payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0125 Worksheet S Peri od: From 07/01/2019 Parts I-III AND SETTLEMENT SUMMARY 06/30/2020 Date/Time Prepared: 11/25/2020 3:02 pm

		11/25/2020 3. 02 pili
PART I - COST	REPORT STATUS	
Provi der	1. [X] Electronically prepared cost report	Date: 11/25/2020 Time: 3:02 pm
use only	2. [] Manually prepared cost report	
	3. [0] If this is an amended report enter the number of ti 4. [F] Medicare Utilization. Enter "F" for full or "L" for	
Contractor use only	5. [1] Cost Report Status (1) As Submitted 7. Contractor No. (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. [N] Initial Report for this	10. NPR Date: 11. Contractor's Vendor Code: 4 12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL (15-0125) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

> DANI EL O' BRI EN (Si gned) Officer or Administrator of Provider(s) CF0 Title 11/25/2020 03: 02: 39 PM

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	589, 440	145, 787	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	24, 077	8		0	3. 00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	o	0		0	9. 00
200.00	Total	0	613, 517	145, 795	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-MEDICARE.

reporting period different from the method used in the prior cost							
reporting period? In column 2, enter "Y" for yes or	"N" for no.						
	In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
	Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
	paid days	eligible	Medicaid	Medi cai d		days	
		unpai d	paid days	el i gi bl e			
		days		unpai d			
	1.00	2. 00	3. 00	4. 00	5. 00	6.00	
24.00 If this provider is an IPPS hospital, enter the	2, 226	393	637	664	9, 35	8 0	24. 00
in-state Medicaid paid days in column 1, in-state							
Medicaid eligible unpaid days in column 2,							
Medicaid eligible unpaid days in column 2,							
Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3,							
Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column							

	ristractions, Errei in corami i, the program name.			1		
	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.					
	, and the second		•			
					1.00	1
	ACA Provisions Affecting the Health Resources and Se	rvices Administration	(HRSA)			
62.00	Enter the number of FTE residents that your hospital	trained in this cost	reporting peri	od for which	0.0	d 62. 00
	your hospital received HRSA PCRE funding (see instruc		3 1			
62.01	Enter the number of FTE residents that rotated from a	a Teaching Health Cent	ter (THC) into	your hospital	0.0	d 62. 01
	during in this cost reporting period of HRSA THC prog	gram. (see instruction	ns)			
	Teaching Hospitals that Claim Residents in Nonprovide	er Settings				
63.00	Has your facility trained residents in nonprovider se	ettings during this co	ost reporting p	eriod? Enter	N	63.00
	"Y" for yes or "N" for no in column 1. If yes, comple	ete lines 64 through 6	67. (see instru	ctions)		
			Unwei ghted	Unwei ghted	Ratio (col. 1,	/
			FTEs	FTEs in	(col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
			Si te			
			1.00	2.00	3.00	1
	Section 5504 of the ACA Base Year FTE Residents in No	onprovider Settings	This base year	is your cost	reporting	
	period that begins on or after July 1, 2009 and before	re June 30, 2010.	•	, and the second	. 0	
64.00	Enter in column 1, if line 63 is yes, or your facilit		0.00	0.00	0. 000000	J 64. 00
	in the base year period, the number of unweighted nor	n-primary care				
	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					
	(cordinit i divided by (cordinit i i cordinit 2)). (see	riisti deti olis)	1	l .	1	1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0125 Peri od: Worksheet S-2 From 07/01/2019 Part I Date/Time Prepared: 06/30/2020 11/25/2020 3:02 pm Program Code Unwei ghted Unwei ghted 3/ Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

	Provider Co	CN: 15-0125	Peri od: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Pre 11/25/2020 3:	epared:
				1. 00	
Long Term Care Hospital PPS 10.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes a single state of the same state of the sam			ng period? Enter	N N	80. 00 81. 00
TEFRA Providers 15.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 7 16.00 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
17.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified u	under section	1	N	87. 00
			V	XIX	
Title V and XIX Services			1. 00	2. 00	+
0.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	servi ces? Er	nter "Y" for	N	Y	90.00
1.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applications.			N	Υ	91.00
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual	l certificati	on)? (see		N	92.00
instructions) Enter "Y" for yes or "N" for no in the applicable 3.00 Does this facility operate an ICF/IID facility for purposes of		d XIX? Enter	N	N	93. 00
"Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, ar applicable column.	nd "N" for no	in the	N	N	94. 00
15.00 If line 94 is "Y", enter the reduction percentage in the appli 16.00 Does title V or XIX reduce operating cost? Enter "Y" for yes o			0. 00 N	O. 00 N	95. 00 96. 00
applicable column. 7.00 If line 96 is "Y", enter the reduction percentage in the appli	icable column	٦.	0. 00	0. 00	97. 00
8.00 Does title V or XIX follow Medicare (title XVIII) for the intestepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.	erns and resi	dents post	N	N	98.00
8.01 Does title V or XIX follow Medicare (title XVIII) for the repo	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for				
8.02 Does title V or XIX follow Medicare (title XVIII) for the calc bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.			N	Y	98. 02
8.03 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.				N	98. 03
8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reoutpatient services cost? Enter "Y" for yes or "N" for no in c in column 2 for title XIX.			N	N	98. 04
18.05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in col column 2 for title XIX.				Y	98. 05
18.06 Does title V or XIX follow Medicare (title XVIII) when cost represented by the Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX.	eimbursed fon 1 for title \	Wkst. D, /, and in	N	N	98.06
Rural Providers 05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it elected the all-ir for outpatient services? (see instructions)	nclusive meth	nod of paymer	N		105. 00 106. 00
07.00 Column 1: If line 105 is Y, is this facility eligible for cost training programs? Enter "Y" for yes or "N" for no in column 1 Column 2: If column 1 is Y and line 70 or line 75 is Y, do yo approved medical education program in the CAH's excluded IPF Enter "Y" for yes or "N" for no in column 2. (see instruction	1. (see inst ou train I&Rs and/or IRF (tructions) s in an			107. 00
08.00 s this a rural hospital qualifying for an exception to the CF CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 42	2 N		108. 00
	Physi cal 1.00	Occupationa 2.00	<u> </u>	Respiratory 4.00	
09.00 of this hospital qualifies as a CAH or a cost provider, are	1.00	N N	3. 00 N	N N	109. 00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				ļ	
				1.00	

therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		
itor yes or in tor no tor each therapy.		
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A	1. 00 N	110.00
Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

Health Financial Systems COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0125 Peri od: Worksheet S-2 From 07/01/2019 Part I 06/30/2020 Date/Time Prepared: То 11/25/2020 3:02 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number Name: COMMUNITY FOUNDATION OF NW IN, Contractor's Name: WPS 141 00 Name: Contractor's Number: 08001 141 00 LNC 142.00 Street: 10100 DON POWERS DRIVE PO Box: 142.00 143.00 Ci ty: MUNSTER State: Zip Code: 46321 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 2.00 1.00 145.00|| f costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is 145.00 no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Ν 146, 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147. 00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1 00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal N Ν Ν N 155. 00 156.00 Subprovi der - IPF 156. 00 Ν Ν Ν Ν 157.00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF N Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν Ν 161.00 1.00 Multicampus 165.00|Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Ν 165.00 Enter "Y" for yes or "N" for no. FTE/Campus Zip Code Name County **CBSA** State | 3.00 5.00 0 1.00 2.00 4.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

hearth fill of matron reclinology (in 1) Theentrive fill the American Recovery and Remives timent	ACI		
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167. 00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"),		168. 00	
reasonable cost incurred for the HIT assets (see instructions)			
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a	a hardshi p		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "!	N"), enter the	0.	00169.00
transition factor. (see instructions)			
	Begi nni ng	Endi ng	
	1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting			170. 00
period respectively (mm/dd/yyyy)			
	1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	N		0 171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section			
1876 Medicare days in column 2. (see instructions)			

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0125	Peri od: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Pro 11/25/2020 3	epared:
				Y/N 1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	N for all NO re	esponses. Ente			
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a	e beginning of	the cost	N		1.0
	preporting perrou? IT yes, enter the date of the change in t	JOI UIIII 2. (See	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare Figure , enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	mn 3, "V" for	N			2.0
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the providences, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3. 0
			Y/N	Type	Date	
	Financial Data and Dananta		1.00	2. 00	3. 00	
	Financial Data and Reports Column 1: Were the financial statements prepared by a Certacountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date available of the column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.0
00	Are the cost report total expenses and total revenues diffe		N			5. 0
	those on the filed financial statements? If yes, submit red	conciliation.		\/ /N	1 1 0	
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	s N		6.0
	the legal operator of the program?					
00	Are costs claimed for Allied Health Programs? If "Y" see in			Υ		7. 0
00	Were nursing school and/or allied health programs approved	and/or renewed	d during the	N		8. 0
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	araduate media	cal education	N		9.00
00	program in the current cost report? If yes, see instruction		car caacatron			/. 0
0. 00	Was an approved Intern and Resident GME program initiated		the current	N		10.0
	cost reporting period? If yes, see instructions.					
1. 00	Are GME cost directly assigned to cost centers other than I	I & Rin an App	proved	N		11.0
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1.00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes	s, see instruct	tions.		Υ	12.0
	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paymone.		-		N N	13. C
	Bed Complement	onto narvou	, jes, see	50. 400. 01.0.	.,,	1
5. 00	Did total beds available change from the prior cost reporti	,		tructions.	Υ	15. 0
			rt A	Par		
		1. 00	2.00	Y/N 3. 00	<u>Date</u> 4. 00	
	PS&R Data	1.00	2.00	3.00	4.00	
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	N		N		16. C
. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/16/2019	Y	10/16/2019	17. 0
3. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18. 0
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Y		Y		19. 0

	Financial Systems COMMUNITY AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0125	Peri od: From 07/01/2019 To 06/30/2020	u of Form CMS- Worksheet S-2 Part II Date/Time Pre 11/25/2020 3:	pared:
		Descr	i pti on	Y/N	Y/N	, , , , , , , , , , , , , , , , , , ,
			0	1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	,	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS F	IOSPI TAI S)		1.00	
	Capital Related Cost	IT CHILDRENS I	iosi i ials)			1
22. 00	Have assets been relifed for Medicare purposes? If yes, see	einstructions				22. 00
23. 00	Have changes occurred in the Medicare depreciation expense		sals made dur	ing the cost		23. 00
	reporting period? If yes, see instructions.					
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost re	eporting period?		24. 00
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	'If yes, see		25. 00
	instructions.					0, 5-
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reporti	ng period? I	т yes, see		26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportir	ng period? If	yes, submit		27. 00
28. 00	Unterest Expense Were new Loans, mortgage agreements or Letters of credit en	ntered into dur	ing the cost	reporting		28. 00
.0. 00	period? If yes, see instructions.	rtered Titto dai	ring the cost	. reporting		20.00
9. 00	Did the provider have a funded depreciation account and/or	bond funds (De	ebt Service R	Reserve Fund)		29.00
	treated as a funded depreciation account? If yes, see instr	ructions		·		
0.00	Has existing debt been replaced prior to its scheduled matu	ırity with new	debt? If yes	s, see		30.00
1. 00	instructions. Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes	s, see		31.00
	Instructions. Purchased Services					1
32.00	Have changes or new agreements occurred in patient care ser	rvi ces furni she	ed through co	ntractual		32.00
	arrangements with suppliers of services? If yes, see instru					
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to competi	tive bidding? If		33.00
	no, see instructions.					
	Provi der-Based Physi ci ans					
4. 00	Are services furnished at the provider facility under an ar	rangement with	n provi der-ba	ised physicians?		34.00
	If yes, see instructions.					0- 0
35. 00	, ,		its with the	provi der-based		35. 00
	physicians during the cost reporting period? If yes, see in	ISTITUCTIONS.		Y/N	Date	
				1. 00	2. 00	
				1.00		
	Home Office Costs				2.00	
16.00	Home Office Costs Were home office costs claimed on the cost report?				2. 00	36.00
	Were home office costs claimed on the cost report?	repared by the	home office?)	2. 00	
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	,	2.00	
37. 00	Were home office costs claimed on the cost report?				2.00	37. 00
37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	ice different	from that of		2.00	37. 00
37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off	ice different I of the home d	from that of office.	-	2,00	37. 00 38. 00
37. 00 38. 00 39. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.	fice different I of the home c er chain compor	from that of office. nents? If yes	-	2, 00	36. 00 37. 00 38. 00 39. 00
37. 00 38. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the	fice different I of the home c er chain compor	from that of office. nents? If yes	-	2, 00	37. 00 38. 00
37. 00 38. 00 39. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.	fice different I of the home c er chain compor	from that of office. nents? If yes	-	2, 00	37. 00 38. 00 39. 00
37. 00 38. 00 39. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the	Fice different d of the home of er chain compor home office?	from that of office. nents? If yes If yes, see	5,		37. 00 38. 00 39. 00
37. 00 38. 00 39. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions.	Fice different d of the home of er chain compor home office?	from that of office. nents? If yes	-		37. 00 38. 00 39. 00
37. 00 38. 00 39. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information	Fice different d of the home of er chain compor home office?	from that of office. nents? If yes If yes, see	2.		37. 00 38. 00 39. 00 40. 00
37. 00 38. 00 39. 00 -0. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position	Fice different d of the home of er chain compor home office?	from that of office. nents? If yes If yes, see	5,		37. 00 38. 00 39. 00 40. 00
37. 00 38. 00 39. 00 -0. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	Fice different d of the home of er chain compor home office?	from that of office. nents? If yes If yes, see	2.		37. 00 38. 00 39. 00 40. 00
7. 00 8. 00 9. 00 0. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	rice different i of the home c er chain compor home office?	from that of office. nents? If yes If yes, see	2.		37. 00 38. 00 39. 00 40. 00
37. 00 38. 00 39. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	Fice different d of the home of er chain compor home office?	from that of office. nents? If yes If yes, see	2.		37. 00 38. 00 39. 00 40. 00
37. 00 38. 00 39. 00 40. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	rice different i of the home c er chain compor home office?	from that of office. nents? If yes If yes, see	2.	00	37. 00 38. 00 39. 00 40. 00 41. 00

Heal th Fi	inancial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI TAL	AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 15-0125	Peri od:	Worksheet S-2	
					From 07/01/2019 To 06/30/2020	Part II Date/Time Pre	narod:
					10 00/30/2020	11/25/2020 3:	
				3. 00			
Co	ost Report Preparer Contact Information						
	nter the first name, last name and the t		DIRECTOR OF	REI MBURSEMENT			41. 00
	eld by the cost report preparer in colum	ns 1, 2, and 3,					
	especti vel y.						
42. 00 Er	nter the employer/company name of the co	st report					42. 00
	reparer.						
	nter the telephone number and email addr						43. 00
re	eport preparer in columns 1 and 2, respe	ecti vel y.					

					''	0 00/30/2020	11/25/2020 3:0	
							I/P Days / 0/P	<u> </u>
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		349	127, 734	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7.00	Total Adults and Peds. (exclude observation			349	127, 734	0.00	0	7.00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		39	14, 274	0. 00	0	8.00
9.00	CORONARY CARE UNIT							9. 00
9. 01	NEONATAL INTENSIVE CARE	32. 01		32	11, 712	0.00	0	9. 01
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	13.00
14.00	Total (see instructions)			420	153, 720	0.00	0	14.00
15. 00	CAH visits						0	15.00
16.00	SUBPROVI DER - I PF							16.00
17. 00	SUBPROVI DER - I RF	41. 00		25	9, 150		0	17.00
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22.00	HOME HEALTH AGENCY	101. 00					0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25.00
26.00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27.00	Total (sum of lines 14-26)			445				27.00
28.00	Observation Bed Days						0	28.00
29. 00	Ambul ance Tri ps							29.00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges							33. 01

				'	0 00/30/2020	11/25/2020 3:	
		I/P Days	o/P Visits	/ Trips	Full Time	Equi val ents	<u> </u>
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30, 506	1, 651	66, 967			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	15, 720	10, 799				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	603	135				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation	30, 506	1, 651	66, 967			7. 00
0.00	beds) (see instructions)	4 (50	_	40.040			0.00
8. 00	INTENSIVE CARE UNIT	4, 653	5	10, 863			8. 00
9.00	CORONARY CARE UNIT						9. 00
9. 01	NEONATAL INTENSIVE CARE	0	328	4, 299			9. 01
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)		000	0.440			12.00
13.00	NURSERY	25 450	223	3, 110		2 440 00	13.00
14.00	Total (see instructions)	35, 159 0	2, 207	85, 239 0		2, 449. 88	14.00
15. 00	CAH visits	U	U	Ü			15.00
16.00	SUBPROVIDER - I PF	(101	39	7 717	0.00	41 50	16.00
17. 00	SUBPROVIDER - I RF	6, 181	39	7, 717	0.00	41. 52	17.00
18. 00 19. 00	SUBPROVI DER						18.00
20. 00	SKILLED NURSING FACILITY NURSING FACILITY						19. 00 20. 00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	30, 217	0	48, 341	0.00	46. 71	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	30, 217	U	40, 341	0.00	40.71	23. 00
24. 00	HOSPICE						24.00
24. 00	HOSPICE (non-distinct part)			25			24. 00
25. 00	CMHC - CMHC			25			25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)	U	U	U	0.00		
28. 00	Observation Bed Days		0	14, 475		2, 330. 11	28.00
29. 00	Ambul ance Tri ps	0	O	14, 473			29.00
30. 00	Employee discount days (see instruction)	J		0			30.00
31. 00	Employee discount days - IRF			0			31.00
32. 00	Labor & delivery days (see instructions)	0	272	666			32.00
32. 00	Total ancillary labor & delivery room	١	212	000			32. 00
JZ. UI	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days	o					33. 00
	LTCH site neutral days and discharges						33. 01
55.51	1 = 1 = 1 = 1 = 1 = au a a a a a a a a a a a a a a a a a	١			I .	ı	, 50.01

| Period: | Worksheet S-3 | From 07/01/2019 | Part | To 06/30/2020 | Date/Time Prepared: Provi der CCN: 15-0125

				To	06/30/2020	Date/Time Prep 11/25/2020 3:0	
		Full Time		Di scha	arges		
		Equi val ents					
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12.00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	6, 543	323	15, 966	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			2, 375	1, 825		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4. 00	HMO IRF Subprovider				13		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	I NTENSI VE CARE UNI T						8. 00
9.00	CORONARY CARE UNIT						9. 00
9. 01	NEONATAL INTENSIVE CARE						9. 01
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0.00		, 540	200	45.077	13.00
14.00	Total (see instructions)	0. 00	0	6, 543	323	15, 966	
15. 00	CAH visits						15. 00
16.00	SUBPROVIDER - I PF	0.00	0	F.()	2	707	16.00
17. 00	SUBPROVIDER - I RF	0. 00	0	562	3	707	17.00
18. 00 19. 00	SUBPROVIDER SKILLED NURSING FACILITY						18. 00 19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01

							11/25/2020 3:	02 pm
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	
				A-6)	3)	col . 4	COI . 3)	
	DART II WACE DATA	1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1. 00	Total salaries (see	200. 00	178, 608, 684	0	178, 608, 684	5, 279, 276. 00	33. 83	1.00
2.00	instructions) Non-physician anesthetist Part A		0	0	0	0. 00	0. 00	2. 00
3.00	Non-physician anesthetist Part		3, 896, 783	0	3, 896, 783	47, 777. 00	81. 56	3. 00
4. 00	Physician-Part A - Administrative		0	0	0	0.00	0. 00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0 9, 729, 508	0		0. 00 64, 884. 00	0. 00 149. 95	
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0. 00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved programs)		0	О	0	0.00	0. 00	7. 01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 10, 192, 838	0 585, 584	0 10, 778, 422	0. 00 332, 702. 00		
	instructions) OTHER WAGES & RELATED COSTS							-
11. 00	Contract labor: Direct Patient Care		3, 196, 093	0	3, 196, 093	32, 734. 64	97. 64	11. 00
12. 00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0. 00	12. 00
13. 00	services Contract Labor: Physician-Part A - Administrative		761, 523	0	761, 523	5, 062. 00	150. 44	13. 00
14. 00	Home office and/or related organization salaries and		0	0	0	0.00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		21, 110, 038	0	21, 110, 038	622, 910. 00	33 89	14. 01
14. 02	Related organization salaries		0	Ō	0	0.00	0. 00	14. 02
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0. 00	15. 00
16. 00	Home office and Contract		0	0	0	0.00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0. 00	0. 00	16. 01
16. 02	- Teaching Home office contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		52, 860, 204	0	52, 860, 204			17. 00
18. 00	instructions) Wage-related costs (core) (see		52, 800, 204	0	52, 860, 204			18. 00
19. 00	(see instructions) Excluded areas		3, 647, 383	0	3, 647, 383			19. 00
20. 00	Non-physician anesthetist Part A		0	0	0			20. 00
21. 00	Non-physician anesthetist Part B		957, 596	0	957, 596			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		1, 977, 908	0	1, 977, 908			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an approved program)		0	0	0			24. 00 25. 00
25. 50	Home office wage-related (core)		5, 448, 650	0	5, 448, 650			25. 50
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	Wage-related (core) Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25. 52

| Peri od: | Worksheet S-3 | From 07/01/2019 | Part II | To 06/30/2020 | Date/Time Prepared:

					11	06/30/2020	Date/lime Prep 11/25/2020 3:0	
		Wkst. A Line	Amount	Reclassi fi cati	Adjusted	Pai d Hours	Average Hourly	
		Number		on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4	, i	
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	686, 885		686, 885			
27. 00	Administrative & General	5. 00	16, 523, 649	0	16, 523, 649	·		
28. 00	Administrative & General under		2, 958, 038	0	2, 958, 038	22, 700. 72	130. 31	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00		29. 00
30. 00	Operation of Plant	7. 00	5, 470, 197		5, 470, 197	·		
31. 00	Laundry & Linen Service	8. 00	133, 756	l .	133, 756	9, 891. 00		
32. 00	Housekeepi ng	9. 00	3, 485, 612	0	3, 485, 612	·		
33. 00	Housekeeping under contract		0	0	0	0. 00	0. 00	33. 00
	(see instructions)							
34. 00	Di etary	10. 00	3, 786, 783	-1, 167, 583	2, 619, 200	·	l .	34. 00
35. 00	Di etary under contract (see		0	0	0	0. 00	0. 00	35. 00
	instructions)	44.00		4 4/7 500	4 4/7 500	/F F00 00	47.00	
36.00	Cafeteri a	11. 00	0	1, 167, 583	1, 167, 583			
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00		
38. 00	Nursing Administration	13. 00	3, 833, 468	-178, 817	3, 654, 651	80, 942. 00		
39. 00	Central Services and Supply	14. 00		0	0	0.00		
40. 00	Pharmacy	15. 00	4, 129, 674	-127, 973	4, 001, 701	99, 657. 00		40. 00
41. 00	Medical Records & Medical	16. 00	0	0	0	0. 00	0. 00	41. 00
	Records Li brary	47.00	005 504		005 504			
42.00	Soci al Servi ce	17. 00	825, 591	0	825, 591	28, 364. 00		42. 00
43.00	Other General Service	18. 00	0	0	0	0. 00	0.00	43. 00

| Peri od: | Worksheet S-3 | From 07/01/2019 | Part III | To 06/30/2020 | Date/Time Prepared:

							11/25/2020 3:0	02 pm
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		167, 940, 431	0	167, 940, 431	5, 189, 315. 72	32. 36	1.00
	instructions)							
2.00	Excluded area salaries (see		10, 192, 838	585, 584	10, 778, 422	332, 702. 00	32. 40	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		157, 747, 593	-585, 584	157, 162, 009	4, 856, 613. 72	32. 36	3.00
	minus line 2)							
4.00	Subtotal other wages & related		25, 067, 654	0	25, 067, 654	660, 706. 64	37. 94	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		58, 308, 854	0	58, 308, 854	0.00	37. 10	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		241, 124, 101	-585, 584	240, 538, 517	5, 517, 320. 36	43. 60	6. 00
7.00	Total overhead cost (see		41, 833, 653	-306, 790	41, 526, 863	1, 388, 311. 72	29. 91	7. 00
	instructions)							

Health Financial Systems	COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0125	Peri od:	Worksheet S-3
		From 07/01/2019	
			D 1 (T) D 1

	To 06/30/2020	Date/Time Prep 11/25/2020 3:0	pared: 02 pm
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	5, 783, 631	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	16, 666, 667	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	20, 765, 725	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	1, 546, 652	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	142, 898	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	114, 901	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	1, 308, 049	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16, 00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	10, 169, 155	17. 00
18.00	Medicare Taxes - Employers Portion Only	2, 491, 883	
19.00	Unempl oyment Insurance	453, 530	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
22.00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	0	23. 00
	Total Wage Related cost (Sum of lines 1 -23)	59, 443, 091	24.00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
		!	

Health Financial Systems	COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0125	From 07/01/2019	Worksheet S-3 Part V Date/Time Prepared: 11/25/2020 3:02 pm
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			11/25/2020 3:	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	3, 196, 093	59, 443, 091	1.00
2.00	Hospi tal	3, 196, 093	59, 443, 091	2. 00
3.00	Subprovi der - I PF			3. 00
4.00	Subprovi der - IRF	0	0	4. 00
5. 00	Subprovi der - (Other)	0	0	5. 00
6. 00	Swing Beds - SNF	0	0	6. 00
7. 00	Swing Beds - NF	0	0	7. 00
8. 00	Hospi tal -Based SNF			8. 00
9. 00	Hospi tal -Based NF			9. 00
10. 00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA	0	0	11.00
	Separately Certified ASC			12.00
13. 00	Hospi tal -Based Hospi ce			13.00
14. 00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16. 00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Dialysis			17.00
18. 00	Other	0	0	18. 00

Heal th	Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOME I	HEALTH AGENCY STATISTICAL DATA			F	eriod: rom 07/01/2019 o 06/30/2020	Worksheet S-4	
-			Component	CCN: 15-7487 T	o 06/30/2020 Home Health	Date/Time Pre 11/25/2020 3: PPS	
					Agency I	PPS	
						00	
0.00	County	Title V	Title XVIII	Title XIX	LAKE Other	Total	0.00
	THOUSE HIS NOT THE ASSESSMENT OF THE STATE O	1.00	2.00	3. 00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	2, 268	0	881	3, 149	1.00
2.00	Unduplicated Census Count (see instructions)	0. 00	1, 143. 00		1, 630. 00 oyees (Ful I Ti		2. 00
				Number of Empi	oyees (ruii ii	me Equi vai ent)	
			er of hours in	Staff	Contract	Total	
		your normai	work week				
	LIGHT HELL THE ASSESSMENT THREE OF THE OVER)	1. 00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3. 00
4.00	Director(s) and Assistant Director(s)			1. 85			1
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			18. 68 12. 64			1
7.00	Nursi ng Supervi sor			0.00			
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			7. 96 0. 00		8. 00 0. 00	1
10.00	Occupational Therapy Service			4. 22			1
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0. 00 0. 03			
13.00	Speech Pathology Supervisor			0.00			
14. 00 15. 00	Medical Social Service Medical Social Service Supervisor			0. 01 0. 00			1
16. 00	Home Health Aide			1. 61	0.00	1. 61	16. 00
17. 00 18. 00	Home Heal th Ai de Supervisor Other (specify)			0.00			1
	HOME HEALTH AGENCY CBSA CODES						
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost			'			19. 00
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			23844			20. 00
20.00	during this cost reporting period (line 20			23044			20.00
	contains the first code).	Full E	oi sodes				
		Wi thout		LUPA Epi sodes	PEP Only	Total (cols.	
		0utliers 1.00	2.00	3.00	Epi sodes 4. 00	1-4) 5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	11, 543	3, 061	287	256	15, 147	21. 00
22. 00	Skilled Nursing Visit Charges	2, 204, 244	586, 347	55, 166	48, 489	2, 894, 246	22. 00
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	7, 062 1, 569, 759		l .			
25. 00	Occupational Therapy Visits	2, 703	792	17	89	3, 601	25. 00
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	596, 781 304	179, 047 151	1		799, 339 466	1
28. 00	Speech Pathology Visit Charges	67, 763		l .			28. 00
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	11 2, 752	1 262	· ·		12 3, 014	
31. 00	Home Health Aide Visits	1, 596	623	3	46	2, 268	31. 00
32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	226, 478 23, 219					
	29, and 31)						
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	4, 667, 777		_		-	34. 00 35. 00
	30, 32, and 34)						
36. 00	Total Number of Episodes (standard/non outlier)	1, 499		2, 268			
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	341, 226	196 181, 628	l .	7 4, 552		

IOSPI TA	Financial Systems COMMUNITY HOSPIT AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	ovider CCN: 15-0°	125 F	Peri od:	u of Form CMS-2 Worksheet S-10	
1001 1 17	TE SHOOME ENOTICE THE THE OTHER DATA	ovider con. 10 c		rom 07/01/2019		
			Т	o 06/30/2020	Date/Time Pre 11/25/2020 3:0	pared 02 pm
					1. 00	
	Uncompensated and indigent care cost computation					
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by line 202 o	col umn	8)	0. 229370	1. (
	Medicaid (see instructions for each line)					
1	Net revenue from Medicaid				12, 955, 792	•
	Did you receive DSH or supplemental payments from Medicaid?			10		3.
00	If line 3 is yes, does line 2 include all DSH and/or supplemental If line 4 is no, then enter DSH and/or supplemental payments from		wedi cai	a?	0	4. 5.
	Medicaid charges	ii wedi card			208, 908, 063	
	Medicaid cost (line 1 times line 6)		47, 917, 242	•		
	Difference between net revenue and costs for Medicaid program (li	ine 7 minus sum o	of line	s 2 and 5: if	34, 961, 450	
	< zero then enter zero)					
ĺ	Children's Health Insurance Program (CHIP) (see instructions for	each line)				
	Net revenue from stand-alone CHIP				0	9.
	Stand-alone CHIP charges				0	10.
	Stand-alone CHIP cost (line 1 times line 10)				0	11.
2. 00	Difference between net revenue and costs for stand-alone CHIP (li	ine 11 minus line	e 9; if	<pre>< zero then</pre>	0	12.
	enter zero) Other state or local government indigent care program (see instru	ictions for each	line)			
	Net revenue from state or local indigent care program (Not included in the inc				3, 894	13.
	Charges for patients covered under state or local indigent care program (Not mer at	·	,		7, 896	
00	10)	or ogram (not riio	· uuou ·		,,0,0	
5. 00	'					15.
5. 00	Difference between net revenue and costs for state or local indig	15 minus line	0	16.		
	13; if < zero then enter zero)				,	
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and state/local	i ndi ge	nt care program	is (see	
7. 00	Private grants, donations, or endowment income restricted to fund	ding charity care	е		0	17.
	Government grants, appropriations or transfers for support of hos				0	18.
	Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)	indigent care pro	ograms	(sum of lines	34, 961, 450	19.
	of 12 and 10)	Uni ns	sured	Insured	Total (col. 1	
		patio	ents	pati ents	+ col . 2)	
		1. (00	2. 00	3. 00	
	Uncompensated Care (see instructions for each line)			0 450 050	10 000 070	
0. 00	Charity care charges and uninsured discounts for the entire facil	16, '	924, 319	2, 459, 053	19, 383, 372	20.
	(see instructions) Cost of patients approved for charity care and uninsured discount	ts (soo 2)	881, 931	2, 459, 053	6, 340, 984	21.
1 00	instructions)	15 (566) 3,	001, 731	2, 457, 055	0, 340, 704	21.
1. 00		ff as	C	0	0	22.
	Payments received from patients for amounts previously written of				-	
	Payments received from patients for amounts previously written of charity care	11 43				
2. 00			881, 931	2, 459, 053	6, 340, 984	23.
2. 00	charity care		881, 931	2, 459, 053		23.
2. 00	charity care Cost of charity care (line 21 minus line 22)	3, 8			1.00	
2. 00	charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient	days beyond a le				23.
2. 00	charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the	days beyond a le	ength o	f stay limit	1.00	
2. 00 3. 00 4. 00 5. 00	charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care proof line 24 is yes, enter the charges for patient days beyond the stay limit	days beyond a le rogram? indigent care pr	ength o	f stay limit	1. 00 N	24. 25.
2. 00 3. 00 4. 00 5. 00	charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care properties of the charges for patient days beyond the stay limit. Total bad debt expense for the entire hospital complex (see instructions)	days beyond a le rogram? indigent care puructions)	ength o	f stay limit	1. 00 N 0 15, 516, 319	24. 25. 26.
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care properties of the charges for patient days beyond the stay limit. Total bad debt expense for the entire hospital complex (see instrument) Medicare reimbursable bad debts for the entire hospital complex (see instrument).	days beyond a le rogram? indigent care pi ructions) (see instructions	ength o	f stay limit	1. 00 N 0 15, 516, 319 1, 192, 519	24. 25. 26. 27.
2. 00 3. 00 4. 00 5. 00 7. 00 7. 01	charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care properties of the charges for patient days beyond the stay limit. Total bad debt expense for the entire hospital complex (see instrument of the complex of the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see	days beyond a le rogram? indigent care pi ructions) (see instructions	ength o	f stay limit	1. 00 N 0 15, 516, 319 1, 192, 519 1, 834, 643	24. 25. 26. 27. 27.
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 7. 01 8. 00	Charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided line 24 is yes, enter the charges for patient days beyond the stay limit total bad debt expense for the entire hospital complex (see instructionary limit) Medicare reimbursable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	days beyond a le	ength o	f stay limit	1. 00 N 0 15, 516, 319 1, 192, 519 1, 834, 643 13, 681, 676	24. 25. 26. 27. 27. 28.
3. 00 4. 00 5. 00 6. 00 7. 00 7. 01 8. 00 9. 00	charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care properties of the charges for patient days beyond the stay limit. Total bad debt expense for the entire hospital complex (see instrument of the complex of the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see	days beyond a le	ength o	f stay limit	1. 00 N 0 15, 516, 319 1, 192, 519 1, 834, 643	24. 25. 26. 27. 27. 28. 29.

	Financial Systems	COMMUNITY H	OSPI TAL		In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
					From 07/01/2019 Fo 06/30/2020	Date/Time Pre	nared·
						11/25/2020 3:	
	Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2.00	2.00	4.00	col . 4)	
	CENEDAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FLXT		14, 708, 420	14, 708, 420	299, 807	15, 008, 227	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		13, 231, 694			13, 257, 997	2. 00
3.00	00300 OTHER CAP REL COSTS		0	(0 0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	686, 885	21, 771, 817	22, 458, 702	-7, 514	22, 451, 188	
5.00	00500 ADMINISTRATIVE & GENERAL	16, 523, 649	96, 858, 002	113, 381, 651	-2, 145, 070	111, 236, 581	5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0	(0	0	
7.00	00700 OPERATION OF PLANT	5, 470, 197	10, 680, 746			16, 165, 250	
8.00	00800 LAUNDRY & LINEN SERVICE	133, 756	1, 466, 290			1, 710, 928	
9.00	00900 HOUSEKEEPI NG	3, 485, 612	1, 503, 872			4, 822, 795	
10.00	01000 DI ETARY	3, 786, 783	2, 672, 016	1		4, 209, 610	
11. 00 12. 00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	0	0	(2, 242, 423	2, 242, 423	11. 00 12. 00
13. 00	01300 NURSING ADMINISTRATION	3, 833, 468	1, 040, 389	4, 873, 85	7 -189, 057	4, 684, 800	
14. 00	01400 CENTRAL SERVI CES & SUPPLY	0, 033, 400	1,040,307	4,075,05	0	1, 004, 000	14. 00
15. 00	01500 PHARMACY	4, 129, 674	15, 198, 089	19, 327, 763	472, 259	19, 800, 022	
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	566			4, 953	
17.00	01700 SOCIAL SERVICE	825, 591	106, 505	932, 096	6 0	932, 096	
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	(0	0	19. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	(0	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	(0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(PHARMACY)	200, 019	17, 128	217, 147	7 127, 973	345, 120	23. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	07.054.004	0 / 1 = 001		1 200 750		
30.00	03000 ADULTS & PEDIATRICS	37, 054, 924	9, 615, 231			44, 767, 397	
31. 00 32. 01	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE	11, 493, 957 3, 091, 905	2, 384, 255 765, 682			13, 946, 006 3, 880, 125	
41. 00	04100 SUBPROVI DER – I RF	2, 392, 759	1, 204, 783				1
43. 00	04300 NURSERY	2, 372, 737	1, 204, 709	3,377,342			
10.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>			1,001,177	1,001,177	10.00
50.00	05000 OPERATI NG ROOM	29, 476, 215	16, 465, 066	45, 941, 281	-1, 917	45, 939, 364	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 354, 991	534, 490	2, 889, 481	20, 889	2, 910, 370	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 610, 421	7, 338, 474	15, 948, 895	49, 900		
60.00	06000 LABORATORY	6, 408, 816	9, 075, 153			16, 036, 495	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	371, 041	2, 181, 677	2, 552, 718	0	2, 552, 718	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0 7/0 0/0	0	(0	0	62. 30
65. 00	06500 RESPIRATORY THERAPY	3, 768, 249	1, 183, 628			4, 951, 877	1
66. 00 70. 00	06600 PHYSI CAL THERAPY 07000 ELECTROENCEPHALOGRAPHY	7, 441, 806 740, 081	3, 672, 674 307, 182			11, 137, 155 1, 046, 741	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	740,081	23, 789, 662			23, 789, 662	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	32, 025, 703			32, 025, 703	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	1
76.00	03140 CARDI OLOGY	8, 380, 840	5, 207, 169	13, 588, 009	-352, 084	13, 235, 925	
76. 97	07697 CARDIAC REHABILITATION	884, 864	130, 514		0	1, 015, 378	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	(0		76. 98
76. 99	07699 LI THOTRI PSY	0	0	(0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	0.000 5/7	75.4 700		-1	0.070.01/	
	09000 CLI NI C	2, 320, 567	754, 788				
91.00	09100 EMERGENCY	7, 141, 554	2, 587, 198	9, 728, 752	72, 785	9, 801, 537	91. 00 92. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101 00	10100 HOME HEALTH AGENCY	4, 414, 136	979, 629	5, 393, 765	-9, 050	5, 384, 715	101 00
101.00	SPECIAL PURPOSE COST CENTERS	4, 414, 130	717,027	3, 373, 700	7, 030	3, 304, 713	1101.00
118.00		175, 422, 760	299, 458, 492	474, 881, 252	2 -1, 239, 944	473, 641, 308	118. 00
	NONREI MBURSABLE COST CENTERS					· · ·	1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0		190. 00
	19100 RESEARCH	421, 714	126, 640			1, 086, 406	
	19200 PHYSICIANS' PRIVATE OFFICES	0	1, 047, 975				
	07950 ADVERTI SI NG	0	0	(686, 674	
	07951 FITNESS POINTE	1, 220, 640	834, 203			2, 054, 843	
	07952 FITNESS POINTE SPA/PRO SHOP/DIETARY 07953 RETAIL PHARMACY	242, 838 875, 020	112, 793 13, 100, 824			355, 631 13, 975, 844	
	07954 HOSPI CE	073,020	13, 100, 624 N	13, 7/3, 042			194. 03
	07955 RUSH RESIDENTS	0	0				194. 05
	07956 EINSTEIN BAGELS	99, 039	117, 616	216, 655	o o	216, 655	
	07957 NORTHWESTERN I MAGING	326, 673	262, 825	589, 498		589, 498	194. 07
200.00	TOTAL (SUM OF LINES 118 through 199)	178, 608, 684	315, 061, 368	493, 670, 052	0	493, 670, 052	200. 00

| Period: | Worksheet A | From 07/01/2019 | To 06/30/2020 | Date/Time Prepared: | 11/25/2020 3:02 pm

				11/25/20)20 3:02 pm
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS	24 227	45.045.454		1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT	36, 927	15, 045, 154		1.00
2. 00 3. 00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS	1, 945, 127 0	15, 203, 124 0		2. 00 3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 877, 859	25, 329, 047		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-45, 996, 912	65, 239, 669		5. 00
6.00	00600 MAI NTENANCE & REPAI RS	43, 770, 712	03, 237, 007		6. 00
7. 00	00700 OPERATION OF PLANT	7	16, 165, 257		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	1, 710, 928		8. 00
9. 00	00900 HOUSEKEEPI NG	-79, 272	4, 743, 523		9. 00
	01000 DI ETARY	-182	4, 209, 428		10.00
	01100 CAFETERI A	-418, 344	1, 824, 079		11. 00
	01200 MAI NTENANCE OF PERSONNEL	0	o		12. 00
13. 00	01300 NURSING ADMINISTRATION	289, 254	4, 974, 054		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	o		14. 00
15. 00	01500 PHARMACY	-1, 485	19, 798, 537		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	5, 245, 619	5, 250, 572		16. 00
	01700 SOCIAL SERVICE	0	932, 096		17. 00
	01900 NONPHYSICIAN ANESTHETISTS	0	0		19. 00
	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0		21. 00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22. 00
23. 00	02300 PARAMED ED PRGM-(PHARMACY)	0	345, 120		23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	400.05/	44 (44 444		
	03000 ADULTS & PEDIATRICS	-120, 956	44, 646, 441		30.00
	03100 I NTENSI VE CARE UNIT	-1, 008, 586	12, 937, 420		31.00
	02060 NEONATAL INTENSIVE CARE 04100 SUBPROVIDER - IRF	-320, 618	3, 559, 507		32. 01
	04300 NURSERY	0	3, 623, 960 1, 651, 479		41. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	U _I	1,001,479		43.00
50. 00	05000 OPERATING ROOM	-13, 916, 525	32, 022, 839		50.00
	05200 DELIVERY ROOM & LABOR ROOM	-5, 388	2, 904, 982		52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-64, 652	15, 934, 143		54.00
60. 00	06000 LABORATORY	-54, 409	15, 982, 086		60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0 1, 10,	2, 552, 718		62. 00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62. 30
	06500 RESPI RATORY THERAPY	-7, 214	4, 944, 663		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	11, 137, 155		66. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	-2, 643	1, 044, 098		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	23, 789, 662		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	32, 025, 703		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0		73. 00
	03140 CARDI OLOGY	-91, 006	13, 144, 919		76. 00
	07697 CARDI AC REHABILI TATI ON	-39, 971	975, 407		76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0		76. 98
	07699 LI THOTRI PSY	0	0		76. 99
	OUTPATIENT SERVICE COST CENTERS	1			
	09000 CLI NI C	-147, 556	2, 926, 360		90.00
	09100 EMERGENCY	-11, 016	9, 790, 521		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
	OTHER REIMBURSABLE COST CENTERS	110 770	E 407 400		101. 00
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	112, 773	5, 497, 488		101.00
118. 00		-51, 779, 169	421, 862, 139		118. 00
	NONREIMBURSABLE COST CENTERS	-31,777,107	421,002,139		118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	O		190. 00
	19100 RESEARCH	-13, 170	1, 073, 236		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	8	1, 063, 201		192. 00
	07950 ADVERTI SI NG	o	686, 674		194. 00
	07951 FI TNESS POI NTE	0	2, 054, 843		194. 01
	07952 FITNESS POINTE SPA/PRO SHOP/DIETARY	Ö	355, 631		194. 02
	07953 RETAIL PHARMACY	0	13, 975, 844		194. 03
	07954 H0SPI CE	0	0		194. 04
	07955 RUSH RESIDENTS	0	Ö		194. 05
	07956 EINSTEIN BAGELS	0	216, 655		194. 06
	07957 NORTHWESTERN I MAGI NG	0	589, 498		194. 07
200.00		-51, 792, 331			200. 00
•		·			

Health Financial Systems RECLASSIFICATIONS Peri od: From 07/01/2019 To 06/30/2020 Date/Time Prepared: Provider CCN: 15-0125

					11/25/2020 3:	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
1. 00	A - BUILDING INSURANCE CAP REL COSTS-BLDG & FIXT	1.00	O	299, 807		1. 00
2.00	CAP REL COSTS-BLDG & FIXT	2. 00	0	26, 303		2.00
2.00	TOTALS			326, 110		2.00
	B - NURSING FLOAT SALARIES		<u> </u>	020, 110		
1.00	INTENSIVE CARE UNIT	31.00	89, 376	0		1.00
2.00	NEONATAL INTENSIVE CARE	32. 01	24, 282	0		2. 00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	20, 889	0		3. 00
4.00	EMERGENCY	91.00	72, 814	0		4. 00
5.00	SUBPROVI DER - I RF	41. 00	26, 418	0		5. 00
6. 00	NURSERY	43.00	11, 677	0		6. 00
	C - CAFETERIA EXPENSE		245, 456	U		
1.00	CAFETERI A	11.00	1, 167, 583	1, 074, 840		1.00
1.00	TOTALS		1, 167, 583	1, 074, 840		1.00
	D - RESEARCH		.,,	.,,		
1.00	RESEARCH	191.00	431, 193	106, 859		1. 00
2.00		0.00	0	0		2. 00
	TOTALS		431, 193	106, 859		
4 00	E - ADVERTISING NON-REIMBURSA		ما	(0) (7)		4 00
1. 00 2. 00	ADVERTI SI NG	194. 00 0. 00	0	686, 674 0		1. 00 2. 00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4. 00
5. 00		0.00	o	0		5. 00
6.00		0.00	o	0		6. 00
7.00		0.00	o	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11.00	•	0.00	0	0		11.00
12. 00 13. 00		0. 00 0. 00	O O	0		12. 00 13. 00
14. 00		0.00	0	0		14. 00
11.00	TOTALS — — — —			686, 674		11.00
	F - RECLASS NURSERY	·	•			
1.00	NURSERY	43.00	1, 305, 584	334, 218		1.00
	TOTALS		1, 305, 584	334, 218		ļ
4 00	G - RECLASS PRECEPTOR TIME	00.00	407.070			4 00
1. 00	PARAMED ED PRGM-(PHARMACY) TOTALS	23.00	127, 973 127, 973	0		1. 00
	H - LINEN RECLASS FOR OFFSITE	12.25	127, 973	U		
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	7, 263		1.00
2. 00	PHYSI CAL THERAPY	66.00	Ö	2, 905		2. 00
3.00	CARDI OLOGY	76. 00	0	1, 453		3. 00
4.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	13, 073		4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	18, 364		5. 00
6.00	CARDI OLOGY	76. 00	0	7, 870		6. 00
7.00	CLINIC	90.00	0	2, 623		7. 00
8. 00 9. 00	RADI OLOGY-DI AGNOSTI C CARDI OLOGY	54. 00 76. 00	0	6, 434 2, 145		8. 00 9. 00
10. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2, 145		10.00
11. 00	LAUNDRY & LINEN SERVICE	8.00	o	110, 882		11. 00
12. 00	E TONDIK! Q E THEN GENTIGE	0.00	Ö	0		12. 00
13. 00		0.00	O	Ö		13. 00
14.00		0.00	О	0		14. 00
15. 00		0.00	0	0		15. 00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18. 00 19. 00		0. 00 0. 00	0	0		18. 00 19. 00
20. 00		0.00	0	0		20.00
20.00	TOTALS — — — —	— 	 	175, 157		20.00
	I - RECLASS OFFSITE HOUSEK CO	STS SJ		-,		1
1.00	ADMINISTRATIVE & GENERAL	5.00	0	44, 675		1.00
2.00	OPERATION OF PLANT	7. 00	0	14, 267		2. 00
3.00	HOUSEKEEPI NG	9.00	0	492		3. 00
4. 00	MEDI CAL RECORDS & LI BRARY	16.00	0	4, 387		4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	19, 185		5.00
6. 00 7. 00	LABORATORY PHYSI CAL THERAPY	60. 00 66. 00	0	4, 177 20, 114		6. 00 7. 00
8. 00	CARDI OLOGY	76. 00	0	20, 114		8. 00
9. 00	ADMINISTRATIVE & GENERAL	5.00	o	8, 407		9. 00
10. 00	OPERATION OF PLANT	7. 00	0	470		10.00
			٩			

Heal th Financial Systems COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0125 Period: Worksheet A-6
From 07/01/2019 To 06/30/2020 Date/Time Prepared:

						 11/25/2020 3:	
		Increases					
	Cost Center	Li ne #	Sal ary	Other			
	2. 00	3. 00	4.00	5. 00			
11.00	RADI OLOGY-DI AGNOSTI C	54.00	0	4, 365	i		11.00
12.00	LABORATORY	60.00	0	1, 531			12. 00
	TOTALS		0	124, 173			
	J - COVID COSTS						
1.00	PHARMACY	15. 00	0	600, 232			1.00
2.00	LABORATORY	60. 00	o	547, 486	1		2. 00
	TOTALS		0	1, 147, 718			
500.00	Grand Total: Increases		3, 277, 789	3, 975, 749			500.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0125 Peri od: Worksheet A-6 From 07/01/2019 To 06/30/2020 Date/Time Prepared:

						06/30/2020 Date/lime Pr 11/25/2020 3	
		Decreases					
	Cost Center	Li ne #	Sal ary	Other 0.00	Wkst. A-7 Ref.		
	6. 00 A - BUI LDI NG I NSURANCE	7. 00	8. 00	9. 00	10. 00		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	299, 807	12		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	0	26, 303			2. 00
	TOTALS		0	326, 110			
	B - NURSING FLOAT SALARIES	00.00	0.5 45.1				4
1. 00 2. 00	ADULTS & PEDIATRICS	30. 00 0. 00	245, 456 0	0	0		1. 00 2. 00
3.00		0.00	o	0	0		3. 00
4. 00		0.00	o	0	0		4. 00
5.00		0. 00	О	0	0		5. 00
6.00		0.00	0	0	0		6. 00
	TOTALS		245, 456	0			-
1.00	C - CAFETERIA EXPENSE DI ETARY	10.00	1, 167, 583	1, 074, 840	0		1.00
1.00	TOTALS — — — —		1, 167, 583	1, 074, 840			1.00
	D - RESEARCH	•	, , , , , , , ,				
1.00	CARDI OLOGY	76. 00	252, 376	106, 859			1. 00
2.00	NURSI NG ADMI NI STRATI ON	13. 00	178, 817	0	0		2. 00
	TOTALS E - ADVERTISING NON-REIMBURSA	DI E	431, 193	106, 859			-
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7, 514	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	Ö	617, 471	0		2. 00
3.00	OPERATION OF PLANT	7. 00	0	272	0		3. 00
4.00	DI ETARY	10.00	0	6, 148	0		4. 00
5.00	NURSING ADMINISTRATION	13. 00	0	10, 240	0		5. 00
6. 00 7. 00	ADULTS & PEDIATRICS NEONATAL INTENSIVE CARE	30. 00 32. 01	0	17, 134 1, 744	0		6. 00 7. 00
8. 00	RADI OLOGY-DI AGNOSTI C	54. 00	o	5, 711	0		8. 00
9. 00	LABORATORY	60.00	o	668	0		9. 00
10.00	PHYSI CAL THERAPY	66. 00	О	280	0		10. 00
11. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	522	0		11. 00
12.00	CARDI OLOGY	76.00	0	6, 420	0		12.00
13. 00 14. 00	CLINIC HOME HEALTH AGENCY	90. 00 101. 00	0	3, 500 9, 050			13. 00 14. 00
14.00	TOTALS	101.00		686, 674			14.00
	F - RECLASS NURSERY	•	,				
1.00	ADULTS & PEDIATRICS	30.00	<u>1, 305, 5</u> 84	33 <u>4, 2</u> 18			1. 00
	TOTALS		1, 305, 584	334, 218			-
1.00	G - RECLASS PRECEPTOR TIME PHARMACY	15. 00	127, 973	0	0		1.00
1.00	TOTALS		127, 973	- - - - - - - - -			1.00
	H - LINEN RECLASS FOR OFFSITE						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	24, 694			1. 00
2.00		0. 00 0. 00	0	0	0		2.00
3. 00 4. 00		0.00	0	0	0		3. 00 4. 00
5. 00	HOUSEKEEPI NG	9. 00	o	28, 857	0		5. 00
6.00		0.00	О	0	0		6. 00
7.00		0.00	0	0	0		7. 00
8. 00	ADMINISTRATIVE & GENERAL	5. 00	0	10, 724	0		8. 00
9. 00 10. 00		0. 00 0. 00	0	0	0		9. 00 10. 00
11. 00	ADMINISTRATIVE & GENERAL	5. 00	o	56, 662	0		11. 00
12. 00	OPERATION OF PLANT	7. 00	o	158	0		12. 00
13.00	HOUSEKEEPI NG	9. 00	0	28, 924	0		13. 00
14. 00	DI ETARY	10.00	0	618	0		14. 00
15. 00	ADULTS & PEDIATRICS	30.00	0	366	0		15. 00
16. 00 17. 00	INTENSIVE CARE UNIT OPERATING ROOM	31. 00 50. 00	0	21, 582 1, 917	0		16. 00 17. 00
18. 00	PHYSICAL THERAPY	66.00	0	1, 917	0		18. 00
19. 00	CLINIC	90.00	o	562	0		19. 00
20.00	EMERGENCY	91.00	0	29	0		20. 00
	TOTALS			175, 157			_
1 00	I - RECLASS OFFSITE HOUSEK CO			100 100	-		1 00
1. 00 2. 00	HOUSEKEEPI NG	9. 00 0. 00	0	109, 400 0	0		1. 00 2. 00
3.00		0.00	0	0	0		3. 00
4. 00		0.00	0	0			4. 00
5. 00		0.00	Ö	0	o		5. 00
6.00		0. 00	O	0	0		6. 00
7.00		0.00	0	0	0		7. 00
8. 00 9. 00	ADMINISTRATIVE & GENERAL	0. 00 5. 00	0	0 14, 773	0		8. 00 9. 00
10. 00	A DENERAL	0.00	0	14, 773			10.00

Heal th Financial Systems COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10

RECLASSIFICATIONS Provider CCN: 15-0125 Period: From 07/01/2019 To 06/30/2020 Date/Time Prepared: Date/Time Prepared: 11/35 (2020 3:03 pm

						10	Date/IIIIe III	
							11/25/2020 3:	:02 pm
		Decreases						
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref			
	6. 00	7.00	8. 00	9. 00	10. 00			
11.00		0.00	0	()	0		11.00
12.00	L	0.00	0	()	o		12.00
	TOTALS		0	124, 173	3			
	J - COVID COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1, 147, 718	3	0		1.00
2.00		0.00	0	()	o		2. 00
	TOTALS		0	1, 147, 718	3]
500.00	Grand Total: Decreases		3, 277, 789	3, 975, 749	9			500.00

					To	06/30/2020	Date/Time Prep	
							11/25/2020 3:0	02 pm
				Acqui si ti ons	s			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2. 00	3. 00		4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	13, 736, 798	0		0	0	539, 936	1. 00
2.00	Land Improvements	1, 257, 038	395, 782		0	395, 782	.,	2.00
3.00	Buildings and Fixtures	387, 492, 049	9, 753, 231		0	9, 753, 231	2, 123, 500	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	147, 574, 739	9, 906, 751		0	9, 906, 751	4, 679, 684	6.00
7.00	HIT designated Assets	0	0		0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	550, 060, 624	20, 055, 764		0	20, 055, 764	7, 357, 970	8.00
9.00	Reconciling Items	o	0		0	0	ol	9. 00
10.00	Total (line 8 minus line 9)	550, 060, 624	20, 055, 764		0	20, 055, 764	7, 357, 970	10.00
		Endi ng Bal ance	Fully					
			Depreciáted					
			Assets					
		6.00	7. 00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES						
1.00	Land	13, 196, 862	0					1.00
2.00	Land Improvements	1, 637, 970	0					2.00
3.00	Buildings and Fixtures	395, 121, 780	0					3.00
4.00	Building Improvements	0	0					4. 00
5.00	Fi xed Equipment	o	0					5. 00
6. 00	Movable Equipment	152, 801, 806	0					6. 00
7. 00	HIT designated Assets	0	0					7. 00
8. 00	Subtotal (sum of lines 1-7)	562, 758, 418	0				ļ	8. 00
9. 00	Reconciling Items	0	0					9. 00
10.00	Total (line 8 minus line 9)	562, 758, 418	n					10. 00
10.00	Trotal (Trile 8 millus Trile 7)	1 332, 730, 410	O	I			ı	10.00

Heal th	Financial Systems	COMMUNI TY	HOSPI TAL		In Lieu of Form CMS-2552-10		
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO	CN: 15-0125	Peri od: From 07/01/2019	Worksheet A-7 Part II	
					To 06/30/2020		pared:
						11/25/2020 3:	02 pm
			SU	JMMARY OF CAF	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK						
1.00	CAP REL COSTS-BLDG & FIXT	13, 287, 060	1, 421, 360		0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	10, 820, 611	2, 411, 083		0 0	0	2.00
3.00	Total (sum of lines 1-2)	24, 107, 671	3, 832, 443		0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	14, 708, 420				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	13, 231, 694				2. 00
3. 00	Total (sum of lines 1-2)	o	27, 940, 114				3. 00

Heal th	n Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 07/01/2019 To 06/30/2020		
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
			Leases	(col . 1 - col 2)			
		1.00	2. 00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	409, 956, 612				0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	152, 801, 806		152, 801, 80			2. 00
3.00	Total (sum of lines 1-2)	562, 758, 418		562, 758, 41			3. 00
		ALLOCA	TION OF OTHER (CAPITAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART LLL DESCRIPTION OF CARLEY COOTS OF	6.00	7. 00	8. 00	9. 00	10.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CL CAP REL COSTS-BLDG & FIXT	ENTERS	1 0	1	0 12 405 (11	1 250 727	1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXI	0	0		0 13, 485, 611 0 12, 765, 738		1. 00 2. 00
3.00	Total (sum of lines 1-2)	0	0		0 12, 765, 738		2. 00 3. 00
3.00	Total (Sull of Titles 1-2)	0	l CI	I JMMARY OF CAPI		3, 070, 019	3.00
			30	DIVINIART OF CAPT	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	•		instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
		11.00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		1	1			
1.00	CAP REL COSTS-BLDG & FLXT	0	2,,,00,		0	, ,	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	26, 303		0	,	2.00
3.00	Total (sum of lines 1-2)	0	326, 110	1	0	30, 248, 278	3. 00

				To	o 06/30/2020		
				Expense Classification on	Worksheet A	11/25/2020 3:0	02 pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00	1. 00
1.00	COSTS-BLDG & FIXT (chapter 2)		U	CAP REL CUSTS-BLDG & FIXT	1.00		1.00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	o	3. 00
4. 00	(chapter 2)		0		0. 00	0	4. 00
4.00	Trade, quantity, and time discounts (chapter 8)		U		0.00		4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6.00	Rental of provider space by		0		0.00	o	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7. 00
7.00	stations excluded) (chapter		0		0.00		7.00
8. 00	21) Tel evi si on and radi o servi ce		0		0. 00	0	8. 00
0.00	(chapter 21)		0		0.00		0.00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -14, 280, 833		0. 00	0	9. 00 10. 00
10.00	adj ustment	A-0-2	- 14, 200, 633				10.00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization	A-8-1	-34, 292, 794			o	12. 00
13. 00	transactions (chapter 10) Laundry and Linen service		0		0. 00	0	13. 00
14. 00	Cafeteria-employees and guests		0		0.00		14. 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 patients						
17. 00	Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and		0		0. 00	0	18. 00
	abstracts		0				
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
	books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00		20. 00 21. 00
21.00	interest, finance or penalty		0		0.00	Ĭ	21.00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
22.00	overpayments and borrowings to		0		0.00	Ĭ	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
20.00	therapy costs in excess of		C		00.00		20.00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of						
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation						
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
07.00	COSTS-BLDG & FLXT		0	DAD DEL COCTO MUDI E EQUID	0.00		07.00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		U	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00	1	28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	0. 00 67. 00	1	29. 00 30. 00
	therapy costs in excess of						
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
31.00	pathology costs in excess of	M-0-3	0	cost center belieted	68.00		31.00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
JZ. UU	Depreciation and Interest				0.00		52.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 15-0125 Peri od: Worksheet A-8 From 07/01/2019

				To	06/30/2020		
				Expense Classification on	Worksheet A	11/25/2020 3:	02 pm
				To/From Which the Amount is			
		D 1 (0 1 (0)					
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
33. 00	OTHER ADJUSTMENTS (SPECIFY)	1.00	2.00		0.00	0.00	33. 00
	(3)						
35. 00	A&G OTHER INCOME	В	·	ADMINISTRATIVE & GENERAL	5. 00	0	
36. 00 36. 01	OFFSET ICU FEES OFFSET PHYSICIAN FEES	A A		INTENSIVE CARE UNIT ADMINISTRATIVE & GENERAL	31. 00 5. 00	0	36. 00 36. 01
36. 01	OFFSET PHYSICIAN FEES OCC	A	·	CLINIC	90.00	0	36. 02
	HEALTH					_	
36. 03	OFFSET LASER CLINIC FEES	A		CARDI OLOGY	76. 00	0	
36. 04	OFFSET ON CALL FEES	A		ADMINISTRATIVE & GENERAL	5.00	0	36. 04
36. 05 36. 06	OFFSET NP SALARIES WOUND OFFSET NP SALARIES NEURO IMCU	A A	-131, 177 -55, 729	ADULTS & PEDIATRICS	90. 00 30. 00	0	36. 05 36. 06
36. 07	OFFSET NP SALARIES WOUND ICU	A		INTENSIVE CARE UNIT	31. 00	0	36. 07
36. 08	OFFSET NP SALARIES WOUND	A		NEONATAL INTENSIVE CARE	32. 01	0	36. 08
0, 00	NEONATOLOGY		00.407				
36. 09 37. 00	OFFSET NP SALARIES WOUND A&G OFFSET MAMMO FEES	A A	·	ADMINISTRATIVE & GENERAL RADIOLOGY-DIAGNOSTIC	5. 00 54. 00	0	36. 09 37. 00
38. 00	OFFSET OTHER OP REV	В		RADI OLOGY-DI AGNOSTI C	54.00	0	38.00
40. 00	PHYSICIAN RENTAL-LAB	В		LABORATORY	60.00	0	
42.00	VARIOUS EH&W OFFSETS	В		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	42. 00
42. 01	EMPLOYEE CAFE REV	В	·	CAFETERI A	11.00	0	
42. 04	OFFSET NURS ADMIN OTHER	В	0	NURSING ADMINISTRATION	13. 00	0	42. 04
42. 05	OTHER INCOME ACUTE	В	-873	ADULTS & PEDIATRICS	30.00	0	42. 05
43. 00	OFFSET OTHER INCOME ICU	В		INTENSIVE CARE UNIT	31.00	Ö	43. 00
43. 02	OFFSET RESEARCH COSTS HEART	A		CARDI OLOGY	76.00	0	43. 02
	CTR			EMEDOENOV	04.00		
43. 07 43. 08	OTHER INCOME ER OTHER INCOME CARDIOLOGY	B B		EMERGENCY CARDI OLOGY	91. 00 76. 00	0	
43. 09	OFFSET OTHER INCOME HHA	В		HOME HEALTH AGENCY	101.00	0	
43. 10	OFFSET RESEARCH RELATED COSTS	A		NURSING ADMINISTRATION	13. 00	Ō	43. 10
	N	_	_			_	
44. 00	OTHER INCOME	В		DI ETARY	10.00	0	
45. 00 45. 01	OFFSET NEONATOLOGY FEES EMPLOYEE CAFETERIA REVENUE	A B		NEONATAL INTENSIVE CARE CAFETERIA	32. 01 11. 00	0	45. 00 45. 01
45. 02	OFFSET RELEASED TEMP REST OP	В		NEONATAL INTENSIVE CARE	32. 01	0	
	IN						
45. 03	OTHER INCOME DIETARY	В		CAFETERI A	11.00	0	
45. 04 45. 05	TELEPHONE SERVICE TELEPHONE SERVICE	A A		ADMINISTRATIVE & GENERAL EMPLOYEE BENEFITS DEPARTMENT	5. 00 4. 00	0	45. 04 45. 05
45. 06	TELEPHONE SERVICE	A		CAP REL COSTS-MVBLE EQUIP	2. 00	9	ı
45. 07	OTHER I NCOME	В		DI ETARY	10. 00	Ó	1
45. 08	TELEVISION SERVICE	A		OPERATION OF PLANT	7. 00	0	
45. 09	TELEVISION SERVICE	A		CAP REL COSTS-MVBLE EQUIP	2.00	9	
45. 21 45. 29	PARETN ASSET DEP AJE OFFSET RELEASED TEMP REST OP	A B	·	CAP REL COSTS-BLDG & FIXT ADMINISTRATIVE & GENERAL	1. 00 5. 00	9	
45. 29	IN	ا	-40, 100	ADMINISTRATIVE & GENERAL	5.00		40. 29
45. 30	OFFSET RELEASED TEMP REST OP	В	-71, 423	CARDI OLOGY	76. 00	0	45. 30
45	IN		=	DECDI DATODY TUESTE			45.5
45. 31	OFFSET RELEASED TEMP REST OP	В	-5, 395	RESPIRATORY THERAPY	65. 00	0	45. 31
45. 32	OFFSET RELEASED TEMP REST OP	В	-11, 000	EMERGENCY	91. 00	0	45. 32
	IN						
45. 33	NON-PT CARE RELATED EXPENSES	Α	·	ADMINISTRATIVE & GENERAL	5. 00	0	
45. 35	OFFSET RELEASED TEMP REST OP	В	-5, 129	RADI OLOGY-DI AGNOSTI C	54. 00	0	45. 35
45. 36	IN OFFSET RELEASED TEMP REST OP	В	Ω	PHARMACY	15. 00	0	45. 36
	IN RELEASED TERM REST OF		0		13.00		10.00
46. 00	OFFSET SURGERY INCOME	В		OPERATING ROOM	50.00	0	
47. 00	OFFSET CARDIAC REHAB CLASS	В	-39, 971	CARDIAC REHABILITATION	76. 97	0	47. 00
47. 01	INCO CLEANING SERVICES-SJ SV	A	-1∩ <i>4</i> 1Ω	ADMINISTRATIVE & GENERAL	5. 00	0	47. 01
47. 01	CLEANING SERVICES-SJ SV	A		HOUSEKEEPI NG	9. 00		47. 03
50.00	TOTAL (sum of lines 1 thru 49)	1	-51, 792, 331	1			50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)			ONC D 45 4			<u> </u>

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

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

Health Financial Systems		COMMUNI TY	HOSPI TAL	In Lie	eu of Form CMS-	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 07/01/2019 To 06/30/2020	Date/Time Pre 11/25/2020 3:	
			Expense Classification o	n Worksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1 00	2 00	3 00	4 00	5 00	

| 1.00 | 2.00 | Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 15-0125

Peri od: Worksheet A-8-1 From 07/01/2019 To 06/30/2020 Date/Time Prepared:

				06/30/2020	11/25/2020 3:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			'	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
1.00		ADMINISTRATIVE & GENERAL	ADMINISTRATIVE NONCAPITAL CO	16, 232, 796	55, 405, 674	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	BLDG DEPR	201, 223	o	2. 00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	EQ DEPR	1, 954, 361	O	3.00
3.01	5. 00	ADMINISTRATIVE & GENERAL	TELECOMMUNI CATI ONS	1, 315, 272	0	3. 01
3.02	16. 00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	5, 245, 619	0	3. 02
3.03	5. 00	ADMINISTRATIVE & GENERAL	PATIENT ACCTING	6, 722, 179	0	3. 03
3.04	4.00	EMPLOYEE BENEFITS DEPARTMENT	ALLOCATED BENEFIT COSTS	2, 903, 179	0	3. 04
3.05	5. 00	ADMINISTRATIVE & GENERAL	ALLOCATED SALARY COSTS	14, 362, 057	0	3. 05
3.06	13. 00	NURSING ADMINISTRATION	CANCER REGISTRY	289, 254	0	3.06
3.07	1.00	CAP REL COSTS-BLDG & FIXT	CDC LEASE DEPRECIATION	61, 188	261, 720	3. 07
3.08	5. 00	ADMINISTRATIVE & GENERAL	CDC LEASE EXPENSES	29	0	3. 08
3.09	7. 00	OPERATION OF PLANT	CDC LEASE EXPENSES	7	0	3. 09
3. 10	9. 00	HOUSEKEEPI NG	CDC LEASE EXPENSES	1	0	3. 10
3. 11	54.00	RADI OLOGY-DI AGNOSTI C	CDC LEASE EXPENSES	39	0	3. 11
3. 12	60.00	LABORATORY	CDC LEASE EXPENSES	4	0	3. 12
3. 13	76.00	CARDI OLOGY	CDC LEASE EXPENSES	1	0	3. 13
3.14	192. 00	PHYSICIANS' PRIVATE OFFICES	CDC LEASE EXPENSES	8	0	3. 14
3. 15	5. 00	ADMINISTRATIVE & GENERAL	PHYSICIAN ALLOCATION	0	28, 121, 257	3. 15
3. 16		CAP REL COSTS-BLDG & FIXT	901 RIDGE RD LEASE	178, 713	96, 711	3. 16
3. 18	101.00	HOME HEALTH AGENCY	901 RIDGE RD EXPENSES	112, 773	0	3. 18
3. 21	1.00	CAP REL COSTS-BLDG & FIXT	800 MACARTHUR LEASE	31, 046	74, 140	3. 21
3. 22	5. 00	ADMINISTRATIVE & GENERAL	800 MACARTHUR LEASE EXP	56, 959	0	3. 22
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			49, 666, 708	83, 959, 502	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.

1103 1101	ids not been posted to worksheet A, cordinas i ana/or 2, the amount arrowable should be mareated in cordinar 4 or this part.								
				Related Organization(s) and/or Home Office					
	Symbol (1)	Name	Percentage of	Name	Percentage of				
			Ownershi p		Ownershi p				
	1. 00	2. 00	3.00	4. 00	5. 00				
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:						

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

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

To mode como te tro ATTTT							
6.00	В	0.00 CFNI 100.00	6. 00				
7.00		0.00	7. 00				
8.00		0.00	8. 00				
9.00		0.00	9. 00				
10.00		0.00	10. 00				
100.00	G. Other (financial or		100.00				
	non-financial) specify:						

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

			To 06/30/2020	Date/Time Prepared: 11/25/2020 3:02 pm
	Net	Wkst. A-7 Ref.		11, 20, 2020 0. 02 p
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
			ENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR	CLAIMED
	HOME OFFICE CO			
1.00	-39, 172, 878			1. 00
2.00	201, 223			2. 00
3.00	1, 954, 361			3.00
3. 01	1, 315, 272			3. 01
3.02	5, 245, 619			3. 02
3.03	6, 722, 179			3. 03
3.04	2, 903, 179			3. 04
3.05	14, 362, 057	1		3. 05
3.06	289, 254			3.06
3.07	-200, 532			3. 07
3.08	29	0		3. 08
3.09	7	0		3. 09
3. 10	1	0		3. 10
3. 11	39	0		3. 11
3. 12	4	0		3. 12
3. 13	1	0		3. 13
3. 14	8			3. 14
3. 15	-28, 121, 257			3. 15
3. 16	82, 002			3. 16
3. 18	112, 773			3. 18
3. 21	-43, 094			3. 21
3. 22	56, 959	1		3. 22
4.00	0			4.00
5.00	-34, 292, 794			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.

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

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

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

6.00	HEALTHCARE	6. 00
7.00		7.00
8.00		8.00
8. 00 9. 00		9.00
10.00		10.00
10. 00 100. 00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- 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.

Peri od: Worksheet A-8-2 From 07/01/2019 Date/Ti me Prepared: 11/25/2020 3:02 pm

							11/25/2020 3:	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	5. 00	AGGREGATE-ADMINISTRATIVE &	297, 773	133, 866	163, 907	211, 500	1, 526	1. 00
2. 00 3. 00		GENERAL AGGREGATE-PHARMACY AGGREGATE-ADULTS &	8, 094 121, 195		8, 094 121, 195	211, 500 211, 500	1	1
4. 00	31.00	PEDIATRICS AGGREGATE-INTENSIVE CARE	55, 708		55, 708	211, 500	371	4. 00
5. 00	32. 01	UNIT AGGREGATE-NEONATAL INTENSIVE	59, 773	30, 000	29, 773	211, 500	200	5. 00
6. 00 7. 00	1	CARE AGGREGATE-OPERATING ROOM AGGREGATE-OPERATING ROOM	75, 638 13, 892, 181		75, 638 0	246, 400 0	433 0	1
8.00		AGGREGATE DELIVERY ROOM &	16, 675		16, 675	211, 500		
9. 00 10. 00		AGGREGATE-RADI OLOGY-DI AGNOST I C AGGREGATE-LABORATORY	41, 350		41, 350	271, 900		
11. 00	65. 00	AGGREGATE-RESPI RATORY THERAPY	78, 550 31, 104		78, 550 31, 104	260, 300 211, 500	1	1
12. 00		AGGREGATE-ELECTROENCEPHALOGR	33, 758		33, 758			
13. 00 14. 00		AGGREGATE-CARDI OLOGY AGGREGATE-CLI NI C	27, 618 43, 427		27, 618 43, 427	211, 500 211, 500		1
15. 00	1	AGGREGATE-CLINIC	34, 727		34, 727	211, 500	1	1
200.00	1711.00	1.001.207.1.2 1.2027.1.101.	14, 817, 571	14, 056, 047		l	1	200.00
	Wkst. A Line #	J	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE Limit	Memberships & Continuing	Component Share of col.	of Malpractice Insurance	
				LIIIII	Education	12	Trisui ance	
	1. 00	2.00	8. 00	9. 00	12. 00	13.00	14.00	
1. 00		AGGREGATE-ADMINISTRATIVE & GENERAL	155, 168			0	_	
2. 00 3. 00	1	AGGREGATE-PHARMACY AGGREGATE-ADULTS &	6, 609 56, 841			0	0	
3.00		PEDI ATRI CS	30,041	2,042		Ĭ		3.00
4. 00		AGGREGATE-INTENSIVE CARE	37, 724			0	_	
5. 00		AGGREGATE - NEONATAL INTENSIVE	20, 337			0		
6. 00 7. 00 8. 00	50.00	AGGREGATE-OPERATING ROOM AGGREGATE-OPERATING ROOM AGGREGATE-DELIVERY ROOM &	51, 294 0 11, 287	0	0	0		7. 00
9. 00		LABOR ROOM AGGREGATE-RADI OLOGY-DI AGNOST	24, 445			0	_	
10.00		I C AGGREGATE - LABORATORY	49, 182			0	_	1
11. 00 12. 00		AGGREGATE-RESPI RATORY THERAPY AGGREGATE-ELECTROENCEPHALOGR	29, 285 31, 115			0	0	
13. 00		APHY AGGREGATE-CARDI OLOGY	14, 846			0		
14. 00		AGGREGATE-CLI NI C	27, 048			0	Ō	1
15. 00	191.00	AGGREGATE-RESEARCH	21, 557			0	0	
200.00	Wkst. A Line #	Cost Center/Physician	536, 738 Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
		I denti fi er	Component Share of col.	Li mi t	Di sal I owance	, , ag ag tg., t		
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1.00		AGGREGATE-ADMINISTRATIVE & GENERAL	C			142, 605		1. 00
2.00 3.00		AGGREGATE-PHARMACY AGGREGATE-ADULTS &	0			1, 485 64, 354		2. 00 3. 00
4. 00	31.00	PEDIATRICS AGGREGATE-INTENSIVE CARE	C			17, 984		4. 00
5. 00	32. 01	UNIT AGGREGATE-NEONATAL INTENSIVE	О	20, 337	9, 436	39, 436		5. 00
6. 00	50.00	CARE AGGREGATE-OPERATING ROOM	O	51, 294	24, 344	24, 344		6. 00
7.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	13, 892, 181		7. 00
8.00		AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	,				8. 00
9. 00		AGGREGATE-RADI OLOGY-DI AGNOST	0	, , , , ,				9. 00
10. 00	[60.00	AGGREGATE-LABORATORY	0	49, 182	29, 368	29, 368	il 	10. 00

Health Financial Syste	ns	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-	-2552-10
PROVI DER BASED PHYSI CI	AN ADJUSTMENT		Provi der (Peri od: From 07/01/2019	Worksheet A-8	8-2
						Date/Time Pro	
Wkst. A Line #	Cost Center/Physician	Provider Component	Adjusted RCE	RCE Di sal I owance	Adj ustment		

							11/25/2020 3:	02 pm
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
11. 00	65. 00	AGGREGATE-RESPI RATORY	0	29, 285	1, 819	1, 819		11. 00
		THERAPY						
12.00	70.00	AGGREGATE-ELECTROENCEPHALOGR	0	31, 115	2, 643	2, 643		12.00
		APHY						
13.00	76. 00	AGGREGATE-CARDI OLOGY	0	14, 846	12, 772	12, 772		13.00
14.00	90.00	AGGREGATE-CLINIC	0	27, 048	16, 379	16, 379		14.00
15.00	191.00	AGGREGATE-RESEARCH	0	21, 557	13, 170	13, 170		15. 00
200.00			0	536, 738	224, 786	14, 280, 833		200. 00

Health Financial Systems COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0125 Peri od: Worksheet B From 07/01/2019 Part I Date/Time Prepared: 06/30/2020 11/25/2020 3:02 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 15, 045, 154 1 00 00100 CAP REL COSTS-BLDG & FLXT 15, 045, 154 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 15, 203, 124 15, 203, 124 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 25, 329, 047 65, 260 25, 400, 933 4.00 6,626 00500 ADMINISTRATIVE & GENERAL 5 00 65, 239, 669 1, 237, 013 534, 560 2, 532, 481 69, 543, 723 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 16, 165, 257 2, 319, 344 520, 208 838, 384 19, 843, 193 7.00 00800 LAUNDRY & LINEN SERVICE 1, 710, 928 25, 549 20,500 1, 756, 977 8.00 8.00 00900 HOUSEKEEPI NG 4, 743, 523 5, 371, 226 9 00 62, 192 31, 292 534, 219 9 00 10.00 01000 DI ETARY 4, 209, 428 188, 095 100, 419 401, 429 4, 899, 371 10.00 01100 CAFETERI A 178, 948 2, 195, 641 11.00 1,824,079 192, 614 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 0 01300 NURSING ADMINISTRATION 4, 974, 054 13.00 47,884 164, 572 560, 126 5, 746, 636 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 19, 798, 537 20, 957, 859 15.00 83, 532 462, 473 613, 317 15.00 5, 250, 572 01600 MEDICAL RECORDS & LIBRARY 89, 275 5, 340, 284 16, 00 16,00 437 17 00 01700 SOCIAL SERVICE 932.096 17, 392 0 126, 533 1,076,021 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 Ω 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 22.00 0 0 02300 PARAMED ED PRGM-(PHARMACY) 0 399, 109 23.00 345, 120 3,720 50, 269 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 44, 646, 441 2, 905, 554 633, 717 5, 441, 493 53, 627, 205 30.00 31.00 03100 INTENSIVE CARE UNIT 12, 937, 420 617, 993 503, 526 1, 775, 308 15, 834, 247 31.00 32.01 02060 NEONATAL INTENSIVE CARE 3, 559, 507 181, 275 163, 964 477, 599 4, 382, 345 32.01 04100 SUBPROVIDER - IRF 41.00 3, 623, 960 202, 762 27, 297 370, 773 4, 224, 792 41.00 43.00 04300 NURSERY 1, 651, 479 28, 926 201, 889 1, 882, 294 43.00 ANCILLARY SERVICE COST CENTERS 39, 956, 636 05000 OPERATING ROOM 32, 022, 839 1, 610, 836 2, 649, 544 50.00 3, 673, 417 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 904, 982 252, 539 123, 662 364, 137 3, 645, 320 52.00 05400 RADI OLOGY-DI AGNOSTI C 22, 017, 402 15, 934, 143 673, 773 4.089.818 1, 319, 668 54 00 54 00 60.00 06000 LABORATORY 15, 982, 086 292, 282 708, 222 982, 241 17, 964, 831 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 2, 552, 718 24, 423 29, 362 56, 867 2, 663, 370 62.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 06500 RESPIRATORY THERAPY 4, 944, 663 59,044 97,606 577. 537 5, 678, 850 65.00 65.00 66.00 66.00 06600 PHYSI CAL THERAPY 11, 137, 155 643, 085 139, 361 1, 140, 561 13, 060, 162 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 044, 098 43, 871 80, 450 113, 428 1, 281, 847 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 23, 789, 662 71 00 C 0 O 23, 789, 662 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 32, 025, 703 C 0 0 32, 025, 703 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 03140 CARDI OLOGY 76.00 13, 144, 919 666, 497 2, 249, 620 1, 245, 801 17, 306, 837 76.00 07697 CARDIAC REHABILITATION 76 97 76 97 975, 407 29, 855 135, 618 1, 214, 558 73,678 76. 98 07698 HYPERBARI C OXYGEN THERAPY C 0 76.98 07699 LI THOTRI PSY 76. 99 76.99 0 OUTPATIENT SERVICE COST CENTERS 90 00 21, 174 90 00 09000 CLI NI C 2, 926, 360 122 884 355 659 3, 426, 077 91.00 09100 EMERGENCY 9, 790, 521 407, 416 184, 478 1, 105, 703 11, 488, 118 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 5, 497, 488 216 6, 174, 232 101. 00 0 676, 528 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 421, 862, 139 13, 138, 708 14, 576, 332 24, 846, 560 418, 774, 528 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19, 708 19, 708 190. 00 1, 073, 236 130, 720 191. 00 19100 RESEARCH 2, 127 1, 212, 560 191. 00 6, 477 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 1, 063, 201 2, 089 1, 969, 462 192. 00 904, 172 0 194. 00 07950 ADVERTI SI NG 686, 674 194. 00 686, 674 194. 01 07951 FITNESS POINTE 2,054,843 754, 646 61, 344 187, 080 3, 057, 913 194. 01 194. 02 07952 FI TNESS POINTE SPA/PRO SHOP/DI ETARY 422, 517 194. 02 355, 631 24, 179 5, 489 37, 218 14, 178, 333 194. 03 194. 03 07953 RETAIL PHARMACY 13, 975, 844 28, 959 134, 109 39, 421 194. 04 07954 HOSPI CE 115, 232 \cap 0 115, 232 194. 04 194. 05 07955 RUSH RESIDENTS 0 194. 05 9, 871 194.06 07956 EINSTEIN BAGELS 216, 655 6,613 15, 179 248, 318 194. 06 1, 192, 476 194. 07 194. 07 07957 NORTHWESTERN I MAGI NG 589, 498 43, 202 509, 709 50,067 200.00 Cross Foot Adjustments 0 200. 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 441, 877, 721 15, 045, 154 15, 203, 124 25, 400, 933 441, 877, 721 202. 00

Provider CCN: 15-0125

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 07/01/2019 | Part I | To 06/30/2020 | Date/Time Prepared: | 11/25/2020 3: 02 pm

						11/25/2020 3:	02 pm
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	Т			1		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	69, 543, 723					5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	C)			6. 00
7.00	00700 OPERATION OF PLANT	3, 706, 272	C				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	328, 165	C	52, 669			8. 00
9.00	00900 HOUSEKEEPI NG	1, 003, 227	C	128, 209		6, 502, 662	9. 00
10.00	01000 DI ETARY	915, 095	C	387, 754		3, 319	10.00
11. 00	01100 CAFETERI A	410, 097	C	397, 071	0	8, 012	•
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	C	0	0	0	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 073, 345	C	98, 713		1, 908	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	C	0	9	0	14. 00
15. 00	01500 PHARMACY	3, 914, 467	C	172, 201		6, 028	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	997, 448	C	184, 040		3, 815	1
17. 00	01700 SOCIAL SERVICE	200, 977	C	35, 853	0	2, 861	
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	C	0	0	0	19. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	C	0	0	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	C	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(PHARMACY)	74, 545	C	7, 668	0	267	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			_			
30. 00	03000 ADULTS & PEDIATRICS	10, 016, 303	C	-, ,			30. 00
31. 00	03100 INTENSIVE CARE UNIT	2, 957, 489	C	1 ., 2, 0, ,00		326, 704	31. 00
32. 01	02060 NEONATAL INTENSIVE CARE	818, 526	C	0,0,0,0		77, 775	32. 01
41. 00	04100 SUBPROVI DER – I RF	789, 098	C	417, 990		250, 322	41. 00
43.00	04300 NURSERY	351, 571	C	59, 631	62, 665	15, 528	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	7, 463, 021	C	1 -,,		1, 418, 566	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	680, 866	C	1,	•	259, 459	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 112, 366	C	1, 388, 974		214, 248	54.00
60. 00	06000 LABORATORY	3, 355, 435	C	602, 535		125, 523	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	497, 459	C	50, 349	0	0	62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C) C	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	1, 060, 684	C	121, 718	0	13, 735	65. 00
66.00	06600 PHYSI CAL THERAPY	2, 439, 351	C	1, 325, 711	37, 183	107, 477	66. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	239, 421	C	90, 439	19, 107	19, 458	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 443, 385	C	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 981, 697	C	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C	0	0	0	73. 00
76.00	03140 CARDI OLOGY	3, 232, 536	C	1, 373, 974	194, 372	218, 254	76. 00
76. 97	07697 CARDIAC REHABILITATION	226, 853	C	151, 886	3, 220	23, 273	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	C	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	C	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	639, 916	C	253, 323	26, 213	46, 375	90.00
91.00	09100 EMERGENCY	2, 145, 728	C	839, 882	141, 303	786, 104	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1, 153, 211	C	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	65, 228, 554	C	19, 619, 351	2, 137, 811	6, 397, 360	118. 00
	NONREI MBURSABLE COST CENTERS			•			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 681	C	40, 629	0	0	190. 00
191.00	19100 RESEARCH	226, 480	C	13, 352	. 0	0	191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	367, 852	C			103, 013	192. 00
194.00	07950 ADVERTI SI NG	128, 256	C		0	0	194. 00
194.01	07951 FITNESS POINTE	571, 151	C	1, 555, 693	0	0	194. 01
	07952 FITNESS POINTE SPA/PRO SHOP/DIETARY	78, 917	C	49, 844			194. 02
194.03	07953 RETAIL PHARMACY	2, 648, 201	C	59, 699		2, 289	194. 03
	1 07954 H0SPI CE	21, 523	C	237, 550			194. 04
	07955 RUSH RESI DENTS	0	r				194. 05
	07956 EINSTEIN BAGELS	46, 380	ľ	20, 348			194. 06
	7 07957 NORTHWESTERN I MAGING	222, 728	r	89, 060			194. 07
200.00]			200. 00
201.00	, ,	0	C		n	n	201. 00
202.00		69, 543, 723			_		
_500	1.1 (1 1				2, .57, 511	3,002,002	,

Provider CCN: 15-0125

				10 06/30/2020	11/25/2020 3:	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF		CENTRAL	
			PERSONNEL	ADMI NI STRATI ON	SERVI CES & SUPPLY	
	10.00	11. 00	12. 00	13.00	14.00	
GENERAL SERVICE COST CENTERS				T		1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	6, 209, 403					10. 00
11. 00 01100 CAFETERI A	0	3, 010, 821				11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL	0	(1.704		-		12.00
13. 00 O1300 NURSI NG ADMINI STRATI ON 14. 00 O1400 CENTRAL SERVI CES & SUPPLY	O O	61, 784	(6, 982, 386	0	13. 00 14. 00
15. 00 01500 PHARMACY	0	76, 075			0	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	70, 075			0	16. 00
17. 00 01700 SOCIAL SERVICE	o	21, 659	Ì		0	17. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	o	0	(ol ol	0	19. 00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	O	0			0	21. 00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	(0	0	22. 00
23.00 O2300 PARAMED ED PRGM-(PHARMACY)	0	8, 098	(0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 189, 824	858, 432		3, 034, 393	0	30. 00
31. 00 03100 INTENSI VE CARE UNI T	438, 485	223, 048		7007 101	0	31.00
32. 01 02060 NEONATAL INTENSIVE CARE	477 254	60, 593		,	0	32. 01
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	477, 256 0	65, 928 29, 137		233, 045 102, 995	0	41. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	29, 137		102, 995	0	43.00
50. 00 05000 OPERATI NG ROOM	0	453, 273	(1, 602, 241	0	50. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	103, 838	52, 130		184, 267	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	187, 940		0 0	0	54.00
60. 00 06000 LABORATORY	0	177, 921	1	o	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	7, 892	(0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0	80, 727	(0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	154, 801	(0	0	66. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	19, 610	(0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	O O	0			0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	O O	0	(0	72. 00 73. 00
76. 00 03140 CARDI OLOGY	0	177, 000			0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	18, 451			0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	o	0			0	76. 98
76. 99 07699 LI THOTRI PSY	O	0			0	76. 99
OUTPATIENT SERVICE COST CENTERS						l
90. 00 09000 CLI NI C	0	47, 779		168, 881	0	90. 00
91. 00 09100 EMERGENCY	0	185, 003	(653, 948	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS		-		ما ما		
101. 00 10100 HOME HEALTH AGENCY	0	0		0	0	101. 00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 209, 403	2, 967, 281	· · · · · · · · · · · · · · · · · · ·	6, 982, 386	0	118. 00
NONREI MBURSABLE COST CENTERS	0, 209, 403	2, 907, 201		0, 902, 300	0	116.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	ol	0		ol ol	0	190. 00
191. 00 19100 RESEARCH	o	18, 896				191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	Ö	0		ol ol		192. 00
194. 00 07950 ADVERTI SI NG	o	0		o o	0	194. 00
194. 01 07951 FI TNESS POINTE	О	0	(o		194. 01
194. 02 07952 FITNESS POINTE SPA/PRO SHOP/DIETARY	0	0	(0	0	194. 02
194. 03 07953 RETAIL PHARMACY	O	19, 150	(이		194. 03
194. 04 07954 HOSPI CE	0	0		이		194. 04
194. 05 07955 RUSH RESI DENTS	0	0	(194. 05
194. 06 07956 EI NSTEI N BAGELS	O	5, 494]			194. 06
194.07 07957 NORTHWESTERN I MAGING 200.00 Cross Foot Adjustments	O	O	'		0	194. 07 200. 00
201.00 Negative Cost Centers		0		اه اد	Ω	200.00
202.00 TOTAL (sum lines 118 through 201)	6, 209, 403	3, 010, 821		6, 982, 386		202.00
	-, -0, , .00	-, -, 0, 021	`	-, /52, 500	O	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0125

			1	0 06/30/2020	Date/IIme Prep 11/25/2020 3:0	
					INTERNS &) <u> </u>
					RESI DENTS	
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	SERVI CES-SALAR	
		RECORDS &		ANESTHETI STS	Y & FRINGES	
		LI BRARY			APPRV	
	15. 00	16.00	17. 00	19. 00	21. 00	
GENERAL SERVICE COST CENTERS	T		T			
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11. 00
12.00 01200 MAINTENANCE OF PERSONNEL						12. 00
13. 00 01300 NURSING ADMINISTRATION						13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 01500 PHARMACY	25, 126, 630					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	6, 525, 587	1			16. 00
17. 00 01700 SOCIAL SERVICE	0	0	1, 337, 371			17. 00
19.00 O1900 NONPHYSICIAN ANESTHETISTS	0	0	0	0		19. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0		0	21. 00
22.00 02200 1 &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22. 00
23. 00 O2300 PARAMED ED PRGM-(PHARMACY)	0	0	0			23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	545, 313	1		0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	104, 976	1		0	31. 00
32. 01 02060 NEONATAL NTENSI VE CARE	0	102, 856			0	32. 01
41. 00 04100 SUBPROVI DER - I RF	0	35, 386	1		-	41. 00
43. 00 04300 NURSERY	0	20, 421	43, 721	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	1, 115, 418		0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	37, 217	1	0		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 137, 394	0	0	0	54.00
60. 00 06000 LABORATORY	0	728, 277	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	41, 774	0	0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0	117, 233	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	172, 763	0	0	0	66.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	53, 387	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	186, 911	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	282, 042	0	0	0	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	25, 126, 630	505, 134	0	0	0	73.00
76. 00 03140 CARDI OLOGY	0	701, 253	0	0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	0	9, 713	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	48, 298			0	90.00
91. 00 09100 EMERGENCY	0	547, 801	18, 923	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	32, 020	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS				1		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	25, 126, 630	6, 525, 587	1, 337, 371	0	0	118. 00
NONREI MBURSABLE COST CENTERS				ı		
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 ADVERTI SI NG	0	0	0	0		194. 00
194. 01 07951 FI TNESS POINTE	0	0	0	0		194. 01
194. 02 07952 FITNESS POINTE SPA/PRO SHOP/DIETARY	0	0	0	0		194. 02
194.03 07953 RETAIL PHARMACY	0	0	0	0		194. 03
194. 04 07954 HOSPI CE	0	0	0	0		194. 04
194. 05 07955 RUSH RESI DENTS	0	0	0	0		194. 05
194. 06 07956 EINSTEIN BAGELS	0	0	0	0		194. 06
194. 07 07957 NORTHWESTERN I MAGI NG	0	0	0	0		194. 07
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	25, 126, 630	6, 525, 587	1, 337, 371	0	0	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0125 Peri od: Worksheet B From 07/01/2019 Part I Date/Time Prepared: 06/30/2020 11/25/2020 3:02 pm INTERNS & **RESI DENTS** SERVI CES-OTHER PARAMED ED Subtotal Intern & Total Cost Center Description PRGM COSTS PRGM-(PHARMACY Residents Cost **APPRV** & Post Stepdown Adjustments 22.00 23.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16,00 17 00 01700 SOCIAL SERVICE 17 00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 0 23.00 02300 PARAMED ED PRGM-(PHARMACY) 489, 687 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 83, 487, 115 83, 487, 115 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 22, 240, 995 0 22, 240, 995 31.00 32.01 02060 NEONATAL INTENSIVE CARE 0 0 6, 093, 054 0 6, 093, 054 32.01 04100 SUBPROVIDER - IRF 0 0 41.00 6, 752, 109 6, 752, 109 41.00 43.00 04300 NURSERY 0 2, 567, 963 2, 567, 963 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 55, 606, 381 55, 606, 381 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 5, 576, 101 0 5, 576, 101 52.00 05400 RADI OLOGY-DI AGNOSTI C 29, 241, 489 29, 241, 489 54 00 54 00 60.00 06000 LABORATORY 22, 954, 522 22, 954, 522 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 00000000 3, 260, 844 0 3, 260, 844 62.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 7, 072, 947 06500 RESPIRATORY THERAPY 7, 072, 947 65.00 65.00 66.00 0 66.00 06600 PHYSI CAL THERAPY 17, 297, 448 17, 297, 448 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 723, 269 0 0 0 1, 723, 269 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 Ω 28 419 958 28, 419, 958 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 38, 289, 442 72.00 C 38, 289, 442 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 489, 687 26, 121, 451 26, 121, 451 73.00 76.00 03140 CARDI OLOGY 0 0 0 0 23, 204, 226 23, 204, 226 76.00 07697 CARDIAC REHABILITATION 76 97 1, 647, 954 76 97 1, 647, 954 Ω 07698 HYPERBARIC OXYGEN THERAPY 76. 98 0 C 0 0 76.98 07699 LI THOTRI PSY 76. 99 76.99 0 0 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 4, 656, 862 0 4, 656, 862 90 00 91.00 09100 EMERGENCY 0 C 16, 806, 810 0 16, 806, 810 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 7, 359, 463 0 7, 359, 463 101. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 489, 687 410, 380, 403 0 410, 380, 403 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 64, 018 64, 018 190. 00 191. 00 19100 RESEARCH 0 1, 471, 288 0 1, 471, 288 191. 00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0000000000 4, 304, 266 192. 00 0 4, 304, 266 194. 00 07950 ADVERTI SI NG 814, 930 194. 00 814, 930 194. 01 07951 FITNESS POINTE 5, 184, 757 5, 184, 757 194. 01 0 0 0 194. 02 07952 FI TNESS POINTE SPA/PRO SHOP/DI ETARY 551, 278 194. 02 551, 278 194. 03 07953 RETAIL PHARMACY 16, 907, 672 16, 907, 672 194. 03 194. 04 07954 HOSPI CE Ω 374, 305 374, 305 194. 04 194. 05 07955 RUSH RESIDENTS 0 194. 05 194.06 07956 EINSTEIN BAGELS 0 320, 540 0 0 320, 540 194. 06 194.07 07957 NORTHWESTERN I MAGING 1, 504, 264 194. 07 0 1, 504, 264 200.00 Cross Foot Adjustments Ω \cap 0 200. 00 201.00 Negative Cost Centers 0 0 201, 00 TOTAL (sum lines 118 through 201) 489, 687 441, 877, 721 441, 877, 721 202. 00 202.00

| Peri od: | Worksheet B | From 07/01/2019 | Part II | To 06/30/2020 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0125

					То	06/30/2020	Date/Time Pre 11/25/2020 3:	
				CAPI TAL REI	ATED COSTS		1172372020 3.	JZ piii
		Cook Cooks Doors at the	D:+1	DIDC & FLVT	MANDLE FOLLID	C	EMDL OVEE	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs					
	CENED	AL SERVICE COST CENTERS	0	1. 00	2.00	2A	4. 00	
1. 00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	0	65, 260		71, 886 1, 771, 573	71, 886 7, 171	4. 00
5. 00 6. 00		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	0	1, 237, 013 0	1	1, 771, 573	7, 171	5. 00 6. 00
7. 00		OPERATION OF PLANT	0	2, 319, 344	520, 208	2, 839, 552	2, 374	7. 00
8.00	1	LAUNDRY & LINEN SERVICE	0	25, 549		25, 549	58	8. 00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	0	62, 192 188, 095	·	93, 484 288, 514	1, 513 1, 137	9. 00 10. 00
11. 00	1	CAFETERI A		192, 614		192, 614	507	11. 00
12.00	01200	MAINTENANCE OF PERSONNEL	o	0		o	0	12. 00
13.00	1	NURSI NG ADMI NI STRATI ON	0	47, 884	164, 572	212, 456	1, 586	13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	83, 532	462, 473	546, 005	0 1, 737	14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	l o	89, 275	· ·	89, 712	0	16. 00
17. 00		SOCIAL SERVICE	O	17, 392	0	17, 392	358	17. 00
19.00		NONPHYSICIAN ANESTHETISTS I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	19. 00
21. 00 22. 00	1	I&R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	21. 00 22. 00
23. 00	02300	PARAMED ED PRGM-(PHARMACY)	0	3, 720	0	3, 720	142	23. 00
		ENT ROUTINE SERVICE COST CENTERS	I al	0.005.554	(00.747	0 500 074	15.0/5	
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	0	2, 905, 554 617, 993		3, 539, 271 1, 121, 519	15, 367 5, 027	30. 00 31. 00
32. 01		NEONATAL INTENSIVE CARE	Ö	181, 275		345, 239	1, 352	
41. 00		SUBPROVI DER - I RF	0	202, 762		230, 059	1, 050	
43. 00		NURSERY LARY SERVICE COST CENTERS] 0	28, 926	0	28, 926	572	43. 00
50. 00		OPERATING ROOM	O	1, 610, 836	3, 673, 417	5, 284, 253	7, 503	50. 00
52. 00		DELIVERY ROOM & LABOR ROOM	O	252, 539		376, 201	1, 031	
54. 00 60. 00		RADI OLOGY-DI AGNOSTI C LABORATORY	0	673, 773 292, 282		4, 763, 591 1, 000, 504	3, 737 2, 781	54. 00 60. 00
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELL	0	24, 423		53, 785	161	62. 00
62. 30	1	BLOOD CLOTTING FOR HEMOPHILIACS	o	0	1	О	0	62. 30
65. 00	1	RESPI RATORY THERAPY	0	59, 044	·	156, 650	1, 635	65. 00
66. 00 70. 00		PHYSI CAL THERAPY ELECTROENCEPHALOGRAPHY	0	643, 085 43, 871		782, 446 124, 321	3, 230 321	66. 00 70. 00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0	0	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00 76. 00		DRUGS CHARGED TO PATIENTS CARDIOLOGY	0	666, 497	2, 249, 620	2, 916, 117	0 3, 528	73. 00 76. 00
		CARDI AC REHABI LI TATI ON	Ö	73, 678		103, 533	384	76. 97
		HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99		LITHOTRIPSY TIENT SERVICE COST CENTERS	0	0	0	0	0	76. 99
90. 00		CLINIC	0	122, 884	21, 174	144, 058	1, 007	90. 00
		EMERGENCY	0	407, 416	184, 478	591, 894	3, 131	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS				0		92. 00
101.00		HOME HEALTH AGENCY	0	0	216	216	1, 916	101. 00
		AL PURPOSE COST CENTERS						
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	0	13, 138, 708	14, 576, 332	27, 715, 040	70, 316	118. 00
190. 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19, 708	0	19, 708	0	190. 00
191.00	19100	RESEARCH	O	6, 477		8, 604		191. 00
		PHYSICIANS' PRIVATE OFFICES ADVERTISING	0	904, 172 0		906, 261 0		192. 00 194. 00
		FITNESS POINTE	0	754, 646	1	815, 990		194. 00
		FITNESS POINTE SPA/PRO SHOP/DIETARY	0	24, 179		29, 668		194. 02
		RETAIL PHARMACY	0	28, 959		68, 380		194. 03
		HOSPI CE RUSH RESI DENTS		115, 232 0		115, 232 0		194. 04 194. 05
194. 06	07956	EINSTEIN BAGELS		9, 871	-	16, 484	43	194. 06
		NORTHWESTERN I MAGING	0	43, 202	509, 709	552, 911	142	194. 07
200. 00 201. 00	1	Cross Foot Adjustments Negative Cost Centers		0	o	0	Ω	200. 00 201. 00
202.00		TOTAL (sum lines 118 through 201)	o	_	-	30, 248, 278	71, 886	
					·			

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0125

Peri od: Worksheet B From 07/01/2019 Part II To 06/30/2020 Date/Time Prepared:

11/25/2020 3:02 pm Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL REPAI RS **PLANT** LINEN SERVICE 9.00 5.00 6.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 1, 778, 744 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 94, 791 2, 936, 717 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8, 393 0 6. 568 40.568 8.00 136, 643 00900 HOUSEKEEPI NG 15, 988 9.00 25, 658 9 00 10.00 01000 DI ETARY 23, 404 48, 355 73 70 10.00 11.00 01100 CAFETERI A 10, 489 49, 516 0 168 11.00 01200 MAINTENANCE OF PERSONNEL Ω 0 12 00 12 00 0 C 0 13.00 01300 NURSING ADMINISTRATION 27, 452 12, 310 0 40 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 0 14.00 01500 PHARMACY 15.00 100.116 0 21.474 127 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 25, 511 0 22, 951 80 16.00 17.00 01700 SOCIAL SERVICE 5, 140 0 4, 471 60 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 0 C 0 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 0 21.00 0 02200 L&R SERVICES-OTHER PRGM COSTS APPRV 0 22 00 0 Ω 0 0 22 00 02300 PARAMED ED PRGM-(PHARMACY) 1, 907 956 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 256, 283 0 746, 948 15, 267 51.869 30.00 31.00 03100 INTENSIVE CARE UNIT 75,640 C 158.871 2, 674 6,865 31.00 32.01 02060 NEONATAL INTENSIVE CARE 20, 934 0 46, 601 50 1,634 32.01 04100 SUBPROVI DER - I RF 20, 182 0 2, 843 41.00 52, 125 5.260 41.00 04300 NURSERY 8, 992 0 43.00 7, 436 1, 189 326 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 190, 873 414, 107 5, 247 29, 809 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 5. 452 52.00 17.414 64, 922 1.753 52.00 05400 RADI OLOGY-DI AGNOSTI C 105, 177 173, 211 54.00 0 3, 476 4,502 54.00 60.00 06000 LABORATORY 85, 818 0 75, 139 2,638 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 12, 723 0 6, 279 0 0 62.00 62 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS Ω 0 62 30 C 0 06500 RESPIRATORY THERAPY 65.00 27, 128 0 15, 179 0 289 65.00 06600 PHYSI CAL THERAPY 62, 388 0 165, 322 706 2, 258 66.00 66.00 70.00 07000 ELECTROENCEPHALOGRAPHY 6.123 0 11, 278 409 70.00 363 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 113,643 0 0 0 Λ 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 152, 987 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 0 73.00 76 00 03140 CARDI OLOGY 82.675 0 171 340 3, 688 4 586 76 00 76.97 07697 CARDIAC REHABILITATION 5,802 0 18, 941 61 489 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 76.98 0 76.99 07699 LI THOTRI PSY 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 16, 366 0 31, 591 497 974 90.00 91.00 09100 EMERGENCY 54, 879 C 104, 737 2.681 16, 519 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 29, 494 0 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 0 40, 568 134, 430 118. 00 1, 668, 382 2, 446, 616 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 94 5,067 191. 00 19100 RESEARCH 5, 792 0 1,665 0 0 191.00 2, 165 192.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 9.408 232, 441 0 194. 00 07950 ADVERTI SI NG 3.280 Ω 0 194.00 194. 01 07951 FITNESS POINTE 14,608 194,001 0 194. 01 0 0 0 0 194. 02 07952 FITNESS POINTE SPA/PRO SHOP/DIETARY 2,018 6, 216 0 194. 02 194. 03 07953 RETAIL PHARMACY 48 194. 03 67.730 0 7, 445 194. 04 07954 HOSPI CE 550 0 29,623 0 194. 04 194. 05 07955 RUSH RESIDENTS 0 0 194. 05 C 0 194.06 07956 EINSTEIN BAGELS 0 194.06 1.186 0 2.537 194. 07 07957 NORTHWESTERN I MAGI NG 5,696 C 11, 106 0 0 194. 07 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 201.00 TOTAL (sum lines 118 through 201) 1.778.744 0 2, 936, 717 40.568 136, 643 202. 00 202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0125

			'	0 00/30/2020	11/25/2020 3:	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF		CENTRAL	
			PERSONNEL	ADMI NI STRATI ON		
	10.00	44.00	10.00	40.00	SUPPLY	
GENERAL SERVICE COST CENTERS	10. 00	11. 00	12.00	13. 00	14. 00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP					I	2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					I	4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL					I	5. 00
6. 00 00600 MAI NTENANCE & REPAI RS					I	6.00
7. 00 00700 OPERATION OF PLANT					I	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE					I	8.00
9. 00 00900 HOUSEKEEPI NG					I	9. 00
10. 00 01000 DI ETARY	361, 553				I	10.00
11. 00 01100 CAFETERI A	0	253, 294			I	11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0		I	12. 00
13.00 01300 NURSING ADMINISTRATION	0	5, 198	0	259, 042	I	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	o	0	14. 00
15. 00 01500 PHARMACY	0	6, 400	0	o	0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
17.00 01700 SOCIAL SERVICE	0	1, 822	0	0	0	17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
21.00 02100 1 &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22.00 02200 1 &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23.00 O2300 PARAMED ED PRGM-(PHARMACY)	0	681	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	302, 186	72, 217	0	,	0	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	25, 532	18, 765	0		0	31. 00
32. 01 02060 NEONATAL NTENSI VE CARE	0	5, 098	0	.,		32. 01
41. 00 04100 SUBPROVI DER - RF	27, 789	5, 546	0			41. 00
43. 00 04300 NURSERY	0	2, 451	0	3, 821	0	43. 00
ANCILLARY SERVICE COST CENTERS		00.400				
50. 00 05000 OPERATI NG ROOM	0	38, 133	0		0	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	6, 046	4, 386	0	6, 836	0	52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	15, 811	0	0	0	54.00
60. 00 06000 LABORATORY	0	14, 968	0	0	0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	664	0	0	0	62.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	(701	0	0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0	6, 791	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	13, 023		0	0 0	66. 00 70. 00
71. 00 07100 ELECTROENCEPHALOGRAPHT	0	1, 650		0	0	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
76. 00 03140 CARDI OLOGY	0	14, 891		0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	1, 552		0	Ö	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	o	0	ĺ	0	ő	76. 98
76. 99 07699 LI THOTRI PSY	o	0	Ö	o	Ö	76. 99
OUTPATIENT SERVICE COST CENTERS		<u> </u>		٥,		/ 0. //
90. 00 09000 CLI NI C	0	4, 020	0	6, 265	0	90.00
91. 00 09100 EMERGENCY	0	15, 564	0	24, 261	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					I	92. 00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	361, 553	249, 631	0	259, 042	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190. 00
191. 00 19100 RESEARCH	0	1, 590	0	0		191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
194. 00 07950 ADVERTI SI NG	0	0	0	0		194. 00
194. 01 07951 FITNESS POINTE	0	0	0	0		194. 01
194. 02 07952 FI TNESS POI NTE SPA/PRO SHOP/DI ETARY	0	0	0	0		194. 02
194. 03 07953 RETAIL PHARMACY	0	1, 611	0	0		194. 03
194. 04 07954 HOSPI CE	0	0	0	0		194. 04
194. 05 07955 RUSH RESIDENTS	0	0		0		194. 05
194.06 07956 EINSTEIN BAGELS	0	462				194. 06 194. 07
194.07 07957 NORTHWESTERN IMAGING 200.00 Cross Foot Adjustments	U	O			0	200. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0	_			200.00
202.00 TOTAL (sum lines 118 through 201)	361, 553	253, 294		259, 042		202.00
202. 00 TOTAL (Sam Tries Tio through 201)	301, 333	200, 274	۰ ۰	257, 042	O	1202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 07/01/2019 | Part II | To 06/30/2020 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0125

				1	0 06/30/2020	Date/IIme Prep 11/25/2020 3:0	
						INTERNS &	52 piii
						RESI DENTS	
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	SERVI CES-SALAR	
			RECORDS &		ANESTHETI STS	Y & FRINGES	
			LI BRARY			APPRV	
le le	SENEDAL CERVILOE COCT CENTERS	15. 00	16. 00	17. 00	19. 00	21. 00	
	SENERAL SERVICE COST CENTERS	Ι		I			1 00
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00500 ADMINISTRATIVE & GENERAL						5. 00
1	00600 MAI NTENANCE & REPAI RS						6. 00
1	00700 OPERATION OF PLANT						7. 00
	00800 LAUNDRY & LINEN SERVICE						8. 00
1	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVICES & SUPPLY						14. 00
1	01500 PHARMACY	675, 859					15. 00
1	01600 MEDI CAL RECORDS & LI BRARY	0	138, 254				16. 00
	01700 SOCIAL SERVICE	0	0	29, 243			17. 00
	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	_		19. 00
	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0	0		0	21. 00
1	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22. 00
	D2300 PARAMED ED PRGM-(PHARMACY) NPATIENT ROUTINE SERVICE COST CENTERS	U U	0	0			23. 00
	03000 ADULTS & PEDIATRICS	O	11, 513	20, 840			30. 00
1	03100 INTENSIVE CARE UNIT		2, 216				31. 00
	22060 NEONATAL INTENSIVE CARE		2, 172				32. 01
	04100 SUBPROVI DER - I RF	o	747				41. 00
	04300 NURSERY	O	431				43.00
Δ	NCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	23, 550	0			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	786	0			52.00
1	05400 RADI OLOGY-DI AGNOSTI C	0	24, 492	•			54.00
	06000 LABORATORY	0	15, 376				60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	882	0			62. 00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62. 30
	06500 RESPI RATORY THERAPY	0	2, 475				65. 00
	06600 PHYSI CAL_THERAPY 07000 ELECTROENCEPHALOGRAPHY	0	3, 648	0			66. 00 70. 00
	071000 MEDICAL SUPPLIES CHARGED TO PATIENT		1, 127 3, 946	0			70.00
1	07200 IMPL. DEV. CHARGED TO PATIENTS		5, 955				71.00
	07300 DRUGS CHARGED TO PATIENTS	675, 859	10, 665	0			73. 00
	03140 CARDI OLOGY	0,0,00,	14, 806	1			76. 00
	07697 CARDI AC REHABI LI TATI ON	l ol	205				76. 97
	07698 HYPERBARI C OXYGEN THERAPY	O	0				76. 98
76. 99	07699 LI THOTRI PSY	0	0	0			76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	1, 020				90.00
	09100 EMERGENCY	0	11, 566	414			91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
_	OTHER REIMBURSABLE COST CENTERS						
	O100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	676	0			101. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	675, 859	138, 254	29, 243	0	0	118. 00
	IONREI MBURSABLE COST CENTERS	070, 009	130, 234	29, 243	U	U	116.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0			190. 00
	9100 RESEARCH		0				191. 00
	9200 PHYSI CLANS' PRI VATE OFFI CES		0				192. 00
	07950 ADVERTI SI NG	o	0	Ō			194. 00
	07951 FITNESS POINTE	O	0	0			194. 01
194. 02 0	07952 FITNESS POINTE SPA/PRO SHOP/DIETARY	O	0	0			194. 02
194. 03	7953 RETAIL PHARMACY	O	0	0			194. 03
	07954 HOSPI CE	0	0	0			194. 04
	07955 RUSH RESIDENTS	0	0	0			194. 05
	07956 EINSTEIN BAGELS	0	0	0			194. 06
	07957 NORTHWESTERN I MAGI NG	0	0	0			194. 07
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers	(75 050	100.054	0 00	0		201.00
202. 00	TOTAL (sum lines 118 through 201)	675, 859	138, 254	29, 243	0	ا	202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0125 Peri od: Worksheet B From 07/01/2019 Part II Date/Time Prepared: 06/30/2020 11/25/2020 3:02 pm INTERNS & **RESI DENTS** Cost Center Description SERVI CES-OTHER PARAMED ED Subtotal Intern & Total PRGM COSTS PRGM-(PHARMACY Residents Cost **APPRV** & Post Stepdown Adjustments 22. 00 23.00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16, 00 16.00 17 00 01700 SOCIAL SERVICE 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 0 02300 PARAMED ED PRGM-(PHARMACY) 23.00 7.412 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 144, 336 5, 144, 336 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 449, 698 0 1, 449, 698 31.00 32.01 02060 NEONATAL INTENSIVE CARE 432, 348 0 432, 348 32.01 04100 SUBPROVIDER - IRF 0 41.00 356, 619 356, 619 41.00 55, 100 55, 100 43.00 04300 NURSERY 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 6, 052, 917 6, 052, 917 50.00 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 484, 827 0 484, 827 52.00 05400 RADI OLOGY-DI AGNOSTI C 5, 093, 997 54 00 5 093 997 54 00 60.00 06000 LABORATORY 1, 197, 224 1, 197, 224 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 74, 494 0 0 0 0 0 0 0 0 0 74, 494 62.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 0 06500 RESPIRATORY THERAPY 210, 147 210.147 65.00 65.00 66.00 66.00 06600 PHYSI CAL THERAPY 1, 033, 021 1, 033, 021 70.00 07000 ELECTROENCEPHALOGRAPHY 145, 592 145, 592 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 117, 589 71 00 117, 589 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 158, 942 158, 942 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 686, 524 686, 524 73.00 03140 CARDI OLOGY 76.00 3, 211, 631 3, 211, 631 76.00 07697 CARDIAC REHABILITATION 76 97 76 97 130, 967 130, 967 76. 98 07698 HYPERBARI C OXYGEN THERAPY C 0 76.98 07699 LI THOTRI PSY 0 76. 99 76.99 0 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 205. 798 0 205, 798 90 00 91.00 09100 EMERGENCY 825, 646 0 825, 646 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART ol 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 32, 302 0 32, 302 101. 00 SPECIAL PURPOSE COST CENTERS 27, 099, 719 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 27, 099, 719 0 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 24, 869 24, 869 190. 00 191. 00 19100 RESEARCH 0 18, 021 191. 00 18,021 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 1, 150, 275 192. 00 1, 150, 275 194. 00 07950 ADVERTI SI NG 3, 280 194. 00 3, 280 194. 01 07951 FITNESS POINTE 1, 025, 129 0 0 0 0 0 0 0 1, 025, 129 194. 01 194. 02 07952 FI TNESS POINTE SPA/PRO SHOP/DI ETARY 38, 007 194. 02 38,007 194. 03 07953 RETAIL PHARMACY 145.594 145, 594 194. 03 194. 04 07954 HOSPI CE 145, 405 145, 405 194. 04 194. 05 07955 RUSH RESIDENTS 0 194. 05 194.06 07956 EINSTEIN BAGELS 20, 712 20, 712 194. 06 194.07 07957 NORTHWESTERN I MAGING 569, 855 569, 855 194. 07 200.00 Cross Foot Adjustments 7, 412 7, 412 7, 412 200. 00 201.00 Negative Cost Centers 0 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 7, 412 30, 248, 278 30, 248, 278 202. 00

Heal th	Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COST A	NLLOCATION - STATISTICAL BASIS		Provi der CC		Period: From 07/01/2019 To 06/30/2020		
		0.00.70.00	ATER 000TO			11/25/2020 3:	
		CAPITAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	oost content boson per on	(SQUARE FEET)	(NEW- \$ VAL	BENEFITS	Reconci i i a ci on	& GENERAL	
		(040/11/2 / 221)	UE)	DEPARTMENT		(ACCUM. COST)	
			02)	(GROSS		(7.000	
				SALARI ES)			
		1.00	2.00	4.00	5A	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	922, 172					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		10, 820, 612				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 000	4, 716	165, 733, 03	6		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	75, 821	380, 466	16, 523, 64	9 -69, 543, 723	372, 333, 998	5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0		0 0	0	6. 00
7.00	00700 OPERATION OF PLANT	142, 161	370, 251	5, 470, 19	7 0	19, 843, 193	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 566	0	133, 75	6 0	1, 756, 977	8. 00
9.00	00900 HOUSEKEEPI NG	3, 812	22, 272	3, 485, 61	2 0	5, 371, 226	
10.00	01000 DI ETARY	11, 529	71, 472	2, 619, 20	0	4, 899, 371	
11. 00	01100 CAFETERI A	11, 806	0	1, 167, 58	3 0	2, 195, 641	11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0		0	0	12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 935	117, 132	3, 654, 65	1 0	5, 746, 636	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0		0	0	1 1.00
15. 00	01500 PHARMACY	5, 120	329, 159	4, 001, 70	1 0	,	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	5, 472	311		0	-, ,	
17. 00	01700 SOCI AL SERVI CE	1, 066	0	825, 59	1 0	1, 076, 021	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	19. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	22.00
23. 00	02300 PARAMED ED PRGM-(PHARMACY)	228	0	327, 99.	2 0	399, 109	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	178, 092	451, 039				1
31. 00	03100 I NTENSI VE CARE UNI T	37, 879	358, 378				1
32. 01	02060 NEONATAL INTENSIVE CARE	11, 111	116, 699				
41. 00	04100 SUBPROVI DER - I RF	12, 428	19, 428				
43.00	04300 NURSERY	1, 773	0	1, 317, 26	1 0	1, 882, 294	43. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	98, 734	2, 614, 504				
52. 00	05200 DELIVERY ROOM & LABOR ROOM	15, 479	88, 015				
54. 00	05400 RADI OLOGY-DI AGNOSTI C	41, 298	2, 910, 868				
60.00	06000 LABORATORY	17, 915	504, 067				
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 497	20, 898	371, 04	1 0	2, 663, 370	1
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0		
65. 00	06500 RESPI RATORY THERAPY	3, 619	69, 470			5, 678, 850	1
66. 00	1	39, 417	99, 188			13, 060, 162	
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 689	57, 259	740, 08	0	1, 281, 847	
71. 00	l l	0	0		0	23, 789, 662	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0		
	07300 DRUGS CHARGED TO PATIENTS	0	0 (04 40)	0.400.44	0		73.00
	03140 CARDI OLOGY	40, 852	1, 601, 136				
76. 97	07697 CARDI AC REHABI LI TATI ON	4, 516	21, 249	884, 86			
76. 98		0	0		0		
76. 99	07699 LI THOTRI PSY	0	0		0	0	76. 99
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	7 520	15, 070	2 220 54	7 0	2 424 077	00.00
91.00	09100 EMERGENCY	7, 532 24, 972	•				1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	24, 972	131, 300	7, 214, 36	0	11, 488, 118	92.00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
101 00	10100 HOME HEALTH AGENCY	O	154	4, 414, 13	6 0	6, 174, 232	101 00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	134	4, 414, 13	0	0, 174, 232	101.00
118.00		805, 319	10, 374, 501	162, 115, 91	9 -69, 543, 723	349, 230, 805	118 00
110.00	NONREI MBURSABLE COST CENTERS	000, 517	10, 374, 301	102, 113, 71	7 07, 545, 725	347, 230, 003	1110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 208	0			10 708	190. 00
	19100 RESEARCH	397	1, 514	852, 90	7 0		
	19200 PHYSI CI ANS' PRI VATE OFFI CES	55, 420	1, 487		, n	1, 969, 462	
	07950 ADVERTI SI NG	00, 120	0, 107	1		686, 674	1
	07951 FITNESS POINTE	46, 255	43, 661			3, 057, 913	1
	07952 FITNESS POINTE SPA/PRO SHOP/DIETARY	1, 482	3, 907			422, 517	
	07953 RETAIL PHARMACY	1, 775	28, 057			14, 178, 333	
	07954 HOSPI CE	7, 063	23, 307	3.3,02	0 0	115, 232	
	07955 RUSH RESIDENTS	0	0		o n		194. 05
	07956 EINSTEIN BAGELS	605	4, 707	99, 03	9 0	248, 318	
	07957 NORTHWESTERN I MAGI NG	2, 648	362, 778				1
200.00		_, _ , _ , _	, . , 0			, , . , 0	200. 00
201.00							201. 00
202.00		15, 045, 154	15, 203, 124	25, 400, 93	3	69, 543, 723	
50	Part I)		,				
203.00		16. 314911	1. 405015	0. 15326	4	0. 186778	203. 00
	<u> </u>	<u>'</u>					

Heal th	Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COST AI	LOCATION - STATISTICAL BASIS		Provi der C		Period: From 07/01/2019	Worksheet B-1	
					To 06/30/2020	Date/Time Pre 11/25/2020 3:	
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(NEW- \$ VAL	BENEFITS		& GENERAL	
			UE)	DEPARTMENT		(ACCUM. COST)	
				(GROSS			
				SALARI ES)			
		1.00	2. 00	4. 00	5A	5. 00	
204.00	Cost to be allocated (per Wkst. B,			71, 88	6	1, 778, 744	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part			0.00043	4	0.004777	205. 00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,			1			207. 00
	Parts III and IV)						

Provider CCN: 15-0125

1. 00 00100 00200 00200 00200 00200 00500 00600 00700 0010000 0010000 0010000 0010000 0010000 00100000 00100000 00100000 00100000 0010000000 00100000000	COST CENTER DESCRIPTION ERAL SERVICE COST CENTERS OO CAP REL COSTS-BLDG & FIXT OO CAP REL COSTS-MVBLE EQUIP OO EMPLOYEE BENEFITS DEPARTMENT OO ADMINISTRATIVE & GENERAL OO MAINTENANCE & REPAIRS OO OPERATION OF PLANT OO LAUNDRY & LINEN SERVICE OO HOUSEKEEPING OO DIETARY OO CAFETERIA OO MAINTENANCE OF PERSONNEL OO NURSING ADMINISTRATION OO CENTRAL SERVICES & SUPPLY OO PHARMACY OO MEDICAL RECORDS & LIBRARY OO SOCIAL SERVICE OO NONPHYSICIAN ANESTHETISTS OO I &R SERVICES-OTHER PRGM COSTS APPRV OO PARAMED ED PRGM-(PHARMACY) ATIENT ROUTINE SERVICE COST CENTERS OO INTENSIVE CARE UNIT 60 NEONATAL INTENSIVE CARE OO SUBPROVIDER - IRF	REPAI RS	700, 190 7, 00 700, 190 1, 566 3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 0 228	99, 581 0 180 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 340, 873 174 420 0 100 316 200 150 0 14	DI ETARY (PATI ENT ME ALS) 10. 00
1. 00 00100 00200 00200 00200 00200 00500 00600 00700 0010000 0010000 0010000 0010000 0010000 00100000 00100000 00100000 00100000 0010000000 00100000000	CAP REL COSTS-BLDG & FIXT CO CAP REL COSTS-MVBLE EQUIP CO EMPLOYEE BENEFITS DEPARTMENT CO ADMINISTRATIVE & GENERAL CO MAINTENANCE & REPAIRS CO OPERATION OF PLANT CO LAUNDRY & LINEN SERVICE CO HOUSEKEEPING CO DIETARY CO CAFETERIA CO MAINTENANCE OF PERSONNEL CO NURSING ADMINISTRATION CO CENTRAL SERVICES & SUPPLY CO PHARMACY CO MEDICAL RECORDS & LIBRARY CO SOCIAL SERVICE CO NONPHYSICIAN ANESTHETISTS CO I & SERVICES-SALARY & FRINGES APPRV CO PARAMED ED PRGM-(PHARMACY) CATIENT ROUTINE SERVICE COST CENTERS CO INTENSIVE CARE CO NONTENSIVE CARE CO NEONATAL INTENSIVE CARE	(SOUARE FEET) 6.00 842, 351 142, 161 1, 566 3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 0 228	700, 190 7, 566 3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 228	99, 581 0 180 0 0 0 0 0 0 0	9. 00 340, 873 174 420 0 100 0 316 200 150 0 0	ALS) 10.00 298, 217 1 0 1 0 1 0 1 0 1 0 1 0 1 0 2 0 2
1. 00 00100 00200 00200 00200 00200 00500 00600 00700 0010000 0010000 0010000 0010000 0010000 00100000 00100000 00100000 00100000 0010000000 00100000000	CAP REL COSTS-BLDG & FIXT CO CAP REL COSTS-MVBLE EQUIP CO EMPLOYEE BENEFITS DEPARTMENT CO ADMINISTRATIVE & GENERAL CO MAINTENANCE & REPAIRS CO OPERATION OF PLANT CO LAUNDRY & LINEN SERVICE CO HOUSEKEEPING CO DIETARY CO CAFETERIA CO MAINTENANCE OF PERSONNEL CO NURSING ADMINISTRATION CO CENTRAL SERVICES & SUPPLY CO PHARMACY CO MEDICAL RECORDS & LIBRARY CO SOCIAL SERVICE CO NONPHYSICIAN ANESTHETISTS CO I & SERVICES-SALARY & FRINGES APPRV CO PARAMED ED PRGM-(PHARMACY) CATIENT ROUTINE SERVICE COST CENTERS CO INTENSIVE CARE CO NONTENSIVE CARE CO NEONATAL INTENSIVE CARE	842, 351 142, 161 1, 566 3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 0 228	700, 190 1, 566 3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 2228	99, 581 0 180 0 0 0 0 0 0 0	340, 873 174 420 0 100 0 316 200 150 0 0	298, 217 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1
1. 00 00100 00200 00200 00200 00200 00500 00600 00700 0010000 0010000 0010000 0010000 0010000 00100000 00100000 00100000 00100000 0010000000 00100000000	CAP REL COSTS-BLDG & FIXT CO CAP REL COSTS-MVBLE EQUIP CO EMPLOYEE BENEFITS DEPARTMENT CO ADMINISTRATIVE & GENERAL CO MAINTENANCE & REPAIRS CO OPERATION OF PLANT CO LAUNDRY & LINEN SERVICE CO HOUSEKEEPING CO DIETARY CO CAFETERIA CO MAINTENANCE OF PERSONNEL CO NURSING ADMINISTRATION CO CENTRAL SERVICES & SUPPLY CO PHARMACY CO MEDICAL RECORDS & LIBRARY CO SOCIAL SERVICE CO NONPHYSICIAN ANESTHETISTS CO I & SERVICES-SALARY & FRINGES APPRV CO PARAMED ED PRGM-(PHARMACY) CATIENT ROUTINE SERVICE COST CENTERS CO INTENSIVE CARE CO NONTENSIVE CARE CO NEONATAL INTENSIVE CARE	142, 161 1, 566 3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 0 228	1, 566 3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 2288	0 180 0 0 0 0 0 0 0 0 0	174 420 0 100 0 316 200 150 0 0	0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1
2. 00 00200 4. 00 00400 5. 00 00500 00700 8. 00 00700 1. 00 01100 1. 00 01500 1. 00 01500 1. 00 01500 1. 00 01500 1. 00 01500 1. 00 01500 1. 00 01500 1. 00 01500 1. 00 01500 1. 00 01500 1. 00 01500 1. 00 01500 1. 00 01500 1. 00 01500	CAP REL COSTS-MVBLE EQUIP CODE EMPLOYEE BENEFITS DEPARTMENT CODE ADMINISTRATIVE & GENERAL CODE MAINTENANCE & REPAIRS CODE OPERATION OF PLANT CODE LAUNDRY & LINEN SERVICE CODE HOUSEKEEPING CODE DIETARY CODE CAFETERIA CODE MAINTENANCE OF PERSONNEL CODE NURSING ADMINISTRATION CODE CENTRAL SERVICES & SUPPLY CODE CENTRAL SERVICES & SUPPLY CODE PHARMACY CODE MAINTENANCE OF PERSONNEL CODE OF PE	142, 161 1, 566 3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 0 228	1, 566 3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 2288	0 180 0 0 0 0 0 0 0 0 0	174 420 0 100 0 316 200 150 0 0	0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1
5. 00 00500 6. 00 00600 7. 00 00700 8. 00 00800 9. 00 00900 10. 00 01100 11. 00 01200 13. 00 01500 15. 00 01500 15. 00 01500 15. 00 01700 19. 00 02200 22. 00 02200 23. 00 02300 31. 00 03100 31. 00 03100 31. 00 03100 31. 00 03100 32. 01 02060 41. 00 04100 43. 00 05200 52. 00 05200 52. 00 05200 52. 00 05200 62. 00 06200 62. 00 06200 62. 00 06250 65. 00 06500 66. 00 06600 62. 00 07200 72. 00 07200	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OD OPERATION OF PLANT LAUNDRY & LINEN SERVICE OD HOUSEKEEPING OD LIETARY OD CAFETERIA MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION OC CENTRAL SERVICES & SUPPLY OPHARMACY OM MEDICAL RECORDS & LIBRARY OSOCIAL SERVICE ONONPHYSICIAN ANESTHETISTS OO I&R SERVICES-SALARY & FRINGES APPRV OO I&R SERVICES-OTHER PRGM COSTS APPRV OO PARAMED ED PRGM-(PHARMACY) ATIENT ROUTINE SERVICE OO ADULTS & PEDIATRICS OO INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE	142, 161 1, 566 3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 0 228	1, 566 3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 2288	0 180 0 0 0 0 0 0 0 0 0	174 420 0 100 0 316 200 150 0 0	0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1
6. 00 00600 7. 00 00700 8. 00 00700 8. 00 00800 9. 00 00900 11. 00 12. 00 13. 00 01400 15. 00 01500 16. 00 01600 17. 00 01700 22. 00 02200 1. 00	MAINTENANCE & REPAIRS OO OPERATION OF PLANT OO LAUNDRY & LINEN SERVICE OO HOUSEKEEPING OO DIETARY OO CAFETERIA ON MAINTENANCE OF PERSONNEL ON OURSING ADMINISTRATION OO CENTRAL SERVICES & SUPPLY OP PHARMACY OO MEDICAL RECORDS & LIBRARY OO SOCIAL SERVICE OO NONPHYSICIAN ANESTHETISTS OO I&R SERVICES-SALARY & FRINGES APPRV OO I&R SERVICES-OTHER PRGM COSTS APPRV OO PARAMED ED PRGM-(PHARMACY) ATIENT ROUTINE SERVICE COST CENTERS OO ADULTS & PEDIATRICS OO INTENSIVE CARE UNIT	142, 161 1, 566 3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 0 228	1, 566 3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 2288	0 180 0 0 0 0 0 0 0 0 0	174 420 0 100 0 316 200 150 0 0	0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1
7. 00 00700 8. 00 00800 9. 00 009000 11. 00 011000 12. 00 01500 02200 02200 03	OD OPERATION OF PLANT OD LAUNDRY & LINEN SERVICE OD HOUSEKEEPING OD DIETARY OD CAFETERIA OD MAINTENANCE OF PERSONNEL ON OWNER OF PERSONNEL OD OPHARMACY OD CENTRAL SERVICES & SUPPLY OD PHARMACY ON MEDICAL RECORDS & LIBRARY ON SOCIAL SERVICE OD NONPHYSICIAN ANESTHETISTS ON I&R SERVICES-SALARY & FRINGES APPRV OD PARAMED ED PRGM-(PHARMACY) ATIENT ROUTINE SERVICE COST CENTERS ON ADULTS & PEDIATRICS ON INTENSIVE CARE	142, 161 1, 566 3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 0 228	1, 566 3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 2288	0 180 0 0 0 0 0 0 0 0 0	174 420 0 100 0 316 200 150 0 0	0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1
8. 00	LAUNDRY & LINEN SERVICE DO HOUSEKEEPING DO DIETARY CAFETERIA DO MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY DO PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE DO NONPHYSICIAN ANESTHETISTS I &R SERVICES-SALARY & FRINGES APPRV DO I&R SERVICES-OTHER PRGM COSTS APPRV DO PARAMED ED PRGM-(PHARMACY) ATIENT ROUTINE SERVICE COST CENTERS DO ADULTS & PEDIATRICS DO INTENSIVE CARE NEONATAL INTENSIVE CARE	1, 566 3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 228	1, 566 3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 2288	0 180 0 0 0 0 0 0 0 0 0	174 420 0 100 0 316 200 150 0 0	0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1
9. 00	HOUSEKEEPING DO DIETARY DO CAFETERIA DO MAINTENANCE OF PERSONNEL DO NURSING ADMINISTRATION DO CENTRAL SERVICES & SUPPLY DO PHARMACY DO MEDICAL RECORDS & LIBRARY DO SOCIAL SERVICE DO NONPHYSICIAN ANESTHETISTS DO I&R SERVICES-SALARY & FRINGES APPRV DO I&R SERVICES-OTHER PRGM COSTS APPRV DO PARAMED ED PRGM-(PHARMACY) ATIENT ROUTINE SERVICE DO ADULTS & PEDIATRICS DO INTENSIVE CARE UNIT HOUSE AND H	3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 0 228	3, 812 11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 228	0 180 0 0 0 0 0 0 0 0 0	174 420 0 100 0 316 200 150 0 0	0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1
10. 00	DO DIETARY DO CAFETERIA DO MAINTENANCE OF PERSONNEL DO NURSING ADMINISTRATION DO CENTRAL SERVICES & SUPPLY DO PHARMACY DO MEDICAL RECORDS & LIBRARY DO SOCIAL SERVICE DO NONPHYSICIAN ANESTHETISTS DO I&R SERVICES-SALARY & FRINGES APPRV DO I&R SERVICES-OTHER PRGM COSTS APPRV DO PARAMED ED PRGM-(PHARMACY) ATIENT ROUTINE SERVICE DO ADULTS & PEDIATRICS DO INTENSIVE CARE UNIT 60 NEONATAL INTENSIVE CARE	11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 0 228	11, 529 11, 806 0 2, 935 0 5, 120 5, 472 1, 066 0 0 228	180 0 0 0 0 0 0 0 0 0 0	174 420 0 100 0 316 200 150 0 0	0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1
12. 00	MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY ON MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS ON I&R SERVICES-SALARY & FRINGES APPRV ON I&R SERVICES-OTHER PRGM COSTS APPRV ON IATIENT ROUTINE SERVICE COST CENTERS ON ADULTS & PEDIATRICS ON INTENSIVE CARE UNIT	0 2, 935 0 5, 120 5, 472 1, 066 0 0 0 228	0 2, 935 0 5, 120 5, 472 1, 066 0 0 228	0 0 0 0 0 0 0 0	0 100 0 316 200 150 0 0	0 1 0 1 0 1 0 1 0 1 0 1 0 2 0 2
13. 00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY DO PHARMACY NO SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NO I&R SERVICES-SALARY & FRINGES APPRV NO I&R SERVICES-OTHER PRGM COSTS APPRV NO IAR SERVICES-OTHER PRGM COSTS APPRV NO INTENSIVE COST CENTERS NO INTENSIVE CARE UNIT	2, 935 0 5, 120 5, 472 1, 066 0 0 228	0 5, 120 5, 472 1, 066 0 0 228	0 0 0 0 0 0 0	0 316 200 150 0 0	0 1 0 1 0 1 0 1 0 1 0 1 0 2 0 2
14. 00	CENTRAL SERVICES & SUPPLY DO PHARMACY DO MEDICAL RECORDS & LIBRARY DO SOCIAL SERVICE DO NONPHYSICIAN ANESTHETISTS DO I&R SERVICES-SALARY & FRINGES APPRV DO I&R SERVICES-OTHER PRGM COSTS APPRV DO PARAMED ED PRGM-(PHARMACY) ATIENT ROUTINE SERVICE COST CENTERS DO ADULTS & PEDIATRICS DI INTENSIVE CARE UNIT HONE PHARMACY INTENSIVE CARE	0 5, 120 5, 472 1, 066 0 0 0 228 178, 092 37, 879	0 5, 120 5, 472 1, 066 0 0 228	0 0 0 0 0 0 0	0 316 200 150 0 0	0 1 0 1 0 1 0 1 0 2 0 2
15. 00	PHARMACY MEDICAL RECORDS & LIBRARY NONPHYSICIAN ANESTHETISTS I &R SERVICES-SALARY & FRINGES APPRV OI &R SERVICES-OTHER PRGM COSTS APPRV OI &R SERVICES-OTHER PRGM COSTS APPRV OI PARAMED ED PRGM-(PHARMACY) ATIENT ROUTINE SERVICE COST CENTERS OI ADULTS & PEDIATRICS I NTENSIVE CARE UNIT NEONATAL INTENSIVE CARE	5, 120 5, 472 1, 066 0 0 228 178, 092 37, 879	5, 472 1, 066 0 0 228 178, 092	0 0 0 0 0 0	316 200 150 0 0	0 1 0 1 0 1 0 1 0 2 0 2
16. 00	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS I &R SERVICES-SALARY & FRINGES APPRV I &R SERVICES-OTHER PRGM COSTS APPRV PARAMED ED PRGM-(PHARMACY) ATIENT ROUTINE SERVICE COST CENTERS ATIENT ROUTINE SERVICE COST CENTERS NO ADULTS & PEDIATRICS NEONATAL INTENSIVE CARE	5, 472 1, 066 0 0 0 228 178, 092 37, 879	5, 472 1, 066 0 0 228 178, 092	0 0 0 0 0 0	200 150 0 0	0 1 0 1 0 1 0 2 0 2
17. 00 01700 19. 00 01900 21. 00 02100 22. 00 02200 23. 00 03300 31. 00 03100 32. 01 02600 41. 00 04300 ANCI L 50. 00 05200 52. 00 05200 54. 00 05400 60. 00 0600 62. 00 06200 62. 00 06500 63. 00 06500 64. 00 07000 71. 00 07100 72. 00 07200 73. 00 07300 76. 90 07697 76. 98 07697 76. 99 07697 76. 99 07697 76. 99 07697 76. 99 07697 76. 91 07697 76. 92 07697 76. 93 07697 76. 94 07697 76. 95 07697 76. 97 07697 76. 98 07699 00 07100 71. 00 07100 71. 00 07100 71. 00 07100 71. 00 07100 71. 00 07100 71. 00 07100 71. 00 07100 71. 00 07100 71. 00 07100 71. 00 07100 71. 00 07950 71. 00 07950 71. 00 07951 71. 00 07951 71. 00 07951 71. 00 07951 71. 00 07951 71. 00 07950 72. 00 07200 72. 00 07950 73. 00 07950 74. 00 07951 75. 00 07950 75. 00 07900 75. 00 07900 75	OO SOCIAL SERVICE OO NONPHYSICIAN ANESTHETISTS OO I&R SERVICES-SALARY & FRINGES APPRV OO I&R SERVICES-OTHER PRGM COSTS APPRV OO PARAMED ED PRGM-(PHARMACY) ATIENT ROUTINE SERVICE COST CENTERS OO ADULTS & PEDIATRICS OO INTENSIVE CARE UNIT 60 NEONATAL INTENSIVE CARE	1, 066 0 0 0 228 178, 092 37, 879	1, 066 0 0 0 228 178, 092	0	150 0 0 0	0 1 0 1 0 2 0 2
21. 00	1 & R SERVICES-SALARY & FRINGES APPRV 10 I & R SERVICES-OTHER PRGM COSTS APPRV 10 PARAMED ED PRGM-(PHARMACY) 11 ENT ROUTINE SERVICE COST CENTERS 10 ADULTS & PEDIATRICS 11 I TENSIVE CARE UNIT 12 NEONATAL INTENSIVE CARE	178, 092 37, 879	178, 092	0	0 0 0 14	0 2
22. 00 02200 23. 00 02300 INPAT 30. 00 03300 31. 00 03100 32. 01 02060 41. 00 04100 43. 00 05000 52. 00 05200 54. 00 05600 62. 00 06200 62. 30 06250 65. 00 06500 66. 00 06000 71. 00 07000 71. 00 07000 71. 00 07100 72. 00 07200 73. 00 07300 76. 98 07699 76. 98 07699 90. 00 09000 91. 00 09100 92. 00 09100 92. 00 07000 118. 00 190. 00 19000 118. 00 190. 00 19000 191. 00 19000	1 &R SERVICES-OTHER PRGM COSTS APPRV DO PARAMED ED PRGM-(PHARMACY) ATIENT ROUTINE SERVICE COST CENTERS DO ADULTS & PEDIATRICS DO INTENSIVE CARE UNIT 60 NEONATAL INTENSIVE CARE	178, 092 37, 879	178, 092	0	0 0 14	0 2
23. 00 02300 INPAT 30. 00 03000 31. 00 03000 32. 01 02206 41. 00 04300 52. 00 05200 54. 00 06200 62. 00 06200 62. 00 06500 66. 00 06500 66. 00 07000 71. 00 07100 72. 00 07200 73. 00 07300 76. 98 07697 76. 98 07697 76. 98 07699 0017PA 90. 00 09100 92. 00 09200 07118. 00 191. 00 191. 00 191. 00 191. 00 191. 00 192.	OO PARAMED ED PRGM-(PHARMACY) ATLENT ROUTINE SERVICE COST CENTERS OO ADULTS & PEDIATRICS OO INTENSIVE CARE UNIT 60 NEONATAL INTENSIVE CARE	178, 092 37, 879	178, 092	0	0 14	
30. 00 03000 31. 00 03100 03100 03100 03100 03100 04100 43. 00 05000 52. 00 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 05200 07300 07000 07100 07200 07300 07300 07300 07697 07697 07697 07697 07699 07	ATIENT ROUTINE SERVICE COST CENTERS OO ADULTS & PEDIATRICS OO INTENSIVE CARE UNIT 60 NEONATAL INTENSIVE CARE	178, 092 37, 879	178, 092	<u> </u>	14	01 2
30. 00	00 ADULTS & PEDIATRICS 00 INTENSIVE CARE UNIT 60 NEONATAL INTENSIVE CARE	37, 879		27 470		
31. 00	00 INTENSIVE CARE UNIT 60 NEONATAL INTENSIVE CARE	37, 879		31 412	129, 392	249, 250
32. 01	60 NEONATAL INTENSIVE CARE		31,019	6, 564	17, 126	21, 059
43. 00	00 SUBPROVIDER - IRF		11, 111	123	4, 077	0 3
50. 00 05000 52. 00 05200 54. 00 05400 60. 00 06000 62. 00 06500 66. 00 06600 70. 00 07000 71. 00 07100 72. 00 07200 73. 00 07300 76. 98 07697 76. 98 07697 76. 99 07697 90. 00 09100 92. 00 09200 91. 00 09100 92. 00 09200 118. 00 191. 00 19000 191. 00 19000 191. 00 19000 192. 00 19000 194. 00 19200 194. 00 07951 194. 01 07951		12, 428	12, 428	6, 978	13, 122	22, 921
50. 00	00 NURSERY	1, 773	1, 773	2, 919	814	0 4
52. 00 05200 54. 00 05400 60. 00 06400 62. 30 06250 65. 00 06600 70. 00 07100 72. 00 07200 73. 00 07300 76. 00 03140 76. 98 07698 76. 99 000 92. 00 09200 07100 118. 00 190. 00 19000 191. 00 19000 191. 00 19000 191. 00 19000 191. 00 19000 191. 00 07900 191. 00 19000 192. 00 07950 194. 00 07950 194. 00 07950 194. 00 07950	ILLARY SERVICE COST CENTERS OO OPERATING ROOM	98, 734	00 724	12 000	74.242	0 5
54. 00	00 DELIVERY ROOM & LABOR ROOM	15, 479	98, 734 15, 479	12, 880 4, 304	74, 362 13, 601	4, 987 5
60. 00 06000 62. 00 06200 62. 30 06250 65. 00 06500 70. 00 07100 71. 00 07200 73. 00 07300 76. 00 03140 76. 97 07697 76. 98 07698 76. 99 0017PA 90. 00 09100 91. 00 09100 92. 00 0000 118. 00 07100 118. 00 07950 194. 00 07950 194. 00 07951 194. 00 07951 194. 00 07951 194. 00 07951 194. 00 07951	DO RADI OLOGY-DI AGNOSTI C	41, 298	41, 298	8, 532	11, 231	4, 707
62. 30 06250 65. 00 06500 66. 00 06600 70. 00 07000 71. 00 07100 72. 00 07300 76. 00 03140 76. 97 07697 76. 98 07699 0017PA 90. 00 09100 92. 00 09200 118. 00 09200 118. 00 07950 194. 01 07951	OO LABORATORY	17, 915	17, 915	0	6, 580	o e
65. 00 06500 66. 00 06600 70. 00 07000 71. 00 07100 72. 00 07300 76. 90 07697 76. 99 07699 76. 99 07699 76. 99 07699 76. 99 07699 76. 99 07699 76. 90 07900 76. 90 07699 76. 90 07699 76. 90 07699 76. 90 07699 76. 90 07699 76. 90 07699 76. 90 07100 776. 90 071	00 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 497	1, 497	0	0	0 6
66. 00 06600 70. 00 07100 71. 00 07200 73. 00 07300 76. 90 07697 07698 76. 99 07699 0017PA 76. 90 09000 71. 00 91. 00 92. 00 07100 75. 118. 00 190. 00 1	50 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 6
70. 00 07000 71. 00 07100 72. 00 07200 73. 00 07300 76. 00 03140 76. 97 07698 76. 98 07699 0UTPA 90. 00 09000 91. 00 09000 92. 00 09200 0THER 101. 00 19100 SPECI. 118. 00 NONRE 190. 00 19200 191. 00 19200 191. 00 19100 192. 00 19200 194. 00 07950 194. 01 07951	00 RESPI RATORY THERAPY	3, 619	3, 619	1 722	720	0 6
71. 00 07100 72. 00 07200 73. 00 07300 76. 00 03140 76. 97 07697 76. 98 07699 0UTPA 90. 00 09000 91. 00 09200 0THER 101. 00 19100 SPECI. 118. 00 NONRE 190. 00 19000 191. 00 19200 191. 00 19200 191. 00 19200 194. 00 07950	00 PHYSI CAL THERAPY 00 ELECTROENCEPHALOGRAPHY	39, 417 2, 689	39, 417 2, 689	1, 732 890	5, 634 1, 020	0 6
72. 00	00 MEDICAL SUPPLIES CHARGED TO PATIENT	2,009	2,009	090	1, 020	0 7
73. 00 07300 76. 00 03140 76. 97 07697 76. 98 07699 90. 00 09100 92. 00 09200 118. 00 SPECL 118. 00 NONRE 190. 00 19000 191. 00 19000 191. 00 19200 194. 00 07950 194. 01 07951	00 IMPL. DEV. CHARGED TO PATIENTS	o	o	0	o	0 7
76. 97	DO DRUGS CHARGED TO PATIENTS	0	0	0	O	0 7
76. 98 07698 76. 99 07699 0017PA 90. 00 09000 91. 00 09100 92. 00 07HER 101. 00 10100 SPECI, 118. 00 NONRE 190. 00 19000 191. 00 19100 192. 00 19200 194. 00 07950 194. 01 07951	40 CARDI OLOGY	40, 852	40, 852	9, 054	11, 441	0 7
76. 99 O7699 OUTPA 90. 00 O9000 91. 00 O9200 OTHER 101. 00 SPECI. 118. 00 NONRE 190. 00 19000 191. 00 19100 192. 00 19200 194. 00 07950 194. 01 07951	97 CARDI AC REHABI LI TATI ON	4, 516	4, 516	150	1, 220	0 7
90. 00 09000 91. 00 09100 92. 00 07100 92. 00 10100 92. 00 19000 191. 00 191. 00 192. 00 194. 00 07951 194. 01 07951	98 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0 7
90. 00	99 LITHOTRIPSY PATIENT SERVICE COST CENTERS	0	0	0	U ₁	0 7
91. 00	DO CLINI C	7, 532	7, 532	1, 221	2, 431	0 9
0THER 101. 00 10100 SPECI. 118. 00 NONRE 190. 00 19000 191. 00 19100 192. 00 19200 194. 00 07950 194. 01 07951		24, 972	24, 972		41, 208	0 9
101. 00 10100 SPECI, 118. 00 NONRE 190. 00 19000 191. 00 192.00 192.00 194. 00 07950 194. 01 07951	OO OBSERVATION BEDS (NON-DISTINCT PART	·	·	·	·	Ç
SPECIA 118. 00 NONRE 190. 00 19000 191. 00 19100 192. 00 19200 194. 00 07950 194. 01 07951	ER REIMBURSABLE COST CENTERS					
118. 00 NONRE 190. 00 19000 191. 00 19100 192. 00 19200 194. 00 07950 194. 01 07951	OO HOME HEALTH AGENCY	0	0	0	0	0 10
NONRE 190. 00 19000 191. 00 19100 192. 00 19200 194. 00 07950 194. 01 07951	CIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	725, 498	583, 337	99, 581	335, 353	298, 217 11
190. 00 19000 191. 00 19100 192. 00 19200 194. 00 07950 194. 01 07951		120, 498	303, 337	77, 081	330, 303	270, 21/
191. 00 19100 192. 00 19200 194. 00 07950 194. 01 07951	ALLWOURSADLE COST CENTERS	1, 208	1, 208	0	0	0 19
194. 00 07950 194. 01 07951	REIMBURSABLE COST CENTERS OO GIFT, FLOWER, COFFEE SHOP & CANTEEN		397	0	0	0 19
194. 01 07951	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	397	•	0	5, 400	0 19
•	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 00 RESEARCH 00 PHYSICIANS' PRIVATE OFFICES	55, 420	55, 420	0	0	0 19
101 0000000	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 00 RESEARCH 00 PHYSICIANS' PRIVATE OFFICES 50 ADVERTISING	55, 420 0	0	-		0 19
	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN OO RESEARCH OO PHYSICIANS' PRIVATE OFFICES 50 ADVERTISING 51 FITNESS POINTE	55, 420 0 46, 255	0 46, 255	0	0	0 19
	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN OO RESEARCH OO PHYSICIANS' PRIVATE OFFICES 50 ADVERTISING 51 FITNESS POINTE 52 FITNESS POINTE SPA/PRO SHOP/DIETARY	55, 420 0 46, 255 1, 482	0 46, 255 1, 482	-	0 0	
	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN OO RESEARCH OO PHYSI CIANS' PRIVATE OFFICES 50 ADVERTISING 51 FITNESS POINTE 52 FITNESS POINTE SPA/PRO SHOP/DIETARY 53 RETAIL PHARMACY	55, 420 0 46, 255 1, 482 1, 775	0 46, 255 1, 482 1, 775	-	0 0 120	0 19
1	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN OO RESEARCH OO PHYSICIANS' PRIVATE OFFICES 50 ADVERTISING 51 FITNESS POINTE 52 FITNESS POINTE SPA/PRO SHOP/DIETARY	55, 420 0 46, 255 1, 482	0 46, 255 1, 482	0 0	0 0 120 0 0	
194. 07 07957	GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH PHYSI CIANS' PRIVATE OFFICES ADVERTISING TINESS POINTE FITNESS POINTE SPA/PRO SHOP/DIETARY HOSPICE	55, 420 0 46, 255 1, 482 1, 775 7, 063	0 46, 255 1, 482 1, 775	0 0	0 0 120 0 0	0 19
200.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH PHYSI CIANS' PRIVATE OFFICES ADVERTISING TITNESS POINTE FITNESS POINTE SAME FROM THE SPA/PRO SHOP/DIETARY SAME HOSPICE RUSH RESIDENTS	55, 420 0 46, 255 1, 482 1, 775 7, 063 0	0 46, 255 1, 482 1, 775 7, 063 0	0 0	0 0 120 0 0 0	0 19 0 19 0 19 0 19 0 19
201. 00	GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH PHYSICIANS' PRIVATE OFFICES ADVERTISING IT INESS POINTE STATE PHARMACY HOSPICE RUSH RESIDENTS IN INSTEIN BAGELS NORTHWESTERN I MAGING Cross Foot Adjustments	55, 420 0 46, 255 1, 482 1, 775 7, 063 0 605	0 46, 255 1, 482 1, 775 7, 063 0 605	0 0	0 0 120 0 0 0	0 19 0 19 0 19 0 19 0 19 20
202. 00	GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH PHYSI CIANS' PRIVATE OFFICES ADVERTISING TINESS POINTE FITNESS POINTE STATE OF THE SPAPRO SHOP/DIETARY RETAIL PHARMACY HOSPI CE RUSH RESI DENTS EINSTEIN BAGELS NORTHWESTERN IMAGING Cross Foot Adjustments Negative Cost Centers	55, 420 0 46, 255 1, 482 1, 775 7, 063 0 605 2, 648	0 46, 255 1, 482 1, 775 7, 063 0 605 2, 648	0 0 0 0 0 0	0 0 0 0	0 19 0 19 0 19 0 19 0 19 20 20
203. 00	GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH PHYSI CIANS' PRIVATE OFFICES ADVERTISING TINESS POINTE SET FITNESS POINTS SET FITN	55, 420 0 46, 255 1, 482 1, 775 7, 063 0 605	0 46, 255 1, 482 1, 775 7, 063 0 605	0 0	0 0 120 0 0 0 0	0 19 0 19 0 19 0 19 0 19 20
204.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH PHYSI CIANS' PRIVATE OFFICES ADVERTISING FITNESS POINTE FITNESS POINTE SAME HOSPICE RUSH RESIDENTS FOR RUSH RUSH RUSH RUSH RUSH RUSH RUSH RUS	55, 420 0 46, 255 1, 482 1, 775 7, 063 0 605 2, 648	0 46, 255 1, 482 1, 775 7, 063 0 605 2, 648	0 0 0 0 0 0 0 0	0 0 0 0 0	0 19 0 19 0 19 0 19 0 19 20 20 6, 209, 403
	GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH PHYSICIANS' PRIVATE OFFICES ADVERTISING FITNESS POINTE FITNESS POINTE SPA/PRO SHOP/DIETARY RETAIL PHARMACY HOSPICE RUSH RESIDENTS FINSTEIN BAGELS NORTHWESTERN IMAGING Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)	55, 420 0 46, 255 1, 482 1, 775 7, 063 0 605 2, 648	0 46, 255 1, 482 1, 775 7, 063 0 605 2, 648 23, 549, 465 33. 632964	0 0 0 0 0 0 0 0 0 2, 137, 811 21, 468061	0 0 0 0 0 6, 502, 662 19. 076495	0 19 0 19 0 19 0 19 0 19 20 20 6, 209, 403 20 20. 821761 20
205. 00	GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH PHYSI CIANS' PRIVATE OFFICES ADVERTISING FITNESS POINTE FITNESS POINTE SAME HOSPICE RUSH RESIDENTS FOR RUSH RUSH RUSH RUSH RUSH RUSH RUSH RUS	55, 420 0 46, 255 1, 482 1, 775 7, 063 0 605 2, 648	0 46, 255 1, 482 1, 775 7, 063 0 605 2, 648	0 0 0 0 0 0 0 0	0 0 0 0 0	0 19 0 19 0 19 0 19 0 19 20 20 6, 209, 403

Heal th Finar	ncial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 07/01/2019	D-+- /T: D	
					To 06/30/2020	Date/Time Pre 11/25/2020 3:	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICI	(TIME SPENT)	(PATLENT ME	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS)		ALS)	
		6. 00	7. 00	8. 00	9. 00	10.00	
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0125 Peri od: Worksheet B-1 From 07/01/2019 To 06/30/2020 Date/Time Prepared:

				10	00/30/2020	Date/lime Pre 11/25/2020 3:	
	Cost Center Description		MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	
		(FTES)	PERSONNEL (NUMBER	ADMI NI STRATI ON	SERVI CES & SUPPLY	(COSTED REQ .)	
			HOUSED)	7	(COSTED REQ .)		
		11.00	12. 00	URS) 13. 00	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS	11.00	12.00	13.00	14.00	15.00	
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						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5.00
6. 00 7. 00	00700 OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	189, 614					11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0				12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	3, 891	0	2, 587, 543	Ō		13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	4, 791	0	0	0	100	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	4, 791	0	0	0	0	16.00
17. 00	01700 SOCIAL SERVICE	1, 364	0	0	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	ő	0	0	19. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	O	0	0	0	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(PHARMACY)	510	0	0	0	0	23. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	54 0/ ol		4 404 400			00.00
30.00	03000 ADULTS & PEDI ATRI CS	54, 062	0	1, 124, 490	0	0	30.00
31. 00 32. 01	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE	14, 047 3, 816	0	292, 178 79, 373	0	0	31. 00 32. 01
41. 00	04100 SUBPROVI DER – I RF	4, 152	0	86, 362	0	0	41.00
43. 00	04300 NURSERY	1, 835	0	38, 168	0		43. 00
	ANCILLARY SERVICE COST CENTERS	, 1					
50.00	05000 OPERATI NG ROOM	28, 546	0	593, 761	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 283	0	68, 286	0	_	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 836	0	0	0	0	54.00
60.00	06000 LABORATORY	11, 205	0	0	0	0	60.00
62. 00 62. 30	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS	497	0	0	0	0	62. 00 62. 30
65. 00	06500 RESPIRATORY THERAPY	5, 084	0	0	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	9, 749	0	ő	0	0	66. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 235	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
76. 00 76. 97	03140 CARDI OLOGY	11, 147	0	0	0	0	76.00
76. 97 76. 98	O7697 CARDI AC REHABILITATION O7698 HYPERBARI C OXYGEN THERAPY	1, 162 0	0	0	0	0	76. 97 76. 98
76. 79	07699 LI THOTRI PSY	ا	0	0	0		76. 99
, 0, , ,	OUTPATIENT SERVICE COST CENTERS	<u> </u>					10.77
90.00	09000 CLI NI C	3, 009	0	62, 584	0	0	90.00
91. 00	09100 EMERGENCY	11, 651	0	242, 341	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00	OTHER REIMBURSABLE COST CENTERS				0		101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
118. 00		186, 872	0	2, 587, 543	0	100	118. 00
. 10. 00	NONREI MBURSABLE COST CENTERS	100,072	0	2,007,040	0	100	1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19100 RESEARCH	1, 190	0	0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	07950 ADVERTI SI NG	0	0	0	0		194. 00
	07951 FI TNESS POI NTE	0	0	0	0		194. 01
	07952 FITNESS POINTE SPA/PRO SHOP/DIETARY 07953 RETAIL PHARMACY	1, 206	0	0	0		194. 02 194. 03
	07954 HOSPI CE	1, 200	0	0	0		194. 03
	07955 RUSH RESIDENTS		0	o o	0		194. 05
	07956 EINSTEIN BAGELS	346	0	o	0		194. 06
194. 07	07957 NORTHWESTERN I MAGING	0	0	0	0		194. 07
200.00							200. 00
201.00							201. 00
202.00		3, 010, 821	0	6, 982, 386	0	25, 126, 630	202. 00
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	15. 878685	0. 000000	2. 698462	0 000000	251, 266. 300000	203 00
203.00		253, 294	0. 000000 N	259, 042		675, 859	
_5 50	Part II)	255, 274	O	237, 372	O	2.5,557	55
		<u> </u>		<u> </u>		<u> </u>	I

Heal th Finar	ncial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 07/01/2019 Fo 06/30/2020	Date/Time Pre	pared:
						11/25/2020 3:	
	Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	
		(FTES)	PERSONNEL	ADMI NI STRATI OI	SERVICES &	(COSTED REQ .)	
			(NUMBER		SUPPLY		
			HOUSED)	(NURSING HO	(COSTED REQ .)		
				URS)			
		11. 00	12. 00	13. 00	14. 00	15. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	1. 335840	0. 000000	0. 100111	0. 000000	6, 758. 590000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: From 07/01/2019 To 06/30/2020 Date/Time Prepared: Provider CCN: 15-0125

			<u> </u>		11/25/2020 3:	
				INTERNS &	RESIDENTS	
Cost Center Description	MEDICAL RECORDS &	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	
	LI BRARY	(TIME SPENT)	(ASSI GNED	APPRV	APPRV	
	(GROSS REVE		TIME)	(ASSI GNED	(ASSI GNED	
	NUE) 16. 00	17. 00	19. 00	TI ME) 21. 00	TI ME) 22. 00	
GENERAL SERVICE COST CENTERS						4 00
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT						6. 00 7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE						8. 00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A						10. 00 11. 00
12. 00 01200 MAINTENANCE OF PERSONNEL						12. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY						14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	1, 789, 164, 017					16. 00
17. 00 01700 SOCIAL SERVICE	0	95, 130				17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0				19. 00 21. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	Ö	0			0	22. 00
23. 00 02300 PARAMED ED PRGM-(PHARMACY)	0	0				23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	149, 523, 612	67, 795		ol ol	0	30.00
31. 00 03100 NTENSI VE CARE UNIT	28, 784, 285	10, 863	Č	1	0	31.00
32. 01 02060 NEONATAL INTENSIVE CARE	28, 202, 953	4, 299	C		0	32. 01
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	9, 702, 695 5, 599, 391	7, 717 3, 110			0	41. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	3, 377, 371	3, 110		η σ		43.00
50. 00 05000 OPERATING ROOM	305, 845, 365	0	C	1	0	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 204, 874 311, 732, 541	0			0	52. 00 54. 00
60. 00 06000 LABORATORY	199, 692, 123	0	C	1	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	11, 454, 287	0	C	o	0	62. 00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 65. 00 06500 RESPIRATORY THERAPY	0 32, 145, 120	0			0	62. 30 65. 00
66. 00 06600 PHYSI CAL THERAPY	47, 371, 197	0			0	66.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	14, 638, 571	0	С	1	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	51, 250, 695 77, 335, 456	0			0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATTENTS	138, 506, 628	0			0	73.00
76. 00 03140 CARDI OLOGY	192, 282, 034	0	C	o	0	76. 00
76. 97 07697 CARDIAC REHABILITATION 76. 98 07698 HYPERBARIC OXYGEN THERAPY	2, 663, 212 0	0		0	0	76. 97 76. 98
76. 99 07699 LI THOTRI PSY	0	0	_	1		
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	13, 243, 230 150, 205, 944	0 1, 346			0	90. 00 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	150, 205, 944	1, 340		,	O	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	8, 779, 804	0	C	0	0	101. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 789, 164, 017	95, 130	C	0	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	0	0		1		190. 00 191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				191.00
194. 00 07950 ADVERTI SI NG	0	0	C	o	0	194. 00
194. 01 07951 FI TNESS POINTE	0	0				194. 01 194. 02
194. 02 07952 FITNESS POINTE SPA/PRO SHOP/DIETARY 194. 03 07953 RETAIL PHARMACY	0	0				194. 02
194. 04 07954 HOSPI CE	0	0	C	o	0	194. 04
194. 05 07955 RUSH RESI DENTS	0	0	C	0		194. 05
194. 06 07956 ELNSTELN BAGELS 194. 07 07957 NORTHWESTERN LIMAGING	0	O				194. 06 194. 07
200.00 Cross Foot Adjustments		Ĭ			· ·	200. 00
201.00 Negative Cost Centers	/ 525 525	4 007 071	_		_	201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	6, 525, 587	1, 337, 371	۱	<u>'</u>	0	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 003647	14. 058352	0. 000000	0.000000	0.000000	203. 00

Health Fina	ancial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provi der Co		Period: From 07/01/2019	Worksheet B-1	
					To 06/30/2020	Date/Time Pre 11/25/2020 3:	pared: 02 pm
					INTERNS &	RESI DENTS	
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	SERVI CES-SALAR	SERVI CES-OTHER	
		RECORDS &		ANESTHETI STS	Y & FRINGES	PRGM COSTS	
		LI BRARY	(TIME SPENT)	(ASSI GNED	APPRV	APPRV	
		(GROSS REVE		TIME)	(ASSI GNED	(ASSI GNED	
		NUE)			TIME)	TIME)	
		16. 00	17. 00	19. 00	21. 00	22. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)	138, 254	29, 243	(0	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000077	0. 307400	0. 000000	0. 000000	0. 000000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0125 Period: Worksheet B-1

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0125 From 07/01/2019 06/30/2020 Date/Time Prepared: 11/25/2020 3:02 pm Cost Center Description PARAMED ED PRGM-(PHARMACY (ASSÍ GNED TIME) 23.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12. 00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17 00 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 22. 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 02300 PARAMED ED PRGM-(PHARMACY) 23.00 100 23 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 0 31.00 03100 INTENSIVE CARE UNIT 31.00 0 02060 NEONATAL INTENSIVE CARE 32.01 32.01 0 41.00 04100 SUBPROVIDER - IRF 41.00 04300 NURSERY 0 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0000000 05400 RADI OLOGY-DI AGNOSTI C 54.00 54.00 60.00 06000 LABORATORY 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 62 00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 06500 RESPIRATORY THERAPY 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 66,00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 100 73.00 0 76.00 03140 CARDI OLOGY 76.00 76. 97 07697 CARDIAC REHABILITATION 76. 97 07698 HYPERBARI C OXYGEN THERAPY 0 76.98 76.98 07699 LI THOTRI PSY 76. 99 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09100 EMERGENCY 0 91 00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 100 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190 00 0 191. 00 19100 RESEARCH 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.00 194. 00 07950 ADVERTI SI NG 00000 194.00 194. 01 07951 FITNESS POINTE 194 01 194. 02 07952 FITNESS POINTE SPA/PRO SHOP/DIETARY 194. 02 194. 03 07953 RETAIL PHARMACY 194. 03 194. 04 07954 HOSPI CE 194. 04 194. 05 07955 RUSH RESIDENTS 194.05 194.06 07956 EINSTEIN BAGELS 0 194.06 194. 07 194. 07 07957 NORTHWESTERN I MAGING 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 202. 00 489, 687 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 4, 896. 870000 203.00 Cost to be allocated (per Wkst. B, 204. 00 204.00 7, 412 Part II)

Health Financial Systems	COMMUNITY HOS	SPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0125	Peri od:	Worksheet B-1
			From 07/01/2019 To 06/30/2020	Date/Time Prepared: 11/25/2020 3:02 pm
Cost Center Description	PARAMED ED			
	PRGM-(PHARMACY			
)			
	(ASSI GNED			
	TIME)			
	23.00			
205.00 Unit cost multiplier (Wkst. B, Par	rt 74. 120000			205. 00
206.00 NAHE adjustment amount to be alloc	cated 0			206. 00
(per Wkst. B-2)				
207.00 NAHE unit cost multiplier (Wkst. [0. 000000			207. 00
Parts III and IV)				

Health Financial Systems	COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0125	Period: Worksheet C		

06/30/2020 Date/Time Prepared: To 11/25/2020 3:02 pm Title XVIII Hospi tal Costs Therapy Limit Cost Center Description Total Cost Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 2.00 4. 00 1.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 83, 487, 115 83, 487, 115 64, 354 83, 551, 469 31.00 03100 INTENSIVE CARE UNIT 22, 240, 995 22, 240, 995 17, 984 22, 258, 979 31.00 02060 NEONATAL INTENSIVE CARE 32.01 6, 093, 054 6, 093, 054 9, 436 6, 102, 490 32.01 04100 SUBPROVI DER - I RF 41.00 6, 752, 109 6, 752, 109 6, 752, 109 41.00 04300 NURSERY 43.00 2, 567, 963 2, 567, 963 2, 567, 963 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 55, 606, 381 55, 606, 381 24, 344 55, 630, 725 50.00 5, 581, 489 5, 388 05200 DELIVERY ROOM & LABOR ROOM 5, 576, 101 5, 576, 101 52.00 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 29, 241, 489 29, 241, 489 16, 905 29, 258, 394 54.00 60.00 06000 LABORATORY 22, 954, 522 22, 954, 522 29, 368 22, 983, 890 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 3, 260, 844 3, 260, 844 3, 260, 844 62.00 62.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 Λ 62.30 65.00 06500 RESPIRATORY THERAPY 7, 072, 947 7, 072, 947 1, 819 7, 074, 766 65.00 06600 PHYSI CAL THERAPY 17, 297, 448 17, 297, 448 17, 297, 448 66.00 66.00 07000 ELECTROENCEPHALOGRAPHY 1, 723, 269 1, 723, 269 1, 725, 912 70 00 2 643 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 28, 419, 958 28, 419, 958 28, 419, 958 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 38, 289, 442 38, 289, 442 0 38, 289, 442 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 26, 121, 451 26, 121, 451 26, 121, 451 73.00 03140 CARDI OLOGY 23, 216, 998 76 00 23, 204, 226 23, 204, 226 76 00 12.772 76.97 07697 CARDIAC REHABILITATION 1,647,954 1, 647, 954 0 1, 647, 954 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 76.98 0 76 99 07699 LI THOTRI PSY 0 76.99 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 4, 656, 862 4, 656, 862 16, 379 4, 673, 241 90.00 91.00 09100 EMERGENCY 16, 806, 810 16, 806, 810 16, 806, 810 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 14, 849, 903 14, 849, 903 92 00 14, 849, 903 92 00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 7, 359, 463 7, 359, 463 7, 359, 463 101. 00 201, 392 200.00 Subtotal (see instructions) 425, 230, 306 0 425, 230, 306 425, 431, 698 200. 00 14, 849, 903 201. 00 14, 849, 903 201.00 Less Observation Beds 14, 849, 903 202.00 Total (see instructions) 410, 380, 403 0 410, 380, 403 201, 392 410, 581, 795 202. 00

Health Financial Systems	COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0125 P	Period: Worksheet C

COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provider CO		Peri od: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Pre 11/25/2020 3:	
				XVIII	Hospi tal	PPS	
			Charges	T		TEFRA	
	Cost Center Description	Inpatient	Outpati ent	+ col . 7)	6 Cost or Other Ratio	Inpatient	
				+ COI. /)	кано	Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
30. 00	03000 ADULTS & PEDIATRICS	110, 448, 396		110, 448, 39	6		30.00
31. 00	03100 I NTENSI VE CARE UNI T	28, 784, 285		28, 784, 28			31. 00
32. 01	02060 NEONATAL INTENSIVE CARE	28, 202, 953		28, 202, 95			32. 01
41. 00	04100 SUBPROVI DER - I RF	9, 702, 695		9, 702, 69			41.00
43. 00	04300 NURSERY	5, 599, 391		5, 599, 39			43. 00
	ANCILLARY SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,			'		
50.00	05000 OPERATI NG ROOM	111, 123, 089	194, 722, 276	305, 845, 36	5 0. 181812	0.000000	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 569, 436	2, 635, 438	10, 204, 87	4 0. 546415	0.000000	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	64, 822, 982	246, 909, 559	311, 732, 54	0. 093803	0.000000	54. 00
60.00	06000 LABORATORY	65, 904, 667	133, 787, 456	199, 692, 12	3 0. 114950	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	7, 266, 439	4, 187, 848	11, 454, 28	0. 284683	0.000000	62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	0		0. 000000	0.000000	62. 30
65.00	06500 RESPI RATORY THERAPY	29, 160, 703	2, 984, 417	32, 145, 12	0. 220032	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	22, 109, 469	25, 261, 728	47, 371, 19	7 0. 365147	0.000000	66.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 589, 897	13, 048, 674	14, 638, 57	0. 117721	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	24, 299, 619	26, 951, 076	51, 250, 69	0. 554528	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	47, 766, 325	29, 569, 131	77, 335, 45	6 0. 495109	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	85, 897, 095	52, 609, 533	138, 506, 62	8 0. 188594	0.000000	
76.00	03140 CARDI OLOGY	74, 878, 247	117, 403, 787			0.000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	416, 955	2, 246, 257	2, 663, 21		0.000000	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0. 000000	0.000000	
76. 99	07699 LI THOTRI PSY	0	0		0. 000000	0.000000	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	482, 413	12, 760, 817			0. 000000	
91.00	09100 EMERGENCY	47, 887, 739	102, 318, 205			0. 000000	
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	5, 384, 775	33, 690, 441	39, 075, 21	6 0. 380034	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS		0.770.004				
	10100 HOME HEALTH AGENCY	0	8, 779, 804				101. 00
200.00		119, 291, 570	1, 009, 866, 447	1, 789, 164, 01 	/		200.00
201.00		770 207 570	1 000 044 447	1 700 1/4 01			201.00
202.00	Total (see instructions)	[179, 297, 570]	1, 009, 866, 447	1, 789, 164, 01	1		202. 00

Health Financial Systems	COMMUNITY HO	SPI TAL	In Lie	u of Form CMS-255	52-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0125	Peri od: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Prepai 11/25/2020 3:02	
		Title XVIII	Hospi tal	PPS	

				11/25/2020 3:02 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
32. 01 02060 NEONATAL NTENSIVE CARE				32. 01
41. 00 04100 SUBPROVI DER - I RF				41. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 181892			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 546943			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 093857			54. 00
60. 00 06000 LABORATORY	0. 115097			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 284683			62. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 220088			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 365147			66. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 117902			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 554528			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 495109			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 188594			73. 00
76. 00 03140 CARDI OLOGY	0. 120744			76.00
76. 97 07697 CARDIAC REHABILITATION	0. 618784			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 352878			90.00
91. 00 09100 EMERGENCY	0. 111892			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 380034			92. 00
OTHER REIMBURSABLE COST CENTERS	<u> </u>			
101.00 10100 HOME HEALTH AGENCY				101. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
				•

Health Financial Systems	COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0125	Peri od: Worksheet C

0//01/2019 | Part | 06/30/2020 | Date/Time Prepared: 11/25/2020 3:02 pm Title XIX Hospi tal PPS Costs Therapy Limit Cost Center Description Total Cost Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 2.00 4. 00 1.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 83, 487, 115 83, 487, 115 64, 354 83, 551, 469 31.00 03100 INTENSIVE CARE UNIT 22, 240, 995 22, 240, 995 17, 984 22, 258, 979 31.00 02060 NEONATAL INTENSIVE CARE 32.01 6, 093, 054 6, 093, 054 9, 436 6, 102, 490 32.01 04100 SUBPROVI DER - I RF 41.00 6, 752, 109 6, 752, 109 6, 752, 109 41.00 04300 NURSERY 43.00 2, 567, 963 2, 567, 963 2, 567, 963 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 55, 606, 381 55, 606, 381 24, 344 55, 630, 725 50.00 5, 581, 489 5, 388 05200 DELIVERY ROOM & LABOR ROOM 5, 576, 101 5, 576, 101 52.00 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 29, 241, 489 29, 241, 489 16, 905 29, 258, 394 54.00 60.00 06000 LABORATORY 22, 954, 522 22, 954, 522 29, 368 22, 983, 890 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 3, 260, 844 3, 260, 844 3, 260, 844 62.00 62.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 Λ 62.30 65.00 06500 RESPIRATORY THERAPY 7, 072, 947 7, 072, 947 1, 819 7, 074, 766 65.00 06600 PHYSI CAL THERAPY 17, 297, 448 17, 297, 448 17, 297, 448 66.00 66.00 07000 ELECTROENCEPHALOGRAPHY 1, 723, 269 1, 723, 269 1, 725, 912 70 00 2 643 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 28, 419, 958 28, 419, 958 28, 419, 958 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 38, 289, 442 38, 289, 442 0 38, 289, 442 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 26, 121, 451 26, 121, 451 26, 121, 451 73.00 03140 CARDI OLOGY 23, 216, 998 76 00 23, 204, 226 23, 204, 226 76 00 12, 772 76.97 07697 CARDIAC REHABILITATION 1,647,954 1, 647, 954 0 1, 647, 954 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 76.98 0 76 99 07699 LI THOTRI PSY 0 76.99 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 4, 656, 862 4, 656, 862 16, 379 4, 673, 241 90.00 91.00 09100 EMERGENCY 16, 806, 810 16, 806, 810 16, 806, 810 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 14, 849, 903 14, 849, 903 14, 849, 903 92 00 92 00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 7, 359, 463 7, 359, 463 7, 359, 463 101. 00 201, 392 200.00 Subtotal (see instructions) 425, 230, 306 0 425, 230, 306 425, 431, 698 200. 00 14, 849, 903 201. 00 14, 849, 903 201.00 Less Observation Beds 14, 849, 903 202.00 Total (see instructions) 410, 380, 403 0 410, 380, 403 201, 392 410, 581, 795 202. 00

Health Financial Systems	COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0125 Peri	iod: Worksheet C

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CO		Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Pre 11/25/2020 3:	
				e XIX	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpatient	+ col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	T	6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	110, 448, 396		110, 448, 39			30. 00
31. 00	03100 I NTENSI VE CARE UNI T	28, 784, 285		28, 784, 28			31. 00
32. 01	02060 NEONATAL INTENSIVE CARE	28, 202, 953		28, 202, 95			32. 01
41. 00	04100 SUBPROVI DER - I RF	9, 702, 695		9, 702, 69			41. 00
43.00	04300 NURSERY	5, 599, 391		5, 599, 39	1		43. 00
	ANCILLARY SERVICE COST CENTERS	1					
50.00	05000 OPERATING ROOM	111, 123, 089	194, 722, 276			0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	7, 569, 436	2, 635, 438			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	64, 822, 982	246, 909, 559			0. 000000	
60.00	06000 LABORATORY	65, 904, 667	133, 787, 456			0. 000000	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	7, 266, 439	4, 187, 848			0. 000000	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0. 000000	0. 000000	
65.00	06500 RESPI RATORY THERAPY	29, 160, 703	2, 984, 417			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	22, 109, 469	25, 261, 728			0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 589, 897	13, 048, 674			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	24, 299, 619	26, 951, 076			0. 000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	47, 766, 325	29, 569, 131			0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	85, 897, 095	52, 609, 533			0. 000000	
76.00	03140 CARDI OLOGY	74, 878, 247	117, 403, 787			0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	416, 955	2, 246, 257	2, 663, 21		0. 000000	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0. 000000	0. 000000	
76. 99	07699 LI THOTRI PSY	0	0		0. 000000	0. 000000	76. 99
	OUTPATIENT SERVICE COST CENTERS	,					
90.00	09000 CLI NI C	482, 413	12, 760, 817			0. 000000	
91.00	09100 EMERGENCY	47, 887, 739	102, 318, 205			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 384, 775	33, 690, 441	39, 075, 21	6 0. 380034	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS	1					
	10100 HOME HEALTH AGENCY	0	8, 779, 804				101. 00
200.00		779, 297, 570	1, 009, 866, 447	1, 789, 164, 01	7		200. 00
201.00	1 1				_		201. 00
202.00	Total (see instructions)	779, 297, 570	1, 009, 866, 447	1, 789, 164, 01	7		202. 00

Health Financial Systems	HOSPI TAL	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0125	From 07/01/2019	Worksheet C Part I Date/Time Prep 11/25/2020 3:0	
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient Ratio				

		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient	THE ALX	поэрг саг	113
oust content besoft per on	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31. 00
32.01 02060 NEONATAL INTENSIVE CARE				32. 01
41. 00 04100 SUBPROVI DER - I RF				41. 00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 181892			50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 546943			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 093857			54. 00
60. 00 06000 LABORATORY	0. 115097			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 284683			62. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 220088			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 365147			66. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 117902			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 554528			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 495109			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 188594			73. 00
76. 00 03140 CARDI OLOGY	0. 120744			76. 00
76. 97 07697 CARDIAC REHABILITATION	0. 618784			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 352878			90.00
91. 00 09100 EMERGENCY	0. 111892			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 380034			92. 00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	COMMUNITY HOS	SPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE CO	ST TO CHARGE RATIOS NET OF	Provider CCN: 15-0125	Peri od:	Worksheet C
DEDUCTIONS FOR MEDICALD ONLY			From 07/01/2010	Dart II

REDUCTIONS FOR MEDICALD ONLY To 06/30/2020 Date/Time Prepared: 11/25/2020 3:02 pm Title XIX Hospi tal PPS Total Cost Capital Cost Operating Cost Operating Cost Cost Center Description Capi tal Reducti on Reducti on Cost (col. 1 Amount col. 2) 5. 00 1.00 2.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 55, 606, 381 6, 052, 917 49, 553, 464 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 484, 827 5, 091, 274 52.00 52.00 5, 576, 101 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 29, 241, 489 5, 093, 997 24, 147, 492 54.00 06000 LABORATORY 22, 954, 522 1, 197, 224 21, 757, 298 60.00 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 62.00 3, 260, 844 74, 494 3, 186, 350 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 65.00 06500 RESPIRATORY THERAPY 7, 072, 947 210, 147 6, 862, 800 0 65.00 66.00 06600 PHYSI CAL THERAPY 17, 297, 448 1, 033, 021 16, 264, 427 66.00 1, 723, 269 1, 577, 677 07000 ELECTROENCEPHALOGRAPHY 145, 592 70.00 Λ 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 28, 419, 958 117, 589 28, 302, 369 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 38, 289, 442 158, 942 38, 130, 500 0 72.00 07300 DRUGS CHARGED TO PATIENTS 26, 121, 451 73.00 686, 524 25, 434, 927 0 73.00 03140 CARDI OLOGY 23, 204, 226 3, 211, 631 19, 992, 595 76.00 76.00 0 76.97 07697 CARDIAC REHABILITATION 1, 647, 954 130, 967 1, 516, 987 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 76. 98 0 76. 99 o 07699 LI THOTRI PSY 76.99 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 4, 656, 862 205, 798 4, 451, 064 0 0 90.00 09100 EMERGENCY 0 91.00 16, 806, 810 825, 646 15, 981, 164 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 14, 849, 903 o 92.00 92.00 914, 323 13, 935, 580 οl OTHER REIMBURSABLE COST CENTERS 32, 302 20, 575, 941 101.00 10100 HOME HEALTH AGENCY 7, 359, 463 0 101.00 7, 327, 161 0 0 0 Subtotal (sum of lines 50 thru 199) 283, 513, 129 0 200.00 200.00 304, 089, 070 14, 849, 903 914, 323 0 201. 00 201.00 Less Observation Beds 13, 935, 580

289, 239, 167

19, 661, 618

269, 577, 549

0 202. 00

202.00

Total (line 200 minus line 201)

Health Financial Systems	COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO	CHARGE RATIOS NET OF Provider CCN: 15-0125	Peri od: Worksheet C
REDUCTIONS FOR MEDICALD ONLY		From 07/01/2019 Part II

					To	06/30/2020	Date/Time Pr 11/25/2020 3	
-			Ti tl	e XIX		Hospi tal	PPS	. 02 piii
	Cost Center Description	Cost Net of	Total Charges					
	p	Capital and	(Worksheet C,		е			
		Operating Cost						
		Reduction	8)	/ col. 7)				
		6. 00	7. 00	8. 00				
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	55, 606, 381	305, 845, 365	0. 18181	2			50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 576, 101	10, 204, 874	0. 54641	5			52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	29, 241, 489	311, 732, 541		-			54. 00
60.00	06000 LABORATORY	22, 954, 522						60. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	3, 260, 844	11, 454, 287					62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000				62. 30
65. 00	06500 RESPI RATORY THERAPY	7, 072, 947						65. 00
	06600 PHYSI CAL THERAPY	17, 297, 448						66. 00
		1, 723, 269						70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28, 419, 958						71. 00
		38, 289, 442	77, 335, 456	0. 49510	9			72. 00
	07300 DRUGS CHARGED TO PATIENTS	26, 121, 451						73. 00
		23, 204, 226						76. 00
	07697 CARDI AC REHABI LI TATI ON	1, 647, 954	2, 663, 212					76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 00000				76. 98
76. 99	07699 LI THOTRI PSY	0	0	0. 00000	0			76. 99
	OUTPATIENT SERVICE COST CENTERS							
	09000 CLI NI C	4, 656, 862						90.00
	09100 EMERGENCY	16, 806, 810						91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	14, 849, 903	39, 075, 216	0. 38003	4			92. 00
	OTHER REIMBURSABLE COST CENTERS							
	10100 HOME HEALTH AGENCY	7, 359, 463			6			101. 00
200.00	,		1, 606, 426, 297					200. 00
201. 00		14, 849, 903	l					201. 00
202.00	Total (line 200 minus line 201)	289, 239, 167	1, 606, 426, 297					202. 00

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	TAL COSTS	Provider Co		Period: From 07/01/2019 Fo 06/30/2020	Worksheet D Part I Date/Time Pre 11/25/2020 3:0	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		Г	1	T		
30. 00 ADULTS & PEDI ATRI CS	5, 144, 336	l e	0, , 00.		63. 17	30. 00
31.00 INTENSIVE CARE UNIT	1, 449, 698	l e	1, 449, 698			
32. 01 NEONATAL INTENSIVE CARE	432, 348	l e	432, 348			
41. 00 SUBPROVI DER - I RF	356, 619	l e	356, 619		46. 21	41. 00
43. 00 NURSERY	55, 100	l e	55, 100			43.00
200.00 Total (lines 30 through 199)	7, 438, 101		7, 438, 10	1 107, 431		200. 00
Cost Center Description	Inpatient	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
LANDATI ENT. DOUTLAND OFFICE OF COOT OFFITEDO	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	00.504	1 227 244				
30. 00 ADULTS & PEDIATRICS	30, 506					30.00
31. 00 INTENSIVE CARE UNIT	4, 653	1	1			31.00
32. 01 NEONATAL INTENSIVE CARE	0	1				32. 01
41. 00 SUBPROVI DER - I RF	6, 181	ľ	1			41.00
43. 00 NURSERY	0	1				43. 00
200.00 Total (lines 30 through 199)	41, 340	2, 833, 631				200. 00

Health Financial Systems COMMUNITY F			OSPI TAL I n			ieu of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS		Provider CC	CN: 15-0125	Peri od: From 07/01/2019 To 06/30/2020	Worksheet D Part II Date/Time Prepared: 11/25/2020 3:02 pm	
			Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	To	tal Charges	Ratio of Co	st Inpatient	Capital Costs	

					From 07/01/2019 To 06/30/2020	Part II Date/Time Pre 11/25/2020 3:	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal		Ratio of Cost		Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col	Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			T			
	05000 OPERATING ROOM	6, 052, 917		1			50.00
	05200 DELIVERY ROOM & LABOR ROOM	484, 827		1			
	05400 RADI OLOGY-DI AGNOSTI C	5, 093, 997		1			1
	06000 LABORATORY	1, 197, 224		1			60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	74, 494	11, 454, 287	1		19, 044	62. 00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C	0.00000		0	62. 30
	06500 RESPI RATORY THERAPY	210, 147		1			65. 00
	06600 PHYSI CAL THERAPY	1, 033, 021	47, 371, 197	0. 02180	6, 836, 091	149, 075	66. 00
	07000 ELECTROENCEPHALOGRAPHY	145, 592	14, 638, 571	0.00994	827, 062		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	117, 589	51, 250, 695	0.00229	4 10, 973, 655	25, 174	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	158, 942	77, 335, 456	0.00205	22, 112, 795	45, 442	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	686, 524	138, 506, 628	0. 00495	7 34, 055, 997	168, 816	73. 00
76.00	03140 CARDI OLOGY	3, 211, 631	192, 282, 034	0. 01670	35, 982, 935	601, 023	76. 00
76. 97	07697 CARDIAC REHABILITATION	130, 967	2, 663, 212	0. 04917	168, 726	8, 297	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	C	0.00000	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	C	0.00000	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	205, 798	13, 243, 230	0. 01554	145, 195	2, 256	90. 00
91.00	09100 EMERGENCY	825, 646	150, 205, 944	0.00549	7 21, 453, 421	117, 929	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	914, 323	39, 075, 216	0. 02339	9 0	0	
200. 00	Total (lines 50 through 199)	20, 543, 639	1, 597, 646, 493		249, 981, 648	2, 744, 122	200. 00

COMMUNI TY	HOSPI TAI				
			In Lie	u of Form CMS-2	2552-10
ER PASS THROUGH COST	S Provider CO	CN: 15-0125	Period: From 07/01/2019 To 06/30/2020		
	Title	XVIII	Hospi tal	PPS	
Nursing School Post-Stepdown Adjustments	Nursing School	Post-Stepdow	n Cost	All Other Medical Education Cost	
1A	1.00	2A	2. 00	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 0		31. 00 32. 01 41. 00
Adjustment Amount (see instructions)	(sum of cols. 1 through 3, minus col. 4)	Days	5 ÷ col . 6)	Program Days	
4.00	3.00	0.00	7.00	0.00	
0	0 0 0 0 0	10, 86 4, 29 7, 71 3, 11	0. 00 0. 00 7 0. 00 0 0. 00	4, 653 0 6, 181 0	31. 00 32. 01 41. 00
Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					30. 00 31. 00 32. 01 41. 00 43. 00 200. 00
	Post-Stepdown Adjustments 1A 0 0 0 0 0 0 0 Swing-Bed Adjustment Amount (see instructions) 4.00 0 Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	Nursing School Nursing School Post-Stepdown Adjustments 1A	Title XVIII	Nursing School Nursing School Allied Health Post-Stepdown Adjustments 1A 1.00 2A 2.00	To

1	Health Financial Systems	COMMUNITY HOS	SPI TAL	In Lie	u of Form CMS-2552-10
	APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0125	Peri od: From 07/01/2019 To 06/30/2020	Worksheet D Part IV Date/Time Prepared:

				'	00,00,2020	11/25/2020 3:0	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Nursing School	Nursing School	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0)	0	01	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0)	0	0	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0) (0	0	54. 00
	06000 LABORATORY	0	0) (0	0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0) (0	0	62. 00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0) (0	0	62. 30
	06500 RESPI RATORY THERAPY	0	0) (0	0	65. 00
	06600 PHYSI CAL THERAPY	0	0) (0	0	66. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0) (0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0) (0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0) (0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0) (0	489, 687	73. 00
76. 00	03140 CARDI OLOGY	0	0)	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0) (0	0	76. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0	0) (0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0) (0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0) (0	0	90.00
91. 00	09100 EMERGENCY	0	0) (0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92. 00
200.00	Total (lines 50 through 199)	0	0) (0	489, 687	200. 00

Health Financial Systems COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10							
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS			Provi der CCN: 15-0125		Worksheet D Part IV Date/Time Pre 11/25/2020 3:0	pared:
			Title	Title XVIII		Hospi tal PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	'	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		305, 845, 365		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		10, 204, 874		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		311, 732, 541		
60.00	06000 LABORATORY	0	0		199, 692, 123		
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		11, 454, 287		
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0.000000	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0		32, 145, 120	0.000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0 47, 371, 197	0.000000	66. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		14, 638, 571	0.000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		51, 250, 695	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		77, 335, 456	0.000000	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	489, 687	489, 68	7 138, 506, 628	0. 003535	
76.00	03140 CARDI OLOGY	0	0		192, 282, 034	0.000000	76. 00
	07697 CARDI AC REHABI LI TATI ON	0	0		2, 663, 212	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0.000000	76. 98
76. 99	07699 LI THOTRI PSY	0	0		0	0.000000	76. 99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0		13, 243, 230	0.000000	90.00

0 0 0

0

489, 687

13, 243, 230 150, 205, 944 39, 075, 216

0

489, 687 1, 597, 646, 493

0. 000000 0. 000000

0.000000

90.00

91.00

92.00

200.00

90. 00 | 09000 | CLINIC | 091. 00 | 09100 | EMERGENCY | 092. 00 | 09200 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 09500 | 0950

Heal th	Financial Systems	COMMUNITY H	OSPI TAL		In Lie	eu of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	VICE OTHER PASS	Provi der CC		Period: From 07/01/2019 Fo 06/30/2020	Worksheet D Part IV Date/Time Prep 11/25/2020 3:0	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8		Outpatient Program Pass-Through Costs (col. 9	
		7)		x col. 10)		x col . 12)	
		9, 00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 000000	44, 367, 987	(52, 541, 323	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	28, 608	(0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	28, 204, 520	(77, 868, 349	0	54.00
60.00	06000 LABORATORY	0. 000000	28, 365, 250	(14, 527, 013	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	2, 928, 106	(1, 153, 282	0	62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	(0	0	62. 30
65.00	06500 RESPIRATORY THERAPY	0. 000000	13, 531, 300	(1, 115, 294	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	6, 836, 091	(583, 325	0	66. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	827, 062	(3, 432, 533	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	10, 973, 655	(9, 934, 831	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	22, 112, 795	(10, 342, 677	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 003535	34, 055, 997	120, 388	20, 410, 469	72, 151	73. 00
76.00	03140 CARDI OLOGY	0. 000000	35, 982, 935	(51, 245, 530	0	76. 00
76. 97	07697 CARDIAC REHABILITATION	0. 000000	168, 726	(997, 485	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	(0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0	(0	0	76. 99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLI NI C	0. 000000	145, 195		7, 400, 915	0	90. 00
01 00	00100 EMEDICENCY	0 000000	21 452 421	1	1/ /20 5/7	l	01 00

0. 000000

0. 000000

21, 453, 421

249, 981, 648

16, 428, 567 9, 091, 404 277, 072, 997

0 91.00

0 92.00

72, 151 200. 00

91.00 | 09100 | EMERGENCY 92.00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART 200.00 | Total (lines 50 through 199)

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-	2552-10	
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	Provi der CCN: 15-0125		Worksheet D Part V Date/Time Pre 11/25/2020 3:		
		Title	XVIII	Hospi tal	PPS		
			Charges		Costs		
Cost Center Description	Cost to Charge			Cost	PPS Services		
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)		
	Worksheet C,	inst.)	Servi ces	Services Not			
	Part I, col. 9		Subject To	Subj ect To			
			Ded. & Coins				
	1.00		(see inst.)	(see inst.)			
ANOLILARY OFRINGE COOT OFFITERS	1.00	2.00	3. 00	4. 00	5. 00		
ANCILLARY SERVICE COST CENTERS	0.101010	F2 F44 222	I	0 2/ 720	0.552.742	F0 00	
50. 00 05000 OPERATING ROOM	0. 181812			0 26, 738			
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 546415			0	7 204 205	52.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 093803			0	7, 304, 285		
60. 00 06000 LABORATORY	0. 114950			0	1, 669, 880		
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 284683			0	328, 320		
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			0	0	62. 30	
65. 00 06500 RESPIRATORY THERAPY	0. 220032			0	245, 400		
66. 00 06600 PHYSI CAL THERAPY	0. 365147			0	212, 999		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 117721			0	404, 081		
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 554528			0	5, 509, 142		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 495109		•	0 0	5, 120, 752		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 188594			0 113, 940			
76. 00 03140 CARDI OLOGY	0. 120678			0	6, 184, 208		
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 618784		1	0	617, 228		
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			0	0	76. 98	
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99	
OUTPATIENT SERVICE COST CENTERS	0.251741	7 400 015	I	0	2 (02 4/5	90.00	
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0. 351641			0	2, 602, 465		
	0. 111892		•	0	1, 838, 225		
	0. 380034			0 140 (70	3, 455, 043		
200.00 Subtotal (see instructions)		277, 072, 997		0 140, 678	48, 893, 963	200.00	
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0		201.00	
202.00 Net Charges (line 200 - line 201)		277, 072, 997		0 140, 678	48, 893, 963	202. 00	

Health Financial Systems	COMMUNITY HOS	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER	HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0125	Peri od:	Worksheet D
			From 07/01/2019	Part V Date/Time Prepared:

				From 07/01/2019 To 06/30/2020	Part V Date/Time Pro 11/25/2020 3:	epared: 02 pm
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7.00				
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATING ROOM	0	4, 861				50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54. 00
60. 00 06000 LABORATORY	0	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62. 00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62. 30
65. 00 06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71. 00
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	21, 488				73. 00
76. 00 03140 CARDI OLOGY	0	0				76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
76. 99 07699 LI THOTRI PSY	0	0				76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90. 00
91. 00 09100 EMERGENCY	0	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92. 00
200.00 Subtotal (see instructions)	0	26, 349				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	26, 349	1			202. 00

	Financial Systems	COMMUNI TY				u of Form CMS-2	2552-10
APP0R1	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co	CN: 15-0125	Peri od:	Worksheet D	
			Component (CCN: 15-T125	From 07/01/2019 To 06/30/2020	Part II Date/Time Pre	narod:
			Component	JCIN. 13-1125	10 00/30/2020	11/25/2020 3:0	
			Title	XVIII	Subprovi der -	PPS	
					I RF		
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	6, 052, 917				2, 537	
52.00	05200 DELIVERY ROOM & LABOR ROOM	484, 827				0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 093, 997				·	
60.00	06000 LABORATORY	1, 197, 224				·	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	74, 494	11, 454, 287			324	62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0. 00000		0	
65.00	06500 RESPI RATORY THERAPY	210, 147					
66. 00	06600 PHYSI CAL THERAPY	1, 033, 021				137, 075	66. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	145, 592	14, 638, 571			132	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	117, 589	51, 250, 695	0. 00229	462, 371	1, 061	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	158, 942	77, 335, 456	0. 00205	19, 592	40	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	686, 524	138, 506, 628	0.00495	2, 686, 310	13, 316	73. 00
76.00	03140 CARDI OLOGY	3, 211, 631	192, 282, 034	0. 01670	269, 983	4, 510	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	130, 967	2, 663, 212	0. 04917	76 0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	00	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0.00000	00	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	205, 798			, ,	268	90. 00
91.00	09100 EMERGENCY	825, 646	150, 205, 944	0. 00549	97 471	3	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	39, 075, 216	0. 00000	00	0	92. 00
200.00	Total (lines 50 through 199)	19, 629, 316	1, 597, 646, 493		12, 418, 122	180, 567	200.00

Health Financial Systems	COMMUNI TY			In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Component	CCN: 15-T125	Peri od: From 07/01/2019 To 06/30/2020	Date/Time Pre 11/25/2020 3:	
		Title	· XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Anesthetist Cost	Post-Stepdown Adjustments	J	Allied Health Post-Stepdown Adjustments		
ANCILLARY SERVICE COST CENTERS	1. 00	2A	2.00	3A	3. 00	
50. 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 489, 687	52. 00 54. 00 60. 00 62. 00 62. 30 65. 00 70. 00 71. 00 72. 00 73. 00 76. 97 76. 98
90. 00 09100 CLINIC O9100 CLINIC O9200 O92	0 0 0 0	0		0 0 0 0 0 0 0	0	91. 00 92. 00

Heal th	Financial Systems	COMMUNI TY	HOSPI TAL		In Li∈	eu of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUG	H COSTS		Component		From 07/01/2019 To 06/30/2020		pared: 02 pm
			Ti tl e	: XVIII	Subprovider - IRF	PPS	- I
	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)	
	ANOLULARY OFRICAS COOT OFFITTED	4. 00	5. 00	6. 00	7. 00	8. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS		0	1	0 205 045 275	0.000000	F0 00
50.00	05000 OPERATING ROOM	0	0	•	0 305, 845, 365		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 10, 204, 874		
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	0		0 311, 732, 541		
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 199, 692, 123		
62. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 11, 454, 287	0.00000	
65. 00	06500 RESPIRATORY THERAPY	0	0		0 32, 145, 120		
66. 00	06600 PHYSI CAL THERAPY	0	0		0 47, 371, 197		
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 14, 638, 571	0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 51, 250, 695		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 77, 335, 456		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	489, 687	489, 68			
76. 00	03140 CARDI OLOGY	0	0	107700	0 192, 282, 034		
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 2, 663, 212		
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0. 000000	
76. 99	07699 LI THOTRI PSY	0	0		0 0	0. 000000	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 13, 243, 230	0.000000	90.00
91.00	09100 EMERGENCY	0	0		0 150, 205, 944		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 39, 075, 216	0.000000	92. 00
200.00	Total (lines 50 through 199)	0	489, 687	489, 68	1, 597, 646, 493		200. 00

Health Financial Systems	COMMUNITY H	OSPI TAI		In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER		Provi der CO	CN: 15-0125	Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2019		
		Component	CCN: 15-T125	To 06/30/2020	Date/Time Pre 11/25/2020 3:	
-		Title	XVIII	Subprovi der -	PPS	02 piii
				. I RF		
Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
	7)		x col. 10)		x col . 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	128, 213		0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	582, 704		0 1, 424	0	
60. 00 06000 LABORATORY	0. 000000	1, 208, 741		0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	49, 887		0	0	62. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0. 000000	693, 498		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	6, 285, 817		0 0	0	66. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	13, 307		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	462, 371		0 122	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	19, 592		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 003535	2, 686, 310	9, 49	6 2, 249	8	73. 00
76. 00 03140 CARDI OLOGY	0. 000000	269, 983		0 0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS	•		•	•		1
90. 00 09000 CLI NI C	0. 000000	17, 228		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	471		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92. 00
200.00 Total (lines 50 through 199)		12, 418, 122	9, 49	6 3, 795	8	200. 00
		'	•		•	

Heal th	Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Component (Period: From 07/01/2019 To 06/30/2020		
			Title	· XVIII	Subprovi der – I RF	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 181812	0		0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 546415	0		0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 093803	1, 424		0 0	134	54.00
60.00	06000 LABORATORY	0. 114950	0		0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 284683	0		0 0	0	62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0. 220032	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 365147	0		0	0	66. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 117721	0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 554528	122		0 0	68	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 495109	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 188594	2, 249		0 0	424	73. 00
76.00	03140 CARDI OLOGY	0. 120678	0		0 0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 618784	0		0 0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 351641	0		0 0	0	90.00
91 00	09100 EMERGENCY	0 111892	l n		n n	l o	91 00

0. 351641 0. 111892

0. 380034

3, 795

3, 795

91.00

201. 00

626 202. 00

0 0 92.00 626 200.00

09100 EMERGENCY

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program

Only Charges Net Charges (line 200 - line 201)

91.00

200.00

201.00

202.00

ealth Financial Systems PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Component	CN: 15-0125 CCN: 15-T125	Peri od: From 07/01/2019 To 06/30/2020	u of Form CMS-25 Worksheet D Part V Date/Time Prepa 11/25/2020 3:02	ared
		Ti tl e	e XVIII	Subprovi der - I RF	PPS	
	Cos	sts		TIXI		
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS						
0.00 05000 OPERATING ROOM 2.00 05200 DELIVERY ROOM & LABOR ROOM 4.00 05400 RADIOLOGY-DIAGNOSTIC 0.00 06000 LABORATORY 2.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 5.00 06500 RESPIRATORY THERAPY 0.00 07000 ELECTROENCEPHALOGRAPHY 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.00 07400 DRUGS CHARGED TO PATIENTS 0.00 07400 DRUGS CHARGED TO PATIENTS 0.00	0 0 0 0 0 0 0 0 0 0					50. 52. 54. 60. 62. 65. 66. 71. 72. 73. 76. 76.
O. 00 OUTPATIENT SERVICE COST CENTERS O. 00 O9000 CLINIC	l ol	C				90.
1. 00 09100 EMERGENCY 2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 00. 00 Subtotal (see instructions) 01. 00 Less PBP Clinic Lab. Services-Program 0nly Charges	0 0	0			20	91. 92. 200. 201.

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C	CN: 15-0125	Period: From 07/01/2019 To 06/30/2020		pared: 02 pm
		Ti tI	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 CENTERS						
30. 00 ADULTS & PEDIATRICS	5, 144, 336	0	5, 144, 33			
31.00 INTENSIVE CARE UNIT	1, 449, 698		1, 449, 69	10, 863	133. 45	
32.01 NEONATAL INTENSIVE CARE	432, 348		432, 34	8 4, 299	100. 57	32. 01
41. 00 SUBPROVI DER - I RF	356, 619	0	356, 61	9 7, 717	46. 21	41. 00
43. 00 NURSERY	55, 100		55, 10	0 3, 110	17. 72	43. 00
200.00 Total (lines 30 through 199)	7, 438, 101		7, 438, 10	107, 431		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	1			
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 651	104, 294	•			30. 00
31.00 INTENSIVE CARE UNIT	5	667	1			31. 00
32. 01 NEONATAL INTENSIVE CARE	328		•			32. 01
41. 00 SUBPROVI DER - I RF	39					41. 00
43. 00 NURSERY	223		1			43. 00
200.00 Total (lines 30 through 199)	2, 246	143, 702	!			200. 00

Health Financial Systems		COMMUNITY HOS	SPI TAL		In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT	ANCILLARY SERVICE CAPITAL	COSTS	Provider CCN: 15-0125	Peri od:	Worksheet D

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider Co		Period: From 07/01/2019 To 06/30/2020	Worksheet D Part II Date/Time Pre 11/25/2020 3:	pared: 02 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	6, 052, 917				17, 063	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	484, 827					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 093, 997			·	•	1
60. 00 06000 LABORATORY	1, 197, 224					60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	74, 494	11, 454, 287		·	944	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000		0	62. 30
65. 00 06500 RESPIRATORY THERAPY	210, 147	32, 145, 120				65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 033, 021	47, 371, 197	0. 02180	7 163, 773	3, 571	66. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	145, 592	14, 638, 571			305	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	117, 589	51, 250, 695			471	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	158, 942	77, 335, 456	0. 00205	5 301, 270	619	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	686, 524	138, 506, 628	0. 00495	7 933, 840	4, 629	73. 00
76. 00 03140 CARDI OLOGY	3, 211, 631	192, 282, 034	0. 01670	308, 082	5, 146	76. 00
76. 97 07697 CARDIAC REHABILITATION	130, 967	2, 663, 212	0. 04917	6 3, 491	172	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 00000	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0. 00000	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	205, 798	13, 243, 230	0. 01554	0 20, 883	325	90. 00
91. 00 09100 EMERGENCY	825, 646	150, 205, 944	0. 00549	7 289, 850	1, 593	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	914, 323	39, 075, 216	0. 02339	9 0	0	92. 00
200.00 Total (lines 50 through 199)	20, 543, 639	1, 597, 646, 493		4, 816, 700	54, 684	200. 00

Harlith Firemai at Contama	COMMUNITY	LIOCDI TAI		1-11-	£ E CMC	2552 40
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	COMMUNITY PASS THROUGH COST	S Provider CO		Period: From 07/01/2019 To 06/30/2020	Date/Time Pre 11/25/2020 3:	pared:
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown	Nursing School	Allied Healt Post-Stepdow	h Allied Health n Cost	All Other Medical	
	Adjustments		Adjustments		Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0		
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	
32. 01 02060 NEONATAL INTENSIVE CARE	0	0		0	0	
41. 00 04100 SUBPROVI DER - RF	0	0		0	0	
43. 00 04300 NURSERY	0	0		0	0	
200.00 Total (lines 30 through 199)	0	0		0 0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		t Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)		7.00	0.00	
INDATIONE DOUBLING CODY CONTEDC	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	0	0	01.4	0.00	1 / [1	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	U	0	81, 44 10, 86			1
31. 00 03100 INTENSI VE CARE UNI T 32. 01 02060 NEONATAL INTENSI VE CARE		0	4, 29			
			1 4, 25	0.00	1 328	1 32.01
		0		7 0 00	1	
41. 00 04100 SUBPROVI DER - RF	0	0	7, 71		39	41.00
41. 00 04100 SUBPROVI DER - RF 43. 00 04300 NURSERY	0	0	7, 71 3, 11	0.00	39 223	41. 00 43. 00
41. 00 04100 SUBPROVI DER - RF 43. 00 04300 NURSERY 200. 00 Total (lines 30 through 199)	0	0	7, 71	0.00	39 223	41. 00 43. 00
41. 00 04100 SUBPROVI DER - RF 43. 00 04300 NURSERY	Inpati ent	0 0	7, 71 3, 11	0.00	39 223	41. 00 43. 00
41. 00 04100 SUBPROVIDER - RF 43. 00 04300 NURSERY 200. 00 Total (Lines 30 through 199)	Program	0 0	7, 71 3, 11	0.00	39 223	41. 00 43. 00
41. 00 04100 SUBPROVIDER - RF 43. 00 04300 NURSERY 200. 00 Total (Lines 30 through 199)	Program Pass-Through	0 0	7, 71 3, 11	0.00	39 223	41. 00 43. 00
41. 00 04100 SUBPROVIDER - RF 43. 00 04300 NURSERY 200. 00 Total (Lines 30 through 199)	Program Pass-Through Cost (col. 7 x	0 0 0	7, 71 3, 11	0.00	39 223	41. 00 43. 00
41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	Program Pass-Through Cost (col. 7 x col. 8)	000000000000000000000000000000000000000	7, 71 3, 11	0.00	39 223	41. 00 43. 00
41. 00	Program Pass-Through Cost (col. 7 x	0 0 0	7, 71 3, 11	0.00	39 223	41. 00 43. 00
41. 00 04100 SUBPROVIDER - IRF 04300 NURSERY Total (lines 30 through 199) Cost Center Description INPATIENT ROUTINE SERVICE COST CENTERS	Program Pass-Through Cost (col. 7 x col. 8)	0 0 0	7, 71 3, 11	0.00	39 223	41. 00 43. 00 200. 00
41.00 04100 SUBPROVIDER - RF 43.00 04300 NURSERY Total (lines 30 through 199) Cost Center Description	Program Pass-Through Cost (col. 7 x col. 8) 9.00	0 0 0	7, 71 3, 11	0.00	39 223	41. 00 43. 00 200. 00
41. 00	Program Pass-Through Cost (col. 7 x col. 8) 9.00	0 0 0	7, 71 3, 11	0.00	39 223	41. 00 43. 00 200. 00 30. 00 31. 00
41. 00	Program Pass-Through Cost (col. 7 x col. 8) 9.00	00000	7, 71 3, 11	0.00	39 223	41. 00 43. 00 200. 00 30. 00 31. 00 32. 01
41. 00	Program Pass-Through Cost (col. 7 x col. 8) 9.00	00000	7, 71 3, 11	0.00	39 223	41. 00 43. 00 200. 00 30. 00 31. 00 32. 01 41. 00
41. 00	Program Pass-Through Cost (col. 7 x col. 8) 9.00	00000	7, 71 3, 11	0.00	39 223	41. 00 43. 00 200. 00 30. 00 31. 00 32. 01

Health Financial Systems	COMMUNITY HOS	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0125	Peri od:	Worksheet D
THROUGH COSTS			From 07/01/2019	Part IV Date/Time Prenared

				0 06/30/2020	11/25/2020 3:	
		Ti tl	e XIX	Hospi tal	PPS	JZ piii
Cost Center Description	Non Physician			Allied Health	Allied Health	
'	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0	C	0	0	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
60. 00 06000 LABORATORY	0	0	(0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0	489, 687	73.00
76. 00 03140 CARDI OLOGY	0	0	(0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	(0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	(0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	(0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	(0	0	90.00
91. 00 09100 EMERGENCY	0	0	(0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		(0	92.00
200.00 Total (lines 50 through 199)	0	0	(0	489, 687	200. 00

Heal th	Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEP H COSTS	RVICE OTHER PASS	S Provider CO		Period: From 07/01/2019 Fo 06/30/2020		pared: 02 pm
			Titl	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	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(305, 845, 365	l .	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(10, 204, 874	0.000000	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(311, 732, 541	0.000000	54.00
60.00	06000 LABORATORY	0	0	(199, 692, 123	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(11, 454, 287	0.000000	62. 00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(0	0.000000	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0		32, 145, 120	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		47, 371, 197	0.000000	66. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		14, 638, 571	0.000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		51, 250, 695	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		77, 335, 456	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	489, 687	489, 68 ⁻	138, 506, 628	0.003535	73. 00
76.00	03140 CARDI OLOGY	0	0		192, 282, 034	0.000000	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		2, 663, 212		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0			0.000000	76. 98
76. 99	07699 LI THOTRI PSY	0	0			0.000000	
	OUTPATIENT SERVICE COST CENTERS	•			•		
00 00	00000 CLINIC			1 /	12 242 220	0.000000	1 00 00

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489, 687

0 13, 243, 230 0 150, 205, 944 0 39, 075, 216 489, 687 1, 597, 646, 493 0. 000000 0. 000000 0. 000000

90. 00 91. 00

92.00

200.00

90. 00 | 09000 | CLINIC | 91. 00 | 09100 | EMERGENCY | 92. 00 | 09200 | 0BSERVATION | BEDS (NON-DISTINCT PART | 200. 00 | Total (lines 50 through 199)

Health Financial Systems	COMMUNITY I	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEITHROUGH COSTS	RVICE OTHER PASS			Period: From 07/01/2019 To 06/30/2020		pared: 02 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.	-	Costs (col.	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.000000	862, 144		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	128, 268		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	493, 829		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	734, 466		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	145, 183		0	0	62.00

0.000000

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195, 610

163, 773

30, 631

205, 380

301, 270

933, 840

308, 082

3, 491

20, 883

289, 850

4, 816, 700

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0 91.00

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62.30

65.00

66.00

71.00

0 73.00

76. 98

76. 99

0 200.00

62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS

71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT

07000 ELECTROENCEPHALOGRAPHY

72.00 07200 IMPL. DEV. CHARGED TO PATIENTS
73.00 07300 DRUGS CHARGED TO PATIENTS

07697 CARDIAC REHABILITATION

07698 HYPERBARI C OXYGEN THERAPY

OUTPATIENT SERVICE COST CENTERS

92.00 | 09200 | 08SERVATION BEDS (NON-DISTINCT PART 200.00 | Total (lines 50 through 199)

65. 00 06500 RESPIRATORY THERAPY

07699 LI THOTRI PSY

76. 00 03140 CARDI OLOGY

90. 00 09000 CLINIC

91. 00 09100 EMERGENCY

66.00

70.00

76. 97

76. 98

76. 99

06600 PHYSI CAL THERAPY

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Component CCN: 15-T125 To				CN: 15-0125			1002 10
Capital Related Cost (From Wkst. C, Part I, col. 2) Column 3 x column 4)					From 07/01/2019	Part II	
Capital Related Cost (from Wisst. B, Part II, col. 26) Related Cost (from Wisst. B, Part II, col. 26) Related Cost (from Wisst. B, Part II, col. 26) Related Cost (from Wisst. B, Part II, col. 26) Related Cost (from Wisst. B, Part II, col. 26) Related Cost (from Wisst. B, Part II, col. 26) Related Cost (from Wisst. B, Part II, col. 26) Related Cost (from Wisst. B, Part II, col. 26) Related Cost (from Wisst. B, Part II, col. 26) Related Cost (from Wisst. B, Part II, col. 26) Related Cost (from Wisst. B, Part II, col. 26) Related Cost (from Wisst. B, Part III, col. 26) Related Cost (from Wisst. B, Part III, col. 26) Related Cost (from Wisst. B, Part III, col. 26) Related Cost (from Wisst. B, Part III, col. 26) Related Cost (from Wisst. B, Part III, col. 26) Related Cost (from Wisst. B, Part III, col. 26) Related Cost (from Wisst. B, Part III, col. 26) Related Cost (from Wisst. B, Part III, col. 26) Related Cost (from Wisst. B, Part III, col. 26) Related Cost (from Wisst. B, Part III, col. 26) Related Cost (from Wisst. B, Part III, col. 26) Related Cost (from Wisst. B, Part III, col. 26) Related Cost (from Wisst. B, Part III, col. 26) Related Cost (from Wisst. B, Part III, col. 27) Related Cost (from Wisst. Col. 27) Related Cost (from W			Component	JCN: 15-1125	10 06/30/2020	11/25/2020 3:	parea: N2 nm
Capital Related Cost (from Wkst. B, Part I, col. Part II, col. Part II	-		Ti tl	e XIX	Subprovi der -	PPS	02 piii
Rel ated Cost (From Wkst. B, Part I, col. 26) Ranci LLary Service Cost Centers Charges (Col. 1 + col. 2 + col. 3 + col. mm 4)							
Column 4 Part II, col. 26 Part II, col. 26 Part II, col. 27 Part II, col. 26 Part III, col. 27 Part III, col. 28 Part III, col. 27 Part III, col. 28 Part III, col. 29 Part III, col. 20	Cost Center Description						
Part II, col. 26) 26) 26) 20 3.00 4.00 5.00							
ANCI LLARY SERVI CE COST CENTERS					. Charges	column 4)	
1.00 2.00 3.00 4.00 5.00			8)	2)			
ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 6, 052, 917 305, 845, 365 0. 019791 0 0 50.00 05000 DELI VERY ROOM & LABOR ROOM 484, 827 10, 204, 874 0. 047509 0 0 52.00 05400 RADIO LOGY-DI AGNOSTI C 5, 093, 997 311, 732, 541 0. 016341 0 0 54.00 06.00 06000 LABORATORY 1, 197, 224 199, 692, 123 0. 005995 1, 913 11 60.00 06.200 WHOLE BLOOD & PACKED RED BLOOD CELL 74, 494 11, 454, 287 0. 006504 0 0 62.00 06.200 06.200 WHOLE BLOOD & RESPI RATORY 1, 197, 224 199, 692, 123 0. 005995 1, 913 11 60.00 0 62.30 06.500 RESPI RATORY THERAPY 210, 147 32, 145, 120 0. 006504 0 0 65.00 06.000 PHYSI CAL THERAPY 1, 033, 021 47, 371, 197 0. 021807 10, 832 236 66.00 06.600 PHYSI CAL THERAPY 1, 1033, 021 47, 371, 197 0. 021807 10, 832 236 66.00 07.000 07.000 ELECTROENCEPHAL GGRAPHY 145, 592 14, 638, 571 0. 009946 0 0 70.00 07.000 10, 000000 0 0 71.00 07.000 10, 000000 0 0 0 0 0 0 0							
50. 00 05000 OPERATING ROOM 6, 052, 917 305, 845, 365 0. 019791 0 0 50. 00		1.00	2. 00	3. 00	4. 00	5. 00	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 484, 827 10, 204, 874 0. 047509 0 0 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 5, 093, 997 311, 732, 541 0. 016341 0 0 54. 00 60. 00 06000 LABORATORY 1, 197, 224 199, 692, 123 0. 005995 1, 913 11 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 74, 494 11, 454, 287 0. 006504 0 0 62. 00 06000 RESPIRATORY THERAPY 210, 147 32, 145, 120 0. 006504 0 0 65. 00 06500 RESPIRATORY THERAPY 210, 147 32, 145, 120 0. 006537 0 0 65. 00 06600 PHYSI CAL THERAPY 1,033, 021 47, 371, 197 0. 021807 10, 832 236 66. 00 070. 00 07100 REDI CAL SUPPLIES CHARGED TO PATIENT 117, 589 51, 250, 695 0. 002294 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 158, 942 77, 335, 456 0. 002294 0 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 158, 942 77, 335, 456 0. 002955 0 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 158, 942 77, 335, 456 0. 004957 1, 938 10 73. 00 07300 DRUGS CHARGED TO PATIENTS 686, 524 138, 506, 628 0. 004957 1, 938 10 73. 00 076. 97 07697 CARDI AC REHABI LI TATI ON 130, 967 2, 663, 212 0. 049176 0 0 76. 97 076. 98 07699 LI THOTRI PSY 0 0 0 0. 000000 0 0 0 76. 98 076. 99 07699 LI THOTRI PSY 0 0 0 0. 000000 0 0 0 0 76. 99 076. 99 076. 99 07600 CLINI C 205, 798 13, 243, 230 0. 015540 0 0 99. 00 0 0. 000000 0 0 99. 00 0 0. 000000 0 0 0							
54. 00						_	
60. 00						0	
62. 00						0	
62. 30	60. 00 06000 LABORATORY	1, 197, 224	199, 692, 123	0.00599	95 1, 913	11	60.00
65. 00	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	74, 494	11, 454, 287	0. 00650	04 0	0	62. 00
66. 00	62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	00	0	62. 30
70. 00 07000 ELECTROENCEPHALOGRAPHY 145, 592 14, 638, 571 0. 009946 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 117, 589 51, 250, 695 0. 002294 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 158, 942 77, 335, 456 0. 002055 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 686, 524 138, 506, 628 0. 004957 1, 938 10 73. 00 76. 00 03140 CARDI OLOGY 3, 211, 631 192, 282, 034 0. 016703 0 0 76. 90 76. 97 O7697 CARDI AC REHABI LI TATI ON 130, 967 2, 663, 212 0. 049176 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0. 000000 0 0 76. 98 76. 99 OUTPATI ENT SERVI CE COST CENTERS 0 0 0. 000000 0 0 0 90.00 91. 00	65. 00 06500 RESPI RATORY THERAPY	210, 147	32, 145, 120	0. 00653	37 0	0	65. 00
71. 00	66. 00 06600 PHYSI CAL THERAPY	1, 033, 021	47, 371, 197	0. 02180	10, 832	236	66. 00
72. 00	70. 00 07000 ELECTROENCEPHALOGRAPHY	145, 592	14, 638, 571	0. 00994	16 0	0	70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 686, 524 138, 506, 628 0. 004957 1, 938 10 73. 00 76. 00 03140 CARDI OLOGY 3, 211, 631 192, 282, 034 0. 016703 0 0 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 130, 967 2, 663, 212 0. 049176 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0. 000000 0 0 76. 98 76. 99 0017PATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 205, 798 13, 243, 230 0. 015540 0 90. 00 91. 00 09100 EMERGENCY 825, 646 150, 205, 944 0. 005497 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 39, 075, 216 0. 000000 0 0 92. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	117, 589	51, 250, 695	0. 00229	94 0	0	71.00
76. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	158, 942	77, 335, 456	0. 00205	55 0	0	72.00
76. 97	73.00 07300 DRUGS CHARGED TO PATIENTS	686, 524	138, 506, 628	0.00495	1, 938	10	73.00
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0.000000 0 0.000000 0 0.000000 0	76. 00 03140 CARDI OLOGY	3, 211, 631	192, 282, 034	0. 01670	0	0	76. 00
76. 99 07699 LITHOTRI PSY 0 0 0.000000 0 0 76. 99 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 205, 798 13, 243, 230 0.015540 0 90. 00 91. 00 91. 00 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 39, 075, 216 0.000000 0 0 92. 00	76. 97 07697 CARDIAC REHABILITATION	130, 967	2, 663, 212	0. 04917	76 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 205, 798 13, 243, 230 0. 015540 0 0 90. 00 91. 00 09100 EMERGENCY 825, 646 150, 205, 944 0. 005497 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 39, 075, 216 0. 000000 0 92. 00	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	00	0	76. 98
90. 00	76. 99 07699 LI THOTRI PSY	0	0	0. 00000	00 0	0	76. 99
91. 00 09100 EMERGENCY 825, 646 150, 205, 944 0. 005497 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 39, 075, 216 0. 000000 0 92. 00	OUTPATIENT SERVICE COST CENTERS						
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 39,075,216 0.000000 0 92. 00	90. 00 09000 CLI NI C	205, 798	13, 243, 230	0. 01554	10 0	0	90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 39,075,216 0.000000 0 0 92. 00	91. 00 09100 EMERGENCY	825, 646	150, 205, 944	0.00549	97 0	0	91.00
200. 00 Total (Lines 50 through 199) 19, 629, 316 1, 597, 646, 493 14, 683 257 200. 00	92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1			00	0	92.00
	200.00 Total (lines 50 through 199)	19, 629, 316	1, 597, 646, 493		14, 683	257	200. 00

Health Financial Systems	COMMUNI TY	HUSDI TVI		Inlie	eu of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS				Period: From 07/01/2019	Worksheet D Part IV	
		Component	CCN: 15-T125	To 06/30/2020	Date/Time Pre 11/25/2020 3:	pared: 02 pm_
		Titl	e XIX	Subprovider - IRF	PPS	
Cost Center Description		Nursing School			Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	O.		0 0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	0		0 0	0	65. 00

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0 72.00

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0 76. 97

0 76. 98

0 90.00

0 91.00

0 92.00

489, 687 200. 00

489, 687

66.00

70.00

71.00 0

73.00

76. 00

76. 99 0

0

0 0 0

66. 00 06600 PHYSI CAL THERAPY

07699 LI THOTRI PSY

76. 00 03140 CARDI OLOGY

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

71.00

76. 97

76. 98

76. 99

200.00

70. 00 07000 ELECTROENCEPHALOGRAPHY

73. 00 07300 DRUGS CHARGED TO PATIENTS

72.00 07200 IMPL. DEV. CHARGED TO PATIENTS

07697 CARDIAC REHABILITATION

07698 HYPERBARI C OXYGEN THERAPY

OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

Heal th	Financial Systems	COMMUNI TY	HOSPI TAL		In Li∈	eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUG	H COSTS		Component		From 07/01/2019 To 06/30/2020	Date/Time Pre	pared:
						11/25/2020 3:0	02 pm
			Titl	e XIX	Subprovi der - I RF	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	0	•	0 305, 845, 365		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 10, 204, 874		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 311, 732, 541		
60.00	06000 LABORATORY	0	0		0 199, 692, 123		
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 11, 454, 287		
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0.000000	
65.00	06500 RESPI RATORY THERAPY	0	0		0 32, 145, 120		
66. 00	06600 PHYSI CAL THERAPY	0	0		0 47, 371, 197		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 14, 638, 571	0.000000	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 51, 250, 695		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 77, 335, 456		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	489, 687	489, 68			
76. 00	03140 CARDI OLOGY	0	0		0 192, 282, 034		
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 2, 663, 212	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0.000000	76. 98
76. 99	07699 LI THOTRI PSY	0	0		0 0	0.000000	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 13, 243, 230		
91. 00	09100 EMERGENCY	0	0		0 150, 205, 944	0.000000	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 39, 075, 216		
200.00	Total (lines 50 through 199)	0	489, 687	489, 68	1, 597, 646, 493		200. 00

Heal th	Financial Systems	COMMUNITY H	OSPI TAL		In Li€	eu of Form CMS-:	<u>2552-10</u>
	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE THROUGH COSTS		Provider CO		Peri od: From 07/01/2019 To 06/30/2020		
			Ti tl	e XIX	Subprovi der - I RF	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Pass-Through	Outpatient Program Charges	Outpatient Program Pass-Through	
		(col. 6 ÷ col. 7)	Ü	Costs (col. x col. 10)	8	Costs (col. 9 x col. 12)	
	1	9. 00	10.00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0. 000000	0		0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0		0	0	
60.00	06000 LABORATORY	0. 000000	1, 913		0	0	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0	0	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0	0	
65. 00	06500 RESPI RATORY THERAPY	0. 000000	0		0	0	
66. 00	06600 PHYSI CAL THERAPY	0. 000000	10, 832		0	0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 003535	1, 938		7 0	0	
76. 00	03140 CARDI OLOGY	0. 000000	0		0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00		0. 000000	0		0	0	
91.00	09100 EMERGENCY	0. 000000	0		0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	92. 00
200.00	Total (lines 50 through 199)		14, 683		7 0	0	200. 00

Health Financial Systems	COMMUNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0125	Peri od: From 07/01/2019		
		To 06/30/2020	Date/Time Prep 11/25/2020 3:0	
	Title XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description				

Cost Conter Description PART 1 = ALL FROVIDER COMPOSENS				10 00, 00, 2020	11/25/2020 3:	02 pm		
PART 1 - ALL PROVIDER COMPONENTS 1.00			Title XVIII	Hospi tal	PPS			
Inpatient days (including private room days and swing bed days, excluding newborn) 1.00		Cost Center Description			1.00			
Impatient days (including private room days and saing-bed days, excluding newborn)		PART I - ALL PROVIDER COMPONENTS						
Impatient days (Including private room days, excluding saing-bed and newborn days) 0.3.00								
Private room days (excluding swing-bed and observation bed days) 17 you have only private room days 4.00 5.00 6								
do not complete this line. 4. 00 Selle-pictate room days (sectualing swing-bed and observation bed days) 5.00 Total swing-bed SW type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed W type inpatient days (including private room days) shrough December 31 of the cost reporting period in the swing-bed W type inpatient days (including private room days) shrough December 31 of the cost reporting period in the swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (it calendar year, enter 0 on this line) 9.00 Total Inpatient days including private room days applicable to the Program (excluding swing-bed and next room days) (see instructions) 10.00 Swing-bed SW type inpatient days applicable to it it is XVIII only (including private room days) after December 31 of the cost reporting period (see Instructions) 11.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see Instructions) 13.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) 14.00 Swing-bed SW type inpatient days applicable to services days and the swing applicable to swing-bed SW type services applicable to services				ivata maam daya				
Semi-private room days (excluding swing-bed and observation bed days) Comporting period Comporting p	3.00		ys). If you have only pr	ivate room days,) 	3.00		
Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) SN ing-bed SNF type inpatient days (applicable to the Program (excluding swing-bed and December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed SNF type inpatient days applicable to the line (see instructions) Swing-bed SNF type inpatient days applicable to title SN including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) SN ing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) SN ing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) SN ing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) Total nursery days (title V or XIX only) SN ing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) SN ing-bed Cost applicable SNF services applicable to services through December 31 of the cost Cost reporting period Redical craft for swing-bed SNF services applicable to services through December 31 of the cost Cost reporting period Redical days of the cost reporting period (including private room days) SN ing-bed cost applicable to SNF type serv	4.00		ed days)		66. 967	4.00		
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reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (ir calendar year, enter 0 on this line) 12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (ir calendar year, enter 0 on this line) 13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 12. 00 through Bocember 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Medically necessarry private room days applicable to titles V or XIX only (including private room days) 0 13. 00 after Bocember 31 of the cost reporting period (if calendar year, enter 0 on this line) 0 16. 00 10 10 10 mrsey days (title V or XIX only) 0 15. 00 10 10 mrsey days (title V or XIX only) 0 15. 00 16. 00 10 mrsey days (title V or XIX only) 0 15. 00 16. 00 10 mrsey days (title V or XIX only) 0 15. 00 16. 00 10 mrsey days (title V or XIX only) 0 15. 00 16. 00 10 mrsey days (title V or XIX only) 0 16. 00	7 00		m days) through Docombor	21 of the cost		7 00		
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Heal th	Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10	
	ATION OF INPATIENT OPERATING COST				Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Pre	pared:	
			T: +1 a	e XVIII	Haani tal	11/25/2020 3:	02 pm	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1	Hospital Program Days	PPS Program Cost (col. 3 x col.		
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00		
42. 00	NURSERY (title V & XIX only)	C					42. 00	
	Intensive Care Type Inpatient Hospital Units							
43. 00	INTENSIVE CARE UNIT	22, 258, 979	10, 863	2, 049. 0	6 4, 653	9, 534, 276	1	
44. 00	CORONARY CARE UNIT	/ 102 400	4 200	1 410 5	1	0	44. 00	
44. 01 45. 00	NEONATAL INTENSIVE CARE BURN INTENSIVE CARE UNIT	6, 102, 490	4, 299	1, 419. 5	1 0	0	44. 01 45. 00	
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00	
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00	
	Cost Center Description					1.00		
48. 00	Program inpatient ancillary service cost (Wk	st D2 col '	2 Lino 200)			1. 00 50, 760, 156	48. 00	
49. 00	Total Program inpatient costs (sum of lines			ons)		91, 590, 537		
171.00	PASS THROUGH COST ADJUSTMENTS	Tr tim dugit 10)	(000 111011 4011 6			717 0707 007	17.00	
50.00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sum	of Parts I and	2, 548, 007	50.00	
E4 00				WI 1 D	6.5	0.0/4.540	F4 00	
51. 00	Pass through costs applicable to Program inpland IV)	atient ancilia	ry services (Tr	OM WKST. D, S	um of Parts II	2, 864, 510	51.00	
52. 00	Total Program excludable cost (sum of lines	50 and 51)				5, 412, 517	52. 00	
53.00	Total Program inpatient operating cost exclu		elated, non-phy	sician anesth	etist, and	86, 178, 020	53. 00	
	medical education costs (line 49 minus line	52)						
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00	
55. 00	Target amount per discharge					0.00		
56. 00	Target amount (line 54 x line 55)	0						
57. 00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (I	ine 56 minus	line 53)	0	57. 00	
58. 00	Bonus payment (see instructions)	0 0. 00	58. 00 59. 00					
59.00	59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							
60. 00								
61.00	61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by						61. 00	
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							
62. 00	amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)							
63. 00								
		63. 00						
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64. 00	
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	oor 21 of the c	ost roporting	pariod (Saa	0	65. 00	
03.00	instructions)(title XVIII only)	ts arter beceili	bei 31 of the C	Jost Tepol tring	perrou (see	0	05.00	
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	55)(title XVII	l only). For	0	66. 00	
	CAH (see instructions)			6.44				
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	n December 31 d	or the cost re	porting period	0	67. 00	
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after [December 31 of	the cost repo	rting period	0	68. 00	
	(line 13 x line 20)				3 1			
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00	
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70.00	
71. 00	Adjusted general inpatient routine service c	•					71.00	
72. 00	Program routine service cost (line 9 x line	71)					72. 00	
73.00	Medically necessary private room cost applic						73.00	
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			art II column		74. 00 75. 00	
75.00	26, line 45)	TOULTHE SELVICE	. costs (IIOII V	IOI KSHEEL D, P	art II, COLUMII		/ 3.00	
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00	
77. 00	Program capital -related costs (line 9 x line						77. 00	
78. 00 79. 00	Inpatient routine service cost (line 74 minu		arovi don rocore	le)			78.00	
	00 0						79. 00 80. 00	
81. 00							81.00	
82. 00	Inpatient routine service cost limitation (ine 9 x line 8	* .				82. 00	
83.00	Reasonable inpatient routine service costs (ns)				83.00	
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84. 00 85. 00	
86. 00								
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87. 00	Total observation bed days (see instructions	•	11 0			14, 475		
	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•				1, 025. 90 14, 849, 903	1	
57.00	(Se	5 1115t1 WOLT 0115,	,			1 7, 0 77, 703	1 57.00	

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/01/2019 To 06/30/2020	Date/Time Pre 11/25/2020 3:0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	5, 144, 336	83, 551, 469	0. 06157	1 14, 849, 903	914, 323	90.00
91.00 Nursing School cost	0	83, 551, 469	0.00000	0 14, 849, 903	0	91.00
92.00 Allied health cost	0	83, 551, 469	0.00000	0 14, 849, 903	0	92.00
93.00 All other Medical Education	0	83, 551, 469	0. 00000	0 14, 849, 903	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0125	Peri od: From 07/01/2019	Worksheet D-1
	Component CCN: 15-T125		Date/Time Prepared: 11/25/2020 3:02 pm
	Title XVIII	Subprovi der -	PPS
		IDE	

		II the Aviii	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			7, 717	1. 00
2.00	Inpatient days (including private room days, excluding swing-berivate room days (excluding swing-bed and observation bed day			7, 717	2.00
3.00	do not complete this line.	(S). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		7, 717	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	11 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becember a	or the cost	Ö	0.00
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becember 31	or the cost	O	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	6, 181	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (i poludi na privoto ro	om days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruct		Joili days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (frict during private	(100 days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13.00
14. 00	after December 31 of the cost reporting period (if calendar ye	· · · · · · · · · · · · · · · · · · ·	, I	0	14. 00
15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	dii (exci dariig swriig-bed d	iays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17.00	SWING BED ADJUSTMENT	- through December 21 of	: 414 T	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 or	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombor 21 of	the cost	0.00	19. 00
19.00	reporting period	through becember 31 of	the cost	0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	3)		6, 752, 109	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
22.00	5 x line 17)	21 -6 +1		0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	ng period (line	0	24. 00
25 00	7 x line 19)	of the east manageting	nominal (line 0	0	25 00
25. 00	Swing-bed cost applicable to NF type services after December (x, y)	of the cost reporting	period (Title 8	U	25. 00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		6, 752, 109	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	irges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		3 ,	0	
30.00	Semi-private room charges (excluding swing-bed charges)	Li = - 20)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	- IThe 28)		0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mir		i ons)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line Reivate room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	0 6, 752, 109	36. 00 37. 00
200	27 minus line 36)	, ,		2, 732, 107	21.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			874. 97	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			5, 408, 190	
40.00	Medically necessary private room cost applicable to the Progra			0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ IINE 4U)	Ţ	5, 408, 190	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	COMMUNITY HO	Provider CO		Period: From 07/01/2019	worksheet D-1	
			Component (To 06/30/2020	Date/Time Pre 11/25/2020 3:	
			Title	XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Total Inpatient Costli	Total npatient Days	Average Per Diem (col. 1 · col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NUDCEDY (+; +l - V 0 VIV and a)	1.00	2. 00	3. 00	4. 00	5. 00	12.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43. 00
	CORONARY CARE UNIT						44. 00
	NEONATAL INTENSIVE CARE BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	44. 01 45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
40.00	Drogram i poeti est apoil la su comi es acet (Wike	at D 2 and 2	Line 200)			1.00	40.00
	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines			ns)		3, 492, 234 8, 900, 424	
17.00	PASS THROUGH COST ADJUSTMENTS	Tr till odgir 10) (3	oc matractro	113)		0,700,121	17.00
50.00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, sum	of Parts I and	285, 624	50.00
F1 00	Dage through costs applicable to Drogram inn	ationt oncillors	complete (fr	om Wko+ D ou	m of Donto II	100.0/3	E1 00
51. 00	Pass through costs applicable to Program inpa and IV)	acrenc andillary	services (Tr	uni wkst. D, St	um UI PAILS II	190, 063	51.00
52. 00	Total Program excludable cost (sum of lines!	50 and 51)				475, 687	52. 00
53. 00	Total Program inpatient operating cost exclude	ding capital rela	ated, non-phy	sician anesthe	etist, and	8, 424, 737	53. 00
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program discharges					0	54.00
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	
	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	ine 56 minus I	ine 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period e	ndina 1996 u	ndated and com	nounded by the	0.00	
	market basket	0 .	o .		pourition by the	0.00	07.00
	Lesser of lines 53/54 or 55 from prior year					0.00	
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61. 00
	amount (line 56), otherwise enter zero (see i		(TITIES 54 X	00), 01 1% 01	the target		
	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	ber 31 of the	cost reportir	na period (See	0	64. 00
	instructions)(title XVIII only)				.9 (
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reporting	peri od (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 nlus line 6	5)(title XVIII	only) For	0	66. 00
00.00	CAH (see instructions)	ic costs (Tric o	+ prus rriic o	5)((11110 XVIII	0111 97. 101	Ĭ	00.00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through I	December 31 o	f the cost rep	orting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after Dec	cember 31 of	the cost renor	rting period	0	68. 00
00.00	(line 13 x line 20)	e costs arter ber	cember 31 or	the cost repor	triig perrou		00.00
69. 00	Total title V or XIX swing-bed NF inpatient I	•				0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70.00
	Adjusted general inpatient routine service of						71.00
	Program routine service cost (line 9 x line			-			72. 00
	Medically necessary private room cost applica			ne 35)			73.00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient i			nrksheet R D	art II column		74. 00 75. 00
73.00	26, line 45)	outine service (20313 (110III W	orksneet b, re	irt II, corumii		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
	Program capital -related costs (line 9 x line						77.00
	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovi der record	s)			78. 00 79. 00
80.00	Total Program routine service costs for compa			*.	ıs line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82.00	Inpatient routine service cost limitation (li	· .	`				82. 00 83. 00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		,				84.00
85. 00	Utilization review - physician compensation		s)				85. 00
86. 00	Total Program inpatient operating costs (sum		ough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	87. 00
	proces observation bed days (SEE HISTIACTIONS)	,				ı	
88. 00	Adjusted general inpatient routine cost per of	diem (line 27 ÷ 1	line 2)			0.00	88.00

Heal th Fi	nancial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATI	ION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
			Component (From 07/01/2019 To 06/30/2020		
-			Title	XVIII	Subprovi der -	PPS	<u> </u>
					. I RF		
	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	
COI	MPUTATION OF OBSERVATION BED PASS THROUGH O						
90.00 Ca	apital-related cost	356, 619	6, 752, 109	0. 05281	6 0	0	90. 00
91. 00 Nu	ırsing School cost	0	6, 752, 109	0. 00000	0 0	0	91.00
92. 00 AI	lied health cost	0	6, 752, 109	0. 00000	0 0	0	92.00
93. 00 AI	I other Medical Education	0	6, 752, 109	0. 00000	0 0	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0125	Peri od: From 07/01/2019	Worksheet D-1	
			Date/Time Pre 11/25/2020 3:	
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	

		Title XIX	Hospi tal	11/25/2020 3: PPS	02 pm
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			81, 442 81, 442	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.		ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		66, 967	4. 00
5.00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through Decembe	r 31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swi ng-bed and	1, 651	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nly (including private r	oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period		e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI>			0	13. 00
14.00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			3, 110 223	
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost				19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	3)		83, 551, 469	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)	(line 21 minus line 24)		02 551 4/0	
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			83, 551, 469	
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	1
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 27 =	- line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	ı
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		ļ	0.00	1
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x lin		,	0.00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	83, 551, 469	•
37.00	27 minus line 36)	ma private room cost di	Tronginal (Title	00, 001, 409	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see		T	1, 025. 90	38. 00
39. 00	Program general inpatient routine service cost per drem (see			1, 693, 761	1
40. 00	Medically necessary private room cost applicable to the Progra			0	40.00
	Total Program general inpatient routine service cost (line 39	•		1, 693, 761	1

Intensive Care Type Input ent Hospital Units 22,258,979 10,863 2,049,06 5 10,245 43.0	Heal th	Financial Systems	COMMUNI TY	HOSPI TAL		In Li∈	eu of Form CMS-2	2552-10
Total	COMPUTA	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0125	From 07/01/2019	Date/Time Pre	
Intal Newgap Per Program Buys Cool 3 x coll				Ti tl	e XIX	Hospi tal		02 piii
1.00 2.00 1.00 3.00 4.00 5.00 3.00 4.00 5.00 3.00 4.00 5.00		Cost Center Description	Total					
1.00 Question Qu		·	Inpatient Cost	Inpatient Days	Diem (col. 1	÷	(col. 3 x col.	
MUSERY (LITE V & XIX only)								
Interest vie Care Type Impattent Respirate Units 12,256,979 10,863 2,049.06 5 10,245 44.00 DIFFERSIVE CARE UNIT 22,256,979 10,863 2,049.06 5 10,245 44.00 DIFFERSIVE CARE UNIT 2,27,256,979 10,863 2,049.06 5 10,245 44.00 DIFFERSIVE CARE UNIT 44.00 DIFFERSIVE CARE UNIT 45.00 BURN THESIVE CARE UNIT 47.00 DIFFERSIVE CAR								
1.00	42. 00		2, 567, 963	3, 110	825. 7	1 223	184, 133	42. 00
4.00 CORONARY CARE UNIT	42.00		22 250 070	10.0/2	2 040 0	./	10.245	42.00
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45.00 SIRROLL INTENSIVE CARE UNIT 45.0			/ 102 /00	4 200	1 410 5	1 220	445 500	•
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		,		- line 2)				
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Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	eu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 07/01/2019 To 06/30/2020		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	5, 144, 336	83, 551, 469	0. 06157	1 14, 849, 903	914, 323	90.00
91.00 Nursing School cost	0	83, 551, 469	0.00000	0 14, 849, 903	0	91.00
92.00 Allied health cost	0	83, 551, 469	0.00000	0 14, 849, 903	0	92.00
93.00 All other Medical Education	0	83, 551, 469	0. 00000	14, 849, 903	0	93. 00

Health Financial Syst	ems C	OMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPAT	ENT OPERATING COST	Provi der CCN: 15-0125	Peri od: From 07/01/2019	Worksheet D-1
		Component CCN: 15-T125		Date/Time Prepared: 11/25/2020 3:02 pm
		Title XIX	Subprovi der -	PPS
			IDE	

		litie xix	I RF	PPS	
	Cost Center Description	<u> </u>	TIM	I	
	T			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s excluding newborn)		7, 717	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			7, 717	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		. 21 -6 +6	7, 717	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roof reporting period	om days) through becembe	1 31 01 the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	- '			
7.00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 2	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceiibei 3	Tor the cost	U	8.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	39	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or	ulv (including private r	oom days) after	0	11. 00
00	December 31 of the cost reporting period (if calendar year, er		days, arts	Ü	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	/ /:		0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year)			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)		,	3, 110	15. 00
16. 00	Nursery days (title V or XIX only)			223	16. 00
47.00	SWING BED ADJUSTMENT		6.11	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	r the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20. 00
20.00	reporting period	s arter becember 31 or t	THE COST	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			6, 752, 109	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	0	23. 00
23.00	x line 18)	31 of the cost reportin	g perrou (Trile o	O	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)				05 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 752, 109	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	: line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	,		0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	
36. 00 37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	6, 752, 109	36. 00 37. 00
200	27 minus line 36)			<u> </u>	27.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			074 07	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			874. 97 34, 124	
40.00	Medically necessary private room cost applicable to the Progra			34, 124	
	Total Program general inpatient routine service cost (line 39			34, 124	
			•		

MPUT	Financial Systems ATION OF INPATIENT OPERATING COST		Provi der CC	N: 15-0125	Peri od:	worksheet D-1	
			Component C	CCN: 15-T125	From 07/01/2019 To 06/30/2020		epare
			·			11/25/2020 3:	
			liti	e XIX	Subprovi der - I RF	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only)	0		0.			42
	Intensive Care Type Inpatient Hospital Units			0	20	Ι ο	4.2
3. 00 4. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0. (00 0	0	43
. 01	NEONATAL INTENSIVE CARE	0	o	0. (00	0	
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGICAL INTENSIVE CARE UNIT						46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
	cost center bescription					1.00	
. 00	Program inpatient ancillary service cost (W					4, 540	
. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instruction	ns)		38, 664	49
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program in	natient routine	services (from	Wkst D sur	n of Parts I and	1, 802	50
. 00		patrent routine	Services (Trom	WKSt. D, Sui	ii or rarts r and	1,002	"
. 00	Pass through costs applicable to Program in	patient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	264	51
	and IV)	FO F1)				2 0//	
2. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non-phy	sician anestl	netist and	2, 066 36, 598	
. 00	medical education costs (line 49 minus line	9 1	rated, non phy	31 CI dil dile3ti	ictist, and	30, 370	"
	TARGET AMOUNT AND LIMIT COMPUTATION	•					
. 00	Program discharges					0	
. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operations	ting cost and ta	rget amount (li	ine 56 minus	line 53)	Ö	
. 00	Bonus payment (see instructions)	· ·			ŕ	0	
. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996, u	pdated and co	ompounded by the	0. 00	59
0. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	ndated by the m	arket hasket		0.00	60
1. 00	If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less that		s (lines 54 x	60), or 1% of	f the target		
2. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62
3. 00	Allowable Inpatient cost plus incentive pay	ment (see instru	ictions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST		,				
. 00	Medicare swing-bed SNF inpatient routine co	sts through Dece	ember 31 of the	cost reporti	ng period (See	0	64
. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co</pre>	sts after Decemb	er 31 of the c	nst renortin	neriod (See	0	65
. 00	instructions) (title XVIII only)	sts arter becenic	el 31 di the ci	ost reporting	g perrou (see		′ 0.
. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line 6	5)(title XVI	I only). For	0	66
. 00	CAH (see instructions)	no ocoto through	Dogombon 21 o	F +bs sss+ m	nonting ported		
. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	ne costs till ougi	i beceiibei 31 0	i the cost it	eporting perrou		67
3. 00	Title V or XIX swing-bed NF inpatient routing	ne costs after D	ecember 31 of	the cost rep	orting period	0	68
	(line 13 x line 20)					_	١
9. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69
0. 00	Skilled nursing facility/other nursing facil)		70
. 00	Adjusted general inpatient routine service						71
. 00	Program routine service cost (line 9 x line			0.5)			72
. 00	Medically necessary private room cost application of the service o		•	ne 35)			73
. 00	Capital -related cost allocated to inpatient	•		orksheet B. I	Part II. column		75
	26, line 45)				,		
. 00	Per diem capital related costs (line 75 ÷ 1)						76
. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 min						78
. 00	Aggregate charges to beneficiaries for excess		rovi der record	s)			79
. 00	Total Program routine service costs for comp			•	nus line 79)		80
. 00	Inpatient routine service cost per diem lim		`				81
. 00	Inpatient routine service cost limitation (Reasonable inpatient routine service costs		* .				82
. 00	Program inpatient ancillary services (see in	•	13)				84
. 00	Utilization review - physician compensation		ns)				85
. 00	Total Program inpatient operating costs (sur		rough 85)				86
7. 00	PART IV - COMPUTATION OF OBSERVATION BED PASTOTAL observation bed days (see instructions					0	87
. 00	Adjusted general inpatient routine cost per		line 2)			0.00	
. 00	That as tea general impatrent routine cost bei						

Health Financial Systems	COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO	Provider CCN: 15-0125		Worksheet D-1	
		Component (CCN: 15-T125	From 07/01/2019 To 06/30/2020		
		Ti tl	e XIX	Subprovider -	PPS	
-				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	356, 619	6, 752, 109	0. 05281	6 0	0	90. 00
91.00 Nursing School cost	0	6, 752, 109	0. 00000	0	0	91. 00
92.00 Allied health cost	0	6, 752, 109	0.00000	0	0	92.00
93.00 All other Medical Education	0	6, 752, 109	0. 00000	0 0	0	93. 00

Health Financial Systems COMMUNITY HOSPITAL In Lieu of Form CMS INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 15-0125 Period: Worksheet D- From 07/01/2019	epared:
From 07/01/2019	epared:
To 06/30/2020 Date/Time Pr	02 pm
Title XVIII Hospital PPS	
Cost Center Description Ratio of Cost Inpatient Inpatient	
To Charges Program Program Costs	
Charges (col. 1 x col	
1.00 2.00 3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	_
30. 00 03000 ADULTS & PEDI ATRI CS 53, 190, 164	30.00
31. 00 03100 NTENSI VE CARE UNI T	31. 00
32. O1 02060 NEONATAL INTENSIVE CARE	32. 01
41. 00 04100 SUBPROVI DER - 1 RF	41. 00
43. 00 04300 NURSERY	43. 00
ANCI LLARY SERVI CE COST CENTERS	1
50. 00 05000 OPERATING ROOM 0. 181892 44, 367, 987 8, 070, 18	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 546943 28, 608 15, 64	52. 00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0. 093857 28, 204, 520 2, 647, 19	54. 00
60. 00 06000 LABORATORY 0. 115097 28, 365, 250 3, 264, 75	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0. 284683 2, 928, 106 833, 58	62. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0	62. 30
65. 00 06500 RESPI RATORY THERAPY 0. 220088 13, 531, 300 2, 978, 07	65. 00
66. 00 06600 PHYSI CAL THERAPY 0. 365147 6, 836, 091 2, 496, 17	66. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 117902 827, 062 97, 51	70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 554528 10, 973, 655 6, 085, 19	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.495109 22, 112, 795 10, 948, 24	
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 188594 34, 055, 997 6, 422, 75	
76. 00 03140 CARDI OLOGY 0. 120744 35, 982, 935 4, 344, 72	
76. 97 07697 CARDI AC REHABI LI TATI ON 0. 618784 168, 726 104, 40	1
761 76 67676 1111 ERBART 6 671 6211 11121011	76. 98
76. 99 07699 LI THOTRI PSY 0. 000000 0	76. 99

0. 352878

0. 111892

0. 380034

145, 195

21, 453, 421

249, 981, 648

249, 981, 648

51, 236

0 92.00

50, 760, 156 200. 00

2, 400, 466

90.00

91.00

201. 00 202. 00

202.00

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS

91.00 O9100 EMERGENCT
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART
200.00 Total (sum of lines 50 through 94 and 96 through 98)
Less PPP Clinic Laboratory Services-Program only charges (line 61)

Net charges (line 200 minus line 201)

	nancial Systems TANCILLARY SERVICE COST APPORTIONMENT	COMMUNITY HOSPITAL Provider C	CN: 15-0125	Peri od:	worksheet D-3	
INPAILENI	ANCILLARY SERVICE COST APPORTIONWENT	Provider C	CN. 13-0123	From 07/01/2019	WOLKSHEEL D-3	
		Component	CCN: 15-T125	To 06/30/2020	Date/Time Pre 11/25/2020 3:	pared: 02 pm
		Ti tl e	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
II NII	DATIENT DOUTING CEDALCE COCT CENTEDS		1.00	2. 00	3. 00	
	PATIENT ROUTINE SERVICE COST CENTERS OOO ADULTS & PEDIATRICS			0	I	30.0
	100 INTENSIVE CARE UNIT			0	l	31.0
	060 NEONATAL INTENSIVE CARE			0		32.0
	100 SUBPROVIDER - IRF			8, 277, 734		41. 0
	300 NURSERY			0, 211, 134		43. 0
	CILLARY SERVICE COST CENTERS					10.0
	OOO OPERATING ROOM		0. 1818	92 128, 213	23, 321	50.00
52. 00 05	200 DELIVERY ROOM & LABOR ROOM		0. 5469	•		52. 0
	400 RADI OLOGY-DI AGNOSTI C		0. 0938		54, 691	54.0
60.00 06	000 LABORATORY		0. 1150	97 1, 208, 741	139, 122	60.0
62. 00 06:	200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 2846	83 49, 887	14, 202	62.0
62. 30 06:	250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000	00 0	0	62. 3
	500 RESPI RATORY THERAPY		0. 2200			
	600 PHYSI CAL THERAPY		0. 3651			
	000 ELECTROENCEPHALOGRAPHY		0. 1179			
	100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 5545	•	256, 398	
	200 I MPL. DEV. CHARGED TO PATIENTS		0. 4951			
	300 DRUGS CHARGED TO PATIENTS		0. 1885			
	140 CARDI OLOGY		0. 1207			
	697 CARDI AC REHABI LI TATI ON		0. 6187		0	
	698 HYPERBARI C OXYGEN THERAPY 699 LI THOTRI PSY		0.0000		0	
	TPATIENT SERVICE COST CENTERS		0.0000	00 0	U	76.9
	000 CLINIC		0. 3528	78 17, 228	6, 079	90.0
	100 EMERGENCY		0. 3528		53	
	200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3800		0	1
200. 00	Total (sum of lines 50 through 94 and 96 thr	rough 98)	0.3000	12, 418, 122	1	
201.00	Less PBP Clinic Laboratory Services-Program			12, 113, 122	0, 1,2,204	201. 0
	Net charges (line 200 minus line 201)	, s.i.a. goo (o oi)	1	12, 418, 122	l	202. 0

	Financial Systems	COMMUNITY HOSPITAL			u of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
				From 07/01/2019 To 06/30/2020	Date/Time Pre	
		T: 11	VI V		11/25/2020 3:0	02 pm
			e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cost		Inpatient	
			To Charges		Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30.00	03000 ADULTS & PEDI ATRI CS			1, 096, 867		30. 00
	03100 INTENSIVE CARE UNIT			246, 190		31.00
32.01	02060 NEONATAL INTENSIVE CARE			1, 823, 350		32. 01
41.00	04100 SUBPROVI DER - I RF			0		41.00
43.00	04300 NURSERY			353, 545		43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 18189:	2 862, 144	156, 817	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 54694	128, 268	70, 155	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 09385	7 493, 829	46, 349	54. 00
60.00	06000 LABORATORY		0. 11509	7 734, 466	84, 535	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 28468	3 145, 183	41, 331	62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000	0 0	0	62. 30
	06500 RESPI RATORY THERAPY		0. 22008		· ·	65. 00
66.00	06600 PHYSI CAL THERAPY		0. 36514	7 163, 773	59, 801	66. 00

0.117902

0.554528

0.495109

0.188594

0.120744

0.618784

0.000000

0.000000

0. 352878

0.111892

0.380034

30, 631

205, 380

301, 270

933, 840

308, 082

3, 491

20, 883

289, 850

4, 816, 700

4, 816, 700

3, 611

113, 889

149, 161

176, 117

37, 199

2, 160

7, 369

32, 432

0

0

1, 023, 977 200. 00

70.00

71 00

72.00

73.00

76.00

76. 97

76. 98

76. 99 0

90.00

91.00

92.00

201. 00

202. 00

07000 ELECTROENCEPHALOGRAPHY

07697 CARDI AC REHABI LI TATI ON

03140 CARDI OLOGY

07699 LI THOTRI PSY

09000 CLI NI C

91. 00 09100 EMERGENCY

07300 DRUGS CHARGED TO PATIENTS

07698 HYPERBARI C OXYGEN THERAPY

OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

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

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

72.00

76.00

76. 97

76. 98

76. 99

90.00

200.00

201.00

202.00

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

07200 IMPL. DEV. CHARGED TO PATIENTS

Health Financial Systems INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	COMMUNITY HOSPITAL Provider C	CN: 15-0125	Peri od:	u of Form CMS- Worksheet D-3	
THE ATTEM AND LEART SERVICE GOST ATTORT ON THE			From 07/01/2019		
	Component	CCN: 15-T125	To 06/30/2020	Date/Time Pre 11/25/2020 3:	
	Ti tl	e XIX	Subprovi der -	PPS	<u>02 p</u>
		1	IRF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs (col. 1 x col.	
			Charges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNIT			0		31.00
32. 01 02060 NEONATAL INTENSIVE CARE			0		32. 01
41. 00 04100 SUBPROVI DER - I RF			11, 880		41.00
43. 00 04300 NURSERY			0		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 1818		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 54694		0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 0938		0	
60. 00 06000 LABORATORY		0. 1150		220	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 28468		0	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 65. 00 06500 RESPIRATORY THERAPY		0. 00000 0. 2200		0	
1		0. 2200			
66. 00 06600 PHYSI CAL THERAPY 70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 30514		3, 955	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 11790		0	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 49510		0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 18859			
76. 00 03140 CARDI OLOGY		0. 1207		0	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 61878		0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 00000		0	76. 98
76. 99 07699 LI THOTRI PSY		0.0000	00	0	76. 99
OUTPATIENT SERVICE COST CENTERS			<u> </u>		
90. 00 09000 CLI NI C		0. 3528		0	90.00
91. 00 09100 EMERGENCY		0. 1118		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 38003		0	1 /2.00
200.00 Total (sum of lines 50 through 94 and 96 t			14, 683	4, 540	200.00
201.00 Less PBP Clinic Laboratory Services-Progra	m only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			14, 683		202.00

				11/25/2020 3:	02 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (s	see	0 18, 884, 373	1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurri	ng on or after October 1	1 (see	52, 868, 941	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring p	orior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring o	on or after	0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)				2. 00
2. 01	Outlier reconciliation amount	>		0	2. 01
2. 02 2. 03	Outlier payment for discharges for Model 4 BPCI (see instructi			0 518, 493	2. 02 2. 03
2.03	Outlier payments for discharges occurring prior to October 1 (Outlier payments for discharges occurring on or after October			1, 178, 904	2.03
3.00	Managed Care Simulated Payments	(See That detrons)		1, 170, 704	3.00
4. 00	Bed days available divided by number of days in the cost repor	ting period (see instru	ctions)	380. 38	4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most			0.00	5. 00
6. 00	or before 12/31/1996 (see instructions) FTE count for allopathic and osteopathic programs that meet th			0.00	6. 00
7. 00	new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified u		·	0.00	7.00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under			0.00	7. 01
8.00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopat affiliated programs in accordance with 42 CFR 413.75(b), 413.71998), and 67 FR 50069 (August 1, 2002).			0.00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slo report straddles July 1, 2011, see instructions.	ots under § 5503 of the A	ACA. If the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slo under § 5506 of ACA. (see instructions)	ots from a closed teaching	ng hospital	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line instructions)	es (8, 8,01 and 8,02) (s	see	0.00	9. 00
10.00	FTE count for allopathic and osteopathic programs in the curre	ent year from your record	ds	0.00	10.00
11. 00	FTE count for residents in dental and podiatric programs.			0.00	11. 00
12.00	Current year allowable FTE (see instructions)				12. 00
13. 00	Total allowable FTE count for the prior year.			0.00	
14. 00	Total allowable FTE count for the penultimate year if that year	ended on or after Sept	tember 30, 1997,	0. 00	14. 00
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16. 00	Adjustment for residents in initial years of the program				16. 00
17. 00	Adjustment for residents displaced by program or hospital clos	sure			17. 00
18.00	Adjusted rolling average FTE count			0.00	18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4)	•		0.000000	
20. 00	Prior year resident to bed ratio (see instructions)			0. 000000	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
22. 00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422	of the MMA		0	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE reside (f)(1)(iv)(C).		FR 412. 105	0. 00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0.00	24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the linstructions)	ower of line 23 or line	24 (see	0. 00	1
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01 Disproportionate Share Adjustment)		0	29. 01
30.00	Percentage of SSI recipient patient days to Medicare Part A pa	ntient days (see instruct	tions)	3. 04	30.00
31. 00	Percentage of Medicaid patient days (see instructions)			15. 46	1
32. 00	Sum of lines 30 and 31			18. 50	32. 00
33.00	Allowable disproportionate share percentage (see instructions)			4. 78	1
34.00	Disproportionate share adjustment (see instructions)		l	857, 452	J 34. 00

	<u> </u>	HOSPI TAL		u of Form CMS-2	2552-1
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0125	Peri od: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Pre 11/25/2020 3:	
		Title XVIII	Hospi tal	PPS	
				On/After 10/1	
	Uncompensated Care Adjustment		1. 00	2. 00	
35. 00	Total uncompensated care amount (see instructions)		8, 272, 872, 447	8, 350, 599, 096	35.00
35. 01	Factor 3 (see instructions)		0. 000396589		35. 0°
35. 02	Hospital uncompensated care payment (If line 34 is zero, e	enter zero on this line) (s	ee 3, 280, 933	2, 508, 108	35. 02
35. 03	instructions) Pro rata share of the hospital uncompensated care payment	amount (see instructions)	826, 976	1, 877, 655	35. 0
	Total uncompensated care (sum of columns 1 and 2 on line 3	,	2, 704, 631	1,0,7,000	36.0
	Additional payment for high percentage of ESRD beneficiary				
40. 00	Total Medicare discharges on Worksheet S-3, Part I excludi	ng discharges for MS-DRGs	0		40.0
	652, 682, 683, 684 and 685 (see instructions)		Before 1/1	On/After 1/1	
			1.00	1. 01	
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682	2, 683, 684 an 685. (see	0	0	41.00
41. 01	instructions) Total ESRD Medicare covered and paid discharges excluding	MS_DDGs 650 600 600 60	4 0	0	41. 0 ⁻
+1.01	an 685. (see instructions)	W3-DRGS 032, 062, 063, 06	4	0	41.0
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qu		0.00		42.0
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,	682, 683, 684 an 685. (se	e 0		43.0
44. 00	instructions) Ratio of average length of stay to one week (line 43 divid	ded by line 41 divided by 7	0. 000000		44. 0
44.00	days)	ied by Title 41 divided by 7	0.00000		44.0
45. 00	Average weekly cost for dialysis treatments (see instructi		0.00	0.00	
16.00	' ' '	e 41.01)	77 012 704		46.0
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH	l small rural hospitals	77, 012, 794		47. 0 48. 0
10. 00	only. (see instructions)	i, silari rarar nespi tars			10.0
				Amount	
49. 00	Total payment for inpatient operating costs (see instructi	one)		1. 00 77, 012, 794	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I)	5, 992, 739	
51. 00	Exception payment for inpatient program capital (Wkst. L,		•	0	51.0
52. 00	Direct graduate medical education payment (from Wkst. E-4,	line 49 see instructions)		0	52.0
53. 00 54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			31, 412 41, 578	
54. 01	Islet isolation add-on payment			41,576	54.0
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iir	ne 69)		0	55. 0
6. 00	Cost of physicians' services in a teaching hospital (see i			0	56.0
57. 00	Routine service other pass through costs (from Wkst. D. Pt		through 35).	120, 200	57.0
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, F Total (sum of amounts on lines 49 through 58)	7t. TV, Cor. Trithe 200)		120, 388 83, 198, 911	
50.00	Primary payer payments			16, 221	
51. 00	Total amount payable for program beneficiaries (line 59 mi	nus line 60)		83, 182, 690	61.0
2. 00	Deductibles billed to program beneficiaries			6, 101, 172	
3. 00	Coinsurance billed to program beneficiaries			543, 356	1
4. 00 5. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			798, 187 518, 822	•
6. 00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		168, 231	66.0
7. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	·		77, 056, 984	67.0
8. 00	Credits received from manufacturers for replaced devices f			516	1
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	96).(For SCH see instruction	ns)	0	69. 0 70. 0
0.50	Rural Community Hospital Demonstration Project (§410A Demo	onstration) adjustment (see	instructions)	0	70. 5
0.87	Demonstration payment adjustment amount before sequestrati			0	70. 8
70. 88	SCH or MDH volume decrease adjustment (contractor use only	<i>y</i>)		0	70.8
70. 89	Pioneer ACO demonstration payment adjustment amount (see i			_	70. 8
70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions HSP bonus payment HRR adjustment amount (see instructions)	•		0 0	1
70. 91	Bundled Model 1 discount amount (see instructions)			0	70. 9
70. 93	HVBP payment adjustment amount (see instructions)			73, 449	
70. 94	HRR adjustment amount (see instructions)			-1, 019, 486	70. 9 70. 9
	Recovery of accelerated depreciation				

70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	0	0	70. 96
70. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	0	0	70. 97
70. 97	the corresponding federal year for the period ending on or after 10/1)	O	0	70.97
70. 98	Low Volume Payment-3		0	70. 98
70. 99	HAC adjustment amount (see instructions)		0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		76, 110, 431	1
71. 01	Sequestration adjustment (see instructions)		1, 271, 044	1
	Demonstration payment adjustment amount after sequestration		0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs			71. 03
72.00	Interim payments		74, 249, 947	72. 00
72. 01	Interim payments-PARHM			72. 01
73.00	Tentative settlement (for contractor use only)		0	73. 00
73. 01	Tentative settlement-PARHM (for contractor use only)			73. 01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and		589, 440	74. 00
	73)			
74. 01	Balance due provider/program-PARHM (see instructions)			74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordance with		934, 517	75. 00
	CMS Pub. 15-2, chapter 1, §115.2			
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90. 00
04.00	plus 2.04 (see instructions)			04.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	
93. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	
	The rate used to calculate the time value of money (see instructions)		0.00	1
95. 00	Time value of money for operating expenses (see instructions)		0	95. 00
96. 00	Time value of money for capital related expenses (see instructions)	Dini +- 10 /1	0 // (45+ 10 //1	96. 00
			On/After 10/1	
	HSP Bonus Payment Amount	1.00	2. 00	
400.00	nor bonus rayment amount			
	IHSD honus amount (see instructions)	0	Λ.	1100 00
100.00	HSP bonus amount (see instructions)	0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment			
101. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	0. 000000000	0. 0000000000	101. 00
101. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions)		0. 0000000000	
101. 00 102. 00	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	0. 0000000000	0. 0000000000	101. 00 102. 00
101. 00 102. 00 103. 00	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. 000000000	0. 0000000000 0	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00	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)	0. 0000000000 0 0. 0000 0	0. 0000000000 0	101. 00 102. 00
101. 00 102. 00 103. 00 104. 00	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 Demonstration) Adjustment	0.0000000000 0 0.0000 0	0. 0000000000 0	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00	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 Demonstration) Adjustments this the first year of the current 5-year demonstration period under the	0.0000000000 0 0.0000 0	0. 0000000000 0	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00 104. 00	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 Demonstration) Adjustment	0.0000000000 0 0.0000 0	0. 0000000000 0	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00 200. 00	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 Demonstration) Adjustment is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no.	0.0000000000 0 0.0000 0	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00 200. 00	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 factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment is the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	0.0000000000 0 0.0000 0	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	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 Demonstration) Adjustment is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	0.0000000000 0 0.0000 0 ent 21st	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	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 Demonstration) Adjustment is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of	0.0000000000 0 0.0000 0 ent 21st	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	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 Demonstration) Adjustment is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period)	0.0000000000 0 0.0000 0 ent 21st	0. 0000000000 0 0. 0000 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	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 Demonstration) Adjustment is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount	0.0000000000 0 0.0000 0 ent 21st	0. 0000000000 0 0. 0000 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	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 Demonstration) Adjustment is this the first year of the current 5-year demonstration period under the century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	0.0000000000 0 0.0000 0 ent 21st	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HVBP Adj ustment for HSP Bonus Payment HVBP adj ustment factor (see instructions) HVBP adj ustment amount for HSP bonus payment (see instructions) HRR Adj ustment for HSP Bonus Payment HRR adj ustment factor (see instructions) HRR adj ustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	0.0000000000 0 0.0000 0 ent 21st	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HVBP Adj ustment for HSP Bonus Payment HVBP adj ustment factor (see instructions) HVBP adj ustment amount for HSP bonus payment (see instructions) HRR Adj ustment for HSP Bonus Payment HRR adj ustment factor (see instructions) HRR adj ustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	0.0000000000 0 0.0000 0 ent 21st	0. 0000000000 0 0. 0000 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HVBP Adj ustment for HSP Bonus Payment HVBP adj ustment factor (see instructions) HVBP adj ustment amount for HSP bonus payment (see instructions) HRR Adj ustment for HSP Bonus Payment HRR adj ustment factor (see instructions) HRR adj ustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	0.0000000000 0 0.0000 0 ent 21st	0.0000000000 0 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	HVBP Adj ustment for HSP Bonus Payment HVBP adj ustment factor (see instructions) HVBP adj ustment amount for HSP bonus payment (see instructions) HRR Adj ustment for HSP Bonus Payment HRR adj ustment factor (see instructions) HRR adj ustment factor (see instructions) HRR adj ustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Line 59)	0.0000000000 0 0.0000 0 ent 21st	0. 0000000000 0 0. 00000 0 cration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	HVBP Adj ustment for HSP Bonus Payment HVBP adj ustment factor (see instructions) HVBP adj ustment amount for HSP bonus payment (see instructions) HRR Adj ustment factor (see instructions) HRR adj ustment factor (see instructions) HRR adj ustment factor (see instructions) HRR adj ustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions)	0.0000000000 0 0.0000 0 ent 21st	0. 0000000000 0 0. 00000 0 cration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HVBP Adj ustment for HSP Bonus Payment HVBP adj ustment factor (see instructions) HVBP adj ustment amount for HSP bonus payment (see instructions) HRR Adj ustment for HSP Bonus Payment HRR adj ustment factor (see instructions) HRR adj ustment factor (see instructions) HRR adj ustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	0.0000000000 0 0.0000 0 ent 21st	0. 0000000000 0 0. 0000 0 cration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HVBP Adj ustment for HSP Bonus Payment HVBP adj ustment factor (see instructions) HVBP adj ustment amount for HSP bonus payment (see instructions) HRR Adj ustment for HSP Bonus Payment HRR adj ustment factor (see instructions) HRR adj ustment amount for HSP bonus payment (see instructions) HRR adj ustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	0.0000000000 0 0.0000 0 ent 21st	0. 0000000000 0 0. 0000 0 cration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00	HVBP Adj ustment for HSP Bonus Payment HVBP adj ustment factor (see instructions) HVBP adj ustment amount for HSP bonus payment (see instructions) HRR Adj ustment for HSP Bonus Payment HRR adj ustment factor (see instructions) HRR adj ustment amount for HSP bonus payment (see instructions) HRR adj ustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	0.0000000000 0 0.0000 0 ent 21st	0. 0000000000 0 0. 00000 0 cration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
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101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	HVBP Adj ustment for HSP Bonus Payment HVBP adj ustment factor (see instructions) HVBP adj ustment amount for HSP bonus payment (see instructions) HRR Adj ustment for HSP Bonus Payment HRR adj ustment factor (see instructions) HRR adj ustment factor (see instructions) HRR adj ustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adj ustment is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adj ustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adj usted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adj ustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adj ustment to Medicare IPPS payments (see instructions) Reserved for future use Total adj ustment to Medicare Part A IPPS payments (from line 211) Low-volume adj ustment (see instructions)	0.0000000000 0 0.0000 0 0 0 0 0 0 0 0 0	0. 0000000000 0 0. 00000 0 cration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 213. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	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) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment is this the first year of the current 5-year demonstration period under the Contury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211) Low-volume adjustment (see instructions) Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement	0.0000000000 0 0.0000 0 0 0 0 0 0 0 0 0	0. 0000000000 0 0. 00000 0 cration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	HVBP Adj ustment for HSP Bonus Payment HVBP adj ustment factor (see instructions) HVBP adj ustment amount for HSP bonus payment (see instructions) HRR Adj ustment for HSP Bonus Payment HRR adj ustment factor (see instructions) HRR adj ustment factor (see instructions) HRR adj ustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adj ustment is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adj ustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of period) Medicare target amount Case-mix adj usted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adj ustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adj ustment to Medicare IPPS payments (see instructions) Reserved for future use Total adj ustment to Medicare Part A IPPS payments (from line 211) Low-volume adj ustment (see instructions)	0.0000000000 0 0.0000 0 0 0 0 0 0 0 0 0	0. 0000000000 0 0. 00000 0 cration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 213. 00

		Title XVIII	Hospi tal	PPS	02 pm
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			26, 349	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruct OPPS payments	ions)		48, 821, 812 46, 840, 560	2. 00 3. 00
4. 00	Outlier payment (see instructions)			71, 645	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0. 000	5. 00
6.00	Line 2 times line 5			0	6.00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	7. 00 8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I'	V, col. 13, line 200		72, 151	9.00
10.00	Organ acqui si ti ons			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			26, 349	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			140, 678	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ne 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			140, 678	14. 00
15.00	Customary charges			0	1 1 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for parameters about that would have been realized from patients liable for			0	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	1 3	r a chargebasi's		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	•		0. 000000	17. 00
18. 00	Total customary charges (see instructions)		44) (140, 678	1
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	y if line 18 exceeds lin	ne 11) (see	114, 329	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	y if line 11 exceeds lir	ne 18) (see	0	20. 00
	instructions)	,	, ,		
21. 00	Lesser of cost or charges (see instructions)			26, 349	
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instru	uctions)		0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	uctions)		46, 984, 356	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions			0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line			8, 515, 797	26.00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) prinstructions)	rus the sum of lines 22	and 23] (See	38, 494, 908	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			38, 494, 908	1
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			7, 698 38, 487, 210	
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)		00, 107, 210	02.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			1, 019, 624	
35. 00 36. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		662, 756 507, 752	
37. 00	Subtotal (see instructions)	uctions)		39, 149, 966	
38. 00				62	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
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 replace	ed devices (see instruct	tions)	0	39. 97 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	ed devices (see mistrac	11 0113)	0	39. 99
40.00	Subtotal (see instructions)			39, 149, 904	1
40. 01	Sequestration adjustment (see instructions)			653, 803	•
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs Interim payments			38, 350, 314	40. 03 41. 00
41. 01	Interim payments-PARHM			00,000,011	41. 01
42.00	Tentative settlement (for contractors use only)			0	42. 00
42. 01	Tentative settlement-PARHM (for contractor use only)			145 707	42. 01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			145, 787	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2, o	chapter 1,	0	44. 00
	§115. 2			_	
00.00	TO BE COMPLETED BY CONTRACTOR			-	00.00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
91.00	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0	93. 00
94. 00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems	COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0125	Peri od: From 07/01/2019	Worksheet E Part B
	Component CCN: 15-T125	To 06/30/2020	Date/Time Prepared: 11/25/2020 3:02 pm
	Title XVIII	Subprovi der -	PPS

			tie wiii	I RF	PPS	
Medical and others services (see instructions)					1 00	
Medical and other services (see instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
200 OPPS suppments 214 3.00 Outliner record lard in amount (see instructions) 0.40 0.40 Outliner record lard in amount (see instructions) 0.40	1.00				0	1.00
0.01 Continue Co		· · · · · · · · · · · · · · · · · · ·				2. 00
0.01 control		1 3				1
Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00 1.00						1
Line 2 times Inle 5						5. 00
Transitional corridor payment (see instructions) 0 8.00	6.00	Line 2 times line 5			0	6. 00
Ancil lary service other pass through costs from West, D, Pt. IV, col. 13, line 200 8 9,00						
10.00 Organ acquisitions 0 10.00 11.00		, , , , , , , , , , , , , , , , , , , ,	12 Line 200			1
11.00			13, 11He 200			•
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Reason		9 1			_	•
12.00 Ancil larry service charges 0 12.00 13.00 Organ acquist it on charges (From West. D-4, Pt. III, col. 4, line 69) 0 13.00 13.00						
13.00 Organ acquist ion charges (From Wist. D-4, Pt. 111, col. 4, line 69)	40.00					
14.00 Otal reasonable charges (sum of lines 12 and 13) Otal Reasonable charges (sum of lines 12 and 13) Otal Reasonable charges (sum of lines 12 and 13) Otal Reasonable charges (sum of lines 12 and 13) Otal Reasonable charges (sum of lines 12 and 13) Otal Reasonable charges (sum of lines 15 to line 16 to		,				
Description						
16.00 Ascount's that would have been real ized from patients I iable for payment for services on a chargebasis had been paged in accordance with 42 CFR \$413.13(e) 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 18.00 17.00 18.00	00					
had such payment been made in accordance with 42 CFR §413.13(e)					0	15. 00
17.00 Ratio of Infe 15 to line 16 (not to exceed 1.000000) 0.000000 17.00 18.00 17.00 18.00 17.00 18.00 18.00 17.00 18	16. 00		for services or	n a chargebasis	0	16. 00
18.00 Total customary charges (see instructions) 0 18.00 18.	17 00				0.00000	17 00
19.00 Excess of customary Charges over reasonable cost (complete only if line 18 exceeds line 11) (see 19.00 19.00 18.00 1						l
Instructions			e 18 exceeds li	ne 11) (see		
Instructions		instructions)			_	
1.00 Lesser of cost or charges (see instructions) 0 21.00	20. 00		e 11 exceeds li	ne 18) (see	0	20. 00
22.00 Interns and residents (see instructions) 0 22.00 02.00	21 00				0	21 00
24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 222 24.00					_	22. 00
COMPUTATION OF RELIMBURSEMENT SETTLEMENT					_	23. 00
25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 0 25.00	24. 00				222	24. 00
26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 43 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 179 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 29.00 ESR0 direct medical education costs (from Wkst. E-4, line 36) 0 29.00 31.00 Primary payer payments 179 30.00 32.00 Subtotal ((line 30 minus lines 27 through 29) 179 30.00 32.00 Subtotal ((line 30 minus lines 27 through 29) 179 32.00 32.00 Subtotal ((line 30 minus lines 27 through 29) 179 32.00 33.00 Subtotal ((line 30 minus lines 27 through 29) 179 32.00 34.00 All Oncompanies (Incompanies 27 through 29) 179 32.00 34.00 All Oncompanies (Incompanies 20 minus lines 27 through 29) 31.00 32.00 Subtotal ((sum of lines 27 through 29) 31.00 32.00 Subtotal ((sum of lines 27 through 29) 30.00 33.00 Composite rate ESR0 (from Wkst. I. 5, line 11) 0 33.00 33.00 Composite rate ESR0 (from Wst. I. 5, line 11) 0 33.00 33.00 Composite rate estable bad debts (see instructions) 0 36.00 34.00 Composite rate estable bad debts (see instructions)	25 00				0	25 00
27. 00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 179 27. 00 179 27. 00 179 27. 00 179 27. 00 179 27. 00 179 27. 00 179 27. 00 179 27. 00 179 27. 00 28. 00 29. 00		· · · · · · · · · · · · · · · · · · ·	CAH, see instr	uctions)		
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29. 00. ESRD di ect medical education costs (From Wkst. E-4, line 36) 0 29. 00 30. 00 Subtotal (sum of lines 27 through 29) 179 30. 00 31. 00 Primary payer payments 0 31. 00 32. 00 Subtotal (line 30 minus line 31) 179 32. 00 33. 00 Composite rate ESRD (from Wkst. I -5, line 11) 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 34. 00 35. 00 Adj usted reimbursable bad debts (see instructions) 0 36. 00 36. 00 All owable bad debts for dual eligible beneficiaries (see instructions) 0 36. 00 37. 00 Subtotal (see instructions) 0 36. 00 38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 99 39. 97 Poemostration payment adjustment amount before sequestration 0 39. 99 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 99 <td< td=""><td>20.00</td><td></td><td></td><td></td><td>0</td><td>20.00</td></td<>	20.00				0	20.00
30. 00 Subtotal (sum of lines 27 through 29) 179 30. 00 31. 00						
31.00 Primary payer payments 31.00 Subtotal (line 30 minus line 31) 179 32.00 32		· · · · · · · · · · · · · · · · · · ·				1
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 0 0 0 0 0 0 0 0 0						1
33.00 Composite rate ESRD (from Wkst. I - 5, line 11) 0 33.00 34.00 All owable bad debts (see instructions) 0 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 0 35.00 36.00 All owable bad debts for dual eligible beneficiaries (see instructions) 179 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 39.50 Demonstration payment adjustment (see instructions) 39.50 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 39.99 RecoVery Of AccellerArted DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 179 40.00	32.00				179	32. 00
34.00	22 00				0	22 00
35. 00						
37.00 Subtotal (see instructions) 179 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 38.00 39.00 39.50 39.00 39.5		· · · · · · · · · · · · · · · · · · ·				
38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 07HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 39.50 39.50 91 oneer ACO demonstration payment adjustment (see instructions) 0 39.97 39.98 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 80.00 39.99 80.00					_	36. 00
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39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 179 40.00 40.01 Sequestration adjustment (see instructions) 0 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 41.01 Interim payments 41.01 Interim payments 41.01 1nterim payments-PARHM 41.01 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement (for contractor use only) 42.01 43.00 Bal ance due provider/program (see instructions) 43.00 43.01 Bal ance due provider/program-PARHM (see instructions) 43.01 Bal ance due provider/program-PARHM (see instructions) 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 9 44.00						ł
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93.00 Time Value of Money (see instructions) 0 93.00	91. 00	Outlier reconciliation adjustment amount (see instructions)				91.00
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Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0125

					11/25/2020 3:0	02 pm
		Titl∈	XVIII	Hospi tal	PPS	
		Inpatier	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		73, 797, 99	3	37, 765, 287	1. 00
2.00	Interim payments payable on individual bills, either		392, 95		585, 027	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	02/05/2020	59, 00	in	0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER	02/03/2020		0		3. 01
3. 02				0		3. 02
3. 03				0		3. 03
3. 05				0		3. 04
3.03	Provider to Program			<u> </u>	0	3.03
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51	7.5000 THE TO THOUSE WILL			0	l ol	3. 51
3. 52			l .	0	l ol	3. 52
3. 53				0	0	3. 53
3.54				0	l ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		59, 00	0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		74, 249, 94	.7	38, 350, 314	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		T		I	
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02	TENTATIVE TO TROVIDER			0	0	5. 02
5. 03				0	l o	5. 03
	Provider to Program		I.		_	
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5.52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		589, 44		145, 787	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		74, 839, 38		38, 496, 101	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1.00	2.00	8. 00
0.00	Induite of contractor			1	1	0.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E-1 | From 07/01/2019 | Part I | To 06/30/2020 | Date/Time Prepared: | 11/25/2020 3:02 pm | PPS Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED COMMUNITY HOSPITAL Provider CCN: 15-0125 Component CCN: 15-T125 Title XVIII

				IRF		
		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	
1.00	Total interim payments paid to provider		11, 175, 807		168	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	T	_		_	
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3. 03			0		0	3. 03
3. 04			0		0	3. 04
3. 05			0		0	3. 05
	Provider to Program	I				
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		11, 175, 807		168	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		11, 175, 607		100	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider	<u> </u>				
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		O	5. 02
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					,
6. 00	Determined net settlement amount (balance due) based on					6. 00
/ 01	the cost report. (1) SETTLEMENT TO PROVIDER		24 077			/ 01
6. 01			24, 077		8	6. 01
6. 02	SETTLEMENT TO PROGRAM		11 100 004		0	6. 02
7. 00	Total Medicare program liability (see instructions)		11, 199, 884	Contractor	176 NPR Date	7. 00
				Number	(Mo/Day/Yr)	
)	1. 00	2.00	
8. 00	Name of Contractor			1. 00	2.00	8. 00
	1	ı		l	1	

Health Financial Systems COMMUNITY HOSPITAL In Lieu					2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0125 Period: From 07/01/2019 To 06/30/2020					
	Title XVIII Hospital					
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	14		1. 00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2. 00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00	
7. 00	OO CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I				7. 00	
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9.00	Sequestration adjustment amount (see instructions)				9. 00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,				
30.00	Initial/interim HIT payment adjustment (see instructions)				30. 00	
	Other Adjustment (specify)				31.00	
22 00	22 00 Release due provides (line 0 (on line 10) minus line 20 and line 21) (one instructions)				22.00	

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

30. 00 31. 00 32. 00

Health Financial Systems	COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0125		Worksheet E-3
		From 07/01/2019	Part III
	Component CCN: 15-T125	To 06/30/2020	Date/Time Prepared:
	·	ı	11/25/2020 3:02 pm
	Title XVIII	Subprovi der -	PPS

PART III - MEDICARE PART A SERVICES - IRF PPS 1.00 Net Federal PPS Payment (see instructions) 2.00 Medicare SSI ratio (IRF PPS only) (see instructions) 3.00 Inpatient Rehabilitation LIP Payments (see instructions) 4.00 Outlier Payments 5.00 Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions) 5.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) 6.00 New Teaching program adjustment. (see instructions) 7.00 Current year's unweighted FTE count of l&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 8.00 Current year's unweighted l&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 10.00 Average Daily Census (see instructions) 21.084699 10.00 11.00 Teaching Adjustment Factor (see instructions) 0.000000111.00
PART III - MEDICARE PART A SERVICES - IRF PPS 1.00 Net Federal PPS Payment (see instructions) 2.00 Medicare SSI ratio (IRF PPS only) (see instructions) 3.00 Inpatient Rehabilitation LIP Payments (see instructions) 4.00 Outlier Payments 5.00 Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions) 5.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 (CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions) 6.00 New Teaching program adjustment. (see instructions) 7.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 8.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 21.084699 10.00
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4.00 Outlier Payments 5.00 Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions) 5.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions) 6.00 New Teaching program adjustment. (see instructions) 7.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 8.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 9.00 Average Daily Census (see instructions) 21.084699 10.00
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7.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 8.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 0.00 9.00 10.00 Average Daily Census (see instructions) 21.084699 10.00
teaching program" (see instructions) 8.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 10.00 Average Daily Census (see instructions) 10.00 Average Daily Census (see instructions)
8.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 10.00 Average Daily Census (see instructions) 21.084699 20.00 8.00 21.084699
teaching program" (see instructions) 9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 10.00 Average Daily Census (see instructions) 10.00 Average Daily Census (see instructions)
9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 0.00 9.00 10.00 Average Daily Census (see instructions) 21.084699 10.00
10.00 Average Daily Census (see instructions) 21.084699 10.00
11.00 Teaching Adjustment Factor (see instructions) 0.000000 11.00
12. 00 Teaching Adjustment (see instructions) 0 12. 00
13. 00 Total PPS Payment (see instructions)
14.00 Nursing and Allied Health Managed Care payments (see instruction) 0 14.00
15. 00 Organ acquisition (DO NOT USE THIS LINE)
16.00 Cost of physicians' services in a teaching hospital (see instructions) 0 16.00
17. 00 Subtotal (see instructions)
18. 00 Primary payer payments
19. 00 Subtotal (line 17 less line 18). 11, 460, 522 19. 00 20. 00 Deductibles 53, 724 20. 00
21. 00 Subtotal (line 19 minus line 20)
22. 00 Coi nsurance 37, 136 22. 00
23. 00 Subtotal (line 21 minus line 22)
24.00 Allowable bad debts (exclude bad debts for professional services) (see instructions)
25. 00 Adjusted reimbursable bad debts (see instructions)
26.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 5,797 26.00
27. 00 Subtotal (sum of lines 23 and 25) 11, 380, 603 27. 00
28.00 Direct graduate medical education payments (from Wkst. E-4, line 49)
29.00 Other pass through costs (see instructions) 9,496 29.00
30.00 Outlier payments reconciliation 0 30.00
31.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 31.00
31.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 31.50
31.99 Demonstration payment adjustment amount before sequestration 0 31.99
32.00 Total amount payable to the provider (see instructions) 11,390,099 32.00
32.01 Sequestration adjustment (see instructions) 190,215 32.01
32.02 Demonstration payment adjustment amount after sequestration 0 32.02
33.00 Interim payments 11,175,807 33.00
34.00 Tentative settlement (for contractor use only) 0 34.00
35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 24,077 35.00
36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00
§115. 2
TO BE COMPLETED BY CONTRACTOR
50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4
51.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00
52.00 The rate used to calculate the Time Value of Money 0.00 52.00
53.00 Time Value of Money (see instructions) 0 53.00

Health Financial Systems	COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0125	Peri od:	Worksheet E-3

From 07/01/2019 | Part VII | To 06/30/2020 | Date/Time Prepared: 11/25/2020 3:02 pm | Hospital | PPS Title XIX

	Ti ti	le XIX	Hospi tal	PPS	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR T	TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		O		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		o	0	4.00
5.00	Inpatient primary payer payments		o		5. 00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		o	0	1
	COMPUTATION OF LESSER OF COST OR CHARGES		-1		
	Reasonable Charges				
8.00	Routine service charges		3, 519, 952		8.00
9. 00	Ancillary service charges		4, 816, 700	0	1
10. 00	Organ acquisition charges, net of revenue		0	ŭ	10.00
11. 00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		8, 336, 652	0	
12.00	CUSTOMARY CHARGES		0,000,002		12.00
13. 00	Amount actually collected from patients liable for payment for services of	on a charge	0	0	13. 00
13.00	basis	on a charge	ı	O	13.00
14. 00	Amounts that would have been realized from patients liable for payment for	or services on	o	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42 CFR §413.		ı	O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	13(0)	0. 000000	0. 000000	15 00
16. 00	Total customary charges (see instructions)		8, 336, 652	0.000000	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only if line 1	16 exceeds	8, 336, 652	0	1
17.00	line 4) (see instructions)	TO CACCCUS	0, 330, 032	O	17.00
18. 00	Excess of reasonable cost over customary charges (complete only if line	1 exceeds line	0	0	18. 00
10.00	16) (see instructions)	+ CACCCUS TITIC	ı	O	10.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed f	for PPS provide			21.00
22. 00	Other than outlier payments	or 113 provide	0	0	22. 00
23. 00	Outlier payments		o	0	
24. 00	Program capital payments		0	O	24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		3, 301	0	
27. 00	Subtotal (sum of lines 22 through 26)		3, 301	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		3, 301	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		3, 301	0	
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		3, 301	U	29.00
30. 00	Excess of reasonable cost (from line 18)		ام	0	30.00
	· · · · · · · · · · · · · · · · · · ·		2 201	0	1
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		3, 301	0	
32. 00	Deductibles		0		
33. 00	Coi nsurance		0	0	
34.00	Allowable bad debts (see instructions)		9	0	
35. 00	Utilization review		0		35.00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		3, 301	0	
37. 00	ZERO OUT SETTLEMENT		-3, 301	0	
38. 00	Subtotal (line 36 ± line 37)		0	0	
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0	_	39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
41. 00	Interim payments		0	0	1
42. 00	Balance due provider/program (line 40 minus line 41)		0	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance with CMS	5 Pub 15-2,	0	0	43. 00
	chapter 1, §115.2		ı I		l

Health Financial Systems	COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0125	Period: From 07/01/2019	Worksheet E-3
	Component CCN: 15-T125		Date/Time Prepared:
			11/25/2020 3:02 pm
	Title XIX	Subprovi der -	PPS

		litle XIX	Subprovi der -	PPS	
			IRF Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES END TITLES V ND YLY		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	CES TOR TITLES V OR ATA	. JERVICES		-
1.00	Inpatient hospital/SNF/NF services		O		1.00
2.00	Medical and other services		U	0	
3.00	Organ acquisition (certified transplant centers only)		o	O	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		0	0	1
5. 00	Inpatient primary payer payments		0	O	5.00
6. 00	Outpatient primary payer payments		J	0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		o	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		١		7.00
	Reasonable Charges				1
8.00	Routi ne servi ce charges		11, 880		8.00
9. 00	Ancillary service charges		14, 683	0	
10.00	Organ acquisition charges, net of revenue		0	Ü	10.00
11. 00	Incentive from target amount computation		0		11.00
	Total reasonable charges (sum of lines 8 through 11)		26, 563	0	
.2.00	CUSTOMARY CHARGES		20,000		12.00
13. 00	Amount actually collected from patients liable for payment for s	ervices on a charge	0	0	13. 00
.0.00	basis	or vi ode on a onal ge		ŭ	10.00
14.00	Amounts that would have been realized from patients liable for p	ayment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42	3			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	. ,	0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		26, 563	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	26, 563	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see instruc	tions)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	mpleted for PPS provide			
	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	0.00
	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		/	0	
27. 00	Subtotal (sum of lines 22 through 26)		/	0	
28.00	Customary charges (title V or XIX PPS covered services only)		0 7	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		/	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		ol	0	20.00
30. 00 31. 00	Excess of reasonable cost (from line 18)		7	0	1
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		0	0	
33. 00	Coi nsurance			0	
	Allowable bad debts (see instructions)			0	
35. 00	Utilization review			U	35.00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	2)	7	0	
37. 00	ZERO OUT SETTLEMENT	3)	_7	0	
	Subtotal (line 36 ± line 37)		0	0	
	Direct graduate medical education payments (from Wkst. E-4)			O	39.00
	Total amount payable to the provider (sum of lines 38 and 39)			0	
41. 00	Interim payments			0	
42. 00	Balance due provider/program (line 40 minus line 41)		0	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2	l o	0	
	chapter 1, §115.2	2 30 2,		ŭ	
			'		•

Health Financial Systems COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10

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

Provider CCN: 15-0125 | Period: From 07/01/20

| Period: | Worksheet G | From 07/01/2019 | To 06/30/2020 | Date/Time Prepared: | 11/25/2020 3:02 pm |

oni y)					11/25/2020 3:	02 pm
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	10, 601	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2. 00
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	65, 629, 559	0	0	0	
5. 00	Other receivable	0	0	0	0	
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	•
7.00	Inventory Proposid expanses	13, 680, 700		0	0	7. 00 8. 00
8. 00 9. 00	Prepaid expenses Other current assets	8, 885, 456		0	0	9. 00
10. 00	Due from other funds	0,000,400	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	88, 206, 316		_	0	11. 00
	FIXED ASSETS			- 1		
12.00	Land	0	0	0	0	12. 00
13.00	Land improvements	0	0	0	0	13. 00
14. 00	Accumulated depreciation	0	0	0	0	•
15. 00	Bui I di ngs	196, 470, 455	1	0	0	15. 00
16.00	Accumulated depreciation	0	0	0	0	16.00
17. 00 18. 00	Leasehold improvements Accumulated depreciation	0		0	0	17. 00 18. 00
19. 00	Fi xed equi pment			0	0	19.00
20. 00	Accumulated depreciation	0		0	0	20.00
21. 00	Automobiles and trucks	ĺ	o o	o	0	•
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23.00	Maj or movable equipment	0	0	0	0	23. 00
24.00	Accumulated depreciation	0	0	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	196, 470, 455	0	0	0	
30.00	OTHER ASSETS	170, 470, 433	0	<u> </u>	0	30.00
31. 00	Investments	0	0	0	0	31.00
32.00	Deposits on Leases	0	1	0	0	32. 00
33.00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	17, 619, 094	0	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	17, 619, 094	1	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	302, 295, 865	0	0	0	36. 00
27.00	CURRENT LIABILITIES	2 1/1 007	,	ام	0	07.00
37. 00 38. 00	Accounts payable	3, 161, 907 25, 215, 451	1	0	0	37. 00 38. 00
39. 00	Salaries, wages, and fees payable Payroll taxes payable	25, 215, 451		0	0	39.00
40. 00	Notes and Loans payable (short term)			0	0	40.00
41. 00	Deferred income	ĺ	o o	o	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43. 00
44. 00	Other current liabilities	79, 103, 864	0	0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	107, 481, 222	2 0	0	0	45. 00
	LONG TERM LIABILITIES	1				
46. 00	Mortgage payable	0	1	0	0	
47. 00 48. 00	Notes payable Unsecured Loans	0	0	0	0	47. 00 48. 00
49. 00	Other long term liabilities	18, 260, 375		0	0	1
50. 00	Total long term liabilities (sum of lines 46 thru 49)	18, 260, 375		o	0	•
51. 00	Total liabilities (sum of lines 45 and 50)	125, 741, 597			0	1
	CAPITAL ACCOUNTS		•			
52.00	General fund balance	176, 554, 268	3			52. 00
53.00	Specific purpose fund		0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance		1	0	_	56.00
57.00	Plant fund balance - invested in plant		1		0	57.00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion		1		0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	176, 554, 268	0	0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	302, 295, 865		Ö	0	60.00
	59)					

Provider CCN: 15-0125

					10	06/30/2020	11/25/2020 3:0	
		General	Fund	Speci al	Purp	ose Fund	Endowment Fund	oz piii
		1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		281, 174, 195			C		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		48, 737, 287					2. 00
3.00	Total (sum of line 1 and line 2)		329, 911, 482			C		3. 00
4.00	Additions (credit adjustments) (specify)	0			0		0	4. 00
5.00	RESTRICTED CONTRIBUTIONS	176, 000			0		0	5. 00
6.00	INVESTMENT INCOME	6, 000			0		0	6. 00
7.00	NET ASSETS RELEASED	14, 786			0		0	7. 00
8.00		0			0		0	8. 00
9.00		0			0		0	9. 00
10.00	Total additions (sum of line 4-9)		196, 786			C		10.00
11. 00	Subtotal (line 3 plus line 10)		330, 108, 268			C		11.00
12.00	Deductions (debit adjustments) (specify)	0			0		0	12.00
13.00	NET ASSETS TRANSFERRED	153, 338, 000			0		0	13.00
14.00	PENSION RELATED ADJUSTMENT	54, 000			0		0	14.00
15.00	NET ASSETS RELEASED	162, 000			0		0	15.00
16.00		0			0		0	16.00
17.00		0			0		0	17.00
18.00	Total deductions (sum of lines 12-17)		153, 554, 000			C		18.00
19.00	Fund balance at end of period per balance		176, 554, 268			C		19.00
	sheet (line 11 minus line 18)							
		Endowment Fund	PI ant	Fund				
		4.00	7.00					
	I 	6. 00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2. 00
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4.00	Additions (credit adjustments) (specify)		0					4. 00
5.00	RESTRICTED CONTRIBUTIONS		0					5. 00
6.00	INVESTMENT INCOME		0					6. 00
7.00	NET ASSETS RELEASED		0					7. 00
8.00			0					8. 00
9.00	T		Ü					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11.00	Subtotal (line 3 plus line 10)	0			U			11. 00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13.00	NET ASSETS TRANSFERRED		0					13.00
14. 00	PENSION RELATED ADJUSTMENT		0					14. 00
15.00	NET ASSETS RELEASED	1	0					15. 00
16.00		1	0					16.00
17. 00	T-1-1 d-du-1; (6.1; 40.47)		0					17. 00
18.00	Total deductions (sum of lines 12-17)	0			0			18. 00
19. 00	Fund balance at end of period per balance	ا			0			19. 00
	sheet (line 11 minus line 18)	1		I	- 1			

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0125

			Го 06/30/2020	Date/Time Pre 11/25/2020 3:	
	Cost Center Description	Inpatient	Outpati ent	Total	<u> </u>
	'	1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	106, 514, 88	7	106, 514, 887	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF	9, 576, 84	5	9, 576, 846	3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		O	0	5.00
6.00	Swing bed - NF		O	0	6.00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	116, 091, 73	3	116, 091, 733	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	29, 532, 80	7	29, 532, 807	11.00
12.00	CORONARY CARE UNIT				12.00
12. 01	NEONATAL INTENSIVE CARE	28, 307, 15	1	28, 307, 151	12. 01
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines	57, 839, 95	3	57, 839, 958	16.00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	173, 931, 69		173, 931, 691	17. 00
18. 00	Ancillary services	605, 220, 82		605, 220, 821	18. 00
19. 00	Outpati ent servi ces	l .		1, 002, 370, 718	19. 00
20. 00	RURAL HEALTH CLINIC	•	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	'	0	0	21. 00
22. 00	HOME HEALTH AGENCY		8, 779, 804	8, 779, 804	22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE	00.540.00	05 05 4 05 0	50 500 450	26. 00
27. 00	OTHER (PHYSICIAN OFFICES)	22, 548, 20	1		27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	t. 801, /00, /1	2 1, 047, 104, 780	1, 848, 805, 492	28. 00
	G-3, line 1)				
20.00	PART II - OPERATING EXPENSES		493, 670, 052		29. 00
29. 00 30. 00	Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY)		193, 670, 052		30.00
30.00	ADD (SPECIFY)				30.00
32.00					32.00
33. 00					33. 00
34. 00					34. 00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)	· ·	0		36. 00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00	DEDUCT (SPECITY)				38. 00
39. 00					39. 00
40. 00					40. 00
41. 00					41. 00
42. 00	Total deductions (sum of lines 37-41)		n		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tran	sfer	493, 670, 052		43. 00
	to Wkst. G-3, line 4)		1,0,0,0,002		
		•	•	•	

Heal th	Financial Systems COMMUNITY	HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0125	Peri od:	Worksheet G-3	
			From 07/01/2019 To 06/30/2020		
				1.00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3,	Line 28)		1. 00 1, 848, 805, 492	1. 00
2.00	Less contractual allowances and discounts on patients' acc			1, 349, 483, 077	2.00
3.00	Net patient revenues (line 1 minus line 2)	oditts		499, 322, 415	ı
4. 00	Less total operating expenses (from Wkst. G-2, Part II, Ii	ne 43)		493, 670, 052	ı
5. 00	Net income from service to patients (line 3 minus line 4)	10)		5, 652, 363	
0.00	OTHER I NCOME			0,002,000	0.00
6.00	Contributions, donations, bequests, etc			31, 603	6.00
7. 00	Income from investments			284, 046	1
8. 00	Revenues from telephone and other miscellaneous communicat	ion services		0	ı
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			2, 133, 641	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to othe	r than patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients			14, 603, 866	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			23, 674	21. 00
22. 00	Rental of hospital space			1, 076, 302	22. 00
23.00	Governmental appropriations			2, 818	23. 00
24.00	REVENUE - CLASSES			36, 414	24. 00
24. 01	ASSETS RELEASED FROM RESTRICTION			152, 595	24. 01
24. 02	FITNESS POINTE/BEAUTY SHOP INCOME			2, 498, 979	24. 02
04.00	CALMO ON CALE OF ACCETS			F00 F00	1

533, 502

159, 662

267, 700

0 28.00

48, 737, 287 29. 00

21, 280, 122

43, 084, 924

48, 737, 287

24. 03

24.04

24.05

24.50

25.00

87 26.00 0 27.00

24. 03 GAINS ON SALE OF ASSETS

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

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

24. 50 COVI D-19 PHE Funding

24. 04 PENSION INCOME

24. 05 OTHER REVENUE

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

0

0

-9.050

0

5, 384, 715

C

112, 773

O

0

5. 497. 488

23 00

23.50

24.00

All Others (specify)

24.00 Total (sum of lines 1-23)

Tel emedi ci ne

23.00

23. 50

Heal th	Financial Systems		COMMUNITY H	INSPLTAL		In li	eu of Form CMS-	2552-10
	LLOCATION - HHA GENERAL SERVICE	COST	OOMMONT TT TE		CN: 15-0125	Peri od:	Worksheet H-1	
				HHA CCN:	15-7487	From 07/01/2019 To 06/30/2020		epared:
						Home Health	PPS	OZ PIII
			Capital Rela	ated Costs		Agency I		
			Capital Rela	ateu costs				
		Net Expenses	BI dgs &	Movabl e	Plant	Transportati or		
		for Cost Allocation	Fixtures	Equi pment	Operation &		(cols. 0-4)	
		(from Wkst. H,			war meenanee			
		col . 10)						
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	3.00	4. 00	4A. 00	
1.00	Capital Related - Bldg. &	0	0				C	1.00
	Fixtures			_				
2. 00	Capital Related - Movable Equipment	0		C)		C	2. 00
3.00	Plant Operation & Maintenance	o	O	C		0	C	3. 00
4.00	Transportation	0	0	C	1		0	4. 00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	1, 959, 474	0)	0 (1, 959, 474	5. 00
6.00	Skilled Nursing Care	1, 453, 703	0	C		0 (1, 453, 703	6. 00
7.00	Physical Therapy	1, 166, 948	0	C			1, 166, 948	
8. 00 9. 00	Occupational Therapy Speech Pathology	492, 396 63, 778	0	(0 0	492, 396 63, 778	1
10.00	Medical Social Services	1, 078	0	C	1	0	1, 078	1
11. 00	Home Health Aide	66, 810	0	C		0	66, 810	
12.00	Supplies (see instructions)	293, 301	0	C	1	٠	293, 301	
13. 00 14. 00	Drugs DME	0 0	0	(1	0		
00	HHA NONREIMBURSABLE SERVICES	, ,	31				91	1 00
15. 00	Home Dialysis Aide Services	0	0	C	•			1
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0	(1	0 0		
18. 00	Clinic		o	C	1	0		1
19. 00	Health Promotion Activities	0	0	C	1	0		
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	(1	0 0		
22. 00	Homemaker Service	0	0	C	1	0		1
23. 00	All Others (specify)	0	0	C		0		23. 00
23. 50	Telemedicine	0 5, 497, 488	0	(1	,	O 5, 497, 488	
24.00	Total (sum of lines 1-23)	Admi ni strati ve	Total (cols.		ή	O C	5, 497, 488	24.00
		& General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5. 00	6. 00					
1.00	Capital Related - Bldg. &							1.00
2 00	Fixtures							2.00
2. 00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3. 00
4.00	Transportation	1 050 474						4. 00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	1, 959, 474						5. 00
6.00	Skilled Nursing Care	805, 112	2, 258, 815					6. 00
7.00	Physical Therapy	646, 295	1, 813, 243					7. 00 8. 00
8. 00 9. 00	Occupational Therapy Speech Pathology	272, 706 35, 322	765, 102 99, 100					9. 00
10.00	Medical Social Services	597	1, 675					10. 00
11.00	Home Heal th Aide	37, 002	103, 812					11.00
12. 00 13. 00	Supplies (see instructions) Drugs	162, 440	455, 741 0					12. 00 13. 00
14. 00		Ö	Ö					14. 00
15 00	HHA NONREI MBURSABLE SERVI CES							15 00
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0					15. 00 16. 00
17. 00	Private Duty Nursing	0	Ö					17. 00
18.00	Clinic	0	0					18. 00
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0					19. 00 20. 00
	Home Delivered Meals Program		0					21.00
22. 00	Homemaker Service	0	O					22. 00
23. 00 23. 50	All Others (specify) Telemedicine	0	0					23. 00 23. 50
	Total (sum of lines 1-23)		5, 497, 488					23. 50
			. ,					

	<u>Financial Systems</u> LLOCATION - HHA STATISTICAL BAS	IS	COMMUNI TY	Provi der C	°N: 15_0125 F	Peri od:	u of Form CMS-2 Worksheet H-1	2332-10
C031 A	LECCATION - THA STATISTICAL DAS	13		HHA CCN:	F	From 07/01/2019 To 06/30/2020	Part II	pared:
						Home Health	PPS	02 piii
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportati or	nReconciliation	Admi ni strati ve	
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Maintenance (SQUARE FEET)			(ACCUM. COST)	
		1. 00	2. 00	3.00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	_						
1. 00	Capital Related - Bldg. & Fixtures	0				0		1. 00
2.00	Capital Related - Movable		0			0		2. 00
2.00	Equi pment		9					2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3. 00
4.00	Transportation (see	0	0	0	(D		4. 00
5. 00	instructions)	0	0	0		-1, 959, 474	2 520 014	F 00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	0	0	U		-1, 959, 474	3, 538, 014	5. 00
6.00	Skilled Nursing Care	0	0	0		0	1, 453, 703	6. 00
7. 00	Physical Therapy	0	0	0		0	1, 166, 948	
8.00	Occupati onal Therapy	0	0	0	(0	492, 396	8. 00
9.00	Speech Pathology	0	0	0	(0	63, 778	9. 00
10.00	Medical Social Services	0	0	0	(0	1, 078	10. 00
11.00	Home Health Aide	0	0	0	(0	66, 810	
12.00	Supplies (see instructions)	0	0	0	(0	293, 301	
13.00	Drugs	0	0	0		0	0	
14. 00	DME	0	0	0	(0	0	14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0	1 /	0	0	15. 00
16. 00	Respiratory Therapy	0	0	0			0	16.00
17. 00	Private Duty Nursing	0	0	0			0	17. 00
18. 00	Clinic	0	0	0			0	18. 00
19. 00	Health Promotion Activities	0	0	0			0	19. 00
20.00	Day Care Program	0	0	0		0	0	20.00
21. 00	Home Delivered Meals Program	0	0	0				21. 00
22. 00	Homemaker Service	0	0	0		-	n	22. 00
	All Others (specify)	0	0	0		o o	ol	23. 00
23. 50	Tel emedi ci ne	0	0	Ō		0	o	23. 50
24.00	Total (sum of lines 1-23)	0	0	0		-1, 959, 474	3, 538, 014	24. 00
25. 00	Cost To Be Allocated (per	0	0	0	(1, 959, 474	25. 00
	Worksheet H-1, Part I)							
26 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.000000	ור	0. 553834	1 26, 00

Health Financial Systems
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 11/25/2020 3:02 pm Provi der CCN: 15-0125 Peri od: From 07/01/2019 To 06/30/2020 HHA CCN: 15-7487 Home Health

						Agency I	PPS	
			CAPITAL REI	ATED COSTS		rigonoy .		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
		0	1.00	2.00	4. 00	4A	5. 00	
1.00	Administrative and General	0	0	216	676, 528	676, 744	126, 401	1. 00
2.00	Skilled Nursing Care	2, 258, 815	0	0	0	2, 258, 815	421, 897	2. 00
3. 00	Physi cal Therapy	1, 813, 243	0		·			3. 00
4.00	Occupational Therapy	765, 102	0		0	7007.02		4. 00
5.00	Speech Pathology Medical Social Services	99, 100 1, 675	0	0	0	99, 100		5. 00 6. 00
6. 00 7. 00	Home Heal th Aide	103, 812	0	0	0	1, 675 103, 812		7. 00
8. 00	Supplies (see instructions)	455, 741	0	0	0	455, 741		8. 00
9.00	Drugs	0	0	0	0	0	0	9. 00
10.00	DME	0	0	0	0	0	0	10.00
11. 00	Home Dialysis Aide Services	0	0		0	_	0	11. 00
12. 00	Respiratory Therapy	0	0	0	0	0	0	12.00
13. 00 14. 00	Private Duty Nursing Clinic	0	0	0	0	0	0	13. 00 14. 00
15. 00	Health Promotion Activities	0	0	0	0	0	0	15. 00
16. 00	Day Care Program	0	0	Ō	Ō	0	O	16. 00
17. 00	Home Delivered Meals Program	0	0		0	0	0	17. 00
18. 00	Homemaker Service	0	0	· ·	0	0	0	18. 00
19.00	All Others (specify)	0	0	1	0	0	0	19.00
19. 50 20. 00	Telemedicine Total (sum of lines 1-19) (2)	5, 497, 488	0	216	676, 528	6, 174, 232	1, 153, 211	19. 50 20. 00
21. 00	Unit Cost Multiplier: column	3, 477, 400	0	210	070, 320	0. 000000		21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places. Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		REPAI RS	PLANT	LINEN SERVICE				
	T	6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
1.00	Administrative and General	0	0	1	· ·		_	1.00
2. 00 3. 00	Skilled Nursing Care Physical Therapy		0	0	0	0	0	2. 00 3. 00
4. 00	Occupational Therapy	l o	0	Ö	l ő	Ö	Ö	4. 00
5. 00	Speech Pathology	0	0	Ō	Ō	0	0	5. 00
6.00	Medical Social Services	0	0	0	0	0	0	6. 00
7. 00	Home Heal th Ai de	0	0	0	0	0	0	7. 00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8. 00
9. 00 10. 00	Drugs DME	0	0		0	_	0	9. 00 10. 00
11. 00	Home Dialysis Aide Services	0	0		0	_	0	11. 00
12. 00	Respiratory Therapy	l o	0	Ö	Ö	Ö	Ö	12. 00
13.00	Private Duty Nursing	0	0	0	0	0	0	13. 00
14. 00	Clinic	0	0	0	0	0	0	14. 00
15. 00	Health Promotion Activities	0	0	0	0	0	0	15.00
16. 00 17. 00	Day Care Program Home Delivered Meals Program	0	0	· ·	0	_	0	
18. 00	Homemaker Service	0	0		·	_		18.00
19. 00	All Others (specify)	l o	0		Ö		Ö	19. 00
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19. 50
20. 00	Total (sum of lines 1-19) (2)	0	0	0	0	0	0	20. 00
21. 00	Unit Cost Multiplier: column							21. 00
	26, line 1 divided by the sum of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

10.00	DIVIL	U	U	U U	U	U	U	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19. 00	All Others (specify)	0	0	0	0	0	0	19.00
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19. 50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	7, 359, 463	0	20.00
21.00	Unit Cost Multiplier: column							21.00
	26, line 1 divided by the sum							
	of column 26, line 20 minus						ļ	
	column 26, line 1, rounded to							
	6 decimal places.							

0

0 10.00

0

10.00

DME

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.

⁽²⁾ Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Peri od: | Worksheet H-2 From 07/01/2019 | Part | Part | Date/Ti me Prepared: | 11/25/2020 3: 02 pm | Home Health | PPS Provi der CCN: 15-0125 HHA CCN: 15-7487

						Home Health	PPS	
						Agency I		
	Cost Center Description	Subtotal	Allocated HHA	Total HHA				
			A&G (see Part	Costs				
		0, 00	11)					
1 00		26. 00	27. 00	28. 00				1 00
1.00	Administrative and General	835, 165						1.00
2.00	Skilled Nursing Care	2, 680, 712	343, 155	3, 023, 867	1			2. 00
3.00	Physi cal Therapy	2, 151, 917	275, 463	2, 427, 380	1			3. 00
4.00	Occupational Therapy	908, 006		1, 024, 238				4. 00
5.00	Speech Pathology	117, 610	15, 055	132, 665	1			5. 00
6.00	Medical Social Services	1, 988	254	2, 242	1			6. 00
7.00	Home Health Aide	123, 202	15, 771	138, 973				7. 00
8.00	Supplies (see instructions)	540, 863	69, 235	610, 098				8. 00
9.00	Drugs	0	0	0				9. 00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11. 00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	O	0				13. 00
14.00	Clinic	0	O	0				14. 00
15.00	Health Promotion Activities	0	O	0				15. 00
16.00	Day Care Program	0	o	0				16. 00
17. 00	Home Delivered Meals Program	0	o	0				17. 00
18.00	Homemaker Service	0	o	0				18. 00
19.00	All Others (specify)	0	ol	0				19. 00
19. 50	Tel emedi ci ne	0	o	0				19. 50
20.00	Total (sum of lines 1-19) (2)	7, 359, 463	835, 165	7, 359, 463				20.00
21. 00	Unit Cost Multiplier: column	, ,	0. 128008	, ,				21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	i process	•	'	'	•			•

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

| In Lieu of Form CMS-2552-10 | Period: | Worksheet H-2 | From 07/01/2019 | Part II | Date/Time Prepared: | 11/25/2020 3:02 pm | Home Health | PPS | P BASIS HHA CCN: 15-7487

						Agency I	PPS	
		CAPITAL REL	LATED COSTS			rigericy i		
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (NEW- \$ VAL UE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2. 00	4. 00	5A	5. 00	6. 00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 14.00 15.00 16.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0 0 0 0 0 0 0 0 0 0 0	154 0 0 0 0 0 0 0 0 0 0 0 0	4, 414, 136 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		676, 744 2, 258, 815 1, 813, 243 765, 102 99, 100 1, 675 103, 812 455, 741	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
18. 00 19. 00 19. 50 20. 00 21. 00 22. 00	Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) Total cost to be allocated Unit cost multiplier Cost Center Description	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 154 216 1. 402597 LAUNDRY & LI NEN SERVI CE (POUNDS)	0 0 4, 414, 136 676, 528 0. 153264 HOUSEKEEPING (TIME SPENT)	3	0 0 0, 174, 232 1, 153, 211 0. 186778 CAFETERIA (FTES)	0 0 0 0 0.000000 MAI NTENANCE OF PERSONNEL (NUMBER HOUSED)	18. 00 19. 00 19. 50 20. 00 21. 00 22. 00
		7. 00	8. 00	9. 00	10.00	11. 00	12. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) Total cost to be allocated Unit cost multiplier	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. 0000000		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	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: 15-0125 Peri od: Worksheet H-2 From 07/01/2019 BASIS Part II HHA CCN: 15-7487 То 06/30/2020 Date/Time Prepared: 11/25/2020 3:02 pm Home Health **PPS** Agency I PHARMACY SOCIAL SERVICE NONPHYSI CI AN Cost Center Description NURSI NG CENTRAL MEDI CAL SERVICES & ADMI NI STRATI ON (COSTED REQ .) RECORDS & **ANESTHETISTS** (TIME SPENT) (ASSI GNED SUPPLY LI BRARY (NURSING HO (COSTED REQ .) (GROSS REVE TIME) URS) NUE) 13. 00 14.00 15. 00 16. 00 17.00 19.00 1.00 Administrative and General 0 8, 779, 804 0 1.00 0 Skilled Nursing Care 2 00 C C O 2 00 3.00 Physical Therapy 0 0 0 0 0 3.00 4.00 Occupational Therapy 0 0000000000000000 0 0 0 0 4.00 Speech Pathology 0 0 0 5 00 5 00 0 6.00 Medical Social Services 0 6.00 7.00 Home Heal th Aide 0 7.00 0 0 8.00 Supplies (see instructions) 0 0 8.00 0 0 9.00 Ω 9 00 Drugs 10.00 DMF 0 0 10.00 Home Dialysis Aide Services 0 0 0 0 0 0 0 0 11.00 11.00 Respiratory Therapy 0 0 12.00 12.00 0 0 13.00 Private Duty Nursing Ω 13.00 14.00 Clinic 0 0 0 14.00 Health Promotion Activities 15.00 15.00 Day Care Program 0 0 0 16.00 16,00 17 00 Home Delivered Meals Program C 0 17 00 0 18.00 Homemaker Service 0 18.00 0 0 19.00 All Others (specify) 0 0 0 19.00 Tel emedi ci ne 0 19.50 0 0 19.50 0 0 0 20.00 Total (sum of lines 1-19) C 8, 779, 804 20.00 Total cost to be allocated 0 32, 020 21.00 21.00 0. 000000 Unit cost multiplier 0. 000000 0.000000 0.000000 0.003647 0.000000 22.00 22.00 INTERNS & RESIDENTS Cost Center Description SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Y & FRINGES PRGM COSTS PRGM-(PHARMACY **APPRV APPRV** (ASSI GNED (ASSI GNED (ASSI GNED TIME) TIME) TIME) 21.00 22.00 23.00 1.00 Administrative and General 0 1. 00 0 2.00 Skilled Nursing Care 000000000000000000 0 2.00 0 3 00 Physical Therapy 0 3 00 4.00 Occupational Therapy 0 4.00 5.00 Speech Pathology 0 0 5.00 0 6 00 Medical Social Services 0 6 00 7.00 Home Health Aide 0 7.00 8.00 Supplies (see instructions) 0 0 8.00 Drugs 0 9.00 0 9.00 0 10.00 DMF 0 10 00 Home Dialysis Aide Services 11.00 0 11.00 Respiratory Therapy 0 12.00 12.00 0 13.00 Private Duty Nursing 0 13.00

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18.00

19.00

19. 50

20.00

21.00

22.00

Clinic

Day Care Program

Homemaker Service

Tel emedi ci ne

All Others (specify)

Unit cost multiplier

Health Promotion Activities

Home Delivered Meals Program

Total (sum of lines 1-19)

Total cost to be allocated

Heal th	Financial Systems		COMMUNITY I	HOSPITAL		III LI E	u of Form CMS-2	2552-10
APPORT	TIONMENT OF PATIENT SERVICE COST	S		Provi der C	CN: 15-0125	Period: From 07/01/2019	Worksheet H-3 Part I	
				HHA CCN:	15-7487	To 06/30/2020	Date/Time Prep 11/25/2020 3:0	pared: 02 pm
				Ti tl e	xVIII	Home Health Agency I	PPS	•
	Cost Center Description		Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from Part II)	+ 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F						
	BENEFICIARY COST LIMITATION							
1 00	Cost Per Visit Computation	2.00	2 022 047		2 022 04	7 22 700	107.10	1 00
1. 00 2. 00	Skilled Nursing Care Physical Therapy	2. 00 3. 00		0	3, 023, 86 2, 427, 38		127. 12 165. 86	1. 00 2. 00
3. 00	Occupati onal Therapy	4.00		0	1			3.00
4. 00	Speech Pathology	5. 00		0	132, 66		164. 60	4. 00
5. 00	Medical Social Services	6. 00	· · · · · · · · · · · · · · · · · · ·	O	2, 24		112. 10	
6.00	Home Health Aide	7. 00			138, 97			6. 00
7.00	Total (sum of lines 1-6)		6, 749, 365	0	1			7. 00
					Program Visit			
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject 1			
					Deducti bl es Coi nsurance			
		0	1.00	2.00	3. 00	4. 00	5. 00	
	Limitation Cost Computation			2.00	0.00		0.00	
8.00	Skilled Nursing Care		23844	0	15, 14	17		8. 00
9.00	Physical Therapy		23844	0	-,			9. 00
10.00	Occupational Therapy		23844	0	3, 60			10. 00
11. 00	Speech Pathology		23844	0	46			11. 00
12. 00	Medical Social Services		23844	0	1	2		12. 00
13.00	Home Heal th Ai de		23844	0	_, _,			13.00
14. 00		From Wkst H_2	Facility Costs	0 Shared	30, 2° Total HHA		Ratio (col. 3	14. 00
	cost center bescription	Part I, col.	(from Wkst.		Costs (cols.		÷ col . 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)	. 661. 1)	
			. ,	Part ÌI)	,	Í		
			1 00	2 00	3.00			
		0	1.00	2. 00	3.00	4. 00	5. 00	
15 00	Supplies and Drugs Cost Comput	ations						15.00
15. 00	Cost of Medical Supplies	ations 8.00	610, 098	0	610, 09	98 557, 276	1. 094786	
		ations	610, 098 0		610, 09			
	Cost of Medical Supplies	ations 8.00	610, 098	0	610, 09 Cost of	98 557, 276	1. 094786	
	Cost of Medical Supplies	ations 8.00	610, 098 0	0	610, 09	98 557, 276	1. 094786	
	Cost of Medical Supplies	ations 8.00	610,098 0 Program Visits	0 0	610, 09 Cost of	08 557, 276 0 0	1. 094786 0. 000000 Subj ect to	
	Cost of Medical Supplies Cost of Drugs	ati ons 8. 00 9. 00	610,098 0 Program Visits Par Not Subject to Deductibles &	t B Subject to Deductibles &	610, 09 Cost of Services	08 557, 276 0 0 Part B Not Subject to Deductibles &	1. 094786 0. 000000 Subject to Deductibles &	
	Cost of Medical Supplies Cost of Drugs	ations 8.00 9.00	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance	0 0 t B Subject to Deductibles & Coinsurance	610, 09 Cost of Servi ces Part A	Part B Not Subject to Deductibles & Coinsurance	1.094786 0.000000 Subject to Deductibles & Coinsurance	
	Cost of Medical Supplies Cost of Drugs Cost Center Description	8.00 9.00 Part A	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00	1. 094786 0. 000000 Subject to Deductibles & Coinsurance 11. 00	
	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER	8.00 9.00 Part A	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00	1. 094786 0. 000000 Subject to Deductibles & Coinsurance 11. 00	
	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	8.00 9.00 Part A	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00	1. 094786 0. 000000 Subject to Deductibles & Coinsurance 11. 00	
	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER	8.00 9.00 Part A	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00	0 0 0 t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00	1. 094786 0. 000000 Subject to Deductibles & Coinsurance 11. 00	
16. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation	Part A 6.00 OF AGGREGATE F	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	0 0 0 t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 IITATION COST, Of	1. 094786 0. 000000 Subject to Deductibles & Coinsurance 11. 00	16.00
1. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	Part A 6.00 OF AGGREGATE F	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, Au	0 0 0 t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 IITATION COST, OF	1. 094786 0. 000000 Subject to Deductibles & Coinsurance 11. 00	1. 00
1. 00 2. 00 3. 00 4. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	Part A 6.00 OF AGGREGATE F	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, Ad 15,147 8,723 3,601 466	0 0 0 t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 IITATION COST, Of 0 1,925,487 0 1,446,797 0 620,596 0 76,704	1. 094786 0. 000000 Subject to Deductibles & Coinsurance 11. 00	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	Part A 6.00 OF AGGREGATE F	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, Ad 15,147 8,723 3,601 466 12	0 0 0 t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 IITATION COST, OF 0 1,925,487 0 1,446,797 0 620,596 0 76,704 0 1,345	1. 094786 0. 000000 Subject to Deductibles & Coinsurance 11. 00	1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	Part A 6.00 OF AGGREGATE F	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, Av 15,147 8,723 3,601 466 12 2,268	0 0 0 t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 IITATION COST, Of 0 1,925,487 0 1,446,797 0 620,596 0 76,704 0 1,345 0 100,087	1. 094786 0. 000000 Subject to Deductibles & Coinsurance 11. 00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
1. 00 2. 00 3. 00 4. 00 5. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)	Part A 6.00 OF AGGREGATE F	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, Av 15,147 8,723 3,601 466 12 2,268	0 0 0 t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 IITATION COST, OF 0 1,925,487 0 1,446,797 0 620,596 0 76,704 0 1,345	1. 094786 0. 000000 Subject to Deductibles & Coinsurance 11. 00	1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	Part A 6.00 OF AGGREGATE F	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 15,147 8,723 3,601 466 12 2,268 30,217	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A 9.00 E PROGRAM LIM	Part B Not Subject to Deductibles & Coinsurance 10.00 II TATION COST, OF 1, 925, 487 0 1, 446, 797 0 620, 596 0 76, 704 0 1, 345 0 100, 087 0 4, 171, 016	1.094786 0.000000 Subject to Deductibles & Coinsurance 11.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)	Part A 6.00 OF AGGREGATE F	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, Av 15,147 8,723 3,601 466 12 2,268	0 0 0 t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 IITATION COST, Of 0 1,925,487 0 1,446,797 0 620,596 0 76,704 0 1,345 0 100,087	1. 094786 0. 000000 Subject to Deductibles & Coinsurance 11. 00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	Part A 6.00 OF AGGREGATE F	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 15,147 8,723 3,601 466 12 2,268 30,217	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A 9.00 E PROGRAM LIM	Part B Not Subject to Deductibles & Coinsurance 10.00 II TATION COST, OF 1, 925, 487 0 1, 446, 797 0 620, 596 0 76, 704 0 1, 345 0 100, 087 0 4, 171, 016	1.094786 0.000000 Subject to Deductibles & Coinsurance 11.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy	Part A 6.00 OF AGGREGATE F	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 15,147 8,723 3,601 466 12 2,268 30,217	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A 9.00 E PROGRAM LIM	Part B Not Subject to Deductibles & Coinsurance 10.00 II TATION COST, OF 1, 925, 487 0 1, 446, 797 0 620, 596 0 76, 704 0 1, 345 0 100, 087 0 4, 171, 016	1.094786 0.000000 Subject to Deductibles & Coinsurance 11.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy	Part A 6.00 OF AGGREGATE F	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 15,147 8,723 3,601 466 12 2,268 30,217	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A 9.00 E PROGRAM LIM	Part B Not Subject to Deductibles & Coinsurance 10.00 II TATION COST, OF 1, 925, 487 0 1, 446, 797 0 620, 596 0 76, 704 0 1, 345 0 100, 087 0 4, 171, 016	1.094786 0.000000 Subject to Deductibles & Coinsurance 11.00	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	Part A 6.00 OF AGGREGATE F	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 15,147 8,723 3,601 466 12 2,268 30,217	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A 9.00 E PROGRAM LIM	Part B Not Subject to Deductibles & Coinsurance 10.00 II TATION COST, OF 1, 925, 487 0 1, 446, 797 0 620, 596 0 76, 704 0 1, 345 0 100, 087 0 4, 171, 016	1.094786 0.000000 Subject to Deductibles & Coinsurance 11.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	Part A 6.00 OF AGGREGATE F	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 15,147 8,723 3,601 466 12 2,268 30,217	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A 9.00 E PROGRAM LIM	Part B Not Subject to Deductibles & Coinsurance 10.00 II TATION COST, OF 1, 925, 487 0 1, 446, 797 0 620, 596 0 76, 704 0 1, 345 0 100, 087 0 4, 171, 016	1.094786 0.000000 Subject to Deductibles & Coinsurance 11.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
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	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	Part A 6.00 OF AGGREGATE F	610,098 0 Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 15,147 8,723 3,601 466 12 2,268 30,217	t B Subject to Deductibles & Coinsurance 8.00 GGREGATE OF TH	Cost of Services Part A 9.00 E PROGRAM LIM	Part B Not Subject to Deductibles & Coinsurance 10.00 II TATION COST, OF 1, 925, 487 0 1, 446, 797 0 620, 596 0 76, 704 0 1, 345 0 100, 087 0 4, 171, 016	1.094786 0.000000 Subject to Deductibles & Coinsurance 11.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00

	Financial Systems		COMMUNI TY			In Lie	u of Form CMS-	
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provider CO	CN: 15-0125 15-7487	Peri od: From 07/01/2019 To 06/30/2020		pared:
				Title	· XVIII	Home Health Agency I	PPS	OZ PIII
		Prog	ram Covered Cha	arges	Cost of Services			
	Cost Center Description	Part A	Not Subject to	Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10.00	11.00	
	Supplies and Drugs Cost Computa	ations						
	Cost of Medical Supplies Cost of Drugs	0	536, 758 0			0 587, 635 0	0	
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	AGGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	?	
	Cost Per Visit Computation		,					
1.00	Skilled Nursing Care	1, 925, 487						1.00
2.00	Physical Therapy	1, 446, 797						2.00
3. 00 4. 00	Occupational Therapy Speech Pathology	620, 596 76, 704						4.0
5. 00	Medical Social Services	1, 345						5.0
6. 00	Home Health Aide	100, 087						6.00
7. 00	Total (sum of lines 1-6)	4, 171, 016						7.00
7.00	Cost Center Description	17 17 17 010						7.00
	, , , , , , , , , , , , , , , , , , ,	12. 00						1
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11. 00
12.00	Medical Social Services							12.00
13.00	Home Heal th Aide							13.00
14. 00	Total (sum of lines 8-13)	I						14.00

Heal th	Financial Systems		COMMUNI TY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	TONMENT OF PATIENT SERVICE COST	S		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:	15-7487	From 07/01/2019 To 06/30/2020		pared:
							11/25/2020 3:	02 pm
				Titl∈	e XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge		HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3.00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	CES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00	Physi cal Therapy	66. 00	0. 365147	0)	0 col. 2, line 2	. 00	1. 00
2.00	Occupational Therapy							2. 00
3.00	Speech Pathology							3. 00
4.00	Cost of Medical Supplies	71.00	0. 554528	0)	0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73.00	0. 188594	0)	0 col. 2, line 1	6. 00	5. 00

LCULA	TION OF HHA REIMBURSEMENT SETTLEMENT	SPITAL Provider CC	N: 15-0125	Peri od:	eu of Form CMS-2 Worksheet H-4	
2002		HHA CCN:	15-7487	From 07/01/2019 To 06/30/2020	Part I-II Date/Time Pre	par
		Title	XVIII	Home Health	11/25/2020 3: PPS	02
				Agency I	rt B	
			Part A	Not Subject to	Subject to	
				Deductibles & Coinsurance	Deductibles & Coinsurance	
		ŀ	1. 00	2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	OMARY CHARGES	5			
	Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)			0 0	0	1
- 1	Total charges			0 0	•	
(Customary Charges					
	Amount actually collected from patients liable for payment fo on a charge basis (from your records)	r servi ces		0 0	0	3
	Amount that would have been realized from patients liable for	payment		0 0	0	4
	for services on a charge basis had such payment been made in					
	with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 00000	0. 000000	
	Total customary charges (see instructions)		0.0000	0.00000	0.000000	1
00	Excess of total customary charges over total reasonable cost	(complete		0 0	Ō	
	only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete on	lvifline			0	8
	1 exceeds line 6)	ily il lille				'
00	Primary payer amounts			0 0		9
				Part A Services	Part B Services	
				1. 00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
	Total reasonable cost (see instructions) Total PPS Reimbursement – Full Episodes without Outliers			0	_	
	Total PPS Reimbursement - Full Episodes with Outliers			0	546, 085	
	Total PPS Reimbursement - LUPA Episodes			0	71, 093	
	Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	51, 806 132, 763	
1	Total PPS Outlier Reimbursement - PEP Episodes with outliers			0	3, 080	
00	Total Other Payments			0	0	
- 1	DME Payments			0	0	1
	Oxygen Payments Prosthetic and Orthotic Payments			0	0	
	Part B deductibles billed to Medicare patients (exclude coins	urance)			0	
	Subtotal (sum of lines 10 thru 20 minus line 21)			0	.,	
	Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)			0	0 4, 960, 765	
	Coinsurance billed to program patients (from your records)				4, 960, 765	١
00	Net cost (line 24 minus line 25)			0	4, 960, 765	26
	Reimbursable bad debts (from your records)	netrueti ana				27
	Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin			0	4, 960, 765	28
- 1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			Ö		1 .
	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	0	
	Demonstration payment adjustment amount before sequestration Subtotal (see instructions)			0	0 4, 960, 765	
	Sequestration adjustment (see instructions)				88, 160	
. 02	Demonstration payment adjustment amount after sequestration			0	0	31
	Interim payments (see instructions)			0	1, -1 -,	
	Tentative settlement (for contractor use only)			1 0) 0	33
	Balance due provider/program (line 31 minus lines 31.01, 32,	and 33)		<u> </u>	0	34

COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems COMMUNITY HANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES Provider CCN: 15-0125 Peri od: From 07/01/2019 To 06/30/2020 Worksheet H-5 Date/Time Prepared: 11/25/2020 3:02 pm HHA CCN: 15-7487

				Home Health Agency I	PPS	
		I npati en	Inpatient Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1. 00 2. 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			0	4, 872, 605 0	1. 00 2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01				0	0	3. 01
3. 02				0	0	3. 02
3. 03 3. 04				0	0	3. 03 3. 04
3. 05				0		3. 05
0.00	Provider to Program			<u> </u>	Ü	0.00
3.50				0	0	3. 50
3.51				0	0	3. 51
3.52				0	0	3. 52
3. 53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		'	0	0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		(0	4, 872, 605	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01				0	0	5. 01
5. 02 5. 03				0	0	5. 02 5. 03
5.03	Provider to Program			U <u> </u>	U	5. 03
5. 50	Trovider to Trogram			ol	0	5. 50
5. 51				Ö	0	5. 51
5. 52				o	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		'	0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			О	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7.00	Total Medicare program liability (see instructions)			0	4, 872, 605	7. 00
				Contractor	NPR Date (Mo/Day/Yr)	
0.00	Name of Contractor	()	1. 00	2. 00	0.00
8.00	Name of Contractor				ı l	8. 00

Health Financial Systems COMMUNITY HOST CALCULATION OF CAPITAL PAYMENT		INITY HOSPITAL Provider CCN: 15-0125	Peri od:	u of Form CMS-2 Worksheet L	
			From 07/01/2019 To 06/30/2020	Parts I-III Date/Time Pre	nared.
				11/25/2020 3:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				٠
1.00	Capital DRG other than outlier	5, 729, 514 0	1		
1. 01 2. 00	Model 4 BPCI Capital DRG other than outlier				1. 01 2. 00
2.00	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments				1
3. 00	Total inpatient days divided by number of days in the	cost reporting period (see inst	ructions)	0 226. 22	
4. 00	Number of interns & residents (see instructions)	cost reporting period (see man	40 (1 0113)	0.00	
5. 00	Indirect medical education percentage (see instructions)				5. 00
6. 00	Indirect medical education adjustment (multiply line § 1.01) (see instructions)	0	6. 00		
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)				7. 00
8.00	Percentage of Medicaid patient days to total days (see instructions)				8. 00
9. 00	Sum of lines 7 and 8				9. 00
10.00					10.00
11.00	, in the second of the second				11.00
12. 00	Total prospective capital payments (see instructions)			5, 992, 739	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instruction			0	
2.00	Program inpatient ancillary capital cost (see instructions)				2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	1
5.00	Total inpatient program capital cost (line 3 x line 4))		0	5. 00
	DADT LLL COMPUTATION OF EVOEDTION DAVINGNES			1. 00	
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs (see instructions)	rumstances (see instructions)		0	
3. 00	Net program inpatient capital costs (line 1 minus line 2)			0	
4. 00	Applicable exception percentage (see instructions)			0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)			0.00	6.00
7.00	Adjustment to capital minimum payment level for extraction	ordinary circumstances (line 2 >	(line 6)	0	1
8.00	Capital minimum payment level (line 5 plus line 7)			0	
9.00	Current year capital payments (from Part I, line 12, a			0	
10. 00 11. 00	Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level	1 1 3 1	,	0	1
12. 00	Worksheet L, Part III, line 14)		•	0	
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) Current year exception payment (if line 12 is positive, enter the amount on this line)			0	1
14. 00	Carryover of accumulated capital minimum payment level		,	0	1
	(if line 12 is negative, enter the amount on this line		ooming period		' '. 50
					1
15. 00				0	15.00
15. 00 16. 00		(see instructions) tions)		0 0 0	16. 00