00	148, 763	0)			2. 00
3.00	MAGNETIC RESONANCE I MAGING	58. 00	26, 904	0)			3. 00
	(MRI)							
4.00	RADI OLOGY-THERAPEUTI C	55. 00		29, 530				4. 00
5. 00	CT SCAN	57. 00		75, 931				5. 00
6.00	MAGNETIC RESONANCE I MAGING	58. 00		13, 732	2			6. 00
	(MRI)	+			-			1
F00 00			233, 521	119, 193				F00 00
500.00	Grand Total: Increases		4, 209, 236	46, 091, 577	T			500.00

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/29/2019 3:00 pm

		-				5/29/2019 3:	T PIII
		Decreases	0.1	0.11			
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10. 00		
	A - Chargeable Medical Suppli						
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	4, 990	0		1. 00
2.00	LAUNDRY & LINEN SERVICE	8. 00	0	613	0		2. 00
3. 00	DI ETARY	10. 00	0	413	0		3. 00
4. 00	ADULTS & PEDIATRICS	30. 00	0	988, 368	0		4. 00
5.00	INTENSIVE CARE UNIT	31. 00	0	206, 511	0		5. 00
6.00	OPERATING ROOM	50.00	0	5, 544, 517	0		6. 00
7.00	RECOVERY ROOM	51.00	0	175, 450	0		7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	522, 319	o		8. 00
9.00	RADI OLOGY-THERAPEUTI C	55. 00	0	607, 250	o		9. 00
10.00	CT SCAN	57.00	0	156, 626	o		10.00
11. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	11, 322	o		11. 00
	(MRI)	00.00	ŭ	, 522	١		
12. 00	CARDIAC CATHETERIZATION	59. 00	0	2, 505, 076	0		12. 00
13. 00	RESPIRATORY THERAPY	65.00	0	340, 250	o		13. 00
14. 00	PHYSI CAL THERAPY	66.00	0	45, 202	0		14. 00
15. 00	ELECTROCARDI OLOGY	69.00	0	9, 229	0		15. 00
	•		0		0		1
16.00	ELECTROENCEPHALOGRAPHY	70.00	U	24, 901			16. 00
17. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	79, 819	0		17. 00
18. 00	RENAL DI ALYSI S	74. 00	0	3, 831	0		18. 00
19. 00	ENDOSCOPY	76. 00	0	448, 881	0		19. 00
20. 00	I MAGING CENTER	76. 06	0	99, 385	0		20. 00
21. 00	CARDIAC REHABILITATION	76. 97	0	8, 164	0		21. 00
22. 00	ANTI-COAGULATION CLINIC	90. 02	0	1, 413	0		22. 00
23.00	EMERGENCY	91. 00	0	214, 386	0		23. 00
24.00	MISC NONREIMBURSABLE COST	194. 08	0	1, 729	0		24. 00
	CENTERS						
				12, 000, 645			
	B - Implantable Device Reclas	SS					1
1.00	OPERATING ROOM	50.00	0	6, 814, 599	0		1.00
2.00	RADI OLOGY-THERAPEUTI C	55. 00	0		o		2. 00
3. 00	CARDIAC CATHETERIZATION	59.00	0		o		3. 00
0.00	0						0.00
	C - Drugs Charges to Pat			10/20//002			
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	89	0		1. 00
2. 00	ADULTS & PEDIATRICS	30.00	0		o		2. 00
3.00	INTENSIVE CARE UNIT	31.00	0	9, 363	o		3. 00
4. 00	OPERATING ROOM	50.00	0	14, 062	o		4. 00
5. 00	RECOVERY ROOM	51.00	0	5, 715	o		5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	18, 506	0		6. 00
	•		0		0		1
7.00	RADI OLOGY-THERAPEUTI C	55.00	0	569	0		7. 00
8.00	CT SCAN	57. 00	0	183, 853			8. 00
9. 00	MAGNETIC RESONANCE I MAGING	58. 00	U	2, 664	0		9. 00
40.00	(MRI)	50.00		70.400			10.00
10.00	CARDIAC CATHETERIZATION	59.00	0	70, 499	0		10.00
11. 00	RESPI RATORY THERAPY	65. 00	0	7, 552	0		11. 00
12. 00	PHYSI CAL THERAPY	66. 00	0	766	0		12. 00
	ELECTROCARDI OLOGY	69. 00	0	372	0		13. 00
14. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	484	0		14. 00
15. 00	RENAL DIALYSIS	74. 00	0	528	0		15. 00
16. 00	ENDOSCOPY	76. 00	0	3, 789	0		16. 00
17. 00	I MAGING CENTER	76. 06	0	25, 538	0		17. 00
18.00	ANTI-COAGULATION CLINIC	90. 02	0	29	0		18. 00
19. 00	EMERGENCY	91.00	0	17, 422	0		19. 00
	TOTALS			415, 635			
	D - Depreciation Expense	•					1
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	3, 810, 066	9		1.00
2.00	OPERATION OF PLANT	7. 00	0	58, 409	ol		2. 00
3. 00	HOUSEKEEPI NG	9.00	0	·	Ö		3. 00
	DI ETARY	10. 00	0	68, 422	o		4. 00
5. 00	SOCI AL SERVI CE	17. 00	0	1, 805	0		5. 00
6.00	ADULTS & PEDIATRICS	30.00	0	469, 916	0		6. 00
7. 00	INTENSIVE CARE UNIT	31.00	0	178, 988	0		7. 00
			0		0		1
8.00	OPERATING ROOM	50. 00 51. 00	0	1, 368, 223			8.00
9.00	RECOVERY ROOM	51.00	0	33, 771	0		9. 00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	338, 814	0		10.00
11. 00	RADI OLOGY-THERAPEUTI C	55.00	0	105, 744	0		11. 00
12. 00	CT SCAN	57. 00	0		0		12. 00
13. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	41, 148	0		13. 00
	(MRI)						
14. 00	CARDIAC CATHETERIZATION	59. 00	0		0		14. 00
15. 00	LABORATORY	60. 00	0	2, 173	0		15. 00
16. 00	RESPI RATORY THERAPY	65. 00	0		0		16. 00
17. 00	PHYSI CAL THERAPY	66.00	0	147, 999	O		17. 00
	'	'	'		'		

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/29/2019 3:00 pm

						5/29/2019 3:	00 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9.00	10.00		
18. 00	ELECTROCARDI OLOGY	69. 00	0	92, 040	0		18. 00
19.00	ELECTROENCEPHALOGRAPHY	70.00	o	35, 181	o		19. 00
20.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	30, 198	ol		20. 00
20.00	PATI ENTS	,	Ĭ	00, 170	ا		20.00
21. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	34, 471	o		21. 00
22. 00	ENDOSCOPY	76. 00	Ö	343, 727	o o		22. 00
			0				
23. 00	I MAGING CENTER	76.06	U	211, 523	-		23. 00
24. 00	CARDIAC REHABILITATION	76. 97	0	5, 628			24. 00
25. 00	ANTI-COAGULATION CLINIC	90. 02	0	16, 793	0		25. 00
26. 00	SPINE CENTER	90. 04	0	14, 082	0		26. 00
27.00	EMERGENCY	91.00	0	97, 782	0		27. 00
28. 00	MISC NONREIMBURSABLE COST	194. 08	ol	5, 825	ol		28. 00
	CENTERS			.,			
			₀	8, 878, 048			1
	E - Interest Expense		-,				
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	4, 640, 464	11		1. 00
1.00	O O CIVERAL		— — — ў	4, 640, 464			1.00
	C Other Conital Dental		Ч	4, 040, 404			-
1 00	F - Other Capital Rental	4 00	ما	71	10		1 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	71	10		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	68, 551	0		2. 00
3.00	HOUSEKEEPI NG	9. 00	0	13, 627	0		3. 00
4.00	DI ETARY	10.00	0	3, 993	0		4. 00
5.00	MEDICAL RECORDS & LIBRARY	16. 00	0	80	0		5. 00
6.00	SOCI AL SERVI CE	17. 00	0	471	o		6. 00
7.00	ADULTS & PEDIATRICS	30.00	0	45, 291	o		7. 00
8. 00	OPERATING ROOM	50.00	0	135, 585			8. 00
9. 00	RECOVERY ROOM	51.00	0	•	0		9. 00
			U	4, 514			1
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	718			10.00
11. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	370			11. 00
12.00	CT SCAN	57. 00	0	20			12. 00
13.00	CARDIAC CATHETERIZATION	59. 00	0	2, 303	0		13. 00
14.00	LABORATORY	60.00	0	80	0		14. 00
15.00	RESPI RATORY THERAPY	65.00	ol	8, 400	o		15. 00
16.00	PHYSI CAL THERAPY	66.00	0	295, 121	o		16. 00
17. 00	ELECTROCARDI OLOGY	69.00	0	538			17. 00
18. 00	ELECTROENCEPHALOGRAPHY	70.00	0	82, 760			18. 00
			0	•			1
19. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	٩	956, 900	۷		19. 00
00.00	PATIENTS	70.00		0.47.044			00.00
20. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	347, 941	0		20. 00
21. 00	RENAL DIALYSIS	74. 00	0	48	0		21. 00
22. 00	ENDOSCOPY	76. 00	0	701	0		22. 00
23.00	I MAGING CENTER	76. 06	0	188, 424	0		23. 00
24.00	ANTI-COAGULATION CLINIC	90. 02	0	40	0		24. 00
25.00	SPINE CENTER	90. 04	o	32, 636	ol		25. 00
		1	o	2, 189, 183			
	G - STD BENEFITS	ı	- 1				
1.00	ADMINISTRATIVE & GENERAL	5. 00	11, 643	0	0		1. 00
2. 00	OPERATION OF PLANT	7. 00	13, 702	0			2. 00
3. 00	HOUSEKEEPI NG	9.00	5, 071	0			3. 00
				•	١		
4.00	DIETARY	10.00	3, 615	0			4. 00
5.00	NURSING ADMINISTRATION	13.00	319	0			5. 00
6.00	MEDICAL RECORDS & LIBRARY	16. 00	287	0			6. 00
7.00	SOCI AL SERVI CE	17. 00	8, 737	0			7. 00
8.00	ADULTS & PEDIATRICS	30. 00	157, 749	0			8. 00
9.00	INTENSIVE CARE UNIT	31.00	10, 491	0	0		9. 00
10.00	OPERATING ROOM	50.00	9, 771	0	o		10. 00
11.00	RECOVERY ROOM	51.00	29, 313	0	o		11. 00
12. 00	RADI OLOGY-DI AGNOSTI C	54.00	5, 226	0	o		12. 00
13. 00	CARDI AC CATHETERI ZATI ON	59. 00	9, 765	0			13. 00
14. 00	RESPIRATORY THERAPY	65. 00	14, 439	0	0		14. 00
15. 00	PHYSICAL THERAPY	66.00	7, 221	0			15. 00
				0	0		1
16.00	ELECTROCARDI OLOGY	69.00	10, 216	0			16. 00
17. 00	ELECTROENCEPHALOGRAPHY	70.00	5, 726	0	0		17. 00
18. 00	DRUGS CHARGED TO PATIENTS	73. 00	19, 826	0	0		18. 00
19. 00	I MAGING CENTER	76. 06	976	0			19. 00
20.00	CARDIAC REHABILITATION	76. 97	1, 397	0	0		20. 00
21.00	EMERGENCY	91.00	2 <u>3, 6</u> 92	0	ol		21. 00
	0		349, 182		1		
	H - Labor and Delivery			-			1
1.00	ADULTS & PEDIATRICS	30.00	2, 443, 948	0			1. 00
2. 00		33. 30	_, , , , , , ,	O			2. 00
3.00	ADULTS & PEDIATRICS	30.00		965, 704			3. 00
	ADULIS & FEDIAIRIUS	30.00		900, 704			1
4. 00	\vdash $ -$	$\vdash +$			├		4. 00
	1		2, 443, 948	965, 704	<u> </u>		1

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 COMMUNITY HOSPITAL SOUTH Provider CCN: 15-0128

Period: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 3:00 pm

		Decreases			·		
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	I - Cafeteria						
1.00	DI ETARY	10. 00	840, 809	0	0	1	1. 00
2.00	DI ETARY	1000	0	<u>1, 099, 0</u> 45		2	2. 00
	0		840, 809	1, 099, 045			
	J - Therapy						
1.00	PHYSI CAL THERAPY	66. 00	690, 958	0		1	1. 00
2.00							2. 00
3.00	PHYSI CAL THERAPY	66. 00		229, 428			3. 00
4.00	L					4	4. 00
			690, 958	229, 428			
	K - Building Depreciation						
1.00	CAP REL COSTS-MVBLE EQUIP		0	<u>4, 727, 8</u> 27		1	1. 00
	0		0	4, 727, 827			
	L - Capital Insurance Costs						
1.00	ADMI NI STRATI VE & GENERAL		0	18 <u>9, 6</u> 21		1	1. 00
	0		0	189, 621			
	M - Radiology Support Staff						
1.00	RADI OLOGY-DI AGNOSTI C	54.00	233, 521	0		1	1. 00
2.00						2	2. 00
3.00						3	3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00		119, 193		4	4. 00
5.00						5	5. 00
6.00						6	6. 00
			233, 521	119, 193			
500.00	Grand Total: Decreases		4, 558, 418	45, 742, 395		500	0. 00

					o 12/31/2018		pared:
				Acqui si ti ons		0,27,2017 0.00	У
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	2, 705, 851	0	C	0	0	1. 00
2.00	Land Improvements	3, 164, 637	582, 896	C	582, 896		2. 00
3.00	Buildings and Fixtures	313, 468, 219	7, 299, 219	C	7, 299, 219		3. 00
4.00	Building Improvements	1, 751, 624	845, 503	C	845, 503	0	4. 00
5.00	Fi xed Equi pment	0	0	C	0	0	5. 00
6.00	Movable Equipment	108, 146, 114	5, 301, 513	C	5, 301, 513	1, 831, 439	6. 00
7.00	HIT designated Assets	0	0	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	429, 236, 445	14, 029, 131	C	14, 029, 131	1, 833, 844	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	429, 236, 445	14, 029, 131	C	14, 029, 131	1, 833, 844	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	2, 705, 851	0				1. 00
2.00	Land Improvements	3, 747, 533	0				2. 00
3.00	Buildings and Fixtures	320, 765, 033	0				3.00
4.00	Building Improvements	2, 597, 127	0				4. 00
5.00	Fi xed Equipment	0	0				5. 00
6.00	Movable Equipment	111, 616, 188	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	441, 431, 732	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	441, 431, 732	o				10. 00

Heal th	Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lieu of Form CMS-2552-10		
RECONC	CILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 15-0128		Peri od: From 01/01/2018	Worksheet A-7		
					To 12/31/2018		pared:
						5/29/2019 3:00	O pm
			SL	JMMARY OF CAF	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
	T	9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	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 WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3. 00	Total (sum of lines 1-2)	0	0			ļ	3. 00

Heal th	n Financial Systems	COMMUNITY HOS	SPITAL SOUTH		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2018 To 12/31/2018		pared:
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	<u> </u>
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col			
		1. 00	2.00	3, 00	4.00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	5.00	
1.00	CAP REL COSTS-BLDG & FLXT	321, 090, 331		321, 090, 33	0. 748050	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	108, 146, 114		108, 146, 11			2. 00
3.00	Total (sum of lines 1-2)	429, 236, 445	0	429, 236, 44	5 1.000000	0	3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum o	f Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART III DECONCILIATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS		1	0 4, 727, 827	0	1. 00
2.00	CAP REL COSTS-BEDG & TTXT	0			0 7, 708, 641		2.00
3.00	Total (sum of lines 1-2)	0			0 12, 436, 468		3. 00
0.00	Trotal (Sam St 1711SS 1 2)	J	SI	JMMARY OF CAPI		1,770,107	0.00
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions) Capi tal -Rel ate		
					d Costs (see	through 14)	
		11.00	12.00	13. 00	instructions) 14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	15.00	
1.00	CAP REL COSTS-BLDG & FLXT	1, 888, 555	189, 621		0 0	6, 806, 003	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		1	0 0	9, 684, 050	2. 00
3.00	Total (sum of lines 1-2)	1, 888, 555	189, 621		0 0		3. 00

					To 12/31/2018	Date/Time Prep 5/29/2019 3:00	
				Expense Classification on	Worksheet A	372772017 3.00	<i>у</i> рііі
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00	5. 00	1. 00
1.00	COSTS-BLDG & FLXT (chapter 2)		U	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
	COSTS-MVBLE EQUIP (chapter 2)		_			_	
3.00	Investment income - other		0		0.00	0	3. 00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	o	4. 00
00	di scounts (chapter 8)		· ·		0.00		00
5.00	Refunds and rebates of	В	-12, 834	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
6.00	suppliers (chapter 8)		U		0.00	0	0.00
7.00	Tel ephone servi ces (pay		0		0.00	o	7. 00
	stations excluded) (chapter						
8. 00	21) Television and radio service		0		0.00	9	8. 00
8.00	(chapter 21)		U		0.00	9	8.00
9.00	Parking Lot (chapter 21)		0		0.00	o	9. 00
10.00	Provi der-based physi ci an	A-8-2	-242, 186			o	10.00
44 00	adjustment				0.00		44 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization	A-8-1	4, 208, 529			0	12. 00
	transactions (chapter 10)						
13.00	Laundry and linen service		0		0.00		13.00
14.00	Cafeteria-employees and guests		-1, 265, 229	CAFETERI A	11.00	1	14.00
15. 00	Rental of quarters to employee and others	1	0		0.00	0	15. 00
16. 00	Sale of medical and surgical		0		0.00	o	16. 00
	supplies to other than						
47.00	patients		•		0.00		47.00
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
	abstracts						
19. 00	Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00	Vendi ng machi nes		0		0.00	0	20. 00
21. 00	Income from imposition of		0		0.00		21. 00
	interest, finance or penalty						
22.00	charges (chapter 21)		0		0.00	0	22.00
22. 00	Interest expense on Medicare overpayments and borrowings to	,	U		0.00	0	22. 00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of						
24, 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	 PHYSI CAL THERAPY	66.00		24. 00
55	therapy costs in excess of		0				55
0.5	limitation (chapter 14)						0.5
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
	COSTS-BLDG & FIXT						
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0	Social Solitor Borotou	0.00		29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of						
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		^	ADULTS & PEDIATRICS	30.00		30. 99
JU. 77	instructions)		U	INDUCTO & LEDIATRICS	30.00		JU. 77
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of						
32 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
32. UU	Depreciation and Interest		U		0.00	"	J∠. UU
33. 00	MI SC REVENUE	В	0	CARDIAC REHABILITATION	76. 97	o	33. 00
33. 00	MI SC REVENUE	В	0	CARDIAC REHABILITATION	76. 97	0	33

From 01/01/2018 | To 12/31/2018 | Date/Time Prepared:

					0 12/31/2018	5/29/2019 3:0	parea: O nm
				Expense Classification on	Worksheet A	372772017 3.0	l pili
				To/From Which the Amount is			
				Top I I om min on the rameant I o	to be haj deted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	, , , , , , , , , , , , , , , , , , ,	1.00	2, 00	3.00	4. 00	5. 00	
33. 01	Mi sc Revenue	В	-240	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	Mi sc Revenue	В		OPERATION OF PLANT	7. 00		1
33. 03	Mi sc Revenue	В		DI ETARY	10. 00	0	33. 03
33. 04	Mi sc Revenue	В		ADULTS & PEDIATRICS	30.00	0	33. 04
33. 05	Mi sc Revenue	В		OPERATING ROOM	50.00	0	33. 05
33. 06	Mi sc Revenue	В	•	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 06
33. 07	Mi sc Revenue	В	•	LABORATORY	60.00	0	
33. 08	Mi sc Revenue	В	-	PHYSI CAL THERAPY	66. 00	0	
33. 09	Mi sc Revenue	B		MEDICAL SUPPLIES CHARGED TO	71. 00	0	33. 09
00.07	iiii oo nevenae			PATI ENTS	, 00		00.07
33. 10	Mi sc Revenue	В	-19, 500	DRUGS CHARGED TO PATIENTS	73.00	0	33. 10
33. 11	Mi sc Revenue	В	-5, 870	CARDIAC REHABILITATION	76. 97	0	33. 11
33. 12	Mi sc Revenue	В	-143	EMERGENCY	91.00	0	33. 12
33. 13	Space Rental Income	В	-541, 098	OPERATION OF PLANT	7. 00	0	33. 13
34.00	HAF Tax Offset	A	-11, 545, 682	ADMINISTRATIVE & GENERAL	5. 00	0	34.00
34. 01	LOC Non-Allow Interest Expense	A	-27, 819	CAP REL COSTS-BLDG & FIXT	1.00	11	34. 01
34. 02	Non-Allowable Interest Expense			CAP REL COSTS-BLDG & FIXT	1.00	11	34. 02
	00						
34. 03	2012B Non- Allow Interest	A	-91, 191	CAP REL COSTS-BLDG & FIXT	1.00	11	34. 03
	Expense						
34.04	50M BMO Non- Allow Interest	A	-53, 338	CAP REL COSTS-BLDG & FIXT	1.00	11	34. 04
	Expense						
34. 05	12B Non-Allow Interest Expense	A	-379, 900	CAP REL COSTS-BLDG & FIXT	1.00	11	34. 05
34.06	50 BMO Loan Non- Allow	A	32, 228	ADMINISTRATIVE & GENERAL	5. 00	0	34. 06
	Interest Expense						
34. 07	NON-ALLOWABLE INTEREST EXPENSE	A	-1, 478, 594	CAP REL COSTS-BLDG & FIXT	1.00	11	34. 07
	18A						
36. 00	Meals of Wheels Cost	A		CAFETERI A	11. 00		00.00
36. 01	Non Allow Sponsorship	A		ADMINISTRATIVE & GENERAL	5. 00		
36. 02	Nurse Practitioner Offset	A	•	ANTI-COAGULATION CLINIC	90. 02	0	36. 02
50.00	TOTAL (sum of lines 1 thru 49)		-13, 978, 438				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 15-0128 Period:
From 01/01/2018 To 12/31/2018 Date/Time Prepared:
5/39/2019 3:00 pm

					5/29/2019 3:00) pm
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:		I	11		
1.00	l control of the cont	ADMINISTRATIVE & GENERAL	1550 CTY LN RD	94, 089	67, 057	1. 00
2.00		ADULTS & PEDIATRICS	1550 CTY LN RD	55, 310	39, 420	2. 00
3.00	1	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	3, 558, 420	0	3. 00
3. 01	1	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	3, 091, 568	0	3. 01
3. 02		ADMINISTRATIVE & GENERAL	HOME OFFICE	32, 057, 039	44, 558, 080	3. 02
3.03	1	OPERATION OF PLANT	HOME OFFICE	360, 512	0	3. 03
3. 04	1	NURSING ADMINISTRATION	HOME OFFICE	2, 637, 622	0	3. 04
3. 05		MEDICAL RECORDS & LIBRARY	HOME OFFICE	1, 656, 860	0	3. 05
3.06		ADULTS & PEDIATRICS	HOME OFFICE	409, 970	0	3. 06
3.07		ADULTS & PEDIATRICS	HOME OFFICE	1, 828, 263	0	3. 07
3.08	1	RADI OLOGY-DI AGNOSTI C	HOME OFFICE	77, 782	0	3. 08
3.09	1	ELECTROCARDI OLOGY	HOME OFFICE	122, 689	0	3. 09
3. 10	1	ELECTROENCEPHALOGRAPHY	HOME OFFICE	138, 621	0	3. 10
3. 11	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	813, 535	0	3. 11
3. 12		DRUGS CHARGED TO PATIENTS	HOME OFFICE	253, 630	0	3. 12
4.00	21.00	I&R SERVICES-SALARY & FRINGE	INTERNS & RESIDENTS	593, 815	0	4.00
4.01	22. 00	I&R SERVICES-OTHER PRGM. COS	INTERNS & RESIDENTS	951, 622	0	4. 01
4.02	5. 00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR AND CAL	171, 739	0	4. 02
5.00	TOTALS (sum of lines 1-4).			48, 873, 086	44, 664, 557	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 RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	C	CHNW	100.00	0. 00	6. 00
7.00			0.00	0. 00	7. 00
8.00			0.00	0. 00	8. 00
9.00			0.00	0. 00	9. 00
10.00			0.00	0. 00	10.00
100.00	G. Other (financial or	OTHER			100.00
	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.

* 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.

3. 12

4.00

4 01

4.02

5.00

Related Organization(s) and/or Home Office			
Type of Business			
6. 00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

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

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

6. 00		6.00
7. 00		7.00
8. 00		8.00
9. 00		9.00
10. 00	10	10.00
7. 00 8. 00 9. 00 10. 00 100. 00	100	00.00

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

253, 630

593, 815

951, 622

171, 739

4, 208, 529

3.12

4.00

4 01

4.02

5.00

0

0

0

0

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT In Lieu of Form CMS-2552-10
Worksheet A-8-2 Peri od: Worksheet A-8-2 From 01/01/2018 Date/Time Prepared: 5/20/2019 3:00 pm Provider CCN: 15-0128

					To 12/31/2018 Date/Time Prepared: 5/29/2019 3:00 pm			
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component	1102 711104111	ider Component	
							Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	5. 00	AGGREGATE-ADMINISTRATIVE &	453, 686	29, 031	424, 655	211, 500	2, 080	1. 00
		GENERAL						
2.00	0. 00		0					2. 00
3.00	0. 00		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	7. 00
8.00	0. 00		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			453, 686					200. 00
	Wkst. A Line #	J	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		ldenti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1. 00	2.00	8. 00	9. 00	Education 12.00	12 13. 00	14. 00	
1.00		AGGREGATE-ADMI NI STRATI VE &	211, 500			13.00		1. 00
1.00	3.00	GENERAL	211, 500	10, 373	0	U	U	1.00
2.00	0.00		0	0	0	0	0	2. 00
3.00	0.00		1 0					3. 00
4.00	0.00		1 0	l o		o o		4. 00
5. 00	0.00		0	Ö	0	o o	o	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	o	o	8. 00
9.00	0.00		0	0	0	0	o	9. 00
10.00	0.00		0	0	0	0	o	
200.00			211, 500	10, 575	0	0	o	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance	_		
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	5. 00	AGGREGATE-ADMINISTRATIVE &	0	211, 500	213, 155	242, 186		1. 00
	GENERAL							
2.00	0.00		0	· ·		0		2. 00
3.00	0.00		0	0		0		3. 00
4.00	0.00		0	0	_	0		4. 00
5.00	0. 00 0. 00			0	0	0		5. 00
6.00					0	0		6. 00
7.00	0. 00 0. 00			0	0	0		7. 00
8.00					0			8. 00
9.00	0.00		0	0		0		9. 00
10. 00 200. 00	0. 00			_	_	0 242, 186		10. 00 200. 00
200.00	I	I	1	1 211,300	Z 13, 133	242, 180		200.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0128 Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 3:00 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 1 00 00100 CAP REL COSTS-BLDG & FLXT 6, 806, 003 6, 806, 003 2.00 00200 CAP REL COSTS-MVBLE EQUIP 9, 684, 050 9, 684, 050 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3, 103, 168 3, 103, 168 4.00 00500 ADMINISTRATIVE & GENERAL 956, 982 3, 696, 245 44, 193, 897 5 00 39, 332, 446 208 224 5 00 00700 OPERATION OF PLANT 7.00 5, 279, 806 904, 047 C 76,873 6, 260, 726 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 695, 769 18, 912 714, 681 8.00 00900 HOUSEKEEPI NG 2, 183, 965 41, 520 18, 431 63, 788 2, 307, 704 9.00 9.00 01000 DI ETARY 10.00 19, 163 1, 083, 772 967.825 72, 552 24, 232 10 00 11.00 01100 CAFETERI A 581, 935 153, 081 46, 104 42, 530 823, 650 11.00 01300 NURSING ADMINISTRATION 2, 954, 007 2, 967, 460 13.00 C 13, 453 13.00 01600 MEDICAL RECORDS & LIBRARY 1, 967, 826 78 12, 822 1, 980, 726 16, 00 16, 00 01700 SOCIAL SERVICE 17.00 1, 574, 057 18, 998 2.231 62,668 1, 657, 954 17.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 593, 815 593, 815 21.00 C 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 22.00 951, 622 951, 622 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 28, 074, 646 1, 776, 066 279 851 976, 027 31, 106, 590 30.00 521, 326 175, 469 03100 INTENSIVE CARE UNIT 3, 516, 790 134, 910 4, 348, 495 31.00 31.00 43.00 04300 NURSERY 947, 054 <u>66, 1</u>05 17, 358 34, 336 1, 064, 853 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 6, 033, 341 595, 391 920, 727 163, 480 7, 712, 939 50.00 05100 RECOVERY ROOM 3, 510, 252 147, 012 37, 213 129, 443 3, 823, 920 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 3, 102, 396 174, 039 45, 135 118, 304 3, 439, 874 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 929, 302 211, 690 302, 278 73, 709 2, 516, 979 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 1,009,028 103, 321 31, 076 1, 143, 425 55.00 05700 CT SCAN 1, 644, 388 57.00 1, 314, 218 26, 029 266, 553 37, 588 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 446, 961 30, 310 10, 461 13, 406 501, 138 58.00 05900 CARDIAC CATHETERIZATION 59.00 2, 674, 601 190, 836 760, 281 65, 872 3, 691, 590 59.00 06000 LABORATORY 5, 927, 308 60.00 5, 838, 173 89,057 78 60.00 64.00 06400 INTRAVENOUS THERAPY C 64.00 06500 RESPI RATORY THERAPY 2, 474, 017 44.442 72,020 92.515 2, 682, 994 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 2, 317, 890 14, 682 539, 229 90, 613 2, 962, 414 66.00 06700 OCCUPATI ONAL THERAPY 799, 272 67.00 734, 675 4, 556 32, 143 27, 898 67.00 06800 SPEECH PATHOLOGY 185, 711 7,052 202, 091 68.00 1, 203 8. 125 68.00 06900 ELECTROCARDI OLOGY 42, 437 1, 399, 193 107, 332 1, 612, 025 69.00 63, 063 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 790,093 43, 291 115, 621 21, 336 970, 341 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 12, 726, 713 967, 666 13, 694, 379 71.00 10, 287, 602 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 10 287 602 C O 72 00 25, 256 11, 927, 572 07300 DRUGS CHARGED TO PATIENTS 73.00 11, 402, 996 365, 010 134, 310 73.00 74.00 07400 RENAL DIALYSIS 415, 339 20, 975 47 436, 361 74.00 03950 ENDOSCOPY 76.00 1,057,696 0 296, 116 33, 298 1, 387, 110 76.00 03330 I MAGING CENTER 1, 383, 119 76 06 392 084 40 353 1, 815, 556 76 06 0 76.97 07697 CARDIAC REHABILITATION 304, 676 0 5, 517 12, 155 322, 348 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 04950 DIABETIC CARE CENTER 90.01 0 Ω 0 0 90 01 90.02 04951 ANTI-COAGULATION CLINIC 356, 012 0 3, 559 26, 544 386, 115 90.02 04952 PALLIATIVE CARE 90.03 90.03 04953 SPINE CENTER 90.04 90.04 213, 422 45. 716 6.331 265, 469 09100 EMERGENCY 518, 266 91.00 91.00 7, 853, 164 72.024 268, 927 8, 712, 381 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 188, 975, 374 6, 773, 956 9, 683, 986 3, 081, 441 188, 921, 536 118. 00 118.00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH 0 191. 00 0 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 126, 425 192. 00 0 126, 425 Ω 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 0 194.00 07950 HOME OFFICE 0 194.00 0 194.06 07956 LEASED OFFICE SPACE 0 194.06 0 194. 08 07958 MISC NONREIMBURSABLE COST CENTERS 570,887 32.047 64 21, 727 624, 725 194. 08 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00 3, 103, 168 202.00 TOTAL (sum lines 118 through 201) 189, 672, 686 6, 806, 003 9, 684, 050 189, 672, 686 202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0128

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

5/29/2019 3:00 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 44, 193, 897 5 00 7.00 00700 OPERATION OF PLANT 1, 901, 896 8, 162, 622 7.00 00800 LAUNDRY & LINEN SERVICE 217, 107 8.00 31, 217 963,005 8.00 9.00 00900 HOUSEKEEPI NG 701, 039 68. 536 0 3, 077, 279 9.00 01000 DI ETARY 329, 230 0 1, 578, 471 10.00 10.00 119, 761 45.708 11.00 01100 CAFETERI A 250, 210 252, 690 0 96, 442 11.00 0 13 00 01300 NURSING ADMINISTRATION 901, 461 0 0 0 13.00 01600 MEDICAL RECORDS & LIBRARY 601, 709 0 16.00 16.00 0 0 0 17.00 01700 SOCIAL SERVICE 503, 657 31, 359 11, 969 0 17.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 180, 390 0 0 21.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 22.00 289, 086 22.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 9, 449, 680 2, 931, 733 432, 611 1, 118, 927 1, 447, 344 30.00 03100 INTENSIVE CARE UNIT 328, 437 31.00 1, 320, 995 860, 548 49, 576 131, 127 31.00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 12, 125 43.00 323, 483 109, 119 43.00 41,646 0 50.00 05000 OPERATING ROOM 2, 343, 052 982, 807 375, 099 50.00 0 05100 RECOVERY ROOM 51.00 1, 161, 638 242, 672 147, 895 92, 618 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 1, 044, 972 287, 285 109, 645 52.00 31, 524 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 764, 613 349, 435 14, 696 133, 366 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 347, 352 0 55.00 57.00 05700 CT SCAN 499, 535 42, 966 16, 399 57.00 76.103 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 152, 237 50, 033 \cap 19.096 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 1, 121, 439 315, 011 10,655 120, 227 0 59.00 06000 LABORATORY 60.00 1,800,609 147,005 56, 106 0 60.00 06400 INTRAVENOUS THERAPY 0 64.00 0 64.00 27, 999 06500 RESPIRATORY THERAPY 815, 045 65.00 73, 361 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 899, 928 24, 236 0 9, 250 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 242, 804 7, 521 0 2,870 0 67.00 68 00 06800 SPEECH PATHOLOGY 61 392 1 987 0 758 0 68 00 06900 ELECTROCARDI OLOGY 0 69.00 489, 704 177, 173 67,620 0 69.00 07000 ELECTROENCEPHALOGRAPHY 294, 772 71, 459 0 27, 273 0 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 4, 160, 106 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 3, 125, 188 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 623, 382 41,689 0 15, 911 0 73.00 07400 RENAL DIALYSIS 74.00 132, 559 34, 623 0 13, 214 0 74.00 76 00 03950 ENDOSCOPY 421, 379 0 Ω 76 00 C 0 03330 I MAGING CENTER 0 76.06 551, 533 0 0 0 76.06 07697 CARDIAC REHABILITATION 97, 924 0 0 76. 97 76.97 0 OUTPATIENT SERVICE COST CENTERS 90 00 0 90 00 09000 CLINIC 0 0 90.01 04950 DIABETIC CARE CENTER 0 0 0 90.01 90.02 04951 ANTI-COAGULATION CLINIC 117, 295 0 0 0 0 90.02 04952 PALLIATIVE CARE 0 90.03 90.03 0 0 04953 SPINE CENTER 90.04 0 90 04 80 645 0 91.00 09100 EMERGENCY 2, 646, 665 855, 497 187, 820 326, 509 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 1, 578, 471 118. 00 118.00 43, 965, 711 8, 109, 723 963, 005 3, 057, 089 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN С 0 190. 00 191. 00 19100 RESEARCH 0 0 0 191. 00 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 38.406 Ω 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 0 0 194.00 07950 HOME OFFICE o 0 0 194.00 194.06 07956 LEASED OFFICE SPACE 0 194, 06 0 194.08 07958 MISC NONREIMBURSABLE COST CENTERS 189, 780 52, 899 0 20, 190 0 194. 08 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201, 00 3, 077, 279 202.00 TOTAL (sum lines 118 through 201) 44, 193, 897 8, 162, 622 963.005 1, 578, 471 202. 00

| Peri od: | Worksheet B | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | Part | Part | Prepared: | Part | P Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0128

				Т	To 12/31/2018	Date/Time Prep 5/29/2019 3:00	
						INTERNS &	D DIII
						RESI DENTS	
	Cost Center Description	CAFETERI A	NURSI NG	MEDICAL RECORDS &	SOCIAL SERVICE	SERVI CES-SALAR	
			ADMI NI STRATI ON	LI BRARY		Y & FRINGES	
		11.00	13.00	16. 00	17. 00	21.00	
	SENERAL SERVICE COST CENTERS	1			•		
1	00100 CAP REL COSTS-BLDG & FLXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
1	00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
	00700 OPERATION OF PLANT						7. 00
	00800 LAUNDRY & LINEN SERVICE						8. 00
	00900 HOUSEKEEPI NG						9. 00
	01000 DI ETARY						10.00
	01100 CAFETERIA	1, 422, 992	1				11.00
	01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	16, 498 6, 187					13. 00 16. 00
	017000 SOCIAL SERVICE	32, 997		2, 300, 022			17. 00
	02100 I&R SERVICES-SALARY & FRINGES APPRVD	02,777	1	d			21. 00
22. 00 C	02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	С	0	C	0		22. 00
_	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	569, 198				588, 915	30.00
	03100 INTENSIVE CARE UNIT 04300 NURSERY	59, 807			1	45, 787 0	31. 00 43. 00
	NCILLARY SERVICE COST CENTERS	18, 561	09, 434	12, 095	178, 300	0	43.00
	05000 OPERATING ROOM	96, 928	8 0	297, 705	5 0	24, 781	50.00
	05100 RECOVERY ROOM	63, 932					51.00
	05200 DELIVERY ROOM & LABOR ROOM	47, 433					52. 00
	05400 RADI OLOGY-DI AGNOSTI C	45, 371	1	93, 546		-,	54.00
	05500 RADI OLOGY-THERAPEUTI C	16, 498 22, 685		58, 499		_	55. 00 57. 00
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	8, 249	1	168, 600 29, 826			58.00
	05900 CARDI AC CATHETERI ZATI ON	32, 997	1				59.00
	06000 LABORATORY	C	1			0	60.00
	06400 I NTRAVENOUS THERAPY	C	o	-	-		64. 00
	06500 RESPI RATORY THERAPY	49, 495	1	38, 497			65. 00
	06600 PHYSI CAL_THERAPY 06700 OCCUPATI ONAL_THERAPY	22, 685	1	28, 521			66.00
	06800 SPEECH PATHOLOGY	14, 43 <i>6</i> 4, 125	1	9, 262 2, 341	-		67. 00 68. 00
	06900 ELECTROCARDI OLOGY	35, 059	1				69.00
	07000 ELECTROENCEPHALOGRAPHY	12, 374	1	13, 456		8, 345	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0	,		_	71. 00
	07200 I MPL. DEV. CHARGED TO PATI ENTS	C	0	99, 243		0	72. 00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	61, 869		179, 781		0	73. 00 74. 00
	03950 ENDOSCOPY	14, 436		3, 773 31, 333			76.00
	03330 I MAGI NG CENTER	2, 062	1				76.06
	07697 CARDIAC REHABILITATION	10, 312				0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	C	0	,	J		90.00
	04950 DIABETIC CARE CENTER 04951 ANTI-COAGULATION CLINIC			3, 890		0	90. 01 90. 02
	04952 PALLI ATI VE CARE			3, 690			90. 02
	04953 SPI NE CENTER	Ċ	o o	1, 033	-		90. 04
	09100 EMERGENCY	158, 798	765, 159	373, 521	0	65, 977	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
_	SPECIAL PURPOSE COST CENTERS	1 422 002	2 005 440	2 500 (22	2 227 027	741 005	110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) IONREI MBURSABLE COST CENTERS	1, 422, 992	3, 885, 419	2, 588, 622	2, 237, 936	741, 885	1118.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		ol		0	0	190. 00
	9100 RESEARCH	C	o				191. 00
	9200 PHYSICIANS' PRIVATE OFFICES	C	o	C			192. 00
	9300 NONPALD WORKERS	C	0	(0		193. 00
	07950 HOME OFFICE 07956 LEASED OFFICE SPACE				0		194. 00 194. 06
	07956 LEASED OFFICE SPACE 07958 MISC NONREIMBURSABLE COST CENTERS					32, 320	1
200.00	Cross Foot Adjustments		<u> </u>				200. 00
201.00	Negative Cost Centers	c	o	(0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	1, 422, 992	3, 885, 419	2, 588, 622	2, 237, 936	774, 205	202. 00

	FINANCIAI SYSTEMS	COMMUNITY HOSP		ON 45 0400 D		U OI FOIII CWS-2	2552-10
CUST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: om 01/01/2018	Worksheet B Part I	
				To	12/31/2018	Date/Time Pre 5/29/2019 3:0	pared:
		INTERNS &				3/29/2019 3.0	O pili
		RESI DENTS					
	Cost Center Description	SERVI CES-OTHER	Subtotal	Intern &	Total		
		PRGM. COSTS		Residents Cost			
				& Post			
				Stepdown			
		22. 00	24. 00	Adjustments 25.00	26. 00		
	GENERAL SERVICE COST CENTERS	22.00	24.00	25.00	20.00		
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					ı	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					ı	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT					ı	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					ı	8. 00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY					ı	9.00
10. 00 11. 00	01100 CAFETERI A					ı	10.00
13. 00	01300 NURSING ADMINISTRATION					ı	13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY					ı	16. 00
	01700 SOCIAL SERVICE					ı	17. 00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD					ı	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	1, 240, 708					22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00		943, 770	53, 553, 888		52, 021, 203	ı	30. 00
31.00	03100 INTENSIVE CARE UNIT	73, 376	7, 696, 673		7, 577, 510	ı	31.00
43. 00	04300 NURSERY	0	1, 849, 616	5 0	1, 849, 616		43. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	39, 712	11, 873, 023	-64, 493	11, 808, 530		50.00
51. 00	05100 RECOVERY ROOM	37, 712	5, 630, 366		5, 630, 366	ı	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		4, 990, 905		4, 990, 905	ı	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	12, 949	3, 939, 035		3, 918, 006	ı	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	1, 565, 774	1 0	1, 565, 774	ı	55.00
57. 00	05700 CT SCAN	0	2, 470, 676		2, 470, 676		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	760, 579		760, 579	ı	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	5, 478, 467		5, 478, 467	ı	59. 00
60.00	06000 LABORATORY	0	8, 155, 755		8, 155, 755	ı	60.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY	0	2 (07 201		2 (07 201	ı	64. 00 65. 00
66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		3, 687, 391 3, 947, 034		3, 687, 391 3, 947, 034	ı	66.00
67. 00	06700 OCCUPATI ONAL THERAPY		1, 076, 165		1, 076, 165	ı	67.00
68. 00	06800 SPEECH PATHOLOGY		272, 694		272, 694	ı	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	2, 456, 915		2, 456, 915	ı	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	13, 374	1, 411, 394	-21, 719	1, 389, 675	ı	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17, 989, 154	1 0	17, 989, 154		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	13, 512, 033		13, 512, 033	ı	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	15, 850, 204		15, 850, 204	ı	73.00
	07400 RENAL DI ALYSI S	0	620, 530	. 1	620, 530	ı	74.00
	03950 ENDOSCOPY 03330 MAGING CENTER	0	1, 854, 258 2, 406, 541		1, 854, 258 2, 406, 541	ı	76. 00 76. 06
	07697 CARDI AC REHABI LI TATI ON		434, 570		434, 570	ı	76. 97
70.77	OUTPATIENT SERVICE COST CENTERS	9	101,070	<u> </u>	101, 070		70.77
90.00	09000 CLI NI C	0	C	0	0		90.00
	04950 DI ABETI C CARE CENTER	0	C	0	o	ı	90. 01
	04951 ANTI-COAGULATION CLINIC	0	507, 300	0	507, 300		90. 02
	04952 PALLI ATI VE CARE	0	C	0	0	ı	90. 03
	04953 SPI NE CENTER	0	347, 147		347, 147	ı	90. 04
	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	105, 732	14, 198, 059	-171, 709	14, 026, 350	ı	91. 00 92. 00
92.00	SPECIAL PURPOSE COST CENTERS			1 0			92.00
118.00		1, 188, 913	188, 536, 146	-1, 930, 798	186, 605, 348		118. 00
	NONREI MBURSABLE COST CENTERS	17 1007 710	100/000/110	, ,,,,,,,,	1007 0007 0 101		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0	0		190. 00
	19100 RESEARCH	0	C	0	0		191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	164, 831	0	164, 831	1	192. 00
	19300 NONPALD WORKERS	0	C	0	0	ı	193. 00
	07950 HOME OFFICE 07956 LEASED OFFICE SPACE		(0	ı	194.00
	07956 LEASED OFFICE SPACE 07958 MISC NONREIMBURSABLE COST CENTERS	51, 795	971, 709	-84, 115	887, 594	ı	194. 06 194. 08
200.00		01,795	7/1, /US) -04, 115)	007, 394 N	ı	200. 00
201.00			(ol	ı	201.00
202.00		1, 240, 708	189, 672, 686	-2, 014, 913	187, 657, 773	ı	202. 00
	•	· •					-

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0128

					To	12/31/2018	Date/Time Prep 5/29/2019 3:00	pared:
				CAPITAL RELATED COSTS			3/24/2014 3.00	o piii
	C+ C+ D-		D:+1	DIDC & FLVT	MVDLE FOULD	C	EMDL OVEE	
	Cost Center De	scription	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs	1.00	2.00	2.4	4.00	
	GENERAL SERVICE COST	CENTERS	0	1. 00	2. 00	2A	4. 00	
1.00	00100 CAP REL COSTS-							1. 00
2.00	00200 CAP REL COSTS-		_	_	_	_	_	2. 00
4.00	00400 EMPLOYEE BENEF 00500 ADMINISTRATIVE		0	0 0 0 0 0 0 0	-	0 4 452 227	0	4. 00 5. 00
5. 00 7. 00	00700 OPERATION OF P		0	956, 982 904, 047		4, 653, 227 904, 047	0	7. 00
8. 00	00800 LAUNDRY & LINE		0	18, 912		18, 912	0	8. 00
9.00	00900 HOUSEKEEPI NG		0	41, 520	18, 431	59, 951	0	9. 00
10.00	01000 DI ETARY		0	72, 552		96, 784	0	10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINI	STRATION	0	153, 081 0		199, 185 0	0	11. 00 13. 00
16. 00	01600 MEDICAL RECORD		0	0	78	78	0	16. 00
17. 00	01700 SOCIAL SERVICE		0	18, 998		21, 229	0	17. 00
21. 00		ALARY & FRINGES APPRVD	0	0		0	0	21. 00
22. 00	INPATIENT ROUTINE SE	THER PRGM. COSTS APPRVD	0	0	0	0	0	22. 00
30. 00	03000 ADULTS & PEDIA	TRI CS	0	1, 776, 066	279, 851	2, 055, 917	0	30. 00
31. 00	03100 I NTENSI VE CARE	UNIT	0	521, 326		696, 795	0	31. 00
43.00	04300 NURSERY		0	66, 105	17, 358	83, 463	0	43. 00
EO 00	ANCILLARY SERVICE CO			EOE 201	020 727	1 51/ 110	0	50. 00
50. 00 51. 00	05100 RECOVERY ROOM		0	595, 391 147, 012		1, 516, 118 184, 225	0	50.00
52. 00	05200 DELIVERY ROOM	& LABOR ROOM	0	174, 039		219, 174	0	52. 00
54.00	05400 RADI OLOGY-DI AG		0	211, 690		513, 968	0	54. 00
55. 00	05500 RADI OLOGY-THER	APEUTI C	0	0	,	103, 321	0	55. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESON	ANCE IMAGING (MRI)	0	26, 029 30, 310		292, 582 40, 771	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHET		0	190, 836		951, 117	0	59. 00
60.00	06000 LABORATORY		0	89, 057		89, 135	0	60. 00
64. 00	06400 I NTRAVENOUS TH		0	0	-	0	0	64. 00
65. 00 66. 00	06500 RESPI RATORY TH 06600 PHYSI CAL THERA		0	44, 442 14, 682		116, 462 553, 911	0	65. 00 66. 00
67. 00	06700 OCCUPATIONAL T		0	4, 556		36, 699	0	67. 00
68. 00	06800 SPEECH PATHOLO		0	1, 203		9, 328	0	68. 00
69. 00	06900 ELECTROCARDI OL		0	107, 332		170, 395	0	69. 00
70.00	07000 ELECTROENCEPHA		0	43, 291		158, 912	0	70.00
71. 00 72. 00	07200 I MPL. DEV. CHA	ES CHARGED TO PATIENTS	0	0	967, 666 0	967, 666 0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED		0	25, 256		390, 266	0	73. 00
74.00	07400 RENAL DIALYSIS		0	20, 975	47	21, 022	0	74. 00
76. 00	03950 ENDOSCOPY		0	0		296, 116	0	76. 00
76. 06 76. 97	03330 I MAGI NG CENTER 07697 CARDI AC REHABI		0	0	392, 084 5, 517	392, 084 5, 517	0	76. 06 76. 97
10. 91	OUTPATIENT SERVICE C		0	0	5, 517	5, 517	U	70.97
90.00	09000 CLI NI C		0	0	0	0	0	90. 00
	04950 DIABETIC CARE		0	0	0	0	0	90. 01
90. 02	04951 ANTI -COAGULATI		0	0	3, 559	3, 559	0	90. 02 90. 03
90. 03	04952 PALLIATIVE CAR 04953 SPINE CENTER	E	0	0	45, 716	45, 716	0	90. 03
91. 00	09100 EMERGENCY		0	518, 266		590, 290	0	91. 00
92. 00		DS (NON-DISTINCT PART)				0		92. 00
110 00	SPECIAL PURPOSE COST			/ 772 05/	0 (02 00)	1/ 457 040	0	110 00
118. 00	NONREI MBURSABLE COST	OF LINES 1 through 117)	0	6, 773, 956	9, 683, 986	16, 457, 942	0	118. 00
190.00		COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19100 RESEARCH		0	0	0	0		191. 00
	19200 PHYSI CLANS' PR		0	0	0	0		192. 00
	19300 NONPALD WORKER 07950 HOME OFFICE	2	0	0	0	0		193. 00 194. 00
	07956 LEASED OFFICE	SPACE	0	0	0	0		194. 00
	07958 MISC NONREIMBU		0	32, 047		32, 111		194. 08
200.00	1 1					0		200. 00
201.00	1 0		_	0	0 (04 050	14 400 053		201. 00
202.00	η IUIAL (SUM IIN	es 118 through 201)	0	6, 806, 003	9, 684, 050	16, 490, 053	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0128

| 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 3:00 pm

						5/29/2019 3:0	0 pm
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
	OFNEDAL CEDIU OF COCT OFNITEDO	5.00	7. 00	8.00	9. 00	10. 00	
1 00	GENERAL SERVI CE COST CENTERS						1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	4 (52 227					4.00
5.00	00500 ADMINISTRATIVE & GENERAL	4, 653, 227	1 104 202				5.00
7.00	00700 OPERATION OF PLANT	200, 256	1, 104, 303				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	22, 860	4, 223		142 027		8. 00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	73, 814	9, 272		143, 037	140 777	9.00
10.00		34, 666	16, 202	1	2, 125	149, 777	
11.00	01100 CAFETERI A	26, 345	34, 186		4, 483	0	11.00
13.00	01300 NURSING ADMINISTRATION	94, 917	0		0	0	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	63, 356	4 242			0	16.00
17. 00	01700 SOCIAL SERVICE	53, 031	4, 243	1	556	0	17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	18, 994	0	0	0	0	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	30, 439	0	0	U	0	22. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	004 020	20/ /27	20.771	F2 011	107 005	20.00
30.00	03000 ADULTS & PEDIATRICS	994, 920	396, 627		52, 011	137, 335	30.00
31.00	03100 I NTENSI VE CARE UNI T	139, 091	116, 422	1		12, 442	
43. 00		34, 060	14, 762	2 579	1, 936	0	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS	244 704	122.0/2	J 0	17 40	0	FO 00
50.00	05000 OPERATI NG ROOM	246, 706	132, 962		17, 435	0	1
51. 00	05100 RECOVERY ROOM	122, 312	32, 831	1	4, 305		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	110, 028	38, 866	1	5, 096	0	52.00
54.00	05400 RADI OLOGY -DI AGNOSTI C	80, 508	47, 274	1	6, 199	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	36, 574	- 010	0	0	0	55. 00
57. 00	05700 CT SCAN	52, 597	5, 813	1	762	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	16, 029	6, 769		888	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	118, 079	42, 617	1	5, 588	0	59. 00
60.00	06000 LABORATORY	189, 591	19, 888		2, 608	0	
64. 00	06400 I NTRAVENOUS THERAPY	0	0	-	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	85, 818	9, 925	1	1, 301	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	94, 756	3, 279	1	430	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	25, 566	1, 017		133	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	6, 464	269		35	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	51, 562	23, 969	0	3, 143	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	31, 037	9, 668	8 0	1, 268	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	438, 028	0	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	329, 059	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	381, 515	5, 640	0	740	0	73. 00
74.00	07400 RENAL DIALYSIS	13, 957	4, 684	0	614	0	74.00
76.00	03950 ENDOSCOPY	44, 368	0	0	0	0	76. 00
76.06	03330 I MAGI NG CENTER	58, 072	0	0	0	0	76.06
76. 97	07697 CARDIAC REHABILITATION	10, 311	0	0	O	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	04950 DIABETIC CARE CENTER	0	0	0	0	0	90. 01
90.02	04951 ANTI-COAGULATION CLINIC	12, 350	0	0	0	0	90. 02
90. 03	04952 PALLI ATI VE CARE	o	0	0	o	0	90. 03
90.04	04953 SPI NE CENTER	8, 491	0	0	o	0	90. 04
91.00	09100 EMERGENCY	278, 674	115, 738	8, 971	15, 177	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	'			'		
118.00		4, 629, 201	1, 097, 146	45, 995	142, 099	149, 777	118.00
	NONREI MBURSABLE COST CENTERS				· '		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0	0	0	190. 00
191.00	19100 RESEARCH	o	O	0	o	0	191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	4,044	0	ol o	o	0	192. 00
	19300 NONPALD WORKERS	o	0	ol o	o		193. 00
	07950 HOME OFFICE	o	n	o o	o		194. 00
	07956 LEASED OFFICE SPACE	ol	O	ol o	o		194. 06
	B 07958 MISC NONREIMBURSABLE COST CENTERS	19, 982	7, 157	0	938		194. 08
200.00			.,		. 00	ū	200.00
201.00	1 1		n	ol o	n	n	201.00
202.00		4, 653, 227	1, 104, 303	45, 995	143, 037	149, 777	
_32.00	, (., 000, 227	.,, 500	1 .5,770		,	,

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0128

					Т	o 12/31/2018	Date/Time Pre 5/29/2019 3:0	
							I NTERNS &	O pili
							RESI DENTS	
		Cost Center Description	CAFETERI A	NURSI NG		SOCIAL SERVICE		
				ADMI NI STRATI ON			Y & FRINGES	
			11 00	12.00	LI BRARY	17.00	21.00	
	GENER	AL SERVICE COST CENTERS	11. 00	13.00	16. 00	17. 00	21. 00	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00		ADMINISTRATIVE & GENERAL						5. 00
7.00	1	OPERATION OF PLANT						7. 00
8.00	1	LAUNDRY & LINEN SERVICE						8. 00
9.00	1	HOUSEKEEPI NG DI ETARY						9.00
10. 00 11. 00	1	CAFETERI A	264, 199	,				10. 00 11. 00
13. 00	1	NURSI NG ADMI NI STRATI ON	3, 063	1				13.00
16. 00	1	MEDICAL RECORDS & LIBRARY	1, 149					16. 00
17. 00		SOCIAL SERVICE	6, 126	1				17. 00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	C	0	0	0	18, 994	21. 00
22. 00		I &R SERVICES-OTHER PRGM. COSTS APPRVD	C	0	0	0		22. 00
		ENT ROUTINE SERVICE COST CENTERS						
30.00	1	ADULTS & PEDIATRICS	105, 680					30.00
31.00	1	INTENSIVE CARE UNIT	11, 104	1				31.00
43. 00		NURSERY _ARY SERVICE COST CENTERS	3, 446	2, 255	300	6, 787		43. 00
50. 00		OPERATING ROOM	17, 996	0	7, 385	0		50.00
51. 00		RECOVERY ROOM	11, 870	1				51. 00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8, 807	0	748	0		52. 00
54.00		RADI OLOGY-DI AGNOSTI C	8, 424	. 0	2, 320	0		54. 00
55. 00		RADI OLOGY-THERAPEUTI C	3, 063	l t	.,			55. 00
57. 00		CT SCAN	4, 212	1	.,			57. 00
58.00	1	MAGNETIC RESONANCE IMAGING (MRI)	1, 532	l t	, , , ,			58. 00
59. 00 60. 00	1	CARDI AC CATHETERI ZATI ON LABORATORY	6, 126	l .				59. 00 60. 00
64. 00	1	INTRAVENOUS THERAPY		o o	1			64. 00
65. 00	1	RESPI RATORY THERAPY	9, 190					65. 00
66.00	06600	PHYSI CAL THERAPY	4, 212	. 0	707	0		66. 00
67. 00		OCCUPATIONAL THERAPY	2, 680	1				67. 00
68. 00		SPEECH PATHOLOGY	766	l .				68. 00
69. 00	1	ELECTROCARDI OLOGY	6, 509	1				69. 00
70. 00 71. 00	1	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 297 (1	1			70. 00 71. 00
71.00		IMPL. DEV. CHARGED TO PATIENTS	(71.00
73. 00		DRUGS CHARGED TO PATIENTS	11, 487	1				73.00
74. 00		RENAL DIALYSIS	C	Ö				74. 00
76.00	1	ENDOSCOPY	2, 680	0	777	0		76. 00
76. 06	03330	I MAGING CENTER	383					76. 06
76. 97		CARDI AC REHABI LI TATI ON	1, 914	0	99	0		76. 97
00 00		TIENT SERVICE COST CENTERS	(0	0		00.00
	1	CLINIC DIABETIC CARE CENTER			· · · · · ·			90. 00 90. 01
	1	ANTI-COAGULATION CLINIC				-		90. 02
		PALLI ATI VE CARE	C	Ō	1			90. 03
90.04	04953	SPINE CENTER	C	0	26	0		90. 04
91. 00		EMERGENCY	29, 483	19, 295	9, 639	0		91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
110 00	-	AL PURPOSE COST CENTERS	2/4 100	07.000	(4.502	05 105		110 00
118. 00	_	SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	264, 199	97, 980	64, 583	85, 185	0	118. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190. 00
		RESEARCH	C	Ō	•			191. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	C	0	0	0		192. 00
		NONPALD WORKERS	C	0	0	0		193. 00
		HOME OFFICE	C	0	0	0		194. 00
		LEASED OFFICE SPACE	0	0	0	0		194. 06
194. 08 200. 00		MISC NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	C	, 	0	0	10 004	194. 08 200. 00
200.00		Negative Cost Centers	ر		_	0		200.00
202.00		TOTAL (sum lines 118 through 201)	264, 199	97, 980	64, 583	85, 185	1	
	•		•			,	•	

ALLOCATION OF CAPITAL RELATED COSTS	COMMUNITY HOSE		CN: 15-0128 Pe	eri od:	Worksheet B	2552-10
				om 01/01/2018	Part II	nared.
				72,01,2010	5/29/2019 3:0	O pm
	I NTERNS & RESI DENTS					
Cost Center Description	SERVI CES-OTHER	Subtotal	Intern &	Total		
·	PRGM. COSTS		Residents Cost			
			& Post			
			Stepdown Adjustments			
	22.00	24. 00	25. 00	26. 00		
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4. 00 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 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A						10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00 01700 SOCI AL SERVI CE						17. 00
21.00 02100 1 &R SERVI CES-SALARY & FRI NGES APPRVD 22.00 02200 1 &R SERVI CES-OTHER PRGM. COSTS APPRVD	20, 420					21.00
22. 00 02200 1 &R SERVI CES-OTHER PRGM. COSTS APPRVD I NPATI ENT ROUTI NE SERVI CE COST CENTERS	30, 439					22. 00
30. 00 03000 ADULTS & PEDIATRICS		3, 912, 607	7 0	3, 912, 607		30.00
31.00 03100 INTENSIVE CARE UNIT		1, 007, 621		1, 007, 621		31. 00
43. 00 04300 NURSERY		147, 588	3 0	147, 588		43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 O5000 OPERATI NG ROOM		1, 938, 602	2 0	1, 938, 602		50.00
51. 00 05100 RECOVERY ROOM		365, 030		365, 030		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		384, 225	1	384, 225		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		659, 395		659, 395		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		144, 409		144, 409		55. 00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		363, 783 66, 729		363, 783 66, 729		57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		1, 128, 663	1	1, 128, 663		59.00
60. 00 06000 LABORATORY		306, 796		306, 796		60.00
64. 00 06400 I NTRAVENOUS THERAPY		C	0	0		64.00
65. 00 06500 RESPIRATORY THERAPY		223, 651		223, 651		65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY		657, 295 66, 325		657, 295 66, 325		66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY		16, 920		16, 920		68. 00
69. 00 06900 ELECTROCARDI OLOGY		257, 447		257, 447		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		203, 516		203, 516		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		1, 409, 034 331, 521		1, 409, 034 331, 521		71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		794, 107		794, 107		73.00
74. 00 07400 RENAL DI ALYSI S		40, 371		40, 371		74. 00
76. 00 03950 ENDOSCOPY		343, 941		343, 941		76. 00
76. 06 03330 I MAGING CENTER		451, 466		451, 466		76.06
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS		17, 841	0	17, 841		76. 97
90. 00 09000 CLI NI C		C	0	0		90. 00
90. 01 04950 DIABETIC CARE CENTER		C	0	0		90. 01
90. 02 04951 ANTI -COAGULATION CLINIC		16, 005	0	16, 005		90. 02
90. 03 04952 PALLI ATI VE CARE 90. 04 04953 SPI NE CENTER		54, 233		0 54, 233		90. 03 90. 04
91. 00 09100 EMERGENCY		1, 067, 267		1, 067, 267		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		.,,	O	.,,		92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	16, 376, 388	3 0	16, 376, 388		118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			ol	0		190. 00
191. 00 19100 RESEARCH		C	ol ol	0		191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES		4, 044	0	4, 044		192. 00
193. 00 19300 NONPALD WORKERS		C	0	0		193. 00
194.00 07950 HOME OFFICE		C		0		194. 00
194.06 07956 LEASED OFFICE SPACE 194.08 07958 MISC NONREIMBURSABLE COST CENTERS		60, 188		60, 188		194. 06 194. 08
200.00 Cross Foot Adjustments	30, 439	49, 433		49, 433		200.00
201.00 Negative Cost Centers	0	C	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	30, 439	16, 490, 053	B 0	16, 490, 053		202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0128 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/29/2019 3:00 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 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 395, 872 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 9, 878, 270 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 61, 349, 621 4.00 00500 ADMINISTRATIVE & GENERAL 145, 478, 789 5 00 3, 770, 378 4, 116, 557 -44, 193, 897 5 00 55 663 7.00 00700 OPERATION OF PLANT 52, 584 1, 519, 771 6, 260, 726 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 1, 100 714, 681 8.00 00900 HOUSEKEEPI NG 2,415 18, 801 1, 261, 085 0 2, 307, 704 9.00 9.00 0 01000 DI ETARY 10.00 4, 220 24, 718 378.848 1, 083, 772 10 00 11.00 01100 CAFETERI A 8,904 47,029 840, 809 0 823, 650 11.00 01300 NURSING ADMINISTRATION 2, 967, 460 13.00 265, 968 0 13.00 01600 MEDICAL RECORDS & LIBRARY 253, 493 1, 980, 726 16, 00 80 16, 00 1, 238, 948 17.00 17.00 01700 SOCIAL SERVICE 1, 105 2, 276 1, 657, 954 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 593, 815 21.00 C 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 22.00 0 951, 622 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 103.305 285, 463 19, 296, 275 0 31, 106, 590 30.00 178, 988 03100 INTENSIVE CARE UNIT 2, 667, 157 4, 348, 495 31.00 30, 323 31.00 43.00 04300 NURSERY 3,845 17, 706 678, 823 0 1,064,853 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 34, 631 939, 192 3, 231, 973 7, 712, 939 50.00 05100 RECOVERY ROOM 8, 551 37, 959 2, 559, 067 0 3, 823, 920 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 10, 123 46, 040 2, 338, 851 0 3, 439, 874 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 308, 340 1, 457, 223 2, 516, 979 12, 313 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 105, 393 614, 360 1, 143, 425 55.00 743, 111 1, 644, 388 57.00 05700 CT SCAN 1.514 271, 899 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 1,763 10, 671 265.042 501, 138 58.00 05900 CARDIAC CATHETERIZATION 59.00 11, 100 775, 529 1, 302, 291 3, 691, 590 59.00 06000 LABORATORY 60.00 5, 180 80 0 0 0 5, 927, 308 60.00 64.00 06400 INTRAVENOUS THERAPY 64.00 06500 RESPIRATORY THERAPY 2, 585 73, 464 1, 829, 008 2, 682, 994 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 854 550, 043 1, 791, 399 2, 962, 414 66.00 06700 OCCUPATI ONAL THERAPY 551, 540 799, 272 67.00 265 32, 788 0 0 0 67.00 06800 SPEECH PATHOLOGY 8, 288 139, 418 202, 091 68.00 68.00 70 06900 ELECTROCARDI OLOGY 64, 328 838, 982 69.00 6.243 1, 612, 025 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 2,518 117, 940 421, 817 970, 341 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 987, 073 0 0 0 13, 694, 379 71.00 10, 287, 602 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 0 72 00 11, 927, 572 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 469 372, 330 2, 655, 288 73.00 74.00 07400 RENAL DIALYSIS 1, 220 48 436, 361 74.00 03950 ENDOSCOPY 0 76.00 302, 055 658, 304 1, 387, 110 76.00 0 03330 I MAGING CENTER 797 771 0 399, 947 1, 815, 556 76 06 76 06 76.97 07697 CARDIAC REHABILITATION 0 5,628 240, 307 322, 348 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 04950 DIABETIC CARE CENTER 90.01 0 0 0 0 90 01 90.02 04951 ANTI-COAGULATION CLINIC 0 3,630 524, 767 0 386, 115 90.02 04952 PALLIATIVE CARE 0 0 90.03 90.03 04953 SPINE CENTER 0 90.04 125, 166 265, 469 90.04 46, 633 09100 EMERGENCY 30.145 91.00 73, 468 5, 316, 664 8, 712, 381 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 394, 008 9, 878, 205 60, 920, 083 -44, 193, 897 144, 727, 639 118. 00 118.00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH 0 191.00 0 0 0 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 126, 425 192. 00 0 0 Ω 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 194.00 07950 HOME OFFICE 0 0 0 194.00 194.06 07956 LEASED OFFICE SPACE 0 0 194, 06 C 194. 08 07958 MISC NONREI MBURSABLE COST CENTERS 429, 538 1,864 65 624, 725 194. 08 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 6, 806, 003 44, 193, 897 202. 00 202.00 Cost to be allocated (per Wkst. B, 9, 684, 050 3, 103, 168 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 17. 192433 0.980339 0.050582 0. 303782 203. 00 204.00 Cost to be allocated (per Wkst. B, 4, 653, 227 204. 00 Part II)

Health Financial Systems	COMMUNITY HOSPITAL SOUTH			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0128		Period: From 01/01/2018	Worksheet B-1		
				Γο 12/31/2018	Date/Time Pre 5/29/2019 3:0		
	CAPITAL REL	ATED COSTS					
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
	1. 00	2. 00	4. 00	5A	5. 00		
205.00 Unit cost multiplier (Wkst. B, Part			0. 00000	D	0. 031986	205. 00	
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10 COMMUNITY HOSPITAL SOUTH Provider CCN: 15-0128 Peri od: Worksheet B-1 From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 3:00 pm LAUNDRY & HOUSEKEEPING DIETARY CAFETERIA
LINEN SERVICE (SQUARE FEET) (PATIENT DAYS) (MEALS SERVED) Cost Center Description OPERATION OF PLANT

		(SQUARE FEET)	(POUNDS OF	(SQUARE FEET)	(PATTENT DAYS)	(MEALS SERVED)	
		7.00	LAUNDRY)	0.00	10.00	44.00	
GENE	RAL SERVICE COST CENTERS	7. 00	8.00	9.00	10. 00	11. 00	
	OO CAP REL COSTS-BLDG & FIXT						1.00
	OO CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 0040	OO EMPLOYEE BENEFITS DEPARTMENT						4. 00
	OO ADMINISTRATIVE & GENERAL						5. 00
1	OO OPERATION OF PLANT	287, 625					7. 00
	00 LAUNDRY & LINEN SERVICE 00 HOUSEKEEPING	1, 100		1			8. 00 9. 00
	00 DI ETARY	2, 415 4, 220		284, 110 4, 220			10.00
	O CAFETERI A	8, 904		8, 904		690	
	NURSING ADMINISTRATION	0	0	0	l	8	13. 00
	00 MEDICAL RECORDS & LIBRARY	0	0	0	0	3	16. 00
	OO SOCIAL SERVICE	1, 105	0	1, 105	l	16	1
	00 & SERVICES-SALARY & FRINGES APPRVD	0	0	0	1	0	21. 00 22. 00
	00 1&R SERVICES-OTHER PRGM. COSTS APPRVD TIENT ROUTINE SERVICE COST CENTERS	0		0	U	0	22.00
	OO ADULTS & PEDIATRICS	103, 305	17, 662	103, 305	31, 877	276	30.00
	OO INTENSIVE CARE UNIT	30, 323		1		29	
	00 NURSERY	3, 845	495	3, 845	0	9	43. 00
	LLARY SERVICE COST CENTERS		_				
	00 OPERATING ROOM 00 RECOVERY ROOM	34, 631	0 4 029		0	47 31	50. 00 51. 00
	DO DELIVERY ROOM & LABOR ROOM	8, 551 10, 123	6, 038 1, 287			23	
	00 RADI OLOGY-DI AGNOSTI C	12, 313		l		22	54.00
1	00 RADI OLOGY-THERAPEUTI C	0	1	l :	l .	8	55. 00
57. 00 0570	OO CT SCAN	1, 514	3, 107	1, 514	0	11	57. 00
	MAGNETIC RESONANCE IMAGING (MRI)	1, 763		.,		4	58. 00
	OO CARDI AC CATHETERI ZATI ON	11, 100		1		16	1
	00 LABORATORY 00 I NTRAVENOUS THERAPY	5, 180	0		l .	0	60. 00 64. 00
4	00 RESPIRATORY THERAPY	2, 585	1	2, 585	-	24	65.00
4	00 PHYSI CAL THERAPY	854	Ö	854		11	66.00
1	OO OCCUPATIONAL THERAPY	265	0	265		7	67. 00
	OO SPEECH PATHOLOGY	70	0			2	68. 00
	OO ELECTROCARDI OLOGY	6, 243		6, 243		17	69. 00
	OO ELECTROENCEPHALOGRAPHY	2, 518	0	2, 518	l .	6	70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS 00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	71. 00 72. 00
	DO DRUGS CHARGED TO PATIENTS	1, 469	ا	1, 469	-	30	73. 00
	00 RENAL DIALYSIS	1, 220		1, 220		0	74. 00
1	50 ENDOSCOPY	0	0	0	0	7	76. 00
	30 I MAGING CENTER	0	0			1	76.06
	PATIENT SERVICE COST CENTERS	0	0	0	0	5	76. 97
	00 CLINIC	0	0	0	O	0	90.00
	50 DIABETIC CARE CENTER	0	Ō	Ō		0	90. 01
	ANTI-COAGULATION CLINIC	0	0	0	0	0	90. 02
	52 PALLIATIVE CARE	0	0	0	0	0	90. 03
	SSI SPI NE CENTER	0	0	0	0	0	
1	00 EMERGENCY 00 OBSERVATION BEDS (NON-DISTINCT PART)	30, 145	7, 668	30, 145	0	77	91. 00 92. 00
	TIAL PURPOSE COST CENTERS		L	l			72.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	285, 761	39, 316	282, 246	34, 765	690	118. 00
	EIMBURSABLE COST CENTERS						
4	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		1			190. 00
	00 RESEARCH	0	0		· ·		191. 00 192. 00
	00 PHYSICIANS' PRIVATE OFFICES 00 NONPAID WORKERS	0	0	0			192.00
1	50 HOME OFFICE	0		Ö	· ·		194. 00
	66 LEASED OFFICE SPACE	0	0	Ō	· ·		194. 06
194. 08 0795	8 MISC NONREIMBURSABLE COST CENTERS	1, 864	0	1, 864	0	0	194. 08
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0.440.400	0/0 005	0.077.070	4 570 474		201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	8, 162, 622	963, 005	3, 077, 279	1, 578, 471	1, 422, 992	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	28. 379390	24. 493972	10. 831294	45. 404027	2, 062. 307246	203 00
204. 00	Cost to be allocated (per Wkst. B,	1, 104, 303				264, 199	
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	3. 839385	1. 169880	0. 503456	4. 308270	382. 897101	205. 00
206 00		1					206 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
	117-: 11.00. 5 2/	1	1	I .	l		<u> </u>

Heal th Finan	cial Systems	COMMUNITY HOS	SPITAL SOUTH		In Lie	eu of Form CMS-	2552-10
COST ALLOCAT	FION - STATISTICAL BASIS		Provi der Co	CN: 15-0128	Peri od:	Worksheet B-1	
					From 01/01/2018		
					To 12/31/2018	Date/Time Pre	
						5/29/2019 3:0	O pm
	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	
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0128

						5/29/2019 3:0	
					INTERNS &	RESI DENTS	
	Cost Center Description	NURSI NG	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	
		ADMI NI STRATI ON	RECORDS &		Y & FRINGES	PRGM. COSTS	
		(DI DECT NUDC	LI BRARY	(TOTAL PATIENT		(ASSI GNED	
		(DI RECT NURS. HRS.)	(GROSS CHARGES)	DAYS)	TIME)	TIME)	
		13. 00	16. 00	17. 00	21. 00	22.00	
	GENERAL SERVICE COST CENTERS	1		1			4 00
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	1					5. 00
	00700 OPERATION OF PLANT						7. 00
	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
	01000 DI ETARY						10.00
	01100 CAFETERI A	1					11. 00
	01300 NURSING ADMINISTRATION	391					13. 00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	917, 188, 279	1			16. 00 17. 00
	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1	78, 762		21.00
	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	0	0	_		78, 762	
	INPATIENT ROUTINE SERVICE COST CENTERS						1
	03000 ADULTS & PEDI ATRI CS	276	115, 010, 803		- '		1
	03100 INTENSIVE CARE UNIT 04300 NURSERY	29	10, 142, 635 4, 286, 079		4, 658 0		1
	ANCILLARY SERVICE COST CENTERS	7	4, 200, 077	3, 104	0		43.00
	05000 OPERATING ROOM	0	105, 494, 392		2, 521	2, 521	50.00
	05100 RECOVERY ROOM	0	34, 617, 569	1			1
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	10, 691, 539 33, 148, 773		0 822	0 822	
	05500 RADI OLOGY-THERAPEUTI C	0	20, 729, 483			l	1
	05700 CT SCAN	0	59, 744, 987			1	1
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	10, 568, 944	1		0	
	05900 CARDI AC CATHETERI ZATI ON	0	66, 104, 731	1		0	
	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	0	79, 633, 893 0	1			60. 00 64. 00
	06500 RESPI RATORY THERAPY	0	13, 641, 721				65. 00
66.00	06600 PHYSI CAL THERAPY	0	10, 106, 814	1	0		66. 00
	06700 OCCUPATI ONAL THERAPY	0	3, 282, 145	1	0	0	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	829, 539 26, 695, 424	1	0	l .	
	07000 ELECTROENCEPHALOGRAPHY	0	4, 768, 085		_		1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	47, 721, 155	1	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	35, 167, 672	1		0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	63, 706, 873 1, 337, 073		0	0	
	03950 ENDOSCOPY		11, 103, 102		0	0	1
	03330 I MAGI NG CENTER	0	13, 249, 405	1		1	
	07697 CARDIAC REHABILITATION	0	1, 412, 301	0	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC			1 0	0	0	90.00
	04950 DI ABETI C CARE CENTER	0	0			l	1
	04951 ANTI -COAGULATION CLINIC	0	1, 378, 419		0	Ö	1
	04952 PALLIATIVE CARE	0	0	0	0	0	
	04953 SPI NE CENTER	0	366, 074		0	0	1
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	77	132, 248, 649	0	6, 712	6, 712	91. 00 92. 00
	SPECIAL PURPOSE COST CENTERS						72.00
118.00		391	917, 188, 279	39, 964	75, 474	75, 474	118. 00
	NONREI MBURSABLE COST CENTERS				_	_	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	0	1			190. 00 191. 00
	19200 PHYSICIANS' PRIVATE OFFICES		0	0	0		191.00
	19300 NONPALD WORKERS	0	0	o	0	l	193. 00
	07950 HOME OFFICE	0	0	0	0		194. 00
	07956 LEASED OFFICE SPACE	0	0	0	0		194.06
194. 08 200. 00	07958 MISC NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	ا	0	0	3, 288	3, 288	194. 08 200. 00
201.00]					201. 00
202. 00	Cost to be allocated (per Wkst. B,	3, 885, 419	2, 588, 622	2, 237, 936	774, 205	1, 240, 708	202. 00
202.00	Part I)	0 027 122002	0 000000	EE 000700	0 000/77	15 750/00	202 00
203. 00 204. 00		9, 937. 132992 97, 980	0. 002822 64, 583	1			203.00
50	Part II)	,,,,,,,,	0., 500	33, .00	.5, ,, ,		

Health Financial Systems	COMMUNITY HOSE	PITAL SOUTH		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0128		Peri od:	Worksheet B-1	
				From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 3:0	pared: O pm
				INTERNS &	RESI DENTS	
Cost Center Description	NURSI NG ADMI NI STRATI ON	RECORDS &		ESERVICES-SALAR Y & FRINGES	PRGM. COSTS	
			(TOTAL PATIEN	,	(ASSI GNED	
	(DI RECT NURS.	(GROSS	DAYS)	TI ME)	TIME)	
	HRS.) 13. 00	CHARGES) 16. 00	17. 00	21, 00	22. 00	
205.00 Unit cost multiplier (Wkst. B, Part	250, 588235	0. 000070			0. 386468	205 00
	200.000200	0.000070	2	0.21.107	0.000100	200.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COMPUTATION OF NATIO OF COSTS TO CHANGES			Trovider co		From 01/01/2018 To 12/31/2018		pared: 0 pm
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	50 004 000		50.004.00		50 004 000	
30.00	03000 ADULTS & PEDIATRICS	52, 021, 203		52, 021, 20		52, 021, 203	
31.00	03100 NTENSI VE CARE UNI T	7, 577, 510		7, 577, 51		7, 577, 510	
43. 00		1, 849, 616		1, 849, 61	6 0	1, 849, 616	43. 00
	ANCILLARY SERVICE COST CENTERS	14 000 500		44 000 50		44 000 500	
50.00	05000 OPERATI NG ROOM	11, 808, 530		11, 808, 53		11, 808, 530	
51. 00	05100 RECOVERY ROOM	5, 630, 366		5, 630, 36		5, 630, 366	
52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 990, 905		4, 990, 90		4, 990, 905	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 918, 006		3, 918, 00		3, 918, 006	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 565, 774		1, 565, 77		1, 565, 774	
57. 00	05700 CT SCAN	2, 470, 676		2, 470, 67		2, 470, 676	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	760, 579		760, 57		760, 579	
59. 00	05900 CARDI AC CATHETERI ZATI ON	5, 478, 467		5, 478, 46		5, 478, 467	1
60.00	06000 LABORATORY	8, 155, 755		8, 155, 75		8, 155, 755	
64. 00	06400 I NTRAVENOUS THERAPY	0			0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	3, 687, 391	0			3, 687, 391	
66. 00	06600 PHYSI CAL THERAPY	3, 947, 034	0	3, 947, 03		3, 947, 034	1
67. 00	06700 OCCUPATI ONAL THERAPY	1, 076, 165	0	1, 076, 16		1, 076, 165	
68. 00	06800 SPEECH PATHOLOGY	272, 694	0	272, 69		272, 694	
69. 00	06900 ELECTROCARDI OLOGY	2, 456, 915		2, 456, 91		2, 456, 915	
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 389, 675		1, 389, 67		1, 389, 675	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 989, 154		17, 989, 15		17, 989, 154	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	13, 512, 033		13, 512, 03		13, 512, 033	
73.00	07300 DRUGS CHARGED TO PATIENTS	15, 850, 204		15, 850, 20		15, 850, 204	
74.00	07400 RENAL DIALYSIS	620, 530		620, 53	0	620, 530	
76. 00	03950 ENDOSCOPY	1, 854, 258		1, 854, 25		1, 854, 258	
76. 06	03330 I MAGI NG CENTER	2, 406, 541		2, 406, 54		2, 406, 541	
76. 97	07697 CARDI AC REHABI LI TATI ON	434, 570		434, 57	0	434, 570	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0			0	0	90.00
90. 01	04950 DIABETIC CARE CENTER	0			0	0	90. 01
90. 02	04951 ANTI-COAGULATION CLINIC	507, 300		507, 30	0 0	507, 300	90. 02
90. 03	04952 PALLI ATI VE CARE	0			0 0	0	90. 03
90. 04	04953 SPI NE CENTER	347, 147		347, 14	7 0	347, 147	
91.00		14, 026, 350		14, 026, 35		14, 026, 350	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 135, 739		6, 135, 73		6, 135, 739	
200.00	Subtotal (see instructions)	192, 741, 087	0	192, 741, 08	7 0		
201.00	Less Observation Beds	6, 135, 739		6, 135, 73		6, 135, 739	
202.00	Total (see instructions)	186, 605, 348	0	186, 605, 34	8 0	186, 605, 348	202. 00

COMMUNITY HOSPITAL SOUTH	In Lie	u of Form CMS-2552-10
Provi der CCN: 15-0128	Peri od:	Worksheet C
	Provi der CCN: 15-0128	

COWII OT	ATTOM OF NATIO OF COSTS TO CHANGES		Trovider co		From 01/01/2018 To 12/31/2018		pared: 0 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpati ent	+ col . 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	LUDATI ENT. DOUTLINE OFFICE OF COST OFFITEDO	6. 00	7. 00	8. 00	9. 00	10.00	
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	400 450 0/0		400 450 04			00.00
30.00	03000 ADULTS & PEDIATRICS	108, 150, 968		108, 150, 96			30.00
31. 00	03100 INTENSIVE CARE UNIT	10, 142, 635		10, 142, 63			31.00
43. 00	04300 NURSERY	4, 286, 079		4, 286, 07	9		43. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS O5000 OPERATI NG ROOM	(1.071.070	42 522 422	105 404 20	0 111005	0.000000	F0 00
50.00	05100 RECOVERY ROOM	61, 971, 270	43, 523, 122	105, 494, 39			
51. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	12, 659, 493 10, 691, 539	21, 958, 076 0	34, 617, 5 <i>6</i> 10, 691, 53			
54. 00	05400 RADI OLOGY-DI AGNOSTI C	7, 496, 892	-	33, 148, 77			
55. 00	05500 RADI OLOGY-THERAPEUTI C	6, 544, 756	25, 651, 881 14, 184, 727	20, 729, 48			
57. 00	05700 CT SCAN	15, 324, 040	44, 420, 947	59, 744, 98			
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 746, 200	7, 822, 744	10, 568, 94			
59. 00	05900 CARDIAC CATHETERIZATION	29, 963, 889	36, 140, 842	66, 104, 73			
60. 00	06000 LABORATORY	44, 234, 890	35, 399, 003			l .	
64. 00	06400 I NTRAVENOUS THERAPY	44, 234, 690	33, 344, 003	17,033,07	0. 000000		
65. 00	06500 RESPIRATORY THERAPY	11, 841, 781	1, 799, 940	13, 641, 72			
66. 00	06600 PHYSI CAL THERAPY	3, 608, 155	6, 498, 659	10, 106, 81			
67. 00	06700 OCCUPATI ONAL THERAPY	2, 337, 841	944, 304	3, 282, 14			
68. 00	06800 SPEECH PATHOLOGY	662, 537	167, 002	829, 53			
69. 00	06900 ELECTROCARDI OLOGY	8, 165, 053	18, 530, 371	26, 695, 42			1
70. 00	07000 ELECTROENCEPHALOGRAPHY	291, 363	4, 476, 722	4, 768, 08		l .	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	28, 224, 505	19, 496, 650	47, 721, 15			
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	22, 901, 933	12, 265, 739				
73. 00	07300 DRUGS CHARGED TO PATIENTS	40, 806, 231	22, 900, 642	63, 706, 87			
74. 00	07400 RENAL DIALYSIS	1, 337, 073	0	1, 337, 07			
76. 00	03950 ENDOSCOPY	2, 144, 495	8, 958, 607	11, 103, 10			1
76. 06	03330 I MAGI NG CENTER	131, 214	13, 118, 191	13, 249, 40			1
76. 97	07697 CARDI AC REHABI LI TATI ON	6, 719	1, 405, 582	1, 412, 30			
	OUTPATIENT SERVICE COST CENTERS	27	.,,	.,,	.,		
90.00	09000 CLI NI C	0	0		0.000000	0.000000	90.00
90. 01	04950 DI ABETI C CARE CENTER	o	0		0. 000000		
90. 02	04951 ANTI-COAGULATION CLINIC	13, 966	1, 364, 453	1, 378, 41	9 0. 368030	0.000000	90. 02
90. 03	04952 PALLI ATI VE CARE	O	0		0.000000	0.000000	90. 03
90.04	04953 SPI NE CENTER	492	365, 582	366, 07	4 0. 948297	0.000000	90. 04
91.00	09100 EMERGENCY	26, 549, 161	105, 699, 488	132, 248, 64	9 0. 106060	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 310, 999	5, 548, 836	6, 859, 83	0. 894444	0.000000	92. 00
200.00	Subtotal (see instructions)	464, 546, 169	452, 642, 110	917, 188, 27	9		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	464, 546, 169	452, 642, 110	917, 188, 27	9		202. 00

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0128	Peri od: Worksheet C From 01/01/2018 Part I Date/Time Prepared: 5/20/2019 3:00 pm

			10 12/31/2016	5/29/2019 3:00 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 111935			50.00
51.00 05100 RECOVERY ROOM	0. 162645			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 466809			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 118195			54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 075534			55. 00
57. 00 05700 CT SCAN	0. 041354			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 071964			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 082876			59. 00
60. 00 06000 LABORATORY	0. 102416			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 270302			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 390532			66. 00
67. 00 06700 OCCUPATIONAL THERAPY	0. 327885			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 328730			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 092035			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 291453			70. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT				71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 384217			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 248799			73. 00
74. 00 07400 RENAL DI ALYSI S	0. 464096			74. 00
76. 00 03950 ENDOSCOPY	0. 167004			76. 00
76. 06 03330 I MAGI NG CENTER	0. 181634			76. 06
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 307704			76. 97
OUTPATIENT SERVICE COST CENTERS	0.000000			00.00
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 ANTI - COAGULATI ON CLI NI C 90. 03 04952 PALLI ATI VE CARE	0. 368030			90. 02 90. 03
	0.000000			
90. 04 04953 SPI NE CENTER 91. 00 09100 EMERGENCY	0. 948297 0. 106060			90. 04 91. 00
	1			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 894444			92.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 3:00 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 03000 ADULTS & PEDIATRICS 30 00 53, 553, 888 53, 553, 888 53, 553, 888 7, 696, 673 31.00 03100 INTENSIVE CARE UNIT 7, 696, 673 0 7, 696, 673 31.00 04300 NURSERY 43.00 1, 849, 616 1, 849, 616 0 1, 849, 616 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 11, 873, 023 11, 873, 023 11, 873, 023 50.00 51.00 05100 RECOVERY ROOM 5, 630, 366 5, 630, 366 0 5, 630, 366 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 4, 990, 905 4, 990, 905 4, 990, 905 52.00 3, 939, 035 05400 RADI OLOGY-DI AGNOSTI C 54.00 3, 939, 035 3, 939, 035 54.00 0 55.00 05500 RADI OLOGY-THERAPEUTI C 1, 565, 774 1, 565, 774 1, 565, 774 55.00 57.00 05700 CT SCAN 2, 470, 676 2, 470, 676 0 0 0 2, 470, 676 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 760, 579 760, 579 760, 579 58.00 05900 CARDIAC CATHETERIZATION 5, 478, 467 59.00 5, 478, 467 5, 478, 467 59.00 60.00 06000 LABORATORY 8, 155, 755 8, 155, 755 8, 155, 755 60.00 06400 INTRAVENOUS THERAPY 64.00 0 0 0 0 0 0 64.00 06500 RESPIRATORY THERAPY 3.687.391 3, 687, 391 3, 687, 391 65 00 65 00 3, 947, 034 3, 947, 034 66.00 06600 PHYSI CAL THERAPY 3, 947, 034 66.00 06700 OCCUPATIONAL THERAPY 1, 076, 165 1, 076, 165 1, 076, 165 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 272, 694 272, 694 272, 694 68.00 06900 ELECTROCARDI OLOGY 2, 456, 915 69 00 2, 456, 915 2, 456, 915 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 411, 394 1, 411, 394 1, 411, 394 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 17, 989, 154 17, 989, 154 71.00 17, 989, 154 0 0 0 71.00 13, 512, 033 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 13 512 033 13, 512, 033 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 15, 850, 204 15, 850, 204 15, 850, 204 73.00 74.00 07400 RENAL DIALYSIS 620, 530 620, 530 620, 530 74.00 0 03950 ENDOSCOPY 76.00 1, 854, 258 1, 854, 258 1, 854, 258 76.00 03330 I MAGING CENTER 76 06 2, 406, 541 2, 406, 541 2, 406, 541 76 06 07697 CARDIAC REHABILITATION 76.97 434, 570 434, 570 434, 570 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 04950 DIABETIC CARE CENTER 0 0 0 90.01 0 90 01 0 90.02 04951 ANTI-COAGULATION CLINIC 507, 300 507, 300 507, 300 90.02 04952 PALLIATIVE CARE 0 90.03 90.03 0 90.04 04953 SPINE CENTER 347.147 347.147 347, 147 90.04 14, 198, 059 91.00 09100 EMERGENCY 14, 198, 059 14, 198, 059 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 6, 135, 739 6, 135, 739 6, 135, 739 92.00 200.00 Subtotal (see instructions) 194, 671, 885 Ω 194, 671, 885 0 194, 671, 885 200. 00 6, 135, 739 201. 00 201.00

6, 135, 739

188, 536, 146

6, 135, 739

188, 536, 146 202. 00

188, 536, 146

Less Observation Beds

Total (see instructions)

202.00

					From 01/01/2018 To 12/31/2018	Part I Date/Time Pre 5/29/2019 3:0	
		_		e XIX	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpati ent Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	108, 150, 968		108, 150, 968	3		30. 00
	03100 INTENSIVE CARE UNIT	10, 142, 635		10, 142, 63	5		31. 00
	04300 NURSERY	4, 286, 079		4, 286, 079	9		43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	61, 971, 270	43, 523, 122			0.000000	
	05100 RECOVERY ROOM	12, 659, 493	21, 958, 076			0.000000	51.00
1	05200 DELIVERY ROOM & LABOR ROOM	10, 691, 539	0	10,0,1,00		0.000000	
	05400 RADI OLOGY-DI AGNOSTI C	7, 496, 892	25, 651, 881	33, 148, 773		0.000000	
	05500 RADI OLOGY-THERAPEUTI C	6, 544, 756	14, 184, 727			0.000000	
	05700 CT SCAN	15, 324, 040	44, 420, 947			0.000000	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 746, 200	7, 822, 744			0.000000	
	05900 CARDIAC CATHETERIZATION	29, 963, 889	36, 140, 842			0. 000000	
	06000 LABORATORY	44, 234, 890	35, 399, 003			0. 000000	
	06400 INTRAVENOUS THERAPY	0	0			0. 000000	
	06500 RESPI RATORY THERAPY	11, 841, 781	1, 799, 940			0.000000	
	06600 PHYSI CAL THERAPY	3, 608, 155	6, 498, 659			0.000000	
	06700 OCCUPATI ONAL THERAPY	2, 337, 841	944, 304			0.000000	67. 00
	06800 SPEECH PATHOLOGY	662, 537	167, 002			0. 000000	
	06900 ELECTROCARDI OLOGY	8, 165, 053	18, 530, 371			0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	291, 363	4, 476, 722			0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	28, 224, 505	19, 496, 650			0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	22, 901, 933	12, 265, 739			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	40, 806, 231	22, 900, 642			0. 000000	
	07400 RENAL DIALYSIS	1, 337, 073	0	1,00,,0,,		0. 000000	
	03950 ENDOSCOPY	2, 144, 495	8, 958, 607			0. 000000	
	03330 I MAGI NG CENTER	131, 214	13, 118, 191			0. 000000	76. 06
	07697 CARDIAC REHABILITATION	6, 719	1, 405, 582	1, 412, 30	0. 307704	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS			1			
	09000 CLINIC	0	0		0. 000000	0. 000000	
	04950 DI ABETI C CARE CENTER	0	0	1		0. 000000	
	04951 ANTI -COAGULATION CLINIC	13, 966	1, 364, 453			0. 000000	
	04952 PALLI ATI VE CARE	0	0	1		0. 000000	1
1	04953 SPI NE CENTER	492	365, 582			0. 000000	
	09100 EMERGENCY	26, 549, 161	105, 699, 488			0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 310, 999	5, 548, 836			0. 000000	
200.00	Subtotal (see instructions)	464, 546, 169	452, 642, 110	917, 188, 279	'		200.00
201.00	Less Observation Beds	4/4 E4/ 1/0	4EO 74O 11O	017 100 07			201. 00 202. 00
202. 00	Total (see instructions)	464, 546, 169	452, 642, 110	917, 188, 279	7		J2U2. UU

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0128	From 01/01/2018	Worksheet C Part I Date/Time Prepared:

			10 12/31/2010	5/29/2019 3:00 pm	1.
		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. 0	00
31.00 03100 INTENSIVE CARE UNIT				31. 0	00
43. 00 04300 NURSERY				43. 0	00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 112546			50. (00
51.00 05100 RECOVERY ROOM	0. 162645			51. (00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 466809			52. (00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 118829			54. (00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 075534			55. (00
57. 00 05700 CT SCAN	0. 041354			57. (00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 071964			58. 0	00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 082876			59. (00
60. 00 06000 LABORATORY	0. 102416			60.0	00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64. 0	00
65. 00 06500 RESPIRATORY THERAPY	0. 270302			65.0	00
66. 00 06600 PHYSI CAL THERAPY	0. 390532			66.0	00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 327885			67. 0	00
68.00 06800 SPEECH PATHOLOGY	0. 328730			68.0	
69. 00 06900 ELECTROCARDI OLOGY	0. 092035			69. 0	00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 296009			70.0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 376964			71.0	00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 384217			72. 0	00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 248799			73. 0	
74. 00 07400 RENAL DIALYSIS	0. 464096			74. 0	00
76. 00 03950 ENDOSCOPY	0. 167004			76. 0	00
76. 06 03330 I MAGI NG CENTER	0. 181634			76. 0	06
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 307704			76. 9	97
OUTPATIENT SERVICE COST CENTERS					
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 ANTI-COAGULATION CLINIC	0. 368030			90. (02
90. 03 04952 PALLI ATI VE CARE	0. 000000			90. (03
90. 04 04953 SPI NE CENTER	0. 948297			90. 0	04
91. 00 09100 EMERGENCY	0. 107359			91. (00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 894444			92. 0	00
200.00 Subtotal (see instructions)				200. 0	
201.00 Less Observation Beds				201. 0	
202.00 Total (see instructions)				202. 0	00
				'	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | Part | | P

					10 12/31/2010	5/29/2019 3:00	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost			Operating Cost	
	'	(Wkst. B, Part				Reduction	
		1, col. 26)	11 col. 26)	Cost (col. 1	_	Amount	
			ŕ	col . 2)			
		1.00	2.00	3.00	4. 00	5. 00	
AN	CILLARY SERVICE COST CENTERS						
50.00 05	000 OPERATING ROOM	11, 873, 023	1, 938, 602	9, 934, 42	1 0	0	50. 00
51.00 05	100 RECOVERY ROOM	5, 630, 366	365, 030	5, 265, 33	6 0	0	51.00
52.00 05	200 DELIVERY ROOM & LABOR ROOM	4, 990, 905	384, 225	4, 606, 68	0 0	0	52. 00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	3, 939, 035	659, 395	3, 279, 64	0 0	0	54.00
55. 00 05	500 RADI OLOGY-THERAPEUTI C	1, 565, 774	144, 409	1, 421, 36	5 0	0	55. 00
57. 00 05	700 CT SCAN	2, 470, 676	363, 783	2, 106, 89	3 0	0	57. 00
58. 00 05	800 MAGNETIC RESONANCE I MAGING (MRI)	760, 579	66, 729	693, 85	0 0	0	58. 00
59. 00 05	900 CARDI AC CATHETERI ZATI ON	5, 478, 467	1, 128, 663	4, 349, 80	4 0	0	59. 00
60. 00 06	000 LABORATORY	8, 155, 755	306, 796			0	60.00
	400 INTRAVENOUS THERAPY	0	0		0	o	64.00
	500 RESPI RATORY THERAPY	3, 687, 391	223, 651	3, 463, 74	0 0	o	65. 00
	600 PHYSI CAL THERAPY	3, 947, 034	657, 295			o	66.00
	700 OCCUPATIONAL THERAPY	1, 076, 165	66, 325			Ö	67. 00
	800 SPEECH PATHOLOGY	272, 694	16, 920			Ö	68. 00
	900 ELECTROCARDI OLOGY	2, 456, 915	257, 447			Ö	69. 00
	000 ELECTROENCEPHALOGRAPHY	1, 411, 394	203, 516			Ö	70. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 989, 154	1, 409, 034			Ö	71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	13, 512, 033	331, 521			Ö	72. 00
	300 DRUGS CHARGED TO PATIENTS	15, 850, 204	794, 107			Ö	73. 00
	400 RENAL DI ALYSI S	620, 530				Ö	74. 00
	950 ENDOSCOPY	1, 854, 258				0	76. 00
	330 I MAGI NG CENTER	2, 406, 541	451, 466			Ö	76. 06
	697 CARDI AC REHABI LI TATI ON	434, 570				_	76. 97
	TPATIENT SERVICE COST CENTERS	101,070	.,, σ	1.07,72	,		70.77
	000 CLINIC	0	0		0 0	0	90. 00
	950 DIABETIC CARE CENTER	0	0	1	0	Ö	90. 01
	951 ANTI -COAGULATI ON CLI NI C	507, 300	16, 005	491, 29	5 0	Ö	90. 02
	952 PALLI ATI VE CARE	0	0	, = .	0	Ö	90. 03
	953 SPI NE CENTER	347, 147	54, 233	292. 91	4	0	90. 04
	100 EMERGENCY	14, 198, 059	1, 067, 267			Ö	91. 00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 135, 739				0	92. 00
200.00	Subtotal (sum of lines 50 thru 199)	131, 571, 708					200. 00
201.00	Less Observation Beds	6, 135, 739					201. 00
202.00	Total (line 200 minus line 201)	125, 435, 969					202. 00
202.00	1.553. (1116 200 111110 201)	120, 100, 707	11,000,072	1 111, 127, 57	.1	1	1202.00

Health Financial Systems	COMMUNITY HOSPIT	AL SOUTH	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE CORREDUCTIONS FOR MEDICALD ONLY	ST TO CHARGE RATIOS NET OF	Provider CCN: 15-0128	From 01/01/2018	Worksheet C Part II Date/Time Prepared:

				'	0 12/31/2010	5/29/2019 3:0	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges		· ·		
	'	Capital and		Cost to Charge			
		Operating Cost	Part I, column	Ratio (col. 6			
		Reduction	8)	/ col. 7)			
		6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	11, 873, 023	105, 494, 392	0. 112546			50. 00
51.00	05100 RECOVERY ROOM	5, 630, 366	34, 617, 569	0. 162645			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 990, 905	10, 691, 539	0. 466809			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 939, 035	33, 148, 773	0. 118829			54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 565, 774		0. 075534			55. 00
57.00	05700 CT SCAN	2, 470, 676	59, 744, 987	0. 041354			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	760, 579	10, 568, 944	0. 071964			58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	5, 478, 467	66, 104, 731	0. 082876			59. 00
60.00	06000 LABORATORY	8, 155, 755					60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0				64.00
65.00	06500 RESPIRATORY THERAPY	3, 687, 391	13, 641, 721	0. 270302			65. 00
66.00	06600 PHYSI CAL THERAPY	3, 947, 034	10, 106, 814	0. 390532			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 076, 165	3, 282, 145				67. 00
68.00	06800 SPEECH PATHOLOGY	272, 694	829, 539				68. 00
69.00	06900 ELECTROCARDI OLOGY	2, 456, 915					69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 411, 394		0. 296009			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 989, 154					71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	13, 512, 033					72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	15, 850, 204	63, 706, 873				73. 00
	07400 RENAL DIALYSIS	620, 530	1, 337, 073	0. 464096			74.00
76.00	03950 ENDOSCOPY	1, 854, 258					76. 00
	03330 I MAGI NG CENTER	2, 406, 541	13, 249, 405				76. 06
	07697 CARDI AC REHABI LI TATI ON	434, 570		0. 307704			76. 97
	OUTPATIENT SERVICE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,				
90.00	09000 CLI NI C	0	0	0.000000			90.00
	04950 DI ABETI C CARE CENTER	0	0	0.000000			90. 01
	04951 ANTI-COAGULATION CLINIC	507, 300	1, 378, 419				90. 02
	04952 PALLI ATI VE CARE	0	0	0.000000			90. 03
	04953 SPI NE CENTER	347, 147	366, 074				90. 04
	09100 EMERGENCY	14, 198, 059					91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 135, 739					92. 00
200.00		131, 571, 708					200.00
201.00	,	6, 135, 739					201. 00
202.00		125, 435, 969					202. 00
				•	1		

Health Financial Systems	COMMUNITY HOS	SPITAL SOUTH		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2018		
				To 12/31/2018	Date/Time Prep 5/29/2019 3:00	
		Title	XVIII	Hospi tal	PPS	o piii
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost	Ť		
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	3, 912, 607	0	3, 912, 60	7 38, 424	101.83	30. 00
31.00 INTENSIVE CARE UNIT	1, 007, 621		1, 007, 62	1 2, 888	348. 90	31.00
43. 00 NURSERY	147, 588		147, 58	3, 184	46. 35	43.00
200.00 Total (lines 30 through 199)	5, 067, 816		5, 067, 81	6 44, 496		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	12, 279	1, 250, 371				30. 00
31.00 INTENSIVE CARE UNIT	945	329, 711				31. 00
43. 00 NURSERY	0	0			ļ	43.00
200.00 Total (lines 30 through 199)	13, 224	1, 580, 082	1			200. 00

lealth Financial Systems	COMMUNITY HOS	SPITAL SOUTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAP	TTAL COSTS	Provi der C		Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prep 5/29/2019 3:00	pared: O pm
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)		Program	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						

Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col.	Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	1, 938, 602			22, 935, 439		
51.00 05100 RECOVERY ROOM	365, 030			3, 733, 036		
52.00 O5200 DELIVERY ROOM & LABOR ROOM	384, 225			20, 431		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	659, 395			3, 115, 049		
55. 00 05500 RADI OLOGY-THERAPEUTI C	144, 409			3, 109, 008		55. 00
57.00 05700 CT SCAN	363, 783	59, 744, 987	0. 006089	6, 278, 351	38, 229	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	66, 729	10, 568, 944	0. 006314	1, 030, 010	6, 503	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 128, 663	66, 104, 731	0. 017074	11, 791, 719	201, 332	59. 00
60. 00 06000 LABORATORY	306, 796	79, 633, 893	0. 003853	17, 668, 878	68, 078	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	223, 651	13, 641, 721	0. 016395	3, 983, 468	65, 309	65. 00
66. 00 06600 PHYSI CAL THERAPY	657, 295	10, 106, 814	0. 065035	1, 595, 614	103, 771	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	66, 325	3, 282, 145	0. 020208	1, 092, 550	22, 078	67.00
68. 00 06800 SPEECH PATHOLOGY	16, 920	829, 539	0. 020397	324, 392	6, 617	68. 00
69. 00 06900 ELECTROCARDI OLOGY	257, 447	26, 695, 424	0.009644	4, 103, 856	39, 578	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	203, 516	4, 768, 085	0. 042683	118, 456	5, 056	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 409, 034	47, 721, 155	0. 029526	9, 629, 779	284, 329	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	331, 521	35, 167, 672	0.009427	9, 296, 733	87, 640	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	794, 107	63, 706, 873	0. 012465	13, 782, 481	171, 799	73. 00
74. 00 07400 RENAL DI ALYSI S	40, 371	1, 337, 073	0. 030194	721, 494	21, 785	74. 00
76. 00 03950 ENDOSCOPY	343, 941	11, 103, 102	0. 030977	33, 682	1, 043	76. 00
76.06 03330 I MAGING CENTER	451, 466			0		76. 06
76. 97 07697 CARDI AC REHABI LI TATI ON	17, 841	1, 412, 301	0. 012633	867	11	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.000000	0	0	90.00
90. 01 04950 DIABETIC CARE CENTER	0	0	0.000000	0	0	90. 01
90. 02 04951 ANTI-COAGULATION CLINIC	16, 005	1, 378, 419	0. 011611	0	0	90. 02
90. 03 04952 PALLIATIVE CARE	0	0	0.000000	0	0	90. 03
90. 04 04953 SPI NE CENTER	54, 233	366, 074	0. 148148	0	0	90. 04
91. 00 09100 EMERGENCY	1, 067, 267			11, 399, 481	91, 994	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	461, 481		0. 067273	462, 795	31, 134	92.00
200.00 Total (lines 50 through 199)	11, 770, 053			126, 227, 569		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0128 Provid	Health Financial Systems	COMMUNITY HOSP	TAL SOUTH		In Lie	eu of Form CMS-2	2552-10
Nursing School Nursing School Allied Health Post-Stepdown Adjustments Cost Medical Education Cost Medical Education Cost Medical Education Cost Medical Education Cost Education Cos	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COSTS	S Provider Co		From 01/01/2018	Part III Date/Time Pre	
NPATI ENT ROUTINE SERVICE COST CENTERS Adj ustments 1.00 2A 2.00 3.			Title	: XVIII	Hospi tal	PPS	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 1	Cost Center Description	Post-Stepdown	lursing School	Post-Stepdown		Medi cal	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0							
100		1A	1. 00	2A	2. 00	3.00	
NATION 03100 031							
A3.00 04300 NURSERY 0 0 0 0 0 0 0 0 0		0	0	(0		
Total (lines 30 through 199)		0	0	(0	· -	
Cost Center Description		0	0		0		
Adjustment Amount (see instructions) Days 5 ÷ col. 6 Program Days 1 through 3, minus col. 4 4.00 5.00 6.00 7.00 8.00		0	0		0		200. 00
Amount (see instructions) 1 through 3, minus col. 4)	Cost Center Description						
INPATI ENT ROUTI NE SERVI CE COST CENTERS				Days	5 ÷ col . 6)	Program Days	
INPATI ENT ROUTI NE SERVI CE COST CENTERS							
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 0 38, 424 0.00 12, 279 30.00 31.00 03100 INTENSI VE CARE UNI T 0 2, 888 0.00 945 31.00 31.00 04300 NURSERY 0 3, 184 0.00 0 43.00 200.00 Total (lines 30 through 199) 13, 224 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00				/ 00	7.00	0.00	
30. 00	INDATIENT DOUTINE CEDVICE COCT CENTEDO	4.00	5.00	6.00	7.00	8.00	
31. 00		٥		20.42	0.00	12.270	20.00
A3.00		٩	0				
Total (lines 30 through 199) 0 44,496 13,224 200.00			0				
Cost Center Description			0				
Program Pass-Through Cost (col. 7 x col. 8) 9.00		Innationt	0	44, 47	ַן	13, 224	200.00
Pass-Through Cost (col. 7 x col. 8) 9.00	cost center bescription						
Cost (col. 7 x col. 8) 9.00							
INPATIENT ROUTINE SERVICE COST CENTERS 9.00 30.00 30.00 ADULTS & PEDIATRICS 0 31.00 31.00 INTENSIVE CARE UNIT 0 31.00 43.00 NURSERY 0 43.00		9					
9.00 I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 0 30.00 31.00 03100 I NTENSI VE CARE UNI T 0 31.00 43.00 04300 NURSERY 0 43.00							
30. 00 03000 ADULTS & PEDIATRICS 0 30. 00 31. 00 03100 I NTENSI VE CARE UNI T 0 31. 00 04300 NURSERY 0 43. 00							
31. 00 03100 INTENSI VE CARE UNI T 0 31. 00 43. 00 04300 NURSERY 0 43. 00	INPATIENT ROUTINE SERVICE COST CENTERS						
43. 00 04300 NURSERY 0 43. 00	30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
	31.00 03100 INTENSIVE CARE UNIT	0					31.00
200.00 Total (lines 30 through 199) 0 200.00		O					
	200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	COMMUNITY HO	OSPITAL SOUTH	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PA	ASS Provi der CCN: 15-0128	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:00 pm

				0 12/31/2018	5/29/2019 3:0	parea: 0 pm
		Title	xVIII	Hospi tal	PPS	о р
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	Anesthetist	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	0	(0	0	59. 00
60. 00 06000 LABORATORY	0	0	(0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	(0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	(0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
74.00 07400 RENAL DIALYSIS	0	0	(0	0	74. 00
76. 00 03950 ENDOSCOPY	0	0	(0	0	76. 00
76.06 03330 I MAGI NG CENTER	0	0	(0	0	76. 06
76. 97 07697 CARDIAC REHABILITATION	0	0	(0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	(0	0	90.00
90. 01 04950 DIABETIC CARE CENTER	0	0	(0	0	90. 01
90.02 04951 ANTI-COAGULATION CLINIC	0	0	(0	0	90. 02
90. 03 04952 PALLI ATI VE CARE	0	0	(0	0	
90. 04 04953 SPI NE CENTER	0	0	(0	0	90. 04
91. 00 09100 EMERGENCY	0	0	(0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		(0	1 ,2.00
200.00 Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0128	Peri od: Worksheet D
THROUGH COSTS		From 01/01/2018 Part IV

THROUGH COSTS				rom 01/01/2018 Fo 12/31/2018		
		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)			
	4.00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	_		1			
50. 00 05000 OPERATI NG ROOM	0	0	(100/ 171/072	0.000000	
51. 00 05100 RECOVERY ROOM	0	0	(
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1	10, 691, 539		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1	33, 148, 773		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	(20, 729, 483		
57. 00 05700 CT SCAN	0	0	(59, 744, 987		
58.00 05800 MAGNETIC RESONANCE I MAGING (MR	0	0	(10, 568, 944		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	(66, 104, 731	0.000000	
60. 00 06000 LABORATORY	0	0	(79, 633, 893		
64.00 06400 INTRAVENOUS THERAPY	0	0		0	0.000000	
65. 00 06500 RESPI RATORY THERAPY	0	0			0.000000	
66. 00 06600 PHYSI CAL THERAPY	0	0	(10, 106, 814		
67. 00 06700 0CCUPATI ONAL THERAPY	0	0	(3, 282, 145		
68.00 06800 SPEECH PATHOLOGY	0	0	(829, 539	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(26, 695, 424	0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(4, 768, 085		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PA	TI ENTS 0	0	(47, 721, 155		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(35, 167, 672	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(63, 706, 873	0.000000	73. 00
74.00 07400 RENAL DIALYSIS	0	0	(1, 337, 073	0.000000	74. 00
76. 00 03950 ENDOSCOPY	0	0	(11, 103, 102	0.000000	76. 00
76.06 03330 I MAGING CENTER	0	0	(13, 249, 405	0.000000	76. 06
76. 97 07697 CARDIAC REHABILITATION	0	0	(1, 412, 301	0.000000	76. 97
OUTPATIENT SERVICE COST CENTERS				_		
90. 00 09000 CLI NI C	0	0	(0	0.000000	
90. 01 04950 DIABETIC CARE CENTER	0	0	(0	0.000000	90. 01
90.02 04951 ANTI-COAGULATION CLINIC	0	0	(1, 378, 419	0.000000	90. 02
90. 03 04952 PALLI ATI VE CARE	0	0	(0	0.000000	90. 03
90. 04 04953 SPI NE CENTER	0	0	(366, 074	0.000000	90. 04
91. 00 09100 EMERGENCY	0	0	(132, 248, 649	0.000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	PART) 0	0	(6, 859, 835	0.000000	92. 00
200.00 Total (lines 50 through 199)	0	0	(794, 608, 597	ĺ	200. 00

Health Financial Systems	COMMUNITY HOSP				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	VICE OTHER PASS	Provi der Co	CN: 15-0128	Period: From 01/01/2018	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2018	Date/Time Pre	pared:
		T: +1 o	xVIII	Hospi tal	5/29/2019 3: 0 PPS	0 pm
Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
cost center bescription	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.	charges	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	7.00	10.00	11.00	12.00	10.00	
50. 00 05000 OPERATING ROOM	0. 000000	22, 935, 439		8, 803, 591	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	3, 733, 036			0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	20, 431			0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 115, 049		6, 386, 102	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	3, 109, 008			0	55. 00
57. 00 05700 CT SCAN	0. 000000	6, 278, 351		9, 844, 097	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	1, 030, 010		2, 066, 983	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	11, 791, 719		13, 003, 638	0	59. 00
60. 00 06000 LABORATORY	0. 000000	17, 668, 878			0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0			0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	3, 983, 468		280, 379	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 595, 614		93, 796	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 092, 550	(49, 991	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000	324, 392		7, 375	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	4, 103, 856		5, 693, 483	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	118, 456		957, 107	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	9, 629, 779		4, 813, 633	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	9, 296, 733		4, 822, 628	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	13, 782, 481		7, 160, 891	0	73. 00
74. 00 07400 RENAL DIALYSIS	0. 000000	721, 494		0	0	74. 00
76. 00 03950 ENDOSCOPY	0. 000000	33, 682		3, 006, 221	0	76. 00
76. 06 03330 I MAGI NG CENTER	0. 000000	0	(0	76. 06
76. 97 07697 CARDIAC REHABILITATION	0. 000000	867		627, 885	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
00 00 00000 CLINIC	0.000000	0) 0	0	1 00 00

0.000000

0.000000

0. 000000

0.000000

0.000000

0. 000000

0.000000

0 90.00

0

0 90.04

0

0

0 90.01

90. 02

0 90.03

91. 00 92. 00

0 200.00

674, 867

14, 319, 882 3, 082, 459

108, 012, 658

7, 394

0

11, 399, 481

126, 227, 569

462, 795

90.00

200.00

09000 CLI NI C

90. 04 04953 SPINE CENTER

91. 00 09100 EMERGENCY

90. 03 04952 PALLIATIVE CARE

90. 01 | 04950 | DI ABETI C CARE CENTER 90. 02 | 04951 | ANTI -COAGULATI ON CLINI C

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0128 Peri od: Worksheet D From 01/01/2018 Part V Date/Time Prepared: 12/31/2018 5/29/2019 3:00 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 111935 8, 803, 591 985, 430 50.00 51.00 05100 RECOVERY ROOM 0. 162645 5, 074, 675 0 0 825, 371 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0 466809 52 00 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.118195 6, 386, 102 754, 805 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.075534 7, 363, 410 0 556, 188 55.00 57.00 05700 CT SCAN 0.041354 9.844.097 0 0 407, 093 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0.071964 2, 066, 983 148, 748 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.082876 13, 003, 638 1, 077, 690 59.00 0 60.00 06000 LABORATORY 0.102416 6, 724, 117 0 688, 657 60.00 0 06400 I NTRAVENOUS THERAPY 0.000000 64 00 64 00 0 65.00 06500 RESPIRATORY THERAPY 0.270302 280, 379 75, 787 65.00 06600 PHYSI CAL THERAPY 0.390532 93, 796 0 0 36, 630 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 0. 327885 49, 991 0 16, 391 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 7, 375 2, 424 0.328730 68 00 69.00 06900 ELECTROCARDI OLOGY 0.092035 5, 693, 483 0 0 524,000 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 291453 957, 107 0 278, 952 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 376964 4, 813, 633 0 0 1, 814, 566 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.384217 0 72 00 4, 822, 628 0 1, 852, 936 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 248799 7, 160, 891 147, 708 1, 781, 623 73.00 07400 RENAL DIALYSIS 0 74.00 0.464096 0 0 74.00 03950 ENDOSCOPY 0 76.00 0.167004 3, 006, 221 0 502, 051 76.00 οĺ 03330 I MAGING CENTER 76.06 0.181634 3, 148, 054 0 571, 794 76.06 07697 CARDIAC REHABILITATION 0.307704 627, 885 0 193, 203 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 90.00 0 0 04950 DIABETIC CARE CENTER 0 90.01 0.000000 0 Λ 90.01 04951 ANTI-COAGULATION CLINIC 0.368030 0 0 248, 371 90.02 674, 867 90.02 0 0 90. 03 04952 PALLIATIVE CARE 0.000000 90.03 0 90 04 04953 SPINE CENTER 0.948297 0 7.394 7,012 90 04 91.00 09100 EMERGENCY 0.106060 14, 319, 882 0 1, 518, 767 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0.894444 3, 082, 459 0 2, 757, 087 92.00 17, 625, 576 200. 00 200.00 Subtotal (see instructions) 108, 012, 658 0 147, 708 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 108, 012, 658 0 147, 708 17, 625, 576 202. 00

ALTONITONIMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		ON. 13-0120	From 01/01/2018 To 12/31/2018	Date/Time Pro 5/29/2019 3:	epared: 00 pm
			XVIII	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.					
	(see inst.)	(see inst.)	-			
ANOTHER DESIGNATION OF STREET	6. 00	7. 00				
ANCI LLARY SERVI CE COST CENTERS	_					
50. 00 05000 OPERATI NG ROOM	0	0	1			50.00
51. 00 05100 RECOVERY ROOM	0	0				51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0				52. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0	1			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	1			55. 00
57. 00 05700 CT SCAN	0	0	1			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (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				60. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0				64. 00
65. 00 06500 RESPI RATORY THERAPY	0	0)			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0)			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0)			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0)			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0)			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0)			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)			72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	36, 750)			73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	1			74. 00
76. 00 03950 ENDOSCOPY	0	0	1			76. 00
76. 06 03330 I MAGI NG CENTER	0	0	1			76. 06
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0)			76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	1			90. 00
90. 01 04950 DI ABETI C CARE CENTER	0	0				90. 01
90. 02 O4951 ANTI-COAGULATION CLINIC	0	0				90. 02
90. 03 04952 PALLI ATI VE CARE	0	0				90. 03
90. 04 04953 SPI NE CENTER	0	0)			90. 04
91. 00 09100 EMERGENCY	0	0	1			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1			92. 00
200.00 Subtotal (see instructions)	0	36, 750	1			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	36, 750	1			202. 00

Health Financial Systems	COMMUNITY HOS	SPITAL SOUTH		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2018 To 12/31/2018		narod:
				10 12/31/2010	5/29/2019 3:0	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	3, 912, 607	0	3, 912, 60	7 38, 424	101.83	30. 00
31.00 INTENSIVE CARE UNIT	1, 007, 621		1, 007, 62	1 2, 888	348. 90	31.00
43. 00 NURSERY	147, 588		147, 58	8 3, 184	46. 35	43.00
200.00 Total (lines 30 through 199)	5, 067, 816		5, 067, 81	6 44, 496		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	811	82, 584				30. 00
31.00 INTENSIVE CARE UNIT	0	0				31. 00
43. 00 NURSERY	1, 550	71, 843				43. 00
200.00 Total (lines 30 through 199)	2, 361	154, 427	1			200. 00

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co	CN: 15-0128	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Pre 5/29/2019 3:0	pared: O pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Total Charges (from Wkst. C, Part I, col. 8)		Program	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4. 00	5. 00	

		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
'	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 + col.	Charges	column 4)	
	Part II, col.	8)	2)	_		
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 938, 602	105, 494, 392		513, 591	9, 438	
51.00 05100 RECOVERY ROOM	365, 030	34, 617, 569	0. 010545	141, 509	1, 492	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	384, 225	10, 691, 539	0. 035937	192, 206	6, 907	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	659, 395	33, 148, 773		122, 250		
55. 00 05500 RADI OLOGY-THERAPEUTI C	144, 409	20, 729, 483		71, 086		
57.00 05700 CT SCAN	363, 783			271, 084		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	66, 729	10, 568, 944		37, 594	237	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 128, 663	66, 104, 731		339, 891	5, 803	
60. 00 06000 LABORATORY	306, 796	79, 633, 893	0. 003853	815, 330	3, 141	60.00
64.00 06400 INTRAVENOUS THERAPY	0	_	0.00000	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	223, 651	13, 641, 721	0. 016395	276, 825	4, 539	65. 00
66. 00 06600 PHYSI CAL THERAPY	657, 295	10, 106, 814	0. 065035	54, 520	3, 546	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	66, 325	3, 282, 145	0. 020208	33, 670	680	67. 00
68.00 06800 SPEECH PATHOLOGY	16, 920	829, 539	0. 020397	22, 385	457	68. 00
69. 00 06900 ELECTROCARDI OLOGY	257, 447	26, 695, 424	0.009644	101, 060	975	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	203, 516	4, 768, 085	0. 042683	10, 725	458	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 409, 034	47, 721, 155	0. 029526	595, 155	17, 573	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	331, 521	35, 167, 672	0.009427	296, 997	2, 800	
73.00 07300 DRUGS CHARGED TO PATIENTS	794, 107	63, 706, 873	0. 012465	942, 297	11, 746	73. 00
74.00 07400 RENAL DIALYSIS	40, 371	1, 337, 073	0. 030194	23, 532	711	74.00
76. 00 03950 ENDOSCOPY	343, 941	11, 103, 102	0. 030977	30, 033	930	76. 00
76.06 03330 I MAGI NG CENTER	451, 466	13, 249, 405	0. 034074	0	0	76. 06
76. 97 07697 CARDIAC REHABILITATION	17, 841	1, 412, 301	0. 012633	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.000000	0	0	90. 00
90. 01 04950 DI ABETI C CARE CENTER	0	0	0.000000	0	0	90. 01
90. 02 04951 ANTI-COAGULATION CLINIC	16, 005	1, 378, 419	0. 011611	0	0	90. 02
90. 03 04952 PALLI ATI VE CARE	0	0	0.000000	0	0	90. 03
90. 04 04953 SPI NE CENTER	54, 233	366, 074	0. 148148	0	0	90. 04
91. 00 09100 EMERGENCY	1, 067, 267	132, 248, 649		478, 551	3, 862	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	461, 479		0. 067273	14, 660		
200.00 Total (lines 50 through 199)	11, 770, 051	794, 608, 597		5, 384, 951	80, 859	200. 00

Health Financial Systems	COMMUNITY HOSPI	TAL SOUTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COSTS	Provider Co	F	Period: From 01/01/2018 Fo 12/31/2018	Worksheet D Part III Date/Time Pre 5/29/2019 3:00	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Nu Post-Stepdown Adjustments	ursing School	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00		2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	(0	0	30. 00
31. 00 03100 INTENSIVE CARE UNIT	O	0	Ċ	0	0	31. 00
43. 00 04300 NURSERY	o	0		0	0	43. 00
200.00 Total (lines 30 through 199)	O	0	Ċ	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
		sum of cols.	Days	5 ÷ col. 6)	Program Days	
		1 through 3,				
		inus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	38, 424		811	30. 00
31. 00 03100 INTENSIVE CARE UNIT		0	2, 888		0	31. 00
43. 00 04300 NURSERY		0	3, 184		1, 550	
200. 00 Total (lines 30 through 199)		0	44, 496		2, 361	200. 00
Cost Center Description	Inpatient Program Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00 03100 INTENSIVE CARE UNIT	1					04 00
	0					31.00
43. 00 04300 NURSERY	0 0					43.00

Health Financial Systems	COMMUNITY HOSPIT	FAL SOUTH	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ATTHROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0128	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared:

				[1	To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
-			Ti tl	e XIX	Hospi tal	PPS	Орш
	Cost Center Description	Non Physician			Allied Health	Allied Health	
	· ·	Anesthetist	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	0) (0	0	59.00
60.00	06000 LABORATORY	0	0) (0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		o	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0		o	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		o	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		o	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		o	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		o	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		o	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		o	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		o	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0	0	74. 00
76. 00	03950 ENDOSCOPY	0	0		0	0	76. 00
76. 06	03330 I MAGI NG CENTER	0	0		0	0	76. 06
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS			•			
90.00	09000 CLI NI C	0	0) (0	0	90.00
90. 01	04950 DIABETIC CARE CENTER	0	0		o	0	90. 01
90. 02	04951 ANTI-COAGULATION CLINIC	0	0		o	0	90. 02
90. 03	04952 PALLI ATI VE CARE	0	0		0	0	90. 03
	04953 SPINE CENTER	0	0		o o	0	90. 04
91. 00	09100 EMERGENCY	0	0		0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	92.00
200.00		0	0		0	0	200. 00

Health Financial Systems	COMMUNITY HOSPIT	TAL SOUTH	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0128	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2018	Part IV

THROUGH COSTS				rom 01/01/2018 o 12/31/2018	Date/Time Pre	ate/Time Prepared:	
		Ti +I	e XIX	Hospi tal	5/29/2019 3: 00 PPS	0 pm	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost		
cost center bescription	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges		
	Education Cost		Cost (sum of		(col . 5 ÷ col .		
	Ludcati on cost	4)	col s. 2, 3,	8)	7)		
		"/	and 4)		' '		
	4. 00	5, 00	6.00	7. 00	8. 00		
ANCILLARY SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00		
50. 00 05000 OPERATI NG ROOM	0	0	(105, 494, 392	0.000000	50.00	
51. 00 05100 RECOVERY ROOM	0	0		34, 617, 569	0. 000000	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		10, 691, 539	0. 000000	52. 00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		33, 148, 773	0. 000000	54.00	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		20, 729, 483	0. 000000	55. 00	
57. 00 05700 CT SCAN	0	0		59, 744, 987	0. 000000	57. 00	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		10, 568, 944			
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		66, 104, 731	0. 000000	59. 00	
60. 00 06000 LABORATORY	0	0				60.00	
64. 00 06400 I NTRAVENOUS THERAPY	0	0			0.000000	64.00	
65. 00 06500 RESPIRATORY THERAPY	0	0		13, 641, 721	0.000000		
66. 00 06600 PHYSI CAL THERAPY	0	0		10, 106, 814	0.000000		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		3, 282, 145	1	67. 00	
68. 00 06800 SPEECH PATHOLOGY	0	0		829, 539		68. 00	
69. 00 06900 ELECTROCARDI OLOGY	0	0		· ·	1		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		4, 768, 085			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			1	71. 00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0					
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		63, 706, 873	1		
74. 00 07400 RENAL DI ALYSI S	0	0		1, 337, 073	1		
76. 00 03950 ENDOSCOPY	0	0			1	76. 00	
76. 06 03330 MAGI NG CENTER	0	0				76. 06	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0			0.000000		
OUTPATIENT SERVICE COST CENTERS				, , , , , , , , , , , , , , , , , , , ,			
90. 00 09000 CLI NI C	0	0	(0	0.000000	90. 00	
90. 01 04950 DIABETIC CARE CENTER	0	O		0	0.000000	90. 01	
90. 02 04951 ANTI-COAGULATION CLINIC	0	0		1, 378, 419	0. 000000	90. 02	
90. 03 04952 PALLI ATI VE CARE	0	0		0	0. 000000	90. 03	
90. 04 04953 SPI NE CENTER	0	0		366, 074	0. 000000	90. 04	
91. 00 09100 EMERGENCY	0	l 0		· ·			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0					
200.00 Total (lines 50 through 199)	0	O				200. 00	
	1	•	•			'	

Health Financial Systems	COMMUNITY HOSPIT	TAL SOUTH	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0128	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2018	Part IV

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 15-0128		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 3:00 pm	
				Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7) 9.00	10.00	x col. 10) 11.00	12.00	x col . 12) 13.00	
ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATING ROOM	0. 000000	513, 591	I	0 0	0	50. 00
51. 00 05100 RECOVERY ROOM	0. 000000	141, 509		0 0		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	192, 206		0 0	1	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	122, 250		0 0	1	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	71, 086		0 0	0	55. 00
57. 00 05700 CT SCAN	0. 000000	271, 084			0	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	37, 594	l .		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	339, 891			1	59.00
60. 00 06000 LABORATORY	0. 000000	815, 330			1	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	010, 000		0 0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	276, 825		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	54, 520		0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	33, 670		0 0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000	22, 385		0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	101, 060		o o	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	10, 725		0 0	1	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	595, 155		0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	296, 997		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	942, 297		0 0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000	23, 532		0 0	0	74.00
76. 00 03950 ENDOSCOPY	0. 000000	30, 033		0 0	0	76. 00
76.06 03330 I MAGING CENTER	0. 000000	0		0 0	0	76. 06
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90. 00
90. 01 04950 DIABETIC CARE CENTER	0. 000000	0		0 0	0	90. 01
90. 02 04951 ANTI-COAGULATION CLINIC	0. 000000	0		0 0	0	90. 02
90. 03 04952 PALLI ATI VE CARE	0. 000000	0		0	0	90. 03
90. 04 04953 SPI NE CENTER	0. 000000	0		0	0	90. 04
91. 00 09100 EMERGENCY	0. 000000	478, 551		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	14, 660		0		92. 00
200.00 Total (lines 50 through 199)		5, 384, 951		0	0	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0128 Peri od: Worksheet D From 01/01/2018 Part V 12/31/2018 Date/Time Prepared: 5/29/2019 3:00 pm Title XIX Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 112546 265, 490 0 50.00 51.00 05100 RECOVERY ROOM 0. 162645 0 102, 034 51.00 05200 DELIVERY ROOM & LABOR ROOM 0. 466809 52 00 0 52 00 C 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.118829 0 427, 554 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.075534 110, 838 0 55.00 57.00 05700 CT SCAN 0.041354 0 596, 501 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0.071964 101, 636 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.082876 226, 507 0 59.00 06000 LABORATORY 60.00 0.102416 0 678, 222 0 60.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64 00 0 64 00 65.00 06500 RESPIRATORY THERAPY 0.270302 0 25, 235 0 65.00 06600 PHYSI CAL THERAPY 0.390532 0 65, 933 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 0. 327885 12, 534 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 0.328730 8.855 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.092035 0 104, 779 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 296009 26, 744 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 376964 0 174, 040 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.384217 0 72.00 72 00 86, 051 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 248799 143, 250 0 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 0.464096 С 0 03950 ENDOSCOPY 54, 805 76.00 0.167004 0 0 76.00 03330 I MAGING CENTER Ω 76.06 0.181634 66, 926 0 76.06 76. 97 07697 CARDIAC REHABILITATION 0.307704 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 90.00 0.000000 0 0 0 0 0 0 0 0 0 04950 DIABETIC CARE CENTER 90.01 0.000000 0 0 0 90.01 04951 ANTI-COAGULATION CLINIC 0.368030 8,070 90.02 90.02 90. 03 04952 PALLIATIVE CARE 0.000000 0 0 90.03 0 90 04 04953 SPINE CENTER 0 948297 90.04 0 Ω Λ 91.00 09100 EMERGENCY 0. 107359 0 2, 496, 830 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0.894444 0 69, 534 0 0 200, 00 200.00 Subtotal (see instructions) 0 5, 852, 368 Less PBP Clinic Lab. Services-Program 201.00 201. 00 Only Charges

5, 852, 368

0 202.00

202.00

Net Charges (line 200 - line 201)

			Т	o 12/31/2018	Date/Time Pre 5/29/2019 3:0	
		Title	e XIX	Hospi tal	PPS	ло ріп
	Cos					
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	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	29, 880	0				50.00
51.00 05100 RECOVERY ROOM	16, 595	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	50, 806	o				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	8, 372	o				55. 00
57. 00 05700 CT SCAN	24, 668	o				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	7, 314	o				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	18, 772	ol				59.00
60. 00 06000 LABORATORY	69, 461	o				60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	o				64.00
65. 00 06500 RESPIRATORY THERAPY	6, 821	0				65.00
66. 00 06600 PHYSI CAL THERAPY	25, 749	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	4, 110	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	2, 911	o				68. 00
69. 00 06900 ELECTROCARDI OLOGY	9, 643					69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	7, 916	0				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	65, 607	0				71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	33, 062	0				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	35, 640	0				73. 00
74. 00 07400 RENAL DIALYSIS	00,010	0				74.00
76. 00 03950 ENDOSCOPY	9, 153	o				76.00
76. 06 03330 I MAGI NG CENTER	12, 156					76.06
76. 97 07697 CARDI AC REHABI LI TATI ON	12, 130					76. 97
OUTPATIENT SERVICE COST CENTERS	<u> </u>	O _I				70.77
90. 00 09000 CLINIC	0	0				90.00
90. 01 04950 DI ABETI C CARE CENTER	0	0				90. 01
90. 02 04951 ANTI -COAGULATION CLINIC	2, 970	0				90. 02
90. 03 04952 PALLI ATI VE CARE	2, 7, 0	o o				90. 03
90. 04 04953 SPI NE CENTER	0	o				90. 04
91. 00 09100 EMERGENCY	268, 057					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	62, 194	0				92.00
200.00 Subtotal (see instructions)	771, 857					200.00
201.00 Less PBP Clinic Lab. Services-Program	771,037	١				200.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)	771, 857	o				202. 00
202. 00 ₁	, , , , , , , ,	١				1-32.00

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lie	eu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-012	Peri od: From 01/01/2018	Worksheet D-1
			Date/Time Prepared: 5/29/2019 3:00 pm
	Title XVIII	Hospi tal	PPS

		Title XVIII	Hospi tal	5/29/2019 3: 00 PPS	O pm	
	Cost Center Description		•	1. 00		
	PART I - ALL PROVIDER COMPONENTS			1.00		
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			38, 424	1. 00 2. 00	
2. 00 3. 00	Private room days (excluding swing-bed and observation bed day	3 /	vate room days	38, 424 0	3.00	
0.00	do not complete this line.	yay. Ti yaa nava aniy pin	vate room days,	١	0.00	
4.00	Semi-private room days (excluding swing-bed and observation be			33, 892	4. 00	
5. 00	Total swing-bed SNF type inpatient days (including private room	om days) through Decembe	r 31 of the cost	0	5. 00	
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00	
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roor	n davs) through December	31 of the cost	0	7. 00	
	reporting period	3 .		0		
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)			_	8. 00	
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	12, 279	9. 00	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruc-		oom days)	0	10. 00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00	
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00	
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	13. 00	
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter O on this line	e)	0	14. 00	
15. 00	Total nursery days (title V or XIX only)	dir (exertaining swring beart	adys)	0		
16. 00	Nursery days (title V or XIX only)			0	16. 00	
17. 00	SWING BED ADJUSTMENT ON Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost					
18. 00	reporting period Madicara rate for swing had SNE services applicable to service	as after December 31 of	the cost	0. 00	18. 00	
	reporting period					
19. 00	Medical drate for swing-bed NF services applicable to services reporting period	9		0. 00		
20. 00	Medical drate for swing-bed NF services applicable to services reporting period	s after December 31 of t	ne cost	0. 00	20. 00	
21. 00	Total general inpatient routine service cost (see instructions			52, 021, 203	•	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 line 17)	er 31 of the cost report	ing 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 7×1 ine 19)	31 of the cost reporti	ng period (line	0	24. 00	
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00	
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)		52, 021, 203		
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation hed ch	arges)	0	28. 00	
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed en	ar ges)	0	29.00	
30. 00	Semi -private room charges (excluding swing-bed charges)			0	30.00	
31. 00	General inpatient routine service cost/charge ratio (line 27 -	line 28)		0. 000000	31. 00	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	32. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	>		0. 00		
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0. 00		
35. 00	Average per diem private room cost differential (line 34 x line)	0. 00 0	ł			
36. 00	, , ,				36.00	
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	rerential (line	52, 021, 203	37. 00	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU					
38. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 353. 87	38. 00	
39. 00	Program general inpatient routine service cost (line 9 x line	•		16, 624, 170	1	
40. 00	Medically necessary private room cost applicable to the Program	,		14 424 170	40.00	
41.00	Total Program general inpatient routine service cost (line 39	+ ITHE 40)	I	16, 624, 170	41.00	

	Financial Systems	COMMUNITY HOSI		CN. 1E 0100		eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0128	Peri od: From 01/01/2018		
					To 12/31/2018	Date/Time Pre 5/29/2019 3:0	pared: 0 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Innatient Days	Average Per		Program Cost (col. 3 x col.	
				col . 2)		4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 00 0	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units			,	0		42.00
43.00	INTENSIVE CARE UNIT	7, 577, 510	2, 888	2, 623.	79 945	2, 479, 482	1
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1.00	
48. 00	Program inpatient ancillary service cost (Wk			`		22, 079, 364	1
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ons)		41, 183, 016	49. 00
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sur	m of Parts I and	1, 580, 082	50.00
51. 00		ationt ancillar	v sarvicas (fr	com Wkst D	cum of Darte II	1, 791, 469	51 00
31.00	and IV)	attent anertrai	y services (ii	om wkst. D,	3411 01 141 (3 11	1,771,407	31.00
52.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non	velelan anaz±	notict and	3, 371, 551	1
53. 00	medical education costs (line 49 minus line		rated, non-pny	sician anesti	netist, and	37, 811, 465	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge					0 00	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)						56.00
57. 00	1	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, u	updated and co	ompounded by the	0.00	59.00
	market basket					0.00	,,,,,,,
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line				the amount by	0.00	60.00
	which operating costs (line 53) are less tha	n expected cost					
62 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			ő	
44.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doso	mbor 21 of the	cost reporti	ng ported (Soc	0	64. 00
64. 00	instructions) (title XVIII only)	ts through bece	liber 31 of the	e cost reporti	riig perrou (see		04.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the d	cost reporting	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	55)(title XVI	II only). For	0	66. 00
	CAH (see instructions)			6.11			
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 c	or the cost re	eporting perioa	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
69 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	e 68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NI						37.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service o)		70.00
72. 00	Program routine service cost (line 9 x line		The 70 - Time	2)			72.00
73.00	Medically necessary private room cost applic						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			Part II. column		74. 00 75. 00
	26, line 45)						
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	, ,						78. 00
79. 00	Aggregate charges to beneficiaries for exces				aug ling 70)		79.00
80.00	Total Program routine service costs for comp. Inpatient routine service cost per diem limi		ost iiiii tati or	ı (ııne /v Mii	ius i i ile 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	* .				82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		s)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)				85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					4, 532	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 353. 87	88. 00
$\omega \Omega = \Omega \Omega$	Observation bed cost (line 87 x line 88) (se	e instructions)				6, 135, 739	89.00

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2018	Worksheet D-1	
				To 12/31/2018	Date/Time Prep 5/29/2019 3:00	
		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	3, 912, 607	52, 021, 203	0. 07521	2 6, 135, 739	461, 481	90.00
91.00 Nursing School cost	0	52, 021, 203	0.00000	0 6, 135, 739	0	91.00
92.00 Allied health cost	0	52, 021, 203	0.00000	0 6, 135, 739	0	92.00
93.00 All other Medical Education	0	52, 021, 203	0.00000	0 6, 135, 739	0	93.00

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0128	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 3:00 pm
	Title XIX	Hospi tal	PPS

DARK I - ALL PROVIDER COMPONENTS PARK I - ALL PROVIDER COMPONENTS			Title XIX	Hospi tal	5/29/2019 3: 0 PPS	0 pm
NART 14 ROUVIDER CRIPOWENTS		Cost Center Description	II tie xix	поѕрі таі	PPS	
NeATHERT DAYS					1. 00	
Impatient days (including private room days and swing-bed days, excluding newborn) 38,424 2.00 Impatient days (including private room days, excluding swing-bed and observation bed days) 38,242 2.00 Private room days (excluding swing-bed and observation bed days) 38,000 3.00 3						
Impatient days (including private room days, excluding saing-bed and newborn days) 1.7 you have only private room days. 0.3.00 2.00				1	20.404	
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23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charges (line 29 + line 3) 30.00 Average per diem private room charge differential (line 32 minus line 23) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 minus line 36) 30.00 Private room cost differential djustment (line 3 x line 35) 30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 37 minus line 36) 30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 37 minus line 36) 30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 53, 553, 888) 30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 53, 553, 888) 30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 53, 553, 888) 30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 53, 553, 888) 30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 53, 553, 888)	22.00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ng period (line	0	22. 00
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7 x line 19) 25.00	24 00		31 of the cost reporting	na period (line	0	24 00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 x line 20 26.00 27.00 26.00 27	24.00		31 of the cost reportin	ig perrou (Trile	U	24.00
x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9.00 Private room charges (excluding swing-bed charges) 9.00 Semi-private room charges (excluding swing-bed charges) 9.01 Semi-private room charges (excluding swing-bed charges) 9.02 Semi-private room charges (excluding swing-bed charges) 9.03 Semi-private room charges (excluding swing-bed charges) 9.04 Average private room per diem charge (line 29 ÷ line 3) 9.05 Average semi-private room per diem charge (line 29 ÷ line 3) 9.00 Average semi-private room per diem charge (line 30 ÷ line 4) 9.00 Average per diem private room cost differential (line 34 x line 31) 9.00 Average per diem private room cost differential (line 34 x line 31) 9.00 Average per diem private room cost differential (line 3 x line 35) 9.00 Private room cost differential adjustment (line 3 x line 35) 9.00 Part II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 88.00 Adjusted general inpatient routine service cost per diem (see instructions) 9.00 Program general inpatient routine service cost per diem (see instructions) 1, 393.76 9.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	25.00	l	31 of the cost reporting	period (line 8	0	25. 00
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Average per diem private room charge differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 53, 553, 888 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 34.00 35.00 36.00 37.00 37.00 38.00 1, 393.76 38.00 1, 130, 339 40.00			,			
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36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 53,553,888 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 37.00 37.00 37.00						
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PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,393.76 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 1,130,339 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37.00		and private room cost di	recential (IIne	53, 553, 888	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,393.76 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,393.76 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,393.76 38.00 39.00 40.00			JSTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,130,339 39.00 40.00	38. 00				1, 393. 76	38. 00
	39. 00					
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 1,130,339 41.00		, , , , , , , , , , , , , , , , , , , ,	•			
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 130, 339	41.00

	Financial Systems	COMMUNITY HOS		ON. 1E 0100		u of Form CMS-2	
COMPUI	TATION OF INPATIENT OPERATING COST		Provi der Co		Peri od: From 01/01/2018	Worksheet D-1	
					To 12/31/2018	Date/Time Pre 5/29/2019 3:0	pared: O pm
	Coat Contan Decemintion	Total		e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Davs	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
		·		col . 2)		4)	
42 00	NURSERY (title V & XIX only)	1. 00 1, 849, 616	2. 00 3, 184	3. 00 580. 9	4. 00 21 1, 550	5. 00 900, 411	42.00
42.00	Intensive Care Type Inpatient Hospital Units	1,047,010	3, 104] 300. 7	1, 330	700, 411	42.00
43. 00	INTENSIVE CARE UNIT	7, 696, 673	2, 888	2, 665. 0	05 0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	1						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			1, 096, 351	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructio	ns)		3, 127, 101	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	Wkst D sum	of Parts L and	154, 427	50.00
00.00		atront routine	301 11 003 (11 011	mot. D, San	or runts i unu	101, 127	00.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	80, 859	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				235, 286	52.00
53. 00	Total Program inpatient operating cost exclu	ding capital re	lated, non-phy	sician anesth	etist, and	2, 891, 815	1
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					1
54. 00	Program discharges					0	54.00
	Target amount per discharge						55. 00
56. 00 57. 00	,	ing cost and ta	ract amount (ino 56 minus	lino 52)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and ta	rget allourt (i	THE SO IIITIUS	111le 55)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi 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	cost report un	dated by the m	arkat haskat		0.00	60.00
61. 00					the amount by	0.00	1
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% of	the target		
62 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
44.00	PROGRAM INPATIENT ROUTINE SWING BED COST	to through Doos	mbor 21 of the	aaat manamti	na noriad (Coo	0	(4.00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 nlus line 6	5)(title XVII	Lonly) For	0	66. 00
00.00	CAH (see instructions)	ne costs (The	04 prus rine o	5)(title XVII	1 Only). 101	0	00.00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	f the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	rtina period	0	68. 00
	(line 13 x line 20)			·	3 1 2		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70. 00	Skilled nursing facility/other nursing facil						70.00
71. 00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 v li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv						74. 00
75. 00	Capital -related cost allocated to inpatient	routine service	costs (from W	orksheet B, P	art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	rovi don rocond	6)			78. 00 79. 00
	Total Program routine service costs for comp	, ,		,	us line 79)		80.00
81. 00	Inpatient routine service cost per diem limi	tati on			,		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (* .				82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		٠,				84. 00
85.00	Utilization review - physician compensation	(see instructio					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		rough 85)				86. 00
87. 00	Total observation bed days (see instructions					4, 532	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 393. 76	
00 00	Observation bed cost (line 87 x line 88) (se					6, 316, 520	

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	eu 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		
		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	3, 912, 607	53, 553, 888	0. 07305	9 6, 316, 520	461, 479	90.00
91.00 Nursing School cost	0	53, 553, 888	0.00000	0 6, 316, 520	0	91.00
92.00 Allied health cost	0	53, 553, 888	0.00000	0 6, 316, 520	0	92.00
93.00 All other Medical Education	0	53, 553, 888	0. 00000	0 6, 316, 520	0	93. 00

Health Financial Systems INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	COMMUNITY HOSPITAL SOUTH	CN: 15-0128	Peri od:	eu of Form CMS-2 Worksheet D-3	
THE THE THOUSE COST THE OWN COMMENT	Trovider c		From 01/01/2018		
			To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
	Ti +I	e XVIII	Hospi tal	PPS	о рііі
Cost Center Description	11 11	Ratio of Cos		Inpati ent	
oust defiter bescription		To Charges	Program	Program Costs	
		l o onar goo		(col. 1 x col.	
			3	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			25, 035, 981		30.00
31. 00 03100 INTENSIVE CARE UNIT			3, 220, 485		31.00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 11193			50.00
51.00 05100 RECOVERY ROOM		0. 16264			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 46680	9 20, 431		
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11819			
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 07553		1	
57. 00 05700 CT SCAN		0. 04135		259, 635	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 07196			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 08287			
60. 00 06000 LABORATORY		0. 10241		l	
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 27030			
66. 00 06600 PHYSI CAL THERAPY		0. 39053		623, 138	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 32788			
68. 00 06800 SPEECH PATHOLOGY		0. 32873			
69. 00 06900 ELECTROCARDI OLOGY		0. 09203			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 29145			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 37696			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 38421			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 24879		3, 429, 067	
74. 00 07400 RENAL DI ALYSI S		0.46409			
76. 00 03950 ENDOSCOPY		0. 16700		5, 625	
76. 06 03330 I MAGI NG CENTER		0. 18163		0	76.06
76. 97 O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS		0. 30770	94 867	267	76. 97
90. 00 09000 CLINIC		0.00000	00	0	90.00
90. 00 09000 CLINI C 90. 01 04950 DI ABETI C CARE CENTER		0.00000		0	
90. 01 04950 DI ABETTO CARE CENTER 90. 02 04951 ANTI -COAGULATION CLINIC		0. 00000		0	
90. 03 04952 PALLI ATI VE CARE		0. 00000			1
ON ON ONOSSI SPINE CENTER		0.00000		1	

0.948297

0. 106060 0. 894444 11, 399, 481 462, 795

126, 227, 569

126, 227, 569

90.04

201. 00 202. 00

1, 209, 029 91. 00 413, 944 92. 00

22, 079, 364 200. 00

90. 04 04953 SPINE CENTER

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

91. 00 09100 EMERGENCY

200.00

201.00

202.00

Health Financial Systems	COMMUNITY HOSPITAL SOUTH		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
			From 01/01/2018 Fo 12/31/2018		pared·
				5/29/2019 3:0	
	Titl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cost		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS			2, 308, 533		30.00
31. 00 03100 NTENSI VE CARE UNI T			344, 283		31.00
43. 00 04300 NURSERY			145, 203		43. 00
ANCILLARY SERVICE COST CENTERS			143, 203		1 43.00
50. 00 05000 OPERATING ROOM		0. 11254	5 513, 591	57, 803	50.00
51. 00 05100 RECOVERY ROOM		0. 16264!			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 46680	9 192, 206	89, 723	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 118829			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 075534	71, 086	5, 369	55. 00
57. 00 05700 CT SCAN		0. 041354	4 271, 084	11, 210	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 071964	4 37, 594	2, 705	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 082876	339, 891	28, 169	59. 00
60. 00 06000 LABORATORY		0. 102416		83, 503	
64. 00 06400 I NTRAVENOUS THERAPY		0. 000000			64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 270302			
66. 00 06600 PHYSI CAL THERAPY		0. 390532			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 32788!			
68. 00 06800 SPEECH PATHOLOGY		0. 328730			
69. 00 06900 ELECTROCARDI OLOGY		0. 09203!			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 29600	·		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 376964			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 38421			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 248799	·		
74. 00 07400 RENAL DI ALYSI S		0. 464090			
76. 00 03950 ENDOSCOPY		0. 167004	30, 033	5, 016	76. 00

0.181634

0. 307704

0.000000

0.000000

0.368030

0.000000

0.948297

0. 107359

0.894444

76.06

90. 01

0 90.02

90.03

90.04

91.00

92.00

201.00

202. 00

0

0 76.97

0 90.00

0

51, 377

13, 113

1, 096, 351 200. 00

0

0

478, 551

14, 660

5, 384, 951

5, 384, 951

03330 I MAGING CENTER 07697 CARDIAC REHABILITATION

04950 DI ABETI C CARE CENTER 04951 ANTI -COAGULATION CLINIC

04952 PALLIATIVE CARE

09000 CLI NI C

90. 04 04953 SPINE CENTER

91. 00 09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

76.06

76. 97

90.00

90.01

90.02

90.03

200.00

201.00

202.00

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0128	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 3:00 pm

		T		5/29/2019 3:0	0 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)				1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring instructions)	ng on or after October	1 (see	7, 479, 426	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI fo 1 (see instructions)	r discharges occurring p	orior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI fo October 1 (see instructions)	r discharges occurring o	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			870, 671 0	2. 00 2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instruction	ons)		0	2. 02
3.00	Managed Care Simulated Payments			11, 866, 205	3. 00
4.00	Bed days available divided by number of days in the cost repor Indirect Medical Education Adjustment			155. 14	4.00
5. 00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)			0.00	5. 00
6. 00 7. 00	FTE count for allopathic and osteopathic programs that meet th new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified u		·	0. 00	6. 00 7. 00
7. 00	ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.			0.00	7. 00
8.00	Adjustment (increase or decrease) to the FTE count for allopat affiliated programs in accordance with 42 CFR 413.75(b), 413.7 1998), and 67 FR 50069 (August 1, 2002).			6.09	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slo report straddles July 1, 2011, see instructions.	ts under § 5503 of the A	ACA. If the cost	0.00	8. 01
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. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line instructions)	s (8, 8,01 and 8,02) (s	see	6. 09	9. 00
11. 00	FTE count for allopathic and osteopathic programs in the curre FTE count for residents in dental and podiatric programs.	nt year from your record	ds		11. 00
	Current year allowable FTE (see instructions)			7. 54	
	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that yea otherwise enter zero.	r ended on or after Sep	tember 30, 1997,	6. 88 3. 80	
15. 00	Sum of lines 12 through 14 divided by 3.			6. 07	15. 00
	Adjustment for residents in initial years of the program			0.00	
	Adjustment for residents displaced by program or hospital clos	ure			17. 00
	Adjusted rolling average FTE count			6. 07 0. 039126	18.00
	Current year resident to bed ratio (line 18 divided by line 4) Prior year resident to bed ratio (see instructions)	•		0. 039128	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 039126	
	IME payment adjustment (see instructions)			614, 823	
22. 01	IME payment adjustment - Managed Care (see instructions)			250, 947	
	Indirect Medical Education Adjustment for the Add-on for § 422				
	Number of additional allopathic and osteopathic IME FTE reside (f)(1)(iv)(C).	nt cap slots under 42 Cl	-R 412. 105		23. 00
	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the li	ower of line 23 or line	24 (see	0. 33	24. 00 25. 00
26. 00	<pre>instructions) Resident to bed ratio (divide line 25 by line 4)</pre>			0. 000000	26. 00
	IME payments adjustment factor. (see instructions)			0.000000	
	IME payments adjustment ractor. (see instructions)		0.000000	28. 00	
	IME add-on adjustment amount - Managed Care (see instructions)		0	28. 01	
			614, 823	1	
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01 Disproportionate Share Adjustment)		250, 947	
30.00	Percentage of SSI recipient patient days to Medicare Part A pa	tien <mark>t days (see instruc</mark> t	tions)	2. 49	30. 00
31.00	Percentage of Medicaid patient days (see instructions)				31. 00
	Sum of lines 30 and 31			25. 24	
	Allowable disproportionate share percentage (see instructions)			10.04	
34.00	Disproportionate share adjustment (see instructions)		l	729, 717	34.00

	Financial Systems COMMUNITY HOSPIT. ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0128	Peri od: From 01/01/2018 To 12/31/2018	u of Form CMS-2 Worksheet E Part A Date/Time Prep 5/29/2019 3:00	pared:
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
	Uncompensated Care Adjustment			0.070.070.447	
5. 00	Total uncompensated care amount (see instructions)			8, 272, 872, 447	35.00
5. 01 5. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, enter instructions)	zero on this line) (see	0. 000196574 1, 330, 154	0. 000193416 1, 600, 102	35. 01 35. 02
5. 03 5. 00	Pro rata share of the hospital uncompensated care payment amou Total uncompensated care (sum of columns 1 and 2 on line 35.03		994, 882 1, 398, 196	403, 314	35. 03 36. 00
	Additional payment for high percentage of ESRD beneficiary dis		gh 46)		
0. 00	Total Medicare discharges on Worksheet S-3, Part I excluding d	ischarges for MS-DRGs	0		40. 00
1. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68 instructions)	3, 684 an 685. (see	0		41. 00
I. 01	Total ESRD Medicare covered and paid discharges excluding MS-D an 685. (see instructions)	RGs 652, 682, 683, 684	0		41. 01
2. 00	Divide line 41 by line 40 (if less than 10%, you do not qualif	y for adjustment)	0.00		42. 00
3. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682 instructions)	•	0		43. 00
1. 00	Ratio of average length of stay to one week (line 43 divided b days)	3	0. 000000		44.00
5. 00 5. 00	Average weekly cost for dialysis treatments (see instructions) Total additional payment (line 45 times line 44 times line 41.		0.00		45. 00 46. 00
7. 00	Subtotal (see instructions)	01)	32, 685, 793		47. 00
3. 00	Hospital specific payments (to be completed by SCH and MDH, sm	all rural hospitals	0		48. 00
	only. (see instructions)	·			
				Amount	
9. 00	Total payment for inpatient operating costs (see instructions)			1. 00 32, 936, 740	49. 00
). 00	Payment for inpatient program capital (from Wkst. L, Pt. I and			2, 626, 098	
1. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.00
2. 00	Direct graduate medical education payment (from Wkst. E-4, lin			178, 996	52.00
3. 00	Nursing and Allied Health Managed Care payment			0	53. 00
1. 00	Special add-on payments for new technologies			0	54.00
1. 01	Islet isolation add-on payment			0	54. 01
5. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69			0	55.00
6. 00 7. 00	Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II	•	arough 25)	0	56. 00 57. 00
3. 00	Ancillary service other pass through costs from Wkst. D, Pt. I		ii ougii 33).	0	58. 00
9. 00	Total (sum of amounts on lines 49 through 58)	v, cor. 11 1111c 200)		35, 741, 834	59.00
0. 00	Primary payer payments			0	60.00
1.00	Total amount payable for program beneficiaries (line 59 minus	line 60)		35, 741, 834	61.00
2. 00	Deductibles billed to program beneficiaries			3, 168, 308	62.00
3. 00	Coinsurance billed to program beneficiaries			49, 580	
1. 00	Allowable bad debts (see instructions)			180, 418	
5. 00	Adjusted reimbursable bad debts (see instructions)			117, 272	
5. 00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		57, 157	66.00
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	nnlicable to MC DDCs (a	as i motrusti ana)	32, 641, 218	1
3. 00 9. 00	Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	68. 00 69. 00
). 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	TO SON SEE THIS CLUCKTON.	5)	0	70.00
). 50	Rural Community Hospital Demonstration Project (§410A Demonstr	ation) adjustment (see i	nstructions)	Ö	70.50
). 87	Demonstration payment adjustment amount before sequestration	atron, aaj astmont (888)		0	70. 87
). 88	SCH or MDH volume decrease adjustment (contractor use only)			Ö	70. 88
). 89	Pioneer ACO demonstration payment adjustment amount (see instr	ructions)			70. 89
). 90	HSP bonus payment HVBP adjustment amount (see instructions)	•		0	70. 90
). 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91
	Bundled Model 1 discount amount (see instructions)			0	70. 92
). 92					
). 93	HVBP payment adjustment amount (see instructions)			-150, 608	
). 93). 94	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions) Recovery of accelerated depreciation			-173, 446	

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0128	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared:

				From 01/01/2018 To 12/31/2018	Part A Date/Time Pre 5/29/2019 3:0	
		Title	XVIII	Hospi tal	PPS	
				(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	n column 0		0	0	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or after the period ending the corresponding federal year for the period ending on or after the period ending the p			0	0	70. 97
70. 98	Low Volume Payment-3	10/1)			0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	59 & 70)			32, 317, 164	1
71. 01	Sequestration adjustment (see instructions)	3, a ,o,			646, 343	
	Demonstration payment adjustment amount after sequestration				010, 010	1
72.00	Interim payments				31, 030, 723	1
	Tentative settlement (for contractor use only)				0.,000,720	1
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			640, 098	
75. 00	Protested amounts (nonallowable cost report items) in accordan	nce with			348, 099	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
90. 00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) 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)	51 2.05			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 instru	,			0	
	Capital outlier reconciliation adjustment amount (see instruc				0	
	The rate used to calculate the time value of money (see instru	uctions)			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 instruc	tions)			0	96. 00
				Prior to 10/1 1.00	0n/After 10/1 2.00	
	HSP Bonus Payment Amount			1.00	2.00	
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)			0.0000000000	0.0000000000	101. 00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions	s)		0	0	102. 00
	HRR Adjustment for HSP Bonus Payment					1
	HRR adjustment factor (see instructions)			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 Demonstr	<u>ration) Adju</u>	stment			
200. 00	Is this the first year of the current 5-year demonstration per	riod under t	he 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					1
	Cost Reimbursement	10)		1		
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	e 49)				201. 00
	Medicare discharges (see instructions)					202. 00
203.00	Case-mix adjustment factor (see instructions)	first waar	of the ourses	+ E voor domonot	rotion	203. 00
	Computation of Demonstration Target Amount Limitation (N/A in	TITST year	or the curren	t 5-year demonst	ration	
204.00	period) Medicare target amount					204. 00
	Case-mix adjusted target amount (line 203 times line 204)					204.00
	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
200.00	Adjustment to Medicare Part A Inpatient Reimbursement					1200.00
207.00	Program reimbursement under the §410A Demonstration (see insti	ructions)				207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,					208. 00
	Adjustment to Medicare IPPS payments (see instructions)	/				209. 00
	Reserved for future use					210.00
	Total adjustment to Medicare IPPS payments (see instructions)					211. 00
50	Comparision of PPS versus Cost Reimbursement			<u> </u>		1
212. 00	Total adjustment to Medicare Part A IPPS payments (from line 2	211)				212. 00
	Low-volume adjustment (see instructions)					213. 00
	Net Medicare Part A IPPS adjustment (difference between PPS ar	nd cost reim	bursement)			218.00
	,		,	1		1
	(line 212 minus line 213) (see instructions)					

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lieu of Form (
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0128	From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/29/2019 3:00 pm			

Note 1.00			'	0 12/31/2016	5/29/2019 3:0	
ART 8 - NEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 17, 65, 756 2.00 1.00 Medical and other services reinfoursed under OPPS (see instructions) 17, 65, 756 2.00 1.00			Title XVIII	Hospi tal		
ART 8 - NEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 17, 65, 756 2.00 1.00 Medical and other services reinfoursed under OPPS (see instructions) 17, 65, 756 2.00 1.00						
Medical and other services (see instructions) 3, 750 1.00					1. 00	
	4 00			1	0/ 750	
1.00 OPPS payments		· · · · · · · · · · · · · · · · · · ·	ti ana)			
0.011 or payment (see instructions)			LI OIIS)			1
0.01 1.01 1.02 1.03						1
Enter the hospit plat space File payment to cost ratio (see Instructions) 0.000 5.00						1
Line 2 Tiens Line 5 0.00		, , , , , , , , , , , , , , , , , , ,	ctions)		0. 000	1
Transit fional corridor payment (see instructions)	6.00				0	6. 00
Ancillary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200 0 9, 00 10, 00 00 00 00 00 00	7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
0 0,00						
10.70 Oxal cost (sum of lines 1 and 10) (see instructions) 10.00 Oxal cost (sum of lines 1 and 10) (see instructions) 10.00 Oxal cost (sum of lines 1 and 10) (see instructions) 10.00 Oxal cost (sum of lines 1 and 10) 10.00 Oxal cost (sum of lines 1 and 10) 10.00 Oxal cost (sum of lines 1 and 10) 10.00 Oxal cost (sum of lines 1 and 10) 10.00 Oxal cost (sum of lines 1 and 10) 10.00 Oxal cost (sum of lines 1 and 10) 10.00 Oxal cost (sum of lines 1 and 10) 10.00 Oxal cost (sum of lines 1 and 10) 10.00 Oxal cost (sum of lines 1 and 10) Oxal cost (sum of l			V, col. 13, line 200			
COUNTINITION OF LESSER OF COST OR CHARGES 12,00 Ancillary service charges 14,708 12,00 13,00 Organ acquisition charges (from West. D-4, Pt. 111, col. 4, 11ne 69) 12,00 13,00 13,00 13,00 13,00 13,00 13,00 13,00 13,00 14,00 14,00 15,00 14,00 15,0		9				
Reasonable charges 147,708 12,00 20 12,00 20 12,00 20 12,00 20 12,00 20 12,00 20 12,00 20 13,00 20 13,00 20 13,00 20 13,00 20 147,708 14,00 20 20 20 20 20 20 20	11.00				30, 730	11.00
12,00 Ancillary service charges 147,708 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 12,00 147,708 12,00 14,00 12,00 147,708 14,00 12,00 14,00 12,00 14,00 14,00 14,00 14,00 14,00 15,00 14,00 14,00 15,00 14,00 15,00 14,00 15,00 16						1
13.00 Organ acquisition charges (From Wkst. D-4, Pt. III., col. 4, line 69) 0 13.00	12.00				147, 708	12.00
Customary_charges			ne 69)			1
15.00 Aggregate amount actually collected from patients Iable for payment for services on a charge basis 0 16.00 Amounts that would have been realized from patients Iable for payment for services on a charge basis 0 16.00 Add such payment been made in accordance with 42 CFR \$413.13(e) 0.000000 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00	14.00	Total reasonable charges (sum of lines 12 and 13)			147, 708	14. 00
16.00 Amounts that would have been realized from patients I able for payment for services on a chargebasis had souch payment been made in accordance with 42 CFR \$413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 17.00 18.00 1						
had such payment been made in accordance with 42 CFR \$413.13(e)						
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00	16.00	·	1 3	a cnargebasis	0	16.00
18.00 Total customery charges (see instructions) 147,708 18.00 10,908 10	17 00		=)		0.000000	17 00
19.00 Excess of customary Charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.0						1
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00		,	y if line 18 exceeds line	11) (see		1
Instructions 30,750 21.00						
1.00 Lesser of cost or charges (see instructions) 0.25.00 0.20.00	20. 00	, , , , , , , , , , , , , , , , , , , ,	y if line 11 exceeds line	18) (see	0	20. 00
22. 00 Interns and residents (see instructions) 0 22. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00 23. 00 24. 00 25. 00	21 00				27. 750	21 00
23. 00 Cost of physicians' services in a teaching hospital (see instructions) 15,848,109 24. 00 15,848,109 24. 00 25. 00 2						1
24. 00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 15, 848,109 24. 00 25. 00 26. 0			cuctions)			1
COMPUTATION OF REIMBURSEMENT SETTLEMENT SET COMPUTED S			uctions)		-	1
26. 00 Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2, 754, 207 26. 00 27. 00 13, 130, 652 13, 130, 652 13, 130, 652 13, 130, 652 13, 130, 652 13, 130, 652 13, 130, 652 13, 130, 652 13, 130, 60. 130, 60. 130, 6					.,	
27. 00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 13,130,652 27. 00 instructions) 76,752 28. 00 10 rect graduate medical education payments (from Wkst. E-4, line 50) 76,752 28. 00 29. 00 25RD direct medical education costs (from Wkst. E-4, line 36) 13,207,404 30. 00 20. 0	25.00	Deductibles and coinsurance amounts (for CAH, see instructions	5)		0	25. 00
Instructions Direct graduate medical education payments (from Wkst. E-4, line 50) 76,752 28. 0 29. 00						1
28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29. 00	27. 00		olus the sum of lines 22 a	nd 23] (see	13, 130, 652	27. 00
9.9 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 30.00 Subtotal (sum of lines 27 through 29) 13.207.404 31.00 Primary payer payments 3.486 32.00 Subtotal (line 30 minus line 31) 13.203,918 41.0WABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 0 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 34.00 All owable bad debts (see instructions) 283,250 35.00 All owable bad debts (see instructions) 281,315 36.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 241,774 36.00 MSP-LCC reconciliation amount from PS&R -118 39.00 MSP-LCC reconciliation amount from PS&R -118 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.97 Perital or full credits received from manufacturers for replaced devices (see instructions) 29.50 39.99 PECOVERY OF ACCELERATED DEPRECIATION 0 40.01 Sequestration adjustment see instructions) 267,763 40.01 Demonstration payment adjustment amount after sequestration	20 00		no E0)		74 752	20 00
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34.00			CES)			
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93.00 Time Value of Money (see instructions) 0 93.00		· · · · · · · · · · · · · · · · · · ·		ļ		
94.00 Total (sum of lines 91 and 93) 0 94.00						1
	94. 00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems COMMANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Period: Worksheet E-1
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/29/2019 3:00 pm Provider CCN: 15-0128

Inpatient Part A						5/29/2019 3:00) pm
					Hospi tal	PPS	
Total interim payments paid to provider 1,00 2,00 3,00 4,00 1,00			Inpatien	t Part A	Par	rt B	
Total interim payments paid to provider 1,00 2,00 3,00 4,00 1,00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interin payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retractive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				2. 00		4.00	
Interin payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retractive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	1. 00	Total interim payments paid to provider		31, 030, 72	3		1. 00
Submitted or to be Submitted to the contractor For services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately sech retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 0				- , ,	-		
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero	2.00					Ĭ	2.00
write "NONE" or enter a zero .0							
List separately each retroactive Lump sum adjustment amount based on subsequent revision of the Interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	2 00						2 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3.00
payment, If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider							
ADJUSTMENTS TO PROVIDER							
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3.05 Provider to Program 0	3.03				O	0	3. 03
Provider to Program	3.04				O	0	3.04
3. 50 ADJUSTMENTS TO PROGRAM	3.05				o	0	3.05
3. 50 ADJUSTMENTS TO PROGRAM		Provider to Program					
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3.52 3.53 3.54 3.99 3.50-3.98 3.50-3.98 3.50-3.99 3.50-3.98					n	0	3. 51
3.53 3.54 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.00 TENTATIVE TO PROVIDER 5.00 Provider to Program TENTATIVE TO PROGRAM 0 0 0 5.02 5.03 Provider to Program TENTATIVE TO PROGRAM 0 0 0 5.55 5.50 5.50 5.50 5.50 5.50 5.					-		
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Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)							
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR		Subtotal (sum of lines 2 01 2 40 minus sum of lines			~	١	
13,080,173 13,	3. 99				J	l 0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 5.00 5.01 TENTATI VE TO PROVI DER 0 0 5.02 5.02 0 0 5.02 5.03 0 0 5.02 5.04 0 0 5.02 5.05 TENTATI VE TO PROGRAM 0 0 5.50 5.50 TENTATI VE TO PROGRAM 0 0 5.51 5.52 0 0 0 5.55 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.05-5.98) 0 0 5.52 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.00 6.00 6.00 6.01 SETTILEMENT TO PROGRAM 0 6.00 6.00 6.00 7.00 Total Medicare program liability (see instructions) 31,670,821 13,120,386 7.00	4 00	1 2 2 2 2 2 2		21 020 72	2	12 000 172	4 00
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			31, 030, 72	3	13, 080, 1/3	4. 00
TO BE COMPLÉTED BY CONTRACTOR							
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desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5. 00
Program to Provider							
TENTATI VE TO PROVIDER							
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TENTATIVE TO PROGRAM	5.03				O	0	5. 03
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7.00 Total Medicare program Liability (see instructions) 31,670,821 13,120,386 Contractor Number (Mo/Day/Yr)							
Contractor NPR Date Number (Mo/Day/Yr)					~	1 - 1	
Number (Mo/Day/Yr)	7.00	iotal medicale program frability (see instructions)		31, 070, 82			7.00
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	0.00	Name of Contractor)	1.00	2. 00	0.00
8.00 Name of Contractor 8.00	0.00	INAIIIE OI COITTI ACTOI			1	ı l	8. 00

Heal th	Financial Systems COMMUNITY HOSPI	In Lie	u of Form CMS-	2552-10		
CALCUL					epared:	
		Title XVIII	Hospi tal	PPS		
1.00						
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1.00	
1.00	0 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00	00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
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	1-12			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	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	-			1	
30.00	Initial/interim HIT payment adjustment (see instructions)				30. 00	
31.00	Other Adjustment (specify)				31.00	
22 00	20 Delenge due provider (Line 9 (or Line 10) minus Line 20 and Line 21) (occ instructions)					

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

30. 00 31. 00 32. 00

	Financial Systems COMMUNITY HOSPI GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der Co	CN: 15-0128	Peri od:	u of Form CMS-2 Worksheet E-4	.002-10
	LE EDUCATION COSTS			From 01/01/2018 To 12/31/2018	Date/Time Prep 5/29/2019 3:00	
		Title	e XVIII	Hospi tal	PPS) piii
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
1. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng peri ods	0. 00	1. 00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CF	. , ,	(1) (see instr	ructions)	0.00	2. 00
3. 00 3. 01	Amount of reduction to Direct GME cap under section 422 of MM Direct GME cap reduction amount under ACA §5503 in accordance		R §413.79 (m).	(see	0. 00 0. 00	3. 00 3. 01
4. 00	instructions 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	6. 09	4. 00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst straddling 7/1/2011)		cost reporti	ng periods	0. 00	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (see inst	ructions for	cost reporting	0. 00	4. 02
5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	line 4 plus l	ines 4.01 and	6. 09	5. 00
6. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	6. 42	6. 00
7. 00	Enter the lesser of line 5 or line 6		Primary Care	e Other	6. 09 Total	7. 00
			1. 00	2. 00	3. 00	
8. 00	Weighted FTE count for physicians in an allopathic and osteop program for the current year.	athi c	5. 7	75 0.67	6. 42	8. 00
9. 00	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6.		5. 4	0. 64	6. 09	9. 00
10.00	Weighted dental and podiatric resident FTE count for the curr Unweighted dental and podiatric resident FTE count for the cu			1. 45 1. 45		10. 00 10. 01
10. 01 11. 00	Total weighted FTE count	rrent year	5.4			11. 00
12. 00	Total weighted resident FTE count for the prior cost reportin instructions)	g year (see	5. 0			12. 00
13. 00	Total weighted resident FTE count for the penultimate cost re year (see instructions)	porti ng	2. 1	1. 22		13. 00
14. 00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	4. 2			14.00
15. 00 15. 01	Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p	rograms	0.0			15. 00 15. 01
16. 00	Adjustment for residents displaced by program or hospital clo		0.0			16. 00
16. 01	Unweighted adjustment for residents displaced by program or h		0.0			16. 01
17. 00	Adjusted rolling average FTE count		4. 2			17. 00
	Per resident amount Approved amount for resident costs		90, 337. 7 379, 41		529, 380	18. 00 19. 00
					1. 00	
20. 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. 00
21. 00	Direct GME FTE unweighted resident count over cap (see instru				0. 33	
22. 00 23. 00	Allowable additional direct GME FTE Resident Count (see instr Enter the locality adjustment national average per resident a		netructione)		0. 00 0. 00	22. 00 23. 00
24. 00	Multiply line 22 time line 23	illouitt (see i	ristructions)		0.00	24. 00
	1 1 3				529, 380	
			Inpatient Par	t Managed care		
			A			
	COMPUTATION OF PROCRAM DATIENT LOAD		1.00	2. 00	3. 00	
25. 00	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions)		1.00		3. 00	26. 00
25. 00 26. 00				24 5, 643	3.00	
26. 00 27. 00 28. 00	Inpatient Days (see instructions) Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days		1.00	5, 643 33 37, 403 55 0. 150870	3.00	26. 00 27. 00 28. 00
26. 00 27. 00	Inpatient Days (see instructions) Total Inpatient Days (see instructions)		1. 00 13, 22 37, 40	5, 643 33 37, 403 55 0. 150870	3. 00	27. 00

Hool +h	Financial Systems COMMUNITY HOSDI	TAL COUTU	In Lie	u of Form CMS-2	DEED 10	
	Health Financial Systems COMMUNITY HOSPITAL SOUTH In Lieu DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT Provider CCN: 15-0128 Period: W					
	MEDICAL EDUCATION COSTS From 01/01/2018 To 12/31/2018 [
		Title XVIII	Hospi tal	5/29/2019 3: 00 PPS		
				1. 00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLIEDUCATION COSTS)	E XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL		
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00	
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	1, 337, 073	33. 00	
34.00	Ratio of direct medical education costs to total charges (lin		<i>,</i>	0.000000		
35.00	Medicare outpatient ESRD charges (see instructions)			0	35. 00	
36.00	Medicare outpatient ESRD direct medical education costs (line			0	36. 00	
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				
	Part A Reasonable Cost					
37. 00	Reasonable cost (see instructions)			41, 183, 016		
38. 00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38. 00	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	39. 00	
40.00	1 3 1 3 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1			0	10.00	
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minu	s line 40)		41, 183, 016	41.00	
42.00	Part B Reasonable Cost Reasonable cost (see instructions)			17, 662, 326	42.00	
	Primary payer payments (see instructions)			3, 486		
44. 00)))))			17, 658, 840		
45. 00	Total reasonable cost (sum of lines 41 and 44)			58, 841, 856		
46. 00	,	e 41 ÷ line 45)		0, 699893		
	Ratio of Part B reasonable cost to total reasonable cost (line			0. 300107		
00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA			27 000 107		
48. 00	Total program GME payment (line 31)			255, 748	48. 00	
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		178, 996	49. 00	
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			76, 752	50. 00	
	•					

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

Provi der CCN: 15-0128

oni y)				10 12/01/2010	5/29/2019 3:0	O pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2. 00	3. 00	4. 00	
1 00	CURRENT ASSETS	1 , 000	J			1 00
1.00	Cash on hand in banks	6, 099			0	1.00
2. 00 3. 00	Temporary investments Notes receivable				0	2.00
4. 00	Accounts receivable	191, 738, 113	1		0	
5. 00	Other recei vable	-153, 052, 809		0	0	
6. 00	Allowances for uncollectible notes and accounts receivable	213, 193			0	
7. 00	Inventory	3, 877, 376		o o	ő	7. 00
8.00	Prepaid expenses	9, 975	l	0	0	
9.00	Other current assets	0) (0	0	9. 00
10.00	Due from other funds	0) (0	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	42, 791, 947	' (0	0	11. 00
	FIXED ASSETS					
12. 00	Land	1, 254, 312		0	-	
13.00	Land improvements	2, 722, 362	1	0	0	
14.00	Accumulated depreciation	0		0	-	14.00
15. 00	Buildings	177, 055, 544	1	0	0	15.00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	1 727 025	1	0	0	16. 00 17. 00
18. 00	Accumulated depreciation	1, 737, 035			0	18.00
19. 00	Fi xed equi pment	76, 709, 244			0	19.00
20. 00	Accumulated depreciation	70, 707, 244			0	20.00
21. 00	Automobiles and trucks	53, 839			0	21.00
22. 00	Accumulated depreciation	00,007	1		Ö	22. 00
23. 00	Major movable equipment	l o	1	o o	0	23. 00
24. 00	Accumulated depreciation	-127, 939, 698	3	0	Ō	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	HIT designated Assets	0) (0	0	27. 00
28.00	Accumulated depreciation	0)	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	115, 657	' (0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	131, 708, 295	j (0	0	30.00
	OTHER ASSETS	1				
31.00	Investments	0		0	-	31.00
32.00	Deposits on Leases	0		1	0	32.00
33. 00	Due from owners/officers	0 0 704 400		1	0	33.00
34. 00	Other assets	365, 794, 488		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)	365, 794, 488 540, 294, 730	1			35. 00 36. 00
30.00	CURRENT LIABILITIES	340, 274, 730	'	<u> </u>	0	30.00
37. 00	Accounts payable	850, 793		0	0	37. 00
38. 00	Salaries, wages, and fees payable	0		0	ő	38. 00
39. 00	Payrol I taxes payable	0		0	Ō	39. 00
40.00	Notes and Loans payable (short term)	0		0	0	40.00
41.00	Deferred income	0		0	0	41.00
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	0) (0	0	43. 00
44.00	Other current liabilities	1, 138, 315	5 (0	0	44. 00
45.00	Total current liabilities (sum of lines 37 thru 44)	1, 989, 108	3	0	0	45. 00
	LONG TERM LIABILITIES	1		T		
46. 00	Mortgage payable	0		٥ -	0	
47. 00	Notes payable	0	1	0		
48. 00	Unsecured Loans	0	1	0	0	48. 00
49. 00	Other long term liabilities	0	1	0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	1 000 100		0		
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	1, 989, 108		0	U	
52.00	General fund balance	538, 305, 622				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				0	
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)	538, 305, 622	,	o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	540, 294, 730			0	60.00
55. 50	[59]	5 10, 274, 730				55.00
	1: /	1	1	ı	•	1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0128

					To		Date/Time Pro 5/29/2019 3:	epa 00	red: pm
		General	Fund	Speci al	Pu	rpose Fund	Endowment Fund	lt	
		1.00	2. 00	3. 00		4. 00	5. 00		
1.00	Fund balances at beginning of period		470, 232, 263			0			1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		68, 073, 357 538, 305, 620			0			2. 00 3. 00
4. 00	ROUNDING	2	336, 303, 620		0	-			4. 00
5. 00	NOOND! NO	0			0		l	ál	5. 00
6. 00		O			0				6. 00
7.00		0			0		(7.00
8.00		0			0				8. 00
9.00	T + 1 - 11111 (C + 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	0			0				9. 00
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		538, 305, 622			0	l		10. 00 11. 00
12. 00	Deductions (debit adjustments) (specify)	0	336, 303, 622		0	ū	l		12.00
13. 00	boddetrons (debrt day detiments) (speerry)				0			1 1	13. 00
14.00		0			0		(14. 00
15. 00		0			0		(15. 00
16. 00		0			0				16. 00
17. 00	T-t-1 d-dti (6 li 12 17)	0	0		0	0	(17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		538, 305, 622			0	ł		18. 00 19. 00
17.00	sheet (line 11 minus line 18)		330, 303, 022			0		'	1 7. 00
		Endowment Fund	PI ant	Fund					
		6.00	7. 00	8.00					
1. 00	Fund balances at beginning of period	0			0			T	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	ROUNDI NG		0						4. 00 5. 00
6. 00			0					ł	6. 00
7. 00			0					ı	7. 00
8.00			0						8.00
9. 00		_	0					١.	9. 00
10.00	Total additions (sum of line 4-9)	0			0				10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0		0				11. 00 12. 00
13. 00	beddetrons (debrt adjustments) (specify)		0						13. 00
14. 00			0						14. 00
15.00			0						15. 00
16. 00			0						16. 00
17. 00	T-1-1 deductions (com C.1; 40.47)		0		_				17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance				0				18. 00 19. 00
17.00	sheet (line 11 minus line 18)				J				17.00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0128

			To 12/31/2018	Date/Time Pre 5/29/2019 3:0	
	Cost Center Description	I npati ent	Outpati ent	Total	O pili
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	109, 142, 34	5	109, 142, 345	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		0	0	5. 00
6.00	Swing bed - NF		0	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)	109, 142, 34	5	109, 142, 345	10.00
	Intensive Care Type Inpatient Hospital Services	1,	-1	,	
11. 00	INTENSIVE CARE UNIT	10, 872, 96	7	10, 872, 967	11. 00
12. 00	CORONARY CARE UNIT				12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	10, 872, 96	7	10, 872, 967	16. 00
	11-15)	'''			
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	120, 015, 31	2	120, 015, 312	17. 00
18. 00	Ancillary services	330, 646, 79		813, 877, 046	
19. 00	Outpati ent servi ces		0 0	0	19. 00
20. 00	RURAL HEALTH CLINIC		0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY			, , , , , , , , , , , , , , , , , , ,	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	OTHER (SPECIFY)		0 76, 175	76, 175	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	450, 662, 10		933, 968, 533	28. 00
20.00	G-3, line 1)	1007 0027 10	100,000,12,	700, 700, 000	20.00
	PART II - OPERATING EXPENSES	·'	· '		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		203, 651, 124		29. 00
30.00	ADD (SPECIFY)		0		30. 00
31.00			0		31. 00
32.00			0		32. 00
33.00			o		33. 00
34.00			0		34.00
35.00			0		35. 00
36.00	Total additions (sum of lines 30-35)		O		36. 00
37.00	DEDUCT (SPECIFY)		0		37. 00
38. 00			o		38. 00
39.00			o		39. 00
40.00			0		40. 00
41.00			O		41.00
42.00	Total deductions (sum of lines 37-41)		o		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	-	203, 651, 124		43.00
	to Wkst. G-3, line 4)				
			•		-

				u of Form CMS-2	
STATE	MENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0128	Peri od: From 01/01/2018	Worksheet G-3	
			To 12/31/2018	Date/Time Pre	nared·
			12, 01, 2010	5/29/2019 3:00	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part			933, 968, 533	
2.00	Less contractual allowances and discounts on	n patients' accounts		665, 662, 310	
3.00	Net patient revenues (line 1 minus line 2)			268, 306, 223	
4.00				203, 651, 124	
5.00	Net income from service to patients (line 3	minus line 4)		64, 655, 099	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			3, 351	
7.00	Income from investments			0	
8.00	Revenues from telephone and other miscellane	eous communication services		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			12, 834	
11. 00	Rebates and refunds of expenses			0	
12.00	Parking Lot receipts			0	
13.00	Revenue from Laundry and Linen service			1, 265, 229	
14.00	Revenue from meals sold to employees and gue	ests		0	14. 00
15.00	Revenue from rental of living quarters			0	
16.00	Revenue from sale of medical and surgical su	upplies to other than patients		0	16. 00
17.00	Revenue from sale of drugs to other than pat			0	
18.00	Revenue from sale of medical records and abs	stracts		0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms,	etc.)		0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, a	and canteen		0	20.00
21.00	Rental of vending machines			0	21. 00
22.00	Rental of hospital space			541, 098	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	MI SC REVENUE			1, 595, 746	24. 00
25.00	Total other income (sum of lines 6-24)			3, 418, 258	25. 00
26.00	Total (line 5 plus line 25)			68, 073, 357	26. 00
27.00	OTHER EXPENSES (SPECIFY)			0	27. 00
28.00	Total other expenses (sum of line 27 and sub	oscri pts)		0	28. 00
	Net income (or loss) for the period (line 26			68, 073, 357	29 00

Heal th	Financial Systems COMMUNITY HOSPI	TAL SOUTH	Inlie	u of Form CMS-2	2552_10
Health Financial Systems COMMUNITY HOSPIT CALCULATION OF CAPITAL PAYMENT		Provi der CCN: 15-0128	Peri od: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III	
		Title XVIII	Hospi tal	PPS	o piii
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			2, 367, 510	
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2.00	Capital DRG outlier payments			95, 229	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost re	porting period (see inst	ructions)	103. 83	
4.00	Number of interns & residents (see instructions)			6. 07	1
5. 00 6. 00	Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and			1. 66 39, 301	5. 00 6. 00
6.00	[1.01) (see instructions)	sum of filles I and I.O.	, corumns r and	39, 301	0.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A p	ationt days (Workshoot F	nart Alina	2. 49	7. 00
7.00	30) (see instructions)	attent days (worksheet i	., part A Title	2.47	7.00
8.00	Percentage of Medicaid patient days to total days (see instru	ictions)		22. 75	8.00
9. 00	Sum of lines 7 and 8			25. 24	1
10.00	Allowable disproportionate share percentage (see instructions	5)		5. 24	10.00
11.00				124, 058	11. 00
12.00	Total prospective capital payments (see instructions)			2, 626, 098	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 circumstances (see instructions)		0		
3.00	Net program inpatient capital costs (line 1 minus line 2)		0		
4.00	Applicable exception percentage (see instructions)		0.00		
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	
6.00	Percentage adjustment for extraordinary circumstances (see in	,		0.00	
7. 00	Adjustment to capital minimum payment level for extraordinary	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 appli			0	
10.00	Current year comparison of capital minimum payment level to c			0	
11. 00	Carryover of accumulated capital minimum payment level over c Worksheet L, Part III, line 14)	apitai payment (from pri	or year	0	11. 00
12. 00	Net comparison of capital minimum payment level to capital pa	wments (line 10 nlue lin	na 11)	0	12. 00
13. 00	Current year exception payment (if line 12 is positive, enter	• •	,	0	
14. 00	Carryover of accumulated capital minimum payment level over c			0	
17.00	(if line 12 is negative, enter the amount on this line)	aprear payment for the f	or owing period		17.00
15. 00				0	15. 00
	Current year operating and capital costs (see instructions)			0	1
	Current year exception offset amount (see instructions)			0	17. 00
				•	