(Signed) HOLLY MILLARD

Officer or Administrator of Provider(s)

NETWORK SVP OF FINANCE

Title

(Dated when report is electronically signed.)

Date

	Cost Center Description		Title	XVIII			
			Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	115, 316	-549, 863	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	115, 316	-549, 863	0	0	200.00

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

PI T.	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DAT	FA I	Provi dei	CCN:	15-0074	Period: From 01/0	1/2020		eet S-2	
								1/2020	Date/T	ime Pre 21 3:24	
	1.00	2.	00	3	. 00			4.00	0/2/20	21 3.24	
	Hospital and Hospital Health Care Co										
	Street: 1500 NORTH RITTER AVENUE City: INDIANAPOLIS	PO Box: State: I	N 71	p Code:	46210	Cour	nty: MARION				1
,	City. Indiana oti 5	Component Na		CCN	CBSA	Provi de	- T		ent Sys	tem (P,	2
			Nu	mber	Number	Туре	Certifie	d T	r, 0, or	· N)	4
		1.00		2.00	3.00	4.00	5.00	V 6. 00	XVIII 7.00	-	-
	Hospital and Hospital-Based Componen		2		3.00	4.00		0.00	7.00	0.00	
)		COMMUNITY HEALTH	15	60074	26900	1	07/01/19	56 N	Р	Р	3
)	Subprovider - IPF	NETWORK, INC.									4
	Subprovider - IRF										5
	Subprovider - (Other)										6
	Swing Beds – SNF Swing Beds – NF										8
	Hospi tal -Based SNF										9
00	Hospital-Based NF										10.
	Hospital-Based OLTC										11
	Hospital-Based HHA Separately Certified ASC										12
00	Hospi tal -Based Hospi ce										14
	Hospital-Based Health Clinic - RHC										15
	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16
00	Renal Dialysis										18
00	Other								Т		19
							Fro			<u>.</u> 00	1
	Cost Reporting Period (mm/dd/yyyy)						01/01		12/31	/2020	20.
00	Type of Control (see instructions)						2				21
						1.00	2.	00	3.	00	1
	Inpatient PPS Information					.,			1		
00	Does this facility qualify and is it disproportionate share hospital adju:					Y	1	I			22.
	§412.106? In column 1, enter "Y" for	yes or "N" for	no. Is thi:	S							
	facility subject to 42 CFR Section §	412.106(c)(2)(Pi c	kle amendm	ent							
	hospital?) In column 2, enter "Y" fo Did this hospital receive interim un			or this		Y		,			22
	cost reporting period? Enter in colu				r	•					
	the portion of the cost reporting per				. +						
	Enter in column 2, "Y" for yes or "N' reporting period occurring on or afte				st						
)2	Is this a newly merged hospital that	requires final u	ncompensat	ed care		Ν	Ν	I			22
	payments to be determined at cost re Enter in column 1, "Y" for yes or "N)						
	cost reporting period prior to Octob				es						
	or "N" for no, for the portion of the										
)3	October 1. Did this hospital receive a geographi	c reclassificatio	on from ur	ban to		Ν	N	I	,	Y	22
	rural as a result of the OMB standard	ds for delineating	g statisti	cal area	as	1 1		•		•	22.
	adopted by CMS in FY2015? Enter in co										
	for the portion of the cost reporting in column 2, "Y" for yes or "N" for i										
	reporting period occurring on or afte	er October 1. (se	e instruct	i ons)							
	Does this hospital contain at least counted in accordance with 42 CFR 41:										
	yes or "N" for no.	Little III	corumn o,	1 101							
00	Which method is used to determine Med				2		3 N	l			23.
	below? In column 1, enter 1 if date o if date of discharge. Is the method o										
	reporting period different from the	nethod used in th	e prior co:	st							
	reporting period? In column 2, enter	r "Y" for yes or	<u>"N" for no</u> In-State	In-Sta	ite (Out-of	Out-of	Medi ca	aid ()ther	
			Medi cai d	Medica		State	State	HMO da		di cai d	
			paid days	eligib		edi cai d	Medicaid			days	
				unpai days	·	aid days	el i gi bl e unpai d				
			1.00	2.00		3.00	4.00	5.00		6.00	1
00	If this provider is an IPPS hospital,		7, 036		736	0	64		795		24
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in colu										
	out-of-state Medicaid paid days in co										
	out-of-state medical d pard days in co	Ji unini 13, I									
	out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu	d days in column									

	Financial Systems COMMUNITY AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	CN: 15-0074	Peri od:		u of Fo Worksh	eet S-2	
					From 01/ To 12/	01/2020 31/2020		ime Pre 21 3:24	
		In-State Medicaid paid days	In-State Medi cai d el i gi bl e unpai d days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	aid C ays Me)ther di cai d days	
. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	1.00	2.00	3.00	4.00 C	5.00	0	6.00	25.
		<u> </u>	<u></u>	<u> </u>		Rural S 00		F Geogr 00	
	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa	rural. age) status	at the end	d of the cos	he	2	10/01		26. 27.
. 00	reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	cation in	column 2.			0	-		35.
						nni ng: 00	Endi	ng: 00	
. 00	Enter applicable beginning and ending dates of SCH st		cript line	36 for numb		00	۷.		36.
. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th	the numbe	·		S	0			37.
00	accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions) If line 37 is 1, enter the beginning and ending dates	or yes or " s of MDH st	N" for no. atus. If li	(see ne 37 is					38
	greater than 1, subscript this line for the number of enter subsequent dates.	f periods i	n excess of	f one and		()			
					1.	/N 00		/N 00	
. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for pain column 1, for discharges prior to Octob), (ii), or the mileage i)? Enter n adjustmen	(iii)? Ent requiremer in column 2 t? Enter "\	ter in colum nts in 2 "Y" for ye (" for yes o	n s r	N Y	1	4	39. 40.
	"N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.			yes or N r	or				
						V 1.00	XVIII 2.00	XI X 3.00	
00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer	nt for disp	roporti onat	te share in	accordance	: N	N	N	45.
00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks1 Pt. III.					N	N	N	46.
00 00	Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals	•		2		N N	N N	N N	47 48
00	Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you i GME payment reduction? Enter "Y" for yes or "N" for	mpacted by no in colu	CR 11642 (mn 2.	(or subseque	nt CR), MA		Y		56
00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimt	r yes or "N th of this (", complet , if appli	" for no ir cost report e Worksheet cable.	n column 1. ting period? t E-4. lf co	If column Enter "Y lumn 2 is				57
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. D-5.		3 03				
00	Are costs claimed on line 100 of Worksheet A? If yes	s, comprete	WKSL. D-2,	Pt. I. NAHE 413.8 Y/N		heet A ne #		hrough cation on Code	
. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent (adjustement? Enter "Y" for yes or "N" for no in col	85? (see umn 1. If CR) NAHE MA	column 1	1.00 N	2.	00	3.	00	60.

OSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ΛTΑ	Provider C		eriod: rom 01/01/2020 p 12/31/2020	Worksheet S-2 Part I Date/Time Pre 8/2/2021 3:24	pared
		Y/N	IME	Direct GME	IME	Direct GME	
	1	1.00	2.00	3.00	4.00	5.00	
1.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see	Y			32.85	29.67	61.0
I. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. (
I. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
1. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being						61.0
1.00	used for cap relief and/or FTEs that are noprimary care or general surgery. (see instructions)						
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
	Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program special ty, 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.	FAMILY MEDICINE		1350	0.00		61
						1.00	1
	ACA Provisions Affecting the Health Resources and Se						
2.00 2.01	your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ctions) a Teachi gram. (s	ng Health Cen see instructio	ter (THC) into			62.(62.(
3. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete	ettings	during this co			Y	63. (
				Unweighted FTEs Nonprovider Site	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	-
	Section 5504 of the ACA Base Year FTE Residents in N	onnrovi	der Settings	1.00 This base year	2.00	3.00	
1. 00	period that begins on or after July 1, 2009 and before Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	<u>re June</u> ty trair n-primar all nor d non-pr n columr	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0. 17	-		64.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPI		(HEALTH NETWORK, INC		Period:	u of Form CMS-: Worksheet S-2	
INSTITUE AND HOSTITAL HEALTH GARE CONT			F	From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	pared:
	Program Name	Program Code	Unweighted	Unweighted	8/2/2021 3:24 Ratio (col. 3/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
	1.00	2.00	Si te	4.00	F 00	-
5.00 Enter in column 1, if line 63	1.00 FAMILY MEDICINE	2.00	3.00	4.00	5.00 0.135219	65.00
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column						
4)). (see instructions)						
			Unweighted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovider Site	FTEs in Hospital	(col. 1 + col. 2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Settin	gsEffective f	or cost reporti	ng periods	
56.00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. ary care resident 3 the ratio of	1.9 Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
			Nonprovider Site	Hospi tal	4))	
	1.00 FAMILY PRACTICE	2.00	3.00	4.00	5.00	
17.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary 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 3 divided by (column 3 + column 4)). (see instructions)			6.8	1 25.90	0. 208193	
				1.0	0 2.00 3.00	
Inpatient Psychiatric Facility P			tain of LDS			70.00
0.00 Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no		IPF), UN UDES IT CON	tain an IPF SUD	provider? N		70.00
1.00 If line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions) Inpatient Rehabilitation Facilit	the facility have a efore November 15, 2 lumn 2: Did this fac R 412.424 (d)(1)(iii cate which program y	2004? Enter "Y" for y ility train residents)(D)? Enter "Y" for	yes or "N" for s in a new teac yes or "N" for	no. (see hi ng no.	N O	71.00
5.00 Is this facility an Inpatient Re	habilitation Facilit	y (IRF), or does it	contain an IRF	N		75.00
subprovider? Enter "Y" for yes 76.00 If line 75 is yes: Column 1: Did recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente	the facility have a ing on or before Nov train residents in a	vember 15, 2004? Enter a new teaching program	r "Y" for yes o m in accordance	r "N" for with 42	N O	76.00

	Financial Systems COMMUNITY HEALTH NETWORK, INC.	= 0074 D		u of Form CMS-	
HUSPITA	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		eriod: rom 01/01/2020 0 12/31/2020	Worksheet S-2 Part I Date/Time Pro	
			12/31/2020	8/2/2021 3: 24	4 pm
				1.00	
80. 00 81. 00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost "Y" for yes and "N" for no.	reporting	period? Enter	N N	80. 00 81. 00
85. 00 86. 00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" Did this facility establish a new Other subprovider (excluded unit) under 42 C			N	85. 00 86. 00
87.00	<pre>§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.</pre>	section		Ν	87.00
			V	XI X	_
	Title V and XIX Services		1.00	2.00	
	Does this facility have title V and/or XIX inpatient hospital services? Enter	"Y" for	N	Y	90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report eit full or in part? Enter "Y" for yes or "N" for no in the applicable column.	her in	Ν	Ν	91.00
	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? instructions) Enter "Y" for yes or "N" for no in the applicable column.	o (see		Ν	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX	(? Enter	N	Ν	93.00
94.00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in	the	N	Ν	94.00
	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column.		0. 00	0.00	95.00
	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in applicable column.	the	N	Ν	96.00
	Does title V or XIX follow Medicare (title XVIII) for the interns and resident	s nost	0. 00 Y	0. 00 N	97.00 98.00
:	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for		I	IN	98.00
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in colu		Y	Y	98.01
98. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of obser bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in co		Y	Y	98. 02
98.03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access hospit	al (CAH)	Ν	N	98.03
	reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in for title V, and in column 2 for title XIX.				
	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for titl in column 2 for title XIX.		N	Ν	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallo Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title		Y	Y	98.05
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wks Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, an column 2 for title XIX.		Y	Y	98.06
	Rural Providers Does this hospital qualify as a CAH?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method o for outpatient services? (see instructions)	of payment	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement f training programs? Enter "Y" for yes or "N" for no in column 1. (see instruct		Ν		107.00
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in approved medical education program in the CAH's excluded IPF and/or IRF unit(an			
108.00	Enter "Y" for yes or "N" for no in column 2. (see instructions) Is this a rural hospital qualifying for an exception to the CRNA fee schedule? CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	See 42	Ν		108.00
ľ	Physi cal Occ	cupational 2.00	Speech	Respi ratory	_
	1.00 If 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.	N	3.00 N	4.00 N	109.00
	•••••••••••••••••••••••••••••••••••••••			1 00	_
	Did this hospital participate in the Rural Community Hospital Demonstration pr			1.00 N	110.00
	Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines applicable.				

leal th Financial Systems COMMUNITY HEALTH NETWORK, INC			eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider	F	Period: From 01/01/2020 To 12/31/2020		repared:
111.00 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 bed for tele-health services.	period? Enter enter the n column 2.	1.00 N	2.00	111.00
	1.00	2.00	3.00	_
112.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N			112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.	N			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00
in the pointy is cruin made. Enter 2 in the pointy is decurrence.	Premi ums	Losses	Insurance	
	1.00	2.00	3.00	_
118.01 List amounts of malpractice premiums and paid losses:	2, 505, 86		0	0 118. 01
		1.00	2.00	-
18.02 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.		N		118. 02
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 ins Enter in column 2, "V" for use or "N" for per-	Y" for yes or the Outpatient	Ν	Ν	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable devic patients? Enter "Y" for yes or "N" for no.	es charged to	Y		121.00
122.00 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.		Ν		122.00
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N	"forno.lf	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter the cert				126.00
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certi				127.00
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter the certi				128.00
in column 1 and termination date, if applicable, in column 2. 29.001f this is a Medicare certified lung transplant center, enter the certif	ication date in			129.00
27. Opin this is a medicale centified rung transplant center, enter the centifi				130. 00
column 1 and termination date, if applicable, in column 2.				131.00
column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, enter the ce date in column 1 and termination date, if applicable, in column 2.	certi fi cati on			
 column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, enter the ce date in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter the date in column 1 and termination date, if applicable, in column 2. 				132.00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the ce date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the	fication date			132. 00 133. 00 134. 00

	X IDENTIFICATION DATA	Provider C	CN: 15-0074		: 01/01/2020	Worksheet S- Part I	-2
					2/31/2020	Date/Time Pr	
1.00		2.00			3.00	8/2/2021 3:2	<u>24 pm</u>
If this facility is part of a chai			bugh 143 tl	ne name an		of the	
home office and enter the home of							
1.00 Name: COMMUNITY HEALTH NETWORK	Contractor's Name		Contr	actor's Nu	umber: 0810)1	141.
2.00 Street: 1500 N RITTER 3.00 City: INDIANAPOLIS	PO Box: State:	SERVI CES I N	Zip C	odo:	1621	19-3095	142. 143.
IS. OUCT LY. TINDI ANAPOLI S			Zip c	Jule.	4021	9-3095	143.
						1.00	-
4.00 Are provider based physicians' cos	sts included in Workshe	et A?				Y	144.
					1.00		_
E 001 f costs for ronal convisos are of	aimed on Wkst A Line	74 are the cost			1.00 Y	2.00	145.
5.00 f costs for renal services are cl inpatient services only? Enter "Y'	'for ves or "N" for no	14, are the cost		\$	ř		145.
no, does the dialysis facility ind							
period? Enter "Y" for yes or "N"				,			
6.00 Has the cost allocation methodolog					N		146.
Enter "Y" for yes or "N" for no ir		b. 15-2, chapter	40, §4020)	lf			
yes, enter the approval date (mm/c	1d/yyyy) in column 2.						
						1.00	
7.00Was there a change in the statisti						N	147.
8.00 Was there a change in the order of						N	148.
9.00Was there a change to the simplifi	ed cost finding method	J				N	149.
		Part A	Part		<u>Fitle V</u>	Title XIX	_
Does this facility contain a provi	ider that qualifies for	1.00	2.00		3.00 f the Lowe	4.00	_
or charges? Enter "Y" for yes or '							
5. 00Hospi tal		N	N N		N	N N	155.
6.00 Subprovider - IPF		N	N		N	N	156.
7.00 Subprovider – IRF		N	N		N	N	157.
8. 00 SUBPROVI DER							158.
59.00 SNF 50.00 HOME HEALTH AGENCY		N	N N		N	N	159. 160.
51.00 CMHC		N	N N		N N	N N	161.
			1				1011
						1.00	
Multicampus						1	_
55.00 Is this hospital part of a Multica	ampus hospital that has	one or more camp	uses in di	fferent C	BSAs?	N	165.
Enter "Y" for yes or "N" for no.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	_
							00 166.
6.00 f ine 165 is yes, for each	ļ					0.0	
campus enter the name in column						0.0	
campus enter the name in column O, county in column 1, state in						0.0	
campus enter the name in column O, county in column 1, state in column 2, zip code in column 3,						0.0	
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						0.0	
campus enter the name in column O, county in column 1, state in column 2, zip code in column 3,							
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)						1.00	
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 (HI						1.00	
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 (HI 7.00 Is this provider a meaningful user	r under §1886(n)? Ente	er "Y" for yes or	"N" for no).			
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 10	r under §1886(n)? Ente D5 is "Y") and is a mea	er "Y" for yes or ningful user (lin	"N" for no).	r the	1.00	
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	r under §1886(n)? Ente D5 is "Y") and is a mea HIT assets (see instruc	er "Y" for yes or ningful user (lin stions)	"N" for no ne 167 is "). 'Y"), enter		1.00	168.
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 (HI 7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 8.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii)?	r under §1886(n)? Ente D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or	r "Y" for yes or ningful user (lin tions) does this provide "N" for no. (see	"N" for no ne 167 is " er qualify instructio	o. 'Y"), enter for a harc ons)	dshi p	1.00 Y	168. 168.
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) Heal th Information Technology (HI 7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 8.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii)? 9.00 If this provider is a meaningful user	r under §1886(n)? Ente 25 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	r "Y" for yes or ningful user (lin tions) does this provide "N" for no. (see	"N" for no ne 167 is " er qualify instructio	o. 'Y"), enter for a harc ons)	dshi p	1.00 Y	168. 168.
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) Heal th Information Technology (HI 7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 8.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii)?	r under §1886(n)? Ente 25 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	r "Y" for yes or ningful user (lin tions) does this provide "N" for no. (see	"N" for no ne 167 is " er qualify instructio). Y"), enter for a harc ons) is "N"), e	dship enter the	1.00 Y 0.0	168. 168.
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 (HI 7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 8.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)? 9.00 If this provider is a meaningful u	r under §1886(n)? Ente 25 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	r "Y" for yes or ningful user (lin tions) does this provide "N" for no. (see	"N" for no ne 167 is " er qualify instructio). Y"), enter for a harc ons) is "N"), e	dship enter the eginning	1.00 Y 0.0	168. 168.
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 8.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii) ? 9.00 If this provider is a meaningful u transition factor. (see instruction	r under §1886(n)? Ente D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	er "Y" for yes or ningful user (lin tions) does this provide "N" for no. (see and is not a CAH	"N" for nc ne 167 is " er qualify instructic (line 105). Y"), enter for a harc ons) is "N"), e	dship enter the	1.00 Y 0.0	168. 168. 00169.
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 7.00 is this provider a meaningful user 8.00 if this provider is a CAH (line 10 reasonable cost incurred for the H 8.01 if this provider is a CAH and is r exception under §413.70(a) (6) (ii) 7 9.00 if this provider is a meaningful u transition factor. (see instruction	r under §1886(n)? Ente D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	er "Y" for yes or ningful user (lin tions) does this provide "N" for no. (see and is not a CAH	"N" for nc ne 167 is " er qualify instructic (line 105). Y"), enter for a harc ons) is "N"), e	dship enter the eginning	1.00 Y 0.0	168. 168. 00169.
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) Heal th Information Technology (HI 7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 8.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii) 7 9.00 If this provider is a meaningful u transition factor. (see instruction 0.00 Enter in columns 1 and 2 the EHR t	r under §1886(n)? Ente D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	er "Y" for yes or ningful user (lin tions) does this provide "N" for no. (see and is not a CAH	"N" for nc ne 167 is " er qualify instructic (line 105). Y"), enter for a harc ons) is "N"), e	dship enter the eginning	1.00 Y 0.0	168. 168. 00169.
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 77.00 Is this provider a meaningful user 88.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 88.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii) 7 99.00 If this provider is a meaningful user transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR th period respectively (mm/dd/yyyy)	r under §1886(n)? Ente D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons) beginning date and endi	r "Y" for yes or ningful user (lin tions) does this provide "N" for no. (see and is not a CAH ng date for the r	"N" for nc e 167 is " er qualify instructic (line 105 reporting). Y"), enter for a harc ons) is "N"), e	dship enter the eginning 1.00	1.00 Y 0.0	167. 168. 168. 00 169. 170.
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the H exception under §413.70(a) (6) (ii) (7 59.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR th period respectively (mm/dd/yyyy)	r under §1886(n)? Ente D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons) Deginning date and endi	r "Y" for yes or ningful user (lin tions) does this provide "N" for no. (see and is not a CAH ng date for the r	"N" for no e 167 is " er qualify instructic (line 105 reporting). Y"), enter for a hard ons) is "N"), (Be Be	dship enter the eginning 1.00	1.00 Y 0.0 Endi ng 2.00	168. 168. 00169.
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 8.01 If this provider is a CAH and is r exception under §413.70(a) (6) (ii)? 9.00 If this provider is a meaningful of transition factor. (see instruction 0.00 Enter in columns 1 and 2 the EHR th period respectively (mm/dd/yyyy)	r under §1886(n)? Ente D5 is "Y") and is a mea HT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons) Deginning date and endi vider have any days for reported on Wkst. S-3,	r "Y" for yes or ningful user (lin tions) does this provide "N" for no. (see and is not a CAH ng date for the r individuals enro Pt. I, line 2, co	"N" for no e 167 is " er qualify instructic (line 105 reporting eporting). Y"), enter for a hard ons) is "N"), (Be Be Care er	dship enter the eginning 1.00	1.00 Y 0.0 Endi ng 2.00	168. 168. 00169. 170.

	Financial Systems COMMUNITY HEALTH AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Provider C	CN: 15-0074	Period:	u of Form CMS Worksheet S-	
				From 01/01/2020 To 12/31/2020		epared
					8/2/2021 3:2	
				Y/N	Date	_
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N	I for all NO re	esponses. Ente	er all dates in 1	the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					_
	Provider Organization and Operation					_
00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.
00	reporting period? If yes, enter the date of the change in c					· · ·
		(Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare F	Program? If	N			2.
	yes, enter in column 2 the date of termination and in colum	nn 3, "V" for				
	voluntary or "I" for involuntary.					
00	Is the provider involved in business transactions, includir		Y			3.
	contracts, with individuals or entities (e.g., chain home of					
	or medical supply companies) that are related to the provid					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other	er similar				
	relationships? (see instructions)	-	Y/N	Туре	Date	-
			1.00	2.00	3.00	
	Financial Data and Reports		1.00	2.00	3.00	-
00	Column 1: Were the financial statements prepared by a Cert	ified Public	Y	A	03/25/2021	4.
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f				00/20/2021	
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
00	Are the cost report total expenses and total revenues diffe	erent from	Y			5.
	those on the filed financial statements? If yes, submit rec	conciliation.				
				Y/N	Legal Oper.	_
				1.00	2.00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is th	ne provider is	s N		6.
	the legal operator of the program?					
00	Are costs claimed for Allied Health Programs? If "Y" see in			Y		7.
00	Were nursing school and/or allied health programs approved	and/or renewed	during the	N		8.
20	cost reporting period? If yes, see instructions.	araduata madia	al advaction	Y		
00	Are costs claimed for Interns and Residents in an approved		al education	Ŷ		9.
. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c		bo curront	Y		10.
. 00	cost reporting period? If yes, see instructions.			'		10.
. 00	Are GME cost directly assigned to cost centers other than I	& R in an Apr	proved	Ν		11.
00	Teaching Program on Worksheet A? If yes, see instructions.		, orou			
					Y/N	
					1.00	
	Bad Debts					
00	Is the provider seeking reimbursement for bad debts? If yes	s, see instruct	i ons.		Y	12.
00	If line 12 is yes, did the provider's bad debt collection p	oolicy change c	luring this co	ost reporting	N	13.
	period? If yes, submit copy.					
00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	°yes, see ins	structions.	N	14.
	Bed Complement					
00	Did total beds available change from the prior cost reporti				Y	15.
			rt A		t B	_
		Y/N	Date	Y/N	Date	_
		1.00	2.00	3.00	4.00	-
00	PS&R Data	N		N		1/
00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	IN		IN		16.
	date of the PS&R Report used in columns 2 and 4 . (see					
	instructions)					
00	Was the cost report prepared using the PS&R Report for	Y	07/01/2021	Y	07/01/2021	17.
00	totals and the provider's records for allocation? If		0770172021	•	0770172021	17.
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
		N		Ν		19.
. 00	If line 16 or 17 is yes, were adjustments made to PS&R					
. 00	Report data for corrections of other PS&R Report					

Health Financial Systems

COMMUNITY HEALTH NETWORK, INC.

In Lieu of Form CMS-2552-10

ealth Financial Systems COMMUNITY HEALT	TH NETWORK, INC.		In Li€	eu of Form CM	S-2552-10
OSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 01/01/2020 To 12/31/2020	Date/Time P	repared:
	Descr	iption	Y/N	8/2/2021 3: Y/N	24 pm
		0	1.00	3.00	
0.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		0	N	N	20.00
	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
1.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
		1		1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS H			1.00	
Capital Related Cost		IUSITIALS)			
2.00 Have assets been relifed for Medicare purposes? If yes, se	e instructions			1	22.00
 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions. 		sals made duri	ng the cost		23.00
4.00 Were new leases and/or amendments to existing leases enter lf yes, see instructions	red into during	this cost rep	orting period?		24.00
 5.00 Have there been new capitalized leases entered into during instructions. 	g the cost repor	rting period?	lf yes, see		25.00
6.00 Were assets subject to Sec.2314 of DEFRA acquired during t instructions.	the cost reporti	ng period? If	yes, see		26.00
 7.00 Has the provider's capitalization policy changed during th copy. 	ne cost reportir	ng period?lf	yes, submit		27.00
Interest Expense8.00Were new Loans, mortgage agreements or Letters of credit edition	entered into dur	ing the cost	reporting		28.00
period? If yes, see instructions.9.00 Did the provider have a funded depreciation account and/or		ebt Service Re	eserve Fund)		29.00
0.00 treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat		debt? If yes,	see		30.00
1.00 Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes,	see		31.00
instructions. Purchased Services				 	
2.00 Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr	ructions.	0			32.00
3.00 If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	oplied pertainir	ng to competit	ive bidding? If		33.00
Provi der-Based Physi ci ans				1	
4.00 Are services furnished at the provider facility under an a	arrangement with	n provider-bas	ed physi ci ans?		34.00
If yes, see instructions.					
5.00 If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see i		nts with the p	orovi der-based		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs				1	
6.00 Were home office costs claimed on the cost report?7.00 If line 36 is yes, has a home office cost statement been p	prepared by the	home office?			36.00 37.00
 If yes, see instructions. 8.00 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 of the provider of the					38.00
9.00 If line 36 is yes, did the provider render services to oth see instructions.					39.00
0.00 If line 36 is yes, did the provider render services to the instructions.	e home office?	lfyes, see			40.00
	1	00	2	00	_
Cost Report Preparer Contact Information	1. 1.		2.		
1.00 Enter the first name, last name and the title/position	SHI RLEY		BI SHOP		41.00
held by the cost report preparer in columns 1, 2, and 3,			1		
held by the cost report preparer in columns 1, 2, and 3, respectively.2.00 Enter the employer/company name of the cost report preparer.	COMMUNITY HEAL	TH NETWORK			42.00

Heal th	Financial Systems COMMUNITY HEAL	TH NETWORK	C, INC.		In Lieu	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Prov	ider CCN: 15-0074		ri od:	Worksheet S-2	
				To	om 01/01/2020 12/31/2020		pared: _pm
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	NETWORK	DI RECTOR OF				41.00
	held by the cost report preparer in columns 1, 2, and 3,	REIMBURS	SEMENT				
	respectively.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the cost						43.00
	report preparer in columns 1 and 2, respectively.						

	Financial Systems CC AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	MMUNITY HEALTH AL DATA	Provi der CO	CN: 15-0074	Period: From 01/01/2020	eu of Form CMS-2 Worksheet S-3 Part I	
					To 12/31/2020		
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	280	100, 97	0.00	0	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider						2.00 3.00 4.00
5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation		280	100, 97	0.00	0 0 0	5.00 6.00 7.00
	beds) (see instructions)						
8.00 9.00 10.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	31. 00 32. 00	68 0	21, 57	6 0.00 0 0.00		8.00 9.00 10.00
11.00 12.00 13.00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT NURSERY	35. 00 43. 00	18	6, 58	0.00	0	11.00 12.00 13.00
14.00 15.00 16.00	Total (see instructions) CAH visits SUBPROVIDER - IPF		366	129, 13	0.00	0 0	14.00 15.00 16.00
17.00 18.00	SUBPROVIDER - TRF SUBPROVIDER - TRF SUBPROVIDER						17.00 17.00 18.00
19.00 20.00 21.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE						19.00 20.00 21.00
22. 00 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)						22. 00 23. 00
24.00 24.10 25.00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	30. 00					24.00 24.10 25.00
26.00 26.25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	88. 00 89. 00				0 0	26.00 26.25
27.00 28.00 29.00	Total (sum of lines 14-26) Observation Bed Days Ambulance Trips		366			0	27.00 28.00 29.00
30. 00 31. 00 32. 00	Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions)		0		0		30.00 31.00 32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)		0				32. 01
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges						33. 00 33. 01

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C		Period: From 01/01/2020 To 12/31/2020		pared
	I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
 .00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) .00 HMO and other (see instructions) .00 HMO IPF Subprovider .00 HMO IRF Subprovider 	13, 753 13, 931 0 0	6, 771 28, 440 0 0		5		1. 0 2. 0 3. 0 4. 0
.00 Hospital Adults & Peds. Swing Bed SNF	0	0		o		5.0
 .00 Hospital Adults & Peds. Swing Bed NF .00 Total Adults and Peds. (exclude observation beds) (see instructions) 	13, 753	0 6, 771		0 5		6. 0 7. 0
00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT 0.00 BURN INTENSIVE CARE UNIT 1.00 SURGICAL INTENSIVE CARE UNIT	3, 549 0	0 0		6 0		8. (9. (10. (11. (
2.00 NEONATAL INTENSIVE GARE UNIT 2.00 NURSERY 4.00 Total (see instructions) 5.00 CAH visits	0 17, 302 0	0 1, 420 8, 191 0	1, 68 85, 92	2	2, 819. 79	12. 13.
 6.00 SUBPROVIDER - IPF 7.00 SUBPROVIDER - IRF 8.00 SUBPROVIDER 9.00 SKILLED NURSING FACILITY 0.00 NURSING FACILITY 1.00 OTHER LONG TERM CARE 2.00 HOME HEALTH AGENCY 3.00 AMBULATORY SURGICAL CENTER (D. P.) 4.00 HOSPICE 						 16. 17. 18. 19. 20. 21. 22. 23. 24.
4.10 HOSPICE (non-distinct part) 5.00 CMHC - CMHC			22	0		24. 25.
5.00 RURAL HEALTH CLINIC 5.25 FEDERALLY QUALIFIED HEALTH CENTER 7.00 Total (sum of lines 14-26)	0 0	0 0		0 0.00 0 0.00 46.84	0.00	26. 26. 1
 00 Observation Bed Days 00 Ambul ance Trips 00 Employee discount days (see instruction) 00 Employee discount days - IRF 	О	1, 623	62	7	_, , ,	28. 29. 30. 31.
 a. 00 Labor & delivery days (see instructions) b. 01 Total ancillary labor & delivery room outpatient days (see instructions) 	Ο	47	39	-		31. 32. 32.
3.00 LTCH non-covered days 3.01 LTCH site neutral days and discharges	0 0					33. 33.

Full Time Equivalents Nonpaid Workers 11.00	Title V	Disc Title XVIII	tharges Title XIX	8/2/2021 3:24	
Nonpaid Workers		Title XVIII	Title XIX	Total All	
11.00		10.00	11.00	Patients	
	12.00	13.00	14.00	15.00	1 00
0. 00 0. 00 0. 00 0. 00 0. 00	0	2, 86	0 5, 545 0 0	18, 166	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 20.00 21.00 22.00 23.00 24.10 25.00 26.00 26.00 26.00 27.00 28.00 29.00 29.00 29.00 20.00 29.00 20.
	0.00 0.00	0. 00 0. 00	0.00 0 3,74	0.00 0 3,742 1,252	0.00 0.00 0.00 0.00

SPLI	AL WAGE INDEX INFORMATION			Provider CC		Period:	Worksheet S-3	
						From 01/01/2020 To 12/31/2020	Date/Time Pre	pare
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	8/2/2021 3:24 Average Hourly	
		Number	Reported	on of Salaries	Sal ari es		Wage (col. 4 ÷	
				(from Wkst.	$(col \cdot 2 \pm col \cdot$		col. 5)	
		1.00	2.00	A-6) 3.00	3) 4.00	<u>col. 4</u> 5. 00	6.00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	3.00	0.00	
~~	SALARI ES	200.00	200 114 000	1 0// 704	207 040 12	1 5 000 001 00	25.52	
00	Total salaries (see instructions)	200.00	208, 114, 908	3 -1, 066, 784	207, 048, 12	4 5, 829, 331.00	35. 52	1
00	Non-physician anesthetist Part		534, 908	3 0	534, 90	4, 390. 00	121.85	2
~~							0.00	
00	Non-physician anesthetist Part B		(, 0	,	0.00	0.00	3
0C	Physician-Part A -		C	0 0	(0.00	0.00	4
01	Administrative Physicians – Part A – Teaching		C			0.00	0. 00	4
00	Physician and Non		((
~~	Physician-Part B						0.00	
00	Non-physician-Part B for hospital-based RHC and FQHC		C	0	(0.00	0.00	6
	servi ces							
00	Interns & residents (in an approved program)	21.00	4, 103, 572	-3, 480	4, 100, 092	2 133, 946. 00	30. 61	7
01	Contracted interns and		C	0 0	(0.00	0.00	7
	residents (in an approved							
00	programs) Home office and/or related		r			0.00	0. 00	6
50	organizati on personnel		· · · · ·		·	0.00	0.00	
00	SNF	44.00	(0	(0.00		
. 00	Excluded area salaries (see instructions)		4, 128, 577	-19, 771	4, 108, 80	6 169, 901. 00	24. 18	10
	OTHER WAGES & RELATED COSTS							
. 00	Contract Labor: Direct Patient Care		4, 633, 995	5 0	4, 633, 99	47, 859. 00	96. 83	1
. 00	Contract Labor: Top Level		2, 701, 178	3 0	2, 701, 17	14, 079. 00	191.86	12
	management and other							
	management and administrative services							
. 00	Contract Labor: Physician-Part		3, 266, 278	3 0	3, 266, 27	3 25, 486. 00	128. 16	1:
. 00	A - Administrative Home office and/or related		ſ			0.00	0. 00	1
. 00	organization salaries and		C		,	0.00	0.00	
	wage-related costs				5 / 007 d /			
. 01 . 02	Home office salaries Related organization salaries		56, 097, 161		56, 097, 16	1 1, 300, 348. 00 0. 00		
. 00	Home office: Physician Part A		2, 105, 452	° I	2, 105, 45			
00	- Administrative Home office and Contract		(0.00	0. 00	1
. 00	Physicians Part A - Teaching		C		,	0.00	0.00	
. 01	Home office Physicians Part A		C	0 0	(0.00	0.00	16
. 02	- Teaching Home office contract		ſ			0.00	0.00	1
. 02	Physicians Part A - Teaching			, o		0.00	0.00	
. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		52, 899, 544	l ol	52, 899, 54	4		117
. 00	instructions)		52, 699, 544	. 0	52, 699, 54	+		'·
. 00	Wage-related costs (other)							18
. 00	(see instructions) Excluded areas		1, 489, 163	3 0	1, 489, 16	3		19
. 00	Non-physician anesthetist Part		42, 438	1 1	42, 43			20
. 00	A Non physician anasthatist Dart		ſ					2
. 00	Non-physician anesthetist Part B		C	<u></u>	,	1		[∠]
. 00	Physician Part A -		C		(D		22
01	Administrative Physician Part A – Teaching		ſ					22
00	Physician Part B		0		(D		2
. 00	Wage-related costs (RHC/FQHC)		(24
. 00	Interns & residents (in an approved program)		963, 148		963, 14	5		2!
. 50	Home office wage-related		11, 013, 538	3 0	11, 013, 53	3		2!
. 51	(core) Related organization		ſ			2		25
. 51	wage-related (core)		C	,	,			2
52	Home office: Physician Part A		C	0	(כ		25
	- Administrative - wage-related (core)							1

lealth Financial Systems		MMUNITY HEALTH				u of Form CMS-2	
HOSPITAL WAGE INDEX INFORMATION			Provider CO	F	Period: From 01/01/2020 To 12/31/2020		parec
	Wkst. A Line		Recl assi fi cati		Paid Hours	Average Hourly	
	Number	Reported	on of Salaries			Wage (col. 4 ÷	
			(from Wkst.	$(col.2 \pm col.$	Salaries in	col. 5)	
			A-6)	3)	col. 4		
	1.00	2.00	3.00	4.00	5.00	6.00	
25.53 Home office: Physicians Pa	rt A	0	0	C)		25.
- Teaching - wage-related							
(core)							
OVERHEAD COSTS - DIRECT SA			-				
26.00 Employee Benefits Departme				,			
27.00 Administrative & General	5.00						
28.00 Administrative & General u	nder	16, 393, 247	0	16, 393, 247	144, 387. 00	113. 54	28.
contract (see inst.)							
29.00 Maintenance & Repairs	6.00	0	0	C	0.00		
80.00 Operation of Plant	7.00	2, 960, 849	-23, 976	2, 936, 873			
31.00 Laundry & Linen Service	8.00	0	0	C	0.00		
32.00 Housekeepi ng	9.00	3, 180, 838					
33.00 Housekeeping under contrac (see instructions)	t	571, 588	0	571, 588	3 13, 253. 00	43. 13	33.
4.00 Dietary	10.00	2, 246, 971	-1, 605, 828	641, 143	36, 209. 00	17. 71	34.
5.00 Dietary under contract (se instructions)	e	497, 714	0	497, 714	10, 400. 00	47.86	35.
6.00 Cafeteria	11.00	189, 434	1, 589, 303	1, 778, 737	98, 835. 00	18.00	36.
7.00 Maintenance of Personnel	12.00	0	0	C	0.00	0.00	37.
8.00 Nursing Administration	13.00	2, 167, 874	-25, 336	2, 142, 538	66, 581. 00	32. 18	38.
9.00 Central Services and Suppl	y 14.00	448, 143	-4, 186	443, 957	17, 655. 00	25.15	39.
10.00 Pharmacy	15.00	6, 908, 181	-31, 384	6, 876, 797	164, 596. 00	41.78	40.
1.00 Medical Records & Medical Records Library	16.00	655, 844	-3, 605	652, 239	16, 191. 00	40. 28	41.
42.00 Social Service	17.00	1, 783, 772	-5, 923	1, 777, 849	45, 370. 00	39. 19	42.
43.00 Other General Service	18.00			l c	0.00	0.00	43.

Heal th	Financial Systems	СО	MMUNITY HEALTH	NETWORK, INC.		In Lieu of Form CMS-2552-10		
HOSPI T	TAL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2020 To 12/31/2020		pared:
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)		col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		220, 938, 977	-1, 063, 304	219, 875, 67	3 5, 859, 035. 00	37.53	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		4, 128, 577	-19, 771	4, 108, 80	6 169, 901. 00	24. 18	2.00
3.00	Subtotal salaries (line 1		216, 810, 400	-1, 043, 533	215, 766, 86	7 5, 689, 134. 00	37.93	3.00
	minus line 2)							
4.00	Subtotal other wages & related		68, 804, 064	. 0	68, 804, 06	4 1, 404, 821. 00	48.98	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		63, 913, 082	0	63, 913, 08	2 0.00	29.62	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		349, 527, 546	-1, 043, 533	348, 484, 01	3 7, 093, 955. 00	49.12	6.00
7.00	Total overhead cost (see		58, 337, 042	-180, 188	58, 156, 85	4 1, 345, 354.00	43.23	7.00
	instructions)							

Heal th	Financial Systems COMMUNITY HEALTH N	NETWORK, INC.	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS	Provider CCN: 15-0074	Peri od: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part IV Date/Time Pre 8/2/2021 3:24	pared:
				Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETIREMENT COST				
1.00	401K Employer Contributions			4, 495, 029	
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)			660, 452	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0	
6.00	Legal /Accounting/Management Fees-Pension Plan			6, 111, 917	
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 Administr			0	0.01
8.02	Health Insurance (Self Funded with a Third Party Administrate	or)		18, 488, 570	
8.03	Health Insurance (Purchased)			0	
9.00	Prescription Drug Plan			2, 739, 669	9.00
10.00	Dental, Hearing and Vision Plan			156, 138	
11.00	Life Insurance (If employee is owner or beneficiary)			6, 055, 266	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0	
13.00	Disability Insurance (If employee is owner or beneficiary)			2, 041, 343	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary	y)		0	14.00
15.00	'Workers' Compensation Insurance			19, 532	15.00
16.00	Retirement Health Care Cost (Only current year, not the extra	aordinary accrual require	ed by FASB 106.	0	16.00
	Non cumulative portion)				
	TAXES				
	FICA-Employers Portion Only			14, 389, 550	
18.00	Medicare Taxes - Employers Portion Only			0	
19.00	Unemployment Insurance			0	
20.00	State or Federal Unemployment Taxes			0	20.00
	OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Finstructions))	Reported on lines 1 throu	igh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances			0	22.00
23.00	Tuition Reimbursement			236, 828	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			55, 394, 294	24.00
	Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)				25.00

Heal th	Financial Systems	COMMUNITY HEALTH NETWORK, INC.	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0074	Peri od:	Worksheet S-3	
			From 01/01/2020 To 12/31/2020		narod
			10 12/31/2020	8/2/2021 3:24	pm pm
	Cost Center Description		Contract Labor		
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Ide				
1.00	Total facility's contract labor and benef	it cost	4, 633, 995		
2.00	Hospi tal		4, 633, 995	53, 905, 131	2.00
3.00	Subprovider - IPF				3.00
4.00	Subprovider - IRF				4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	
7.00	Swing Beds - NF		0	0	11.00
8.00	Hospital-Based SNF				8.00
9.00	Hospital-Based NF				9.00
10.00	Hospital-Based OLTC				10.00
11.00	Hospital-Based HHA				11.00
12.00	Separately Certified ASC				12.00
13.00	Hospital-Based Hospice				13.00
14.00	Hospital-Based Health Clinic RHC		0	0	14.00
15.00	Hospital-Based Health Clinic FQHC		0	0	15.00
16.00	Hospital-Based-CMHC				16.00
17.00	Renal Dialysis		0	0	17.00
18.00	Other		0	1, 489, 163	18.00

Heal th	Financial Systems COMMUNITY HEALTH NET	WORK, INC.		In Lie	eu of Form CMS-2	2552-10
		Provider CC	N: 15-0074	Peri od:	Worksheet S-1	0
				From 01/01/2020 To 12/31/2020		pared:
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	/ided by lin	ne 202 column	8)	0. 227426	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				141, 360, 303	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement			i d?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicai	d		-6, 156, 588	5.00
6.00 7.00	Medicaid charges Medicaid cost (line 1 times line 6)				532, 394, 656 121, 080, 387	6.00 7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minu	us sum of lir	es 2 and 5 if	121,000,387	8.00
0.00	< zero then enter zero)				, o	0.00
	Children's Health Insurance Program (CHIP) (see instructions fo	or each line	e)			
9.00	Net revenue from stand-alone CHIP				0	9.00
	Stand-alone CHIP charges				0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			с н	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (enter zero)	line ii mir	nus line 9; i	τ < zero then	0	12.00
	Other state or local government indigent care program (see inst	ructions fo	or each line)		I	
13.00	Net revenue from state or local indigent care program (Not incl)	0	13.00
14.00	Charges for patients covered under state or local indigent care	e program (N	Not included	in lines 6 or	0	14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line 14		(1)	45	0	15.00
16.00	Difference between net revenue and costs for state or local inc 13; if < zero then enter zero)	ingent care	program (IIr	e 15 minus line	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/local indic	ent care program	ns (see	
	instructions for each line)			1.5		
	Private grants, donations, or endowment income restricted to fu				0	17.00
18.00	Government grants, appropriations or transfers for support of h			(C.I.I	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent o	care programs	(sum of lines	0	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2)	
			1.00	2.00	3.00	
~~ ~~	Uncompensated Care (see instructions for each line)		00 440 75		40.00(.447	
20.00	Charity care charges and uninsured discounts for the entire face (see instructions)	llity	38, 410, 75	3, 885, 663	42, 296, 417	20.00
21.00	Cost of patients approved for charity care and uninsured discou	unts (see	8, 735, 60	3, 885, 663	12, 621, 267	21.00
	instructions)		.,, .			
22.00	Payments received from patients for amounts previously written	off as	22, 59	9 0	22, 599	22.00
22.00	charity care		0 712 00		10 500 //0	22.00
23.00	Cost of charity care (line 21 minus line 22)	I	8, 713, 00	3, 885, 663	12, 598, 668	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patier	nt days beyo	ond a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care	program?	0	5		
25.00	If line 24 is yes, enter the charges for patient days beyond the	ne indigent	care program	's length of	0	25.00
24 00	stay limit					24 00
26.00 27.00	Total bad debt expense for the entire hospital complex (see ins Medicare reimbursable bad debts for the entire hospital complex		ructions)		37, 069, 769 937, 058	
27.00	Medicare allowable bad debts for the entire hospital complex (s				1, 441, 627	
28.00	Non-Medicare bad debt expense (see instructions)				35, 628, 142	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	oense (see i	instructions)		8, 607, 335	
	Cost of uncompensated care (line 23 column 3 plus line 29)				21, 206, 003	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			21, 206, 003	31.00

	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OMMUNITY HEALTH	Provider CO		eriod: rom 01/01/2020	Worksheet A	2552-10
				Ť		Date/Time Pre 8/2/2021 3:24	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	
	·			+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		0				1.00
2.00 3.00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		0			25, 572, 126 0	2.00
3.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	212, 587	505, 637		-		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	20, 120, 000	207, 421, 516			196, 515, 589	5.00
7.00	00700 OPERATION OF PLANT	2, 960, 849	11, 467, 454			13, 452, 446	
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 315, 400			1, 315, 400	
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 180, 838 2, 246, 971	2, 091, 579 2, 897, 862			5, 233, 675 1, 436, 876	
11.00	01100 CAFETERI A	189, 434	2, 897, 862				
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 167, 874	810, 845				
14.00	01400 CENTRAL SERVICES & SUPPLY	448, 143	1, 377, 546			-235, 115	14.00
15.00	01500 PHARMACY	6, 908, 181	117, 615, 687				
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	655, 844 1, 783, 772	678, 648 440, 650			1, 334, 492 2, 224, 262	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	4, 103, 572	1, 147, 761			5, 249, 083	
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	6, 176, 058	1, 902, 667			8, 007, 956	
23.00	02300 EMS TRAINING-ALLIED HEALTH	0	0		0	0	23.00
	02301 RADIOLOGY SCHOOL-ALLIED HEALTH	0	0	0	0	0	23.01
23.02	02302 PHARMACY RESIDENCY-ALLIED HEALTH	0	0		0	0	23.02
23. 03	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	0	0	0	23.03
30.00	03000 ADULTS & PEDIATRICS	41, 156, 598	19, 479, 077	60, 635, 675	-5, 853, 603	54, 782, 072	30.00
31.00	03100 INTENSIVE CARE UNIT	9, 421, 954	5, 116, 936				
32.00	03200 CORONARY CARE UNI T	0	0	-	0	0	32.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	1, 162, 680	512, 447			1, 620, 112	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	710, 663	710, 663	43.00
50.00	05000 OPERATI NG ROOM	7, 924, 553	27, 737, 302	35, 661, 855	-18, 645, 479	17, 016, 376	50.00
51.00	05100 RECOVERY ROOM	570, 488	313, 926				
52.00	05200 DELIVERY ROOM & LABOR ROOM	462, 055	896, 559				
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 790, 684	2, 758, 137			4, 038, 555	
55.00 57.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	388, 365 964, 787	1, 113, 471 1, 959, 359				
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	464, 608	1, 019, 904				
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 115, 126	30, 908, 255				
60.00	06000 LABORATORY	0	14, 436, 815			14, 318, 948	
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	619, 384	1, 150, 522 1, 783, 294				
66. 00	06600 PHYSI CAL THERAPY	3, 489, 224 6, 019, 311	3, 118, 460				
	06700 OCCUPATI ONAL THERAPY	0	0, 110, 100				
	06800 SPEECH PATHOLOGY	0	0	0	783, 599	783, 599	
69.00	06900 ELECTROCARDI OLOGY	2, 455, 084	972, 891			2, 880, 261	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	515, 592 0	428, 867			753, 267 23, 398, 728	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	25, 685, 689		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	123, 660, 157	123, 660, 157	
74.00	07400 RENAL DIALYSIS	0	1, 721, 782	1, 721, 782	-527	1, 721, 255	74.00
76.00	03330 ENDOSCOPY	370, 199	537, 664			581, 150	
76.01 76.03	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	28, 739, 579	12, 450, 211			39, 277, 168	
76. 03 76. 04	03951 LUTHERWOOD PARTNERSHIP 03952 WOUND CARE CENTER	8, 288, 368 866, 247	5, 982, 473 2, 196, 179		-191, 476 -609, 629	14, 079, 365 2, 452, 797	1
76.05	03480 ONCOLOGY-CANCER CARE CENTER	15, 894, 884	36, 810, 757				
76.06	03953 I MAGI NG CENTERS	2, 965, 293	4, 557, 577			5, 323, 284	
76.07	03954 BREAST DIAGNOSTIC CENTER	0	2, 127, 883			2, 077, 899	
76.97	07697 CARDI AC REHABI LI TATI ON	652, 409	378, 804			859, 183	
76. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATI ENT SERVI CE COST CENTERS	0	0	0	420, 106	420, 106	76. 98
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	04950 DI ABETI C CARE CENTER	0	0	0	0	0	90.01
90. 02	04951 HEALTHY HEARTS CENTER 09001 CLI NI C	1, 618, 941	669, 366 0	2, 288, 307	-194, 442	2, 093, 865	90.02 90.03
00 02	04953 SPINE CENTER	0	0	0	0	0	90.03
90. 03 90. 04	The second	202 257	9, 419, 861	9, 722, 218	-9, 273, 233	448, 985	90.05
90. 03 90. 04 90. 05	04954 INFUSION CENTERS	302, 357	, , , , , , , , , , , , , , , , , , , ,				
90. 04 90. 05 90. 06	09002 MEDCHECK CLINICS	0	0	0	0	0	90.06
90. 04 90. 05 90. 06 90. 07	09002 MEDCHECK CLINICS 09003 KNEE CENTER	302, 357 0 1, 926, 655	2, 249, 846	0	0	0 3, 982, 806	90.06 90.07
90. 04 90. 05 90. 06	09002 MEDCHECK CLINICS	0	0	0	0	0	90.06 90.07 90.08

Health Financial Systems Co	OMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider CO		Period:	Worksheet A	
				From 01/01/2020 To 12/31/2020		nared
				10 12/31/2020	8/2/2021 3: 24	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
			+ col. 2)	ons (See A-6)		
					(col. 3 +-	
	1.00	2.00	2.00	4.00	<u>col.4)</u> 5.00	
91. 00 09100 EMERGENCY	1.00	2.00	3.00	4.00		91.00
	8, 686, 783	6, 529, 746	15, 216, 52	9 -1, 004, 761	14, 211, 768	
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	1	0 0	0	98.00
SPECIAL PURPOSE COST CENTERS	<u>ч</u>	0		0 0	0	70.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	203, 986, 331	549, 249, 488	753, 235, 81	9 1, 479, 554	754, 715, 373	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	231	23	1 -231	0	192.00
194.0007950 HOME OFFICE	0	0		0 0	0	194.00
194.01079510CCUPATIONAL HEALTH ONSITE SVCS	0	0		0 0		194.01
194.0207952ACCOUNTABLE CARE	428, 613	136, 430	565, 04	3 0	565, 043	194.02
194.0307953 SCHOOL BASED CLINICS	44, 448	159, 924	204, 37		204, 372	194.03
194.0407954 SMO-NON PROVIDER BASED	444, 108	156, 557	600, 66	5 – 1, 568		
194.0507955 FAMILY PRACTICE MEDICINE	2, 403, 746	2, 504, 105	4, 907, 85	1 -1, 341, 716	3, 566, 135	194.05
194. 07 07957 LI FECHECK	0	0		0 0		194.07
194.0807958 GROUP HOMES AND MISC. N_R CTRS	807, 662	488, 380	1, 296, 04	2 -136, 039		
194.0907959SURGERY CENTER EAST	0	0		0 0		194.09
200.00 TOTAL (SUM OF LINES 118 through 199)	208, 114, 908	552, 695, 115	760, 810, 02	3 0	760, 810, 023	200. 00

Heal th Financial	Systems		COMMUNI TY HEALTH N	JETWORK, INC.	
RECLASSI FI CATI ON	N AND ADJUSTMENTS	OF TRIAL BALAN	ICE OF EXPENSES	Provider CCN: 15-0074	Peri od:

RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE ()F EXPENSES	Provider CCN: 15-007	From 01/01/2020	A Prepared:
	Cost Center Description	Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	8/2/2021	
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-8, 206, 128			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	9, 997, 703			2.00
3.00	00300 OTHER CAP REL COSTS	0	-		3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 696, 732			4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	-88, 149, 198			5.00
7.00	00700 OPERATION OF PLANT	546, 833			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0			8.00
9.00	00900 HOUSEKEEPING	0			9.00
10.00	01000 DI ETARY	-18, 648			10.00
11.00		-1, 772, 059			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	4, 522, 728			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	10, 962, 673			14.00
		-75, 102			15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	4, 461, 363			16.00 17.00
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	-1, 407, 344	_, ,		21.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	-2, 319, 807			21.00
	02300 EMS TRAINING-ALLIED HEALTH	-2, 319, 007	5, 668, 149		23.00
	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH	0	0		23.00
23.01	02302 PHARMACY RESIDENCY-ALLIED HEALTH	0	0		23.01
	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	ő		23.02
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	5		20.00
30 00	03000 ADULTS & PEDIATRICS	-818,008	53, 964, 064		30.00
	03100 I NTENSI VE CARE UNI T	010,000			31.00
	03200 CORONARY CARE UNI T	0			32.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	0			35.00
	04300 NURSERY	0	710, 663		43.00
	ANCI LLARY SERVICE COST CENTERS		· · ·		
50.00	05000 OPERATI NG ROOM	-517, 359	16, 499, 017		50.00
51.00	05100 RECOVERY ROOM	0	747, 578		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-881, 480	3, 119, 850		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-7, 999	4, 030, 556		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	1, 065, 527		55.00
57.00	05700 CT SCAN	0	2, 980, 784		57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	722, 402		58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	-225, 224	5, 880, 025		59.00
60.00	06000 LABORATORY	15, 496	14, 334, 444		60.00
64.00	06400 I NTRAVENOUS THERAPY	-29, 462	1, 706, 846		64.00
	06500 RESPI RATORY THERAPY	0	., ,		65.00
66.00	06600 PHYSI CAL THERAPY	-73, 376			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1, 875, 427		67.00
68.00	06800 SPEECH PATHOLOGY	0	783, 599		68.00
69.00	06900 ELECTROCARDI OLOGY	-54, 402			69.00
	07000 ELECTROENCEPHALOGRAPHY	13, 650			70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0			71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS				72.00
	07300 DRUGS CHARGED TO PATIENTS	1, 695, 526			73.00
	07400 RENAL DI ALYSI S	0	1, 721, 255		74.00
76.00 76.01	03330 ENDOSCOPY 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	-32, 709, 382			76.00 76.01
	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-32, 709, 382			76.01
76.03 76.04	03951 LUTHERWOOD PARTNERSHIP	-7, 343, 104	2, 452, 797		76.03
	03480 ONCOLOGY-CANCER CARE CENTER	-16, 101, 453			76.04
	03953 I MAGI NG CENTERS	- 10, 101, 455			76.05
	03954 BREAST DI AGNOSTI C CENTER	-33			76.07
	07697 CARDIAC REHABILITATION	-5, 741			76.97
	07698 HYPERBARI C OXYGEN THERAPY	-5,741			76.98
, 5. 70	OUTPATIENT SERVICE COST CENTERS	0	120, 100		, 0. 70
88.00	08800 RURAL HEALTH CLINIC	0	0		88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000 CLINIC	۰ ۱	l õl		90.00
	04950 DIABETIC CARE CENTER		l ől		90.00
90.01	04951 HEALTHY HEARTS CENTER	-1, 018, 384	1, 075, 481		90.02
	09001 CLINIC	Λ			90.02
90.03 90.04	04953 SPI NE CENTER		l ő		90.03
	04954 I NFUSI ON CENTERS	0	448, 985		90.04
	09002 MEDCHECK CLINICS				90.05
90.00 90.07	09003 KNEE CENTER	-140, 490	3, 842, 316		90.00
	09004 PALLI ATI VE CARE	- 140, 490	5, 0+2, 510		90.07
	09004 PALLIATIVE CARE 09006 WORK SITE CLINICS				90.08
	04961 FAMILY PRACTICE AND MATERNITY CARE				90.10
	09100 EMERGENCY	2, 802, 244	17,014,012		90. 12
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,002,244			92.00
00		1	I I		1 . 2. 00

Health Financial Systems CC	MMUNITY HEALTH	NETWORK, INC.		In Lieu	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CC	CN: 15-0074	Peri od:	Worksheet A
				From 01/01/2020 To 12/31/2020	Date/Time Prepared: 8/2/2021 3:24 pm
Cost Center Description	Adjustments	Net Expenses			
	· · · · · · · · · · · · · · · · · · ·	For Allocation			
	6.00	7.00			
OTHER REIMBURSABLE COST CENTERS					
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0			98.00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-123, 359, 235	631, 356, 138			118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.00
191. 00 19100 RESEARCH	0	0			191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0			192.00
194.0007950 HOME OFFICE	0	0			194.00
194.0107951 OCCUPATIONAL HEALTH ONSITE SVCS	0	0			194.01
194.0207952 ACCOUNTABLE CARE	0	565, 043			194. 02
194.03 07953 SCHOOL BASED CLINICS	0	204, 372			194.03
194.04 07954 SMO-NON PROVIDER BASED	0	599, 097			194.04
194.0507955 FAMILY PRACTICE MEDICINE	0	3, 566, 135			194.05
194. 07 07957 LI FECHECK	0	0			194.07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	0	1, 160, 003			194.08
194.0907959 SURGERY CENTER EAST	0	0			194.09
200.00 TOTAL (SUM OF LINES 118 through 199)	-123, 359, 235	637, 450, 788			200.00

Internation Internation Internation Internation 42010 12010 12010 12010 12010 42010 12010 12010 12010 12010 42010 12010 12010 12010 12010 42010 02010 02010 12010 12010 42010 02010 02010 02010 12010 12010 42010 02010 02010 02010 12010 12010 42010 02010 02010 02010 02010 12010 42010 02010 02010 02010 02010 12010 42010 02010 02010 02010 12010 12010 72010 02010 02010 02010 02010 12010 72010 02010 02010 02010 02010 12010 72010 02010 02010		Financial Systems	СС	MMUNITY HEALTH	I NETWORK, INC. Provider CCN	I: 15-0074	In Lie Period:	u of Form CMS Worksheet A-	
Image: construction of the solution of								Date/Time Pr	epared:
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A Chargeold & Notical Supplies									
200 PATI PATS 0 <td< td=""><td></td><td>A - Chargeable Medical Suppli</td><td>es</td><td></td><td></td><td></td><td></td><td></td><td></td></td<>		A - Chargeable Medical Suppli	es						
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COMMUNITY HEALTH NETWORK, INC. Provider CCN: 15-0074

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2020

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(MR1) - <td>20.00</td> <td>CT SCAN</td> <td>57.00</td> <td>C</td> <td>9, 532</td> <td></td> <td>20.00</td>	20.00	CT SCAN	57.00	C	9, 532		20.00
(MR1) - <td>21.00</td> <td>MAGNETIC RESONANCE IMAGING</td> <td>58.00</td> <td>C</td> <td>251</td> <td></td> <td>21.00</td>	21.00	MAGNETIC RESONANCE IMAGING	58.00	C	251		21.00
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27.00 ELECTROENCEPHALOGRAPHY 70.00 0 895 27.00 28.00 ENDOSCOPY 76.00 0 2,924 28.00 29.00 PSYCHI ATRI C/PSYCHOLOGI CAL 76.01 0 94,167 29.00 30.00 LUTHERWOOD PARTNERSHI P 76.03 0 65,331 30.00 31.00 WOUND CARE CENTER 76.04 0 2,260 31.00 32.00 ONCOLOGY-CANCER CARE CENTER 76.05 0 90,556 32.00 33.00 IMAGI NG CENTERS 76.06 0 17.181 33.00 34.00 CARDI AC REHABI LI TATI ON 76.97 0 3,528 36.00 35.00 HEALTHY HEARTS CENTER 90.07 0 123 36.00 36.00 KNEE CENTER 90.07 0 1.821 38.00 38.00 SCHOUL BASED CLINICS 194.03 0 1.821 38.00 39.00 FAMI LY PRACTICE MEDI CINE 194.08 0 7.73 40.00 CTRS	25.00	PHYSICAL THERAPY	66.00	C	24, 572		25.00
27.00 ELECTROENCEPHALOGRAPHY 70.00 0 895 27.00 28.00 ENDOSCOPY 76.00 0 2,924 28.00 29.00 PSYCHI ATRI C/PSYCHOLOGI CAL 76.01 0 94,167 29.00 30.00 LUTHERWOOD PARTNERSHI P 76.03 0 65,331 30.00 31.00 WOUND CARE CENTER 76.04 0 2,260 31.00 32.00 ONCOLOGY-CANCER CARE CENTER 76.05 0 90,556 32.00 33.00 IMAGI NG CENTERS 76.06 0 17.181 33.00 34.00 CARDI AC REHABI LI TATI ON 76.97 0 3,528 36.00 35.00 HEALTHY HEARTS CENTER 90.07 0 123 36.00 36.00 KNEE CENTER 90.07 0 1.821 38.00 38.00 SCHOUL BASED CLINICS 194.03 0 1.821 38.00 39.00 FAMI LY PRACTICE MEDI CINE 194.08 0 7.73 40.00 CTRS	26 00	ELECTROCARDI OLOGY	69 00	C	12 302		26 00
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29.00 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.01 0 94, 167 29.00 30.00 LUTHERWOOD PARTNERSHIP 76.03 0 65, 331 30.00 31.00 WOUND CARE CENTER 76.04 0 2, 260 31.00 32.00 ONCOLOGY-CANCER CARE CENTER 76.05 90, 556 32.00 33.00 34.00 CARDI AC REHABI LI TATI ON 76.97 0 3, 528 34.00 35.00 HEALTHY HEARTS CENTER 90.02 0 7, 497 35.00 36.00 KNEE CENTER 90.07 0 123 36.00 37.00 EMERGENCY 91.00 0 50.892 37.00 38.00 SCHOOL BASED CLI NI CS 194.03 0 1, 821 39.00 39.00 FAMI LY PRACTICE MEDI CI NE 194.05 0 10, 217 39.00 40.00 GRUP HOMES AND MI SC. N_R 194.08 0 7, 733 40.00 CTRS				C C			
SERVICES 30.00 LUTHERWOD PARTNERSHIP 76.03 0 65,331 30.00 31.00 WOUND CARE CENTER 76.04 0 2,260 31.00 32.00 ONCOLOGY-CANCER CARE CENTER 76.04 0 2,260 32.00 33.00 IMAGI NG CENTERS 76.06 0 17,181 33.00 34.00 CARDI AC REHABI LI TATI ON 76.97 0 3,528 34.00 35.00 HEALTHY HEARTS CENTER 90.02 0 7,497 35.00 36.00 KNEE CENTER 90.07 123 36.00 38.00 37.00 EMERGENCY 91.00 0 50,892 37.00 38.00 SCHOUL BASED CLINICS 194.03 1,821 38.00 39.00 FAMI LY PRACTICE MEDICINE 194.05 0 7,733 40.00 40.00 GROUP HOMES AND MI SC. N_R 194.08 7,733 40.00 2.00 CTRS							
30.00 LUTHERWOOD PARTNERSHIP 76.03 0 65,331 30.00 31.00 WOUND CARE CENTER 76.04 0 2,260 31.00 32.00 ONCOLOGY-CANCER CARE CENTER 76.05 0 90,556 32.00 33.00 IMAGI NG CENTERS 76.06 0 17,181 33.00 34.00 CARDI AC REHABI LITATION 76.97 0 3,528 34.00 35.00 HEALTHY HEARTS CENTER 90.02 0 7,497 35.00 36.00 KNEE CENTER 90.07 0 123 36.00 37.00 EMERGENCY 91.00 0 50,892 37.00 38.00 SCHOOL BASED CLINICS 194.03 0 1,821 38.00 39.00 FAMI LY PRACTICE MEDICINE 194.05 0 1,02,77 39.00 40.00 GROUP HOMES AND MISC. N_R 194.08 0 7,733 40.00 CTRS	29.00	PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	C	94, 167		29.00
31.00 WOUND CARE CENTER 76.04 0 2,260 31.00 32.00 ONCOLOGY-CANCER CARE CENTER 76.05 0 90,556 32.00 33.00 IMAGING CENTERS 76.06 0 17,181 33.00 34.00 CARDIAC REHABILITATION 76.97 0 3,528 34.00 35.00 HEALTHY HEARTS CENTER 90.02 0 7,497 35.00 36.00 KNEE CENTER 90.07 0 123 36.00 37.00 EMERGENCY 91.00 0 50,892 37.00 38.00 SCHOOL BASED CLINICS 194.03 0 1,821 38.00 39.00 FAMI LY PRACTICE MEDICINE 194.05 0 10,217 39.00 40.00 GROUP HOMES AND MISC. N_R 194.08 0 7,733 40.00 CTRS 0 1,066,784 1 1.00 2,280,708 1.072,671 1.00 NURSERY 43.00 483,338 227,325 2.00 2.00 1.00 CAFETERIA 2,280,708 1,072,671 2.00 2.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
31.00 WOUND CARE CENTER 76.04 0 2,260 31.00 32.00 ONCOLOGY-CANCER CARE CENTER 76.05 0 90,556 32.00 33.00 IMAGING CENTERS 76.06 0 17,181 33.00 34.00 CARDIAC REHABILITATION 76.97 0 3,528 34.00 35.00 HEALTHY HEARTS CENTER 90.02 0 7,497 35.00 36.00 KNEE CENTER 90.07 0 123 36.00 37.00 EMERGENCY 91.00 0 50,892 37.00 38.00 SCHOOL BASED CLINICS 194.03 0 1,821 38.00 39.00 FAMI LY PRACTICE MEDICINE 194.05 0 10,217 39.00 40.00 GROUP HOMES AND MISC. N_R 194.08 0 7,733 40.00 CTRS 0 1,066,784 1 1.00 2,280,708 1.072,671 1.00 NURSERY 43.00 483,338 227,325 2.00 2.00 1.00 CAFETERIA 2,280,708 1,072,671 2.00 2.00 </td <td>30.00</td> <td>LUTHERWOOD PARTNERSHIP</td> <td>76.03</td> <td>C</td> <td>65, 331</td> <td></td> <td>30.00</td>	30.00	LUTHERWOOD PARTNERSHIP	76.03	C	65, 331		30.00
32.00 ONCOLOGY-CANCER CARE CENTER 76.05 0 90,556 32.00 33.00 IMAGING CENTERS 76.06 0 17,181 33.00 34.00 CARDIAC REHABILITATION 76.97 0 3,528 34.00 35.00 HEALTHY HEARTS CENTER 90.02 0 7,497 35.00 36.00 KNEE CENTER 90.07 0 123 36.00 36.00 SCHOOL BASED CLINICS 194.03 0 1,821 38.00 39.00 FAMILY PRACTICE MEDICINE 194.05 0 1,0217 39.00 40.00 GROUP HOMES AND MISC. N_R 194.08 7,733 40.00 CTRS				ſ			
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34. 00 CARDI AC REHABILITATION 76. 97 0 3, 528 34. 00 35. 00 HEALTHY HEARTS CENTER 90. 02 0 7, 497 35. 00 36. 00 KNEE CENTER 90. 07 0 123 36. 00 37. 00 EMERGENCY 91. 00 0 50, 892 37. 00 38. 00 SCHOOL BASED CLINICS 194. 03 0 1, 821 38. 00 39. 00 FAMILY PRACTICE MEDICINE 194. 05 0 10, 217 39. 00 40. 00 GROUP HOMES AND MISC. N_R 194. 08 0 7, 733 40. 00 CTRS				C .			
35. 00 HEALTHY HEARTS CENTER 90. 02 0 7, 497 35. 00 36. 00 KNEE CENTER 90. 07 0 123 36. 00 37. 00 EMERGENCY 91. 00 0 50, 892 37. 00 38. 00 SCHOOL BASED CLINICS 194. 03 0 1, 821 38. 00 39. 00 FAMILY PRACTICE MEDICINE 194. 05 0 10, 217 39. 00 40. 00 GROUP HOMES AND MISC. N_R 194. 08 0 7, 733 40. 00 CTRS				C			
36.00 KNEE CENTER 90.07 0 123 36.00 37.00 EMERGENCY 91.00 0 50,892 37.00 38.00 SCHOOL BASED CLINICS 194.03 0 1,821 38.00 39.00 FAMILY PRACTICE MEDICINE 194.05 0 10,217 39.00 40.00 GROUP HOMES AND MISC. N_R 194.08 7,733 40.00 40.00 CTRS 0 1,066,784 10.00 1.006,784 40.00 1.00 NURSERY 43.00 483,338 227,325 1.00 2.00 DELIVERY ROOM & LABOR ROOM 52.00 1,797,370 845,346 2.00 1 - Cafeteria Reclass 1.00 1,591,478 1,898,785 1.00	34.00	CARDI AC REHABI LI TATI ON	76.97	C	3, 528		34.00
36.00 KNEE CENTER 90.07 0 123 36.00 37.00 EMERGENCY 91.00 0 50,892 37.00 38.00 SCHOOL BASED CLINICS 194.03 0 1,821 38.00 39.00 FAMILY PRACTICE MEDICINE 194.05 0 10,217 39.00 40.00 GROUP HOMES AND MISC. N_R 194.08 7,733 40.00 40.00 CTRS 0 1,066,784 10.00 1.006,784 40.00 1.00 NURSERY 43.00 483,338 227,325 1.00 2.00 DELIVERY ROOM & LABOR ROOM 52.00 1,797,370 845,346 2.00 1 - Cafeteria Reclass 1.00 1,591,478 1,898,785 1.00	35.00	HEALTHY HEARTS CENTER	90.02	C	7, 497		35.00
37. 00 EMERGENCY 91. 00 0 50, 892 37. 00 38. 00 SCHOOL BASED CLINICS 194. 03 0 1, 821 38. 00 39. 00 FAMILY PRACTICE MEDICINE 194. 05 0 10, 217 39. 00 40. 00 GROUP HOMES AND MISC. N_R 194. 08 0 7, 733 40. 00 CTRS 0 1, 066, 784 1 100 1, 066, 784 40. 00 1. 00 NURSERY 0 1, 797, 370 845, 346 2. 00 2. 00 2. 00 DELIVERY ROOM & LABOR ROOM 52. 00 1, 797, 370 845, 346 2. 00 1. 00 CAFETERIA 1 1, 1.00 1, 591, 478 1, 898, 785 1. 00				ſ			
38. 00 SCHOOL BASED CLINICS 194.03 0 1,821 38.00 39. 00 FAMI LY PRACTICE MEDICINE 194.05 0 10,217 39.00 40. 00 GROUP HOMES AND MISC. N_R 194.08 0 7,733 40.00 TOTALS 0 1,066,784 10.00 1.006,784 40.00 1. 00 NURSERY 43.00 483,338 227,325 1.00 2. 00 DELI VERY ROOM & LABOR ROOM 52.00 1,797,370 845,346 2.00 1 Cafeteria Reclass 2,280,708 1,072,671 1.00 1.00 1.00							
39.00 FAMI LY PRACTICE MEDICINE 194.05 0 10,217 39.00 40.00 GROUP HOMES AND MISC. N_R 194.08 0 7,733 40.00 TOTALS 0 1,066,784 10 1.00 40.00 H - Labor and Delivery 43.00 483,338 227,325 1.00 2.00 DELIVERY ROOM & LABOR ROOM 52.00 1,797,370 845,346 2.00 I - Cafeteria Reclass 2,280,708 1,072,671 1.00 1.00				(
40. 00 GROUP HOMES AND MISC. N_R 194.08 0 7,733 40.00 CTRS				C			
CTRS	39.00	FAMILY PRACTICE MEDICINE	194.05	C) 10, 217		39.00
CTRS	40.00	GROUP HOMES AND MISC. N R	194.08	C	7, 733		40.00
TOTALS 0 1,066,784 H - Labor and Delivery H Labor and Delivery 1.00 NURSERY 43.00 483,338 227,325 1.00 2.00 DELIVERY ROOM & LABOR ROOM 52.00 1,797,370 845,346 2.00 1.01 1.02,800,708 1,072,671 1.072,671 1.00 1.002 1.00 CAFETERIA 1.00 1,591,478 1,898,785 1.00		_					
H - Labor and Delivery 1.00 NURSERY 43.00 2.00 DELIVERY ROOM & LABOR ROOM 52.00 1,797,370 845,346 TOTALS 2,280,708 1 - Cafeteria Reclass 1.00 CAFETERIA 11.00 1.591,478 1,898,785 1.00			+	— — — ī	1 066 784	1	1
1.00 NURSERY 43.00 483,338 227,325 1.00 2.00 DELI VERY ROOM & LABOR ROOM 52.00 1,797,370 845,346 2.00 TOTALS 2,280,708 1,072,671 2.00 1.00 2.00 1.00 CAFETERIA 11.00 1,591,478 1,898,785 1.00				L. L	1,000,764	l	1
2. 00 DELI VERY ROOM & LABOR ROOM 52. 00 1,797,370 845,346 2.00 2.00 TOTALS 2,280,708 1,072,671 1.072,671 1.00 1.072,671 1.00 1. 00 CAFETERIA 1.00 1,591,478 1.898,785 1.00 1.00	4 6 6		10	100.655	007.0		1
TOTALS 2, 280, 708 1, 072, 671 I - Cafeteria Reclass 1.00 CAFETERIA							
TOTALS 2, 280, 708 1, 072, 671 I - Cafeteria Reclass 1.00 CAFETERIA	2.00	DELIVERY ROOM & LABOR ROOM	52.00	<u>1, 797, 3</u> 70	845, 346		2.00
I - Cafeteria Reclass 1.00 CAFETERIA		TOTALS	- T	2, 280, 708	1,072,671		
1.00 CAFETERIA 11.00 1,591,478 1,898,785 1.00						·	1
	1 00		11 00	1 501 /70	1 808 795		1 1 00
	1.00						1.00
		TOTALS		1, 371, 478	ו, 078, 785	1	1

Heal th	Financial Systems	CO	OMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-:	2552-10
RECLAS	SIFICATIONS			Provider C	CN: 15-0074	Peri od:	Worksheet A-6)
						From 01/01/2020 To 12/31/2020	Date/Time Pre 8/2/2021 3:24	epared:
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	J - Therapy Reclass							
1.00	OCCUPATI ONAL THERAPY	67.00	1, 295, 668	579, 759				1.00
2.00	SPEECH PATHOLOGY	68.00	541, 362	242, 237				2.00
	TOTALS		1, 837, 030	821, 996				
	K - Builiding Depreciation							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	14, 059, 942				1.00
	TOTALS			14,059,942				
	L - Capital Insurance Costs		•					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	513, 755				1.00
	TOTALS			513, 755				
	M - Radiology Support							
1.00	RADI OLOGY-THERAPEUTI C	55.00	237, 722	68, 005				1.00
2.00	CT SCAN	57.00	105, 381	30, 146				2.00
3.00	MAGNETIC RESONANCE IMAGING	58.00	15, 947	4, 562				3.00
	(MRI)							
4.00	I MAGING CENTERS	76.06	75, 003	21, 456				4.00
	TOTALS		434, 053	124, 169				
	N - Hyperbaric Oxygen Therapy	/						
1.00	HYPERBARI C OXYGEN THERAPY	76.98	114, 018	306, 088				1.00
	TOTALS		114,018	306, 088				
	0 - IHH Cat Scan	· · · · · ·						
1.00	CT SCAN	57.00	633, 493	172, 970				1.00
	TOTALS		633, 493	172, 970				
500.00	Grand Total: Increases		6, 890, 780	248, 471, 339				500.00
500.00		I I	0, 0, 0, 0, 000	,,,	I		I	200.00

COMMUNITY HEALTH NETWORK, INC.

	Financial Systems	CC	MMUNITY HEALTH				u of Form CMS-2552-10
RECLAS	SI FI CATI ONS			Provider (CCN: 15-0074	Period: From 01/01/2020	Worksheet A-6
						To 12/31/2020	Date/Time Prepared: 8/2/2021 3:24 pm
		Decreases					0/2/2021 3.24 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref		
	6.00 A - Chargeable Medical Suppli	7.00	8.00	9.00	10.00		
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	107, 372		0	1.00
2.00	OPERATION OF PLANT	7.00	0	151, 984		0	2.00
3.00		10.00	0	520		0	3.00
4.00 5.00	CENTRAL SERVICES & SUPPLY PHARMACY	14.00 15.00	0	98, 740 163, 182		0	4.00
6.00	ADULTS & PEDIATRICS	30.00	0	828, 782		0	6.00
7.00	INTENSIVE CARE UNIT	31.00	о	661, 392		0	7.00
8.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	23,005		0	8.00
9.00 10.00	OPERATING ROOM RECOVERY ROOM	50.00 51.00	0	6, 120, 206 18, 693		0	9.00 10.00
11.00	RADI OLOGY-DI AGNOSTI C	54.00	0	146, 316		0	11.00
12.00	RADI OLOGY-THERAPEUTI C	55.00	О	532, 382		o	12.00
13.00	CT SCAN	57.00	0	88, 850		0	13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	10, 726		0	14.00
15.00 16.00	CARDI AC CATHETERI ZATI ON	59.00 64.00	0	11, 725, 204 28, 279		0	15.00 16.00
17.00	RESPIRATORY THERAPY	65.00	0	583, 290		0	17.00
18.00	PHYSI CAL THERAPY	66.00	0	5, 015		0	18.00
19.00	ELECTROCARDI OLOGY	69.00	0	18, 266		0	19.00
20. 00 21. 00	ELECTROENCEPHALOGRAPHY ENDOSCOPY	70.00 76.00	0	16, 684 150, 277		0	20.00 21.00
21.00	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	76.01	0	487			22.00
23.00	LUTHERWOOD PARTNERSHIP	76.03	о	20, 026		o	23.00
24.00	WOUND CARE CENTER	76.04	0	131, 727		0	24.00
25.00	ONCOLOGY-CANCER CARE CENTER	76.05	0	403, 373		0	25.00
26.00 27.00	I MAGI NG CENTERS CARDI AC REHABI LI TATI ON	76.06 76.97	0	718, 514 4, 848		0	26.00 27.00
28.00	HEALTHY HEARTS CENTER	90.02	0	15, 444		0	28.00
29.00	INFUSION CENTERS	90. 05	0	44, 681		0	29.00
30.00	KNEE CENTER	90.07	0	1, 297		0	30.00
31.00 32.00	EMERGENCY SMO-NON PROVIDER BASED	91.00 194.04	0	576, 514 38		0	31.00 32.00
33.00	FAMILY PRACTICE MEDICINE	194.05	0	2, 614		0	33.00
	TOTALS		0	23, 398, 728			
1.00	B - Implantable Device Reclas	50.00	0	10, 289, 849		0	1.00
2.00	RADI OLOGY-THERAPEUTI C	55.00	0	180, 118		0	2.00
3.00	CARDI AC CATHETERI ZATI ON	59.00	0	15, 164, 231		0	3.00
4.00	ENDOSCOPY	76.00	0	22, 079		0	4.00
5.00	WOUND CARE CENTER		— — — o	<u>29, 412</u> 25, 685, 689		0	5.00
	C - Drugs Charges to Pat	<u> </u>	0	23,003,007			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	2, 655		0	1.00
2.00		10.00	0	163		0	2.00
3.00 4.00	CENTRAL SERVICES & SUPPLY PHARMACY	14.00 15.00	0	1, 944 113, 067, 492		0	3.00
5.00	ADULTS & PEDIATRICS	30.00	0	45, 513		0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	31, 163		0	6.00
7.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	909		0	7.00
8.00 9.00	OPERATING ROOM RECOVERY ROOM	50.00 51.00	0	30, 956 199		0	8.00 9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	237, 076		0	10.00
11.00	RADI OLOGY-THERAPEUTI C	55.00	0	2, 812		0	11.00
12.00	CT SCAN	57.00	0	121, 208		0	12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	49, 923		0	13.00
14.00	CARDI AC CATHETERI ZATI ON	59.00	О	78, 522		0	14.00
15.00	INTRAVENOUS THERAPY	64.00	0	95		0	15.00
16.00 17.00		65.00 66.00	0	1, 912		0	16.00
17.00 18.00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66.00 69.00	0	2, 019 12, 979		0	17.00 18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	570		0	19.00
20.00	RENAL DIALYSIS	74.00	0	24		0	20.00
21.00	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	76.01	0	20, 866	1	0	21.00
22.00	LUTHERWOOD PARTNERSHIP	76.03	о	24, 241		0	22.00
23.00	WOUND CARE CENTER	76.04	0	21, 400		0	23.00
24.00	ONCOLOGY-CANCER CARE CENTER	76.05	0	553, 992		0	24.00
25.00 26.00	I MAGI NG CENTERS CARDI AC REHABI LI TATI ON	76.06 76.97	0	92, 979 5		0	25.00 26.00
27.00	INFUSION CENTERS	90.05	0	8, 962, 647		0	27.00
			-1		1	1	

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	IS

COMMUNITY HEALTH NETWORK, INC. Provider CCN: 15-0074

In Lieu of Form CMS-2552-10

Period: Worksheet A-6 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

						To 12/31/2020 Date/Time P 8/2/2021 3::	
		Decreases					
	Cost Center 6.00	Li ne # 7.00	<u>Sal ary</u> 8.00	0ther 9.00	<u>Wkst. A-7 Ref.</u> 10.00		
28.00	KNEE CENTER	90.07	0.00	4, 993	0		28.00
29.00	EMERGENCY	91.00	0		0		29.00
30.00	SMO-NON PROVIDER BASED	194.04	0	.,	0		30.00
31.00	FAMILY PRACTICE MEDICINE	194.05	0	268, 338	0		31.00
32.00	GROUP HOMES AND MISC. N_R CTRS	194.08	0	242	0		32.00
	TOTALS	— — — +	— — — ō	123, 660, 157			
	D - Depreciation Expense	<u> </u>		120,000,10,			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0		9		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0		0		2.00
3.00 4.00	OPERATION OF PLANT	7.00	0		0		3.00
4.00 5.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	0	9, 168 212, 916	0		4.00 5.00
6.00	CAFETERIA	11.00	0	12, 184	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	38, 530	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	118, 074	0		8.00
9.00	PHARMACY	15.00	0	109, 335	0		9.00
10.00	I &R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	66, 932	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	1, 305, 315	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	1, 037, 139	0		12.00
13.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	31, 101	0		13.00
14.00	OPERATING ROOM	50.00	0	1, 880, 658	0		14.00
15.00	RECOVERY ROOM	51.00	0	,	0		15.00
16. 00 17. 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	54.00 55.00	0	742, 352 26, 644	0		16.00 17.00
18.00	CT SCAN	57.00	0		0		18.00
19.00	MAGNETIC RESONANCE IMAGING	58.00	0		0		19.00
	(MRI)						
20.00	CARDIAC CATHETERIZATION	59.00	0	948, 266	0		20.00
21.00		60.00	0	64, 654	0		21.00
22. 00 23. 00	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	64.00 65.00	0	5, 224 96, 130	0		22.00 23.00
23.00	PHYSICAL THERAPY	66.00	0	81, 747	0		23.00
25.00	ELECTROCARDI OLOGY	69.00	0	338, 535	0		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	126, 479	0		26.00
27.00	RENAL DI ALYSI S	74.00	0	503	0		27.00
28.00	ENDOSCOPY	76.00	0	76, 607	0		28.00
29.00	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	76.01	0	274, 839	0		29.00
30.00	LUTHERWOOD PARTNERSHIP	76.03	0	122, 522	0		30.00
31.00	WOUND CARE CENTER	76.04	0	6, 984	0		31.00
32.00	ONCOLOGY-CANCER CARE CENTER	76.05	0	4, 413, 097	0		32.00
33.00	I MAGI NG CENTERS	76.06	0	1, 034, 983	0		33.00
34.00	BREAST DI AGNOSTI C CENTER	76.07	0	587	0		34.00
35.00 36.00	CARDIAC REHABILITATION HEALTHY HEARTS CENTER	76.97 90.02	0	30, 552 17, 120	0		35.00 36.00
	INFUSION CENTERS	90.02 90.05	0	52, 762	0		37.00
38.00	KNEE CENTER	90.07	0		0		38.00
39.00	EMERGENCY	91.00	0		0		39.00
40.00	FAMILY PRACTICE MEDICINE	194.05	0	172, 184	0		40.00
41.00	GROUP HOMES AND MISC. N_R	194.08	0	50, 876	0		41.00
	CTRS	├── ── ┼		29, 188, 943	┝── ── ─		
	E - Interest Expense		0	27, 100, 743			-
1.00	ADMI NI STRATI VE & GENERAL	5.00	0		11		1.00
	TOTALS		0				
	F - Other Capital Rental						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	24,672	10		1.00
2.00 3.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00 7.00	0	.,	0		2.00 3.00
3.00 4.00	HOUSEKEEPI NG	9.00	0	205, 835 29, 574	0		4.00
4.00 5.00	DI ETARY	10.00	0		0		5.00
6.00	CAFETERI A	11.00	0	12, 281	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	855	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	1, 842, 046	0		8.00
9.00	PHARMACY	15.00	0	709, 876	0		9.00
10. 00 11. 00	SOCIAL SERVICE	17.00 21.00	0	160 2, 250	0		10.00 11.00
11.00	FRINGES APPRVD	21.00	0	2,230	0		11.00
12.00	I&R SERVICES-OTHER PRGM	22.00	0	3, 837	0		12.00
	COSTS APPRVD						
13.00	ADULTS & PEDIATRICS	30.00	0		0		13.00
14.00	INTENSIVE CARE UNIT	31.00	0	266	0	l	14.00

Health Financial Systems RECLASSIFICATIONS

COMMUNITY HEALTH NETWORK, INC.

	Financial Systems	C	OMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2552-10
RECLAS	SIFICATIONS			Provider (Period: From 01/01/2020	Worksheet A-6
						To 12/31/2020	Date/Time Prepared: 8/2/2021 3:24 pm
		Decreases					0/2/2021 0.21 pm
	Cost Center 6.00	Line # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00	-	
15.00	OPERATING ROOM	50.00	0	323, 810)	15.00
16.00	RECOVERY ROOM	51.00	0	393			16.00
17.00	RADI OLOGY-DI AGNOSTI C	54.00	0	19, 837	(17.00
18. 00 19. 00	RADI OLOGY-THERAPEUTI C CT SCAN	55.00 57.00	0	80 80	(18.00 19.00
20.00	MAGNETIC RESONANCE IMAGING	58.00	0	319			20.00
	(MRI)		-				
21.00	CARDIAC CATHETERIZATION	59.00	0	1, 909			21.00
22. 00 23. 00	LABORATORY RESPI RATORY THERAPY	60.00 65.00	0	53, 213 878			22.00 23.00
24.00	PHYSICAL THERAPY	66.00	0	1, 148, 273	(24.00
25.00	ELECTROCARDI OLOGY	69.00	0	177, 934	(25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	47, 459			26.00
27.00		76.00	0	77, 750			27.00
28.00	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	76.01	0	1, 616, 430	l l		28.00
29.00	LUTHERWOOD PARTNERSHI P	76. 03	О	24, 687	(29.00
30.00	ONCOLOGY-CANCER CARE CENTER	76.05	0	410, 651	0		30.00
31.00	I MAGI NG CENTERS	76.06	0	449, 569			31.00
32.00 33.00	BREAST DIAGNOSTIC CENTER CARDIAC REHABILITATION	76.07 76.97	0	49, 397 136, 625	(32.00 33.00
34.00	HEALTHY HEARTS CENTER	90.02	0	161, 878			34.00
35.00	INFUSION CENTERS	90.05	0	213, 143	(35.00
36.00	KNEE CENTER	90.07	0	2, 780			36.00
37.00 38.00	EMERGENCY PHYSICIANS' PRIVATE OFFICES	91.00 192.00	0	730 231	(37.00 38.00
38.00 39.00	FAMILY PRACTICE MEDICINE	192.00	0	898, 580		-	39.00
40.00	GROUP HOMES AND MISC. N_R	194.08	Ö	84, 921	(40.00
	CTRS					_	
	TOTALS G - STD BENEFIT		0	10, 443, 125			
1.00	ADMI NI STRATI VE & GENERAL	5.00	44, 665	0	()	1.00
2.00	OPERATION OF PLANT	7.00	23, 976	0			2.00
3.00	HOUSEKEEPING	9.00	24, 588	0			3.00
4.00 5.00	DI ETARY CAFETERI A	10.00 11.00	14, 350	0 0			4.00
6.00	NURSING ADMINISTRATION	13.00	2, 175 25, 336	0			6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	4, 186	0			7.00
8.00	PHARMACY	15.00	31, 384	0			8.00
9.00	MEDI CAL RECORDS & LI BRARY	16.00	3, 605	0		-	9.00
10. 00 11. 00	SOCIAL SERVICE	17.00 21.00	5, 923 3, 480	0			10.00
11.00	FRINGES APPRVD	21.00	3, 400	0			11.00
12.00	I&R SERVICES-OTHER PRGM	22.00	37, 606	0	(12.00
12 00		20,00	240 510	0			12.00
13.00 14.00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30.00 31.00	240, 519 58, 408	0 0			13.00
15.00	NEONATAL INTENSIVE CARE UNIT	35.00	14, 671	0			15.00
16.00	OPERATING ROOM	50.00	41, 224	0			16.00
17.00	RECOVERY ROOM	51.00	4, 424	0			17.00
18. 00 19. 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	54.00 55.00	26, 587 3, 612	0 0			18.00 19.00
20.00	CT SCAN	57.00	9, 532	0			20.00
21.00	MAGNETIC RESONANCE IMAGING	58.00	251	0	()	21.00
22.00		F0 00	22 720	~			
22. 00 23. 00	CARDIAC CATHETERIZATION	59.00 64.00	23, 730 255	0 0			22.00 23.00
23.00 24.00	RESPIRATORY THERAPY	65.00	30, 298	0			23.00
25.00	PHYSICAL THERAPY	66.00	24, 572	0			25.00
26.00	ELECTROCARDI OLOGY	69.00	12, 302	0			26.00
27.00 28.00	ELECTROENCEPHALOGRAPHY ENDOSCOPY	70.00 76.00	895 2, 924	0			27.00 28.00
28.00 29.00	PSYCHI ATRI C/PSYCHOLOGI CAL	76.01	2, 924 94, 167	0			28.00
	SERVICES			0			
30.00	LUTHERWOOD PARTNERSHI P	76.03	65, 331	0			30.00
31.00	WOUND CARE CENTER	76.04	2, 260	0			31.00
32. 00 33. 00	ONCOLOGY-CANCER CARE CENTER	76.05 76.06	90, 556 17, 181	0			32.00 33.00
33.00 34.00	CARDIAC REHABILITATION	76.97	3, 528	0			34.00
35.00	HEALTHY HEARTS CENTER	90.02	7, 497	0			35.00
36.00	KNEE CENTER	90.07	123	0			36.00
37.00	EMERGENCY	91.00	50, 892	0			37.00
38.00	SCHOOL BASED CLINICS	194.03 194.05	1, 821 10, 217	0 0			38.00 39.00
39.00	FAMILY PRACTICE MEDICINE						

	Financial Systems	C01	MMUNITY HEALTH				u of Form CMS-2552
ECLAS	SIFICATIONS			Provider (CCN: 15-0074	Period: From 01/01/2020	Worksheet A-6
						To 12/31/2020	Date/Time Prepare
						10 12/01/2020	8/2/2021 3:24 pm
		Decreases			-		
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	<u>f.</u>	
	6. 00	7.00	8.00	9.00	10.00		
0.00	GROUP HOMES AND MISC. N_R	194.08	7, 733	0		0	40.
	CTRS	+				_	
	TOTALS		1, 066, 784	0			
	H - Labor and Delivery				1		
. 00	ADULTS & PEDIATRICS	30.00	2, 280, 708	1, 072, 671		0	1.
. 00		0.00	0	0		Ō	2.
	TOTALS		2, 280, 708	1, 072, 671			
	I - Cafeteria Reclass						
. 00	DI ETARY		1, 591, 478	<u>1, 898, 7</u> 85		Ō	1.
	TOTALS		1, 591, 478	1, 898, 785			
	J - Therapy Reclass				1		
. 00	PHYSICAL THERAPY	66.00	1, 837, 030	821, 996		0	1.
. 00		0.00	0	0		O	2.
	TOTALS		1, 837, 030	821, 996			
	K - Builiding Depreciation						
. 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	<u>14, 059, 9</u> 42		9	1.
	TOTALS		0	14, 059, 942			
	L - Capital Insurance Costs					1	
. 00	ADMI NI STRATI VE & GENERAL	5.00	0	<u>513, 7</u> 55		12	1.
	TOTALS		0	513, 755			
	M - Radiology Support						
. 00	RADI OLOGY-DI AGNOSTI C	54.00	434, 053	124, 169		0	1.
. 00		0.00	0	0		0	2.
. 00		0.00	0	0		0	3.
. 00		0.00	0	0		0	4.
	TOTALS		434, 053	124, 169			
	N - Hyperbaric Oxygen Therapy						
. 00	WOUND CARE CENTER	76.04	114, 018	306, 088		0	1.
	TOTALS		114, 018	306, 088			
	0 - IHH Cat Scan						
. 00	RADI OLOGY-DI AGNOSTI C	54.00	633, 493	172, 970		0	1.
	TOTALS		633, 493	172, 970			
00.00	Grand Total: Decreases		7, 957, 564	247, 404, 555			500.

	Financial Systems	COMMUNI TY HEALTH	Provi der C	N· 15_0074	Peri od:	eu of Form CMS-2 Worksheet A-7	
RECONC	TERATION OF GALLINE COSTS CENTERS			N. 13 0074	From 01/01/2020	Part I	
					To 12/31/2020	Date/Time Pre	pared:
						8/2/2021 3:24	pm
				Acqui si ti on			
		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 ASS						
1.00	Land	2, 743, 049			0 0	0	
2.00	Land Improvements	4, 209, 543			0 0	0	2.00
3.00	Buildings and Fixtures	489, 131, 131			0 44, 006, 718		•
4.00	Building Improvements	11, 166, 075	440, 762		0 440, 762		
5.00	Fixed Equipment	0	0		0 0	0	1 0.00
6.00	Movable Equipment	216, 513, 907	8, 196, 743		0 8, 196, 743	6, 556, 719	
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1–7)	723, 763, 705	52, 644, 223		0 52, 644, 223	22, 246, 781	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	723, 763, 705			0 52, 644, 223	22, 246, 781	10.00
		Endi ng Bal ance					
			Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASS						
1.00	Land	2, 743, 049					1.00
2.00	Land Improvements	4, 209, 543					2.00
3.00	Buildings and Fixtures	517, 411, 040	0				3.00
4.00	Building Improvements	11, 643, 584	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	218, 153, 931	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	754, 161, 147	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	754, 161, 147	0				10.00

Health Financial Systems COMMUNITY HEALTH NETWORK, INC. In Lieu of Form (u of Form CMS-2	2552-10	
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0074	Period:	Worksheet A-7		
					From 01/01/2020 To 12/31/2020	Part II Date/Time Pre	nared	
					10 12/31/2020	8/2/2021 3:24	pm	
		SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see			
		9,00	10.00	11.00	instructions) 12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2	12.00	13.00		
1.00	CAP REL COSTS-BLDG & FIXT				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		Total (1) (sum					
		Capi tal -Rel ate						
		d Costs (see	through 14)					
		instructions) 14.00	15.00	-				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT						1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00	
3.00	Total (sum of lines 1-2)	0	Ő				3.00	
		-	-	1				

	MMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2020 Fo 12/31/2020		pared:
	COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	536, 007, 216 218, 153, 931 754, 161, 147		536, 007, 216 218, 153, 93 754, 161, 14 CAPI TAL	0. 289267	0 0 F CAPITAL	1.00 2.00 3.00
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE			1	14.050.040		4 00
1.00CAP REL COSTS-BLDG & FIXT2.00CAP REL COSTS-MVBLE EQUIP3.00Total (sum of lines 1-2)	0	0		 14, 059, 942 25, 126, 704 39, 186, 646 		1.00 2.00 3.00
SUMMARY OF CAPITAL					10, 443, 123	3.00
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00 CAP REL COSTS-BLDG & FLXT 2.00 CAP REL COSTS-MVBLE EQUIP	7, 851, 409 0	0			22, 425, 106 35, 569, 829	1.00
3.00 Total (sum of lines 1-2)	7, 851, 409	513, 755	(ט וי	57, 994, 935	3.00

COMMUNITY HEALTH NETWORK INC.

Heal th	Financial Systems	CO	MMUNITY HEALTH	NETWORK, INC.	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provi der CCN: 15-0074		Period: From 01/01/2020	Worksheet A-8	
					To 12/31/2020	Date/Time Prep 8/2/2021 3:24	pared:
				Expense Classification or	Worksheet A	87272021 3:24	pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	О	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
3.00	(chapter 2)		0		0.00	U	3.00
4.00	Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of	В	-6.353	ADMI NI STRATI VE & GENERAL	5.00	o	5.00
	expenses (chapter 8)						
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Tel ephone servi ces (pay		0		0.00	0	7.00
	stations excluded) (chapter 21)						
8.00	Television and radio service		0		0.00	о	8.00
9.00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9.00
9.00 10.00	Provi der-based physici an	A-8-2	-858, 627		0.00	0	
11 00	adjustment		0		0.00		11 00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization	A-8-1	18, 038, 963			О	12.00
13.00	transactions (chapter 10) Laundry and linen service		0		0.00	o	13.00
	Cafeteria-employees and guests	s B	-1, 645, 712	CAFETERI A	11.00		
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical		0		0.00	о	16.00
	supplies to other than						
17.00	patients Sale of drugs to other than		0		0.00	о	17.00
	patients		_				
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health		0		0.00	О	19.00
	education (tuition, fees, books, etc.)						
20.00	Vendi ng machi nes		0		0.00		
21.00	Income from imposition of		0		0.00	0	21.00
	interest, finance or penalty charges (chapter 21)						
22.00	Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review -		0	*** Cost Center Deleted ***	114.00		25.00
	physicians' compensation (chapter 21)						
26.00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	о	26.00
27 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.00	COSTS-MVBLE EQUIP		0	CAP REL CUSTS-MUBLE EQUIP	2.00	U	27.00
	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00		29.00 30.00
	therapy costs in excess of		-				
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		Ω	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31.00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
33.00	Depreciation and Interest Space Rental Income	В	-28, 344	ADMI NI STRATI VE & GENERAL	5.00	о	33.00

Heal th	Fi nanci a	l Systems	
	MENTO TO		

COMMUNITY HEALTH NETWORK INC

ADJUSTM	ENTS TO EXPENSES				eriod: rom 01/01/2020	Worksheet A-8	3
				T		Date/Time Pre 8/2/2021 3:24	
				Expense Classification on		0/2/2021 3.24	
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
33. 01	Space Rental Income	В	-482, 230	OPERATION OF PLANT	7.00	(
	Investment Income	В		ADMI NI STRATI VE & GENERAL	5.00		
	Misc Revenue Misc Revenue	B B		EMPLOYEE BENEFITS DEPARTMENT	4.00 5.00		
	Mi sc Revenue	B		OPERATION OF PLANT	7.00		
1	Misc Revenue	В		DI ETARY	10.00		33. (
	Misc Revenue	В		PHARMACY	15.00		
33. 08	Misc Revenue	В	-3,000	I &R SERVICES-OTHER PRGM COSTS APPRVD	22.00	(33.0
3. 09	Misc Revenue	В	-135, 709	RADI OLOGY-DI AGNOSTI C	54.00	0	33. (
	Misc Revenue	В		CARDIAC CATHETERIZATION	59.00		
	Misc Revenue	В		PHYSICAL THERAPY	66.00		
-	Misc Revenue Misc Revenue	B		ELECTROCARDI OLOGY	69.00 76.01		
55. IS I	WISC Revenue	D	-1,090,214	SERVICES	70.01		53.
33. 14	Misc Revenue	В	-50, 299	ONCOLOGY-CANCER CARE CENTER	76.05	(33.
1	Misc Revenue	В		I MAGI NG CENTERS	76.06		
1	Misc Revenue	В		CARDI AC REHABI LI TATI ON	76.97	(
1	Misc Revenue HAF Tax Offset	B A		KNEE CENTER	90.07 5.00		
1	Loss on Assets	A		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5.00		
	Loss on Assets	A		PSYCHI ATRI C/PSYCHOLOGI CAL	76.01		
4.03	Sponsorshi p	А	-2.389	SERVI CES ADMI NI STRATI VE & GENERAL	5.00		34.
	Sponsorshi p	A		ADULTS & PEDIATRICS	30.00		
	Sponsorshi p	A		PHYSICAL THERAPY	66.00		
4.06	Sponsorshi p	A	-821	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	76.01	(34.0
84.07	Sponsorshi p	A	-5, 725	ONCOLOGY-CANCER CARE CENTER	76.05	0	34. (
	APP	A		ADULTS & PEDIATRICS	30.00	(
	APP	A		OPERATING ROOM	50.00		
	APP APP	A A		HEALTHY HEARTS CENTER	90. 02 90. 07		
	Bad Debt	A		ADMINI STRATI VE & GENERAL	5.00		
	Bad Debt	A	-389	PHARMACY	15.00		35.
5.02	Bad Debt	A	-220, 498	I &R SERVICES-OTHER PRGM COSTS APPRVD	22.00	(35.
35. 03 I	Bad Debt	А	-435, 378	ADULTS & PEDIATRICS	30.00	0	35.
35. 04 E	Bad Debt	A		OPERATING ROOM	50.00	(35.
1	Bad Debt	A		INTRAVENOUS THERAPY	64.00		
	Bad Debt Bad Debt	A A		PHYSI CAL THERAPY PSYCHI ATRI C/PSYCHOLOGI CAL	66. 00 76. 01		
55.07		A	-1,030,931	SERVICES	70.01		35.
5. 08 I	Bad Debt	A	-5,347	LUTHERWOOD PARTNERSHIP	76.03	(35.
1	Bad Debt	A		HEALTHY HEARTS CENTER	90.02		
1	Bad Debt Bad Debt	A A		2 KNEE CENTER 3 EMERGENCY	90.07 91.00		
	CARDIAC CATH SHAREDSERVICES	A		CARDIAC CATHETERIZATION	59.00		
36. 01	TELEMERTY SHARED SERVICES TRUE			ELECTROCARDI OLOGY	69.00		
	UP Non Allow Marketing Expense	А	_ 160 700		5.00		36. (
1	Non Allow Marketing Expense Pavillions	A		DADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5.00		
1	Meals on Wheels Cost	A		CAFETERI A	11.00		
1	Debt Issuance Expense	A		ADMINISTRATIVE & GENERAL	5.00	0	1
1	LOC Non-Allow Interest Expense			CAP REL COSTS-BLDG & FIXT	1.00		
	12A Non-Allow Interest Expense			ICAP REL COSTS-BLDG & FIXT	1.00		
	12B Non-Allow Interest Expense 50 BMO Loan Non- Allow	A A		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT	1.00 1.00		
	Interest Expense 12B Non-Allow Interest Expense	А	-552 507	CAP REL COSTS-BLDG & FIXT	1.00	11	1 36.
1	00 Non-Allow Interest Expense	A		CAP REL COSTS-BEDG & FIXT	1.00		
	00 Non-Allow Interest Expense	A	-1, 245, 207	CAP REL COSTS-BLDG & FIXT	1.00		
	Gallahue Professional Fee	А		PSYCHI ATRI C/PSYCHOLOGI CAL	76. 01	0	36.
36. 14	Gallahue Professional Fee	А	-9, 537, 757	SERVICES	76.03		36.
36. 15	OB Laborist Loss	А	-881, 480	DELIVERY ROOM & LABOR ROOM	52.00	() 36. ⁻
6.16 I	Anderson Cancer Center	A	-16 055 643	ONCOLOGY-CANCER CARE CENTER	76.05) 36. '

Heal th	Financial Systems	СО	MMUNITY HEALTH	NETWORK, INC.	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2020 To 12/31/2020		pared: _pm
				Expense Classification c	n Worksheet A		
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
50.00	TOTAL (sum of lines 1 thru 49)		-123, 359, 235				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).

(2) basis for adjustment (see first detroits).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	COMMUNI TY HEALT	H NETWORK, INC.	In Lie	eu of Form CMS-	2552-10
STATEMENT OF COSTS OF SERVICES FROM OFFICE COSTS		RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-0074	Period: From 01/01/2020 To 12/31/2020		pared:
	Li ne No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	IENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANIZATIONS OR	CLAI MED	
1.00	21.00	I&R SERVICES-SALARY & FRINGE	INTERNS & RESIDENTS	3, 841, 739	5, 249, 083	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM COST	INTERNS & RESIDENTS	5, 697, 349	7, 784, 458	2.00
3.00	7.00	OPERATION OF PLANT	1400 N RITTER	185, 243	143, 466	3.00
3.01	15.00	PHARMACY	1400 N RITTER	108, 462	84, 001	3. 01
3.02	60.00	LABORATORY	1400 N RITTER	68, 709	53, 213	3. 02
3.03	70.00	ELECTROENCEPHALOGRAPHY	1400 N RITTER	60, 528	46, 878	3.03
3.04	76.05	ONCOLOGY-CANCER CARE CENTER	1400 N RITTER	198, 011	153, 354	3.04
3.05	76.01	PSYCHIATRIC/PSYCHOLOGICAL SE	7250 CLEARVI STA	30, 650	20, 447	3.05
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	9, 997, 703	0	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	5, 701, 219	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	89, 324, 796	110, 184, 430	4.02
4.03	7.00	OPERATION OF PLANT	HOME OFFICE	1, 694, 052	0	4.03
4.04	13.00	NURSING ADMINISTRATION	HOME OFFICE	4, 522, 728	0	4.04
4.05	14.00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	10, 962, 673	0	4.05
4.06	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	4, 461, 363	0	4.06
4.07	30.00	ADULTS & PEDIATRICS	HOME OFFICE	241, 887	0	4.07
4.08	54.00	RADI OLOGY-DI AGNOSTI C	HOME OFFICE	127, 710	0	4.08
4.09	73.00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	1, 695, 526	0	4.09
4.10	76.05	ONCOLOGY-CANCER CARE CENTER	HOME OFFICE	0	34, 443	4.10
4.11	91.00	EMERGENCY	HOME OFFICE	232, 028	0	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	68, 806	0	4.12
4.13	91.00	EMERGENCY	CPN ED ON-CALL	2, 571, 554	0	4.13
5.00	TOTALS (sum of lines 1-4).			141, 792, 736	123, 753, 773	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	
					1
					1
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownership	1
1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELA	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	В	CHNW	100.00	C	. 00	6.00
7.00			0.00	C	. 00	7.00
8.00			0.00	C	. 00	8.00
9.00			0.00	C	. 00	9.00
10.00			0.00	C	. 00	10.00
100.00	G. Other (financial or				1	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.

Health Financial Systems COMMUNITY HEALTH NETWORK, INC.			In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM I OFFICE COSTS	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0074	Period: From 01/01/2020	Worksheet A-8-1
			To 12/31/2020	Date/Time Prepared:

			8	/2/2021 3:24 pm
		Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
		RED AND ADJUSTMENTS REQUIRED AS A RESULT OF TR	ANSACTIONS WITH RELATED ORGANIZATIONS OR CLA	AI MED
	HOME OFFICE CO			
1.00	-1, 407, 344	0		1.00
2.00	-2, 087, 109	0		2.00
3.00	41, 777	0		3.00
3.01	24, 461	0		3.01
3.02	15, 496			3. 02
3.03	13, 650	0		3. 03
3.04	44, 657	0		3.04
3.05	10, 203	0		3.05
4.00	9, 997, 703	9		4.00
4.01	5, 701, 219	0		4. 01
4.02	-20, 859, 634	0		4. 02
4.03	1, 694, 052	0		4.03
4.04	4, 522, 728	0		4.04
4.05	10, 962, 673	0		4.05
4.06	4, 461, 363	0		4.06
4.07	241, 887	0		4.07
4.08	127, 710	0		4.08
4.09	1, 695, 526	0		4.09
4.10	-34, 443	0		4.10
4.11	232, 028	0		4. 11
4.12	68, 806	0		4. 12
4.13	2, 571, 554	0		4. 13
5.00	18, 038, 963			5.00

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

nus not	been posted to norkaneet A,	conditions in and/or 2, the allocate another should be that eated the condition 4 of this	pur t.
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00 7.00 8.00 9.00 10.00 100.00		6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00	10	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.

Heal th	Fi nanci a	I Systems	
DDOUUD		DUNCL OF AN	

COMMUNITY HEALTH NETWORK, INC. In Lieu of Form CMS-2552-10

	R BASED PHYSIC			Provider C	CCN: 15-0074	Period:	Worksheet A-8	
						rom 01/01/2020		
						Го 12/31/2020	Date/Time Pre 8/2/2021 3:24	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	pin
		I denti fi er	Remuneration	Component	Component		ider Component	
					•		Hours	
	1.00	2.00	3.00	4.00	5.00	6. 00	7.00	
1.00		ADMINISTRATIVE & GENERAL	675, 976	395, 910			864	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM	9, 200	9, 200	0	0	0	2.00
		COSTS APPRVD						
3.00		ADULTS & PEDIATRICS	261, 305	261, 305		0	0	3.00
4.00	0.00		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	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		046 401	U		0	0	10.00
200.00	Wkot Alipo #	Cost Costos (Dhusi si on	946, 481	666, 415	280,066 Cost of		864 Physician Cost	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	Unadjusted RCE			of Malpractice	
		rdentifier			Continuing	Share of col.	Insurance	
					Education	12	r nou ance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADMINISTRATIVE & GENERAL	87, 854	4, 393	0		0	1.00
2.00		I&R SERVICES-OTHER PRGM	0	0	0	0	0	2.00
		COSTS APPRVD						
3.00		ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			87, 854	4, 393		-	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l 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		ADMI NI STRATI VE & GENERAL	0	87, 854	192, 212	588, 122		1.00
2.00		I &R SERVICES-OTHER PRGM	0					2.00
2.00	22.00	COSTS APPRVD		0	0	7,200		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	261, 305		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0		0	0		9.00
10.00	0.00		0		0	0		10.00
200.00			0	87, 854	192, 212	858, 627		200.00

	Financial Systems C ALLOCATION - GENERAL SERVICE COSTS	OMMUNITY HEALTH	Provi der CO		eriod:	u of Form CMS-2 Worksheet B	2002 10
					rom 01/01/2020 o 12/31/2020	Part I Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		8/2/2021 3:24	pm
	Cost Conton Deparintion	Not Experses				Subtatal	
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
		0	1.00	2.00	4.00	4A	
1 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	22,425,104	22 425 104				1.00
1.00 2.00	00200 CAP REL COSTS-BEDG & FIXT	22, 425, 106 35, 569, 829		35, 569, 829			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	6, 389, 547		24, 648	6, 624, 752		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	108, 366, 391	976, 376		642, 993	123, 118, 308	5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	13, 999, 279 1, 315, 400		299, 306	94, 065 0	17, 302, 521 1, 315, 400	7.00 8.00
9.00	00900 HOUSEKEEPING	5, 233, 675		35, 661	101, 092	5, 693, 215	
10.00	01000 DI ETARY	1, 418, 228		23, 658	20, 535	1, 719, 110	
11.00 13.00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	2, 121, 038 7, 462, 062		177, 997 39, 347	56, 971 68, 623	3, 033, 723 7, 777, 757	11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	10, 727, 558				13, 154, 367	
	01500 PHARMACY	10, 398, 881	239, 131	787, 669	220, 257	11, 645, 938	
16.00	01600 MEDI CAL RECORDS & LI BRARY	5, 795, 855	46, 841	0	20, 891	5, 863, 587	16.00
17.00 21.00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD	2, 224, 262 3, 841, 739		160 2, 248	56, 943 131, 322	2, 303, 851 3, 975, 309	17.00 21.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	5, 688, 149		70, 701	196, 608	6, 075, 958	
	02300 EMS TRAINING-ALLIED HEALTH	0	0	0	0	0	23.00
23. 01 23. 02	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 02302 PHARMACY RESI DENCY-ALLI ED HEALTH	0	0		0	0	23.01 23.02
23.02	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	0	0	0	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	53, 964, 064 12, 808, 930		1, 004, 052 915, 846		59, 193, 139 15, 791, 402	
32.00	03200 CORONARY CARE UNIT	12, 808, 930	1,700,721	915, 840	299,905	13, 791, 402	32.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	1, 620, 112	76, 123	31, 071	36, 770	1, 764, 076	
43.00	04300 NURSERY	710, 663	163, 376	70, 857	15, 481	960, 377	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	16, 499, 017	2, 905, 170	1, 868, 280	252, 495	21, 524, 962	50.00
51.00	05100 RECOVERY ROOM	747, 578		117, 829	18, 130	1, 124, 735	
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 119, 850		263, 492	72, 367	4, 063, 194	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	4, 030, 556 1, 065, 527	784, 539 11, 979	735, 509 28, 947	86, 368 19, 937	5, 636, 972 1, 126, 390	
57.00	05700 CT SCAN	2, 980, 784	37, 807	674, 619	54, 261	3, 747, 471	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	722, 402		722, 171	15, 384	1, 460, 750	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	5, 880, 025 14, 334, 444	416, 639 122, 171	770, 301 109, 493	99, 014 0	7, 165, 979 14, 566, 108	
	06400 I NTRAVENOUS THERAPY	1, 706, 846		5, 219	-	1, 741, 835	1
	06500 RESPI RATORY THERAPY	4, 590, 308			110, 786	4, 825, 378	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	5, 168, 315 1, 875, 427	306, 022 94, 814	1, 203, 909 17, 579	133, 167 41, 499	6, 811, 413 2, 029, 319	
	06800 SPEECH PATHOLOGY	783, 599				2, 029, 319 847, 902	
	06900 ELECTROCARDI OLOGY	2, 825, 859	17, 615	501, 723	78, 240	3, 423, 437	69.00
	07000 ELECTROENCEPHALOGRAPHY	766, 917		152, 143		935, 545	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	23, 398, 728 25, 685, 689			0	23, 398, 728 25, 685, 689	
73.00	07300 DRUGS CHARGED TO PATIENTS	125, 355, 683		0	0	125, 355, 683	
74.00	07400 RENAL DI ALYSI S	1, 721, 255		0	0	1, 728, 958	
76.00 76.01	03330 ENDOSCOPY 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	581, 150		154, 208 1, 879, 888	11, 763 917, 484	747, 121 9, 365, 158	
	03951 LUTHERWOOD PARTNERSHI P	4, 536, 261	0	139, 105	263, 376	4, 938, 742	
76.04	03952 WOUND CARE CENTER	2, 452, 797	140, 267	5, 888	24, 021	2, 622, 973	76.04
	03480 ONCOLOGY-CANCER CARE CENTER 03953 I MAGI NG CENTERS	30, 823, 075				37, 642, 717	
76.06 76.07	03953 I MAGING CENTERS 03954 BREAST DI AGNOSTI C CENTER	5, 323, 251 2, 077, 899		1, 473, 012 49, 349	96, 827 0	6, 981, 844 2, 287, 254	
76. 97	07697 CARDI AC REHABI LI TATI ON	853, 442	179, 433	161, 602	20, 783	1, 215, 260	76.97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	420, 106	25, 941	1, 089	3, 652	450, 788	76. 98
88. 00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	o o	0	
		0	0	0	0	0	90.00
90. 01 90. 02	04950 DI ABETI C CARE CENTER 04951 HEALTHY HEARTS CENTER	0 1, 075, 481	0 93, 172	0 165, 735	0 51, 613	0 1, 386, 001	90.01 90.02
90. 02 90. 03	09001 CLINIC	0	0	00,730	0	1, 380, 001	90.02
90. 04	04953 SPI NE CENTER	0	0	0	0	0	90.04
90.05	04954 I NFUSI ON CENTERS 09002 MEDCHECK CLINICS	448, 985	0	245, 757	9, 684	704, 426 0	90.05 90.06
				ı 0		()	
90.06 90.07	09003 KNEE CENTER	3, 842, 316	424, 795	22, 168	61, 705	4, 350, 984	•

J	MMUNITY HEALTH				u of Form CMS-2	2552-1
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	Period: From 01/01/2020 Fo 12/31/2020	Worksheet B Part I Date/Time Pre 8/2/2021 3:24	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
90.10 09006 WORK SITE CLINICS 90.12 04961 FAMILY PRACTICE AND MATERNITY CARE 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 17, 014, 012	0 0 1, 624, 726	((389, 127	0	0 0 19, 304, 464 0	90.10 90.12 91.00 92.00
OTHER REIMBURSABLE COST CENTERS		· · · · · · · · · · · · · · · · · · ·				
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	(0 0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	631, 356, 138	22, 267, 592	34, 389, 023	6, 493, 152	629, 886, 218	118.00
NONREI MBURSABLE COST CENTERS				· · · · · ·		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0		190.00
191. 00 19100 RESEARCH	0	0	(0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	231	0		192.00
194. 00 07950 HOME OFFI CE	0	0	(0 0		194.00
194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS	0	0	(0 0		194.0
194. 02 07952 ACCOUNTABLE CARE	565, 043	0	(13, 728	578, 771	
194. 03 07953 SCHOOL BASED CLINICS 194. 04 07954 SMO-NON PROVIDER BASED	204, 372	0	(0 1, 365 0 14, 224	205, 737 613, 321	
194. 04 07955 FAMILY PRACTICE MEDICINE	599, 097 3, 566, 135	0	1, 069, 732		4, 712, 529	•
194. 07 07 955 FAMILE PRACTICE MEDICINE	3, 300, 133	0	1,009,732			194.0
194. 08 07958 GROUP HOMES AND MISC. N R CTRS	1, 160, 003	157, 514	110, 843		1, 453, 981	
194. 09 07959 SURGERY CENTER EAST	1, 100, 003	137, 314	110, 04			194.00
200.00 Cross Foot Adjustments	0	0				200.00
201.00 Negative Cost Centers		0	(201.00
202.00 TOTAL (sum lines 118 through 201)	637, 450, 788	22, 425, 106	35, 569, 829	6, 624, 752	637, 450, 788	

OST ALL	OCATION - GENERAL SERVICE COSTS		Provider C	F	eriod: rom 01/01/2020 o 12/31/2020	Worksheet B Part I Date/Time Pre 8/2/2021 3:24	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT	LAUNDRY & LI NEN SERVI CE	HOUSEKEEPI NG	DI ETARY	
GE	ENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
00 00	0100 CAP REL COSTS-BLDG & FIXT						1.0
	0200 CAP REL COSTS-MVBLE EQUIP						2.0
	0400 EMPLOYEE BENEFITS DEPARTMENT	100 110 000					4.0
	0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT	123, 118, 308 4, 141, 791	21, 444, 312				5.0
	0800 LAUNDRY & LINEN SERVICE	314, 874	21, 444, 312				8.0
	0900 HOUSEKEEPI NG	1, 362, 813	377, 665				9.0
D. 00 0'	1000 DI ETARY	411, 512	300, 329	0	105, 976	2, 536, 927	10.0
	1100 CAFETERIA	726, 197	792, 937			0	
		1, 861, 801	243, 040			0	
	1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY	3, 148, 827 2, 787, 746	531, 607 279, 786			0	
	1600 MEDICAL RECORDS & LIBRARY	1, 403, 596	54, 804		- 1	0	
	1700 SOCIAL SERVICE	551, 484	26, 309			0	
	2100 I &R SERVICES-SALARY & FRINGES APPRVD	951, 590	0	0		0	21.0
	2200 I & R SERVI CES-OTHER PRGM COSTS APPRVD	1, 454, 432	140, 986	0	49, 749	0	1
	2300 EMS TRAINING-ALLIED HEALTH 2301 RADIOLOGY SCHOOL-ALLIED HEALTH	0	0	0	0	0	
	2302 PHARMACY RESIDENCY-ALLIED HEALTH	0	0		Ű	0	
	2303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0			0	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	14, 169, 358	3, 495, 465				
	3100 INTENSIVE CARE UNIT	3, 780, 067	2,067,082			380, 783	
	3200 CORONARY CARE UNIT 2060 NEONATAL INTENSIVE CARE UNIT	0 422, 276	0 89, 065	0	0 31, 428	0	
	4300 NURSERY	229, 890	191, 152			0	
	NCILLARY SERVICE COST CENTERS		•	· ·			
	5000 OPERATING ROOM	5, 152, 538	3, 399, 081				
	5100 RECOVERY ROOM	269, 233	282, 205			0	
	5200 DELIVERY ROOM & LABOR ROOM 5400 RADIOLOGY-DIAGNOSTIC	972, 627 1, 349, 350	710, 764 917, 919			0	
	5500 RADI OLOGY-THERAPEUTI C	269, 630	14, 016			0	
	5700 CT SCAN	897, 051	44, 234			0	
	5800 MAGNETIC RESONANCE IMAGING (MRI)	349, 667	928		-	0	
	5900 CARDI AC CATHETERI ZATI ON	1, 715, 356	487, 472			0	
	6000 LABORATORY 6400 I NTRAVENOUS THERAPY	3, 486, 762 416, 952	142, 941 11, 630			0 711	
	6500 RESPI RATORY THERAPY	1, 155, 075	32, 273			0	
	6600 PHYSI CAL THERAPY	1, 630, 482	358, 049			0	
	6700 OCCUPATI ONAL THERAPY	485, 768	110, 934			0	
	6800 SPEECH PATHOLOGY	202, 967	46, 355			0	
	6900 ELECTROCARDI OLOGY 7000 ELECTROENCEPHALOGRAPHY	819, 485 223, 946	20, 610 0				
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 601, 071	0	0	0	0	
	7200 I MPL. DEV. CHARGED TO PATIENTS	6, 148, 512	0	0	0	0	
	7300 DRUGS CHARGED TO PATIENTS	30, 006, 988	0	0	0	0	
	7400 RENAL DI ALYSI S	413, 869	9, 013		3, 180	0	
	3330 ENDOSCOPY 3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	178, 842 2, 241, 785	0	5, 178	0	0	
	3951 LUTHERWOOD PARTNERSHIP	1, 182, 211	0	0	0	0	1
	3952 WOUND CARE CENTER	627, 874	164, 114	24, 892	57, 910	0	76.0
	3480 ONCOLOGY-CANCER CARE CENTER	9, 010, 725	2, 878, 939				1
	3953 I MAGI NG CENTERS	1, 671, 279	103, 843		36, 643	0	
	3954 BREAST DI AGNOSTI C CENTER 7697 CARDI AC REHABI LI TATI ON	547, 511 290, 903	187, 209 209, 939		66, 060 74, 080	0	
	7698 HYPERBARI C OXYGEN THERAPY	107, 907	30, 351			0	
	UTPATIENT SERVICE COST CENTERS			-			
	8800 RURAL HEALTH CLINIC	0	0	0	0	0	
	8900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
	9000 CLINIC	0	0		0	0	
	4950 DI ABETI C CARE CENTER 4951 HEALTHY HEARTS CENTER	331, 774	0 109, 012	33, 830	38, 467	0	
	9001 CLINIC	0	0	00,000	0	0	
	4953 SPI NE CENTER	0	0	0	0	0	90.0
1	4954 INFUSION CENTERS	168, 622	0	0	0	0	
	9002 MEDCHECK CLINICS	0	0	0	0	0	
	9003 KNEE CENTER 9004 PALLI ATI VE CARE	1, 041, 517	497, 014		175, 379	0	
	9004 PALLIATIVE CARE 9006 WORK SITE CLINICS	0	0		0	0	1
	4961 FAMILY PRACTICE AND MATERNITY CARE	0	0	0	0	0	
	9100 EMERGENCY	4, 621, 006	1, 900, 947	288, 237	670, 779	-	91.
	9200 OBSERVATION BEDS (NON-DISTINCT PART)			1	1		92.

Health Financial Systems CC	MMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		eri od:	Worksheet B	
				rom 01/01/2020	Part I	
			1	o 12/31/2020	Date/Time Pre 8/2/2021 3:24	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL		LINEN SERVICE			
	5.00	7.00	8.00	9.00	10.00	
OTHER REIMBURSABLE COST CENTERS						
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS			_			
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	121, 307, 539	21, 260, 019	1, 630, 274	7, 368, 662	2, 536, 927	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	55	0	0	0		192.00
194. 00 07950 HOME OFFICE	0	0	0	0		194.00
194.01079510CCUPATIONAL HEALTH ONSITE SVCS	0	0	0	0		194.01
194.0207952ACCOUNTABLE CARE	138, 543	0	0	0		194. 02
194. 03 07953 SCHOOL BASED CLINICS	49, 248	0	0	0		194. 03
194.04 07954 SMO-NON PROVIDER BASED	146, 814	0	0	0		194.04
194.0507955 FAMILY PRACTICE MEDICINE	1, 128, 062	0	0	0		194.05
194. 07 07957 LI FECHECK	0	0	0	0		194. 07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	348, 047	184, 293	0	65, 031		194.08
194.09 07959 SURGERY CENTER EAST	0	0	0	0	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	123, 118, 308	21, 444, 312	1, 630, 274	7, 433, 693	2, 536, 927	202.00

	ALLOCATION - GENERAL SERVICE COSTS	OMMUNITY HEALTH	Provider CC		eriod: rom 01/01/2020	Worksheet B Part I	
				To		Date/Time Pre 8/2/2021 3:24	pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	
		11.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 01\\ 23.\ 02\\ 02\\ 23.\ 02\\ 02\\ 02\\ 02\\ 02\\ 02\\ 02\\ 02\\ 02\\ 02\\$	00100CAPRELCOSTS-BLDG& FIXT00200CAPRELCOSTS-MVBLEEQUI P00400EMPLOYEEBENEFI TSDEPARTMENT00500ADMI NI STRATI VE& GENERAL00700OPERATI ON OFPLANT00800LAUNDRY& LI NEN00900HOUSEKEEPI NG01000DI ETARY01100CAFETERI A01300NURSI NGADMI NI STRATI ON01400CENTRALSERVI CES01600MEDI CALRECORDS& LI BRARY01700SOCI ALSERVI CESSALARY01700SOCI ALSERVI CES-SALARY& FRI NGES02100I & RSERVI CES-OTHERPRGM COSTS02300EMSTRAI NI NG-ALLI EDHEALTH02302PHARMACYRESI DENCY-ALLI EDHEALTH	4, 832, 657 91, 075 22, 769 224, 841 22, 769 62, 614 0 273, 224 0 0 0 0 0	10, 059, 433 0 0 0 0 0 0 0 0 0 0 0 0 0	17, 045, 156 0 12 115 0 2, 103 0 0 0	15, 037, 038 0 0 0 0 0 0 0 0 0 0 0	7, 364, 106 0 0 0 0 0 0 0 0	17.00 21.00 22.00 23.00 23.01 23.02
23. 03	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	0	0	0	23.03
30. 00 31. 00 32. 00 35. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY	1, 306, 351 341, 531 0 45, 537 19, 923	1, 442, 213 0 0	175, 905 79, 793 0 7, 321 4, 181	0 0 0 0 0	491, 658 155, 619 0 44, 745 6, 891	31.00 32.00
50 00		202 147	1 227 900	1 202 002	0	415 410	50.00
$\begin{array}{c} 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 76.\ 01\\ 76.\ 03\\ 76.\ 04\\ 76.\ 05\\ 76.\ 06\\ 76.\ 07\\ \end{array}$	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06900 CARDIAC CATHETERIZATION 06400 INTRAVENOUS THERAPY 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 PHYSICAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 03330 ENDOSCOPY 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 033951 LUTHERWOOD PARTNERSHIP 03952 WOUND CARE CENTER 03480 ONCOLOGY-CANCER CARE CENTER 03953 IMAGING CENTERS 03954 BREAST DIAGNOSTIC CENTER 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 0UTPATIENT SERVICE COST CENTERS	293, 147 17, 077 68, 306 59, 768 22, 769 91, 075 14, 230 102, 459 0 28, 461 119, 536 71, 152 42, 691 17, 077 113, 844 19, 923 0 0 0 11, 384 147, 997 0 31, 307 5, 692 0 0 0 0 0 0 0 0 0 0 0 0 0		1, 302, 883 2, 282 15, 571 776 20, 716 5, 722 20 1, 514, 131 246, 664 1, 057 16, 774 10, 716 2, 191 915 9, 184 6, 240 2, 114, 496 0 11, 174, 884 335 5, 120 14, 387 31, 917 19, 026 118, 398 10, 362 0 1, 636 2, 544	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	415, 410 34, 021 25, 625 138, 168 58, 909 233, 695 34, 962 622, 542 436, 975 6, 458 82, 493 47, 001 15, 037 6, 284 139, 887 16, 416 193, 530 219, 213 2, 409, 304 19, 704 12, 034 65, 257 3, 618 34, 590 589, 550 161, 398 13, 541 7, 267 6, 638	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 52.\ 00\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 60.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 67.\ 00\\ 67.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 74.\ 00\\ 76.\ 01\\ 76.\ 03\\ 76.\ 05\\ 76.\ 06\\ 76.\ 07\\ 76.\ 97\\ \end{array}$
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 04950 DIABETIC CARE CENTER 04951 HEALTHY HEARTS CENTER 09001 CLINIC 04953 SPINE CENTER 04954 INFUSION CENTERS 09002 MEDCHECK CLINICS 09003 KNEE CENTER 09004 PALLIATIVE CARE 09004 VORK SITE CLINICS 04961 FAMILY PRACTICE AND MATERNITY CARE	0 0 59, 768 0 0 99, 613 0 99, 613 0 352, 915		0 0 0 4,077 0 2,725 0 0 0 112,431		0 0 0 8, 588 0 0 5, 746 0 12, 135 211 0 0 588, 986	89.00 90.00 90.01 90.02 90.03 90.04 90.05 90.06 90.07 90.08 90.10 90.12

Health Financial Systems CC	MMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Prep 8/2/2021 3:24	
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
OTHER REIMBURSABLE COST CENTERS						
98.00 09850 OTHER REIMBURSABLE COST CENTERS	C	0		0 0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	4, 832, 657	10, 059, 433	17, 037, 48	7 15, 037, 038	7, 364, 106	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0		0 0	0	190. 00
191. 00 19100 RESEARCH	C	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	C	0		0 0	0	192.00
194.0007950 HOME OFFICE	C	0		0 0	0	194.00
194.01079510CCUPATIONAL HEALTH ONSITE SVCS	C	0		0 0	0	194.01
194.0207952ACCOUNTABLE CARE	C	0	9	9 0	0	194.02
194. 03 07953 SCHOOL BASED CLINICS	C	0	84	5 0	0	194.03
194.0407954SMO-NON PROVIDER BASED	C	0		0 0	0	194.04
194.0507955 FAMILY PRACTICE MEDICINE	C	0	3	6 0	0	194.05
194. 07 07957 LI FECHECK	C	0		0 0	0	194.07
194.0807958GROUP HOMES AND MISC. N_R CTRS	C	0	6, 68	9 0	0	194.08
194.0907959 SURGERY CENTER EAST	C	0		0 0	0	194.09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	C	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	4, 832, 657	10, 059, 433	17, 045, 15	6 15, 037, 038	7, 364, 106	202.00

ST A	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	COMMUNI TY HEALTH	Provider C	CN: 15-0074 F	Period:	u of Form CMS-2 Worksheet B	2002
017				F	rom 01/01/2020 o 12/31/2020	Part I Date/Time Pre	pared
			INTERNS &	RESI DENTS		8/2/2021 3:24	
			THTERNS &	KEST DENTS			
	Cost Center Description	SOCI AL SERVI CES	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	EMS TRAI NI NG-ALLI E	RADI OLOGY	
			T & FRINGES	PRGW CUSTS	D HEALTH	HEALTH	
		17.00	21.00	22.00	23.00	23.01	
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.0
00	00200 CAP REL COSTS-MUBLE EQUIP						2.0
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. (
00	00500 ADMINI STRATI VE & GENERAL						5.0
)0)0	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 8.
0	00900 HOUSEKEEPING						9.
00	01000 DI ETARY						10.
00							11.
00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13. 14.
00							15.
00							16.
00 00	01700 SOCIAL SERVICE	2, 953, 656	4 004 000				17. 21.
00	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM COSTS APPRVD	0	4, 926, 899	7, 996, 452			21.
00		0			0		23.
01	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH	0				0	23.
02 03	02302 PHARMACY RESIDENCY-ALLIED HEALTH 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0					23. 23.
05	INPATIENT ROUTINE SERVICE COST CENTERS	0					23.
00	03000 ADULTS & PEDI ATRI CS	2, 400, 826	2, 290, 611	3, 717, 706		0	30.
00	03100 I NTENSI VE CARE UNI T	423, 345	20, 947	33, 998		0	31.
00	03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	0 71, 669	0 28, 721	46, 616		0	32. 35.
00	04300 NURSERY	57, 816	20, 721	C	-	0	43.
	ANCI LLARY SERVI CE COST CENTERS						
00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	184, 297 0	299, 118 C		0	50. 51.
00	05200 DELIVERY ROOM & LABOR ROOM	0	0		-	0	51.
00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.
00	05500 RADI OLOGY-THERAPEUTI C	0	0	C	, i i i i i i i i i i i i i i i i i i i	0	55.
00 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			0	57. 58.
00	05900 CARDI AC CATHETERI ZATI ON	0	0		-	0	59.
00	06000 LABORATORY	0	0	C	0	0	60.
00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0		0	0	64. 65.
00	06600 PHYSI CAL THERAPY	0	0		-	0	66.
00		0	0	C	0	0	67.
	06800 SPEECH PATHOLOGY	0	0	C	0	0	68.
00		0	54, 454	88, 379	0	0	69. 70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	70.
00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72.
	07300 DRUGS CHARGED TO PATIENTS	0	94, 245			0	73.
	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	0	0			0	74. 76.
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	265, 370	430, 700	0	0	76.
	03951 LUTHERWOOD PARTNERSHI P	0	0	C	0 0	0	76.
	03952 WOUND CARE CENTER	0	17, 651	28, 648	0	0	76.
05	03480 ONCOLOGY-CANCER CARE CENTER 03953 I MAGI NG CENTERS	0	0			0	76. 76.
	03954 BREAST DI AGNOSTI C CENTER	0	0		0	0	76.
97	07697 CARDI AC REHABI LI TATI ON	0	0	c c	0	0	76.
98	07698 HYPERBARI C OXYGEN THERAPY	0	0	C	0 0	0	76.
00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	88.
00		0	0	c	o o	0	89.
	09000 CLINIC	0	0	C	0	0	90.
)1)2	04950 DI ABETI C CARE CENTER 04951 HEALTHY HEARTS CENTER	0	0			0	90. 90.
	09001 CLINIC	0	0			0	90. 90.
04	04953 SPI NE CENTER	0	0	c	o o	0	90.
	04954 INFUSION CENTERS	0	0	C	0	0	90.
06 07		0	0 100 TC		0	0	90. 90.
07	09003 KNEE CENTER 09004 PALLIATIVE CARE	0	27, 824 0	45, 158 C		0	90. 90.
10		0	0	C	0	0	90.
	04961 FAMILY PRACTICE AND MATERNITY CARE		0		0 0	0	

Health Financial Systems C	OMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 01/01/2020 o 12/31/2020		pared:
Cost Center Description	SOCI AL SERVI CE	Y & FRINGES	SERVICES-OTHER PRGM COSTS	TRAI NI NG-ALLI E D HEALTH	RADI OLOGY SCHOOL-ALLI ED HEALTH	
	17.00	21.00	22.00	23.00	23.01	
91. 00 09100 EMERGENCY	0	149, 225	242, 194	0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REI MBURSABLE COST CENTERS	TT			1		
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0	98.00
SPECIAL PURPOSE COST CENTERS				1		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 953, 656	3, 133, 345	5, 085, 479	0	0	118.00
NONREI MBURSABLE COST CENTERS	· · · · · ·					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
191. 00 19100 RESEARCH	0	0	C	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0		192.00
194.0007950 HOME OFFICE	0	0	C	0		194.00
194.01079510CCUPATIONAL HEALTH ONSITE SVCS	0	0	C	0		194. 01
194.0207952 ACCOUNTABLE CARE	0	0	C	0		194. 02
194.0307953 SCHOOL BASED CLINICS	0	36, 496	59, 234	0		194. 03
194.0407954SMO-NON PROVIDER BASED	0	0	C	0	0	194.04
194.0507955 FAMILY PRACTICE MEDICINE	0	1, 720, 858	2, 792, 985	0	0	194.05
194. 07 07957 LI FECHECK	0	0	C	0	0	194.07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	0	36, 200	58, 754	0	0	194.08
194.0907959 SURGERY CENTER EAST	0	0	C	0	0	194.09
200.00 Cross Foot Adjustments		0	C	0	0	200.00
201.00 Negative Cost Centers	0	0	C	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	2, 953, 656	4, 926, 899	7, 996, 452	0	0	202.00

ST AL	LOCATION - GENERAL SERVICE COSTS		Provider (Period:	Worksheet B	
					From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	
	Cost Center Description	PHARMACY	PHARMACY	Subtotal	Intern &	8/2/2021 3:24 Total	pm
		RESI DENCY-ALLI			Residents Cost	Total	
		ED HEALTH	ALLI ED HEALTH	1	& Post		
					Stepdown		
		23.02	23.03	24.00	Adjustments 25.00	26.00	
	GENERAL SERVICE COST CENTERS	1		1			
	00100 CAP REL COSTS-BLDG & FIXT						1.0
	00200 CAP REL COSTS-MVBLE EQUIP						2.0
	DO400 EMPLOYEE BENEFITS DEPARTMENT						4.0
	DO5OO ADMINISTRATIVE & GENERAL DO7OO OPERATION OF PLANT						5.0
	DO800 LAUNDRY & LINEN SERVICE						8.0
	DO900 HOUSEKEEPING						9.1
	D1000 DI ETARY						10.
00 0	D1100 CAFETERI A						11.
00 0	01300 NURSI NG ADMI NI STRATI ON						13.
	01400 CENTRAL SERVICES & SUPPLY						14.
	D1500 PHARMACY						15.
	01600 MEDICAL RECORDS & LIBRARY						16.
	01700 SOCIAL SERVICE						17.
	D2100 I &R SERVI CES-SALARY & FRI NGES APPRVD D2200 I &R SERVI CES-OTHER PRGM COSTS APPRVD						21. 22.
	D2300 EMS TRAINING-ALLIED HEALTH						22.
	D2301 RADI OLOGY SCHOOL-ALLI ED HEALTH						23.
	D2302 PHARMACY RESIDENCY-ALLIED HEALTH						23.
	D2303 PHARMACY RESIDNECY-BTH ALLIED HEALTH			0			23.
	NPATIENT ROUTINE SERVICE COST CENTERS			-1	1 1		
00 0	03000 ADULTS & PEDIATRICS	()	0 96, 873, 89	9 -6, 008, 317	90, 865, 582	30.
00 0	D3100 INTENSIVE CARE UNIT	0		0 25, 447, 39	2 -54, 945	25, 392, 447	31.
00 0	03200 CORONARY CARE UNI T	0		0	0 0	0	32.
00 0	02060 NEONATAL INTENSIVE CARE UNIT	0		0 2, 551, 45	4 -75, 337	2, 476, 117	35.
	04300 NURSERY	(0 1, 633, 53	2 0	1, 633, 532	43.
	ANCI LLARY SERVICE COST CENTERS		1	0 05 400 57	- 400 445	04 (45 4(0	1 50
	D5000 OPERATING ROOM D5100 RECOVERY ROOM			0 35, 128, 57 0 1, 829, 13		34, 645, 160	
	D5200 DELIVERY ROOM & LABOR ROOM			0 1, 829, 13 0 6, 438, 91		1, 829, 133 6, 438, 917	
	D5400 RADI OLOGY-DI AGNOSTI C			0 8, 508, 95		8, 508, 954	
	05500 RADI OLOGY-THERAPEUTI C			0 1, 517, 37		1, 517, 376	
	D5700 CT SCAN			0 5, 034, 85		5, 034, 857	
	D5800 MAGNETIC RESONANCE I MAGING (MRI)			0 1, 860, 88		1, 860, 884	
00 0	05900 CARDI AC CATHETERI ZATI ON	0		0 11, 813, 89		11, 813, 895	
00 0	06000 LABORATORY	0		0 18, 929, 88	9 0	18, 929, 889	60.
	06400 INTRAVENOUS THERAPY	0		0 2, 211, 20	8 0	2, 211, 208	64.
	06500 RESPI RATORY THERAPY	(0 6, 242, 91		6, 242, 917	
	06600 PHYSI CAL THERAPY	0		0 9, 055, 15		9, 055, 156	
	06700 OCCUPATIONAL THERAPY	0	D	0 2, 725, 08		2, 725, 085	
	06800 SPEECH PATHOLOGY	()	0 1, 137, 85		1, 137, 857	
				0 4, 676, 55		4, 533, 719	
	07000 ELECTROENCEPHALOGRAPHY			0 1, 202, 07		1, 202, 070	
	D7100 MEDICAL SUPPLIES CHARGED TO PATIENTS D7200 IMPL. DEV. CHARGED TO PATIENTS			0 31, 307, 82 0 32, 053, 41		31, 307, 825 32, 053, 414	
	D7300 DRUGS CHARGED TO PATIENTS			0 184, 231, 10		183, 983, 897	
	07400 RENAL DIALYSIS			0 2, 175, 05		2, 175, 059	
	03330 ENDOSCOPY			0 959,67		959, 679	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		0 12, 530, 65		11, 834, 584	
	03951 LUTHERWOOD PARTNERSHI P	0		0 6, 156, 48		6, 156, 488	
04 0	03952 WOUND CARE CENTER	0		0 3, 628, 98	5 -46, 299	3, 582, 686	76.
05 0	03480 ONCOLOGY-CANCER CARE CENTER	0		0 51, 914, 33	5 0	51, 914, 335	
06 0	03953 I MAGI NG CENTERS	0		0 8, 965, 36	9 0	8, 965, 369	
	03954 BREAST DI AGNOSTI C CENTER	0	D	0 3, 101, 57		3, 101, 575	
	07697 CARDI AC REHABI LI TATI ON	()	0 1, 830, 39		1, 830, 392	
	07698 HYPERBARI C OXYGEN THERAPY	(J	0 614, 63	0 0	614, 630	76.
				0			00
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	()	0		0	
	09000 CLINIC		ί.	0		0	90.
	D4950 DIABETIC CARE CENTER		Ś.	0		0	
	D4950 DTABETTC CARE CENTER		á	0 1, 971, 51	7 0	1, 971, 517	
	09001 CLINIC		á	0 1, 7/1, 51		1, 971, 517	
	04953 SPINE CENTER)	o	õ n	0	90.
	04954 I NFUSI ON CENTERS			0 879, 27	1 0	879, 271	90.
	09002 MEDCHECK CLINICS			0	0 0	079,271	90.
	09003 KNEE CENTER			6, 252, 34	9 -72, 982	6, 179, 367	
	09004 PALLI ATI VE CARE			0 21		211	90.
	09006 WORK SITE CLINICS			0	o o	0	
		1	1	1	Ŭ,	0	

Health Financial Systems C	OMMUNITY HEALTH	NETWORK, INC.		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period:	Worksheet B	
				From 01/01/2020 To 12/31/2020		nared
				10 12/31/2020	8/2/2021 3:24	pm pm
Cost Center Description	PHARMACY	PHARMACY	Subtotal	Intern &	Total	
	RESI DENCY-ALLI			Residents Cost		
	ED HEALTH	ALLI ED HEALTH		& Post		
				Stepdown		
				Adjustments		
	23.02	23.03	24.00	25.00	26.00	
91. 00 09100 EMERGENCY	0	0	29, 721, 47	0 -391, 419	29, 330, 051	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS						00.00
98.00 09850 OTHER REI MBURSABLE COST CENTERS	0	0		0 0	0	98.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	(22 112 02	0 0 010 004	(14 005 105	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	0	623, 113, 92	9 -8, 218, 824	614, 895, 105	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190.00
191, 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	28	6 0		191.00
194. 00 07950 HOME OFFICE	0	0	20			192.00
194. 01 07951 OCCUPATIONAL HEALTH ONSITE SVCS	0	0				194.00
194. 02 07952 ACCOUNTABLE CARE	0	0	717, 41	3 0	717, 413	
194. 03 07953 SCHOOL BASED CLINICS	0	0	351, 56			
194. 04 07954 SMO-NON PROVIDER BASED	0	0	760, 13		760, 135	
194. 05 07955 FAMILY PRACTICE MEDICINE	0	0	10, 354, 47			
194. 07 07957 LI FECHECK	0	0		0 0		194.07
194.0807958 GROUP HOMES AND MISC. N R CTRS	0	0	2, 152, 99	-94,954	2, 058, 041	194.08
194. 09 07959 SURGERY CENTER EAST	0	0	, - ,	0 0		194.09
200.00 Cross Foot Adjustments	0	0		0 0	0	200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	0	637, 450, 78	8 -12, 923, 351	624, 527, 437	202.00

	Financial Systems C TION OF CAPITAL RELATED COSTS	COMMUNITY HEALTH	NETWORK, INC. Provider Co		eriod: rom 01/01/2020	u of Form CMS-2 Worksheet B Part II Date/Time Pre	pared:
	· · · · · · · · · · · · · · · · · · ·		CAPI TAL REL	ATED COSTS		8/2/2021 3:24	pm
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00 5.00 7.00 8.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0 0 50, 198 0	210, 557 976, 376 2, 909, 871 0	13, 132, 548 299, 306 0	235, 205 14, 108, 924 3, 259, 375 0	235, 205 22, 826 3, 339 0	2.00 4.00 5.00 7.00 8.00
9.00 10.00 11.00 13.00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	000000000000000000000000000000000000000	322, 787 256, 689 677, 717 207, 725	23, 658 177, 997 39, 347	358, 448 280, 347 855, 714 247, 072	3, 589 729 2, 022 2, 436	
15. 00 16. 00 17. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02100 I & SERVICES-SALARY & FRINGES APPRVD	0 29, 392 0 0	454, 360 239, 131 46, 841 22, 486 0	787, 669 0	2, 412, 590 1, 056, 192 46, 841 22, 646 2, 248	505 7, 819 742 2, 021 4, 662	15. 00 16. 00 17. 00
22. 00 23. 00 23. 01 23. 02	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 EMS TRAI NI NG-ALLI ED HEALTH 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 02302 PHARMACY RESI DENCY-ALLI ED HEALTH	0 0 0 0	120, 500 0 0 0	70, 701 0 0 0	191, 201 0 0 0	6, 979 0 0 0	22.00 23.00 23.01 23.02
23.03	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	0	0	0	23.03
31. 00 32. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	000000000000000000000000000000000000000	2, 987, 552 1, 766, 721 0	915, 846 0	3, 991, 604 2, 682, 567 0	43, 961 10, 646 0	32.00
35.00 43.00	02060 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY	0	76, 123 163, 376		107, 194 234, 233	1, 305 550	35.00 43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	2, 905, 170	1, 868, 280	4, 773, 450	8, 963	50.00
52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADI 0LOGY-DI AGNOSTI C	0	241, 198 607, 485 784, 539	263, 492	359, 027 870, 977 1, 520, 048	644 2, 569 3, 066	
55.00 57.00 58.00	05500 RADIOLOGY-THERAPEUTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	11, 979 37, 807 793	28, 947 674, 619	40, 926 712, 426 722, 964	708 1, 926 546	55.00
59.00 60.00 64.00	05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06400 I NTRAVENOUS THERAPY	0 0 18, 619 0	416, 639 122, 171 9, 940	770, 301 109, 493	1, 186, 940 250, 283	340 3, 515 0 704	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	27, 583 306, 022	96, 701 1, 203, 909		3, 933 4, 727	65.00 66.00
68.00 69.00 70.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0 0 0 16, 402	94, 814 39, 619 17, 615 0	7, 345 501, 723	112, 393 46, 964 519, 338 168, 545	1, 473 616 2, 777 585	68.00 69.00 70.00
72. 00 73. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		0 0 7, 703	0 0 0	0 0 0 7, 703	0 0 0 0	73.00
76. 01 76. 03	03330 ENDOSCOPY 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 03951 LUTHERWOOD PARTNERSHI P	0 9, 027 0	0 0 140 247	154, 208 1, 879, 888 139, 105	154, 208 1, 888, 915 139, 105	418 32, 570 9, 350	76. 01 76. 03
76. 05 76. 06	03952 WOUND CARE CENTER 03480 ONCOLOGY-CANCER CARE CENTER 03953 I MAGI NG CENTERS 03954 BREAST DI AGNOSTI C CENTER	53, 658 0	140, 267 2, 460, 609 88, 754 160, 006	1, 473, 012	146, 155 6, 367, 103 1, 561, 766 209, 355	853 17, 970 3, 437 0	76. 05 76. 06
76. 97 76. 98	07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	0	179, 433 25, 941	161, 602	341, 035 27, 030	738 130	76.97
89. 00 90. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	88.00 89.00 90.00
90. 02 90. 03	04950 DI ABETI C CARE CENTER 04951 HEALTHY HEARTS CENTER 09001 CLI NI C	000000000000000000000000000000000000000	0 93, 172 0	0 165, 735 0	0 258, 907 0	0 1, 832 0	90.03
90. 05 90. 06	04953 SPINE CENTER 04954 INFUSION CENTERS 09002 MEDCHECK CLINICS		0 0 404 705	0 245, 757 0 22, 168	0 245, 757 0 446, 963	0 344 0 2 190	90.06
90.08	09003 KNEE CENTER 09004 PALLI ATI VE CARE 09006 WORK SI TE CLI NI CS	0	424, 795 0 0	0	446, 963 0 0	2, 190 0 0	90.08

91.00 09100 EMERGENCY 0 1, 624, 726 389, 127 2, 013, 853 9, 819 91.0 92.00 092000 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 92.00 098.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 98.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 98.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 177,296 22,267,592 34,389,023 56,833,911 230,534 118.0 NONREL MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 191.00 RESEARCH 0 0 0 0 191.00 191.00 192.00 P1951 CLANS' PRI VATE OFFI CES 0 0 0 0 192.0 194.00 079551 OCUPATI ONAL HEALTH ONSI TE SVCS 0 0 0 0 194.01 194.01 07952 ACCUNTA	Health Financial Systems CO	OMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-:	2552-10
Cost Center Description Directly Assigned New Capital Related Costs CAPITAL RELATED COSTS Subtotal EMPLOYEE BENEFITS DEPARTMENT 90.12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0	ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		From 01/01/2020	Part II Date/Time Pre	pared: pm
Assigned New Capital Related Costs BENEFITS DEPARTMENT 90.12 04961 FAMI LY PRACTICE AND MATERNITY CARE 0 0 0 0 0 0 90.12 90.12 09910 EMERGENCY 0 1.00 2.00 2A 4.00 90.12 91.00 09100 EMERGENCY 0 1.624,726 389,127 2.013,853 9,819 91.0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92.0 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 98.0 98.01 SUBTOLLS (SUM OF LINES 1 through 117) 177,296 22,267,592 34,389,023 56,833,911 230,534 118.00 SUBTOLLS (SUM OF LINES 1 through 117) 177,296 22,267,592 34,389,023 56,833,911 230,534 191.00 019000 RESEARCH 0 0 0 0 191.0 191.00 019000 RESEARCH 0 0 0 0 192.0 192.00 19200 PHYSI CLANS' PRI VATE OFFICES			CAPI TAL REL	ATED COSTS			
Capit tal Rel ated Costs DEPARTMENT 90. 12 04961 FAMI LY PRACTI CE AND MATERNI TY CARE 0 0 0 0 0 0 0 90. 2 90. 12 04961 FAMI LY PRACTI CE AND MATERNI TY CARE 0 0 0 0 0 0 90. 7 91. 00 09100 EMERGENCY 0 1, 624, 726 389, 127 2, 013, 853 9, 819 91. 0 0 09200 08SERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 98. 0 0 09200 00SERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 98. 0 0 09200 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 98. 0 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 177. 296 22, 267, 592 34, 389, 023 56, 833, 911 230, 534 118. 0 190. 00 IFT, FLOWRE, COFFEE SHOP & CANTEEN 0 0 0 0 0 0	Cost Center Description		BLDG & FIXT	MVBLE EQUIP	Subtotal		
0 1.00 2.00 2A 4.00 90.12 04961 FAMILY PRACTICE AND MATERNITY CARE 0		Capi tal					
90. 12 04961 FAMILY PRACTICE 0			1 00	2 00	24	4 00	
91.00 09100 EMERGENCY 0 1, 624, 726 389, 127 2, 013, 853 9, 819 91.0 92.00 092000 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 92.00 098.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 98.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 98.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 177,296 22,267,592 34,389,023 56,833,911 230,534 118.0 NONREL MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 191.00 RESEARCH 0 0 0 0 191.00 191.00 192.00 P1951 CLANS' PRI VATE OFFI CES 0 0 0 0 192.0 194.00 079551 OCUPATI ONAL HEALTH ONSI TE SVCS 0 0 0 0 194.01 194.01 07952 ACCUNTA	90 12 04961 FAMILY PRACTICE AND MATERNITY CARE	-					90, 12
92.00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART) 0 92.0 OTHER REIMBURSABLE COST CENTERS 0 <		0	1, 624, 726	389, 12	7 2.013.853	-	
OTHER REI MBURSABLE COST CENTERS O </td <td></td> <td></td> <td>.,</td> <td></td> <td>0</td> <td>.,</td> <td>92.00</td>			.,		0	.,	92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 177,296 22,267,592 34,389,023 56,833,911 230,534 118.00 NONREL MBURSABLE COST CENTERS 0 0 0 0 0 190.00 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191.00 191.00 19100 RESEARCH 0 0 0 0 191.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 192.01 194.01 07950 HOME OFFICE 0 0 0 0 194.02 07952 ACCOUNTABLE CARE 0 0 0 194.02 07953 SCHOOL BASED CLINICS 0 0 0 487 194.02 07954 SMO-NON PROVI DER BASED 0 0 0 487 194.02 07955 SCHOOL BASED CLINICS 0 0 0 0 505 194.02 194.02 07955 FAMI LY PRACTICE MEDICINE 0 0 0 0 505 194.02 194.					-1		
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 177, 296 22, 267, 592 34, 389, 023 56, 833, 911 230, 534 118.00 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 0 0 0 0 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191.00 192.00 192.00 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192.00 192.00 192.00 192.00 192.01 192.01 192.00 192.01 192.01 0 0 0 192.01 194.01 194.02 07952 ACCOUNT	98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
NONRE IMBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP A 190.00 GI FT, FLOWER, COFFEE SHOP A 191.00 19100 RESEARCH 0 0 0 0 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 231 231 0 192.0 194.00 07950 HOME OFFI CE 0 0 0 0 0 194.0 194.01 07951 OCCUPATI ONAL HEALTH ONSI TE SVCS 0 0 0 0 194.0 194.02 07952 ACCOUNTABLE CARE 0 0 0 487 194.0 194.02 07953 SCHOOL BASED CLINICS 0 0 0 487 194.0 194.03 07953 SCHOOL BASED 0 0 0 0 481 194.0 194.04 07955 FAMILY PRACTICE MEDICINE 0	SPECIAL PURPOSE COST CENTERS						1
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.00 194.00 07950 HOME OFFI CE 0 0 0 0 194.00 194.01 07951 OCCUPATI ONAL HEALTH ONSI TE SVCS 0 0 0 0 194.00 194.02 07953 SCHOOL BASED CLINICS 0 0 0 0 194.00 194.03 07954 SMO-NON PROVI DER BASED 0 0 0 48194.00 194.04 07954 SMO-NON PROVI DER BASED 0 0 0 48194.00 194.04 07955 FAMI LY PRACTICE MEDI CINE 0 0 0 0 194.02 194.04 07957 LI FECHECK 0 0 0 0 0 194.02 194.05 07957 SINGERY CENTER EAST 0 0 0 0		177, 296	22, 267, 592	34, 389, 02	3 56, 833, 911	230, 534	118.00
191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 231 231 0 192.00 194.00 07950 HOME OFFI CE 0 0 0 0 194.00 194.01 07950 HOME OFFI CE 0 0 0 0 194.00 194.01 07950 ICCUPATI ONAL HEALTH ONSI TE SVCS 0 0 0 0 194.00 194.02 07952 ACCOUNTABLE CARE 0 0 0 0 194.00 194.02 07953 SCHOOL BASED CLINICS 0 0 0 48 194.00 194.04 07954 SMO-NON PROVI DER BASED 0 0 0 505 194.00 194.05 07955 FAMI LY PRACTI CE MEDI CI NE 0 0 0 0 194.00 194.04 07957 LI FECHECK 0 0 0 0 0 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00							
192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 231 231 0 192.00 194.00 07950 HOME OFFICE 0 0 0 0 194.00 194.01 07951 OCCUPATI ONAL HEALTH ONSI TE SVCS 0 0 0 194.00 194.02 07952 ACCOUNTABLE CARE 0 0 0 0 194.00 194.02 07953 SCHOOL BASED CLINICS 0 0 0 0 487 194.00 194.04 07954 SMO-NON PROVIDER BASED 0 0 0 0 487 194.00 194.04 07954 SMO-NON PROVIDER BASED 0 0 0 0 505 194.00 194.00 1,069,732 1,069,732 2,721 194.00 194.00 0 0 0 0 0 194.00 0 0 0 194.00 0 0 0 0 0 0 0 194.00 0 0 0 0 0 0 0 0 0 0 0 <t< td=""><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td></td><td>190.00</td></t<>		0	0		0 0		190.00
194.00 07950 HOME OFFICE 0 0 0 194.01 194.01 07951 OCCUPATI ONAL HEALTH ONSI TE SVCS 0 0 0 0 194.02 194.02 07952 ACCOUNTABLE CARE 0 0 0 0 194.02 194.03 07953 SCHOOL BASED CLINICS 0 0 0 0 487 194.02 194.04 07954 SMO-NON PROVIDER BASED 0 0 0 0 505 194.02 194.04 07954 SMO-NON PROVIDER BASED 0 0 0 0 505 194.02 194.05 07955 FAMILY PRACTICE MEDICINE 0 0 1,069,732 1,069,732 2,721 194.02 194.07 07957 LI FECHECK 0 0 0 0 0 194.02 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 0 157,514 110,843 268,357 910 194.02 194.09 07959 SURGERY CENTER EAST 0 0 0 0 0 0 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td>191.00</td>		0	0		0 0		191.00
194.01 07951 OCCUPATI ONAL HEALTH ONSI TE SVCS 0 0 0 194.02 194.02 07952 ACCOUNTABLE CARE 0 0 0 0 487 194.02 194.03 07953 SCHOOL BASED CLINICS 0 0 0 0 481 194.02 194.04 07954 SMO-NON PROVIDER BASED 0 0 0 0 481 194.02 194.04 07954 SMO-NON PROVIDER BASED 0 0 0 0 505 194.02 194.05 07955 FAMILY PRACTICE MEDICINE 0 0 1,069,732 1,069,732 2,721 194.02 194.07 07957 LI FECHECK 0 0 0 0 194.02 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 0 157,514 110,843 268,357 910 194.02 194.09 07959 SURGERY CENTER EAST 0 0 0 0 194.02 00.02 0 0 0 0 0 0 0 0 0 0 0<		0	0	23	1 231		192.00
194.02 07952 ACCOUNTABLE CARE 0 0 0 487 194.02 194.03 07953 SCHOOL BASED CLINICS 0 0 0 0 48 194.02 194.04 07954 SMO-NON PROVIDER BASED 0 0 0 0 48 194.02 194.04 07954 SMO-NON PROVIDER BASED 0 0 0 0 505 194.02 194.05 07955 FAMILY PRACTICE MEDICINE 0 0 1,069,732 1,069,732 2,721 194.02 194.07 07957 LI FECHECK 0 0 0 0 194.02 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 0 157,514 110,843 268,357 910 194.02 194.09 07959 SURGERY CENTER EAST 0 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 200.02 0 0 0 0 200.02 201.00 Negative Cost Centers 0 0 0 0	194.0007950 HOME OFFICE	0	0		0 0	0	194.00
194.03 07953 SCHOOL BASED CLINICS 0 0 0 48 194.04 194.04 07954 SMO-NON PROVIDER BASED 0 0 0 0 505 194.05 194.05 07955 FAMILY PRACTICE MEDICINE 0 0 1,069,732 1,069,732 2,721 194.05 194.07 07957 LIFECHECK 0 0 0 0 194.05 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 0 157,514 110,843 268,357 910 194.05 194.09 07959 SURGERY CENTER EAST 0 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 200.02 201.00 Negative Cost Centers 0 0 0 0 0 200.02	194.01079510CCUPATIONAL HEALTH ONSITE SVCS	0	0		0 0	0	194.01
194.04 07954 SMO-NON PROVIDER BASED 0 0 0 00 194.05 194.06 194.07 1,069,732 1,069,732 2,721 194.07 194.07 07957 LIFECHECK 0 0 0 0 194.07 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 0 0 0 0 194.07 194.09 07959 SURGERY CENTER EAST 0 0 0 0 194.07 200.00 Cross Foot Adjustments 0 0 0 0 200.00 0 0 0 0 200.00 0 0 0 0 0 0 0 0 200.00 0 0 0 0 0 0 0 200.00 0 0 0 0 0 0 0 0 200.00 0 </td <td>194. 02 07952 ACCOUNTABLE CARE</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>487</td> <td>194.02</td>	194. 02 07952 ACCOUNTABLE CARE	0	0		0 0	487	194.02
194.05 07955 FAMILY PRACTICE MEDICINE 0 1,069,732 2,721 194.0 194.07 07957 LI FECHECK 0 0 0 0 194.0 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 0 157,514 110,843 268,357 910 194.0 194.09 07959 SURGERY CENTER EAST 0 0 0 0 194.0 200.00 Cross Foot Adjustments 0 0 0 0 200.00 0 0 200.00 0 0 0 0 200.00 0 0 0 0 200.00 0 0 0 0 200.00 0 0 0 200.00 0 0 0 200.00 0 0 0 200.00 0 0 0 200.00 0 0 0 200.00 0 0 0 200.00 0 0 200.00 0 0 0 0 200.00 0 0 0 0 0 0 0 0 0 0 0<	194.0307953 SCHOOL BASED CLINICS	0	0		0 0	48	194.03
194.07 07957 LI FECHECK 0 0 0 194.0 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 0 157,514 110,843 268,357 910 194.0 194.09 07959 SURGERY CENTER EAST 0 0 0 0 194.0 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00	194.0407954 SMO-NON PROVIDER BASED	0	0		0 0	505	194.04
194.08 07958 GROUP HOMES AND MISC. N_R CTRS 0 157,514 110,843 268,357 910 194.0 194.09 07959 SURGERY CENTER EAST 0 0 0 0 194.0 200.00 Cross Foot Adjustments 0 0 0 200.00 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00	194.0507955 FAMILY PRACTICE MEDICINE	0	0	1, 069, 73	2 1, 069, 732	2, 721	194.05
194.09 07959 SURGERY CENTER EAST 0 0 0 194.0 200.00 Cross Foot Adjustments 0 0 200.0 200.0 0 200.0 200.0 0 200.0 <t< td=""><td>194. 07 07957 LI FECHECK</td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>194.07</td></t<>	194. 07 07957 LI FECHECK	0	0		0 0	0	194.07
200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0		0	157, 514	110, 84	3 268, 357	910	194.08
201.00 Negative Cost Centers 0 0 0 0 0 0 201.00		0	0		0 0	0	194.09
	200.00 Cross Foot Adjustments				0		200.00
202 00 TOTAL (sum Lipps 119 through 201) 177 206 22 425 106 25 560 920 59 172 221 225 205 202 (201.00 Negative Cost Centers		0		0 0		201.00
202.00 101AL (Sum 11 Hes 110 through 201) 177,240 22,423,100 33,304,624 36,172,231 233,203/202.0	202.00 TOTAL (sum lines 118 through 201)	177, 296	22, 425, 106	35, 569, 82	9 58, 172, 231	235, 205	202.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	COMMUNI TY HEALTH	NETWORK, INC. Provider C		eriod:	u of Form CMS- Worksheet B	2552-10
			T T	rom 01/01/2020 o 12/31/2020	Date/Time Pre	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	8/2/2021 3: 24 DI ETARY	pm
	& GENERAL	PLANT	LINEN SERVICE			
GENERAL SERVI CE COST CENTERS	5.00	7.00	8.00	9.00	10.00	-
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	44 404 750					4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT	14, 131, 750 475, 404	3, 738, 118				5.00 7.00
8.00 00800 LAUNDRY & LINEN SERVICE	36, 142	3,730,110	36, 142			8.00
9.00 00900 HOUSEKEEPI NG	156, 427	65, 834		584, 298		9.00
10. 00 01000 DI ETARY	47, 234	52, 353		8, 330	388, 993	1
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	83, 355 213, 702	138, 223 42, 366			0	1
14. 00 01400 CENTRAL SERVICES & SUPPLY	361, 429	42, 300 92, 668			0	
15. 00 01500 PHARMACY	319, 984	48, 772				1
16. 00 01600 MEDI CAL RECORDS & LI BRARY	161, 108	9, 553				
17.00 01700 SOCIAL SERVICE	63, 301	4, 586			0	
21.00 02100 I & SERVI CES-SALARY & FRINGES APPRVD 22.00 02200 I & SERVI CES-OTHER PRGM COSTS APPRVD	109, 226 166, 943	0 24, 576	, s	0 3, 910	0	
23. 00 02300 EMS TRAINING-ALLIED HEALTH	100, 943	24, 370	0	0	0	
23.01 02301 RADIOLOGY SCHOOL-ALLIED HEALTH	0	0	0	0	0	
23. 02 02302 PHARMACY RESIDENCY-ALLIED HEALTH	0	0	0		0	
23. 03 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0	0	0	0	23.03
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	1, 626, 391	609, 320	16, 479	96, 947	328, 076	30.00
31. 00 03100 I NTENSI VE CARE UNI T	433, 885	360, 329		57, 332	58, 386	
32.00 03200 CORONARY CARE UNI T	0	0	0	0	0	32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	48, 470	15, 526		2, 470	0	
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	26, 387	33, 321	260	5, 302	0	43.00
50. 00 05000 OPERATING ROOM	591, 420	592, 519	2, 306	94, 276	2, 422	50.00
51.00 05100 RECOVERY ROOM	30, 903	49, 193		7, 827	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	111, 640	123, 899			0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	154, 881	160, 009		25, 459		
55. 00 05500 RADI OLOGY-THERAPEUTI C 57. 00 05700 CT SCAN	30, 949 102, 966	2, 443 7, 711		389 1, 227	0	55.00 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	40, 136	162		26	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	196, 892	84, 975	753	13, 520	0	59.00
60. 00 06000 LABORATORY	400, 218	24, 917			0	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	47, 859 132, 582	2, 027 5, 626			109 0	1
66. 00 06600 PHYSI CAL THERAPY	187, 150	62, 414			0	1
67.00 06700 OCCUPATI ONAL THERAPY	55, 758	19, 338			0	1
68.00 06800 SPEECH PATHOLOGY	23, 297	8, 080		1, 286		68.00
	94, 062	3, 593			0	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 705 642, 903	0	0	0	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	705, 740	0	0	0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 444, 222	0	0	0	0	
74.00 07400 RENAL DI ALYSI S	47, 505	1, 571		250	0	
76. 00 03330 ENDOSCOPY 76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	20, 528 257, 317	0	115 0		0	
76. 03 03951 LUTHERWOOD PARTNERSHI P	135, 697	0	0	0	0	
76.04 03952 WOUND CARE CENTER	72, 069	28, 608		4, 552	0	
76.05 03480 ONCOLOGY-CANCER CARE CENTER	1, 034, 271	501, 849				
76. 06 03953 I MAGI NG CENTERS	191, 833	18, 102		2,880		
76. 07 03954 BREAST DI AGNOSTI C CENTER 76. 97 07697 CARDI AC REHABI LI TATI ON	62, 845 33, 390	32, 634 36, 596		5, 192 5, 823		
76. 98 07698 HYPERBARI C OXYGEN THERAPY	12, 386	5, 291			0	1
OUTPATIENT SERVICE COST CENTERS		· · · · · ·				
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0		0	0	0	
90. 01 04950 DI ABETI C CARE CENTER	0	0	0	0	0	
90. 02 04951 HEALTHY HEARTS CENTER	38, 082	19, 003		3, 024	0	1
90. 03 09001 CLINIC	0	0	0	0	0	
90. 04 04953 SPINE CENTER	0	0	0	0	0	
90. 05 04954 INFUSION CENTERS 90. 06 09002 MEDCHECK CLINICS	19, 355	0	0	0	0	90.05 90.06
90. 06 09002 MEDCHECK CETNICS 90. 07 09003 KNEE CENTER	119, 548	86, 638	0 0	13, 785	, i i i i i i i i i i i i i i i i i i i	1
90. 08 09004 PALLIATIVE CARE	0	0	0	0	0	
90. 10 09006 WORK SITE CLINICS	0	0	0	0	0	
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0 E 20 400	0	0	0	0	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	530, 409	331, 368	6, 390	52, 724	0	91.00 92.00
2. 33 107200 000ERWATTON DEDS (NON-DISTINCT FART)	1 1	I	I	I	I	1 /2.00

Health Financial Systems CC	MMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period:	Worksheet B	
				From 01/01/2020	Part II	
				To 12/31/2020	Date/Time Pre 8/2/2021 3:24	
Cost Center Description	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	pili
cost center bescription	& GENERAL		LINEN SERVICE		DILIAN	
	5.00	7.00	8.00	9.00	10.00	
OTHER REIMBURSABLE COST CENTERS						
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	(0 0	0	98.00
SPECIAL PURPOSE COST CENTERS						1
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	13, 923, 906	3, 705, 993	36, 142	2 579, 187	388, 993	118.00
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0	0	190.00
191. 00 19100 RESEARCH	0	0	(0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	6	0	(0 0	0	192.00
194.00 07950 HOME OFFICE	0	0	(0 0	0	194.00
194.01079510CCUPATIONAL HEALTH ONSITE SVCS	0	0	(0 0	0	194.01
194.0207952 ACCOUNTABLE CARE	15, 902	0	(0 0	0	194.02
194. 03 07953 SCHOOL BASED CLINICS	5, 653	0	(0 0	0	194.03
194.04 07954 SMO-NON PROVIDER BASED	16, 852	0	(0 0	0	194.04
194.0507955 FAMILY PRACTICE MEDICINE	129, 481	0	(0 0	0	194.05
194. 07 07957 LI FECHECK	0	0	(0 0		194.07
194.08 07958 GROUP HOMES AND MISC. N_R CTRS	39, 950	32, 125	(5, 111		194.08
194.0907959 SURGERY CENTER EAST	0	0	(0 0		194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	(0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	14, 131, 750	3, 738, 118	36, 142	2 584, 298	388, 993	202.00

ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider CC	N: 15-0074	Peri od: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Pre 8/2/2021 3:24	pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 14.00 15.00 14.00 21.00 22.00 23.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-BUBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL 01700 SOCIAL SERVICE 02200 02100 I&R SERVICE SALARY 02200 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 02300 EMS TRINING-ALLIED HEALTH 02301 RADIOLOGY SCHOL-ALLIED HEALTH	1, 101, 307 20, 755 5, 189 51, 239 5, 189 14, 269 0 62, 265 0 0	533, 072 0 0 0 0 0 0 0	2, 887, 12	25 0 1, 491, 766 2 0 19 0 0 0	224, 955 0 0 0 0 0 0 0 0 0	1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 15.00 12.00 22.00 23.00
23. 02 23. 03	02302 PHARMACY RESIDENCY-ALLIED HEALTH 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0	0		0 0	0	23.02
20.00	INPATIENT ROUTINE SERVICE COST CENTERS					0	23.03
30. 00 31. 00 32. 00 35. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY	297, 702 77, 831 0 10, 377 4, 540	76, 426 0 0	29, 79 13, 51 1, 24 7(16 0 0 0 40 0	14, 981 4, 742 0 1, 363 210	32.00 35.00
50 00	ANCI LLARY SERVICE COST CENTERS	66,805	65 599	220 68		12 658	50.00
71. 00 72. 00 73. 00 74. 00 76. 01 76. 03 76. 04 76. 05 76. 06 76. 07 76. 97 76. 98 88. 00	05000OPERATI NG ROOM05100RECOVERY ROOM05200DELI VERY ROOM & LABOR ROOM05400RADI OLOGY-DI AGNOSTI C05500RADI OLOGY-THERAPEUTI C05700CT SCAN05800MAGNETI C RESONANCE I MAGI NG (MRI)05900CARDI AC CATHETERI ZATI ON06000LABORATORY06400INTRAVENOUS THERAPY06500RESPI RATORY THERAPY06600PHYSI CAL THERAPY06600PHYSI CAL THERAPY06600PHYSI CAL THERAPY06600PHYSI CAL THERAPY06600PHYSI CAL SUPPLIES CHARGED TO PATI ENTS07000ELECTROENCEPHALOGRAPHY07100MEDI CAL SUPPLI ES CHARGED TO PATI ENTS07200IMPL. DEV. CHARGED TO PATI ENTS07300DRUGS CHARGED TO PATI ENTS07400RENAL DI ALYSI S03330ENDOSCOPY03550PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES03951LUTHERWOOD PARTNERSHI P03480ONCOLOGY-CANCER CARE CENTER03953IMAGI NG CENTERS03954BREAST DI AGNOSTI C CENTER07697CARDI AC REHABI LI TATI ON07698HYPERBARI C OXYGEN THERAPY0UTPATI ENT SERVI CE COST CENTERS08800RURAL HEALTH CLI NI C	66, 805 3, 892 15, 566 13, 620 5, 189 20, 755 3, 243 23, 349 0 6, 486 27, 241 16, 215 9, 729 3, 892 25, 944 4, 540 0 0 0 0 0 0 0 0 0 0 0 0 0	0 15, 285 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 63 3, 55 96 256, 41 17 2, 84 1, 87 33 15 1, 05 358, 16 1, 892, 78	36 0 38 0 39 0 39 0 39 0 39 0 31 0 71 0 31 0 71 0 55 0 55 0 56 0 57 0 58 1, 491, 766 57 0 57 0 57 0 57 0 57 0 57 0 57 0 57 0 57 0 57 0 57 0 55 0 55 0 0 0 55 0 0 0 55 0 0 0 55 0 0 0 55 0 0 0 55	500 5, 897 6, 679 73, 982 600 367 1, 988 110 1, 054 17, 964 4, 918 413 221 202 0	51.00 52.00 54.00 55.00 57.00 58.00 59.00 60.00 64.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 73.00 74.00 74.00 76.01 76.04 76.05 76.04 76.07 76.97 76.98 88.00
89. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 90. 08 90. 10 90. 12 91. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 04950 DIABETIC CARE CENTER 04951 HEALTHY HEARTS CENTER 09001 CLINIC 04953 SPINE CENTER 04954 INFUSION CENTERS 09002 MEDCHECK CLINICS 09003 KNEE CENTER 09004 PALLIATIVE CARE	0 0 0 13, 620 0 0 0 22, 701 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		69 8 40 19, 04	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 262 0 175 0 370 6 0 0 17, 946	89.00 90.02 90.02 90.03 90.04 90.05 90.06 90.07 90.08 90.00 90.12

Health Financial Systems CC	MMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period:	Worksheet B	
				From 01/01/2020 To 12/31/2020	Part II Date/Time Pre	pared:
					8/2/2021 3:24	pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11.00	13.00	14, 00	15.00	16.00	
OTHER REIMBURSABLE COST CENTERS	11.00	10.00	11.00	10.00	10.00	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 101, 307	533, 072	2, 885, 82	6 1, 491, 766	224, 955	118.00
NONREI MBURSABLE COST CENTERS		1 1				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
194.00 07950 HOME OFFICE	0	0		0 0		194.00
194.0107951 OCCUPATIONAL HEALTH ONSITE SVCS	0	0		0 0		194.01
194. 02 07952 ACCOUNTABLE CARE	0	0	1			194.02
194. 03 07953 SCHOOL BASED CLINICS	0	0	14	3 0		194.03
194. 04 07954 SMO-NON PROVIDER BASED	0	0		J 0	-	194.04
194. 05 07955 FAMILY PRACTICE MEDICINE	0	0		6 0		194.05
	0	0	1 10	J 0		194.07
194. 08 07958 GROUP HOMES AND MISC. N_R CTRS		0	1, 13	3 0		194.08 194.09
194.0907959 SURGERY CENTER EAST 200.00 Cross Foot Adjustments	0	0		5 0	0	200.00
200.00Cross Foot Adjustments201.00Negative Cost Centers	0				0	200.00
201.00 Negative cost centers 202.00 TOTAL (sum Lines 118 through 201)	1, 101, 307	533, 072	2, 887, 12	5 1, 491, 766	224, 955	
202.00 TOTAL (Sum TIMES TTO LIFUUGH 201)	1, 101, 307	555,072	2,007,12	1, 491, 700	224, 933	202.00

	Financial Systems (ATION OF CAPITAL RELATED COSTS	COMMUNITY HEALTH	Provider C	CN: 15-0074	Period:	u of Form CMS-2 Worksheet B	2002-1
LLUUF	THOR OF CATTAL RELATED COSTS			F	From 01/01/2020 To 12/31/2020	Part II Date/Time Pre	pared:
			INTERNS &	RESI DENTS		8/2/2021 3:24	pm
	Cost Center Description	SOCI AL SERVI CES	SERVICES-SALAR Y & FRINGES	SERVICES-OTHEF PRGM COSTS	EMS TRAI NI NG-ALLI E	RADI OLOGY	
			I & ININGLS		D HEALTH	HEALTH	
		17.00	21.00	22.00	23.00	23.01	
00	GENERAL SERVICE COST CENTERS						1 1 00
. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
. 00	00500 ADMINI STRATI VE & GENERAL						5.00
. 00	00700 OPERATION OF PLANT						7.00
. 00 . 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
0.00	01000 DI ETARY						10.0
1.00	01100 CAFETERI A						11.0
3.00	01300 NURSING ADMINISTRATION						13.0
4.00 5.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						14.0 15.0
6.00	01600 MEDICAL RECORDS & LIBRARY						16.00
7.00	01700 SOCIAL SERVICE	107, 572					17.0
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	116, 136				21.0
	02200 I & SERVICES-OTHER PRGM COSTS APPRVD	0		456, 230			22.0
3.00	02300 EMS TRAINING-ALLIED HEALTH 02301 RADIOLOGY SCHOOL-ALLIED HEALTH	0			0	0	23.0 23.0
3. 02	02302 PHARMACY RESIDENCY-ALLIED HEALTH	0					23.0
3. 03	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH	0					23. 0
0 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	87, 438		[1		30. 0
1.00	03100 I NTENSI VE CARE UNI T	15, 418					31.0
2.00	03200 CORONARY CARE UNI T	0					32.0
5.00	02060 NEONATAL INTENSIVE CARE UNIT	2, 610					35.0
3.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	2, 106					43.0
0. 00	05000 OPERATING ROOM	0					50.0
1.00	05100 RECOVERY ROOM	0					51.00
2.00	05200 DELIVERY ROOM & LABOR ROOM	0					52.0
4.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0					54.0 55.0
7.00	05700 CT SCAN	0					57.0
8.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0					58.0
9.00	05900 CARDI AC CATHETERI ZATI ON	0					59.0
0.00 4.00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	0					60.0 64.0
5.00	06500 RESPI RATORY THERAPY	0					65.0
6. 00	06600 PHYSI CAL THERAPY	0					66. 0
	06700 OCCUPATIONAL THERAPY	0					67.0
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0					68.0 69.0
	07000 ELECTROENCEPHALOGRAPHY	0					70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.0
	07200 I MPL. DEV. CHARGED TO PATIENTS	0					72.0
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0					73.0 74.0
	03330 ENDOSCOPY	0					76.0
6. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0					76.0
	03951 LUTHERWOOD PARTNERSHI P	0					76.0
	03952 WOUND CARE CENTER 03480 ONCOLOGY-CANCER CARE CENTER	0					76.0 76.0
	03953 I MAGI NG CENTERS	0					76.0
	03954 BREAST DI AGNOSTI C CENTER	0					76.0
	07697 CARDI AC REHABI LI TATI ON	0					76.9
6. 98	07698 HYPERBARI C OXYGEN THERAPY OUTPATI ENT SERVI CE COST CENTERS	0					76.9
8.00	08800 RURAL HEALTH CLINIC	0					88. 0
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0					89.0
	09000 CLINIC	0					90.0
		0					90.0 90.0
	04951 HEALTHY HEARTS CENTER 09001 CLINIC	0					90.0
	04953 SPI NE CENTER	0					90.0
0. 05	04954 INFUSION CENTERS	0					90.0
		0					90.0
	09003 KNEE CENTER	0					90.0 90.0
	09004 PALLIATIVE CARE						
0. 08	09004 PALLIATIVE CARE 09006 WORK SITE CLINICS	0					90.0

Health Financial Systems Co	OMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	F	Period: From 01/01/2020 Fo 12/31/2020		pared:
Cost Center Description	SOCI AL SERVI CE	I NTERNS & SERVI CES-SALAR Y & FRI NGES 21.00		EMS TRAI NI NG-ALLI E D HEALTH 23.00	RADI OLOGY SCHOOL-ALLI ED HEALTH 23. 01	
91.00 09100 EMERGENCY	0	21.00	22.00	23.00	23.01	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
OTHER REIMBURSABLE COST CENTERS	I I		<u> </u>			72.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0					98.00
SPECIAL PURPOSE COST CENTERS						1
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	107, 572	0	(0 0	0	118.00
NONREI MBURSABLE COST CENTERS			_			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190. 00
191. 00 19100 RESEARCH	0					191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0					192.00
194.0007950 HOME OFFICE	0					194.00
194.01079510CCUPATIONAL HEALTH ONSITE SVCS	0					194.01
194.02 07952 ACCOUNTABLE_CARE	0					194. 02
194.0307953 SCHOOL BASED CLINICS	0					194. 03
194.04 07954 SMO-NON PROVIDER BASED	0					194.04
194.0507955 FAMILY PRACTICE MEDICINE	0					194.05
194. 07 07957 LI FECHECK	0					194.07
194.0807958 GROUP HOMES AND MISC. N_R CTRS	0					194.08
194.0907959 SURGERY CENTER EAST	0					194.09
200.00 Cross Foot Adjustments		116, 136	456, 230	0 0		200.00
201.00 Negative Cost Centers	0	0	(0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	107, 572	116, 136	456, 230	0 0	0	202.00

ALLOCA	Financial Systems (TION OF CAPITAL RELATED COSTS		Provider CO		Period:	Worksheet B	
					From 01/01/2020 To 12/31/2020		
	Cost Center Description	PHARMACY	PHARMACY	Subtotal	Intern &	8/2/2021 3: 24 Total	pm
			RESI DNECY-BTH		Residents Cost		
		ED HEALTH	ALLI ED HEALTH		& Post Stepdown		
					Adjustments		
		23.02	23.03	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS		1	I	1		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A						10.00
13.00	01300 NURSI NG ADMI NI STRATI ON						11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY						16.00
17.00	01700 SOCIAL SERVICE						17.00
21.00 22.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM COSTS APPRVD						21.00 22.00
23.00	02300 EMS TRAINING-ALLIED HEALTH						23.00
23.01	02301 RADI OLOGY SCHOOL-ALLI ED HEALTH						23.01
23. 02	02302 PHARMACY RESIDENCY-ALLIED HEALTH	C					23.02
23. 03	02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH		0				23.03
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS		1	7, 435, 02	5 0	7, 435, 025	30.00
31.00	03100 I NTENSI VE CARE UNI T			3, 795, 53		3, 795, 539	
32.00	03200 CORONARY CARE UNI T			0, 170, 00		0, 770, 007	32.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT			190, 55	5 0	190, 555	1
43.00	04300 NURSERY			312, 07	5 0	312, 075	43.00
F0 00	ANCI LLARY SERVI CE COST CENTERS		1	(421 10	7	(401 107	
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM			6, 431, 10 452, 90		6, 431, 107 452, 909	
52.00	05200 DELIVERY ROOM & LABOR ROOM			1, 164, 03		1, 164, 035	
54.00	05400 RADI OLOGY-DI AGNOSTI C			1, 883, 15		1, 883, 156	
55.00	05500 RADI OLOGY-THERAPEUTI C			85, 90		85, 908	55.00
57.00	05700 CT SCAN			855, 10		855, 101	
58.00 59.00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION			768, 14 1, 785, 38		768, 145 1, 785, 384	
60.00	06000 LABORATORY			734, 47		734, 479	
64.00	06400 I NTRAVENOUS THERAPY			73, 04		73, 043	
65.00	06500 RESPI RATORY THERAPY			299, 91		299, 916	
66.00	06600 PHYSI CAL THERAPY			1, 793, 61		1, 793, 615	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY			202, 59 84, 48		202, 597 84, 481	
	06900 ELECTROCARDI OLOGY			652, 10		652, 104	
	07000 ELECTROENCEPHALOGRAPHY			200, 93		200, 932	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			1, 006, 96		1, 006, 964	
72.00				712, 41		712, 419	
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS			6, 902, 75 57, 68		6, 902, 759 57, 686	
76.00	03330 ENDOSCOPY			179, 09		179,097	
76.01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES			2, 216, 95		2, 216, 954	
76.03	03951 LUTHERWOOD PARTNERSHI P			289, 66		289, 668	
76.04	03952 WOUND CARE CENTER			264, 200		264, 200	
	03480 ONCOLOGY-CANCER CARE CENTER			8, 177, 19		8, 177, 191	
76.06	03953 I MAGI NG CENTERS 03954 BREAST DI AGNOSTI C CENTER			1, 784, 69 310, 43		1, 784, 691 310, 439	
76.97	07697 CARDI AC REHABI LI TATI ON			425, 21		425, 214	
	07698 HYPERBARI C OXYGEN THERAPY			47,60		47,609	
	OUTPATIENT SERVICE COST CENTERS	1	1		-1		
	08800 RURAL HEALTH CLINIC				0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC					0	
90.00	04950 DI ABETI C CARE CENTER					0	
90. 02	04951 HEALTHY HEARTS CENTER			336, 17	1 0	336, 171	
90. 03	09001 CLI NI C			(0 0	0	90.03
90.04	04953 SPINE CENTER				0 0	0	90.04
90.05	04954 INFUSION CENTERS			265, 71	2 0	265, 712	
90.06	09002 MEDCHECK CLINICS 09003 KNEE CENTER			692, 65		0 692 657	90.06 90.07
	09003 KNEE CENTER			092,00	, U	692, 657 6	
90.10	09006 WORK SITE CLINICS				0 0	0	1
90.10							

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0074 Period: Provider CCN: 15-0074 Period: Por 01/01/2020 To 12/31/2020 Worksheet B Part II Bate/Time Prepared: 8/2/2021 3: 24 pm Cost Center Description PHARMACY RESIDENCY-ALLI ED HEALTH Subtotal RESIDENCY-ALLI ED HEALTH Subtotal Residents Cost & Post Stepdown Adjustments Intern & Residents Cost & Post Stepdown Adjustments Total 91.00 09100 EMERGENCY 23.02 23.03 24.00 25.00 26.00 92.00 09200 09550 01TER REIMBURSABLE COST CENTERS 0 0 3,140,952 91.00 98.00 99850 0THER REIMBURSABLE COST CENTERS 0 0 0 98.00 99850 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 56,010,495 98.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 56,010,495 0 99.00 191.00 19100 FESLAL PURPOSE COST CENTERS 0 0 0 0 0 0 0 191.00 192.00 192051 0CUPATIONAL HEALTH ONSITE SVCS 0 0	Health Financial Systems Co	OMMUNITY HEALTH	NETWORK, INC.		In Lie	eu of Form CMS-:	2552-10
RESI DENCY-ALLI ED HEALTH RESI DENCY-BTH ALLI ED HEALTH Resi dents Cost & Post Stepdown Adjustments 91.00 09100 EMERGENCY 23.02 23.03 24.00 25.00 26.00 91.00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART) 0 3,140,952 0 3,140,952 91.00 98.00 OSBERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 98.00 98.00 OSBECI AL PURPOSE COST CENTERS 0 0 0 98.00 SPECI AL PURPOSE COST CENTERS 0 0 0 98.00 118.00 SUBTOLLS (SUM OF LINES 1 through 117) 0 0 56,010,495 118.00 191.00 019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 237 0 237 192.00 194.00 07951 OCLPATI ONAL HEALTH ONSI TE SVCS 0 0 0 194.01 194.02 07953 SCHOUNTABLE CARE 16,406 1,406 19	ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0074	From 01/01/2020	Part II Date/Time Pre	
ED HEALTH ALLI ED HEALTH & Post Stepdown Adj ustments 91. 00 09100 EMERGENCY 23. 02 23. 03 24. 00 25. 00 26. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 3, 140, 952 0 3, 140, 952 0 3, 140, 952 0 3, 140, 952 92. 00 0 09250 0DSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92. 00 0 09250 0THER REI MBURSABLE COST CENTERS 0 0 0 98. 00 SPECIAL PURPOSE COST CENTERS	Cost Center Description						
PI.00 OP100 EMERGENCY Stepdown Adjustments 91.00 09100 EMERGENCY 0 3.140,952 0 3.140,952 0 3.140,952 91.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 92.00 0 92.00 0 92.00 0 3.140,952 0 3.140,952 92.00 92.00 0 0 0 0 0 92.00 92.00 0 92.00 0 0 0 0 0 0 0 0 92.00 92.00 98.00 SUBTORIALS (SUM OF LINES 1 through 117) 0 0 0 0 0 0 18.00 18.00 0 0 0 190.00 191.00 191.00 192.00 190.00 0 191.00 192.00 192.00 192.00 192.00 192.00 192.00 0 0 0 194.00 194.00 0 0 0 194.00 194.00 194.00 194.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
Image: Problem Stress Adjustments Adjustments 91.00 09100 EMERGENCY 23.02 23.03 24.00 25.00 26.00 92.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 0 3.140,952 0 3.140,952 91.00 92.00 07HER REI MBURSABLE COST CENTERS 0 0 0 0 98.00 98.00 0 0 0 98.00 98.00 98.00 98.00 0 0 0 0 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 99.00 100.00 0 0 0 98.00 99.00 99.00 99.00 99.00 98.00 98.00 99.00		ED HEALTH	ALLIED HEALTH				
23.02 23.03 24.00 25.00 26.00 91.00 09100 EMERGENCY 0 3,140,952 0 3,140,952 91.00 92.00 09200 09SERVATI ON BEDS (NON-DI STI NCT PART) 0 0 92.00 0THER REI MBURSABLE COST CENTERS 0 0 0 0 92.00 98.00 OSBETALS (SUM OF LI NES 1 through 117) 0 0 0 0 98.00 SPECI AL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LI NES 1 through 117) 0 0 56,010,495 0 56,010,495 118.00 100.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191.00 191.00 19100 RESEARCH 0 0 0 191.00 192.00 194SI CLANS' PRI VATE OFFI CES 237 0 237 192.00 194.00 07951 OCUPATI ONAL HEALTH ONSI TE SVCS 0 0 0 194.01 194.02 07953 SCHOOL BASED CLINICS							
91.00 09100 EMERGENCY 0 3, 140, 952 0 3, 140, 952 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 92.00 92.00 0THER REI MBURSABLE COST CENTERS 0 0 0 0 98.00 SPECIAL PURPOSE COST CENTERS 0 0 0 0 98.00 SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 98.00 NONREL MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 118.00 NONREL MBURSABLE COST CENTERS 0 0 0 0 0 0 190.00 190.00 19100 191.00 192.00 192.00 192.00 192.00 192.00 0 0 0 192.00		22.02	22.02	24.00		24.00	
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 92.00 OTHER REIMBURSABLE COST CENTERS 98.00 0 0 0 0 0 0 98.00 SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 98.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 56,010,495 0 56,010,495 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 190.00 0 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 191.00 0 0 0 0 190.00 191.00 0 0 191.00 0 0 191.00 0 191.00 0 0 191.00 0 0 0 194.00 0 0 0 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00		23.02	23.03				01.00
OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98.00 OPBS0 OTHER REI MBURSABLE COST CENTERS 0				3, 140, 93		3, 140, 952	
98.00 09850 OTHER REIMBURSABLE COST CENTERS 0					0		92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 56,010,495 0 56,010,495 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 191.00 191000 RESEARCH 0 0 0 191.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 237 0 237 192.00 194.00 07950 HOME OFFICE 0 0 0 194.00 194.01 07951 OCCUPATI ONAL HEALTH ONSI TE SVCS 0 0 0 194.00 194.02 07952 ACCOUNTABLE CARE 16,406 0 194.02 194.03 07953 SCHOOL BASED CLINICS 5,844 0 5,844 194.03 194.04 07954 SMO-NON PROVIDER BASED 17,357 0 17,357 194.04 194.03 194.04 07955 FAMI LY PRACTICE MEDICINE 1,201,940 1,201,940 194.03 194.04 194.05 194.07 194.07 194.07 1					0 0	0	98 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 56,010,495 0 56,010,495 118.00 NONREL MBURSABLE COST CENTERS 0 0 0 0 0 190.00 19100 0 0 0 190.00 19100 19100 RESEARCH 0 0 0 191.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 0 0 0 0 191.00 194.00 0 0 0 191.00 194.00 0 0 0 191.00 194.01 0 0 0 0 191.00 194.00 194.00 0 0 0 194.00 194.00 0 0 0 0 194.0		1	I	I	0 0	0	70.00
NONRE I MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 237 0 237 192.00 194.00 07950 HOME OFFI CE 0 0 0 194.00 194.01 07951 OCCUPATI ONAL HEALTH ONSI TE SVCS 0 0 0 194.00 194.02 07952 ACCOUNTABLE CARE 16,406 0 16,406 194.02 194.03 07953 SCHOOL BASED CLINICS 5,844 0 5,844 194.02 194.04 07954 SMO-NON PROVI DER BASED 17,357 0 17,357 194.04 194.05 07955 FAMI LY PRACTICE MEDI CINE 1,201,940 0 1,404 194.05 194.07 07957 LI FECHECK 0 0 0 0 194.07 194.09 07958 GROU		0	0	56, 010, 49	95 0	56, 010, 495	118.00
191.00 19100 RESEARCH 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 237 0 237 192.00 194.00 07950 HOME OFFI CE 0 0 0 194.00 194.01 07950 ICCUPATI ONAL HEALTH ONSI TE SVCS 0 0 0 194.00 194.02 07953 SCHOOL BASED CLINICS 0 0 194.01 194.04 07954 SMO-NON PROVI DER BASED 5,844 0 5,844 194.03 194.04 07955 FAMI LY PRACTI CE MEDI CI NE 17,357 0 17,357 194.04 194.07 07957 SI FECHECK 0 0 0 194.05 194.09 07957 SI FECHECK 0 0 194.07 194.09 07957 SI FECHECK 0 0 194.08 194.09 07957 SURGERY CENTER EAST 0 0 194.08 194.09 07957 SURGERY CENTER EAST 0 0 194.08 194.09 07957 SURGERY CENTER EA							
192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 237 0 237 192.00 194.00 07950 HOME OFFICE 0 0 0 194.00 194.01 07951 OCCUPATI ONAL HEALTH ONSI TE SVCS 0 0 0 194.01 194.02 07952 ACCOUNTABLE CARE 16,406 0 16,406 194.02 194.03 07953 SCHOOL BASED CLINICS 5,844 0 5,844 194.03 194.04 07954 SMO-NON PROVIDER BASED 17,357 0 17,357 194.04 194.05 07955 FAMI LY PRACTICE MEDICINE 1,201,940 194.05 194.05 194.07 07957 LI FECHECK 0 0 0 194.05 194.09 07958 GROUP HOMES AND MISC. N_R CTRS 347,586 0 347,586 194.08 194.09 07959 SURGERY CENTER EAST 0 0 0 194.09 200.00 Cross Foot Adjustments 0 0 572,366 0 572,366 200.00 201.00 Negative Cost Centers	190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				0 0	0	190.00
194.00 07950 HOME OFFICE 0 0 194.00 194.01 07951 OCCUPATI ONAL HEALTH ONSI TE SVCS 0 0 0 194.01 194.02 07952 ACCOUNTABLE CARE 16,406 0 16,406 194.02 194.03 07953 SCHOOL BASED CLINICS 5,844 0 5,844 194.03 194.04 07954 SMO-NON PROVIDER BASED 17,357 0 17,357 194.04 194.05 07955 FAMILY PRACTICE MEDICINE 1,201,940 194.05 194.05 194.07 07957 LI FECHECK 0 0 0 194.07 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 347,586 0 347,586 194.09 194.09 07959 SURGERY CENTER EAST 0 0 0 194.09 200.00 Cross Foot Adjustments 0 0 572,366 0 572,366 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00	191. 00 19100 RESEARCH				0 0	0	191.00
194. 01 07951 OCCUPATI ONAL HEALTH ONSI TE SVCS 0 0 194. 01 194. 02 07952 ACCOUNTABLE CARE 16, 406 0 16, 406 194. 02 194. 03 07953 SCHOOL BASED CLINICS 5, 844 0 5, 844 194. 03 194. 04 07954 SMO-NON PROVIDER BASED 17, 357 0 17, 357 194. 04 194. 05 07955 FAMILY PRACTICE MEDICINE 1, 201, 940 0 1, 201, 940 194. 05 194. 07 07957 LI FECHECK 0 0 0 194. 07 194. 08 07958 GRUP HOMES AND MISC. N_R CTRS 347, 586 0 0 194. 08 194. 09 07959 SURGERY CENTER EAST 0 0 0 194. 09 200. 00 Cross Foot Adjustments 0 0 572, 366 0 572, 366 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 201. 00	192.00 19200 PHYSI CLANS' PRI VATE OFFI CES			23	37 0	237	192.00
194.02 07952 ACCOUNTABLE CARE 16,406 0 16,406 194.02 194.03 07953 SCHOOL BASED CLINICS 5,844 0 5,844 194.03 194.04 07954 SMO-NON PROVIDER BASED 17,357 0 17,357 194.04 194.05 07955 FAMILY PRACTICE MEDICINE 1,201,940 0 1,201,940 194.05 194.07 07957 LIFECHECK 0 0 0 194.07 194.09 07959 SURGERY CENTER EAST 347,586 0 347,586 194.08 200.00 Cross Foot Adjustments 0 0 572,366 0 572,366 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00	194.0007950 HOME OFFICE				0 0	0	194.00
194.03 07953 SCHOOL BASED CLINICS 5,844 0 5,844 194.03 194.04 07954 SMO-NON PROVIDER BASED 17,357 0 17,357 194.04 194.05 07955 FAMILY PRACTICE MEDICINE 1,201,940 0 1,201,940 194.05 194.07 07957 LIFECHECK 0 0 0 194.07 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 347,586 0 347,586 194.08 194.09 07959 SURGERY CENTER EAST 0 0 0 0 194.08 200.00 Cross Foot Adjustments 0 0 572,366 0 572,366 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00	194.0107951 OCCUPATIONAL HEALTH ONSITE SVCS				0 0	0	194.01
194.04 07954 SMO-NON PROVI DER BASED 17, 357 0 17, 357 194.04 194.05 07955 FAMI LY PRACTICE MEDICINE 1, 201, 940 0 1, 201, 940 194.05 194.07 07957 LI FECHECK 0 0 0 194.07 194.09 07958 GROUP HOMES AND MI SC. N_R CTRS 347, 586 0 347, 586 194.08 194.09 07959 SURGERY CENTER EAST 0 0 0 194.09 200.00 Cross Foot Adjustments 0 0 572, 366 0 572, 366 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00	194.0207952 ACCOUNTABLE CARE			16, 40	06 0	16, 406	194.02
194.05 07955 FAMILY PRACTICE MEDICINE 1, 201, 940 0 1, 201, 940 194.05 194.07 07957 LI FECHECK 0 0 194.07 194.08 07958 GROUP HOMES AND MISC. N_R CTRS 347, 586 0 347, 586 194.08 194.09 07959 SURGERY CENTER EAST 0 0 194.09 200.00 Cross Foot Adjustments 0 0 572, 366 0 572, 366 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 0 201.00	194.0307953 SCHOOL BASED CLINICS			5, 84	14 0	5, 844	194.03
194. 07 07957 LI FECHECK 0 0 194. 07 194. 08 07958 GROUP HOMES AND MI SC. N_R CTRS 347, 586 0 347, 586 194. 08 194. 09 07959 SURGERY CENTER EAST 0 0 194. 09 200. 00 Cross Foot Adjustments 0 0 572, 366 0 572, 366 201. 00 Negative Cost Centers 0 0 0 0 0 0	194.04 07954 SMO-NON PROVIDER BASED			17, 35	57 0	17, 357	194.04
194.08 07958 GROUP HOMES AND MI SC. N_R CTRS 347,586 0 347,586 194.08 194.09 07959 SURGERY CENTER EAST 0 0 194.09 200.00 Cross Foot Adjustments 0 0 572,366 0 572,366 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00				1, 201, 94	10 0		
194.09 07959 SURGERY CENTER EAST 0 0 194.09 200.00 Cross Foot Adjustments 0 0 572,366 0 572,366 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00					0 0	-	
200.00 Cross Foot Adjustments 0 0 572, 366 0 572, 366 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00				347, 58	36 0		
201.00 Negative Cost Centers 0 0 0 0 0 0 201.00					0 0		
5		0	0	572, 36	6 0		
202.00 TOTAL (sum Lines 118 through 201) 0 0 58, 172, 231 0 58, 172, 231 202.00	5	0	0		0 0		
	202.00 TOTAL (sum lines 118 through 201)	0	0	58, 172, 23	31 0	58, 172, 231	202.00

OST ALLOCATION - STATISTICAL BASIS		Provider CO		eriod: rom 01/01/2020	Worksheet B-1	
				o 12/31/2020	Date/Time Pre 8/2/2021 3:24	
	CAPI TAL REL	LATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci l i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
	1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS 00 00100 CAP REL COSTS-BLDG & FIXT	791, 857					1 1 0
00 00100 CAP REL COSTS-BLDG & FIXT 00 00200 CAP REL COSTS-MVBLE EQUIP	/91,85/	35, 604, 169				1.0 2.0
00 00400 EMPLOYEE BENEFITS DEPARTMENT	7, 435	24, 672	206, 835, 537			4.0
00 00500 ADMI NI STRATI VE & GENERAL 00 00700 OPERATI ON OF PLANT	34, 477 102, 751	13, 145, 237 299, 595			514, 332, 480 17, 302, 521	
00 00800 LAUNDRY & LINEN SERVICE	02,731		2, 30, 873		1, 315, 400	
00 00900 HOUSEKEEPI NG	11, 398				5, 693, 215	
D. 00 01000 DI ETARY 1. 00 01100 CAFETERI A	9, 064 23, 931	23, 681 178, 169	641, 143 1, 778, 737		1, 719, 110 3, 033, 723	
3. 00 01300 NURSING ADMINISTRATION	7, 335				7, 777, 757	
4.00 01400 CENTRAL SERVICES & SUPPLY	16, 044				13, 154, 367	
5. 00 01500 PHARMACY 6. 00 01600 MEDICAL RECORDS & LIBRARY	8, 444 1, 654				11, 645, 938 5, 863, 587	
7. 00 01700 SOCIAL SERVICE	794	160			2, 303, 851	
1.00 02100 I & R SERVICES-SALARY & FRINGES APPRVD	0	2, 250			3, 975, 309	
2.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 3.00 02300 EMS TRAINING-ALLIED HEALTH	4, 255 0	70, 769	6, 138, 452 0		6, 075, 958 0	
3. 01 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH	0	0	0	-	0	
3. 02 02302 PHARMACY RESIDENCY-ALLIED HEALTH	0	0	0		0	
3. 03 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23.0
D. 00 03000 ADULTS & PEDIATRICS	105, 494	1, 005, 021	38, 635, 371	0	59, 193, 139	30. C
1. 00 03100 I NTENSI VE CARE UNI T	62, 385	916, 730			15, 791, 402	
2. 00 03200 CORONARY CARE UNIT 5. 00 02060 NEONATAL INTENSIVE CARE UNIT	0 2, 688	0 31, 101	-	-	0 1, 764, 076	
3. 00 04300 NURSERY	5, 769				960, 377	
ANCI LLARY SERVICE COST CENTERS	102 505	1 070 000	7 002 220		21 524 0/2	1 50 0
D. 00 05000 OPERATING ROOM 1. 00 05100 RECOVERY ROOM	102, 585 8, 517				21, 524, 962 1, 124, 735	
2. 00 05200 DELIVERY ROOM & LABOR ROOM	21, 451	263, 746			4, 063, 194	
4. 00 05400 RADI OLOGY - DI AGNOSTI C	27, 703				5, 636, 972	
5. 00 05500 RADI OLOGY-THERAPEUTI C 7. 00 05700 CT_SCAN	423 1, 335				1, 126, 390 3, 747, 471	
3.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	28				1, 460, 750	
9. 00 05900 CARDI AC CATHETERI ZATI ON	14, 712				7, 165, 979	
D. 00 06000 LABORATORY 4. 00 06400 I NTRAVENOUS THERAPY	4, 314 351	109, 599 5, 224		-	14, 566, 108 1, 741, 835	
5. 00 06500 RESPI RATORY THERAPY	974	96, 794	3, 458, 926		4, 825, 378	
6. 00 06600 PHYSI CAL_THERAPY 7. 00 06700 0CCUPATI ONAL_THERAPY	10, 806				6, 811, 413	
7. 00 06700 OCCUPATI ONAL THERAPY 3. 00 06800 SPEECH PATHOLOGY	3, 348 1, 399				2, 029, 319 847, 902	
2. 00 06900 ELECTROCARDI OLOGY	622	502, 207	2, 442, 782	0	3, 423, 437	69.
D. 00 07000 ELECTROENCEPHALOGRAPHY 1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	152, 290	514, 697 0		935, 545 23, 398, 728	
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0		25, 685, 689	
8. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	125, 355, 683	
4. 00 07400 RENAL_DIALYSIS 5. 00 03330 ENDOSCOPY	272	0 154, 357	0 367, 275	0	1, 728, 958 747, 121	
5. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	1, 881, 702			9, 365, 158	
0. 03 03951 LUTHERWOOD PARTNERSHIP	0	139, 239			4, 938, 742	
5. 04 03952 WOUND CARE CENTER 5. 05 03480 ONCOLOGY-CANCER CARE CENTER	4, 953 86, 887	5, 894 3, 856, 554			2, 622, 973 37, 642, 717	
0. 06 03953 I MAGI NG CENTERS	3, 134				6, 981, 844	
07 03954 BREAST DI AGNOSTI C CENTER	5,650			-	2, 287, 254	
5. 97 07697 CARDI AC REHABI LI TATI ON 5. 98 07698 HYPERBARI C OXYGEN THERAPY	6, 336 916				1, 215, 260 450, 788	
OUTPATI ENT SERVICE COST CENTERS	////					1,0.1
8. 00 08800 RURAL HEALTH CLINIC	0	0	0		0	
0.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0		0	
0. 01 04950 DIABETIC CARE CENTER	0	0	0	0	0	
0. 02 04951 HEALTHY HEARTS CENTER	3, 290	165, 895	1, 611, 444	0	1, 386, 001	
0. 03 09001 CLI NI C 0. 04 04953 SPI NE_CENTER	0		0	0	0	
D. 05 04954 INFUSION CENTERS	0	245, 994		-	704, 426	
D. 06 09002 MEDCHECK CLINICS	0	0	0	0	0	90.0
D. 07 09003 KNEE CENTER D. 08 09004 PALLI ATI VE CARE	15,000	22, 189			4, 350, 984	90. C
		. ()	0	()	0	

Heal th	Fi nanci al	Systems	
COST A			R/

COMMUNITY HEALTH NETWORK, INC. Provider CCN: 15-0074 Period:

In Lieu of Form CMS-2552-10 Worksheet B-1

Heal th Financ	cial Systems CC	MMUNIIY HEALIH	NETWORK, INC.		In Lie	u of Form CMS-:	2552-10
COST ALLOCAT	ION - STATISTICAL BASIS		Provider CC		Peri od:	Worksheet B-1	
					rom 01/01/2020		
				[]	o 12/31/2020		
		0451 T41 551	1752 00070			8/2/2021 3:24	pm
		CAPI TAL REL	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation		
		(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	WORK SITE CLINICS	0	0	(0 0	0	90.10
90.12 04961	FAMILY PRACTICE AND MATERNITY CARE	0	0	(0 0	0	90.12
91.00 09100	EMERGENCY	57, 371	389, 502	8, 635, 891	0	19, 304, 464	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER	REIMBURSABLE COST CENTERS						
	OTHER REIMBURSABLE COST CENTERS	0	0	(0 0	0	98.00
	L PURPOSE COST CENTERS				, <u> </u>	<u> </u>	10100
	SUBTOTALS (SUM OF LINES 1 through 117)	786, 295	34, 422, 224	202, 726, 731	-123, 118, 308	506, 767, 910	118 00
	MBURSABLE COST CENTERS	700,270	01, 122, 221	202, 720, 70	120, 110, 000	000, 101, 110	110.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	0	190.00
191.0019100		0		(191.00
	PHYSI CLANS' PRI VATE OFFI CES	0	231				192.00
194.0007950		0	231		0		192.00
	OCCUPATIONAL HEALTH ONSITE SVCS	0	0	(0		194.00
	ACCOUNTABLE CARE	0	0	420 411	0	578, 771	
		0	0	428, 613			
	SCHOOL BASED CLINICS	0	0	42, 627		205, 737	
	SMO-NON PROVIDER BASED	0	0	444, 108		613, 321	
	FAMILY PRACTICE MEDICINE	0	1, 070, 764	2, 393, 529	9 0	4, 712, 529	
194.0707957		0	0	(0 0		194.07
	GROUP HOMES AND MISC. N_R CTRS	5, 562	110, 950	799, 929	0	1, 453, 981	
	SURGERY CENTER EAST	0	0	(0 0	0	194.09
	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	22, 425, 106	35, 569, 829	6, 624, 752	2	123, 118, 308	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	28. 319641	0. 999036	0. 032029)	0. 239375	203.00
204.00	Cost to be allocated (per Wkst. B,			235, 205	5	14, 131, 750	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part			0.001137	7	0. 027476	205.00
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						
1 1		ı – – – – – – – – – – – – – – – – – – –			1	I Contraction of the second seco	

Health Financial Systems (COST ALLOCATION - STATISTICAL BASIS	COMMUNITY HEALTH	Provi der C	CN: 15-0074	Period: From 01/01/2020	u of Form CMS-2 Worksheet B-1	
				To 12/31/2020	Date/Time Pre 8/2/2021 3:24	
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	CAFETERI A	
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT						1 1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMINI STRATI ON 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVICE 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 23.01 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 23.01 02302 PHARMACY RESI DENCY-ALLI ED HEALTH 23.02 02303 PHARMACY RESI DENCY-ALLI ED HEALTH	647, 194 0 11, 398 9, 064 23, 931 7, 335 16, 044 8, 444 1, 654 794 0 4, 255 0 0 0 0	272, 320 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	635, 790 9, 064 23, 93	4 82,054 1 0 5 0 4 0 4 0 4 0 4 0 5 0 5 0 5 0 0 0 0 0 0 0 0 0 0	1, 698 32 8 79 8 22 0 96 0 0 0 0 0 0	13.00 14.00 15.00 16.00 17.00 21.00
INPATIENT ROUTINE SERVICE COST CENTERS				-		
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT	105, 494 62, 385 0 2, 688	124, 169 33, 610 0		5 12, 316 0 0	459 120 0 16	31.00 32.00
43. 00 04300 NURSERY	5, 769	1, 958		-	7	43.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY-THERAPEUTI C 57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 06600 PEECH PATHOLOGY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 71.00 07100 DRUGS CHARGED TO PATI ENTS	5, 769 102, 585 8, 517 21, 451 27, 703 423 1, 335 28 14, 712 4, 314 351 974 10, 806 3, 348 1, 399 622 0 134 14 15, 650	17, 376 0 7, 280 13, 814 0 0 0 5, 670 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	102, 58 8, 51 21, 45 27, 70 42 1, 33 24 14, 71 4, 31 35 97 10, 80 3, 34 1, 39 62 (0 (0 (0 (0 (0 (0 (0 (0 (0 (5 511 7 0 1 0 3 0 5 0 8 0 2 0 4 0 6 0 9 0 0 0 <td< td=""><td>103 6 24 21 8 32 5 36 0 10 10 42 25 15 6 40 7 7 0 0 0 0 0 0 0 11 211 0 0 11 211 211 211</td><td>50.00 51.00 52.00 52.00 55.00 55.00 57.00 59.00 64.00 64.00 64.00 65.00 65.00 66.00 67.00 68.00 67.00 72.00 73.00 74.00 72.00 73.00 74.00 76.01 76.97 76.98</td></td<>	103 6 24 21 8 32 5 36 0 10 10 42 25 15 6 40 7 7 0 0 0 0 0 0 0 11 211 0 0 11 211 211 211	50.00 51.00 52.00 52.00 55.00 55.00 57.00 59.00 64.00 64.00 64.00 65.00 65.00 66.00 67.00 68.00 67.00 72.00 73.00 74.00 72.00 73.00 74.00 76.01 76.97 76.98
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90.00 09000 CLINIC 90.01 04950 DIABETIC CARE CENTER 90.02 04951 HEALTHY HEARTS CENTER 90.03 09001 CLINIC 90.04 04953 SPINE CENTER 90.05 04954 INFUSION CENTERS 90.06 09002 MEDCHECK CLINICS 90.07 09003 KNEE CENTER 90.08 09004 PALLIATIVE CARE 90.10 09006 WORK SITE CLINICS 90.12 04961 FAMILY PRACTICE AND MATERNITY CARE 91.00 09100 EMERGENCY	0 0 0 3, 290 0 0 0 15, 000 0 15, 000 0 57, 371	0 0 5, 651 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(((((((((((((((((((0 0 0 21 0 0 0 35 0 0 0 124	89.00 90.01 90.02 90.03 90.04 90.05 90.06 90.07 90.08 90.10 90.12

Health Financial Systems (COMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre	nared
				12/31/2020	8/2/2021 3: 24	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
	PLANT	LINEN SERVICE	(SQUARE FEET)	(PATIENT DAYS)	(MEALS SERVED)	
	(SQUARE FEET)	(POUNDS OF				
	7.00	LAUNDRY)	9,00	10.00	11.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7.00	8.00	9.00	10.00	11.00	92.00
072.00 09200 063ERVATION BEDS (NON-DISTINCT PART)						92.00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS	0	0		0 0	0	98.00
SPECIAL PURPOSE COST CENTERS	0	0	· · · · ·	0	0	/0.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	641, 632	272, 320	630, 234	82, 054	1 698	118.00
NONREI MBURSABLE COST CENTERS	011,002	272,020	000,20	02,001	1,070	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0	0	190.00
191. 00 19100 RESEARCH	0	0	(0	0	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0 0		192.00
194.00 07950 HOME OFFICE	0	0		0 0	0	194.00
194.0107951 OCCUPATIONAL HEALTH ONSITE SVCS	0	0		0 0	0	194.01
194.0207952 ACCOUNTABLE CARE	0	0		0 0	0	194.02
194.03 07953 SCHOOL BASED CLINICS	0	0	(0 0	0	194.03
194.0407954 SMO-NON PROVIDER BASED	0	0	(0 0	0	194.04
194. 05 07955 FAMILY PRACTICE MEDICINE	0	0	(0 0		194.05
194. 07 07957 LI FECHECK	0	0	(0 0		194.07
194.0807958 GROUP HOMES AND MISC. N_R CTRS	5, 562	0	5, 562	2 0		194.08
194.0907959SURGERY CENTER EAST	0	0	0	0 0	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	21, 444, 312	1, 630, 274	7, 433, 693	3 2, 536, 927	4, 832, 657	202.00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	33. 134287	5. 986611	11. 691947	30. 917774	2, 846. 087750	202 00
203.00 Cost to be allocated (per Wkst. B,						
Part II)	3, 738, 118	36, 142	584, 298	3 388, 993	1, 101, 307	204.00
205.00 Unit cost multiplier (Wkst. B, Part	5. 775885	0. 132719	0. 919002	4. 740695	648. 590695	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

Tron Closel. Gender Description Description <thdescription< th=""> <thdescription< th=""> <th< th=""><th></th><th>Financial Systems (LLOCATION - STATISTICAL BASIS</th><th>COMMUNI TY HEALTH</th><th>NETWORK, INC. Provider CC</th><th>N: 15-0074</th><th>Pe</th><th>In Lie</th><th>u of Form CMS-2 Worksheet B-1</th><th>2552-10</th></th<></thdescription<></thdescription<>		Financial Systems (LLOCATION - STATISTICAL BASIS	COMMUNI TY HEALTH	NETWORK, INC. Provider CC	N: 15-0074	Pe	In Lie	u of Form CMS-2 Worksheet B-1	2552-10
Cost Center Description NUMESING CONTROL (UHEL NUME (BS.) CONTROL COSTED (COS	00017				514. 15 0074	Fr	om 01/01/2020	Date/Time Pre	
UNECT NURS CONTROL CONTROL CONTROL UNISCI 13. 00 110. 00 100. 00 10. 00 10.		Cost Center Description		SERVICES &	(COSTED		RECORDS &	SOCI AL SERVI CE	pin
Internal Stand CE COST CLULES 13.00 14.00 15.00 16.00 17.00 4.00 1000 00000 CAP BEL COST CLULES FOUR P 1.00 <t< td=""><td></td><td></td><td></td><td>(COSTED</td><td>REQUIS.)</td><td></td><td>(GROSS</td><td></td><td></td></t<>				(COSTED	REQUIS.)		(GROSS		
1.00 DOUD CAP REL COSTS-MUSE & HAIL 1.00 0.00 DOUD CAP REL COSTS-MUSE & SUPPLY 2.00 0.00 DOUD CAP REL COSTS-MUSE & SUPPLY 2.00 0.00 DOUD CAP REL COSTS-MUSE & SUPPLY 0.00 1.00 DIADO CAPTERIA A 1.00 1.00 DIADO CAPTERIA A <t< td=""><td></td><td></td><td></td><td></td><td>15.00</td><td></td><td></td><td>17.00</td><td></td></t<>					15.00			17.00	
2.00 00200 CAP FIEL COSTS-WELE EQUIP. 2.00 0.00000 CAP FIEL COSTS-WELE TO PLAY A MERTING 4.00 0.00000 COSTS-WELE TO PLAY A MERTING 4.00 0.00000 COSTS-WELE TO PLAY A MERTING 5.00 1.000 COSTAL SERVICES - SUBJECT 0 1000 1.000 COSTAL SERVICES - SUBJECT 0 1000 2.703, 714, 707 11.00 1.000 COSTAL SERVICES - SUBJECT A MERTING 0 2.20, 70 0 0 0 2.20, 70 100 0 2.20, 70 100 0 2.20, 70 100 0 2.20, 70 100 0 0 0 0 2.20, 70 100 0 0 0 2.20, 70 10, 70, 70 10, 70, 70 10, 70, 70 10, 70, 70 10, 70, 70 10, 70, 70	1 00								1 00
5.00 DODORD LARMENY ALL OF ALTON OF PART 5.00 S.00		00200 CAP REL COSTS-MVBLE EQUIP							
7.00 00/00 (DEPATION F LINES FUNCE 7.00									
0.00 00000 LUNREY REVICE 8.00 0000 0000 0.00									
9 00 00500 10015FLEEP N6 0057 00570									
11.00 01100 CAFETERIA 11.00 12.00 01200 CAFETERIA 11.00 13.00 01300 CHRTRAL SERVICES & SUPPLY 0 10.00 13.00 01300 CHRTRAL SERVICES & SUPPLY 0 10.00 17.00 01700 DOLAL SERVICES - SUPLY 0 10.00 17.00 DOLAL SERVICES - SUPLY 0 1.271 0 0 0 2.00 2.00 2.00 2.00 0 0 0 2.00 2.00 2.00 0 0 0 2.00 2.00 0 0 0 2.00 2.00 0 0 0 0 2.00 2.00 2.00 0 0 0 0 2.00 <td></td> <td>00900 HOUSEKEEPI NG</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		00900 HOUSEKEEPI NG							
13. 00 01300 NURSING ADMINISTRATION B37 13. 00 14. 00 15. 00									
15.00 01500 PHARMACY 0 10 01 00 100 15.00 17.00 0700 SOCIAL SERVICE 0 1,271 0 2,232,714,970 15.00 17.00 0700 SOCIAL SERVICES-SALAY & FRINCES APPAND 0 2,202 0 0 0 2,202 0 0 0 2,202 0 0 0 2,202 0 0 0 2,202 0 0 0 0 0 2,202 0			837						
16. 00 0FCOD (PEDICAL RECORDS & LIBRARY 0 129 2, 703, 714, 970 16. 00 21. 00 D2100 (AR SERV(CS-SALARY & FRINCES APPRVD 0 1, 00 1, 00 2, 200 0 0 0 0 0 0 0 0 2, 200 0<			0	188, 619, 773					
17. 00 01700 SERVICE 0 1.7. 20 0			0	0	1		2 702 714 070		
21:00 02100 LAB SLEWICES-SALARY & FRINCES APPRVD 0 0 0 0 0 0 0 21:00 22:00 02200 LAB STRVICES-SALARY & FRINCES APPRVD 0 23:07 0 0 0 0 22:00 23:00 D2300 LAB STRVICE-ONLER FRIM COST SAPPRVD 0 0 0 0 0 0 0 0 22:00 23:01 D2301 PARAMENT REST IRER THER LET INT I 0			0			0	2, 703, 714, 970	85, 928	
23.00 02300 EMS TRAIN NO-ALLIED HEALTH 0 0 0 0 0 23.00 23.01 02301 PIARMACY RESIDENCY-ALLIED HEALTH 0 0 0 0 23.00 10 02301 PIARMACY RESIDENCY-ALLIED HEALTH 0 0 0 0 23.00 10 02300 PIARMACY RESIDENCY-BIALLIED HEALTH 0 0 0 0 0 23.00 10 000 00000 ADULTS & FEDRUCE-UBH ALLIED HEALTH 0 0 0 0 0 0 0 23.00 10 000 0000 ADULTS & FEDRUCE-UBN LILED HEALTH 0 0 0 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 13.00 00 0.00 0.000 OPLALTAL INFERSIVE CARE UNIT 0 13.00 0.0300 UNESTAL INFERSIVE CARE UNIT 0 14.17, 521 0 15.02, 50.012 0 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.0			0	0		0	0		
23.01 2307 RADICLORY SCHOOL-ALLED HEALTH 0 0 0 0 23.02 23.02 230.02 PHARMACY RESIDENCY-ALLED HEALTH 0 0 0 0 23.02 10 230.02 PHARMACY RESIDENCY-ALLED HEALTH 0 0 0 0 0 23.02 10.00 03000 ADULTS & PEDIATRICS 459 1.946.546 0 180.491.114 69.645 30.00 10.00 03200 CORMARY CAFE UNIT 1 0 0 0 1.0 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 32.00 2.083.35 35.00 1.00 1.0.00 1.0.0 1.0.00 32.00 35.00 1.0.00 32.00 2.00 2.0.01 2.0.01 2.0.01 2.0.01 2.0.01 2.0.01 2.0.01 1.0.00 1.0.00 1.0.00 1.0.00 1.0.00 1.0.00 1.0.00 1.0.00 1.0.00 1.0.00 1.0.00 1.0.00 1.0.00 1.0.00 1.0.00 1.0.00 1.0.00 1.0.0.00 1.0.00 1.0.00 1.			0			0	0		
23. 02 23.02 <t< td=""><td></td><td></td><td>0</td><td>-</td><td></td><td>0</td><td>0</td><td></td><td></td></t<>			0	-		0	0		
INPATI ENT ROUTINE SERVICE COST CENTERS			0	-			-		
90.00 03000 ADULTS & PEDIATRICS 459 1.946,546 0 180,491,114 69,445 30.00 91.00 03200 COROMARY CARE UNIT 0 0 0 0 20.00 25,92,92,12 1.622,431,022 45.00 22.00 2.529,728 1.622,431,022 45.00 04300 NURSERY 04300 NURSERY 7 46,222 0 2.529,728 1.622 45.00 04300 NURSERY 05000 QFEANTIA INFENVE CASE CHITES 0 152,500,122 0 51.00 50.00 05200 QFELVERY ROMA & LABOR ROM 0 2.5249 0 1.2,489,412 0 51.00 51.00 05200 QELIVERY ROMA & LABOR ROM 24 172,310 0 9.407,196 0 52.00 55.00 05500 RADI OLOGY-INERAPEUTIC 0 1.951 0 57.00 <td< td=""><td>23.03</td><td></td><td>0</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>23. 03</td></td<>	23.03		0	0		0	0	0	23. 03
11.00 03100 INTENSIVE CARE UNIT 120 882.975 0 57.128.719 12.316 31.00 32.00 35.00 02060 NEOMATAL INTENSIVE CARE UNIT 0 0 10.00 27.00 0 10.00 20.085 35.00 0.00 05000 NERSERY 0 14.475.521 0 152.500.122 0 50.00 0.00 05000 OPERATING ROM 03 14.477.521 0 152.500.122 0 50.00 55.00 0.00 05000 OPERATING ROM 03 14.477.521 0 152.500.122 0 50.00 55.0	30 00		150	1 0/6 5/6		0	180 /01 11/	60.815	30.00
35. 00 02060 NEONARAL INTENSIVE CARE UNIT 0 11.009 0 16.426, 210 2.085 35. 00 ANDILLARY SERVICE COST CONTERS									
43. 00 043.00 NURSERY 7 46. 62 2. 529, 7.28 1.682 43. 00 ANCLLARY SERVE COST CENTERS 50. 00 05000 0F5AR1 NG ROOM 103 14, 417, 521 0 152, 500, 122 0 50. 00 50. 00 51. 00 51. 00 51. 00 51. 00 51. 00 52. 049 124, 489, 412 0 51. 00 52. 049 0. 407, 198 0. 52. 00 52. 040 72. 443 0 54. 00 55. 00 55. 00 55. 00 55. 00 55. 00 0. 550.00 71. 625, 786 0 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 58. 00 0. 560.00 480.71.0 CKP-112 (R12A) 0 16. 755. 166 228. 59. 596 0 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00		03200 CORONARY CARE UNI T					0	0	
ANCLLARY SERVICE COST CENTERS Control Control <thcontrol< th=""> Control <thcon< td=""><td></td><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td><td></td></thcon<></thcontrol<>			0						
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52.00 DESLOV DELL'REY ROMÀ & LABOR ROM 24 172,310 0 9,407,198 0 52.00 54.00 55.00 ORSO RADI LOCY-THERAPUTI C 0 229,325 0 1,625,785 0 57.00 57.00 OSTO CT SCAN 0 63.324 0.85,791,000 0 57.00 58.00 OSBOD IMARTI C RESONANCE IMAGING (MRI) 0 2.16,55,785 0 59.00 59.00 OSOD CARDI AC CATHETERI ZATI ON 0 16,755,166 228,539,596 69.00 60.00 CARDI AC CATHETERI ZATI ON 0 16,755,166 228,139,596 69.00 60.00 CARDI AC CATHETERI ZATI ON 0 16,755,166 228,239,230 64.00 61.00 CARDI AC CATHETERI ZATHENY 0 118,652 17,254,474 66.00 62.00 CESPI RATIORY THERAPY 0 101,228 2,306,721 64.00 63.00 SECOL PARTIOLOCY 0 101,228 52.0,379 67.00 64.00 CELCTROCACATARE 0 101,228		05000 OPERATI NG ROOM	103					0	
54 00 05400 RADI LOCY-DI AGNOSTIC 0 1,951 0 50,22,443 0 54,00 55 00 05700 RADI LOCY-DI REAPEUTIC 0 229,235 0 21,425,785 0 55,00 56 00 05900 MARCHET C RESONANCE I MAGI NG (MRI) 0 21,625,785 0 58,00 59,00 56 00 05900 CARDI AC CATHETERI ZATI ON 0 16,755,166 0 228,539,596 59,00 60 00 06000 INTRAVENDUS THERAPY 0 11,693 0 2,370,930 0 64,00 64 00 06000 INTRAVENDUS THERAPY 0 118,585 0 17,254,474 0 65,00 65 00 06500 PESCH PATHOLOGY 0 10,128 0 2,306,721 0 68,00 68 00 06000 PESCH PATHOLOGY 0 10,128 0 2,306,721 0 69,00 71 00 DI CAL SUPPLIES CHARGED TO PATI ENTS 0 23,308,724 0 71,0046,143 0 71,00 72 00 07200 DUCDA ECHROCRAPHY 0									
55.00 05500 RADIOLGOY-THERAPUTIC 0 229, 235 0 21, 625, 785 0 55.00 57.00 05700 CT CAN 0 63, 324 0 85, 791, 1000 57.00 58.00 OSBO0 MAGNETIC C RESONANCE I MAGING (MRI) 0 16, 755, 166 0 228, 539, 596 59.00 60.00 OADOO LABDIAC CATHETERIZATION 0 16, 755, 166 0 228, 539, 596 0 59.00 60.00 INTRAVEMOUS THERAPY 0 11, 693 2, 370, 393 0 64.00 66.00 06500 INTRAVEMOUS THERAPY 0 118, 624 0 30, 283, 923 0 65.00 67.00 050700 OCCUPATIONAL THERAPY 0 118, 624 0 30, 283, 923 0 67.00 68.00 06600 FHESCH PATHOLOGY 0 101, 628 0 51, 303, 609 0 69.00 70.00 CTUCO TATIONAL THERAPY 0 101, 628 0 51, 333, 609 0 69.00 70.00 CTUCO TATIONAL THERAPY 0 101, 628 0 53, 350			1			~		Ű	
58:00 OSBOO (ARDIA C ATHETER LATION 0 216 0 12, 834, 841 0 58.00 59:00 05000 (ARDIA C ATHETER LATION 0 16, 755, 166 0 28, 593, 596 0 59.00 60:00 06000 (LABORATORY 0 2, 729, 548 0 160, 416, 808 0 60.00 64:00 06400 (INTRAVENOUS THERAPY 0 118, 632 0 2, 370, 930 64.00 65:00 06500 (RESPI RATORY THERAPY 0 118, 555 0 17, 254, 474 0 65.00 66:00 06400 (RESPI RATORAL THERAPY 0 114, 635 0 7.00 67.00 67.00 67.00 67.00 69.00 101, 628 0 51, 35, 609 0 69.00 0 0 0 68.00 0 60.026, 477 0 70.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>0</td> <td></td> <td>0</td> <td>55.00</td>			0			0		0	55.00
99:00 059:00 CARDIAC CATHETERI ZATION 0 16, 755, 166 0 228, 539, 596 0 59.00 06:00 06:00 LABORATORY 0 2, 729, 548 0 160, 416, 808 0 60.00 06:00 06:00 LABORATORY 0 11, 693 0 2, 370, 930 0 64.00 06:00 06:00 06:00 06:00 0 66:00 0 66:00 0 66:00 0 66:00 0 66:00 0 66:00 0 66:00 66:00 0 66:00 0 66:00 0 66:00 60:00 66:00 60:00 66:00 60:00			0			-			
60:00 060:00 LABORATORY 0 2.729, 548 0 160, 416, 808 0 60:00 64:00 064:00 INTRAVENUS THERAPY 0 116, 693 0 23:00, 930 0 64:00 66:00 06600 PHYSICAL THERAPY 0 185, 524 0 30: 283, 923 0 66: 00 67:00 067:00 OCCUPATIONAL THERAPY 0 24, 241 0 5; 520, 319 0 67: 00 69:00 069000 ELECTROCARDIDLOGY 0 101, 628 0 51, 535, 609 0 69: 00 01:00 07000 ELECTROCARDED TO PATIENTS 0 23, 398, 724 0 71, 046, 143 0 71. 00 01:00 07000 B04, 704, 513 0 73.00 0 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 74.40 74.403 71.00 76.00 76.03 76.01 76.03 76.01 76.03 76.01			-						
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92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 92. OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 0 98950 0 0 0 0 0 98. 98. 0 0 0 0 0 0 98. 98. 0 0 0 0 0 98. 100 2, 703, 714, 970 85, 928 118. 98. 100 2, 703, 714, 970 85, 928 118. 118. 0 NONREI MBURSABLE COST CENTERS 118. 118. 100 2, 703, 714, 970 85, 928 118. 118. 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190.	Health Financial Systems CO	MMUNITY HEALTH	NETWORK, INC.		In Lie	eu of Form CMS-	2552-10
To 12/31/2020 Date/Time Prepare 8/2/2021 3: 24 pm Cost Center Description NURSI NG ADMI NI STRATI ON SERVI CES & SUPPLY PHARMACY (COSTED REOUIS.) MEDI CAL RECORDS & LI BRARY (GROSS SOCI AL SERVI CE RECORDS & LI BRARY (GROSS 91. 00 09100 EMERGENCY 01 RECT NURS. (COSTED HRS.) REOUI S.) CHARGES) (TOTAL PATI ENT DAYS) 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 124 1, 244, 143 0 216, 221, 018 0 91. 92. 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 98.00 SPECIAL PURPOSE COST CENTERS 98. 99.00 SUBTOTALS (SUM OF LINES 1 through 117) 837 188, 534, 908 100 2, 703, 714, 970 85, 928 118. 118. 00 0 0 0 0 0 0 0 0 0 0 0 0 190.00 190.00 190.00 190.00 190.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td>COST ALLOCATION - STATISTICAL BASIS</td> <td></td> <td>Provider CC</td> <td></td> <td></td> <td></td> <td></td>	COST ALLOCATION - STATISTICAL BASIS		Provider CC				
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OTHER REI MBURSABLE COST CENTERS O </td <td></td> <td>121</td> <td>1,211,110</td> <td></td> <td>210, 221, 010</td> <td></td> <td>92.00</td>		121	1,211,110		210, 221, 010		92.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 98. SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 837 188, 534, 908 100 2, 703, 714, 970 85, 928 118. NONREL MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 190.00 19100 RESEARCH 0 0 0 0 191. 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192. 194.00 07950 HOME OFFI CE 0 0 0 0 192. 194.00 07950 HOME OFFI CE 0 0 0 194. 194.02 07952 ACCOUNTABLE CARE 0 1,093 0 0 194. 194.02 07952 ACCOUNTABLE CARE 0 1,093 0						1	
SUBTOTALS SUBTOTALS SUM OF LINES 1 through 117) 837 188, 534, 908 100 2, 703, 714, 970 85, 928 188, 534, 908 100 2, 703, 714, 970 85, 928 188, 534, 908 100 2, 703, 714, 970 85, 928 188, 534, 908 100 2, 703, 714, 970 85, 928 188, 534, 908 100 2, 703, 714, 970 85, 928 188, 534, 908 100 2, 703, 714, 970 85, 928 188, 534, 908 100 2, 703, 714, 970 85, 928 188, 534, 908 100 2, 703, 714, 970 85, 928 188, 534, 908 100 2, 703, 714, 970 85, 928 188, 534, 908 100 2, 703, 714, 970 85, 928 188, 534, 908 100 2, 703, 714, 970 85, 928 188, 534, 908 100 2, 703, 714, 970 85, 928 188, 534, 908 100 190, 190, 190, 190, 190, 190, 190, 190,		0	0		0 0	0	98.00
NONREI MBURSABLE COST CENTERS 190. 00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 191. 00 19100 RESEARCH 0 0 0 0 191. 192. 00 19100 RESEARCH 0 0 0 0 191. 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192. 194. 00 07950 HOME OFFI CES 0 0 0 0 194. 194. 01 07950 HOME OFFI CE 0 0 0 0 194. 194. 02 07952 ACCOUNTABLE CARE 0 1,093 0 0 0 194. 194. 03 07953 SCHOOL BASED CLINICS 0 9,352 0 0 0 194.	SPECIAL PURPOSE COST CENTERS						
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 191.00 19100 RESEARCH 0 0 0 0 191. 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 192. 194.00 07950 HOME OFFICE 0 0 0 0 192. 194.00 07950 HOME OFFICE 0 0 0 0 194. 194.01 07951 OCCUPATI ONAL HEALTH ONSI TE SVCS 0 0 0 0 194. 194.02 07952 ACCOUNTABLE CARE 0 1,093 0 0 0 194.03 07953 SCHOOL BASED CLINICS 0 9,352 0 0 0 194.	118.00 SUBTOTALS (SUM OF LINES 1 through 117)	837	188, 534, 908	10	0 2, 703, 714, 970	85, 928	118.00
191.00 19100 RESEARCH 0 0 0 191. 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 192. 194.00 07950 HOME OFFICE 0 0 0 0 194. 194.01 07951 OCCUPATI ONAL HEALTH ONSI TE SVCS 0 0 0 0 194. 194.02 07952 ACCOUNTABLE CARE 0 1,093 0 0 194. 194.03 07953 SCHOOL BASED CLINICS 0 9,352 0 0 0 194.							
192.00 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192. 194.00 07950 HOME OFFICE 0 0 0 194. 194.01 07951 OCCUPATI ONAL HEALTH ONSI TE SVCS 0 0 0 0 194. 194.02 07952 ACCOUNTABLE CARE 0 1,093 0 0 194. 194.03 07953 SCHOOL BASED CLINICS 0 9,352 0 0 0 194.		0	0				190.00
194.00 07950 HOME OFFICE 0 0 0 194. 194.01 07951 OCCUPATI ONAL HEALTH ONSITE SVCS 0 0 0 0 194. 194.02 07952 ACCOUNTABLE CARE 0 1,093 0 0 0 194. 194.03 07953 SCHOOL BASED CLINICS 0 9,352 0 0 0 194.		0	0				191.00
194. 01 07951 OCCUPATI ONAL HEALTH ONSI TE SVCS 0 0 0 194. 194. 02 07952 ACCOUNTABLE CARE 0 1,093 0 0 194. 194. 03 07953 SCHOOL BASED CLINICS 0 9,352 0 0 0 194.		0	0		° °		
194. 02 07952 ACCOUNTABLE CARE 0 1,093 0 0 194. 194. 03 07953 SCHOOL BASED CLINICS 0 9,352 0 0 0 194.		0	0				
194. 03 07953 SCHOOL BASED CLINICS 0 9, 352 0 0 0 194.		0	0				
		0			0		
194. 04 07 954 SMO-NUN PROVIDER BASED 0 0 0 01 01 01 01 01 01 01 01 01 01 01		0	9, 352				
		0	0		0 0		
		0	403		0 0		194.05 194.07
		0	74 017				194.07
		0	74,017				194.08
		0	0		0 0	0	200.00
							200.00
201. 00 Regarive cost centers 201. 202. 00 Cost to be allocated (per Wkst. B, 10,059,433 17,045,156 15,037,038 7,364,106 2,953,656 202.		10 059 433	17 045 156	15 037 03	8 7 364 106	2 953 656	
Part 1)		10,007,400	17, 045, 150	15,057,05	7, 304, 100	2, 755, 050	202.00
203.00 Unit cost multiplier (Wkst. B, Part I) 12,018.438471 0.090368150,370.380000 0.002724 34.373615203.		12.018.438471	0. 090368	150, 370, 38000	0 0.002724	34. 373615	203.00
204.00 Cost to be allocated (per Wkst. B, 533,072 2,887,125 1,491,766 224,955 107,572 204.							
Part II)	Part II)						
205.00 Unit cost multiplier (Wkst. B, Part 636.884110 0.015307 14,917.660000 0.00083 1.251885 205.	205.00 Unit cost multiplier (Wkst. B, Part	636. 884110	0. 015307	14, 917. 66000	0.000083	1. 251885	205.00
							206.00
(per Wkst. B-2)							
							207.00
Parts III and IV)	Parts III and IV)	.			I	I	I

	Financial Systems (ALLOCATION - STATISTICAL BASIS	COMMUNITY HEALTH		CN: 15-0074 P	<u>In Lie</u> eriod: rom 01/01/2020	u of Form CMS- Worksheet B-1	
					o 12/31/2020	Date/Time Pre 8/2/2021 3:24	
		INTERNS &	RESI DENTS			0/2/2021 3.24	
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES (ASSI GNED TI ME)	SERVI CES-OTHER PRGM COSTS (ASSI GNED TI ME)	EMS TRAI NI NG-ALLI E D HEALTH (ASSI GNED TI ME)	RADI OLOGY SCHOOL-ALLI ED HEALTH (ASSI GNED TI ME)	PHARMACY RESI DENCY-ALLI ED HEALTH (ASSI GNED TI ME)	
	OFNEDAL OFDILLOF ODOT OFNITEDO	21.00	22.00	23.00	23.01	23.02	
1.00 2.00 4.00 5.00 7.00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT O0200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						1.00 2.00 4.00 5.00 7.00
8.00 9.00 10.00 11.00 13.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION						8.00 9.00 10.00 11.00 13.00
14.00 15.00 16.00 17.00 21.00 22.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	449, 951	449, 951				14.00 15.00 16.00 17.00 21.00 22.00
23. 00 23. 01 23. 02 23. 03	02300 EMS TRAI NI NG-ALLI ED HEALTH 02301 RADI OLOGY SCHOOL-ALLI ED HEALTH 02302 PHARMACY RESI DENCY-ALLI ED HEALTH 02303 PHARMACY RESI DNECY-BTH ALLI ED HEALTH I NPATI ENT ROUTI NE SERVI CE COST CENTERS		449, 931	0	0	0	23. 00 23. 01
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T	209, 191	209, 191		-	0	
31.00	03200 CORONARY CARE UNIT	1, 913 0	1, 913 (0	0	
35. 00 43. 00	02060 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY ANCILLARY SERVICE COST CENTERS	2, 623 0	2, 623			0	
50.00	05000 OPERATING ROOM	16, 831	16, 831	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	C		-	0	
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0				0	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C		-	0	55.00
57.00	05700 CT SCAN	0	0	-	0	0	
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0			0	0	
60.00	06000 LABORATORY	0	0		0	0	
64.00	06400 I NTRAVENOUS THERAPY	0	C			0	
	06500 RESPI RATORY THERAPY	0	C	-	-	0	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0			0	0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	
69.00	06900 ELECTROCARDI OLOGY	4, 973	4, 973	3 0	0	0	
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	
72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 607	8, 607	0	0	0	
74.00	07400 RENAL DI ALYSI S	0	C	0	0	0	
76. 00 76. 01	03330 ENDOSCOPY 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0 24, 235	24, 235) O 5 O	0	0	
	03951 LUTHERWOOD PARTNERSHI P	24,233	24,235		0	0	
76.04	03952 WOUND CARE CENTER	1, 612	1, 612	2 0	0	0	76.04
	03480 ONCOLOGY-CANCER CARE CENTER	0	0	0	0	0	
76.06 76.07	03953 I MAGI NG CENTERS 03954 BREAST DI AGNOSTI C CENTER	0			0	0	
	07697 CARDI AC REHABI LI TATI ON	0	C	o o	0	0	
76. 98		0	0	00	0	0	76. 98
00 00					0	0	
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	
90.00	09000 CLINIC	0	C	o o	0	0	
90.01	04950 DI ABETI C CARE CENTER	0	C	0	0	0	
90. 02 90. 03	04951 HEALTHY HEARTS CENTER 09001 CLI NI C	0			0	0	90. 02 90. 03
	04953 SPINE CENTER	0	(0	0	
90.05	04954 INFUSION CENTERS	0	0	o o	0	0	90.05
		0	0	0	0	0	
90. 07 90. 08	09003 KNEE CENTER 09004 PALLI ATI VE CARE	2, 541	2, 541 C		0	0	
70.00		0		γ U	0	0	1 /0.00

OST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 8/2/2021 3:24	pared:
	INTERNS &	RESI DENTS			0/2/2021 3.24	
Cost Center Description	SERVI CES-SALAR		EMS	RADI OLOGY	PHARMACY	
Cost center bescription	Y & FRINGES			E SCHOOL-ALLI ED		
	(ASSI GNED	(ASSI GNED	D HEALTH	HEALTH	ED HEALTH	
	TIME)	TIME)	(ASSI GNED	(ASSI GNED	(ASSI GNED	
	,	,	TIME)	TIME)	TIME)	
	21.00	22.00	23.00	23.01	23.02	
0.10 09006 WORK SITE CLINICS	0	0		0 0	0	1
0.12 04961 FAMILY PRACTICE AND MATERNITY CARE	0	0		0 0	0	
1.00 09100 EMERGENCY	13, 628	13, 628		0 0	0	
2. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS						92.0
8. 00 09850 OTHER REIMBURSABLE COST CENTERS	o	0		0 0	0	98.0
SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	70.0
18.00 SUBTOTALS (SUM OF LINES 1 through 117)	286, 154	286, 154		0 0	0	118.0
NONREI MBURSABLE COST CENTERS					-	1
90.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 0
91. 00 19100 RESEARCH	0	0		0 0		191.0
92.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.0
94.00 07950 HOME OFFICE	0	0		0 0		194.0
94. 01 07951 OCCUPATI ONAL HEALTH ONSI TE SVCS	0	0		0 0		194.0
94. 02 07952 ACCOUNTABLE CARE	0	2 2 2 2 2		0 0		194. C
94.03 07953 SCHOOL BASED CLINICS 94.04 07954 SMO-NON PROVIDER BASED	3, 333	3, 333		0 0		194. C
94. 05 07955 FAMILY PRACTICE MEDICINE	157, 158	157, 158				194. C
94. 07 07957 LI FECHECK	137, 130	137, 130		0 0		194.0
94. 08 07958 GROUP HOMES AND MISC. N R CTRS	3, 306	3, 306		0 0		194.0
94.0907959 SURGERY CENTER EAST	0	0		0 0		194. C
00.00 Cross Foot Adjustments						200. C
01.00 Negative Cost Centers						201.0
02.00 Cost to be allocated (per Wkst. B, Part I)	4, 926, 899	7, 996, 452		0 0	0	202. 0
03.00 Unit cost multiplier (Wkst. B, Part I)	10. 949857	17. 771828	0.00000	0 0. 000000	0.000000	203.0
04.00 Cost to be allocated (per Wkst. B, Part II)	116, 136	456, 230		0 0	0	204.0
D5.00 Unit cost multiplier (Wkst. B, Part	0. 258108	1. 013955	0. 00000	0 0. 000000	0.000000	205. C
06.00 NAHE adjustment amount to be allocated (per Wkst. B-2)				0 0	0	206. 0
07.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0. 00000	0 0. 000000	0.000000	207.0

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	COMMUNI TY HEALTH	NETWORK, INC. Provider CCN: 15-0074	In Lieu Period:	of Form CMS-2552-10 Worksheet B-1
			From 01/01/2020 To 12/31/2020	Date/Time Prepared:
Cost Center Description	PHARMACY RESI DNECY-BTH ALLI ED HEALTH (ASSI GNED TI ME) 23. 03			8/2/2021 3: 24 pm
GENERAL SERVICE COST CENTERS				1.00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 O1100 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 CANTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVICE 21.00 02100 I & SERVICE				$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 21.$
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 23.00 02300 EMS TRAINING-ALLIED HEALTH				22.00 23.00
23. 01 02301 RADIOLOGY SCHOOL-ALLIED HEALTH 23. 02 02302 PHARMACY RESIDENCY-ALLIED HEALTH				23. 01 23. 02
23. 03 02303 PHARMACY RESIDNECY-BTH ALLIED HEALTH INPATIENT ROUTINE SERVICE COST CENTERS	0			23.03
30. 00 03000 ADULTS & PEDI ATRI CS	0			30.00
31. 00 03100 INTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T	0			31.00 32.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0			35.00
43. 00 04300 NURSERY	0			43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0			50.00
51.00 05100 RECOVERY ROOM	0			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	0			52.00 54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			55.00
57.00 05700 CT SCAN	0			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	0			58.00 59.00
60. 00 06000 LABORATORY	0			60.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0			64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0			66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0			67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			71.00 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0			73.00
74. 00 07400 RENAL DI ALYSI S 76. 00 03330 ENDOSCOPY	0			74.00 76.00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0			76.01
76. 03 03951 LUTHERWOOD PARTNERSHIP 76. 04 03952 WOUND CARE CENTER	0			76.03
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	0			76. 04 76. 05
76. 06 03953 I MAGI NG CENTERS	0			76.06
76. 07 03954 BREAST DI AGNOSTI C CENTER 76. 97 07697 CARDI AC REHABI LI TATI ON	0			76. 07 76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	0			76. 98
88.00 08800 RURAL HEALTH CLINIC	0			88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0			89.00 90.00
90. 01 04950 DI ABETI C CARE CENTER	0			90. 01
90. 02 04951 HEALTHY HEARTS CENTER 90. 03 09001 CLI NI C	0			90. 02 90. 03
90. 04 04953 SPI NE CENTER	0			90.03
90. 05 04954 I NFUSI ON CENTERS	0			90.05
90. 06 09002 MEDCHECK CLINICS 90. 07 09003 KNEE CENTER	0			90.06 90.07
90. 08 09004 PALLI ATI VE CARE	0			90.08
90.10 09006 WORK SITE CLINICS 90.12 04961 FAMILY PRACTICE AND MATERNITY CARE	0			90. 10 90. 12
30. 12 U4901 FAMILI PRACIICE AND MATERNITY CARE	I U			90.12

alth Financial Syst		OMMUNITY HEALTH N				eu of Form CMS-25
OST ALLOCATION - STA	TI STI CAL BASI S		Provider CCN:	15-0074	Peri od:	Worksheet B-1
					From 01/01/2020 To 12/31/2020	
					10 12/31/2020	8/2/2021 3: 24 p
Cost Cent	er Description	PHARMACY				
		RESI DNECY-BTH				
		ALLI ED HEALTH				
		(ASSI GNED				
		TIME)				
		23.03				
. 00 09100 EMERGENCY		0				ç
	ON BEDS (NON-DISTINCT PART)					ç
	BLE COST CENTERS	1				
	MBURSABLE COST CENTERS	0				ç
SPECIAL PURPOSE		TT				
	(SUM OF LINES 1 through 117)	0				11
NONREI MBURSABLE		1				
	WER, COFFEE SHOP & CANTEEN	0				19
1.0019100 RESEARCH		0				19
2. 00 19200 PHYSI CI AN		0				19
4.0007950 HOME OFFI		0				19
	NAL HEALTH ONSITE SVCS	0				19
4. 02 07952 ACCOUNTAE		0				19
4.0307953 SCHOOL BA		0				19
4.0407954 SMO-NON F		0				19
94.0507955 FAMILY PF		0				19
04. 07 07957 LI FECHECK		0				19
	ES AND MISC. N_R CTRS	0				19
4.0907959SURGERY C		0				19
	t Adjustments					20
	Cost Centers					20
	e allocated (per Wkst. B,	0				20
Part I)						
	multiplier (Wkst. B, Part I)	0. 000000				20
	e allocated (per Wkst. B,	0				20
Part II)		0.000000				
	multiplier (Wkst. B, Part	0. 000000				20
	atment amount to be all					
	stment amount to be allocated	0				20
(per Wkst		0,000000				
	cost multiplier (Wkst. D, and IV)	0. 000000				20

Heal th	Fi nar	ici a	I Syst	ems			
COMPLIE		OF	PATIO	OF	27200	ΤO	СН

Health Financial Systems	COMMUNI TY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-	2552-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0074 F	Period: From 01/01/2020	Worksheet C Part I	
			T	0 12/31/2020	Date/Time Pre 8/2/2021 3:24	pared:
		Title	XVIII	Hospi tal	PPS	piii
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)		0.00	1.00	- 00	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	90, 865, 582		90, 865, 582		00 045 502	30.00
31. 00 03100 INTENSIVE CARE UNIT	25, 392, 447		25, 392, 447		90, 865, 582 25, 392, 447	
32. 00 03200 CORONARY CARE UNIT	23, 372, 447		23, 372, 447	0	23, 372, 447	
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	2, 476, 117		2, 476, 117		2, 476, 117	
43. 00 04300 NURSERY	1, 633, 532		1, 633, 532		1, 633, 532	
ANCI LLARY SERVICE COST CENTERS			.,,	-1	.,	
50. 00 05000 OPERATI NG ROOM	34, 645, 160		34, 645, 160) 0	34, 645, 160	50.00
51.00 05100 RECOVERY ROOM	1, 829, 133		1, 829, 133	3 0	1, 829, 133	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 438, 917		6, 438, 917	0	6, 438, 917	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 508, 954		8, 508, 954		8, 508, 954	
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 517, 376		1, 517, 376		1, 517, 376	
57.00 05700 CT SCAN	5, 034, 857		5, 034, 857		5, 034, 857	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 860, 884		1, 860, 884		1, 860, 884	
59. 00 05900 CARDI AC_CATHETERI ZATI ON 60. 00 06000 LABORATORY	11, 813, 895		11, 813, 895		11, 813, 895	
64. 00 06400 INTRAVENOUS THERAPY	18, 929, 889 2, 211, 208		18, 929, 889 2, 211, 208		18, 929, 889	
65. 00 06500 RESPIRATORY THERAPY	6, 242, 917	0			2, 211, 208 6, 242, 917	
66. 00 06600 PHYSI CAL THERAPY	9, 055, 156	0	9, 055, 156		9, 055, 156	•
57. 00 06700 OCCUPATI ONAL THERAPY	2, 725, 085	0	2, 725, 085		2, 725, 085	
58. 00 06800 SPEECH PATHOLOGY	1, 137, 857	0	1, 137, 857		1, 137, 857	
69. 00 06900 ELECTROCARDI OLOGY	4, 533, 719	0	4, 533, 719		4, 533, 719	
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 202, 070		1, 202, 070		1, 202, 070	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			31, 307, 825		31, 307, 825	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	32, 053, 414		32, 053, 414		32, 053, 414	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	183, 983, 897		183, 983, 897	0	183, 983, 897	73.00
74.00 07400 RENAL DIALYSIS	2, 175, 059		2, 175, 059		2, 175, 059	
76. 00 03330 ENDOSCOPY	959, 679		959, 679		959, 679	
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	11, 834, 584		11, 834, 584		11, 834, 584	
76. 03 03951 LUTHERWOOD PARTNERSHIP	6, 156, 488		6, 156, 488		6, 156, 488	
76.04 03952 WOUND CARE CENTER 76.05 03480 ONCOLOGY-CANCER CARE CENTER	3, 582, 686 51, 914, 335		3, 582, 686 51, 914, 335		3, 582, 686 51, 914, 335	
76. 06 03953 I MAGI NG CENTERS	8, 965, 369		8, 965, 369		8, 965, 369	
76. 07 03954 BREAST DIAGNOSTIC CENTER	3, 101, 575		3, 101, 575		3, 101, 575	
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 830, 392		1, 830, 392		1, 830, 392	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	614, 630		614, 630		614, 630	
OUTPATIENT SERVICE COST CENTERS	· · ·					1
88.00 08800 RURAL HEALTH CLINIC	0		C	0 0	0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0 0	0	
90. 00 09000 CLINIC	0		C	-	0	
90. 01 04950 DI ABETI C CARE CENTER	0			0	0	
90. 02 04951 HEALTHY HEARTS CENTER	1, 971, 517		1, 971, 517	0	1, 971, 517	
90. 03 09001 CLINIC	0				0	
90. 04 04953 SPI NE CENTER 90. 05 04954 I NFUSI ON CENTERS	0				0 870 271	
90. 05 04954 I NFUSI ON CENTERS 90. 06 09002 MEDCHECK CLINICS	879, 271		879, 271		879, 271 0	1
20. 07 09002 MEDCHECK CETNICS	6, 179, 367		6, 179, 367		6, 179, 367	
90. 08 09004 PALLI ATI VE CARE	211		211		211	
90. 10 09006 WORK SITE CLINICS	0		211		0	
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0		() Ö	0	
91.00 09100 EMERGENCY	29, 330, 051		29, 330, 051	0	29, 330, 051	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			6, 797, 012		6, 797, 012	
OTHER REIMBURSABLE COST CENTERS						
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0		C		0	
200.00 Subtotal (see instructions)	621, 692, 117	0			621, 692, 117	
				NI I	/ 707 040	1001 00
201.00Less Observation Beds202.00Total (see instructions)	6, 797, 012 614, 895, 105	0	6, 797, 012 614, 895, 105		6, 797, 012 614, 895, 105	

OMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider C	1	Period: From 01/01/2020 Fo 12/31/2020	Worksheet C Part I Date/Time Pre 8/2/2021 3:24	2552-10
			Title	XVIII	Hospi tal	PPS	piii
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
0.00	03000 ADULTS & PEDIATRICS	171, 161, 842		171, 161, 842	2		30. 00
1.00	03100 I NTENSI VE CARE UNI T	57, 128, 719		57, 128, 719	9		31.00
2.00	03200 CORONARY CARE UNIT	0		(D		32.00
	02060 NEONATAL INTENSIVE CARE UNIT	16, 426, 210		16, 426, 210			35.00
	04300 NURSERY	2, 529, 728		2, 529, 728	3		43.00
	ANCI LLARY SERVI CE COST CENTERS	1					
	05000 OPERATING ROOM	103, 923, 030	48, 577, 092	152, 500, 122		0.000000	
	05100 RECOVERY ROOM	6, 340, 643	6, 148, 769	12, 489, 412		0.00000	
	05200 DELIVERY ROOM & LABOR ROOM	9, 407, 198	0	9, 407, 198		0.000000	
	05400 RADI OLOGY-DI AGNOSTI C	10, 518, 441	40, 204, 002	50, 722, 44		0.000000	
	05500 RADI OLOGY-THERAPEUTI C	8, 283, 816	13, 341, 969	21, 625, 78		0.000000	
	05700 CT SCAN	23, 408, 787	62, 382, 213			0.000000	
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	3, 975, 090	8, 859, 751 134, 913, 633	12, 834, 84 ⁻ 228, 539, 596		0. 000000 0. 000000	
		93, 625, 963					
	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	78, 707, 637 902, 789	81, 709, 171	160, 416, 808		0.000000	60.00 64.00
		27, 340, 309	1, 468, 141	2, 370, 930			
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		2, 943, 614 13, 942, 312	30, 283, 92		0. 000000 0. 000000	
	06700 OCCUPATIONAL THERAPY	3, 312, 162 2, 701, 492	2, 818, 827	17, 254, 474 5, 520, 319		0.000000	
	06800 SPEECH PATHOLOGY	1, 113, 120	1, 193, 601	2, 306, 72		0.000000	
	06900 ELECTROCARDI OLOGY	13, 568, 478	37, 785, 131	51, 353, 60		0.000000	
	07000 ELECTROEARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	748, 736	5, 277, 741	6, 026, 47		0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 200, 151	33, 845, 992	71, 046, 143		0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	50, 678, 111	29, 796, 620	80, 474, 73		0.000000	
	07300 DRUGS CHARGED TO PATIENTS	67, 756, 864	817, 013, 589	884, 770, 453		0.000000	
	07400 RENAL DIALYSIS	7, 233, 567	0	7, 233, 56		0. 000000	
	03330 ENDOSCOPY	1, 782, 369	2, 635, 501	4, 417, 870		0. 000000	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	23, 956, 453			0. 000000	
	03951 LUTHERWOOD PARTNERSHIP	0	1, 328, 250	1, 328, 250		0. 000000	
	03952 WOUND CARE CENTER	602, 507	12, 095, 851	12, 698, 358		0.000000	
	03480 ONCOLOGY-CANCER CARE CENTER	1, 555, 306	214, 872, 839	216, 428, 14		0.000000	
6.06	03953 I MAGI NG CENTERS	102, 601	59, 147, 667	59, 250, 268	0. 151314	0.000000	76.0
6. 07	03954 BREAST DIAGNOSTIC CENTER	9, 033	4, 961, 888	4, 970, 92 ⁻	0. 623944	0. 000000	76.0
	07697 CARDI AC REHABI LI TATI ON	63, 992	2, 603, 874	2, 667, 860	0. 686088	0.000000	76.9
6. 98	07698 HYPERBARI C OXYGEN THERAPY	0	2, 436, 896	2, 436, 890	0. 252218	0.00000	76.9
	DUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0		ס		88.0
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		D		89.0
	09000 CLI NI C	0	0		0. 000000	0. 000000	
	04950 DIABETIC CARE CENTER	0	0		0. 000000	0.000000	
1	04951 HEALTHY HEARTS CENTER	16, 783	3, 135, 753	3, 152, 530		0.000000	
		0	0	(0.00000	0.000000	90.0
1	04953 SPI NE CENTER	0	0	(0.00000	0.000000	
1	04954 INFUSION CENTERS	0	2, 109, 518	2, 109, 518		0.000000	
	09002 MEDCHECK CLINICS	0	0	(0.000000	0.000000	
	09003 KNEE CENTER	9, 409	4, 445, 590	4, 454, 999		0.000000	
		0	77, 549	77, 549		0.000000	90.0
	09006 WORK SITE CLINICS	0	0		0.000000	0.000000	90.1
	04961 FAMILY PRACTICE AND MATERNITY CARE				0.00000	0.000000	90.1
	09100 EMERGENCY	45, 755, 962	170, 465, 056			0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 652, 797	6, 676, 475	9, 329, 272	0. 728568	0. 000000	92.0
	OTHER RELIMBURSABLE COST CENTERS	2	2			0,000000	
	09850 OTHER REIMBURSABLE COST CENTERS	0			0. 000000	0.000000	
	Subtotal (coo instructions)						
8.00 00.00 01.00	Subtotal (see instructions) Less Observation Beds	850, 543, 642	1, 853, 171, 328	2, 703, 714, 970			200.00

Health Financial Systems	COMMUNITY HEALTH N	ETWORK, INC.	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0074	Peri od:	Worksheet C
			From 01/01/2020	Part I Data /Tima Draparadi
			To 12/31/2020	Date/Time Prepared: 8/2/2021 3:24 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient	- <u>I</u>		
	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
32.00 03200 CORONARY CARE UNI T				32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT				35.00
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVICE COST CENTERS	0.007101			F0.00
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	0. 227181 0. 146455			50.00 51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 148455			52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 167755			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 070165			55.00
57. 00 05700 CT SCAN	0. 058687			57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 144987			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 051693			59.00
60. 00 06000 LABORATORY	0. 118004			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 932633			64.00
65.00 06500 RESPI RATORY THERAPY	0. 206146			65.00
66.00 06600 PHYSI CAL THERAPY	0. 524800			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 493646			67.00
68.00 06800 SPEECH PATHOLOGY	0. 493279			68.00
69.00 06900 ELECTROCARDI OLOGY	0. 088284			69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 199465			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	ENTS 0. 440669			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 398304			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 207945			73.00
74.00 07400 RENAL DI ALYSI S	0. 300690			74.00
76.00 03330 ENDOSCOPY	0. 217227			76.00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CE	1 1			76.01
76. 03 03951 LUTHERWOOD PARTNERSHIP	4. 635037			76.03
76. 04 03952 WOUND CARE CENTER	0. 282138			76.04
76.05 03480 ONCOLOGY-CANCER CARE CENTER 76.06 03953 I MAGI NG CENTERS	0. 239869			76.05
76.06 03953 IMAGING CENTERS 76.07 03954 BREAST DIAGNOSTIC CENTER	0. 151314 0. 623944			76.06 76.07
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 686088			76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 252218			76.98
OUTPATIENT SERVICE COST CENTERS	0.232210			/0./0
88.00 08800 RURAL HEALTH CLINIC				88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	2			89.00
90. 00 09000 CLINIC	0. 000000			90.00
90. 01 04950 DI ABETI C CARE CENTER	0. 000000			90. 01
90. 02 04951 HEALTHY HEARTS CENTER	0. 625375			90.02
90. 03 09001 CLINIC	0. 000000			90.03
90. 04 04953 SPINE CENTER	0. 000000			90.04
90.05 04954 INFUSION CENTERS	0. 416811			90.05
90. 06 09002 MEDCHECK CLINICS	0. 000000			90.06
90. 07 09003 KNEE CENTER	1. 387064			90.07
90. 08 09004 PALLI ATI VE CARE	0. 002721			90.08
90. 10 09006 WORK SITE CLINICS	0. 000000			90.10
90. 12 04961 FAMILY PRACTICE AND MATERNITY CAP				90.12
91.00 09100 EMERGENCY	0. 135648			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PA	ART) 0. 728568			92.00
OTHER REIMBURSABLE COST CENTERS	0. 000000			
98.00 09850 OTHER REIMBURSABLE COST CENTERS 200.00 Subtotal (see instructions)	0.00000			98.00 200.00
200.00 Subtotal (see Instructions) 201.00 Less Observation Beds				200.00
202.00 Total (see instructions)				201.00
	1			1

Heal th	Fi nar	ici a	I Syst	ems			
COMPLIE			DATIO		COSTS	ΤO	CL

Health Financial Systems	COMMUNI TY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0074 F	Period:	Worksheet C	
			F	rom 01/01/2020 o 12/31/2020	Part I	norod.
			1	0 12/31/2020	Date/Time Pre 8/2/2021 3:24	pared:
		Ti †1	e XIX	Hospi tal	PPS	piii
		1111		Costs	113	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
cost center bescription	(from Wkst. B,	Adj.		Di sal l owance	TOTAL COSTS	
		Auj .		DISALIOWALICE		
	Part I, col.					
	26)	2.00	2.00	4.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTER			04 070 000		04 070 000	0.00
30. 00 03000 ADULTS & PEDI ATRI CS	96, 873, 899		96, 873, 899		96, 873, 899	
31.00 03100 I NTENSI VE CARE UNI T	25, 447, 392		25, 447, 392		25, 447, 392	
32.00 03200 CORONARY CARE UNI T	0		C	-	0	
35.00 02060 NEONATAL INTENSIVE CARE UNIT	2, 551, 454		2, 551, 454		2, 551, 454	
43.00 04300 NURSERY	1, 633, 532		1, 633, 532	2 0	1, 633, 532	43.00
ANCI LLARY SERVI CE COST CENTERS				1		
50. 00 05000 OPERATI NG ROOM	35, 128, 575		35, 128, 575	5 0	35, 128, 575	
51.00 05100 RECOVERY ROOM	1, 829, 133		1, 829, 133	3 0	1, 829, 133	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 438, 917		6, 438, 917	0	6, 438, 917	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	8, 508, 954		8, 508, 954	l 0	8, 508, 954	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	1, 517, 376		1, 517, 376	0	1, 517, 376	55.00
57.00 05700 CT SCAN	5, 034, 857		5, 034, 857		5,034,857	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI			1, 860, 884		1, 860, 884	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	11, 813, 895		11, 813, 895		11, 813, 895	•
60. 00 06000 LABORATORY	18, 929, 889		18, 929, 889		18, 929, 889	•
64. 00 06400 I NTRAVENOUS THERAPY	2, 211, 208		2, 211, 208		2, 211, 208	
65. 00 06500 RESPIRATORY THERAPY	6, 242, 917	0			6, 242, 917	•
		0				
66. 00 06600 PHYSI CAL THERAPY	9, 055, 156	0	9, 055, 156		9, 055, 156	
67.00 06700 OCCUPATIONAL THERAPY	2, 725, 085	0	2, 725, 085		2, 725, 085	
68.00 06800 SPEECH PATHOLOGY	1, 137, 857	0	1, 137, 857		1, 137, 857	
69. 00 06900 ELECTROCARDI OLOGY	4, 676, 552		4, 676, 552		4, 676, 552	
70.00 07000 ELECTROENCEPHALOGRAPHY	1, 202, 070		1, 202, 070		1, 202, 070	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	I ENTS 31, 307, 825		31, 307, 825	5 0	31, 307, 825	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	32, 053, 414		32, 053, 414	l 0	32, 053, 414	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	184, 231, 104		184, 231, 104	l 0	184, 231, 104	73.00
74.00 07400 RENAL DIALYSIS	2, 175, 059		2, 175, 059	0	2, 175, 059	74.00
76.00 03330 ENDOSCOPY	959, 679		959, 679	0	959, 679	76.00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI			12, 530, 654		12, 530, 654	
76. 03 03951 LUTHERWOOD PARTNERSHIP	6, 156, 488		6, 156, 488		6, 156, 488	
76. 04 03952 WOUND CARE CENTER	3, 628, 985		3, 628, 985		3, 628, 985	
76. 05 03480 ONCOLOGY-CANCER CARE CENTER	51, 914, 335		51, 914, 335		51, 914, 335	
76. 06 03953 I MAGI NG CENTERS	8, 965, 369		8, 965, 369		8, 965, 369	
76. 07 03954 BREAST DI AGNOSTI C CENTER	3, 101, 575		3, 101, 575		3, 101, 575	
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 830, 392		1, 830, 392		1, 830, 392	•
76. 98 07698 HYPERBARI C OXYGEN THERAPY	614, 630		614, 630		614, 630	
	014,030		014,030	0	014, 030	/0.90
OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC				0	0	
					0	
90. 00 09000 CLINIC	0		C	0	0	
90. 01 04950 DI ABETI C CARE CENTER	0		C	0	0	1
90. 02 04951 HEALTHY HEARTS CENTER	1, 971, 517		1, 971, 517	0	1, 971, 517	
90. 03 09001 CLI NI C	0		[C	0	0	
90. 04 04953 SPI NE CENTER	0		C	0	0	
90. 05 04954 INFUSION CENTERS	879, 271		879, 271	0	879, 271	90.05
90. 06 09002 MEDCHECK CLINICS	0		C	0	0	90.06
90. 07 09003 KNEE CENTER	6, 252, 349		6, 252, 349	0	6, 252, 349	90.07
90. 08 09004 PALLI ATI VE CARE	211		211		211	
90. 10 09006 WORK SITE CLINICS	0		.		0	
90. 12 04961 FAMILY PRACTICE AND MATERNITY C					0	•
91. 00 09100 EMERGENCY	29, 721, 470		29, 721, 470		29, 721, 470	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT			6, 797, 012		6, 797, 012	
014200 052000 05200000000	0,777,012		0, 171, 012	-	0, 777, 012	72.00
	0) 0	0	98.00
	629, 910, 941	0	629, 910, 941		0 629, 910, 941	
200 00 Subtotal (coo instructions)						1200.00
200.00 Subtotal (see instructions)		0				
200.00Subtotal (see instructions)201.00Less Observation Beds202.00Total (see instructions)	6, 797, 012 623, 113, 929	0	6, 797, 012	2	6, 797, 012 623, 113, 929	201.00

	Financial Systems CO ATION OF RATIO OF COSTS TO CHARGES	OMMUNITY HEALTH	Provider CO		Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 8/2/2021 3:24	epared:
				e XIX	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
	03000 ADULTS & PEDIATRICS	171, 161, 842		171, 161, 84			30.00
	03100 INTENSIVE CARE UNIT	57, 128, 719		57, 128, 71	9		31.00
	03200 CORONARY CARE UNIT	0			0		32.00
	02060 NEONATAL INTENSIVE CARE UNIT	16, 426, 210		16, 426, 21			35.00
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	2, 529, 728		2, 529, 72	8	<u> </u>	43.00
	05000 OPERATING ROOM	103, 923, 030	48, 577, 092	152, 500, 12	2 0. 230351	0.000000	50.00
	05100 RECOVERY ROOM	6, 340, 643	6, 148, 769	12, 489, 41			
	05200 DELIVERY ROOM & LABOR ROOM	9, 407, 198	0, 140, 707	9, 407, 19		0.000000	
	05400 RADI OLOGY-DI AGNOSTI C	10, 518, 441	40, 204, 002	50, 722, 44		0. 000000	
	05500 RADI OLOGY-THERAPEUTI C	8, 283, 816	13, 341, 969	21, 625, 78			
	05700 CT SCAN	23, 408, 787	62, 382, 213			0. 000000	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 975, 090	8, 859, 751	12, 834, 84	0. 144987	0. 000000	58.00
	05900 CARDI AC CATHETERI ZATI ON	93, 625, 963		228, 539, 59		0.000000	
	06000 LABORATORY	78, 707, 637	81, 709, 171	160, 416, 80		0. 000000	
	06400 I NTRAVENOUS THERAPY	902, 789	1, 468, 141	2, 370, 93		0.000000	
	06500 RESPI RATORY THERAPY	27, 340, 309	2, 943, 614			0.000000	•
	06600 PHYSI CAL THERAPY	3, 312, 162	13, 942, 312	17, 254, 47		0.000000	
	06700 OCCUPATI ONAL THERAPY	2, 701, 492	2, 818, 827	5, 520, 31			
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 113, 120	1, 193, 601	2, 306, 72		0.000000	
	07000 ELECTROENCEPHALOGRAPHY	13, 568, 478 748, 736	37, 785, 131 5, 277, 741	51, 353, 60 6, 026, 47		0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 200, 151	33, 845, 992	71, 046, 14		0.000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	50, 678, 111	29, 796, 620	80, 474, 73		0.000000	
	07300 DRUGS CHARGED TO PATIENTS	67, 756, 864	817, 013, 589	884, 770, 45		0.000000	
	07400 RENAL DI ALYSI S	7, 233, 567	0	7, 233, 56		0.000000	
76.00	03330 ENDOSCOPY	1, 782, 369	2, 635, 501	4, 417, 87	0. 217227	0. 000000	76.00
76.01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	23, 956, 453	23, 956, 45	3 0. 523060	0. 000000	76.01
76.03	03951 LUTHERWOOD PARTNERSHIP	0	1, 328, 250	1, 328, 25	4. 635037	0.000000	76.03
	03952 WOUND CARE CENTER	602, 507	12, 095, 851	12, 698, 35			
	03480 ONCOLOGY-CANCER CARE CENTER	1, 555, 306	214, 872, 839	216, 428, 14			
	03953 I MAGI NG CENTERS	102, 601	59, 147, 667	59, 250, 26		0.000000	
	03954 BREAST DI AGNOSTI C CENTER	9,033	4, 961, 888	4, 970, 92		0.000000	
	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C 0XYGEN THERAPY	63, 992 0	2, 603, 874			0.000000	
	OUTPATIENT SERVICE COST CENTERS	0	2, 436, 896	2, 436, 89	6 0. 252218	0.000000	76.98
	08800 RURAL HEALTH CLINIC	0	0		0.00000	0.000000	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0. 000000		
	09000 CLINIC	0	0		0. 000000		•
	04950 DI ABETI C CARE CENTER	0	0		0. 000000		
90. 02	04951 HEALTHY HEARTS CENTER	16, 783	3, 135, 753	3, 152, 53	6 0. 625375	0. 000000	90.02
90. 03	09001 CLI NI C	0	0		0. 000000	0. 000000	90.03
1	04953 SPI NE CENTER	0	0		0. 000000	0. 000000	
1	04954 INFUSION CENTERS	0	2, 109, 518	2, 109, 51		0. 000000	
	09002 MEDCHECK CLINICS	0	0		0. 000000	0.000000	
	09003 KNEE CENTER	9, 409	4, 445, 590	4, 454, 99		0.000000	
	09004 PALLIATIVE CARE	0	77, 549	77, 54		0.000000	
	09006 WORK SITE CLINICS	0	0		0.00000	0.000000	
	04961 FAMILY PRACTICE AND MATERNITY CARE 09100 EMERGENCY	45, 755, 962	0 170, 465, 056	216 221 01	0.000000 0.137459	0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	45, 755, 962 2, 652, 797	6, 676, 475	216, 221, 01 9, 329, 27		0.000000	
	OTHER REIMBURSABLE COST CENTERS	2,052,191	0,070,475	7, 327, 21	0.720300	0.00000	72.00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0.00000	0.000000	98.00
98,00					5.00000		1
98.00 200.00	Subtotal (see instructions)	850, 543, 642	1, 853, 171, 328	2, 703, 714, 97	C		200.00
		850, 543, 642	1, 853, 171, 328	2, 703, 714, 97			200. 00 201. 00

Heal th	Financial Systems	COMMUNITY HEALTH N	JETWORK, INC.	In Lie	u of Form CMS-2552-10
	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0074	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared:
			Title XIX	Hospi tal	8/2/2021 3:24 pm PPS
	Cost Center Description	PPS Inpatient		nospi tai	FF3
	cost center bescription	Ratio			
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30.00	03000 ADULTS & PEDI ATRI CS				30.00
	03100 I NTENSI VE CARE UNI T				31.00
	03200 CORONARY CARE UNIT				32.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT				35.00
43.00	04300 NURSERY				43.00
	ANCI LLARY SERVI CE COST CENTERS				
	05000 OPERATI NG ROOM	0. 230351			50.00
	05100 RECOVERY ROOM	0. 146455			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 684467			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 167755			54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 070165			55.00
57.00	05700 CT SCAN	0. 058687			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 144987			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 051693			59.00
60.00	06000 LABORATORY	0. 118004			60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 932633			64.00
65.00	06500 RESPI RATORY THERAPY	0. 206146			65.00
66. 00	06600 PHYSI CAL THERAPY	0. 524800			66.00
67.00					
	06700 OCCUPATI ONAL THERAPY	0. 493646			67.00
68.00	06800 SPEECH PATHOLOGY	0. 493279			68.00
69.00	06900 ELECTROCARDI OLOGY	0. 091066			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 199465			70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 440669			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 398304			72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 208225			73.00
74.00	07400 RENAL DI ALYSI S	0. 300690			74.00
76.00	03330 ENDOSCOPY	0. 217227			76.00
76.01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 523060			76.01
76.03	03951 LUTHERWOOD PARTNERSHI P	4. 635037			76.03
76.04	03952 WOUND CARE CENTER	0. 285784			76.04
76.05	03480 ONCOLOGY-CANCER CARE CENTER	0. 239869			76.05
76.06	03953 I MAGI NG CENTERS	0. 151314			76.06
76.07	03954 BREAST DIAGNOSTIC CENTER	0. 623944			76.07
	07697 CARDI AC REHABI LI TATI ON	0. 686088			76.97
	07698 HYPERBARI C OXYGEN THERAPY	0. 252218			76.98
/0//0	OUTPATIENT SERVICE COST CENTERS	01202210			
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89.00
	09000 CLINIC	0. 000000			90.00
	04950 DI ABETI C CARE CENTER	0. 000000			90.00
	04950 DIADETTC CARE CENTER	0. 625375			90.01
		0. 000000			90.03
	04953 SPINE CENTER	0.00000			90.04
	04954 INFUSION CENTERS	0. 416811			90.05
	09002 MEDCHECK CLINICS	0. 000000			90.06
	09003 KNEE CENTER	1. 403446			90.07
	09004 PALLIATIVE CARE	0. 002721			90.08
	09006 WORK SITE CLINICS	0. 000000			90.10
	04961 FAMILY PRACTICE AND MATERNITY CARE	0. 000000			90.12
91.00	09100 EMERGENCY	0. 137459			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 728568			92.00
	OTHER REIMBURSABLE COST CENTERS				
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98.00
200.00					200.00
201.00					201.00
202.00					202.00
	· · · · · · · · · · · · · · · · · · ·	ı I			1

	ATION OF OUTPATIENT SERVICE COST TO CHARGE R. ONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C	CN: 15-0074	Period: From 01/01/2020 To 12/31/2020		parec pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost			Operating Cost	
		(WKST. B, Part	(Wkst. B, Part II col. 26)			Reduction Amount	
		1, COL 20)		col . 2)		Allount	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
. 00	05000 OPERATING ROOM	35, 128, 575	6, 431, 107	28, 697, 40	68 0	0	50.
. 00	05100 RECOVERY ROOM	1, 829, 133	452, 909	1, 376, 22	24 0	0	51.
. 00	05200 DELIVERY ROOM & LABOR ROOM	6, 438, 917	1, 164, 035	5, 274, 88	32 0	0	52.
. 00	05400 RADI OLOGY-DI AGNOSTI C	8, 508, 954	1, 883, 156	6, 625, 79	98 0	0	54.
. 00	05500 RADI OLOGY-THERAPEUTI C	1, 517, 376	85, 908	1, 431, 40	68 0	0	55.
	05700 CT SCAN	5, 034, 857	855, 101	4, 179, 75	56 0	0	57.
. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 860, 884	768, 145	1, 092, 73	39 0	0	58.
. 00	05900 CARDI AC CATHETERI ZATI ON	11, 813, 895	1, 785, 384	10, 028, 5	11 0	0	59.
. 00	06000 LABORATORY	18, 929, 889	734, 479	18, 195, 4 ⁻	10 0	0	60.
. 00	06400 INTRAVENOUS THERAPY	2, 211, 208	73, 043	2, 138, 10	65 0	0	64.
. 00	06500 RESPI RATORY THERAPY	6, 242, 917	299, 916	5, 943, 00	01 0	0	65.
. 00	06600 PHYSI CAL THERAPY	9, 055, 156	1, 793, 615	7, 261, 54	41 0	0	66.
	06700 OCCUPATI ONAL THERAPY	2, 725, 085				0	67.
	06800 SPEECH PATHOLOGY	1, 137, 857				0	68.
	06900 ELECTROCARDI OLOGY	4, 676, 552				0	69.
	07000 ELECTROENCEPHALOGRAPHY	1, 202, 070				0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	31, 307, 825					71.
	07200 I MPL. DEV. CHARGED TO PATIENTS	32, 053, 414					72.
	07300 DRUGS CHARGED TO PATIENTS	184, 231, 104				0	73.
	07400 RENAL DIALYSIS	2, 175, 059				0	74.
	03330 ENDOSCOPY	959, 679					76.
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	12, 530, 654				0	76.
	03951 LUTHERWOOD PARTNERSHI P	6, 156, 488					76.
	03952 WOUND CARE CENTER	3, 628, 985				0	76.
	03480 ONCOLOGY-CANCER CARE CENTER	51, 914, 335					76.
	03953 I MAGI NG CENTERS	8, 965, 369				0	76.
	03954 BREAST DI AGNOSTI C CENTER					0	76.
		3, 101, 575				0	76.
	07697 CARDIAC REHABILITATION	1, 830, 392			-		
	07698 HYPERBARIC OXYGEN THERAPY OUTPATIENT SERVICE COST CENTERS	614, 630	47,609	567, 02	21 0	0	1 /0.
	08800 RURAL HEALTH CLINIC	0	C		0 0	0	88.
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		1	0 0		
	09000 CLINIC	0			0 0	0	90.
	04950 DI ABETI C CARE CENTER	0			0 0	0	90.
	04950 DTABETTC CARE CENTER 04951 HEALTHY HEARTS CENTER	1, 971, 517	336, 171		-	0	90.
	09001 CLINIC	1, 7/1, 31/	330, 171 0		+0 0 0	0	90.
	04953 SPI NE CENTER				0 0	0	90.
	04953 SPINE CENTER 04954 INFUSION CENTERS	879, 271	265, 712	613, 55	-	0	90.
	09002 MEDCHECK CLINICS	017,211	205,712		0 0		
	09002 MEDCHECK CEINICS 09003 KNEE CENTER	6, 252, 349	-				
	09003 RNEE CENTER 09004 PALLIATIVE CARE					0	
		211	6	20	05 0	0	
	09006 WORK SITE CLINICS 04961 FAMILY PRACTICE AND MATERNITY CARE				0	-	90. 90.
				24 500 5	10 0	0	
	09100 EMERGENCY	29, 721, 470				0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 797, 012	556, 159	6, 240, 8	53 0	0	92.
	OTHER REIMBURSABLE COST CENTERS	-					1
	09850 OTHER REIMBURSABLE COST CENTERS	0			0 0		98.
0.00	Subtotal (sum of lines 50 thru 199)	503, 404, 664					200.
1.00 2.00	Less Observation Beds Total (line 200 minus line 201)	6, 797, 012 496, 607, 652					201. 202.

	LATION OF OUTPATIENT SERVICE COST TO CHARGE TIONS FOR MEDICAID ONLY	RATIOS NET OF	Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet C Part II Date/Time Prepar 8/2/2021 3:24 pm
				e XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges			
		Capital and	(Worksheet C,			
			Part I, column		6	
		Reduction	8)	/ col . 7)		
		6.00	7.00	8.00		
00	ANCI LLARY SERVICE COST CENTERS	25 120 575	152 500 122	0 22025	1	
00		35, 128, 575				5
00		1, 829, 133		0. 14645		5
00		6, 438, 917				5.
00		8, 508, 954				5
00		1, 517, 376				5
00		5, 034, 857				5
00		1, 860, 884		0. 14498		5
00		11, 813, 895				5
00		18, 929, 889				6
00	06400 I NTRAVENOUS THERAPY	2, 211, 208				6
00		6, 242, 917	30, 283, 923	0. 20614	16	6
00	06600 PHYSI CAL THERAPY	9, 055, 156				6
00		2, 725, 085		0. 49364	16	6
00	06800 SPEECH PATHOLOGY	1, 137, 857	2, 306, 721	0. 49327	79	6
00	06900 ELECTROCARDI OLOGY	4, 676, 552		0. 09106	56	6
00	07000 ELECTROENCEPHALOGRAPHY	1, 202, 070	6, 026, 477	0. 19946	55	7
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	31, 307, 825	71, 046, 143	0. 44066	59	7
		32, 053, 414	80, 474, 731	0. 39830		7
00		184, 231, 104				7
		2, 175, 059		0. 30069		7
00		959, 679				7
		12, 530, 654				7
		6, 156, 488				7
		3, 628, 985				7
		51, 914, 335				7
		8, 965, 369				7
		3, 101, 575		0. 62394		7
		1, 830, 392				7
98		614, 630	2, 436, 896	0. 25221	18	7
00	OUTPATIENT SERVICE COST CENTERS			0.0000		
00		0				8
00		0				8
		0	0	0.0000		9
	04950 DI ABETI C CARE CENTER	0	0	0.0000		9
		1, 971, 517				9
		0	0	0.00000		9
04		0	0	0.00000		9
		879, 271	2, 109, 518	0. 41681	1	9
		0	0	0.00000		9
07	09003 KNEE CENTER	6, 252, 349	4, 454, 999	1. 40344	16	9
80	09004 PALLIATIVE CARE	211			21	9
10	09006 WORK SITE CLINICS	0	0	0. 00000	00	9
12	04961 FAMILY PRACTICE AND MATERNITY CARE	0	0	0. 00000		9
00		29, 721, 470	216, 221, 018			9
		6, 797, 012		0. 72856		9.
	OTHER REIMBURSABLE COST CENTERS		,			
00		0		0.0000	00	9
). 00		503 404 664	2, 456, 468, 471	0.00000		20
1.00		6, 797, 012				20
	0 Total (line 200 minus line 201)		2, 456, 468, 471			20

Health Financial Systems	COMMUNI TY HEALTH	I NETWORK, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERV	VI CE CAPI TAL COSTS	Provider C	F	Period: From 01/01/2020 Fo 12/31/2020	Date/Time Pre 8/2/2021 3:24	pared: pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal Rel ated Cost	Swing Bed Adjustment	Reduced Capital	Total Patient Days	Per Diem (col. 3 / col. 4)	
	(from Wkst. B,		Related Cost	Days	37 601. 4)	
	Part II, col.		$(col \cdot 1 - col \cdot$			
	26)		2)			
	1.00	2.00	3.00	4.00	5,00	
INPATIENT ROUTINE SERVICE COST C						
30.00 ADULTS & PEDIATRICS	7, 435, 025	0	7, 435, 025	5 75, 492	98.49	30.00
31. 00 INTENSIVE CARE UNIT	3, 795, 539		3, 795, 539	12, 316	308.18	31.00
32.00 CORONARY CARE UNIT	0		0	0 0	0.00	32.00
35.00 NEONATAL INTENSIVE CARE UNIT	190, 555		190, 555	2, 085	91.39	35.00
43.00 NURSERY	312,075		312, 075	5 1, 682	185.54	43.00
200.00 Total (lines 30 through 199)	11, 733, 194		11, 733, 194	91, 575		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	(6)	-			
	6.00	7.00				
I NPATI ENT ROUTI NE SERVI CE COST C		4 05 4 500				0.00
30.00 ADULTS & PEDIATRICS	13, 753		•			30.00
31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT	3, 549	1, 093, 731				31.00
35.00 NEONATAL INTENSIVE CARE UNIT	0					32.00
43.00 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	17, 302	2, 448, 264				200.00
200. OUTOLAI (TITIES SU LIILOUYII 199)	17,302	2, 440, 204	1			I∠00. 00

Form D1/01/2020 Pert 11 (5/2)		Financial Systems C ONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	OMMUNI TY HEALTH		NI: 15 0074	In Lie Period:	u of Form CMS-2 Worksheet D	2552-1
Cost Center Description Capital Related Cost (From Wst. B, Part 11, col. Thte XVIII Hospital Program (Capital Related Cost (From Wst. B, Part 11, col. Hospital Column 3, column 4) Hospital Program (Capital Related Cost (Column 3, column 4) Hospital Program (Capital Related Cost (Capital Related Cost (Column 3, column 4) Hospital Related Cost (Column 3, column 4) Hospital Related Cost (Column 3, column 4) Hospital Related Cost (Column 4, column 4) Hospit	UKTI	UNMENT OF INPATIENT ANGILLART SERVICE CAPITA	AL CUSTS		JN. 15-0074	From 01/01/2020	Part II Date/Time Pre	pared:
Rel ated Cost Part II. col. Col. I (Col. 1 + col. 26) Col. I (Col. I + col. 27) Col. I (Col. I + col. 27) <thc< th=""><th></th><th></th><th>_</th><th>Title</th><th>XVIII</th><th>Hospi tal</th><th></th><th></th></thc<>			_	Title	XVIII	Hospi tal		
Image: Constraint of the second sec		Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
Part II., col. 26) 8) 20 1.00 2.00 3.00 4.00 5.00 50.00 55000 0PFRATING ROM 6.431, 107 152, 500, 122 0.042171 30, 404, 546 1, 282, 190 51.00 55000 65000 DELIVERY MOOM & LABOR ROOM 1, 462, 942 0.33262 1, 667, 248 60, 459 52.00 05500 RAUDIOLOS / JARONSTIC 1, 883, 165 50, 722, 443 0.037127 3, 192, 741 118, 553 50.00 5500 RAUDIOLOS / THERAPEUTIC 85, 908 21, 625, 785 00 0.09721 3, 917, 717 115, 560 50.00 5500 RAUDIOLOS / THERAPEUTIC 85, 908 21, 825, 956 0.09572 3, 917, 071 15, 560 50.00 5500 RAUDIOLOS / THERAPEUTIC 85, 908 21, 238, 248 1, 000, 100, 023 236, 001 50.00 5500 RAUDRATORY 734, 479 100, 416, 880 0.09572 3, 21, 723, 248 72, 177, 303 1, 206, 114 1, 206, 114 1, 206, 114 1, 201, 114 1, 201, 114			Related Cost				(column 3 x	
Part II., col. 20 30 20 1.00 2.00 3.00 4.00 5.00 0.00 5.00 05000 0PFRATING ROM 6.431, 107 152, 500, 122 0.042171 30, 404, 546 1, 282, 190 50.00 05000 DEVVEX ROM & LABOR ROM 1.164, 035 9, 407, 198 0.12379 0 0 0 52.00 DS300 RELIVERY ROM & LABOR ROM 1.164, 035 9, 407, 198 0.123739 0 0 0 55.00 DS300 RADI OLOO-THERAPEUTIC 863, 508 21, 425, 788 0.009742 3, 947, 677 15, 660 56.00 DS900 CARDI AC CATHETERI ATION 1.788, 354 22, 834, 890 0.00972 3, 947, 677 155, 660 0.00972 3, 947, 673 156, 660 0.00972 3, 947, 673 156, 660 0.00972 3, 947, 673 156, 660 0.00972 3, 947, 673 156, 660 0.00972 3, 947, 673 156, 660 0.00972 3, 947, 673 156, 660 0.00972 3, 947, 673 156, 660 0.00972 <			(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
260 200 3.00 4.00 5.00 MCLILARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 00 05000 (PERATING ROOM 6.431,107 152,500,122 0.042171 30,404,546 1.282,190 51:00 05100 RECOVERY ROCM 4.452,909 12,489,412 0.032623 1.667,245 60,437 50:00 0500 RECOVERY ROCM 4.800 ROOM 1.56,717 0.032727 3,497,871 15.681 57:00 05500 CT SCNM 885,101 85,791,000 0.009967 7,034,159 70,102 50:00 05600 CARDI AC CATHETERI ATION 1,755,384 228,539,596 0.003068 1.002,422,509 74,225,997 72,322,459 74,662 60:00 06000 CARDI AC CATHETERI ATION 1,756,344 20,997 10,223,226,077,662 70,662 60:00 06000 CARDI AC CATHETERI ATION 1,756,341 20,000,772,23,432,957 21,226,007,762 71,064,173 11,701,102,711,223,1107 12,246,07,162 70,000 72,22,345,97,162 71,174,160,416,30 72,250,171,72,223,423,100,009,172,223			Part II, col.	8)	2)	Ŭ	· · · ·	
NACL LARY SERVICE COST CENTERS 0 2.00 3.00 4.00 5.00 50.00 05000 (PERATING ROM 6.431, 107 152, 500, 122 0.042171 30, 404, 546 1.282, 190 52.00 05200 (DELIVERY ROM & LABOR ROM 1.164, 025 9, 407, 198 0.03277 3, 192, 747 118, 537 52.00 05500 (RADIOLOCY-INERAPEUTIC 85, 908 21, 625, 785 0.033972 3, 947, 871 15, 601 55.00 05500 (RADIOLOCY-INERAPEUTIC 859, 908 21, 625, 785 0.003972 3, 947, 871 15, 601 56.00 05500 (MACRETIC RESONANCE IMAGING (MRI) 766, 145 85, 908 20, 625, 956 0.003972 23, 234, 601 236, 201 50.00 05500 (MACRETIC RESONANCE IMAGING (MRI) 766, 143 23, 230, 00 0.30360 0 00 0.004579 21, 228, 266 97, 662 0.00400 0.004579 21, 228, 266 07, 602 60, 600 0.00700 0.0024579 21, 228, 266 0.00731 23, 216 0.004579 21, 228, 266 0.004000 0.004000 0.004000 0.0040000 <td></td> <td></td> <td>26)</td> <td></td> <td></td> <td></td> <td></td> <td></td>			26)					
MACLILARY SERVICE COST CONTRES 00 005000 (DEFRATINE ROOM 6.431, 107 152, 500, 122 0.042171 30, 404, 546 1, 222, 190 51.00 05100 [RECOVERY ROOM 452, 909 12, 489, 412 0.036263 1, 667, 245 60, 435 52.00 05200 [DELVERY ROOM & LABOR ROOM 1, 164, 035 9, 407, 198 0.123739 0 0 55.00 05500 [CT SCAN 883, 156 50, 722, 443 0.037127 3, 947, 571 15, 681 57.00 05700 [CT SCAN 855, 101 85, 791, 000 0.099967 7, 034, 159 70, 102 59.00 05900 [ARDIAC CATHETERI ATI ON 1, 786, 344 12, 834, 411 0.099979 21, 232, 255 97, 662 60.0 06000 [CARDIAC CATHETERI ATI ON 1, 783, 445 289, 593 500 0.030808 0 0 0.0237 23, 215 72, 117 66.00 06000 [CULPATI ONAL THERAPY 73, 043 2, 370, 930 0.03608 0 0 0.030808 0 0 13, 215 70.00 7000 [CARDIAC CATHETERI PATION <td></td> <td></td> <td></td> <td>2.00</td> <td>3,00</td> <td>4,00</td> <td>5.00</td> <td></td>				2.00	3,00	4,00	5.00	
00.00 05000 0PERATING ROOM 6.431,107 152,500,122 0.042171 30,404,546 1,282,100 52.00 05200 DELIVERY ROOM & LABOR ROOM 1,164,035 9,407,198 0.123739 0.02372 3,192,747 118,537 55.00 05500 RADI OLGOV-THERAPUTI C 885,906 21,625,786 0.033727 3,947,871 15,640,102 0.023972 3,947,871 15,640,102 0.003972 3,947,871 15,640,102 0.023972 3,947,871 15,640,102 0.023972 3,947,871 15,640,102 0.003972 3,947,871 15,640,102 0.003972 3,947,871 15,640,102 0.003972 3,947,871 15,640,102 0.003972 3,947,871 15,640,102 0.00596 0.004579 21,328,265 0.00402 0.002 20,001 0.03600 0.004579 21,328,265 0.00402 0.001,002 26,001 0.004579 21,328,264 97,662 0.004509 1,328,266 0.0040 0.004000 0.004579 21,328,264 12,101,014 10,102,014 10,102,014 10,102,014 10	ŀ	ANCILLARY SERVICE COST CENTERS						
51:00 005100 RECOVERY ROM 452,909 12,489,412 0.332423 1,67,248 60,409 54:00 05400 RADI LOGY-IN RAPEDTIC 1,883,156 50,722,443 0.37127 3,192,747 118,537 55:00 05500 CT SCAW 855,101 85,791,000 0.009972 3,947,877 155,681 57:00 05700 CT SCAW 855,101 85,791,000 0.009967 7,034,159 70,020 59:00 05900 CARDIAC CATHETER TATION 1,785,384 228,539,596 0.007872 3,224,265 97,662 60:00 06000 CARDIAC CATHETER TATION 1,733,415 2,3370,930 0.03808 0 00 0.00000 7,282,345 72,117 66:00 06500 DESPI RATORY THERAPY 299,75 5,52,0319 0.033600 90,533 32,15 66:00 06500 SPEE CHATORY THERAPY 200,932 6,024,477 0.033624 308,607 11,302 70:00 OTOO DELETERCROADI LIES CHARGED TO PATIENTS 1,7254,474 0.033642 <td></td> <td></td> <td>6, 431, 107</td> <td>152, 500, 122</td> <td>0.0421</td> <td>71 30, 404, 546</td> <td>1, 282, 190</td> <td>50.0</td>			6, 431, 107	152, 500, 122	0.0421	71 30, 404, 546	1, 282, 190	50.0
22 00 06200 DELI VERY ROOM & LABOR ROOM 1, 164, 035 9, 407, 198 0.123739 0 0 55 00 05500 RADI OLOCY - THERAPUTI C 885, 908 21, 625, 785 0.033727 3, 797, 817, 91 156, 637 56 00 05500 RADI OLOCY - THERAPUTI C 885, 908 21, 625, 785 0.033727 3, 797, 817, 156, 637 57 00 05500 MACRETI C, RESONANCE LIMACI NG (MRI) 768, 145 12, 834, 841 0.059848 1.006, 402 60, 023 50 00 05600 MACRETIC RESONANCE LIMACI NG (MRI) 7784, 479 160, 416, 808 0.004579 21, 328, 265 97, 600 0 0.00050 1.782, 345 72, 179, 100 0.004579 21, 328, 265 97, 600 0.0000 1.8837, 309, 803 0.009903 7, 282, 345 72, 171, 101 1.005, 420 109, 102 50 00 06500 RESPI RATORY THERAPY 202, 597 5, 520, 319 0.036700 905, 533 33, 215 50 00 06000 DELECTRECOLOPHALOCEY 844, 41 2, 366, 721 0.036700 905, 533								51.0
44.00 05400 RADI OLOKY- FIRAPELTIC 1, 883, 156 50, 722, 443 0, 037127 3, 192, 747 118, 537 57, 00 050700 CT SCAN 855, 101 85, 791, 000 0, 0099967 7, 034, 159 70, 00 58, 00 05500 CARDIACCATHETERIZATION 1, 785, 384 228, 539, 596 0, 007812 30, 210, 033 236, 00, 231 59, 00 05500 CARDIAC CATHETERIZATION 1, 785, 384 2, 370, 930 0, 007812 30, 210, 033 236, 00, 231 50, 00 05600 CARDIAC CATHETERIZATION 1, 785, 384 2, 370, 930 0, 007812 30, 210, 033 236, 97, 662 50, 00 06400 INTRAVENUIS THERAPY 299, 916 30, 283, 923 0, 0038760 7, 282, 345 77, 117 66, 00 66000 PERIVATINT THERAPY 200, 550, 719 0, 0336700 905, 037 33, 215 77, 20, 333, 215 77, 20, 333, 215 77, 20, 333, 215 77, 20, 333, 216 77, 20, 333, 216 77, 20, 333, 216 77, 20, 333, 216 77, 20, 333, 216 77, 20, 333, 216 77, 20, 333, 216 77, 20, 333, 216 77, 20, 333, 216 77, 20, 333, 216 77, 20, 333, 216 77, 20, 333								52.0
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4.00 06400[INTRAVENOUS THERAPY 73,043 2,370,930 0.030608 0 0 5.00 06500 RESPI RATORY THERAPY 299,916 30,283,923 0.039703 7,22,345 72,117 6.00 06600 PHYSI CAL THERAPY 202,597 5,520,319 0.036700 905,037 33,215 8.00 06800 SPECH PATHOLOGY 84,481 2,306,721 0.036624 308,607 11,302 9.00 06900 ELECTRORCREPHALOGRAPH 200,932 6,026,477 0.0333,215 54,407 0.03357,009 0.034624 308,607 11,302 0.00 07000 IPL. EV. CHARGED TO PATI ENTS 1,006,964 71,046,113 0.01473 11,201,114 158,753 3.00 07300 DRUAL DL ALYSIS 57,666 7,233,567 0.007752 2,744,293 1,918 6.00 03350 ENDALADIALYSIS 57,666 7,233,567 0.00752 2,748,293 2,1918 6.00 03351 LUTHERMOOD PARTINERSHIP 28,966 1,289,266	00 0	05900 CARDI AC CATHETERI ZATI ON	1, 785, 384	228, 539, 596	0.0078	12 30, 210, 023	236, 001	59.0
5:00 0 60500 RESPI RATORY THERAPY 299, 916 30, 289, 923 0.009903 7, 282, 345 72, 17, 11, 733, 615 6:00 06600 PHYSICAL THERAPY 1, 733, 615 17, 254, 474 0.1035670 905, 037 33, 215 8:00 06800 SPEECH PATHOLOGY 84, 481 2, 306, 721 0.036624 308, 607 11, 302 9:00 06900 ELECTRORACEPHALGRAPHY 200, 932 6, 026, 477 0.033342 196, 764 6, 551 10:00 07000 ELECTRORACEPHALGORAPHY 200, 932 6, 026, 477 0.033342 196, 764 6, 561 10:00 07000 DRUGS CHARGED TO PATIENTS 71, 241, 98 80, 477, 473 0.008853 18, 574, 156 164, 437 10:00 OT400 RENAL DI ALYSI S 77, 884, 770, 453 0.00775 2, 748, 293 21, 976 6:00 03330 ENDSCHARGRAPHY 289, 566, 65 1, 328, 567 0.00775 2, 748, 293 21, 978 6:00 03351 LUTHERMOD PARTINERSHI P 289, 566, 65 1, 238, 566	00 0	D6000 LABORATORY	734, 479	160, 416, 808	0.0045	79 21, 328, 265	97, 662	60.0
6.00 06600 PHYSICAL THERAPY 1, 793, 615 17, 294, 617 0.03951 1, 050, 420 109, 192 7.00 06700 OCCUPATIONAL THERAPY 202, 597 5, 520, 319 0.036700 905, 037 33, 215 8.00 06800 SPECH PATHOLOGY 84, 481 2, 306, 721 0.036624 308, 607 11, 302 9.00 06900 ELECTROCARDIOLOGY 652, 104 51, 335, 609 0.012698 4, 491, 230 57, 030 0.00 07000 ELECTROECREPHALOGRAPHY 200, 9720 46, 143 0.014173 11, 201, 114 158, 753 2.00 07200 IMPL EVC CHARGED TO PATIENTS 712, 419 80, 474, 731 0.008653 18, 574, 156 16, 433, 723 129, 776 3.00 07300 DRUGS CHARGED TO PATIENTS 179, 097 4, 417, 870 0.00659 62, 391 2, 554, 553 0.00795 2, 748, 283 21, 976 6.00 03350 PSVCHLATRC/PSVCHOLOGI CAL SERVICES 2, 216, 954 23, 956, 453 0.002541 0 0 <td< td=""><td>00 0</td><td>D6400 INTRAVENOUS THERAPY</td><td>73, 043</td><td>2, 370, 930</td><td>0. 03080</td><td>0 80</td><td>0</td><td>64.0</td></td<>	00 0	D6400 INTRAVENOUS THERAPY	73, 043	2, 370, 930	0. 03080	0 80	0	64.0
6.00 0.6600 PHYSI CAL THERAPY 1, 793, 615 17, 254, 474 0. 103951 1, 050, 420 109, 192 7.00 0.6700 OCCUPATI ONAL THERAPY 202, 597 5, 520, 319 0. 036700 905, 037 33, 215 8.00 06900 ELECTROCARDI OLOGY 84, 481 2, 306, 721 0. 036624 308, 607 11, 302 9.00 06900 ELECTRORCHPHALOGRAPHY 200, 932 6, 026, 477 0. 03342 196, 764 6, 551 1.00 07100 MEDI CAL, SUPPLIES CHARGED TO PATIENTS 1, 706, 964 71, 046, 143 0. 014173 11, 201, 114 158, 753 2.00 07200 IMPL DEV, CHARGED TO PATIENTS 57, 686 72, 333, 567 0. 007802 16, 633, 723 129, 776 6.00 03350 PSVCHIATRI C/PSVCHOLOGI CAL SERVICES 2, 216, 954 23, 956, 453 0. 007802 16, 633, 723 129, 776 6.01 03550 PSVCHIATRI C/PSVCHOLOGI CAL SERVICES 2, 217, 686 73, 356 0. 007902 2, 437, 452 0. 007902 2, 367 0. 000006 0. 00 <t< td=""><td>00 0</td><td>06500 RESPI RATORY THERAPY</td><td>299, 916</td><td>30, 283, 923</td><td>0.00990</td><td>7, 282, 345</td><td>72, 117</td><td>65.0</td></t<>	00 0	06500 RESPI RATORY THERAPY	299, 916	30, 283, 923	0.00990	7, 282, 345	72, 117	65.0
7.00 06700 0CUPATIONAL THERAPY 202, 597 55, 20, 319 0.036700 905, 037 33, 215 8.00 06800 SPEECH PATHOLOGY 84, 481 2, 306, 721 0.036700 308, 607 11, 302 9.00 06900 ELECTROCARDIOLOGY 84, 481 2, 306, 721 0.03342 196, 764 6, 561 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71, 24, 19 80, 474, 731 0.008853 18, 574, 156 164, 437 2.00 07400 RENGED TO PATIENTS 717, 97 4, 417, 870 0.040539 62, 391 2, 529 6.00 0330 RDOSCOPY 179, 097 4, 417, 870 0.040539 62, 391 2, 529 6.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 2, 216, 994, 656 1, 328, 250 0.218082 0 0 0 6.03 03251 UMINERARE CENTER 8, 170, 453 0.037782 461, 924 17, 452 6.00 0330 RMOSOCOPY 178, 907 54, 239, 956,	00 0	06600 PHYSI CAL THERAPY						66.0
8.00 06600 SPEECH PATHOLOCY 84, 481 2, 306, 721 0.036624 308, 607 11, 302 9.00 06900 ELECTROCARDIOLOGY 652, 104 51, 353, 609 0.012698 4, 491, 230 57, 030 0.00 07000 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 006, 964 71, 046, 143 0.0114713 11, 201, 114 158, 754, 156 164, 437 3.00 07300 DRUGS CHARGED TO PATIENTS 57, 636 7, 233, 567 0.007975 2, 748, 293 21, 918 6.00 03300 ENDOSCOPY 179, 097 4, 417, 870 0.040539 62, 391 2, 529 6.01 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 2, 216, 954 23, 956, 453 0.092841 0 0 0 6.03 03551 LUTHERWOOD PARTINERSHIP 289, 666 1, 328, 250 0.218082 0 0 0 6.04 03552 WOUND CARE CENTER 8, 177, 191 216, 428, 155 0.37782 461, 924 17, 452 6.07 03953 MAGI NG CENTERS								67.0
9.00 06900 ELECTROCARDIOLOGY 652, 104 51, 353, 609 0.012698 4, 491, 230 57, 030 0.00 07000 ELECTROCARDIOLOGRAPHY 200, 932 6, 026, 477 0.033342 196, 764 6, 561 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 712, 419 80, 474, 731 0.00853 18, 574, 156 164, 433 0.00 07400 RENGED TO PATIENTS 6, 902, 759 884, 770, 453 0.007802 16, 633, 723 129, 776 0.0330 DRUGS CHARGED TO PATIENTS 57, 686 7, 233, 567 0.007802 16, 633, 723 129, 976 0.03330 ENDOSCOPY 179, 097 4, 17, 870 0.040539 62, 391 2, 59 0.03355 DSYCHIATRIC/PSYCHOLOGICAL SERVICES 2, 216, 954 38, 020806 241, 883 5, 033 0.0330 BUNDSCOLOGY - CANCER CARE CENTER 8, 177, 191 216, 428, 145 0.03782 461, 924 17, 452 0.0340 0X00LOGY - CANCER CARE CENTER 310, 439 4, 970, 921 0.62451 1, 548 97								68.0
0.00 07000 ELECTROENCEPHALOGRAPHY 200,932 6,026,477 0.033342 196,764 6,561 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1,006,964 71,046,143 0.014173 11,201,114 158,753 2.00 07200 IMPL. DEV. CHARGED TO PATIENTS 57,686 7,233,567 0.007902 16,633,723 129,776 6.00 03300 ENDOSCOPY 179,097 4,417,870 0.040539 62,391 2,529 6.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 2,216,954 23,956,453 0.025541 0 0 0 6.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 2,216,954 23,956,453 0.025241 0 0 0 6.01 03552 WOUND CARE CENTER 8,177,191 2698,358 0.020806 241,883 5,033 6.02 03480 ONCOLOGY-CANCER CARE CENTER 310,439 4,970,921 0.062451 1,548 97 7 07697 CAROIA CREMABLI TATI ON 425,214 2,667,866 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
1.00 07100 NEDICAL SUPPLIES CHARGED TO PATIENTS 1,006,964 71,046,143 0.014173 11,201,114 158,753 2.00 07200 IMPL. DEV. CHARGED TO PATIENTS 712,419 80,474,731 0.008853 18,574,156 164,437 3.00 07300 REVAL DI ALYSI S 57,686 7,233,567 0.007975 2,748,293 21,918 6.00 03350 ENDOSCOPY 179,097 4,417,870 0.040539 62,391 2,529 6.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 2,216,954 23,956,453 0.022806 241,883 5,033 6.03 03951 MUIND CARE CENTER 264,200 12,698,358 0.020806 241,883 5,033 6.05 03480 ONCOLOGY-CANCER CARE CENTER 178,491 59,20,268 0.03121 7,520 227 6.07 0354 BREAST DI AGNOSTI C CENTER 310,439 4,970,921 0.062451 1,548 97 6.97 07697 CARDIA C REHABI LITATION 425,214 2,667,866 0.195337 0 0 0.0170471 CANCE CENTER 0								69.0
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6. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 2, 216, 954 23, 956, 453 0.092541 0 0 6. 03 03951 LUTHERWOOD PARTNERSHI P 289, 668 1, 328, 250 0.218082 0 0 6. 04 03952 WOUND CARE CENTER 264, 200 12, 698, 358 0.0202806 241, 883 5, 033 76. 05 03480 ONCOLOGY-CANCER CARE CENTER 8, 177, 191 216, 428, 145 0.037782 461, 924 17, 452 6. 06 03953 I MAGI NG CENTERS 1, 784, 691 59, 250, 268 0.030121 7, 520 227 76, 77 OR697 CARDI AC REHABI LI TATI ON 425, 214 2, 667, 866 0.159384 337 54 0 07697 CARDI AC REHABI LI TATI ON 425, 214 2, 667, 866 0.19537 0 0 0 0.7697 CARDI AC REHABI LI TATI ON 425, 214 2, 667, 866 0.195384 337 54 0 0.6800 RURAT SERVI CE COST CENTER 0 0 0.000000 0 0 19.00 0 0.8800 FURERATI H CLINI C	00 0	D3330 ENDOSCOPY			0. 04053			76.0
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76.05 03480 0NCOLOGY-CANCER CARE CENTER 8,177,191 216,428,145 0.037782 461,924 17,452 6.06 03953 IMAGING CENTERS 1,784,691 59,250,268 0.030121 7,520 227 76.07 03954 BREAST DI AGNOSTI C CENTER 310,439 4,970,921 0.062451 1,548 97 76.97 07677 CARDI AC REHABILI TATI ON 425,214 2,667,866 0.159384 337 54 76.98 07698 HYPERBARI C 0XYGEN THERAPY 47,609 2,436,896 0.019537 0 0 00000 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0								76.0
76.06 03953 IMAGI NG CENTERS 1,784,691 59,250,268 0.030121 7,520 227 6.07 03954 BREAST DI AGNOSTI C CENTER 310,439 4,970,921 0.062451 1,548 97 6.97 07697 CARDI AC REHABI LI TATI ON 425,214 2,667,866 0.159384 337 54 6.98 07698 HYPERBARI C OXYGEN THERAPY 47,609 2,436,896 0.019537 0 0 00100 RURAL HEALTH CLINI C 0 0 0.000000 0 0 0 90.00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0.000000 0 0 0 90.00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0.000000 0								76.0
6.07 03954 BREAST DI AGNOSTI C CENTER 310,439 4,970,921 0.062451 1,548 97 6.97 07697 CARDI AC REHABI LI TATI ON 425,214 2,667,866 0.159384 337 54 6.98 07698 HYPERBARI C OXYGEN THERAPY 47,609 2,436,896 0.019537 0 0 0UTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>76.0</td>								76.0
76.97 O7697 CARDIAC REHABILITATION 425,214 2,667,866 0.159384 337 54 76.98 O7698 HYPERBARI C OXYGEN THERAPY 47,609 2,436,896 0.019537 0 0 0UTPATI ENT SERVICE COST CENTERS 0 0 0.00000 0 0 0 0 08.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0 0 0 00.01 04950 DI ABETI C CARE CENTER 0 0 0.000000 0								
6.98 07698 HYPERBARI C 0XYGEN THERAPY 47,609 2,436,896 0.019537 0 0 0UTPATI ENT SERVICE COST CENTERS 0 0 0.00000 0 0 0 0 88.00 0800 RURAL HEALTH CLINIC 0 0 0.00000 0 0 0 99.00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0.000000 0 0 0 90.01 04950 DI ABETI C CARE CENTER 0 0 0.000000 0								76.0
OUTPATI ENT SERVICE COST CENTERS 8.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0 0 9.00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0.000000 0 0 0 0.01 04950 DLABETI C CARE CENTER 0 0 0.000000 0 0 0 0.02 04951 HEALTHY HEARTS CENTER 0 0 0.000000 0 0 0 0.02 04951 HEALTHY HEARTS CENTER 336, 171 3, 152, 536 0.106635 0								76.9
88.00 08800 RURAL HEALTH CLINIC 0 0 0.00000 0 0 99.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00000 0 0 00.01 04950 DI ABETIC CARE CENTER 0 0 0.000000 0 0 0.02 04951 HEALTHY HEARTS CENTER 336, 171 3, 152, 536 0.106635 0 0 0.03 09001 CLINIC 0 0 0.000000 0 0 0 0.04953 SPI NE CENTER 336, 171 3, 152, 536 0.106635 0 0 0 0.000000 0 0 0 0 0.000000 0 <t< td=""><td></td><td></td><td>47,609</td><td>2, 436, 896</td><td>0. 01953</td><td>37 0</td><td>0</td><td>76.9</td></t<>			47,609	2, 436, 896	0. 01953	37 0	0	76.9
99.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0			1					
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0.02 04951 HEALTHY HEARTS CENTER 336, 171 3, 152, 536 0. 106635 0 0 0.03 09001 CLI NI C 0 0 0.000000 0 0 0.04 04953 SPI NE_CENTER 0 0 0.000000 0 0 0.05 04954 I NFUSI ON CENTERS 265, 712 2, 109, 518 0. 125959 0 0 0.06 09002 MEDCHECK CLI NI CS 0 0 0.000000 0	00 0	29000 CLINIC	0	0	0.0000	0 00	0	90.0
0.02 04951 HEALTHY HEARTS CENTER 336, 171 3, 152, 536 0. 106635 0 0 0.03 09001 CLI NI C 0 0 0.000000 0 0 0.04 04953 SPI NE CENTER 0 0 0.000000 0 0 0.05 04954 INFUSION CENTERS 265, 712 2, 109, 518 0. 125959 0 0 0.06 09002 MEDCHECK CLI NI CS 0 0 0.000000 0 </td <td>01 0</td> <td>D4950 DIABETIC CARE CENTER</td> <td>0</td> <td>0</td> <td>0.0000</td> <td>0 00</td> <td>0</td> <td>90.0</td>	01 0	D4950 DIABETIC CARE CENTER	0	0	0.0000	0 00	0	90.0
0.03 09001 CLINIC 0 0 0.00000 0 0 0.04 04953 SPINE CENTER 0 0 0.000000 0 0 0.05 04954 INFUSION CENTERS 265,712 2,109,518 0.125959 0 0 0.06 09002 MEDCHECK CLINICS 0 0 0.000000 0 0 0.07 09003 KNEE CENTER 692,657 4,454,999 0.155479 0 0 0.08 09004 PALLIATIVE CARE 6 77,549 0.000077 0 0 0.12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0.000000 0 0 0 0.12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0.000000 0 0 0 0.12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0.014527 12,706,284 184,584 2.00 OBSERVATION BEDS (NON-DISTINCT PART) 556,159 9.3			336.171	3, 152, 536				90.0
0.04 04953 SPI NE CENTER 0 0 0.00000 0 0 0.05 04954 I NFUSI ON CENTERS 265,712 2,109,518 0.125959 0								90.0
0.05 04994 INFUSION CENTERS 265,712 2,109,518 0.125959 0 0 0.06 09002 MEDCHECK CLINICS 0 0 0.000000 0 0 0.07 09003 KNEE CENTER 692,657 4,454,999 0.155479 0 0 0.08 09004 PALLI ATI VE CARE 6 77,549 0.000077 0 0 0.10 09006 WORK SITE CLINICS 0 0 0.000000 0 0 0.10 09006 WORK SITE CLINICS 0 0 0.000000 0 0 0.12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0.000000 0 0 1.00 09100 EMERGENCY 3,140,952 216,221,018 0.014527 12,706,284 184,584 2.00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 556,159 9,329,272 0.059614 1,104,791 65,861 0THER REI MBURSABLE COST CENTERS 0 0								90.0
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0.07 09003 KNEE CENTER 692, 657 4, 454, 999 0. 155479 0 0 0.08 09004 PALLI ATI VE CARE 6 77, 549 0. 000077 0 0 0.10 09006 WORK SI TE CLI NI CS 0 0 0. 000000 0 0 0.12 04961 FAMI LY PRACTI CE AND MATERNI TY CARE 0 0 0. 000000 0 0 1.00 09100 EMERGENCY 3, 140, 952 216, 221, 018 0. 014527 12, 706, 284 184, 584 2.00 09SERVATI ON BEDS (NON-DI STI NCT PART) 556, 159 9, 329, 272 0. 059614 1, 104, 791 65, 861 0THER REI MBURSABLE COST CENTERS 0 0 0. 000000 0 0			205, /12	2, 109, 518				
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D. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0.000000 0 00 1.00 09100 EMERGENCY 3, 140, 952 216, 221, 018 0.014527 12, 706, 284 184, 584 2.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 556, 159 9, 329, 272 0.059614 1, 104, 791 65, 861 OTHER REI MBURSABLE COST CENTERS 3.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0.000000 0 0			6	77, 549			0	90.0
1. 00 09100 EMERGENCY 3, 140, 952 216, 221, 018 0. 014527 12, 706, 284 184, 584 2. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 556, 159 9, 329, 272 0. 059614 1, 104, 791 65, 861 OTHER REI MBURSABLE COST CENTERS 3. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0. 000000 0 0	10 0	D9006 WORK SITE CLINICS	0	0	0.0000	0 0	0	90.1
1. 00 09100 EMERGENCY 3, 140, 952 216, 221, 018 0. 014527 12, 706, 284 184, 584 2. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 556, 159 9, 329, 272 0. 059614 1, 104, 791 65, 861 0THER REI MBURSABLE COST CENTERS 0 0 0. 000000 0 0	12 0	04961 FAMILY PRACTICE AND MATERNITY CARE	0	0	0.0000	0 0	0	90.1
2. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 556, 159 9, 329, 272 0. 059614 1, 104, 791 65, 861 OTHER REI MBURSABLE COST CENTERS 0 0. 000000 0 0 0 8. 00 09850 OTHER REI MBURSABLE COST CENTERS 0			3, 140, 952	216, 221, 018			184.584	91.0
OTHER REI MBURSABLE COST CENTERS 8.00 09850 OTHER REI MBURSABLE COST CENTERS								92.0
8.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0.00000 0 0				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0.0070			1
			0		0 0000	00	<u>^</u>	98.0

Health Financial Systems	COMMUNI TY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST			Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 8/2/2021 3:24	pared: pm
			XVIII	Hospi tal	PPS	
Cost Center Description		Nursing School	Allied Healt	h Allied Health	All Other	
	Post-Stepdown		Post-Stepdow	n Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	· · ·					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	o	0		0 0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0		0 0	0	32.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0	0		0 0	0	
43. 00 04300 NURSERY	0	0		0 0	0	
200.00 Total (lines 30 through 199)	0	0		0 0	-	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Dation	t Per Diem (col.	Inpatient	200.00
cost center bescription	Adjustment	(sum of cols.	Days	$5 \div \text{col}$. 6)	Program Days	
	Amount (see	1 through 3,	Days	5 ÷ COI. 0)	FIOGLAIII DAYS	
		minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	75, 49	0.00	13, 753	30,00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	12, 31			
		0				
		0		0 0.00	0	
35. 00 02060 NEONATAL INTENSIVE CARE UNIT		0	2, 08			00.00
43.00 04300 NURSERY		0	1, 68			
200.00 Total (lines 30 through 199)		0	91, 57	5	17, 302	200.00
Cost Center Description	I npati ent					
	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 I NTENSI VE CARE UNI T	0					31.00
32.00 03200 CORONARY CARE UNI T	0					32.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0					35.00
43.00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0074 Period: From 01/01/202 To 12/31/2020 Period: Bat/STIE Worksheet D Bat/STIE Worksheet D Bat/STIE Period: To 12/31/2020 Period: To 01/2020 To 2020 Period: To 01/20	50. 00 51. 00 52. 00 54. 00 55. 00 57. 00
Cost Center Description Non Physician Anesthetist Non Supervising School Adjustments All led Heal th Post-Stepdown Adjustments ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 50.00 05000 0PERATING ROM 0	51.00 52.00 54.00 55.00
Anesthetist Post-Stepdown Adjustments Post-Stepdown Adjustments ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00 ANCILLARY SERVICE COST CENTERS 0	51.00 52.00 54.00 55.00
Cost Adjustments Adjustments 1.00 2A 2.00 3A 3.00 50.00 05000 0PERATI NO: ROOM 0	51.00 52.00 54.00 55.00
I. 00 2A 2. 00 3A 3. 00 50.00 05000 OPERATI NG ROM 0	51.00 52.00 54.00 55.00
ANCILLLARY SERVICE COST CENTERS Image: Cost Centers 50.00 05000 (DPEATI NG ROOM 0	51.00 52.00 54.00 55.00
50.00 OPERATI NG ROOM 0	51.00 52.00 54.00 55.00
51.00 05100 RECOVERY ROOM 0	51.00 52.00 54.00 55.00
52.00 05200 DELIVERY ROM & LABOR ROOM 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 <td>52.00 54.00 55.00</td>	52.00 54.00 55.00
52.00 05200 DELIVERY ROM & LABOR ROOM 0 0 0 0 54.00 05400 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 55.00 05500 CT SCAN 0 <	54.00 55.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 <t< td=""><td>54.00 55.00</td></t<>	54.00 55.00
55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 0 57.00 05700 CT SCAN 0 <td>55.00</td>	55.00
57.00 05700 CT SCAN 0 0 0 0 0 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0	
58:00 OSB00 MAGNETIC RESONANCE I MAGI NG (MRI) 0 0 0 0 59:00 OS900 CARDI AC CATHETERI ZATI ON 0	57.00
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 60.00 LABORATORY 0	58.00
60.00 CABORATORY 0 0 0 0 0 64.00 C6400 INTRAVENOUS THERAPY 0	
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 66.00 06400 PHYSI CAL THERAPY 0	59.00
65.00 06500 RESPI RATORY THERAPY 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 68.00 06800 SPECH PATHOLOGY 0 <td>60.00</td>	60.00
66.00 06600 PHYSI CAL THERAPY 0 0 0 0 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 <t< td=""><td>64.00</td></t<>	64.00
67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0	65.00
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 69.00 06900 ELECTROCARDIOLOGY 0	66.00
69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0<	67.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0	68.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0	69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 76.00 03330 ENDOSCOPY 0 <	70.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 74.00 07400 RENAL DI ALYSI S 0	71.00
74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 76.00 03330 ENDOSCOPY 0<	72.00
76.00 03330 ENDOSCOPY 0	73.00
76.00 03330 ENDOSCOPY 0	74.00
76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0<	76.00
76. 03 03951 LUTHERWOOD PARTNERSHIP 0 <t< td=""><td>76.01</td></t<>	76.01
76.04 03952 WOUND CARE CENTER 0 <td>76.03</td>	76.03
76.05 03480 ONCOLOGY-CANCER CARE CENTER 0 0 0 0 0 76.06 03953 I MAGI NG CENTERS 0	76.04
76.06 03953 I MAGI NG CENTERS 0 <td>76.05</td>	76.05
76. 07 03954 BREAST DI AGNOSTI C CENTER 0	76.06
76. 97 07697 CARDI AC REHABI LI TATI ON 0	76.07
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0	
	76.97
	76. 98
OUTPATIENT SERVICE COST CENTERS	00.00
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0	89.00
	90.00
90. 01 04950 DI ABETI C CARE CENTER 0 0 0 0 0	90.01
90. 02 04951 HEALTHY HEARTS CENTER 0 0 0 0 0	90. 02
90. 03 09001 CLINIC 0 0 0 0 0	90.03
90. 04 04953 SPINE CENTER 0 0 0 0 0	90.04
90. 05 04954 I NFUSI ON CENTERS 0 0 0 0 0	90.05
90. 06 09002 MEDCHECK CLINICS 0 0 0 0 0	90.06
90. 07 09003 KNEE CENTER 0 0 0 0 0	90.07
90. 08 09004 PALLIATIVE CARE 0 0 0 0 0	90.08
90. 10 09006 WORK SITE CLINICS 0 0 0 0	90.10
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 0 0	90.12
91.00 09100 EMERGENCY 0 0 0 0	91.00
22. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0	92.00
OTHER REIMBURSABLE COST CENTERS	00
98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0	
	98, 00
	98.00 200.00

	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	NICE ATHED DASS	S Provider CO	CN- 15 0074	Peri od:	Worksheet D	2552-10
	COMMENT OF INPATIENT/OUTPATIENT ANGILLARY SEP I COSTS	VICE UTHER PASS		UN: 15-0074	From 01/01/2020 To 12/31/2020	Part IV	pared:
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	F 00	(00	7.00	instructions)	
	ANCILLARY SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
	05000 OPERATI NG ROOM	0	0		0 152, 500, 122	0.00000	50.00
	05100 RECOVERY ROOM	0	0		0 12, 489, 412	0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 9, 407, 198		
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 50, 722, 443	0. 000000	
5.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 21, 625, 785	0. 000000	55. OC
7.00	05700 CT SCAN	0	0		0 85, 791, 000	0. 000000	57.00
8.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 12, 834, 841	0. 000000	58.00
9.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 228, 539, 596	0. 000000	
0.00	06000 LABORATORY	0	0		0 160, 416, 808	0. 000000	60.00
4.00	06400 I NTRAVENOUS THERAPY	0	0		0 2, 370, 930	0. 000000	64.00
5.00	06500 RESPI RATORY THERAPY	0	0		0 30, 283, 923	0. 000000	65.00
6.00	06600 PHYSI CAL THERAPY	0	0		0 17, 254, 474	0. 000000	66.00
7.00	06700 OCCUPATI ONAL THERAPY	0	0		0 5, 520, 319	0. 000000	67.00
8.00	06800 SPEECH PATHOLOGY	0	0		0 2, 306, 721	0. 000000	68.00
9.00	06900 ELECTROCARDI OLOGY	0	0		0 51, 353, 609	0.000000	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 6, 026, 477	0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 71, 046, 143	0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 80, 474, 731	0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 884, 770, 453	0.000000	
	07400 RENAL DI ALYSI S	0	0		0 7, 233, 567	0.000000	
	03330 ENDOSCOPY	0	0		0 4, 417, 870		
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 23, 956, 453	0.000000	
	03951 LUTHERWOOD PARTNERSHIP	0	0		0 1, 328, 250	0.000000	
	03952 WOUND CARE CENTER	0	0		0 12, 698, 358	0.000000	
	03480 ONCOLOGY-CANCER CARE CENTER 03953 I MAGI NG CENTERS	0	0		0 216, 428, 145 0 59, 250, 268	0.000000	
	03954 BREAST DIAGNOSTIC CENTER	0	0		0 59, 250, 268 0 4, 970, 921	0.000000	
	07697 CARDI AC REHABI LI TATI ON	0	0		0 2, 667, 866		
	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 2, 436, 896		
	OUTPATIENT SERVICE COST CENTERS				2, 100, 070	0.000000	/0./0
	08800 RURAL HEALTH CLINIC	0	0		0 0	0.000000	88. 00
9.00	08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0		0 0	0. 000000	
	09000 CLINIC	0	0		0 0	0. 000000	
0. 01	04950 DIABETIC CARE CENTER	0	0		0 0	0. 000000	
0. 02	04951 HEALTHY HEARTS CENTER	0	0		0 3, 152, 536	0. 000000	90.02
	09001 CLI NI C	0	0		0 0	0. 000000	
	04953 SPI NE CENTER	0	0		0 0	0. 000000	90.04
0. 05	04954 INFUSION CENTERS	0	0		0 2, 109, 518	0. 000000	90.05
	09002 MEDCHECK CLINICS	0	0		0 0	0. 000000	90.06
	09003 KNEE CENTER	0	0		0 4, 454, 999		
	09004 PALLIATIVE CARE	0	0		0 77, 549	0. 000000	
	09006 WORK SITE CLINICS	0	0		0 0	0.000000	
	04961 FAMILY PRACTICE AND MATERNITY CARE	0	0		0 0	0.000000	
	09100 EMERGENCY	0	0		0 216, 221, 018		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 9, 329, 272	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0.00000	
0 00							

THROUGH COSTS From 01/01/2202 Part 1 V To Program Part 1 V To Program Part 1 V B3/2/2007 B 3 22 Pa		I FINANCIAL SYSTEMS C TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA	OMMUNITY HEALTH I		N. 15 0074	Dor	ri od:	u of Form CMS-2 Worksheet D	2552-10
Cost Center Description Outpatient Program (col. 6 + col. 2) Inpatient Program (col. 6 + col. 2) Inpatient Program (col. 6 + col. 2) Hospitent Program (col. 6 + col. 2) Hospitent Program (col. 6 + col. 2) Hospitent Program (col. 6 + col. 2) Program (col. 6 + col. 2) <th></th> <th></th> <th>WICE UTHER PASS</th> <th></th> <th>LN. 15-0074</th> <th>Fro</th> <th>om 01/01/2020</th> <th>Part IV Date/Time Pre</th> <th></th>			WICE UTHER PASS		LN. 15-0074	Fro	om 01/01/2020	Part IV Date/Time Pre	
Cost Center Description Outpatient to Charges (co. 6 + col. 7) Inpatient Program Charges (co. 8 + col. 7) Inpatient Program (harges (costs (col. 8) Outpatient Program (harges (costs (col. 8) Outpatient Program (harges (costs (col. 8) Outpatient Program (harges) 0.0				Title	XVIII		Hospi tal		piii
Ratio of Cost (col. 6 + col. 7) Program (col. 7) Procol 7)<		Cost Center Description	Outpatient						
Image: transmission of the second s									
Cost 6 Cost 7 Cost 6 Cost 7 Cost 7<						h			
T) x col. 12) x col. 12) ACC LLARY SERVICE COST CENTERS 0 11.00 12.00 13.00 ACC LLARY SERVICE COST CENTERS 0 0 05.00 65.00 <td></td> <td></td> <td></td> <td>ondi goo</td> <td></td> <td></td> <td>ondi goo</td> <td></td> <td></td>				ondi goo			ondi goo		
MACI LLARY SERVICE COST CENTRES 0.00 11.00 12.00 13.00 50.00 05000 [PECATING ROOM 0.000000 10.404,546 0 6.099,634 0 51.00 05200 [PECVERY ROW & LABOR ROOM 0.000000 1.667,248 0 4.975,484 0 52.00 05200 [PELVERY ROW & LABOR ROOM 0.000000 3.947,871 8.857,24 0 55.00 05500 [RADI CLOCY - HERAPEUTIC 0.000000 7.034,159 0 10.592,561 0 58.00 05800 [MAGRETIC RESONANCE IMAGING (MRI) 0.000000 10.064,402 1,663,324 0 0 59.00 05600 [ARDIA CATHERRIZATION 0.000000 10.023 0 43,597,593 0 25,9 9,6						Ŭ		•	
MCILLARY SERVICE COST CENTERS 0.00 05000 (PERATI IKS ROOM 0.000000 30.404,546 0 6.099,634 0 51.00 05100 RECOVERY ROOM 0.000000 31,52,747 0 8.857,246 0<				10.00			12 00		
50.00 05000 (OPERATI NG ROOM 0.000000 30.404,546 0 6.099,634 0 51.00 05100 RECOVERY ROOM 0.000000 1.667,248 0 4.975,484 0 51.00 05500 RADI LOCY-THEAPEUTI C 0.000000 3.947,871 0 8.83,305 0 51.00 05500 RADI LOCY-THEAPEUTI C 0.000000 3.947,871 0 8.83,305 0 51.00 05500 RADI LOCY-THEAPEUTI C 0.000000 1.006,402 1.663,324 0 51.00 05500 MAGETI C RESONANCE IMAGING (MRI) 0.000000 1.006,402 1.663,324 0 50.00 05600 CARD AC CATHETERI ZATI ON 0.000000 21.328,265 0 18.892,656 0 60.00 06600 LABORATORY 0.000000 1.265,420 0 38.676 0 61.00 06500 RESPI RATORY THERAPY 0.000000 1.052,420 0 38.676 0 61.00 06500 RESPI RATORY THERAPY 0.000000 1.633,723 0 8.43,759 0 0.00 05000		ANCLULARY SERVICE COST CENTERS	7.00	10.00	11.00		12.00	10.00	
51.00 05100 RECOVERY BOOM 0.000000 1, 647, 248 0 4, 975, 484 0 52.00 05200 RADIOLOCY-DIAENOSTIC 0.000000 3, 192, 747 0 8, 857, 246 0 55.00 05500 RADIOLOCY-THERAPEUTIC 0.000000 3, 947, 8771 0 8, 853, 305 0 57.00 05700 CT SCAN 0.000000 7, 034, 159 0 10, 592, 561 0 59.00 05900 CARDIAC CATHETERJATION 0.000000 7, 034, 159 0 1, 663, 324 0 0.000000 CARDIAC CATHETERJATION 0.000000 21, 232, 255 0 18, 892, 656 0	50.00		0,000000	30, 404, 546		0	6, 099, 634	0	50.00
52. 00 05200 DEL/VERY ROM & LABOR ROM 0.000000 0								-	51.00
54. 00 05400 RADIOLOGY-DIAGNOSTIC 0.000000 3, 192, 747 0 8, 857, 7246 0 57. 00 05500 RADIOLOGY-THERAPEUTIC 0.000000 7, 034, 159 0 1, 563, 324 0 57. 00 05500 CARDIAC CATHETERIZATION 0.000000 30, 210, 023 0 43, 597, 593 0 68. 00 05600 CARDIAC CATHETERIZATION 0.000000 30, 210, 023 0 43, 597, 593 0 64. 00 06000 INTRAVENUS THERAPY 0.000000 0 0 0 0 0 66. 00 06000 CCLPATIONAL THERAPY 0.000000 1, 562, 294 0 38, 676 0 07. 00 06200 SPECEN PATHOLOGY 0.000000 1, 563, 324 0							1, 770, 101		52.00
55. 00 05500 RADI LUGY-THERAPEUTI C 0.000000 3, 947, 871 0 8, 883, 305 0 57. 00 05700 CTSCAN 0.000000 7, 034, 159 0 10, 592, 561 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MR1) 0.000000 1, 064, 324 0 69. 00 05000 CARDI AC CATHETERI ZATI NN 0.000000 21, 228, 265 0 18, 892, 656 0 64. 00 06400 INTRAVENUS THERAPY 0.000000 7, 282, 345 0 252, 996 0 65. 00 06400 PHYSI CAL THERAPY 0.000000 905, 037 0 6, 710 0 66. 00 06400 SPEECH PATHOLOGY 0.000000 308, 607 1, 216 0 70. 00 07000 ELECTROARAPY 0.000000 190, 764 0 97, 759 0 71. 00 07000 ELECTROARAPHY 0.000000 149, 7230 0 92, 531, 200 0 72. 00 0700 I MEL CAL SUPPLIES CHARGED T0 PATI ENTS 0.000000				0		-	0 057 246	-	54.00
57.00 05700 CT SCAN 0.000000 7, 334, 159 0 10, 659, 264 0 59.00 05800 CABDUAC CATHETER LATION 0.000000 30, 210, 023 0 43, 597, 593 0 64.00 06000 LABORATORY 0.000000 21, 328, 265 0 18, 892, 656 0 64.00 06400 INTRAVENDUS THERAPY 0.000000 7, 282, 345 0 252, 996 0 65.00 06500 RESPI RATORY THERAPY 0.000000 7, 282, 345 0 252, 996 0 66.00 06600 PHYSICAL THERAPY 0.000000 7, 282, 345 0 252, 996 0 67.00 06700 OCENTIONAL THERAPY 0.000000 308, 607 0 1, 216 0 68.00 68000 ELECTROCARDI OLOCY 0.000000 14, 91, 130 9, 948, 250 0 71.00 07300 PRIOS CHARGED TO PATI ENTS 0.000000 14, 871 0 0 0 72.00 07200 PRI								-	
58. 00 05800 MAGNETI C. RESONANCE IMAGING (MRI) 0.000000 1, 064, 042 0 1, 663, 324 0 69. 00 CARDIA C. CATHETERI ZATI ON 0.000000 21, 328, 265 0 18, 892, 656 0 0 60. 00 CARDIA C. CATHETERI ZATI ON 0.000000 7, 282, 345 0 252, 996 0 1 0 1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								-	55.00
59:0.0 6590.0 ASD.04.C. CATHETER LATION 0.000000 30, 21.0.23 0 43, 597, 593 0 64:0.0 6600.1 LARDRATORY 0.000000 0 0 0 0 65:00 66600 PHYSI CAL THERAPY 0.000000 7, 282, 345 0 252, 996 0 66:00 0.6700 0.021071 TINAL THERAPY 0.000000 7, 282, 345 0 252, 996 0 68:00 68600 PHYSI CAL THERAPY 0.000000 7, 282, 345 0 6, 710 0 69:00 0.6600 FECH PATHOLOGY 0.000000 308, 607 0 1, 216 0 00 06000 ELECTROEARDI OLOGY 0.000000 14, 917, 230 0 848, 250 0 71:0.0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 14, 357, 30 282, 531, 200 0 0 0 0 73.00 73.00 0 0 0 0 0 0 0 0									57.00
60.00 06000 L80RATORY 0.000000 21.328,245 0 18,892,656 0 64.00 06400 INTRAVEMUUS THERAPY 0.000000 7,282,345 0 252,996 0 65.00 06500 RESPI RATORY THERAPY 0.000000 7,862,345 0 38,676 0 67.00 06700 OCUPAT TONAL THERAPY 0.000000 395,637 0 6,710 0 68.00 OECUPAT TONAL THERAPY 0.000000 34,676 0 1,216 0 69.00 06900 ELECTROCARDEPHALOGRAPHY 0.000000 4,491,230 0 9,848,250 0 70.00 07000 ELECTROCARGED TO PATI ENTS 0.000000 11,201,114 0 9,717,731 0 72.00 INBL LSV CHARGED TO PATI ENTS 0.000000 16,633,723 0 282,531,200 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td> <td>-</td> <td>58.00</td>						-		-	58.00
64.00 0 6400 INTRAVENUS THERAPY 0.000000 0								-	59.00
65:00 06500 RESPIRATORY THERAPY 0.000000 7, 282, 345 0 252, 996 0 66:00 06600 PHYSICAL THERAPY 0.000000 1, 050, 420 0 38, 676 0 67:00 0CUPATIONAL THERAPY 0.000000 995, 637 0 6, 710 0 68:00 0F600 SEECH PATHOLOGY 0.000000 4, 491, 230 0 9, 848, 250 0 70:00 DIOD ELECTRORCEPHALOGRAPHY 0.000000 14, 491, 230 0 9, 848, 250 0 71:00 DIOD MEDI CAL SUPLIE SC HARGED TO PATI ENTS 0.000000 11, 201, 114 0 9, 717, 731 0 72:00 DIPL. DEV. CHARGED TO PATI ENTS 0.000000 18, 574, 156 0 9, 153, 885 0 73:00 OT300 RENA CHARGED TO PATI ENTS 0.000000 2, 748, 293 0 0 0 74:00 RAMO RANGED TO PATI ENTS 0.000000 2, 391 0 682, 689 0 76:00 G3330 ENDSCOPY 0.000000 0	60.00			21, 328, 265		0	18, 892, 656	0	60.00
66.00 06600 PHYSI CAL THERAPY 0.000000 1,50,420 0 38,676 0 67.00 06700 OCCUPATIONAL THERAPY 0.000000 308,607 0 1,216 0 68.00 SPEECH PATHOLOGY 0.000000 4,91,230 0 9,848,250 0 00 07000 ELECTROCARDI OLOGY 0.000000 1,96,764 0 937,579 0 01.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 18,574,156 0 9,153,885 0 073.00 DRUOS CHARGED TO PATIENTS 0.000000 18,574,156 0 9,153,885 0 0.00000 RAS,723 0 282,531,200 0	64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	0	64.00
67.00 0c700 0ccuparti ONAL THERAPY 0.000000 905,037 0 6,710 0 68.00 06800 SPEECH PATHOLOGY 0.000000 308,607 0 1,216 0 06.00 06900 ELECTROCARDIOLOGY 0.000000 4,491,230 0 9,848,250 0 07.00 07000 MEDICAL SUPPLIES 0.000000 14,211,40 0,9,717,731 0 072.00 07200 MEL DEV. CHARGED TO PATIENTS 0.000000 16,633,723 0 282,531,200 0 074.00 07400 RENAE DIALVISTS 0.000000 2,748,293 0 <t< td=""><td>65.00</td><td>06500 RESPI RATORY THERAPY</td><td>0.000000</td><td>7, 282, 345</td><td></td><td>0</td><td>252, 996</td><td>0</td><td>65.00</td></t<>	65.00	06500 RESPI RATORY THERAPY	0.000000	7, 282, 345		0	252, 996	0	65.00
68:00 ORSON SPECH PATHOLOGY 0.000000 308;607 0 1.216 0 69:00 06900 ELECTROCARDIOLOGY 0.000000 4,491,230 0 9,848,250 0 00:00 07000 ELECTROCACEPHALOGRAPHY 0.000000 196,764 0 937,579 0 01:00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 18,574,156 0 9,153,885 0 07:00 RENDAL DIALYSIS 0.000000 16,633,723 0 0 0 0 0:01 03330 ENDSCOPY 0.000000 62,391 0 682,689 0	66.00	06600 PHYSI CAL THERAPY	0.000000	1, 050, 420		0	38, 676	0	66.00
68:00 ORSON SPECH PATHOLOGY 0.000000 308;607 0 1.216 0 69:00 06900 ELECTROCARDIOLOGY 0.000000 4,491,230 0 9,848,250 0 00:00 07000 ELECTROCACEPHALOGRAPHY 0.000000 196,764 0 937,579 0 01:00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 18,574,156 0 9,153,885 0 07:00 RENDAL DIALYSIS 0.000000 16,633,723 0 0 0 0 0:01 03330 ENDSCOPY 0.000000 62,391 0 682,689 0	67.00	06700 OCCUPATI ONAL THERAPY	0, 000000	905, 037		0	6, 710	0	67.00
69:00 0.00000 1.491,230 0 9.848,250 0 70:00 07000 ELECTROCARDIOLOGY 0.000000 196,764 0 937,579 0 71:00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 11,201,114 0 9,717,731 0 70:00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 16,633,723 0 282,531,200 0 70:00 07400 RENAL DI ALYSI S 0.000000 2,748,293 0 0 662,689 0 70:01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 2,748,293 0 682,689 0 70:03 03551 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 0 0 152,567 0 70:03 03551 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 7,520 0 14,504,767 0 70:03 0346 DREAST DI AGNOSTI C CENTER 0.000000 1,548 0 379,727 0 <	68 00	06800 SPEECH PATHOLOGY				0		0	68.00
70.00 0.7000 ELECTROENCEPHALOGRAPHY 0.000000 196,764 0 937,579 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 11,201,114 0 9,717,731 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 18,574,156 0 9,153,885 0 04.00 07400 REMA LAYSIS 0.000000 2,748,293 0 282,531,200 0 0 06.01 03530 ENDOSCOPY 0.000000 2,748,293 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td>69.00</td>								-	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 11, 201, 114 0 9, 717, 731 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 18, 574, 156 0 9, 153, 885 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 16, 633, 723 0 282, 531, 200 0 06.00 0330 ENDSCOPY 0.000000 2, 748, 293 0 0 0 0 076.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 0.000000 <									70.00
72.00 INPL. DEV. CHARGED TO PATI ENTS 0.000000 18, 574, 156 0 9, 153, 885 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 16, 633, 723 0 282, 531, 200 0 74.00 07400 RENAL DI ALYSIS 0.000000 62, 391 0 682, 689 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 0 0 0 0 76.03 03951 LUTHERWOOD PARTNERSHI P 0.000000 241, 883 0 4, 345, 102 0 76.04 03952 WOUND CARE CENTER 0.000000 241, 883 0 4, 345, 102 0 76.05 03480 ONCLOGY-CANCER CARE CENTER 0.000000 1, 544, 767 0 0 0 0 0 0 0 0 70.0754 BREAST DI AGNOSTI C CENTER 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td> <td>-</td> <td>71.00</td>						-		-	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 16, 633, 723 0 282, 531, 200 0 0 74.00 07400 RENAL DIALYSIS 0.000000 2, 748, 293 0 0 0 00 03301 ENDOSCOPY 0.000000 62, 391 0 682, 689 0 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 0 0 0 0 0 76.02 03951 LUTHERWOOD PARTNERSHIP 0.000000 0								-	
74.00 07400 RENAL DI ALYSIS 0.000000 2, 748, 293 0 0 0 76.00 03350 ENDOSCOPY 0.000000 0 0 682, 689 0 76.01 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 0 0 0 0 76.02 03480 DAVID CARE CENTER 0.000000 241, 883 0 4, 345, 102 0 76.05 03480 ONCLOGY-CANCER CARE CENTER 0.000000 7, 520 0 14, 504, 767 0 76.07 03951 INAGI NG CENTERS 0.000000 1, 548 0 139, 727 0 76.97 07697 CARDI AC REHABLI LTATI ON 0.000000 337 0 872, 137 0 0.017691 CARPI AC REHABLI LITATI ON 0.000000 0 0 0 0 0 0.0800 RUAL HEALTH CLINIC 0.000000 0 0 0 0 0 0.9000 CLINIC 0.000000 0 0 0 0 0 0 0.9000 CLINIC 0.000								-	72.00
76.00 03330 ENDOSCOPY 0.000000 62,391 0 682,689 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVICES 0.000000 0 0 0 0 76.03 03951 LUTHERWOOD PARTNERSHI P 0.000000 241,883 0 4,345,102 0 76.05 03460 ONCOLOGY-CANCER CARE CENTER 0.000000 7,520 0 14,504,767 0 76.07 03954 BREAST DI AGNOSTI C CENTER 0.000000 1,548 0 139,727 0 76.97 07697 CARDI AC REHABI LI TATI ON 0.000000 337 0 872,137 0 00017471 ENT SERVI CE COST CENTER 0.000000 0 0 0 0 88.00 08800 RURAL HEALTH CLI NI C 0.000000 0 0 0 0 0 90.00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0.000000 0 0 0 0 90.01 04950 IABETI C CARE CENTER							282, 531, 200	-	73.00
76.01 03550 PSYCH1 ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 0							0		74.00
76.03 03951 LUTHERWOOD PARTNERSHIP 0.000000 0 0 0 0 76.04 03952 WOUND CARE CENTER 0.000000 241,883 0 4,345,102 0 76.05 03953 IMAGI NG CENTERS 0.000000 7,520 0 14,504,767 0 76.06 03953 IMAGI NG CENTERS 0.000000 7,520 0 14,504,767 0 76.07 03954 BREAST DI AGNOSTI C CENTER 0.000000 1,548 0 139,727 0 76.97 07697 CARDI AC REHABI LI TATI ON 0.000000 <								-	76.00
76.04 03952 WOUND CARE CENTER 0.000000 241,883 0 4,345,102 0 76.05 03480 ONCOLOGY-CANCER CARE CENTER 0.000000 461,924 0 68,772,063 0 76.06 03953 IMAGING CENTERS 0.000000 7,520 0 14,504,767 0 76.07 03954 BREAST DI AGNOSTI C CENTER 0.000000 1,548 0 139,727 0 76.97 07697 CARDI AC REHABI LI TATI ON 0.000000 337 0 872,137 0 76.98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 0 0 0 0 0 0 76.98 08900 FEDERALLY QUALI FIED HEALTH CENTER 0.000000 0				0			152, 567		76.01
76.05 03480 ONCOLOGY-CANCER CARE CENTER 0.000000 461,924 0 68,772,063 0 76.05 03951 IMAGING CENTERS 0.000000 7,520 0 14,504,767 0 76.07 03954 BREAST DI AGNOSTI C CENTER 0.000000 1,548 0 139,727 0 76.97 07697 CARDI AC REHABI LI TATI ON 0.000000 337 0 872,137 0 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0.000000 0 0 0 0 0 0 0 000000 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0.000000 0<	76.03			0		-	0	0	76.03
76.06 03953 I MAGI NG CENTERS 0.000000 7,520 0 14,504,767 0 76.07 03954 BREAST DI AGNOSTI C CENTER 0.000000 1,548 0 139,727 0 76.97 OR697 CARDI AC REHABI LI TATI ON 0.000000 337 0 872,137 0 0017041 ENT SERVICE COST CENTERS 0.000000 0<	76.04	03952 WOUND CARE CENTER	0. 000000	241, 883		0	4, 345, 102	0	76.04
76.07 03954 BREAST DI AGNOSTI C CENTER 0.000000 1,548 0 139,727 0 76.97 07697 CARDI AC REHABI LI TATI ON 0.000000 337 0 872,137 0 76.98 HYPERBARI C 0XYGEN THERAPY 0.000000 0	76.05	03480 ONCOLOGY-CANCER CARE CENTER	0.000000	461, 924		0	68, 772, 063	0	76.05
76. 97 07697 CARDI AC REHABI LI TATI ON 0.000000 337 0 872, 137 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0	76.06	03953 I MAGI NG CENTERS	0. 000000	7, 520		0	14, 504, 767	0	76.06
76.97 O7697 CARDI AC REHABI LI TATI ON 0.000000 337 0 872,137 0 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0.000000 0 <td>76.07</td> <td>03954 BREAST DIAGNOSTIC CENTER</td> <td>0. 000000</td> <td>1, 548</td> <td></td> <td>0</td> <td>139, 727</td> <td>0</td> <td>76.07</td>	76.07	03954 BREAST DIAGNOSTIC CENTER	0. 000000	1, 548		0	139, 727	0	76.07
76.98 07698 HYPERBARI C 0XYGEN THERAPY 0.000000 0 0 0 0 0 0UTPATI ENT SERVICE COST CENTERS	76.97					0		0	76.97
OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0						0		0	76.98
88.00 08800 RURAL HEALTH CLINIC 0.000000 0				-		-1	-		
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 <th0< td=""><td>88.00</td><td></td><td>0,000000</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>88.00</td></th0<>	88.00		0,000000	0		0	0	0	88.00
90.00 09000 CLINIC 0.000000 0									89.00
90.01 04950 DI ABETI C CARE CENTER 0.000000 0				-		-	-	-	90.00
90.02 04951 HEALTHY HEARTS CENTER 0.000000 0 820,286 0 90.03 0901 CLINIC 0.000000 0				-		-	0	-	90.01
90.03 09001 CLINIC 0.000000 0 0 0 0 90.04 04953 SPINE CENTER 0.000000 0				-		-	020 204	-	90.01
90.04 04953 SPINE CENTER 0.00000 0 0 0 0 90.05 04954 INFUSION CENTERS 0.000000 0 879,325 0 90.06 09002 MEDCHECK CLINICS 0.000000 0 0 0 0 90.07 09003 KNEE CENTER 0.000000 0 0 0 0 0 90.08 09004 PALLI ATI VE CARE 0.000000 0 0 91 0 90.10 09006 WORK SI TE CLINICS 0.000000 0				-		-		-	
90.05 04954 INFUSION CENTERS 0.000000 0 879,325 0 90.06 09002 MEDCHECK CLINICS 0.000000 0						-	0	-	90.03
90.06 09002 MEDCHECK CLINICS 0.00000 0 0 0 0 90.07 09003 KNEE CENTER 0.000000 0 538,359 0 90.08 09004 PALLIATIVE CARE 0.000000 0 91 0 90.10 09006 WORK SITE CLINICS 0.000000 0 0 0 0 90.12 04961 FAMILY PRACTICE AND MATERNITY CARE 0.000000 0 0 0 0 91.00 09100 EMERGENCY 0.000000 12,706,284 0 19,826,015 0 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 1,104,791 0 1,564,245 0				-		-	0	-	90.04
00.07 09003 KNEE CENTER 0.000000 0 538,359 0 90.07 09003 KNEE CENTER 0.000000 0 0 91 0 90.07 09004 PALLIATIVE CARE 0.000000 0 0 91 0 90.10 09006 WORK SITE CLINICS 0.000000 0									90.05
90.08 09004 PALLI ATI VE CARE 0.00000 0 91 0 90.10 09006 WORK SI TE CLINICS 0.000000 0 </td <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>-</td> <td>-</td> <td></td>				0			-	-	
90.10 09006 WORK SITE CLINICS 0.00000 0 <t< td=""><td>90.07</td><td></td><td></td><td>0</td><td></td><td>0</td><td>538, 359</td><td>0</td><td></td></t<>	90.07			0		0	538, 359	0	
90.12 04961 FAMILY PRACTICE AND MATERNITY CARE 0.00000 0			0. 000000	0		0	91	0	90.08
91.00 09100 EMERGENCY 0.000000 12,706,284 0 19,826,015 0 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 1,104,791 0 1,564,245 0 0THER REI MBURSABLE COST CENTERS	90.10	09006 WORK SITE CLINICS	0. 000000	0		0	0	0	90.10
91. 00 09100 EMERGENCY 0. 000000 12, 706, 284 0 19, 826, 015 0 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0. 000000 1, 104, 791 0 1, 564, 245 0 0THER REI MBURSABLE COST CENTERS	90.12	04961 FAMILY PRACTICE AND MATERNITY CARE	0. 000000	0		0	0	0	90.12
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 1, 104, 791 0 1, 564, 245 0 OTHER_REI_MBURSABLE_COST_CENTERS	91.00			12, 706, 284		0	19, 826, 015	0	91.00
OTHER REIMBURSABLE COST CENTERS						0			92.00
				, = , , , , , , , ,		1	,,		
	98, 00		0, 000000	0		0	0	0	98.00
							-		200.00

		OMMUNI TY HEALTH				u of Form CMS-2	2552-10
APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0074	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pre 8/2/2021 3:24	pared: pm
			Title	2 XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From Worksheet C,	Services (see inst.)	Reimbursed Services	Reimbursed Services Not	(see inst.)	
		Part I, col. 9	· · ·	Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	NCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	0. 227181				1, 385, 721	50.00
	D5100 RECOVERY ROOM	0. 146455			0 0	728, 685	51.00
	D5200 DELIVERY ROOM & LABOR ROOM	0. 684467			0 0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 167755			0 0	1, 485, 847	54.00
	05500 RADI OLOGY-THERAPEUTI C	0. 070165			0 0	623, 297	55.00
	05700 CT SCAN	0. 058687			0 0	621, 646	
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 144987			0 0	241, 160	
	05900 CARDI AC CATHETERI ZATI ON	0. 051693				2, 253, 690	
		0. 118004		14		2, 229, 409	60.00
	06400 INTRAVENOUS THERAPY	0. 932633			0 0	0	64.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0. 206146			0 0	52, 154	65.00
	06700 OCCUPATIONAL THERAPY	0. 324800			0 0	20, 297 3, 312	66.00 67.00
	06800 SPEECH PATHOLOGY	0. 493279			0 0	600	68.00
	06900 ELECTROCARDI OLOGY	0. 088284			0 0	869, 443	
	07000 ELECTROENCEPHALOGRAPHY	0. 199465			0 0	187, 014	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 440669			0 0	4, 282, 303	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 398304			0 0	3, 646, 029	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 207945				58, 750, 950	73.00
	07400 RENAL DIALYSIS	0. 300690			0 0	0	74.00
	D3330 ENDOSCOPY	0. 217227	682, 689	5, 10	09 0	148, 298	76.00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 494004			0 0	75, 369	
76.03 0	03951 LUTHERWOOD PARTNERSHIP	4. 635037	0		0 0	0	76.03
76.04 0	03952 WOUND CARE CENTER	0. 282138	4, 345, 102		0 0	1, 225, 918	76.04
76.05 0	03480 ONCOLOGY-CANCER CARE CENTER	0. 239869	68, 772, 063		0 1,701	16, 496, 286	76.05
	03953 I MAGI NG CENTERS	0. 151314	14, 504, 767		0 0	2, 194, 774	76.06
	03954 BREAST DIAGNOSTIC CENTER	0. 623944			0 0	87, 182	
	07697 CARDI AC REHABI LI TATI ON	0. 686088			0 0	598, 363	76.97
	07698 HYPERBARI C OXYGEN THERAPY	0. 252218	C		0 0	0	76. 98
	DUTPATIENT SERVICE COST CENTERS		1	1			00.00
	08800 RURAL HEALTH CLINIC						88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	o c		0 0	0	89.00 90.00
	04950 DI ABETI C CARE CENTER	0. 000000			0 0	0	90.00
	04951 HEALTHY HEARTS CENTER	0. 625375			0 0	512, 986	90.02
	09001 CLI NI C	0. 000000			0 0	0	90.03
	04953 SPI NE CENTER	0, 000000			0 0		
	04954 INFUSION CENTERS	0. 416811	879, 325		0 0	366, 512	
	09002 MEDCHECK CLINICS	0. 000000			0 0	0	90.06
90.07 0	09003 KNEE CENTER	1. 387064	538, 359		0 0	746, 738	90.07
90.08 0	09004 PALLIATIVE CARE	0. 002721	91		0 0	0	90.08
	09006 WORK SITE CLINICS	0. 000000			0 0	0	90.10
	04961 FAMILY PRACTICE AND MATERNITY CARE	0. 000000	0 0		0 0	0	90.12
	09100 EMERGENCY	0. 135648			0 670	2, 689, 359	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 728568	1, 564, 245	2, 98	30 206	1, 139, 659	92.00
	OTHER REIMBURSABLE COST CENTERS		1	1			
	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			0 0	0	98.00
200.00	Subtotal (see instructions)		529, 147, 419	81, 26		103, 663, 001	
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00
202.00	Net Charges (line 200 - line 201)		529, 147, 419	81, 26	229, 654	103, 663, 001	202 00
-02.00		1	1 027, 177, 417	1 01,20	227,004	100,000,001	-02.00

PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0074	In Lien Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pre 8/2/2021 3:24	
		Title	× XVIII	Hospi tal	PPS	· p
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins.	Cost Reimbursed Services Not Subject To Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00	-			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	1			
D. 00 05000 OPERATI NG ROOM	7,835	0				50.00
1.00 05100 RECOVERY ROOM	0	0				51.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
5. 00 05500 RADI OLOGY - THERAPEUTI C	0	0				55.00
7.00 05700 CT SCAN	0	0				57.00
B. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0					58.00
9. 00 05900 CARDIAC CATHETERIZATION	1, 974					59.00
D. 00 06000 LABORATORY	17					60.00
4. 00 06400 I NTRAVENOUS THERAPY	0					64.00
5. 00 06500 RESPI RATORY THERAPY	0	-				65.00
6. 00 06600 PHYSI CAL THERAPY	0	-				66.00
7.00 06700 OCCUPATI ONAL THERAPY	0	-				67.00
B. 00 06800 SPEECH PATHOLOGY	0	0				68.00
9. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
0.00 07000 ELECTROENCEPHALOGRAPHY	0	-	1			70.00
1. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	-				71.00
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0					72.00
3. 00 07300 DRUGS CHARGED TO PATIENTS	76					73.00
4. 00 07400 RENAL DI ALYSI S	0		•			74.00
	1, 110					76.00
6. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 6. 03 03951 LUTHERWOOD PARTNERSHI P	0					76.0
6. 04 03952 WOUND CARE CENTER	0	0				76.04
6. 05 03480 ONCOLOGY-CANCER CARE CENTER	0	408	1			76.05
6. 06 03953 I MAGI NG CENTERS	0	400	1			76.00
6. 07 03954 BREAST DI AGNOSTI C CENTER		0				76.0
6. 97 07697 CARDI AC REHABI LI TATI ON	0					76.97
6. 98 07698 HYPERBARI C OXYGEN THERAPY	0		1			76.98
OUTPATIENT SERVICE COST CENTERS	-	-				
8.00 08800 RURAL HEALTH CLINIC						88. 00
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
D. 00 09000 CLINIC	0	0				90.00
D. 01 04950 DIABETIC CARE CENTER	0	0				90.0
D. 02 04951 HEALTHY HEARTS CENTER	0	0				90.0
D. 03 09001 CLINIC	0	-				90.0
D. 04 04953 SPINE CENTER	0	0				90.0
D. 05 04954 INFUSION CENTERS	0					90.0
D. 06 09002 MEDCHECK CLINICS	0					90.0
D. 07 09003 KNEE CENTER	0	-	•			90.0
D. 08 09004 PALLIATIVE CARE	0		•			90.08
D. 10 09006 WORK SITE CLINICS	0	-	1			90.10
0. 12 04961 FAMILY PRACTICE AND MATERNITY CARE	0	-	1			90.1
1.00 09100 EMERGENCY	0		1			91.00
2. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REI MBURSABLE COST CENTERS	2, 171	1	1			92.00
B. 00 09850 OTHER REIMBURSABLE COST CENTERS	0					98.00
00.00 Subtotal (see instructions)	13, 183	47, 869				200.00
01.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
02.00 Net Charges (line 200 - line 201)	13, 183	47, 869	1			202.0

Health Financial Systems	COMMUNI TY HEALTH				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	CAPI TAL COSTS	Provider C	<u> </u>	Period: From 01/01/2020 Fo 12/31/2020		pared:
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTE	RS					
30.00 ADULTS & PEDIATRICS	7, 435, 025	0	7, 435, 02	5 75, 492	98.49	30.00
31.00 INTENSIVE CARE UNIT	3, 795, 539		3, 795, 53	9 12, 316	308.18	31.00
32.00 CORONARY CARE UNIT	0			0 0	0.00	32.00
35.00 NEONATAL INTENSIVE CARE UNIT	190, 555		190, 55	5 2, 085	91.39	35.00
43.00 NURSERY	312,075		312, 07	5 1, 682	185.54	43.00
200.00 Total (lines 30 through 199)	11, 733, 194		11, 733, 19	4 91, 575		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 CENTE	RS					
30. 00 ADULTS & PEDIATRICS	6, 771	666, 876	,			30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
32.00 CORONARY CARE UNIT	0	0				32.00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0				35.00
43.00 NURSERY	1, 420	263, 467				43.00
200.00 Total (lines 30 through 199)	8, 191	930, 343				200.00

Health Financial Sy		OMMUNI TY HEALTH				eu of Form CMS-2	2552-10
APPORIIONMENI OF II	NPATIENT ANCILLARY SERVICE CAPIT	AL COSIS	Provider C	CN: 15-0074	Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
				e XIX	Hospi tal	8/2/2021 3:24 PPS	рш
Cost C	enter Description	Capi tal	Total Charges			Capital Costs	
0001 0			(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col		column 4)	
		Part II, col.	8)	2)	5	Í Í	
		26)		· ·			
		1.00	2.00	3.00	4.00	5.00	
	RVICE COST CENTERS						
50.00 05000 OPERAT		6, 431, 107					
51.00 05100 RECOVE		452, 909					
	RY ROOM & LABOR ROOM	1, 164, 035					52.00
	DGY-DI AGNOSTI C	1, 883, 156					
	DGY-THERAPEUTI C	85, 908					
57.00 05700 CT SCA		855, 101	85, 791, 000				
	C RESONANCE I MAGING (MRI)	768, 145					58.00
	C CATHETERI ZATI ON	1, 785, 384					59.00
60.00 06000 LABORA		734, 479					60.00
	ENOUS THERAPY	73,043					64.00
	ATORY THERAPY	299, 916					
66. 00 06600 PHYSI C		1, 793, 615					
	TIONAL THERAPY	202, 597				4, 714	67.00
68.00 06800 SPEECH	PATHOLOGY	84, 481	2, 306, 721	0. 03662	24 85, 669	3, 138	68.00
69.00 06900 ELECTR	DCARDI OLOGY	652, 104	51, 353, 609	0. 01269	492, 896	6, 259	69.00
	DENCEPHALOGRAPHY	200, 932	6, 026, 477			1, 621	70.00
71.00 07100 MEDI CA	_ SUPPLIES CHARGED TO PATIENTS	1, 006, 964	71, 046, 143	0.01417	2, 176, 964	30, 854	71.00
72.00 07200 I MPL.	DEV. CHARGED TO PATIENTS	712, 419	80, 474, 731	0.00885	53 1, 108, 916	9, 817	72.00
73.00 07300 DRUGS	CHARGED TO PATIENTS	6, 902, 759	884, 770, 453	0.00780	3, 840, 647	29, 965	73.00
74.00 07400 RENAL	DI ALYSI S	57, 686	7, 233, 567	0.00797	75 176, 027	1, 404	74.00
76.00 03330 ENDOSC)PY	179, 097	4, 417, 870	0. 04053	39 100, 776	4, 085	76.00
76.01 03550 PSYCHI	ATRI C/PSYCHOLOGI CAL SERVI CES	2, 216, 954	23, 956, 453	0. 09254	1 0	0	76.01
76. 03 03951 LUTHER	NOOD PARTNERSHI P	289, 668	1, 328, 250	0. 21808	32 0	0	76.03
76.04 03952 WOUND	CARE CENTER	264, 200	12, 698, 358	0. 02080	38, 693	805	76.04
76.05 03480 ONCOLO	GY-CANCER CARE CENTER	8, 177, 191	216, 428, 145	0. 03778	32 206, 264	7, 793	76.05
76.06 03953 I MAGI N	G CENTERS	1, 784, 691	59, 250, 268	0. 03012	3, 985	120	76.06
	DIAGNOSTIC CENTER	310, 439	4, 970, 921	0. 06245	51 0	0	76.07
76. 97 07697 CARDI A	C REHABILITATION	425, 214	2, 667, 866	0. 15938	34 442	70	76.97
	ARIC OXYGEN THERAPY	47,609	2, 436, 896	0. 01953	37 0	0	76.98
	ERVICE COST CENTERS		L	1			
	HEALTH CLINIC	0	-				88.00
	LLY QUALIFIED HEALTH CENTER	0	-				89.00
90.00 09000 CLINIC		0	-				90.00
	C CARE CENTER	0	-				90.01
	Y HEARTS CENTER	336, 171	3, 152, 536				90.02
90. 03 09001 CLI NI C		0	-				90.03
90. 04 04953 SPI NE		0	-				90.04
90. 05 04954 I NFUSI		265, 712	2, 109, 518				90.05
90. 06 09002 MEDCHE		0	0	0.0000		-	
90.07 09003 KNEE C		692, 657	4, 454, 999			0	
90. 08 09004 PALLI A		6	77, 549			0	
90.10 09006 WORK S		0	0	0.0000		0	
	PRACTICE AND MATERNITY CARE	0		0.0000		0	
91.00 09100 EMERGE		3, 140, 952					
	ATION BEDS (NON-DISTINCT PART)	556, 159	9, 329, 272	0. 0596	4 153, 853	9, 172	92.00
	RSABLE COST CENTERS	1	I	1		1	
	REIMBURSABLE COST CENTERS	0					
200.00 Total	(lines 50 through 199)	44,833,460	2, 456, 468, 471		25, 908, 284	460, 569	200.00

Health Financial Systems	COMMUNI TY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	R PASS THROUGH COST	S Provider C		Period: From 01/01/2020 To 12/31/2020		pared: pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdowr	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0)	0 0	0	31.00
32.00 03200 CORONARY CARE UNI T	0	0		0 0	0	32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0		0 0	0	35.00
43.00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,			0 5	
	instructions)	minus 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	75, 49	2 0.00	6, 771	30.00
31.00 03100 INTENSIVE CARE UNIT		0	12, 31	6 0.00	0	31.00
32.00 03200 CORONARY CARE UNI T		0		0.00	0	32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT		0	2, 08	5 0.00	0	35.00
43. 00 04300 NURSERY		0	1, 68	2 0.00	1, 420	43.00
200.00 Total (lines 30 through 199)		0	91, 57			200.00
Cost Center Description	I npati ent		•	-		
	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	0					31.00
32.00 03200 CORONARY CARE UNI T	0					32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0					35.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
······································						

APPORT IDMENT OF THPATTENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCX: 15-0074 Period: Provider COX: 15-0074 Period: 1	Health Financial Systems C	OMMUNI TY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-:	2552-10
Cast Center Description Into XIX Hospital and Nursing School Allied Healt HA Healt Hase Hase Hase Hase Hase Hase Hase Hase	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	6 Provider C		From 01/01/2020	Part IV Date/Time Pre	pared:
Cost Center Description Non Physical an Nursing School Nursing School Alified Healt th Alified Healt th Aligustments Aligustments Adjustments Adjustments Adjustments Adjustments Adjustments 0 00 00000 (PEEAATI IN ROD) 0 </td <td></td> <td></td> <td>Titl</td> <td>e XIX</td> <td>Hospi tal</td> <td></td> <td></td>			Titl	e XIX	Hospi tal		
Anesthetist Post-Stepdom Cost Adjustments Adjustments 0.00 05000 OPFRATING ROX 0	Cost Center Description	Non Physician	Nursing School	Nursing Schoo		Allied Health	
Incit Larry Service Cost Centres 1.00 2A 2.00 3A 3.00 50.00 05000 (PERATING ROOM 0 0 0 0 0 0 0 0 0 50.00 51.00 05100 (DEL VERY ROM & LABOR ROM 0 0 0 0 0 51.00 51.00 51.00 51.00 51.00 51.00 51.00 0 0 0 0 0 0 51.00 55.00 65.00				Ŭ			
ANCILLARY SERVICE COST CENTERS 0 <th< td=""><td></td><td>Cost</td><td>Adjustments</td><td></td><td>Adjustments</td><td></td><td></td></th<>		Cost	Adjustments		Adjustments		
ARCILLARY SERVICE COST CENTERS 0.0 0.0 0		1.00		2.00		3.00	
50. 00 05000 DFEATING ROOM 0 <td>ANCI LLARY SERVI CE COST CENTERS</td> <td>· · · · · · · · · · · · · · · · · · ·</td> <td></td> <td></td> <td></td> <td></td> <td></td>	ANCI LLARY SERVI CE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
51.00 05100 RECOVERY FOOM 0 0 0 0 0 0 51.00 52.00 05200 DELIVERY FOOM 0 0 0 0 51.00 52.00 DS200 DELIVERY FOOM 0 0 0 0 55.00 50.00 DS500 DS500 DS500 0 DS500 DS		0	0		0 0	0	50.00
52.00 05200 DELUFERY FROM & LABOR FROM 0 0 0 0 52.00 54.00 05400 RADULOCY-THERAPEUTIC 0 0 0 0 55.00 57.00 05700 RADULOCY-THERAPEUTIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 55.00 57.00 57.00 57.00 0	51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
54.00 05400 RADIOLOCY-THERAPEUTIC 0 0 0 0 0 0 0 0 55.00 55.00 05500 KADIOLOCY-THERAPEUTIC 0 0 0 0 0 57.00 0 0500 KADIOLOCY-THERAPEUTIC 0 0 0 0 55.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
55. 00 05500 (RADIOLOCY-THERAPEUTIC 0 0 0 0 55. 00 57. 00 58. 00 66. 00 67. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 </td <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td>			0				
57.00 65700 (CT SCAN 0 0 0 0 0 0 0 58.00 59.00 05900 (ARGHET (CESONANCE TARLING (NRT)) 0 0 0 0 0 59.00 59.00 05900 (ARGHET (CESONANCE TARLING (NRT)) 0 <t< td=""><td></td><td></td><td>0</td><td></td><td>° °</td><td></td><td></td></t<>			0		° °		
58. 00 0 SB00 MACRETIC RESONANCE I MACING (MRI) 0		-	-				
59:00 05900 CARDIAC CATHETERIZATION 0							
60.00 LABORATORY 0		-	-				
64.00 06400 INTRAVENUUS THERAPY 0<		-					
65.00 06500 PESPI RATORY THERAPY 0		Ŭ					
66:00 06:600 PHYSICAL THERAPY 0 <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td></td>		-					
67.00 06700 0CUPATIONAL THERAPY 0<		-					
68: 00 068:00 SPECH PATHOLOGY 0 0 0 66: 00 0 0 66: 00 0		-	-			-	
69.00 0000 0000 0000 00000 00000 00000 000000 000000 000000000000000000000000000000000000		-	-			-	
70.00 0 <td></td> <td>0</td> <td></td> <td></td> <td>0 0</td> <td>0</td> <td>68.00</td>		0			0 0	0	68.00
11.00 07100 IDPCAL SUPPLIES CHARGED TO PATIENTS 0	69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
72.00 OP2.00 MPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 72.00 73.00 00 73.00 73.00 73.00 0 0 0 0 0 0 0 0 73.00 73.00 73.00 0 0 0 0 0 73.00 73.00 73.00 0 0 0 0 73.00 73.00 73.00 0 0 0 0 0 73.00 73.00 73.00 73.00 73.00 0 0 0 0 73.00 73.00 73.00 73.00 73.00 74.00 74.00 76.00 76.01 76.01 76.01 76.01 76.01 76.01 76.01 76.01	70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
73.00 ORUGS CHARGED TO PATIENTS 0 0 0 73.00 74.00 O7400 RENAL DI ALYSI S 0 0 0 0 0 74.00 74.00 O7400 RENAL DI ALYSI S 0 0 0 0 0 0 74.00 76.00 O3330 ENDOSCOPY 0 0 0 0 0 0 0 76.00 76.01 O3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 76.00 76.02 O3951 LUTHERWOOD PARTNERSHIP 0 0 0 0 0 76.03 76.04 03952 WOUND CARE CENTER 0 0 0 0 76.04 76.05 03953 IMAGI NG CENTERS 0 0 0 0 76.05 76.07 CARDI AC REHABI LI TATI ON 0 0 0 0 76.97 76.98 O7698 HYPERARIC OXYGEN THERAPY 0 0 0 0 0 0 89.00 90.00 OBSOR RURAL HALTH CLINC 0 0 0 0 <	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
74.00 O O O O 74.00 76.00 0330 ENDOSCOPY O O O O 76.00 76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES O <td>72.00 07200 IMPL. DEV. CHARGED TO PATIENTS</td> <td>0</td> <td>0</td> <td>1</td> <td>0 0</td> <td>0</td> <td>72.00</td>	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0 0	0	72.00
74.00 O O O O 74.00 76.00 0330 ENDOSCOPY O O O O 76.00 76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES O <td>73.00 07300 DRUGS CHARGED TO PATIENTS</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>73.00</td>	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00 03330 ENDOSCOPY 0 0 0 0 76.00 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL_SERVI CES 0 0 0 0 0 76.01 76.02 03951 LUTHERWOOD PARTNERSHI P 0 0 0 0 0 76.01 76.04 03952 WOUND CARE CENTER 0 0 0 0 76.05 76.05 03480 ONCOLOCY-CANCER CENTER 0 0 0 0 76.05 76.06 03953 IMAGI NG CENTERS 0 0 0 0 76.06 76.07 76.97 7677 CARDI AC REHABIL LITATI ON 0 0 0 76.07 76.98 07598 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.98 001791 17577 CARDI AC RELATH LATTA CINIC 0 0 0 0 90.06 89.00 08800 RURAL HALTH CLINIC 0 0 0 0 90.07 90.01 04900 CLINIC 0 0 <		0	0				
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 76. 01 76. 03 03951 LUTHERWOOD PARTNERSHI P 0 0 0 0 0 76. 03 76. 04 03952 WOUND CARE CENTER 0 0 0 0 0 76. 04 76. 03 03951 IMAGI NG CENTER 0 0 0 0 0 76. 05 76. 07 03954 BREAST DI AGNOSTI C CENTER 0 0 0 0 76. 07 76. 70 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 76. 97 76. 98 MYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76. 98 0UTPATI ENT SERVICE COST CENTERS 80.00 B800 RURAL HEALTH CLINIC 0 0 0 90. 00		0	0			0	
76.03 03951 LUTHERWOOD PARTNERSHIP 0 <			0				
76. 04 03952 WOUND CARE CENTER 0		-	-				
76.05 03480 0NCOLOGY-CANCER CARE CENTER 0 0 0 0 0 76.05 76.06 03953 IMAGING CENTERS 0 0 0 0 0 76.06 76.07 03954 BREAST DI AGNOSTIC CENTER 0 0 0 0 0 0 76.07 76.97 07697 CARDI AC REHABILI TATI ON 0 0 0 0 0 0 76.97 76.98 07697 CARDI AC REHABILI TATI ON 0 0 0 0 0 76.98 001791 ENT SERVICE COST CENTER 0 <td></td> <td>-</td> <td>-</td> <td></td> <td></td> <td></td> <td></td>		-	-				
76.06 03953 IMAGING CENTERS 0 0 0 0 76.06 76.07 03954 BREAST DI AGNOSTI C CENTER 0 0 0 0 76.07 76.97 07697 CARDI AC REHABI LI TATI ON 0		-	-				
76.07 03954 BREAST DI AGNOSTI C CENTER 0 0 0 0 0 0 0 0 76.97 76.97 07697 CARDI AC REHABI LI TATI ON 0 <td></td> <td>Ŭ</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		Ŭ	0				
76.97 O7697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 76.97 0000 000000000000000000000000000000000000		Ŭ,	0				
76.98 O7698 HYPERBARI C 0XYGEN THERAPY 0			-				
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 90.00 09000 CLINIC 0 0 0 0 90.00 90.01 04950 DIABETIC CARE CENTER 0 0 0 90.00 90.02 CHINIC 0 0 0 0 90.00 90.02 D4951 HEALTHY HEARTS CENTER 0 0 0 90.02 90.03 09001 CLINIC 0 0 0 90.02 90.04 04953 SPI NE CENTER 0 0 0 90.03 90.05 04954 INFUSION CENTERS 0 0 0 90.04 90.05 09002 MEDCHECK CLINICS 0 0 0 90.07 90.06 09002 MEDCHECK CLINICS 0 0 <							
88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 90.00 09000 CLINIC 0 0 0 0 90.00 90.01 04950 DI ABETIC CARE CENTER 0 0 0 0 90.01 90.02 04951 HEALTHY HEARTS CENTER 0 0 0 0 90.01 90.03 09011 CLINIC 0 0 0 0 90.03 90.04 04953 SPI NE CENTER 0 0 0 90.04 90.05 04954 INFUSION CENTERS 0 0 0 90.05 90.05 04954 INFUSION CENTERS 0 0 0 90.05 90.07 09003 KNEE CENTER 0 0 0 0 90.05 90.07 09003 KNEE CENTER 0 0 0 0 90.06 90.08 09004 PALLIATI		0	0		0 0	0	76.98
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 90.00 09000 CLINIC 0 0 0 0 0 90.00 90.01 04950 DIABETIC CARE CENTER 0 0 0 0 0 90.00 90.02 04951 HEALTHY HEARTS CENTER 0 0 0 0 90.02 90.03 09001 CLINIC 0 0 0 0 90.02 90.04 04953 SPINE CENTER 0 0 0 0 90.04 90.05 04954 INFUSION CENTERS 0 0 0 90.05 90.06 09002 WEDCHECK CLINICS 0 0 0 90.06 90.06 90.07 09003 KNEE CENTER 0 0 0 0 90.06 90.06 90.08 09004 PALLIATIVE CARE 0 0 0 0 90.07 90.08 09044 PALLIATIVE CARE 0 0 0 0 90.10 90.10				1			00.00
90.00 09000 CLINIC 0 0 0 0 90.00 90.01 04950 DIABETIC CARE CENTER 0 0 0 0 90.01 90.02 04951 HEALTHY HEARTS CENTER 0 0 0 0 90.02 90.03 09001 CLINIC 0 0 0 0 90.02 90.04 04953 SPINE CENTER 0 0 0 0 90.03 90.05 04954 INFUSION CENTERS 0 0 0 0 90.05 90.06 09002 MEDCHECK CLINICS 0 0 0 0 90.05 90.07 09003 KNEE CENTER 0 0 0 0 90.06 90.07 09003 KNEE CENTER 0 0 0 90.06 90.07 90.08 0904 PALLIATIVE CARE 0 0 0 0 90.08 90.10 09006 WORK SITE CLINICS 0 0 0 0 90.10 90.12 04961							
90.01 04950 DI ABETI C CARE CENTER 0 0 0 0 90.01 90.02 04951 HEALTHY HEARTS CENTER 0 0 0 0 90.02 90.03 09001 CLI NI C 0 0 0 0 90.03 90.04 04953 SPI NE CENTER 0 0 0 0 90.04 90.05 04954 INFUSION CENTERS 0 0 0 0 90.05 90.06 09002 MEDCHECK CLINICS 0 0 0 0 90.06 90.07 09003 KNEE CENTER 0 0 0 0 90.06 90.08 09004 PALLI ATI VE CARE 0 0 0 0 90.07 90.08 09004 PALLI ATI VE CARE 0 0 0 0 90.08 90.10 09006 WORK SI TE CLINICS 0 0 0 0 90.01 90.10 09006 WORK SI TE CLINICS 0 0 0 0 90.10 91.10		-					
90.02 04951 HEALTHY HEARTS CENTER 0 0 0 0 90.02 90.03 09001 CLINIC 0 0 0 0 90.03 90.04 04953 SPINE CENTER 0 0 0 0 90.04 90.05 04954 INFUSION CENTERS 0 0 0 0 90.05 90.06 09002 MEDCHECK CLINICS 0 0 0 0 90.06 90.07 09003 KNEE CENTER 0 0 0 0 90.06 90.07 09003 KNEE CENTER 0 0 0 0 90.07 90.08 09004 PALLI ATI VE CARE 0 0 0 0 90.08 90.10 09006 WORK SI TE CLINICS 0 0 0 0 90.10 90.12 04961 FAMI LY PRACTICE AND MATERNITY CARE 0 0 0 0 90.12 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00							
90.03 09001 CLINIC 0		-					
90.04 04953 SPINE CENTER 0 0 0 0 90.04 90.05 04954 INFUSION CENTERS 0 0 0 0 90.05 90.06 09002 MEDCHECK CLINICS 0 0 0 0 90.06 90.07 09003 KNEE CENTER 0 0 0 0 90.07 90.08 09004 PALLIATIVE CARE 0 0 0 0 90.07 90.08 09006 WORK SITE CLINICS 0 0 0 0 90.08 90.10 09006 WORK SITE CLINICS 0 0 0 90.08 90.11 09006 WORK SITE CLINICS 0 0 0 90.10 90.12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 90.12 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 092200 UBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 92.00 98.00 98.00		-					
90.05 04954 INFUSION CENTERS 0 0 0 0 90.05 90.06 09002 MEDCHECK CLINICS 0 0 0 0 90.06 90.07 09003 KNEE CENTER 0 0 0 0 90.07 90.08 09004 PALLIATIVE CARE 0 0 0 0 90.08 90.10 09006 WORK SITE CLINICS 0 0 0 0 90.07 90.10 09006 WORK SITE CLINICS 0 0 0 0 90.10 90.12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 90.12 91.00 09100 EMERGENCY 0 0 0 90.12 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 91.00 92.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 92.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 98.00		0	-				
90.06 09002 MEDCHECK CLINICS 0 0 0 0 0 90.06 90.07 09003 KNEE CENTER 0 0 0 0 0 90.07 90.08 09004 PALLI ATI VE CARE 0 0 0 0 0 90.08 90.10 09006 WORK SI TE CLINICS 0 0 0 0 0 90.10 90.12 04961 FAMI LY PRACTICE AND MATERNITY CARE 0 0 0 0 90.12 91.10 09100 EMERGENCY 0 0 0 0 90.12 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (COST CENTERS 0 0 0 92.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 98.00	90. 04 04953 SPI NE CENTER	0	0		0 0	0	90.04
90.07 09003 KNEE CENTER 0 0 0 0 90.07 90.08 09004 PALLI ATI VE CARE 0 0 0 0 90.08 90.10 09006 WORK SI TE CLI NI CS 0 0 0 0 0 90.07 90.12 04961 FAMI LY PRACTICE AND MATERNI TY CARE 0 0 0 0 90.12 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92.00 09200 OBSERVATI ON BEDS (COST CENTERS 0 0 0 0 92.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98.00	90. 05 04954 INFUSION CENTERS	0	0		0 0	0	90.05
90.08 09004 PALLIATIVE CARE 0 0 0 0 0 90.08 90.10 09006 WORK SITE CLINICS 0 0 0 0 0 90.10 90.12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 0 0 90.12 91.00 EMERGENCY 0 0 0 0 0 91.00 92.00 OSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 91.00 92.00 OSERVATION BEDS (COST CENTERS 0 0 0 0 91.00 98.00 O9850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 98.00	90.06 09002 MEDCHECK CLINICS	0	0		0 0	0	90.06
90.10 09006 WORK SITE CLINICS 0 0 0 0 90.10 90.12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 0 90.12 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 98.00	90. 07 09003 KNEE CENTER	0	0		0 0	0	90.07
90.10 09006 WORK SITE CLINICS 0 0 0 0 90.10 90.12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 0 90.12 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 98.00		0	0		0 0	0	90.08
90. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 0 0 0 0 90. 12 91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00 98.00		0	0		0 0	0	90.10
91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92.00 0THER REI MBURSABLE COST CENTERS 0 0 0 0 98.00		0	0				
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00 9850 0THER REI MBURSABLE COST CENTERS 0 0 0 98. 00 98. 00			0				
OTHER REI MBURSABLE COST CENTERS 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98.00			0				
98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 98. 00		<u> </u>		1	<u> </u>	0	12.00
		0	0		0 0	0	98 00
		, Ч	0	I	- -	0	

Health Financial Systems	COMMUNITY HEALTH	NETWORK, INC.		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-0074	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Pre 8/2/2021 3:24	pared:
		Ti †I	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 152, 500, 122	0,000000	50.00
51.00 05100 RECOVERY ROOM	0	0		0 12, 489, 412		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 9, 407, 198		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 50, 722, 443		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 21, 625, 785		
57. 00 05700 CT SCAN	0	0		0 85, 791, 000		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0 12, 834, 841	0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 228, 539, 596		
60. 00 06000 LABORATORY	0	0		0 160, 416, 808		
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 2, 370, 930		
65. 00 06500 RESPIRATORY THERAPY	0	0		0 30, 283, 923		
	0	0				
66. 00 06600 PHYSI CAL THERAPY	0	-				
67.00 06700 OCCUPATIONAL THERAPY	0	0		0/020/01/		
68. 00 06800 SPEECH PATHOLOGY	0	-		0 2, 306, 721	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 51, 353, 609		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 6, 026, 477	0.000000	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 71, 046, 143		
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 80, 474, 731	0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 884, 770, 453		
74.00 07400 RENAL DIALYSIS	0	0		0 7, 233, 567		
76.00 03330 ENDOSCOPY	0	0		0 4, 417, 870		
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 23, 956, 453		
76. 03 03951 LUTHERWOOD PARTNERSHI P	0	0		0 1, 328, 250		
76.04 03952 WOUND CARE CENTER	0	0		0 12, 698, 358		
76.05 03480 ONCOLOGY-CANCER CARE CENTER	0	0		0 216, 428, 145		
76.06 03953 I MAGI NG CENTERS	0	0		0 59, 250, 268		
76.07 03954 BREAST DIAGNOSTIC CENTER	0	0		0 4, 970, 921	0. 000000	
76. 97 07697 CARDIAC REHABILITATION	0	0		0 2, 667, 866		
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 2, 436, 896	0.00000	76.98
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0			0 0		
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0. 000000	
90. 00 09000 CLINIC	0	0		0 0	0. 000000	90.00
90. 01 04950 DIABETIC CARE CENTER	0	0		0 0	0.000000	90.01
90. 02 04951 HEALTHY HEARTS CENTER	0	0		0 3, 152, 536	0.000000	90. 02
90. 03 09001 CLINIC	0	0		0 0	0.000000	90.03
90. 04 04953 SPI NE CENTER	0	0)	0 0	0.000000	90.04
90.05 04954 INFUSION CENTERS	0	0)	0 2, 109, 518	0.000000	90.05
90. 06 09002 MEDCHECK CLINICS	0	0		0 0	0. 000000	90.06
90. 07 09003 KNEE CENTER	0	0		0 4, 454, 999	0. 000000	90.07
90. 08 09004 PALLI ATI VE CARE	0	0		0 77, 549		
90. 10 09006 WORK SITE CLINICS	0	0		0 0	0. 000000	
90.12 04961 FAMILY PRACTICE AND MATERNITY CARE	0	0		0 0	0. 000000	
91.00 09100 EMERGENCY	0	0		0 216, 221, 018		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 9, 329, 272		
OTHER REIMBURSABLE COST CENTERS						1
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0.000000	98.00
200.00 Total (lines 50 through 199)	0			0 2, 456, 468, 471		200. 00

Health Financial Systems 0	COMMUNITY HEALTH	NETWORK, INC.		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0074	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2020 To 12/31/2020		nared
				10 12/31/2020	8/2/2021 3: 24	pareu. pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	1 1		1		1	
50. 00 05000 OPERATI NG ROOM	0. 000000	2, 915, 498		0 0		
51.00 05100 RECOVERY ROOM	0. 000000	330, 039		0 0		•
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	455, 775		0 0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	561, 269		0 0		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	402, 234		0 0	0	55.00
57.00 05700 CT SCAN	0. 000000	1, 389, 394		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	242, 310		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 699, 212		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	4, 898, 647		0 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	38, 109		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 480, 833		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	161, 931		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	128, 459		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	85, 669		0 0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	492, 896		0 0		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	48, 619		0 0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	2, 176, 964		0 0		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 108, 916		0 0		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	3, 840, 647		0 0		•
74. 00 07400 RENAL DIALYSIS	0.000000	176, 027		0 0		
76. 00 03330 ENDOSCOPY	0.000000	100, 776		0 0		76.00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0.000000	100, 770				76.00
	0.000000	0				•
76. 03 03951 LUTHERWOOD PARTNERSHIP		0				76.03
76.04 03952 WOUND CARE CENTER	0.00000	38, 693		-		76.04
76.05 03480 ONCOLOGY-CANCER CARE CENTER	0. 000000	206, 264		0 0		76.05
76.06 03953 I MAGI NG CENTERS	0. 000000	3, 985		0 0		76.06
76. 07 03954 BREAST DI AGNOSTI C CENTER	0. 000000	0		0 0		
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	442		0 0		•
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76.98
OUTPATIENT SERVICE COST CENTERS	0.000000		1	0		
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0		
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0		89.00
90. 00 09000 CLINIC	0. 000000	0		0 0		90.00
90. 01 04950 DI ABETI C CARE CENTER	0. 000000	0		0 0		90.01
90. 02 04951 HEALTHY HEARTS CENTER	0. 000000	250		0 0		90.02
90. 03 09001 CLINIC	0. 000000	0		0 0		90.03
90. 04 04953 SPI NE CENTER	0. 000000	0		0 0	0	90.04
90. 05 04954 INFUSION CENTERS	0. 000000	0		0 0		
90. 06 09002 MEDCHECK CLINICS	0. 000000	0		0 0	-	
90. 07 09003 KNEE CENTER	0. 000000	0		0 0	0	
90. 08 09004 PALLI ATI VE CARE	0. 000000	0		0 0	0	90.08
90. 10 09006 WORK SITE CLINICS	0. 000000	0		0 0	0	90.10
90.12 04961 FAMILY PRACTICE AND MATERNITY CARE	0. 000000	0		0 0	0	90.12
91. 00 09100 EMERGENCY	0. 000000	2, 770, 573		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	153, 853		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0		98.00
200.00 Total (lines 50 through 199)		25, 908, 284		0 0	0	200.00

To 12/31/2020 Destry Time Prepared Bart lo Prom Services To the XIX insplict Destry Time Prepared Bart lo Prom President Prepared Finitorsed Services Cost Reinborsed Services Cost Reinborsed Services Cost Reinborsed Services Cost Services	Health Financial Systems C APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND C	COMMUNITY HEALTH D VACCINE COST	I NETWORK, INC. Provider C	CN: 15-0074	In Lie Period: From 01/01/2020	eu of Form CMS- Worksheet D Part V	2552-10
Cost Center Description Cost to Durges Cost to Durges PS Reinburges Part 1, col o Cost Cost PS Reinburges Finit 1, col o Description Cost Subject To Subject To Ded. & Coins. Description Cost Subject To Ded. & Coins. PC Services PS Reinburges Services (Services Subject To Ded. & Coins. Cost Subject To Ded. & Coins. 50 00 05000 0PERATING ROW 0.20051 0 0 1.329, E03 5.00 51 00 05100 0PERATING ROW 0.146455 0 0 1.329, E03 5.00 52 00 05200 DELIVERY ROW & LABOR ROW 0.044407 0 0 1.329, E03 5.00 52 00 05200 DELIVERY ROW & LABOR ROW 0.044407 0 0 1.329, E03 5.00 53 00 05200 DELIVERY ROW & LABOR ROW 0.054647 0 0 1.329, E03 5.00 54 00 05500 RAND (COV-THERAPEVTIC 0.07165 0 0 1.343, 90' 0 55.00 55 00 05500 RAND (COV-THERAPEVTIC 0.020146 0 0 1.343, 90' 0 56.00						Date/Time Pre	pared:
Cost Center Description Cost of Cost Center Description Cost of Cost Centers See Services See Services See Services Not Subject To Post Services Not Subject Not Not Services Not		1	Titl	e XIX	Hospi tal		
Ratio From Services (see bits) Reinbursed bits) Reinbursed bits) Reinbursed bits) MCILLARY SERVICE COST CLNTERS 100 2.00 3.00 4.01ms. 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000 0.00000000 0.0000000000 0.000000000 0.0000000000				· · · · · · · · · · · · · · · · · · ·	-		
Worksheet C, Part I, col. o Inst.) Services Norther	Cost Center Description						
Part I. col. 9 Subject To (see inst.) Subject To (see inst.) 50.00 2.00 3.00 4.00 5.00 50.00 3.00 4.00 5.00 5.00 50.00 0.000 4.00 5.00 5.00 50.00 0.000 1.000 5.00 5.00 50.00 0.000 0.000 1.000 5.00 50.00 0.0000 0.0000 0.000 5.00 5.00 50.00 0.0000 0.0000 0.0000 0.000 5.00 5.00 50.00 05500 RAD (LOGY-THERAPEUTIC 0.070165 0 1.715, 938 5.64 50.00 05800 MAORETIC RESONANCE IMAGING (NRI) 0.144987 0 3.45, 967 58.0 50.00 05800 IMAORETIC RESONANCE IMAGING (NRI) 0.144987 0 3.27, 967 6.60 60.00 0.0001 IARAVENOST HERAPY 0.320440 0 1.20, 573 6.61 60.00 0.8000 SPECH NATIONY THERAPY 0.230400 0 25, 772 6.61						(see Inst.)	
Dec. R_C or R_S or			· · ·				
Image: service cost centers: (see inst.) (see inst.) (see inst.) MCI LLARY SERVICE COST CENTERS 0 0 0.00 0.0000							
NACILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 (PHEALING ROOM 0.23031 0 0 1.329,505 0 50.00 50.00 05200 (PHEALING ROOM 0.146455 0 0 0 0 55.00 52.00 05200 (PELVERY ROUA & LABORS II C 0.07165 0 1.1715,933 0 55.00 55.00 05500 (RADIDLOCY-INERAPEUTIC 0.070165 0 1.464,970 0 55.00 59.00 05500 (ADDIDLOCY-INERAPEUTIC 0.070165 0 0.400 1.464,970 0 55.00 50.00 05500 (ADDIDLOCY-INERAPEUTIC 0.036460 0 1.346,970 0 55.00 50.00 05500 (CARDIA C, CATHETER RAIGING (MRI) 0.118090 0 1.346,9775 0 64.00 64.00 0.46400 (INTRAVROUS THERAPY 0.2524800 0 129,735 0 65.0 65.00 0.6600 (CUPATIONAL THERAPY 0.2524800 0 120,736 0 67.0							
ANCI LLARY SERVICE COST CENTERS		1.00	2.00			5.00	
51.00 05100 RECOVERY ROOM 0.146455 0 0 274.649 0 51.0 52.00 05200 DELVERY ROOM 0.6400 RADIOLOCY-INERPEUTIC 0.167755 0 0 1.715,938 0 54.0 55.00 05500 MADIOLOCY-INERPEUTIC 0.070165 0 4.06,114 0 55.0 56.00 05500 MARDEI C. CATHERPEUTIC 0.070165 0 4.06,970 58.0 58.00 05900 CARDIA C. CATHERPEUTIC 0.050897 0 4.46,970 58.0 59.00 05900 CARDIA C. CATHERENARY 0.324,970 0 1.44,69,970 59.0 06400 INTRAVENUS THERARY 0.324400 0 1.54,287 0.40 65.0 0500 DECOMPACIAL THRARY 0.524800 0 0 2.77,781 0.46 06400 PECHALAL THRARY 0.524800 0 0 2.77,753 0 65.0 0500 DECOMPARIAL THRARY 0.524800 0 0 2.77,754 0 66.0 04600 PECHALAL THRARY 0.524800 0 0.5	ANCI LLARY SERVI CE COST CENTERS					•	
52.00 65200 DELUSERY ROOM & LABOR ROOM 0. 684467 0 0 0 0 55.00 55.00 05500 RADI LOCO-THERAPUTI C 0. 070165 0 0 4.213,560 55.00 57.00 05500 RADI LOCO-THERAPUTI C 0. 070165 0 0 4.213,560 55.00 58.00 05800 ARADET C. RESONANCE HAGING (MR1) 0. 144987 0 0 345,967 55.00 60.00 06000 LABORATORY 0. 118004 0 0 3.727,967 66.00 60.00 06500 RESPI RATORY THERAPY 0. 206146 0 0 1.57,2 66.00 60.00 06600 PYSICAL THERAPY 0. 2043460 0 0.229,376 66.0 60.00 06700 DECIPATI ONAL THERAPY 0. 493346 0 0 90.736 67.0 60.00 06700 DECIPATI ONAL THERAPY 0. 493646 0 0 90.736 67.0 60.00 06700 DECIPATIONAL THERAPY 0. 493646 0 0 10.0 750.0 70.00	50. 00 05000 OPERATI NG ROOM	0. 230351	0		0 1, 329, 505	i 0	50.00
54.00 05400 RADIOLOCY-DLAGNOSTIC 0.107755 0 0 1.715,938 0 56.0 55.00 05500 MARDELCC ATHERAPEUTIC 0.07065 0 4.705,560 57.00 56.0 55.00	51.00 05100 RECOVERY ROOM	0. 146455	C		0 274, 649	0	51.00
55. 00 05500 RADIOLOGY-THERAPUTIC 0.070165 0 408, 114 9 55. 57. 00 05700 CT SCAN 0.058087 0 4.21, 3.500 57. 58. 00 05600 MAGNETIC RESONANCE (MRI.) 0.144987 0 9.345, 967 55. 59. 00 0500 CAPDIA CCATHERER (MRI.) 0.051693 0 1.466, 970 66. 60. 00 06000 LABORATORY 0.929, 376 66. 67. 66. 67. 66. 67. 66. 67. 66. 67. 66. 67. 67. 67.<		0. 684467	0		0 0	0	52.00
57.00 06700 CT SCAN 0.058687 0 4.213,560 57.0 55.0 59.00 05600 CARDIA C, CATHETERI ZATI ON 0.051693 0 0 3.45,967 0 56.0 59.00 06500 CARDIA C, CATHETERI ZATI ON 0.051693 0 0 3.727,967 0 60.0 60.00 06600 INTRAVENUS THERARY 0.932633 0 0 154,287 0 64.0 65.00 06500 OCCUPATI ONAL THERAPY 0.524800 0 0 229,376 0 66.0 0 06600 PEST CAL THERAPY 0.493279 0 0 56.722 0 66.0 0 0700 ELECTROCARDHAL DIGAY 0.99465 0 0 120.31 0 70.0 <t< td=""><td>54. 00 05400 RADI OLOGY-DI AGNOSTI C</td><td>0. 167755</td><td></td><td></td><td>0 1, 715, 938</td><td>8 0</td><td>54.00</td></t<>	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 167755			0 1, 715, 938	8 0	54.00
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90.10 09006 WORK SITE CLINICS 0.000000 0 0 0 0 90.12 90.12 04961 FAMILY PRACTICE AND MATERNITY CARE 0.000000 0 0 0 0 90.12 91.00 09100 EMERGENCY 0.137459 0 0 15,453,594 0 91.0 92.00 0BSERVATION BEDS (NON-DISTINCT PART) 0.728568 0 0 401,630 0 92.0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 0 0 0 98.0 200.00 Subtotal (see instructions) 0 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 0 201.00 201.00 0 0 0 201.00 0 0 201.00 0 0 201.00 0 0 0 201.00 0 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 201.00	90. 07 09003 KNEE CENTER	1. 403446	0		0 5,650	0 0	
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91.00 09100 EMERGENCY 0.137459 0 15,453,594 0 91.0 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.728568 0 0 401,630 92.0 07HER REIMBURSABLE COST CENTERS 0.000000 0 0 0 98.00 0 95.7,790,164 0 200.00 200.00 201.00 0 0 0 0 0 201.00 0 0 0 201.00 0 0 0 201.00 0 0 0 201.00 0 0 0 201.00 0 0 0 201.00 0 0 0 201.00 0 0 0 201.00 0 0 0 201.00 0 0 0 201.00 201.00 0 0 201.00 0 0 0 201.00 0 0 0 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00<					0		
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.728568 0 0 401,630 0 92. 0 0THER REIMBURSABLE COST CENTERS 0.000000 0 0 0 0 98.00 9850 0THER REIMBURSABLE COST CENTERS 0.000000 0 0 98.00 200.00 Subtotal (see instructions) 0 0 57,790,164 0 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 201.00 201.00 0 0 0 201.00 0 0 0 201.00 0 0 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 0 201.00 201							
OTHER REI MBURSABLE COST CENTERS98. 0009850OTHER REI MBURSABLE COST CENTERS0.00000000098.00200. 00Subtotal (see i nstructions)0057, 790, 1640200.00201. 00Less PBP Clinic Lab. Services-Program000201.000nl y Charges000201.00							
98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 0 0 0 98.0 200.00 Subtotal (see i nstructions) 0 0 57, 790, 164 0 200.0 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.0		0. 728568	0	1	0 401,630	0	92.00
200.00 Subtotal (see instructions) 0 0 57, 790, 164 0 200.0 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 0 201.0		0.000000		1	0		
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.0 0nly Charges 0 0 201.0		0.00000					
Only Charges					0 57, 790, 164	0	
							201.00
202.00 Net Charges (line 200 - line 201) 0 0 57, 790, 164 0 202.0	202.00 Net Charges (line 200 - line 201)		0		0 57, 790, 164	n –	202.00

Health Financial Systems C APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	OMMUNI TY HEALTH VACCI NE COST	Provider C	CN: 15-0074	Period: From 01/01/2020 To 12/31/2020	u of Form CMS- Worksheet D Part V Date/Time Pre 8/2/2021 3:24	epared:
	-	Titl	e XIX	Hospi tal	PPS	
Cost Center Description	(see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS		00/ 050				1 50 00
50.00 05000 0PERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY-THERAPEUTI C		306, 253 40, 224 0 287, 857 28, 635				50.00 51.00 52.00 54.00 55.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	0	247, 281 50, 161 75, 832				57.00 58.00 59.00
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY		439, 915 143, 893 34, 994 120, 377 44, 791				60.00 64.00 65.00 66.00 67.00
68. 00 06900 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		27, 980 46, 021 24, 008 196, 717				68. 00 69. 00 70. 00 71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S 76. 00 03330 ENDOSCOPY		247, 790 3, 894, 214 0 14, 014				72.00 73.00 74.00 76.00
76. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 03 03951 LUTHERWOOD PARTNERSHI P 76. 04 03952 WOUND CARE CENTER 76. 05 03480 ONCOLOGY-CANCER CARE CENTER	0 0 0 0	355, 138 2, 344, 462 177, 933 1, 076, 604				76.01 76.03 76.04 76.05
76. 06 03953 I MAGI NG CENTERS 76. 07 03954 BREAST DI AGNOSTI C CENTER 76. 97 07697 CARDI AC REHABI LI TATI ON 76. 98 07698 HYPERBARI C OXYGEN THERAPY	0 0 0 0	131, 508 31, 883 8, 526 0				76.00 76.0 76.9 76.9
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90.00 09000 CLINIC	0	0				88.00 89.00 90.00
90. 01 04950 DI ABETI C CARE CENTER 90. 02 04951 HEALTHY HEARTS CENTER 90. 03 09001 CLINI C	0	0 22, 132 0				90.01 90.02 90.03
00.04 04953 SPI NE CENTER 00.05 04954 I NFUSI ON CENTERS 00.06 09002 MEDCHECK CLI NI CS	000000000000000000000000000000000000000	6, 918 0				90.04 90.05 90.06
00. 07 09003 KNEE CENTER 10. 08 09004 PALLI ATI VE CARE 10. 10 09006 WORK SI TE CLI NI CS 10. 10 04004 FANDER SI TE CLI NI CS		7, 929 13 0 0				90.0 90.0 90.1
20. 12 04961 FAMILY PRACTICE AND MATERNITY CARE 21. 00 09100 EMERGENCY 22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0 2, 124, 236 292, 615				90.12 91.00 92.00
OTHER NET MODRSABLE COST CENTERS 088.00 09850 OTHER REI MBURSABLE COST CENTERS 200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program	000000000000000000000000000000000000000					98.00 200.00 201.00
Only Charges 202.00 Net Charges (line 200 - line 201)	0	12, 850, 854				202. 00

Health Financial System

COMMUNI TY	HEALTH	NE	TWOF	RΚ,	NC.	
			-		0.011	

In Lieu of Form CMS-2552-10

iour tri	Financial Systems COMMUNITY HEALTH N	IETWORK, INC.	In Lie	u of Form CMS-2	2552-1
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0074	Peri od:	Worksheet D-1	
			From 01/01/2020 To 12/31/2020		
		Title XVIII	llaanital	8/2/2021 3: 24 PPS	pm
	Cost Center Description		Hospi tal	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	(s excluding newborn)		75, 492	1.00
2.00	Inpatient days (including private room days, excluding swing-			75, 492	2.0
3.00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3.0
1 00	do not complete this line.			(0.045	
4.00 5.00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	69, 845 0	4.0 5.0
	reporting period			, i i i i i i i i i i i i i i i i i i i	
5.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.0
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m days) through December	r 31 of the cost	0	7.0
7.00	reporting period	in days) through becember	ST OF the cost	0	/.0
3.00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	8.0
0.00	reporting period (if calendar year, enter 0 on this line)	a the Dreaman (avaluding	a owing bod and	13, 753	
9.00	Total inpatient days including private room days applicable t newborn days) (see instructions)	the program (excluding	y swing-bed and	13, 753	9.0
10.00	Swing-bed SNF type inpatient days applicable to title XVIII c	only (including private i	room days)	0	10. 0
	through December 31 of the cost reporting period (see instruct				
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		room days) atter	0	11.0
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.0
	through December 31 of the cost reporting period			_	
	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.0
	Medically necessary private room days applicable to the Progr			0	14.0
5.00	Total nursery days (title V or XIX only)		5,	0	
16.00	Nursery days (title V or XIX only)			0	16.0
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31 (of the cost	0.00	17.00
	reporting period			0,00	
18.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18.0
19.00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19.0
17.00	reporting period			0.00	17.0
20. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.0
21.00	reporting period Total general inpatient routine service cost (see instruction	s)		90, 865, 582	21.0
	Swing-bed cost applicable to SNF type services through Decemb		ting period (line	0,000,002	22.0
	5 x line 17)				
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportion	ng period (line 6	0	23.0
24.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24.0
	7 x line 19)		0.1		
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25.0
26.00	Total swing-bed cost (see instructions)			0	26.0
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		90, 865, 582	
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT		<u>,</u>		
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed cl	narges)	0	
	Semi-private room charges (excluding swing-bed charges)			0	30.0
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x li		5 (1 0113)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 0
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	90, 865, 582	37.0
ſ	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
				1, 203. 65	38.0
38.00	Adjusted general inpatient routine service cost per diem (see	-			
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	2 38)		16, 553, 798 0	39.00

	ATION OF INPATIENT OPERATING COST		Provider C	N: 15-0074	Period: From 01/01/2020		
					To 12/31/2020	Date/Time Pre 8/2/2021 3:24	
	Cast Conton Deceription	Tatal		XVIII Average Der	Hospital Program Days	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
00	NURSERY (title V & XIX only)	0	0	0. (0 00	0) 42
	Intensive Care Type Inpatient Hospital Units					7.017.115	
00	INTENSIVE CARE UNIT	25, 392, 447	12, 316				
00 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0.0	0 00	0	44
00	SURGI CAL I NTENSI VE CARE UNI T						40
00		2, 476, 117	2, 085	1, 187. !	59 0	0	
	Cost Center Description						
00	Program inpatient ancillary service cost (Wk	at D 2 and 2	Line 200)			1.00	1 48
00 00	Total Program inpatient costs (sum of lines			ns)		35, 031, 404 58, 902, 317	
00	PASS THROUGH COST ADJUSTMENTS			10)			
00	Pass through costs applicable to Program inp	atient routine s	ervices (from	Wkst. D, sur	n of Parts I and	2, 448, 264	1 50
00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	2, 981, 008	3 51
00	and IV) Total Program excludable cost (sum of lines	50 and 51)				5, 429, 272	2 52
00	Total Program inpatient operating cost exclu	,	ated, non-phy	sician anesth	netist, and	53, 473, 045	
	medical education costs (line 49 minus line	52)				<u> </u>	
~~	TARGET AMOUNT AND LIMIT COMPUTATION						
00 00	Program discharges Target amount per discharge					0.00	
00	Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
00	Bonus payment (see instructions)	5	5		,	0	58
00	Lesser of lines 53/54 or 55 from the cost re	eporting period e	ending 1996, u	pdated and co	ompounded by the	0.00) 59
~~	market basket					0.00	
00 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	
00	which operating costs (line 53) are less that					Ĭ	10
	amount (line 56), otherwise enter zero (see		、		<u>J</u>		
00	Relief payment (see instructions)					0	
00	Allowable Inpatient cost plus incentive paym	ent (see instruc	ctions)			0) 63
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	her 31 of the	cost reporti	na period (See	0	64
00	instructions) (title XVIII only)	the ough becch		0031 100011		Ĭ	101
00	Medicare swing-bed SNF inpatient routine cos	sts after Decembe	er 31 of the c	ost reportino	g period (See	0	65
~~	instructions)(title XVIII only)						
00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 6	64 plus line 6	5)(title XVII	I ONLY). FOR	0	66
00	Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31 o	f the cost re	eporting period	0	67
	(line 12 x line 19)	0					
00	Title V or XIX swing-bed NF inpatient routin	ne costs after De	ecember 31 of	the cost repo	orting period	0	68
00	(line 13 x line 20)	rautina aasta (l	ing (7 . ling	(0)			
00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0) 69
00	Skilled nursing facility/other nursing facil)		70
00	Adjusted general inpatient routine service of						71
00	Program routine service cost (line 9 x line			05)			72
00	Medically necessary private room cost applic	U	•	ne 35)			73
00 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		orksheet R I	Part II column		74
00	26, line 45)	. Such to Scivice	55515 (110m W	S. Ronoot D, I	a. e. r., corunin		'
00	Per diem capital-related costs (line 75 ÷ li	ne 2)				1	76
00	Program capital-related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minu	,					78
00 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	• •			us line 70)		80
00	Inpatient routine service cost per diem limi				103 I I IIC /7)	1	81
00	Inpatient routine service cost limitation (I					1	82
00	Reasonable inpatient routine service costs (1	83
00	Program inpatient ancillary services (see in						84
00	Utilization review - physician compensation						85
00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ougn 85)			l	86
00	Total observation bed days (see instructions					5, 647	7 87
00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 203. 65	98 88

Health Financial Systems CO	OMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2020	Worksheet D-1	
				To 12/31/2020	Date/Time Pre 8/2/2021 3:24	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	7, 435, 025	90, 865, 582	0. 08182	4 6, 797, 012	556, 159	90.00
91.00 Nursing School cost	0	90, 865, 582	0.00000	0 6, 797, 012	0	91.00
92.00 Allied health cost	0	90, 865, 582	0.00000	6, 797, 012	0	92.00
93.00 All other Medical Education	0	90, 865, 582	0.00000	6, 797, 012	0	93.00

COMMUNI TY	HEALTH	NETWORK,	INC.

COMPUTATION OF INFATIENT OPERATING COST Provider CDN: 15-007 Part CD: Info U1/J/2000 Description SZZZUDI 3: 24 pm. Cost Center Description TI (Lo XIX Hogst Ial PPS Institute Aday: (Incluing private room days, and saling bed days, excluding newtorn) 1.00 F75.492 1.00 Institute Aday: (Incluing private room days, and saling bed days, excluding newtorn) 75.492 1.00 1.00 Inpattent days: (Incluing private room days, and saling bed days, excluding newtorn) 75.492 1.00 2.00 Inpattent days: (Incluing private room days, and saling bed days) Frought of the cost 91.00 91.00 4.00 Sam private room days (secluding and private room days) through becember 31 of the cost 0 50.00 70.00 1.00 70.00 1.00 80.00 70.00 70.00 1.00 80.00 70.00 1.00 80.00 70.00 1.00 80.00 70.00 1.00 80.00 70.00 1.00 80.00 70.00 1.00 80.00 70.00 1.00 80.00 70.00 1.00 80.00 70.00 1.00 80.00 70.00	<u>Hea</u> l th	Financial Systems COMMUNITY HEALTH N	IETWORK, INC.	In Lie	u of Form CMS-2	2552-10
Cost Center Description Title XIX Hogh Tail District The Proper ed. Interval Title XIX Hogh Tail PR PR Interval Title XIX Hogh Tail PR PR PR Interval Title XIX Hogh Tail PR			Provider CCN: 15-0074	Peri od:		
Example ALL Information 1.00 IMMIT ENT DAYS 1.00 IMMIT ENT DAYS 1.00 Impact First Days (Including private room days, accluding seing-bed and neekhorm days) 75, 427 1.00 Cold Impact First Days (Including private room days, accluding seing-bed and neekhorm days) 60 3.00 Cold Impact First Days (Including private room days, accluding seing-bed and observation bed days) 100 60				To 12/31/2020	8/2/2021 3:24	
PART I - ALL PROVIDER COMPONENTS 1.00 100 ImPAILING DAYS Internation of the composition of the compositis the compositing period of the compositis period of the composit		Cost Contor Description	Title XIX	Hospi tal	PPS	
INPACT L ALL PROVIDER COMPORED AND INVECTION AND Inpattent days (including private room days, and swing-bed days, excluding aning-bed and needorm days) 75,492 1.00 1.00 Inpattent days (including private room days, and using-bed days, excluding aning-bed and beservation bed days). 75,492 2.00 0.01 Institution days (including private room days). 17,902 2.00 0.01 Institution days (including private room days). 17,902 2.00 0.02 Intal swing-bed SM Type Inpattent days (including private room days) after December 31 of the cost reporting period. 0 6.00 0.01 Intal swing-bed M Type Inpattent days (including private room days) after December 31 of the cost reporting period. 0 7.00 0.02 Total shing-bed M Type Inpattent days (including private room days) after December 31 of the cost reporting period. 0 8.00 0.00 Sing-bed SM Type Inpattent days (including private room days) after December 31 of the cost reporting period. 0 1.00 1.00 Sing-bed SM Type Inpattent days applicable to title XVII only (including private room days). 0 1.00 0.01 Sing-bed SM Type Inpattent days applicable to title XVII only (including private room days). 0 1		Cost center bescription			1.00	
1.00 Inpatient days (including private room days, and swing-bed days, excluding newhorn) 75,492 1.00 1.00 Inpatient days (including private room days, excluding swing-bed and boservation bed days). 75,492 2.00 3.00 Private room days, (axcluding swing-bed and observation bed days). 69,944 400 5.00 Total swing-bed SWF type inpatient days (including private room days). 69,944 400 6.00 Total swing-bed SWF type inpatient days (including private room days). 69,944 400 6.00 Total swing-bed SWF type inpatient days (including private room days). 100 600 600 700 600 700 600 700 600 700 600 700 600 700 600 700 600 700 600 700 600 700 600 700 600 700 600 700 600 700 600 800 700 700 600 800 700 700 600 800 700 700 600 800 700 700 800 800 800 800 800 800 800 800 800 80						
2.00 Injestient days (including private room days, excluding samp-bed and networm days) 75,492 2.00 00 Derivate room days (seculating samp-bed and observation bed days) 17 you have only private room days, only private room days, after December 31 of the cost 69,845 4.00 00 Total samp-bed SNF type inpatient days (including private room days) after December 31 of the cost 0 6.00 100 Total samp-bed SNF type inpatient days (including private room days) after December 31 of the cost 0 0 00 Total samp-bed SNF type inpatient days (including private room days) (after December 31 of the cost 0 0 00 Total samp-bed SNF type inpatient days applicable to the Program (ascluding saving-bed and heaving) 0 0 00 Total samp bed SNF type inpatient days applicable to the set saving (including private room days) 0 0 00 Samp bed SNF type inpatient days applicable to the set saving (including private room days) 0 0 010.00 Samp bed SNF type inpatient days applicable to the set saving (including private room days) 0 0 02 Samp bed SNF type inpatient days applicable to the Program (tred of the cost 0 0 03.00 Samp bed SNF type inpatient days applicable to the SNF type inpatient days applicable to the seco			(s excluding newborn)		75 492	1 1 00
4.00 Semi_private room days (excluding swing-bed and observation bed days) 69,445 4.00 5.00 0.01 Total swing-bed SMF type inpatient days (including private room days) strough December 31 of the cost 0 5.00 0.01 Total swing-bed SMF type inpatient days (including private room days) strough December 31 of the cost 0 0 0.00 Total swing-bed MF type inpatient days (including private room days) strough December 31 of the cost 0 0 0.00 Total swing-bed MF type inpatient days (including private room days) strough December 31 of the cost 0 0 0.00 Total swing-bed MF type inpatient days applicable to the the XVII only (including private room days) after 0 0 0.00 Swing-bed SMF type inpatient days applicable to the the XVII only (including private room days) after 0 1 0 1.00 Swing-bed SMF type inpatient days applicable to the tites VI on XX only (including private room days) after 0 1 0 1.00 Swing-bed MF type inpatient days applicable to the tites VI on XX only (including private room days) after 0 1 0 1.00 Swing-bed MF type inpatient days applicable to the tites VI on XX only (including private room days) including the tocst reporting period (including swing-bed days) 0 1 0	2.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da	bed and newborn days)	rivate room days,	75, 492	2.00
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27.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)96,873,89927.00PRI VATEROOM DIFFERENTIAL ADJUSTMENT28.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.0029.00Pri vate room charges (excluding swing-bed charges)029.0030.00Semi-pri vate room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.000000032.00Average pri vate room per diem charge (line 29 + line 3)0.0033.00Average per diem pri vate room cost differential (line 30 + line 4)0.0034.00Average per diem pri vate room cost differential (line 34 x line 31)0.0035.00Average per diem pri vate room cost differential (line 3 x line 35)037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36)96,873,899PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1,283.2338.0038.00Adjusted general inpatient routine service cost (line 9 x line 38)1,283.2338.0090.00Medi cally necessary private room cost applicable to the Program (line 14 x line 35)040.00		x line 20)	31 of the cost reporting	g period (line 8		
28.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.0029.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 29 + line 3)0.0032.0033.00Average per diem private room charge differential (line 30 + line 4)0.0032.0034.00Average per diem private room cost differential (line 32 minus line 33) (see instructions)0.0034.0035.00Average per diem private room cost differential (line 3 x line 35)0.0035.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36)036.0027.minus line 36)PART 11 - HOSPITAL AND SUBPROVIDERS ONLY96, 873, 89937.0078.00Adj usted general inpatient routine service cost per diem (see instructions)1, 283.2338.0039.00Program general inpatient routine service cost (line 9 x line 38)8, 688, 75039.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00		General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)			
29.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 29 + line 3)0.0032.0033.00Average per diem private room per diem charge differential (line 32 minus line 33) (see instructions)0.0032.0034.00Average per diem private room cost differential (line 34 x line 31)0.0034.0035.00Average per diem private room cost differential (line 3 x line 35)036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 96, 873, 89937.0027.minus line 36)PART 11 - HOSPI TAL AND SUBPROVI DERS ONLY038.0038.00Adjusted general inpatient routine service cost per diem (see instructions)1, 283.2338.0039.00Program general inpatient routine service cost (line 9 x line 38)8, 688, 75039.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00	20 00		d and obconvetion het -			20 00
30.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 29 + line 3)0.0032.0033.00Average semi-private room per diem charge (line 30 + line 4)0.0033.0034.00Average per diem private room cost differential (line 32 minus line 33) (see instructions)0.0034.0035.00Average per diem private room cost differential (line 3 x line 31)0.0035.0036.00Private room cost differential adjustment (line 3 x line 35)0.0036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36)96,873,89937.00PART 11 - HOSPI TAL AND SUBPROVI DERS ONLYPROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1,283.2338.0039.00Program general inpatient routine service cost per diem (see instructions)1,283.2339.0090.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00			and observation bed Cr	iai yes <i>)</i>		•
31.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 29 + line 3)0.0032.0033.00Average semi-private room per diem charge (line 30 + line 4)0.0033.0034.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0033.0035.00Average per diem private room cost differential (line 34 x line 31)0.0034.0036.00Private room cost differential adjustment (line 3 x line 35)036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 96, 873, 89937.0027 minus line 36)PART 11 - HOSPITAL AND SUBPROVIDERS ONLY96, 873, 89937.0078.00Adjusted general inpatient routine service cost per diem (see instructions)1, 283.2338.0039.00Program general inpatient routine service cost (line 9 x line 38)8, 688, 75039.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00						
32.00Average private room per diem charge (line 29 + line 3)0.0032.0033.00Average semi-private room per diem charge (line 30 + line 4)0.0033.0034.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0034.0035.00Average per diem private room cost differential (line 34 x line 31)0.0035.0036.00Private room cost differential adjustment (line 3 x line 35)0.0036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 96, 873, 899)37.0027 minus line 36)PART 11 - HOSPITAL AND SUBPROVIDERS ONLY96, 873, 899PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1, 283.2338.00Adjusted general inpatient routine service cost per diem (see instructions)1, 283.2339.00Program general inpatient routine service cost (line 9 x line 38)8, 688, 75040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0			÷line 28)			
33.00 Average semi-private room per diem charge (line 30 + line 4) 0.00 33.00 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 34.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 96, 873, 899) 0.00 36.00 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY 96, 873, 899 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 1, 283.23 38.00 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 283.23 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 8, 688, 750 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			/			1
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0 0.00 35.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 96, 873, 899) 0 36.00 37.00 PRT 11 - 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, 283.23 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 8, 688, 750 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 26, 873, 899) 0 37.00 27 minus line 36) PART 11 - HOSPI TAL AND SUBPROVI DERS ONLY 96, 873, 899 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 1, 283.23 38.00 39.00 Program general inpatient routine service cost per diem (see instructions) 1, 283.23 38.00 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			nus line 33)(see instruc	ctions)		
36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) 96,873,899 37.00 PART 11 - HOSPI TAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 1,283.23 38.00 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,283.23 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 8,688,750 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			, ,			
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 26, 873, 899) 37. 00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY 96, 873, 899 37. 00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 1, 283. 23 38. 00 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 283. 23 38. 00 39. 00 Program general inpatient routine service cost (line 9 x line 38) 8, 688, 750 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00						•
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, 283.23 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 8, 688, 750 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS38.00Adjusted general inpatient routine service cost per diem (see instructions)1, 283.2339.00Program general inpatient routine service cost (line 9 x line 38)8, 688, 75040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0		PART II - HOSPITAL AND SUBPROVIDERS ONLY			1	1
38.00Adjusted general inpatient routine service cost per diem (see instructions)1, 283.2338.0039.00Program general inpatient routine service cost (line 9 x line 38)8, 688, 75039.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00			IUSTMENTS			1
39.00Program general inpatient routine service cost (line 9 x line 38)8, 688, 75039.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00	38.00				1, 283. 23	38.00
	39.00	Program general inpatient routine service cost (line 9 x line	2 38)			1

WPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0074	Period: From 01/01/2020	Worksheet D-1	1
					To 12/31/2020		
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	-
. 00	NURSERY (title V & XIX only)	1, 633, 532	1, 682				42.
	Intensive Care Type Inpatient Hospital Units						
	INTENSIVE CARE UNIT	25, 447, 392	12, 316				
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	C	0.	0 00	C	
	SURGICAL INTENSIVE CARE UNIT						45
	NEONATAL INTENSIVE CARE UNIT	2, 551, 454	2, 085	1, 223.	72 0	c	47
t	Cost Center Description						
1						1.00	
	Program inpatient ancillary service cost (Wks			>		5, 352, 956	
	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ns)		15, 420, 782	2 49
	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst D sur	n of Parts L and	930, 343	50
)		(,	
00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	460, 569	51
~	and IV)	50 and 51)				1 200 010	<u>-</u> ~
	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclud		lated non-phy	sician anoc+1	netist and	1, 390, 912 14, 029, 870	
	medical education costs (line 49 minus line 5		atea, non-phy		istist, anu	17,027,070	
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
	Program di scharges					C	
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	na cost and ta	raet amount (1	ing 56 minus	line 53)		
	Bonus payment (see instructions)	ng cost and ta			THE 55)		
	Lesser of lines 53/54 or 55 from the cost rep	porting period	ending 1996, ι	pdated and co	ompounded by the		
	market basket		-				
	Lesser of lines 53/54 or 55 from prior year of lines 52/54 is the laws of lines				All	0.00	
00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					C	61
	amount (line 56), otherwise enter zero (see i		3 (ITTIES 34 X	00), 01 1/00	the target		
. 00	Relief payment (see instructions)	,				C	62
	Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)			C	63
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	to through Doco	mbor 21 of the	cost report	ng pariod (Saa	l c	64
00	instructions)(title XVIII only)	is through bece		cost report	ng period (see		04
00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the c	ost reporting	g period (See	C C	65
	instructions)(title XVIII only)						
00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVI	l only). For	C	66
00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	f the cost r	porting period	0	67
00	(line 12 x line 19)		becchiber of e		sporting porrod		
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	orting period	C	68 (
	(line 13 x line 20)			()			
	Total title V or XIX swing-bed NF inpatient m PART III - SKILLED NURSING FACILITY, OTHER NU) 69
- H	Skilled nursing facility/other nursing facili		•)		70
	Adjusted general inpatient routine service of						71
00	Program routine service cost (line 9 x line 1	71)					72
	Medically necessary private room cost applica						73
	Total Program general inpatient routine servi	•			Part II column		74
00	Capital-related cost allocated to inpatient r 26. line 45)	Satine Service		UINSIICEL B, I	artir, corumn		/ '
00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
00	Program capital-related costs (line 9 x line	76)					77
	Inpatient routine service cost (line 74 minus	,					78
	Aggregate charges to beneficiaries for excess				aus lino 70)		80
	Total Program routine service costs for compa Inpatient routine service cost per diem limit				103 I I I E /7)		80
	Inpatient routine service cost per drem rimi)				82
	Reasonable inpatient routine service costs (s						83
	Program inpatient ancillary services (see ins						84
	Utilization review - physician compensation						85
	Total Program inpatient operating costs (sum		rough 85)				86
- t	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					5, 647	87
	÷ · · · · · · · · · · · · · · · · · · ·		Line 2)			1, 283. 23	
	Adjusted general inpatient routine cost per o	uem (nne ∠/ ÷	TTHE Z)			1,203.23	

Health Financial Systems C	OMMUNITY HEALTH	NETWORK, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2020	Worksheet D-1	
				To 12/31/2020	Date/Time Pre 8/2/2021 3:24	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	7, 435, 025	96, 873, 899	0. 07675	7, 246, 400	556, 161	90.00
91.00 Nursing School cost	0	96, 873, 899	0.00000	7, 246, 400	0	91.00
92.00 Allied health cost	0	96, 873, 899	0.00000	7, 246, 400	0	92.00
93.00 All other Medical Education	0	96, 873, 899	0.00000	7, 246, 400	0	93.00

IPATIENT A	ncial Systems COMMUNITY H NCILLARY SERVICE COST APPORTIONMENT		CN: 15-0074	Peri od:	u of Form CMS-: Worksheet D-3	
				From 01/01/2020 To 12/31/2020		pare
		Title	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
	IENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	ADULTS & PEDIATRICS		1	31, 541, 762		30.
	INTENSIVE CARE UNIT			15, 096, 571		31.
	CORONARY CARE UNIT			0		32.
	NEONATAL INTENSIVE CARE UNIT			0		35.
	NURSERY					43.
ANCI L	LARY SERVICE COST CENTERS					
0.00 05000	OPERATING ROOM		0. 22718	30, 404, 546	6, 907, 335	50.
	RECOVERY ROOM		0. 14645	5 1, 667, 248	244, 177	51.
	DELIVERY ROOM & LABOR ROOM		0. 68446		0	
	RADI OLOGY-DI AGNOSTI C		0. 16775		535, 599	
	RADI OLOGY-THERAPEUTI C		0.07016		277,002	
	CT SCAN		0.05868		412, 814	
) MAGNETIC RESONANCE IMAGING (MRI)) CARDIAC CATHETERIZATION		0. 14498		145, 915 1, 561, 647	
	LABORATORY		0. 11800		2, 516, 821	
	INTRAVENOUS THERAPY		0. 93263		2, 510, 021	
	RESPIRATORY THERAPY		0. 20614		1, 501, 226	
	PHYSI CAL THERAPY		0. 52480		551, 260	
	OCCUPATIONAL THERAPY		0. 49364		446, 768	
	SPEECH PATHOLOGY		0. 49327		152, 229	
06900	ELECTROCARDI OLOGY		0. 08828	4, 491, 230	396, 504	69
07000	ELECTROENCEPHALOGRAPHY		0. 19946	5 196, 764	39, 248	70
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 44066		4, 935, 984	
	IMPL. DEV. CHARGED TO PATIENTS		0. 39830		7, 398, 161	
	DRUGS CHARGED TO PATIENTS		0. 20794		3, 458, 900	
	RENAL DIALYSIS		0. 30069		826, 384	
			0. 21722		13, 553	
	PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES		0. 49400		0	76
	WOUND CARE CENTER		0. 28213		68, 244	
	ONCOLOGY-CANCER CARE CENTER		0. 23986		110, 801	
	I MAGI NG CENTERS		0. 15131		1, 138	
. 07 03954	BREAST DIAGNOSTIC CENTER		0. 62394		966	
6. 97 07697	CARDIAC REHABILITATION		0. 68608	38 337	231	76
	HYPERBARI C OXYGEN THERAPY		0. 25221	8 0	0	76
	TI ENT SERVICE COST CENTERS			-	-	
	RURAL HEALTH CLINIC		0.00000		0	
	FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
) CLINIC DIABETIC CARE CENTER		0.00000			
	HEALTHY HEARTS CENTER		0. 62537		0	
	CLINIC		0. 00000		0	90
	SPINE CENTER		0.00000		0	90
	INFUSION CENTERS		0. 41681		0	90
	MEDCHECK CLINICS		0.00000		0	90
	KNEE CENTER		1. 38706		0	90
	PALLIATIVE CARE		0. 00272		0	90
	WORK SITE CLINICS		0.00000		0	90
	FAMILY PRACTICE AND MATERNITY CARE		0.00000		0	90
			0. 13564			
	OBSERVATION BEDS (NON-DISTINCT PART)		0. 72856	1, 104, 791	804, 915	92
	REIMBURSABLE COST CENTERS		0.00000		<u>^</u>	
	OTHER REIMBURSABLE COST CENTERS	00)	0.00000		0	
00.00 01.00	Total (sum of lines 50 through 94 and 96 through Less PBP Clinic Laboratory Services-Program only			176, 769, 628	35, 031, 404	200
	TESSS THE VEHICLE AUULATULY SELVICES FLOUDAND ONLY					1201

IPATI ENT AN	ICILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0074	Peri od:	Worksheet D-3	
				From 01/01/2020 To 12/31/2020		pared:
			e XIX	Hospi tal	8/2/2021 3:24 PPS	pm
	Cost Center Description	11.01	Ratio of Cos		Inpatient	
	'		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2) 3.00	
I NPAT	I ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	5.00	
. 00 03000	ADULTS & PEDIATRICS			13, 762, 063		30.00
	INTENSIVE CARE UNIT			2, 769, 859		31.00
	CORONARY CARE UNIT			0		32.00
	NEONATAL INTENSIVE CARE UNIT			2, 804, 251		35.00
	NURSERY LARY SERVICE COST CENTERS			373, 505		43.00
	OPERATING ROOM		0. 23035	2, 915, 498	671, 588	50.0
	RECOVERY ROOM		0. 23033			
	DELIVERY ROOM & LABOR ROOM		0. 68446			
	RADI OLOGY-DI AGNOSTI C		0. 16775			
	RADI OLOGY-THERAPEUTI C		0. 07016			
	CT SCAN		0. 05868			
	MAGNETIC RESONANCE I MAGI NG (MRI)		0. 14498			
	CARDI AC CATHETERI ZATI ON LABORATORY		0. 05169 0. 11800		87, 837 578, 060	•
	I NTRAVENOUS THERAPY		0. 11800			
	RESPIRATORY THERAPY		0. 93203			
	PHYSI CAL THERAPY		0. 52480			
	OCCUPATIONAL THERAPY		0. 49364			
8. 00 06800	SPEECH PATHOLOGY		0. 49327		42, 259	68.00
	ELECTROCARDI OLOGY		0. 09106			69.00
	ELECTROENCEPHALOGRAPHY		0. 19946			70.00
	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 44066			
	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS		0. 39830 0. 20822			
	RENAL DIALYSIS		0. 20822		52, 930	
	ENDOSCOPY		0. 21722			
	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 52306			76.0
	LUTHERWOOD PARTNERSHIP		4. 63503		0	76.03
	WOUND CARE CENTER		0. 28578			
	ONCOLOGY-CANCER CARE CENTER		0. 23986			76. 0
	I MAGI NG CENTERS		0. 15131			76.00
	BREAST DI AGNOSTI C CENTER CARDI AC REHABI LI TATI ON		0. 62394		-	76.0
	HYPERBARIC OXYGEN THERAPY		0. 68608			76.9
	TI ENT SERVICE COST CENTERS		0.23221	0 0	0	10. /
3. 00 08800	RURAL HEALTH CLINIC		0.0000	0 0	0	88.00
	FEDERALLY QUALIFIED HEALTH CENTER		0.00000			89.00
	CLINIC		0.0000			90.00
	DI ABETI C CARE CENTER		0.00000			
	HEALTHY HEARTS CENTER CLINIC		0. 62537			
	SPINE CENTER		0.00000		-	90.0 90.0
	INFUSION CENTERS		0. 41681			90.0
	MEDCHECK CLINICS		0. 00000		-	90.0
	KNEE CENTER		1. 40344		0	90.0
	PALLI ATI VE CARE		0. 00272		-	90.0
	WORK SITE CLINICS		0.00000		-	90.1
	FAMILY PRACTICE AND MATERNITY CARE		0.00000		0	90.1
	EMERGENCY		0. 13745			
	OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS		0. 72856	153, 853	112, 092	92.0
	OTHER REIMBURSABLE COST CENTERS		0.00000	0 0	0	98.00
0.00	Total (sum of lines 50 through 94 and 96 through 98)		0.00000	25, 908, 284	-	
1.00	Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.00
	Net charges (line 200 minus line 201)	. ,		25, 908, 284		202.00

CALCUL	Financial Systems COMMUNITY HEALTH NETA ATION OF REIMBURSEMENT SETTLEMENT F	Provider CCN: 15-0074	Period: From 01/01/2020 To 12/31/2020	u of Form CMS-2 Worksheet E Part A Date/Time Prep 8/2/2021 3:24	pared:
		Title XVIII	Hospi tal Before GEO Reclass	PPS On/After GEO Reclass	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		1.00	1.01	
I.00 I.01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring	g prior to October 1	0 29, 797, 166	0 0	1.00 1.01
1.02	(see instructions) DRG amounts other than outlier payments for discharges occurring (see instructions)	g on or after October	1 0	13, 874, 554	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCl for prior to October 1 (see instructions)		0	0	1.03
1.04 2.00	DRG for federal specific operating payment for Model 4 BPCI for on or after October 1 (see instructions) Outlier payments for discharges. (see instructions)	di scharges occurring	0	0	1.04 2.00
2.01	Outlier reconciliation amount		0	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instruction	ns)	0	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see	ee instructions)	920, 835	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1	(see instructions)	0	312, 991	2.04
3.00 4.00	Managed Care Simulated Payments Bed days available divided by number of days in the cost report instructions)	ing period (see	22, 874, 299 336. 80	11, 924, 699	3.00 4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most period ending on or before 12/31/1996. (see instructions)	recent cost reporting	32.51		5.00
5.00	FTE count for all opathic and osteopathic programs that meet the to the cap for new programs in accordance with 42 CFR 413.79(e)	criteria for an add-o	n 0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified un $\$412.105(f)(1)(iv)(B)(1)$		2.69		7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 4. $412.105(f)(1)(iv)(B)(2)$ If the cost report straddles July 1, 24 instructions.		0.00		7.01
3. 00	Adjustment (increase or decrease) to the FTE count for allopath programs for affiliated programs in accordance with 42 CFR 413.	75(b),	-11.05		8.00
3. 01	413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (A The amount of increase if the hospital was awarded FTE cap slot: ACA. If the cost report straddles July 1, 2011, see instruction:	s under § 5503 of the	9.83		8. 01
3. 02	The amount of increase if the hospital was awarded FTE cap slot teaching hospital under § 5506 of ACA. (see instructions)	s from a closed	0.00		8. 02
9.00 10.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (see instructions) FTE count for allopathic and osteopathic programs in the curren		28.60		9.00 10.00
11.00	records FTE count for residents in dental and podiatric programs.		3. 24		11.00
12.00	Current year allowable FTE (see instructions)		31.84		12.00
13.00	Total allowable FTE count for the prior year.		33.31		13.00
14.00	Total allowable FTE count for the penultimate year if that year September 30, 1997, otherwise enter zero.	ended on or after	26.15		14.00
15.00 16.00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program		30. 43 0. 00		15.00 16.00
17.00	Adjustment for residents displaced by program or hospital closu	re	0.00		17.00
	Adjusted rolling average FTE count	0	30.43		18.00
	Current year resident to bed ratio (line 18 divided by line 4).		0. 090350		19.00
20.00	Prior year resident to bed ratio (see instructions)		0. 085726		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0. 085726		21.00
22.00	IME payment adjustment (see instructions)		1, 362, 535	634, 442	22.00
22. 01	IME payment adjustment - Managed Care (see instructions)		1, 045, 973	545, 281	
	Indirect Medical Education Adjustment for the Add-on for § 422 of Number of additional allopathic and osteopathic IME FTE residen		0.00		23.00
04 00	CFR 412.105 (f)(1)(iv)(C).		15 01		24 00
24.00 25.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the lor 24 (see instructions)	wer of line 23 or line	15. 01 0. 00		24.00 25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0. 000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0	0	28.00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)		0	0	28.01
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		1, 362, 535 1, 045, 973	634, 442 545, 281	29. 00 29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pat	ient days (see	9. 25		30.00
31.00	instructions) Percentage of Medicaid patient days (see instructions)		42.18		31.00
	Sum of Lines 30 and 31		42.18		31.00
JZ. UU	Allowable disproportionate share percentage (see instructions)		31.64	31.64	
33.00					

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0074	Peri od:	Worksheet E	
			From 01/01/2020 To 12/31/2020		
		Title XVIII	Hospi tal	PPS	- piii
			Prior to 10/1	0n/After 10/1	
			1.00	2.00	
- 00	Uncompensated Care Adjustment		0 050 500 00/	0.000.014.501	0.5
5.00	Total uncompensated care amount (see instructions)		8, 350, 599, 096		
5. 01 5. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, ente	or zoro on this line) (co	0. 000259811 e 2, 169, 581		
). UZ	instructions)	er zero on this rine) (se	2, 109, 301	2, 030, 440	30.
5. 03	Pro rata share of the hospital uncompensated care payment amo	ount (see instructions)	1, 624, 222	668, 059	35.
. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0	. , ,	2, 292, 281		36.
	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 throu	gh_46)		
. 00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 6	84 and 685. (see	0		40.
	instructions)		Defense CEO		
			Before GEO Reclass	On/After GEO Reclass	
			1.00	1.01	
. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	683, 684 an 685. (see	0		41.
	instructions)	•			
. 01	Total ESRD Medicare covered and paid discharges excluding MS-	DRGs 652, 682, 683, 684	0	0	41.
~ ~	an 685. (see instructions)				
. 00	Divide line 41 by line 40 (if less than 10%, you do not quali Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68		0.00		42.
. 00	instructions)	32, 683, 684 an 685. (See	0		43.
. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.
	days)				
. 00	Average weekly cost for dialysis treatments (see instructions	5)	0.00	0.00	45.
. 00	Total additional payment (line 45 times line 44 times line 41	. 01)	0		46.
. 00	Subtotal (see instructions)		36, 153, 571		
. 00	Hospital specific payments (to be completed by SCH and MDH, s only. (see instructions)	small rural nospitals	0	0	48.
				Amount	
				1.00	
. 00	Total payment for inpatient operating costs (see instructions	5)		54, 240, 491	49.
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an			3, 704, 673	
00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	
. 00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		349, 442	
. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			0 87, 187	
00	Islet isolation add-on payment			07, 187	
	1 3			0	
	Net organ acquisition cost (Wkst. D-4 Pt. III. col. 1. line 6	9)		1 Ui	1 55
. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr			0	
00 00		ructions)	hrough 35).	-	56
00 00 00 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt.	ructions) II, column 9, lines 30 t	hrough 35).	0	56 57 58
00 00 00 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	ructions) II, column 9, lines 30 t	hrough 35).	0 0 0 58, 381, 793	56 57 58 59
00 00 00 00 00 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments	ructions) II, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	0 0 58, 381, 793 33, 155	56 57 58 59 60
00 00 00 00 00 00 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus	ructions) II, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	0 0 58, 381, 793 33, 155 58, 348, 638	56 57 58 59 60 61
00 00 00 00 00 00 00 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	ructions) II, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	0 0 58, 381, 793 33, 155 58, 348, 638 3, 595, 856	56 57 58 59 60 61 62
00 00 00 00 00 00 00 00 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries	ructions) II, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	0 0 58, 381, 793 33, 155 58, 348, 638 3, 595, 856 156, 178	56 57 58 59 60 61 62 63
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)	ructions) II, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	0 0 58, 381, 793 33, 155 58, 348, 638 3, 595, 856 156, 178 590, 121	56 57 58 59 60 61 62 63 64
00 00 00 00 00 00 00 00 00 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	ructions) II, column 9, lines 30 t IV, col. 11 line 200) s line 60)	hrough 35).	0 0 58, 381, 793 33, 155 58, 348, 638 3, 595, 856 156, 178 590, 121 383, 579	56 57 58 59 60 61 62 63 64 65
00 00 00 00 00 00 00 00 00 00 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions) II, column 9, lines 30 t IV, col. 11 line 200) s line 60)	hrough 35).	0 58, 381, 793 33, 155 58, 348, 638 3, 595, 856 156, 178 590, 121 383, 579 418, 391	56 57 58 59 60 61 62 63 64 65 66
00 00 00 00 00 00 00 00 00 00 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	ructions) II, column 9, lines 30 t IV, col. 11 line 200) s line 60) rructions)		0 0 58, 381, 793 33, 155 58, 348, 638 3, 595, 856 156, 178 590, 121 383, 579	56 57 58 59 60 61 62 63 64 65 66 67
00 00 00 00 00 00 00 00 00 00 00 00 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63)	ructions) II, column 9, lines 30 t IV, col. 11 line 200) s line 60) rructions) applicable to MS-DRGs (s	ee instructions)	0 58, 381, 793 33, 155 58, 348, 638 3, 595, 856 156, 178 590, 121 383, 579 418, 391 54, 980, 183	56 57 58 60 61 62 63 64 65 66 67 68
00 00 00 00 00 00 00 00 00 00 00 00 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions) II, column 9, lines 30 t IV, col. 11 line 200) s line 60) cructions) applicable to MS-DRGs (s (For SCH see instruction	ee instructions) s)	0 0 58, 381, 793 33, 155 58, 348, 638 3, 595, 856 156, 178 590, 121 383, 579 418, 391 54, 980, 183 8, 370	566 577 588 599 600 611 622 633 644 655 666 677 688 699 70
00 00 00 00 00 00 00 00 00 00 00 00 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst	ructions) II, column 9, lines 30 t IV, col. 11 line 200) s line 60) cructions) applicable to MS-DRGs (s (For SCH see instruction	ee instructions) s)	0 0 58, 381, 793 33, 155 58, 348, 638 3, 595, 856 156, 178 590, 121 383, 579 418, 391 54, 980, 183 8, 370 0 0 0	56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 70
00 00 00 00 00 00 00 00 00 00 00 00 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration	ructions) II, column 9, lines 30 t IV, col. 11 line 200) s line 60) cructions) applicable to MS-DRGs (s (For SCH see instruction	ee instructions) s)	0 0 58, 381, 793 33, 155 58, 348, 638 3, 595, 856 156, 178 590, 121 383, 579 418, 391 54, 980, 183 8, 370 0 0 0	56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 70 70 70
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries Coinsurance billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	ructions) II, column 9, lines 30 t IV, col. 11 line 200) s line 60) applicable to MS-DRGs (s (For SCH see instruction cration) adjustment (see	ee instructions) s)	0 0 58, 381, 793 33, 155 58, 348, 638 3, 595, 856 156, 178 590, 121 383, 579 418, 391 54, 980, 183 8, 370 0 0 0	56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 70 70 70 70
00 00 00 00 00 00 00 00 00 00 00 00 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst	ructions) II, column 9, lines 30 t IV, col. 11 line 200) s line 60) applicable to MS-DRGs (s (For SCH see instruction cration) adjustment (see	ee instructions) s)	0 0 58, 381, 793 33, 155 58, 348, 638 3, 595, 856 156, 178 590, 121 383, 579 418, 391 54, 980, 183 8, 370 0 0 0 0 0 0 0	56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 70 70 70 70 70 70
00 00 00 00 00 00 00 00 00 00 00 00 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (see instructions)	ructions) II, column 9, lines 30 t IV, col. 11 line 200) s line 60) applicable to MS-DRGs (s (For SCH see instruction cration) adjustment (see	ee instructions) s)	0 0 58, 381, 793 33, 155 58, 348, 638 3, 595, 856 156, 178 590, 121 383, 579 418, 391 54, 980, 183 8, 370 0 0 0 0 0 0	56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 70 70 70 70 70 70 70 70
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HRR adjustment amount (see instructions)	ructions) II, column 9, lines 30 t IV, col. 11 line 200) s line 60) applicable to MS-DRGs (s (For SCH see instruction cration) adjustment (see	ee instructions) s)	0 0 58, 381, 793 33, 155 58, 348, 638 3, 595, 856 156, 178 590, 121 383, 579 418, 391 54, 980, 183 8, 370 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	566 577 588 599 600 611 622 633 644 655 666 677 688 699 700 700 700 700 700 700 700 700 700 7
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	ructions) II, column 9, lines 30 t IV, col. 11 line 200) s line 60) applicable to MS-DRGs (s (For SCH see instruction cration) adjustment (see	ee instructions) s)	0 0 58, 381, 793 33, 155 58, 348, 638 3, 595, 856 156, 178 590, 121 383, 579 418, 391 54, 980, 183 8, 370 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	58 59 60 61 62 63 64 65 66 67 68 69 70 70 70 70 70 70 70 70 70 70 70 70
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HRR adjustment amount (see instructions)	ructions) II, column 9, lines 30 t IV, col. 11 line 200) s line 60) applicable to MS-DRGs (s (For SCH see instruction cration) adjustment (see	ee instructions) s)	0 0 58, 381, 793 33, 155 58, 348, 638 3, 595, 856 156, 178 590, 121 383, 579 418, 391 54, 980, 183 8, 370 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	566 577 588 599 600 611 622 633 644 655 666 677 688 699 700 700 700 700 700 700 700 700 700 7

	TION OF REIMBURSEMENT SETTLEMENT	Provider C		Period: From 01/01/2020	Worksheet E Part A	
				To 12/31/2020	Date/Time Pre 8/2/2021 3:24	pare
		Title	XVIII	Hospi tal	PPS	pin
			FFY	(уууу)	Amount	
. 96	low volume adjustment for foderal fiscal year (unau) (Enter i			0	1.00	70
	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)			0	0	///
	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70
1	the corresponding federal year for the period ending on or af	ter 10/1)				
	Low Volume Payment-3				0	70
	HAC adjustment amount (see instructions)	(0 0 70)			378, 225	
	Amount due provider (line 67 minus lines 68 plus/minus lines Sequestration adjustment (see instructions)	69 & 70)			54, 119, 241 357, 187	
	Demonstration payment adjustment amount after sequestration				0	71
	Sequestration adjustment-PARHM pass-throughs				0	71
	Interim payments				53, 646, 738	
01	Interim payments-PARHM					72
	Tentative settlement (for contractor use only)				0	
	Tentative settlement-PARHM (for contractor use only)					73
	Balance due provider/program (line 71 minus lines 71.01, 71.0.	2, 72, and			115, 316	74
	73) Balance due provider/program-PARHM (see instructions)					74
	Protested amounts (nonallowable cost report items) in accorda	nce with			1, 398, 592	
	CMS Pub. 15-2, chapter 1, §115.2				1,070,072	
	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
	plus 2.04 (see instructions)				_	
	Capital outlier from Wkst. L, Pt. I, line 2				0	91
	Operating outlier reconciliation adjustment amount (see instru Capital outlier reconciliation adjustment amount (see instruc				0	92 93
	The rate used to calculate the time value of money (see instruc	,			0.00	
	Time value of money for operating expenses (see instructions)				0.00	95
	Time value of money for capital related expenses (see instruc	tions)			0	96
				Prior to 10/1		
	ASP Bonus Payment Amount			1.00	2.00	
	HSP Bonus Payment Amount HSP bonus amount (see instructions)					100
0. 00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			0		100
). 00	HSP bonus amount (see instructions)					
). 00 . 00 2. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction:	s)		0	0.000000000	101
). 00 . 00 2. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction: HRR Adjustment for HSP Bonus Payment	s)		0. 0000000000	0 0.000000000 0	101 102
). 00 . 00 2. 00 3. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			0. 000000000000000000000000000000000000	0. 0000000000 0. 0000000000 0 0. 0000	101 102 103
). 00 1. 00 2. 00 3. 00 4. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions))	stmont	0. 0000000000	0. 0000000000 0. 0000000000 0 0. 0000	101 102 103
). 00 1. 00 2. 00 3. 00 4. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr) ration) Adju		0. 000000000000000000000000000000000000	0.000000000 0 0.0000 0.0000 0	101 102 103 104
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CALCUL	ATION OF REIMBURSEMENT SETTLEMENT Pro	ovider CCN: 15-0074	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Pre	
		Title XVIII	Hospi tal	8/2/2021 3: 24 PPS	pm
	· · · · · · · · · · · · · · · · · · ·		10301 tu	113	
				1.00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			61, 052	1.00
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruction	s)		103, 663, 001	
3.00	OPPS payments	0)		78, 925, 383	
4.00	Outlier payment (see instructions)			544, 652	
4.01	Outlier reconciliation amount (see instructions)	20		0	
5.00 6.00	Enter the hospital specific payment to cost ratio (see instructio Line 2 times line 5	115)		0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	
10.00 11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 61, 052	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			01,002	1 1.00
	Reasonabl e charges]
	Ancillary service charges	(0)		310, 917	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line Total reasonable charges (sum of lines 12 and 13)	69)		0 310, 917	
14.00	Customary charges			310, 717	14.00
15.00	Aggregate amount actually collected from patients liable for paym			0	15.00
16.00	Amounts that would have been realized from patients liable for pa	yment for services of	on a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			310, 917	
19.00	Excess of customary charges over reasonable cost (complete only i	fline 18 exceeds li	ne 11) (see	249, 865	
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete only i instructions)	T line ii exceeds ii	ne 18) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			61, 052	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instruct	i ons)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			79, 470, 035	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			16, 180	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24	(for CAH, see instr	ructions)	13, 405, 074	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus	the sum of lines 22	2 and 23] (see	66, 109, 833	27.00
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, line	50)		615, 661	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	50)		013,001	
30. 00	Subtotal (sum of lines 27 through 29)			66, 725, 494	
31.00	Primary payer payments			5, 727	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			66, 719, 767	32.00
33.00				0	33.00
34.00	Allowable bad debts (see instructions)			851, 506	
35.00	Adjusted reimbursable bad debts (see instructions)			553, 479	
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see instruct Subtotal (see instructions)	I ONS)		668, 525 67, 273, 246	1
	MSP-LCC reconciliation amount from PS&R			110	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			_	39.50
39.97 39.98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced	dovices (see instru	stions)	0 29, 976	
39.90 39.99	RECOVERY OF ACCELERATED DEPRECIATION	devices (see institut	.110115)	29,978	
40.00	Subtotal (see instructions)			67, 273, 136	
40. 01	Sequestration adjustment (see instructions)			444, 003	
40.02	Demonstration payment adjustment amount after sequestration			0	40.02
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs Interim payments			67, 378, 996	
41.01	Interim payments-PARHM			2., 0.0, .,0	41.0
42.00	Tentative settlement (for contractors use only)			0	
42.01	Tentative settlement-PARHM (for contractor use only)			E40 0/0	42.0
43.00 43.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-549, 863	43.00 43.0
44.00	Protested amounts (nonallowable cost report items) in accordance §115.2	with CMS Pub. 15-2,	chapter 1,	0	
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	
91.00 92.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0.00	91.0 92.0
93.00	Time Value of Money (see instructions)			0.00	
94.00	Total (sum of lines 91 and 93)			0	94.0

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0074	Period: From 01/01/2020 To 12/31/2020		parec
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00 00	Total interim payments paid to provider Interim 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 retroactive lump sum adjustment amount based on subsequent revision of the interim rate		53, 414, 3	38 0	66, 937, 096 0	1. (2. (3. (
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
01	Program to Provider ADJUSTMENTS TO PROVIDER	10/02/2020	232, 4	00 10/02/2020	441, 900	3.
01		10/02/2020	232, 4	0	441, 900	3.
03				0	0	3.
04				0	0	
05				0	0	3.
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	
52				0	0	
53				0	0	
54 99	Subtatal (sum af lines 2.01.2.40 minus sum af lines		222.4	0	0	3
19	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		232, 4	00	441, 900	3
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)		53, 646, 7	38	67, 378, 996	4
	TO BE COMPLÉTED BY CONTRACTOR					1
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
1	Program to Provider			0	0	
)1)2	TENTATI VE TO PROVI DER			0	0	5
)3				0	0	
	Provider to Program					
50 51	TENTATI VE TO PROGRAM			0	0	5
52				0	0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		115, 3	16	0	6
02	SETTLEMENT TO PROGRAM			0	549, 863	
00	Total Medicare program liability (see instructions)		53, 762, 0		66, 829, 133	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
)	1.00	2.00	-

Heal th	Financial Systems COMMUNITY HEA	LTH NETWORK, INC.	In Lie	u of Form CMS	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0074	Peri od: From 01/01/2020 To 12/31/2020		epared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPOR	TS			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCUL	ATI ON			
1.00	Total hospital discharges as defined in AARA §4102 from	Wkst. S-3, Pt. I col. 15 line	e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines	1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines	1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 2				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col	. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase line 168	of certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructio	ns)			8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestra	tion (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30	and line 31) (see instructior	is)		32.00

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS	Provider CC	CN: 15-0074	Period: From 01/01/2020	Worksheet E-4	
		Titlo	XVIII	To 12/31/2020 Hospi tal	Date/Time Pre 8/2/2021 3:24 PPS	
			AVIII			
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
00	Unweighted resident FTE count for allopathic and osteopathic	programs for	cost reporti	ng periods	26. 92	1.0
00	ending on or before December 31, 1996. Unweighted FTE resident cap add-on for new programs per 42 CF	R 413.79(e)(1) (see instr	uctions)	0.00	2.0
00	Amount of reduction to Direct GME cap under section 422 of MM	A	, .		2.82	3.
01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)	with 42 CFR	§413.79 (m).	(see	0.00	3.
00	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	-11.05	4.
01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst straddling 7/1/2011)		cost reporti	ng periods	8. 75	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.
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	21.80	5.
00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	43.61	6.
00	Enter the lesser of line 5 or line 6		Drimory Core	0ther	21.80 Total	7.
			Primary Care 1.00	2.00	3.00	
00	Weighted FTE count for physicians in an allopathic and osteop program for the current year.	athi c	32.7	0 10.90	43.60	8.
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		16.3	5 5.45	21.80	9.
. 00	6. Weighted dental and podiatric resident FTE count for the curr	ent year		3.24		10.
. 01	Unweighted dental and podiatric resident FTE count for the cu	rrent year		6.24		10.
. 00 . 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reportini instructions)	g year (see	16. 3 18. 0			11. 12.
. 00	Total weighted resident FTE count for the penultimate cost re year (see instructions)	porting	33. 1	3 7.26		13.
. 00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	22.5			14
. 00	Adjustment for residents in initial years of new programs		0.0			15
. 01 . 00	Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital clo		0. C 0. C			15. 16.
. 00 . 01	Unweighted adjustment for residents displaced by program of hospital cro closure		0. C			16
. 00	Adjusted rolling average FTE count		22.5	2 8.13		17.
. 00	Per resident amount		87, 856. 2			18
. 00	Approved amount for resident costs		1, 978, 52	3 721, 027	2, 699, 550	19
					1.00	
00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots rec	eived under 42	0.00	20
. 00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instru	ctions)			21.81	21
. 00	Allowable additional direct GME FTE Resident Count (see instr				0.00	
. 00	Enter the locality adjustment national average per resident a		nstructions)		0.00	
00	Multiply line 22 time line 23				0	24
00	Total direct GME amount (sum of lines 19 and 24)				2, 699, 550	25
			Inpatient Par A	t Managed Care	Total	
	CONDUCTATION OF DECEMBERATION DATIENT LOAD		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) (Title XIX - see S-2 Part I 3.02, column 2)	X, line	17, 30	13, 931		26.
. 00	Total Inpatient Days (see instructions)		84, 63	6 84, 636		27.
. 00	Ratio of inpatient days to total inpatient days		0. 20442	0. 164599		28.
. 00	Program direct GME amount		551, 86		996, 207	
9. 01). 00	Percent reduction for MA DGME Reduction for direct GME payments for Medicare Advantage			7.00 31,104	04 404	29. 30.
				31 10/1	31, 104	i ≺()

Heal th	Financial Systems COMMUNITY HEALTH N	ETWORK, INC.	In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0074	Peri od:	Worksheet E-4	
MEDI CAL	_ EDUCATION COSTS		From 01/01/2020 To 12/31/2020	Date/Time Pre	arod
			10 12/31/2020	8/2/2021 3:24	
-		Title XVIII	Hospi tal	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)	E XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL	
	Renal dialysis direct medical education costs (from Wkst. B,	Pt I sum of col 20 an	d 23 lines 74	0	32.00
	and 94)			0	02.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	7, 233, 567	33.00
34.00	Ratio of direct medical education costs to total charges (lin	e 32 ÷ line 33)		0.00000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
	Medicare outpatient ESRD direct medical education costs (line			0	36.00
H	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost		1		
	Reasonable cost (see instructions)			58, 902, 317	
	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
	Primary payer payments (see instructions)			33, 155	
	<u>Total Part A reasonable cost (sum of lines 37 through 39 minu</u> Part B Reasonable Cost	s Tine 40)		58, 869, 162	41.00
H 1	Reasonable cost (see instructions)			103, 724, 053	42.00
	Primary payer payments (see instructions)			5, 727	42.00
	Total Part B reasonable cost (line 42 minus line 43)			103, 718, 326	
	Total reasonable cost (sum of lines 41 and 44)			162, 587, 488	
	Ratio of Part A reasonable cost to total reasonable cost (lin	e 41 ÷ line 45)		0, 362077	46.00
	Ratio of Part B reasonable cost to total reasonable cost (lin			0.637923	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA	RT B			
48.00	Total program GME payment (line 31)			965, 103	48.00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)			349, 442	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		615, 661	50.00

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet G Date/Time Pre 8/2/2021 3:24	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
. 00	Cash on hand in banks	10, 280		0 0	0	1.
. 00	Temporary investments	0		0 0	0	
. 00	Notes receivable	131, 833		0 0	0	3.
. 00	Accounts receivable	510, 979, 151		0 0	0	4.
. 00	Other receivable	53, 400, 585		0 0	0	
. 00	Allowances for uncollectible notes and accounts receivable	22, 166, 122		0 0	0	
. 00	Inventory	11, 905, 174			0	
. 00 . 00	Prepaid expenses Other current assets	0 4, 687, 853		0 0	0	
. 00 D. 00	Due from other funds	4,007,000		0 0	0	
1.00	Total current assets (sum of lines 1-10)	603, 280, 998		0 0	0	
1.00	FIXED ASSETS	000,200,770				
2.00	Land	2, 743, 049		0 0	0	12.
3.00	Land improvements	4, 209, 543		0 0	0	13.
4.00	Accumulated depreciation	0		0 0	0	14.
5.00	Bui I di ngs	517, 411, 041		0 0	0	
5.00	Accumulated depreciation	0		0 0	0	
. 00	Leasehold improvements	11, 643, 583		0 0	0	
3.00 9.00	Accumulated depreciation Fixed equipment	217, 856, 751		0 0 0 0	0	
). 00	Accumulated depreciation	217, 650, 751		0 0	0	
	Automobiles and trucks	238, 280		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Major movable equipment	0		0 0	0	
. 00	Accumulated depreciation	-372, 821, 632		0 0	0	24
. 00	Minor equipment depreciable	0		0 0	0	25
. 00	Accumulated depreciation	0		0 0	0	
	HIT designated Assets	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Minor equipment-nondepreciable	58, 900		0 0	0	
. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	381, 339, 515		0 0	0	30.
. 00	Investments	0		0 0	0	31
. 00	Deposits on Leases	o o		0 0	0	
. 00	Due from owners/officers	0		0 0	0	
. 00	Other assets	249, 283, 586		0 0	0	34
. 00	Total other assets (sum of lines 31-34)	249, 283, 586		0 0	0	35
. 00	Total assets (sum of lines 11, 30, and 35)	1, 233, 904, 099		0 0	0	36
	CURRENT LIABILITIES	I	1			
	Accounts payable	-2, 523, 123		0 0	0	
. 00 . 00	Salaries, wages, and fees payable Payroll taxes payable	-2		0 0 0 0	0	
	Notes and Loans payable (short term)				0	
	Deferred income			0 0	0	
. 00	Accel erated payments	l o			0	42
8. 00	Due to other funds	0		0 0	0	43
ł. 00	Other current liabilities	30, 308, 049		0 0	0	44.
5.00	Total current liabilities (sum of lines 37 thru 44)	27, 784, 924		0 0	0	45
	LONG TERM LIABILITIES	-	1	-1 -1		
. 00	Mortgage payable	0		0 0	0	
. 00	Notes payable	0		0 0 0 0	0	
. 00 . 00	Unsecured Loans Other Long term Liabilities	52, 445, 782		0 0	0	
. 00	Total long term liabilities (sum of lines 46 thru 49)	52, 445, 782		0 0	0	
	Total liabilities (sum of lines 45 and 50)	80, 230, 706		0 0	0	
	CAPITAL ACCOUNTS			-1 -1		
. 00	General fund balance	1, 153, 673, 393				52
. 00	Specific purpose fund			0		53
. 00	Donor created - endowment fund balance - restricted			0		54
. 00	Donor created - endowment fund balance - unrestricted			0		55
. 00	Governing body created - endowment fund balance			0		56
. 00	Plant fund balance - invested in plant				0	
8. 00	Plant fund balance - reserve for plant improvement,				0	58
. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	1 153 672 202		0 0	0	59
. 00 . 00	Total liabilities and fund balances (sum of lines 52 thru 58)	1, 153, 673, 393 1, 233, 904, 099			0	
		1 ., 200, 707, 077	1	~ ₁ V	0	1 00

STATEMENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0074	Period: From 01/01/2 To 12/31/2	2020 2020	Worksheet G-1 Date/Time Pre	pared:
	General	Fund	Speci al	Purpose Fund		<u>8/2/2021 3:24</u> ndowment Fund	
	1.00	2.00	3.00	4.00		5.00	
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments) (specify)5.006.007.008.009.00Total additions (sum of line 4-9)11.00Subtotal (line 3 plus line 10)12.00Deductions (debit adjustments) (specify)13.0014.0015.0016.0017.00Total deductions (sum of lines 12-17)19.00Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 919, 266, 229 234, 407, 164 1, 153, 673, 393 0 1, 153, 673, 393 0 1, 153, 673, 393	3.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	5.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
	Endowment Fund	PI ant	Fund				
	6.00	7.00	8.00				
 Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) O Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) O 6.00 O 8.00 O 9.00 	0	0 0 0 0 0 0		0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
<pre>10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17)</pre>	0 0 0	0 0 0 0 0		0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

	Financial Systems COMMUNITY HEALTH N				eu of Form CMS-	
STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-0074	Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
	Cost Center Description		Inpati ent	Outpati ent	8/2/2021 3:24 Total	
		F	1.00	2,00	3.00	
	PART I - PATIENT REVENUES	I				
	General Inpatient Routine Services					
1.00	Hospi tal		65, 695, 5	18	65, 695, 518	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE			10	15 105 540	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		65, 695, 5	18	65, 695, 518	10.00
11 00	Intensive Care Type Inpatient Hospital Services INTENSIVE CARE UNIT		16, 417, 0	40	16, 417, 049	111 00
11.00 12.00	CORONARY CARE UNIT		10, 417, 0	0	16, 417, 049	1
12.00	BURN INTENSIVE CARE UNIT			0	0	12.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	NEONATAL INTENSIVE CARE UNIT		16, 539, 0	90	16, 539, 090	
16.00	Total intensive care type inpatient hospital services (sum of	lines	32, 956, 1		32, 956, 139	1
10.00	11-15)	111103	02, 700, 1	0,	02, 700, 107	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	98, 651, 6	57	98, 651, 657	17.00
18.00	Ancillary services	, ,	740, 046, 1		2, 721, 725, 995	
19.00	Outpatient services			0 0		
20.00	RURAL HEALTH CLINIC			0 0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE					26.00
27.00	PROFESSIONAL FEES			0 15, 981, 559		
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	838, 697, 7	82 1, 997, 661, 429	2, 836, 359, 211	28.00
	G-3, line 1)					
29.00	PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200)			760, 810, 023	1	29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			C		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			C		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		760, 810, 023		43.00
	to Wkst. G-3, line 4)				1	1

STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0074	Peri od:	Worksheet G-3	
			From 01/01/2020		
			To 12/31/2020	Date/Time Prep 8/2/2021 3:24	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			2, 836, 359, 211	1.00
2.00	Less contractual allowances and discounts on patients' accou	ints		1, 908, 923, 195	2.00
3.00	Net patient revenues (line 1 minus line 2)			927, 436, 016	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		760, 810, 023	
5.00	Net income from service to patients (line 3 minus line 4)			166, 625, 993	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			3, 940, 324	
7.00	Income from investments			11, 143, 975	
8.00	Revenues from telephone and other miscellaneous communicatio	n services		0	
9.00	Revenue from television and radio service			0	9.00
	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			0	11.00
	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	
	Revenue from meals sold to employees and guests			1, 644, 698	
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			6, 353	20.00
21.00	Rental of vending machines			1, 014	21.00
22.00	Rental of hospital space			510, 574	22.00
23.00	Governmental appropriations			0	23.00
24.00	MISC REVENUE			16, 063, 710	24.00
24.50	COVI D-19 PHE Funding			34, 470, 526	24.50
25.00	Total other income (sum of lines 6-24)			67, 781, 174	25.00
	Total (line 5 plus line 25)			234, 407, 167	26.00
	ROUNDING			3	27.00
	Total other expenses (sum of line 27 and subscripts)			3	28.00
	Net income (or loss) for the period (line 26 minus line 28)			234, 407, 164	

ALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0074	Period: From 01/01/2020 To 12/31/2020		
		Title XVIII	Hospi tal	PPS	
			Urban	Rural	
			1.00	1.01	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				1
00	Capital DRG other than outlier		2, 357, 643	1,067,432	1 1.
01	Model 4 BPCI Capital DRG other than outlier		_,,	0	1.
00	Capital DRG outlier payments		150, 815	-	2.
01	Model 4 BPCI Capital DRG outlier payments		0		2.
00	Total inpatient days divided by number of days in the cost re	eporting period (see	232.96		3.
	instructions)				
00	Number of interns & residents (see instructions)		30.43		4.
00	Indirect medical education percentage (see instructions)		3. 76		5.
00	Indirect medical education adjustment (multiply line 5 by the	e sum of lines 1 and 1.01	, 128, 783		6.
	columns 1 and 1.01) (see instructions)				
00	Percentage of SSI recipient patient days to Medicare Part A p	atient days (Worksheet E	, 0.00		7.
	part A line 30) (see instructions)	5 (
00	Percentage of Medicaid patient days to total days (see instru	ictions)	0.00		8.
00	Sum of lines 7 and 8		0.00		9.
. 00	Allowable disproportionate share percentage (see instructions	5)	0.00		10
. 00	Disproportionate share adjustment (see instructions)		0		11.
. 00	Total prospective capital payments (see instructions)		3, 704, 673		12
				1.00	
00	PART II - PAYMENT UNDER REASONABLE COST			0	1 1
00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions)			0	
00	Total inpatient program capital cost (line 1 plus line 2)			0	3
00	Capital cost payment factor (see instructions)			0	4
00	Total inpatient program capital cost (line 3 x line 4)			0	
00	Total inpatrent program capital cost (The 3 x The 4)			0	5.
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00	Program inpatient capital costs (see instructions)			0	1
00	Program inpatient capital costs for extraordinary circumstanc	ces (see instructions)		0	2
00	Net program inpatient capital costs (line 1 minus line 2)			0	3
00	Applicable exception percentage (see instructions)			0.00	
00	Capital cost for comparison to payments (line 3 x line 4)			0	5
00	Percentage adjustment for extraordinary circumstances (see in	istructions)		0.00	6
00	Adjustment to capital minimum payment level for extraordinary	/circumstances (line 2 x	line 6)	0	7
00	Capital minimum payment level (line 5 plus line 7)			0	8
00	Current year capital payments (from Part I, line 12, as appli	cabl e)		0	9
. 00	Current year comparison of capital minimum payment level to c			0	10
. 00	Carryover of accumulated capital minimum payment level over c	apital payment (from pri	or year	0	11.
	Worksheet L, Part III, line 14)			_	
	Net comparison of capital minimum payment level to capital pa			0	
	Current year exception payment (if line 12 is positive, enter			0	
. 00	Carryover of accumulated capital minimum payment level over c	apital payment for the f	ollowing period	0	14
	(if line 12 is negative, enter the amount on this line)				
. 00	Current year allowable operating and capital payment (see ins	structions)		0	1
					16
	Current year operating and capital costs (see instructions) Current year exception offset amount (see instructions)			0	17