AND SETTLEMENT	SUMMARY			Parts I-III Date/Time Prepared: 8/2/2021 3:42 pm
PART I - COST	REPORT STATUS			
Provi der	1. [ X ] Electronically prepared cost report		Date: 8/2/202	1 Time: 3:42 pm
use only	<ol> <li>[ ] Manually prepared cost report</li> <li>[ 0 ] If this is an amended report enter the number</li> <li>[ F ] Medicare Utilization. Enter "F" for full or "L</li> </ol>		resubmitted this co	ost report
Contractor use only	5. [ 1 ]Cost Report Status 6. Date Received:     (1) As Submitted 7. Contractor No.     (2) Settled without Audit 8. [ N ]Initial Report for     (3) Settled with Audit 9. [ N ]Final Report for     (4) Reopened     (5) Amended	or this Provider CCN 12		

## PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPITAL SOUTH (15-0128) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 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.

(Si gned) HOLLY MI LLARD

Officer or Administrator of Provider(s)

NETWORK SVP OF FINANCE

Title

(Dated when report is electronically signed.)

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						
Hospi tal	0	689, 596	-110, 514	0	0	1. 00
Subprovi der - IPF	0	0	0		0	2. 00
Subprovi der - I RF	0	0	0		0	3. 00
Swing Bed - SNF	0	0	0		0	5. 00
Swing Bed - NF	0				0	6. 00
Total	0	689, 596	-110, 514	0	0	200. 00
	PART III - SETTLEMENT SUMMARY Hospital Subprovider - IPF Subprovider - IRF Swing Bed - SNF	1.00	Cost Center Description	Cost Center Description	Cost Center Description	Cost Center Description

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

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

Health Financial Systems COMMUNITY HOSPITAL SOUTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0128 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 8/2/2021 3:42 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1402 EAST COUNTY LINE ROAD SOUTH 1.00 1.00 PO Box: State: IN 2.00 City: INDIANAPOLIS Zip Code: 46227 County: MARION 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COMMUNITY HOSPITAL 150128 26900 07/01/1966 N 3.00 SOUTH Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 11.00 Hospi tal -Based OLTC 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2020 12/31/2020 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Υ Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

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

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

reporting period? In column 2, enter "Y" for yes or	"N" for no						
	In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
	Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
	paid days	el i gi bl e	Medi cai d	Medi cai d		days	
		unpai d	pai d days	eligible			
		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	1, 805	332	0	7	7, 256	38	24.00
in-state Medicaid paid days in column 1, in-state							
Medicaid eligible unpaid days in column 2,							
out-of-state Medicaid paid days in column 3,							
out-of-state Medicaid eligible unpaid days in column							
4, Medicaid HMO paid and eligible but unpaid days in							
column 5, and other Medicaid days in column 6.							

Health Financial Systems COMMUNITY HOSPITAL SOUTH In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0128 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 8/2/2021 3:42 pm Y/N IME Direct GME IME Direct GME 5.00 1.00 2.00 3. 00 4.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA 0 00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA \$5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00

	"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 6	57. (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	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	This base year	is your cost r	eporti ng	
	period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents	0.00	0. 00	0. 000000	64. 00
	in the base year period, the number of unweighted non-primary care				
	resident FTEs attributable to rotations occurring in all nonprovider				
	settings. Enter in column 2 the number of unweighted non-primary care				
	resident FTEs that trained in your hospital. Enter in column 3 the ratio				
	of (column 1 divided by (column 1 + column 2)). (see instructions)				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0128 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 8/2/2021 3:42 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. 3/ (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 66.00 2. 10 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 2.00 3. 00 1.00 4.00 5.00 67.00 Enter in column 1, the program FAMILY MEDICINE 0.000000 67.00 1350 0.00 7.58 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Long Term Care Hospital PPS  Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.  Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.  TEFRA Providers  Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes on  Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section	or "N" for no.	Part I Date/Time Pre 8/2/2021 3: 42 1.00	epare 2 pm 80.
Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.  Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.  TEFRA Providers  Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes of Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section	or "N" for no.	N	90
Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.  Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.  TEFRA Providers  Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes of Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section	or "N" for no.		90
Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes on Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section			81.
C440 40(C)(4)(!!)0 E	•	N	85. 86.
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.  1s this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87
11000(d)(1)(b)(vr): Effect 1 for yes of N for no.	V	XIX	
Title V and XIX Services	1. 00	2. 00	+
Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90
OO Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91
OO Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92
Do Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93
Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94
DO If line 94 is "Y", enter the reduction percentage in the applicable column. DO Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	0. 00 N	0. 00 N	95 96
applicable column. OD If line 96 is "Y", enter the reduction percentage in the applicable column.	0. 00	0. 00	97
Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	N	98
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 title XIX.	Y	Y	98
Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98
Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1	N	N	98
for title V, and in column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and	N	N	98
<pre>in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.</pre>	Y	Y	98
Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98
Rural Providers  OD Does this hospital qualify as a CAH?  OD If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		105 106
OCOlumn 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?			107
Enter "Y" for yes or "N" for no in column 2. (see instructions)  Ols this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42  CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108
Physical Occupational 1.00 2.00	Speech 3.00	Respiratory 4.00	
00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	3.00	1. 00	109
		1.00	

Tor yes or "N" for no for each therapy.		
	1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

Health Financial Systems COMMUNITY HOSF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	PITAL SOUTH Provider CO	`N· 15_∩12Ω	In Lie Period:	u of Form CMS Worksheet S-	
HOSTITAL AND HOSTITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Frovider CC	DIN. 10-U128	From 01/01/2020 To 12/31/2020	Part I Date/Time Pr	epared:
				8/2/2021 3: 4	12 pm
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	ost reporting polumn 1 is Y, e rticipating in	period? Enter enter the column 2.	1.00 N	2.00	111. 00
		1.00	2. 00	3. 00	$\dashv$
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceaparticipation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information	peri od? s "Y", enter ne	N			112. 00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	3, or E only) 93" percent (includes	N			0 115. 00
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116. 00
117.00 ls this facility legally-required to carry malpractice insur "Y" for yes or "N" for no.	rance? Enter	Y			117. 00
118.00 Is the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurr			1		118. 00
The portey is craim made. Enter 2 if the portey is occur	onco.	Premi ums	Losses	Insurance	
		1. 00	2.00	3. 00	
118.01 List amounts of malpractice premiums and paid losses:		814, 7	74 C		0 118. 01
118.02 Are malpractice premiums and paid losses reported in a cost	contor other t	than tha	1. 00 N	2. 00	118. 02
Administrative and General? If yes, submit supporting sched and amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	dule listing co d Harmless prov n column 1, "Y" ualifies for th	ost centers vision in ACA ' for yes or ne Outpatient	N	N	119. 00
121.00 Did this facility incur and report costs for high cost impla	antable devices	s charged to	Y		121. 00
patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as def  Act?Enter "Y" for yes or "N" for no in column 1. If column 1  the Worksheet A line number where these taxes are included.					122. 00
Transplant Center Information  125.00  Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126.00  If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2  127.00  If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2  128.00  If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2  129.00  If this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2  130.00  If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col 131.00  If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col 132.00  If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in col 133.00  Removed and reserved  134.00  If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2  All Providers	enter the certification the certification the certification and th	cation date cation date cation date itification cation date cation date itification cation date			125. 00 126. 00 127. 00 128. 00 129. 00 130. 00 131. 00 132. 00 134. 00
All Providers  140.00 Are there any related organization or home office costs as d chapter 10? Enter "Y" for yes or "N" for no in column 1. If are claimed, enter in column 2 the home office chain number.	yes, and home	office costs	Y	HB0720	140.00

					To 1	2/31/2020	Date/Time Pr 8/2/2021 3:4	
1.00		2. 00				3. 00	0/2/2021 3.4	Z piii
If this facility is part of a chai					e name and	d address	of the	
home office and enter the home off	<u>ice contractor name a</u>  Contractor's Nam				ctor's Nu	mher 0810	 )1	141. 00
141. OONAMO. GOWWONT IT HEALTH NETWORK	Contractor 3 Nam	SERVI CES	1 11113101	ANSCOILL	Ctor 3 No	iiibci . oo io	, ,	141.00
142.00 Street: 1500 NORTH RITTER AVENUE	PO Box:							142. 00
143. 00 Ci ty: I NDI ANAPOLI S	State:	I N		Zi p Co	de:	4621	9-3095	143. 00
							1.00	_
144.00 Are provider based physicians' cos	ts included in Worksh	neet A?					Y	144. 00
						4.00	0.00	
145.00 If costs for renal services are cl	aimed on Wkst A lir	ne 74 are t	he costs	for		1. 00 Y	2. 00	145. 00
inpatient services only? Enter "Y"								1 10. 00
no, does the dialysis facility inc		ation for th	is cost	reporti ng				
period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodolog		reviously fi	lad cost	report2		N		146. 00
Enter "Y" for yes or "N" for no in					lf	IN		140.00
yes, enter the approval date (mm/d								
							1.00	
147.00 Was there a change in the statisti	cal basis? Enter "Y"	for ves or	"N" for	no.			1.00 N	147. 00
148.00 Was there a change in the order of							N	148. 00
149.00 Was there a change to the simplifi	ed cost finding metho						N	149. 00
			rt A	Part B 2.00	T	itle V 3.00	Title XIX 4.00	_
Does this facility contain a provi	der that qualifies fo				cation of			
or charges? Enter "Y" for yes or "							3. 13)	
155. 00 Hospi tal			N	N		N	N	155. 00
156.00 Subprovi der - IPF 157.00 Subprovi der - IRF			N N	N N		N N	N N	156. 00 157. 00
158. OOSUBPROVI DER			IV.	11		IN	I IV	158. 00
159. 00 SNF			N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY			N	N		N	N	160.00
161. 00 CMHC				N		N	N	161. 00
							1.00	-
Multicampus								
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that ha	as one or mo	re campu	ises in dif	ferent CE	BSAs?	N	165. 00
Effect 1 for yes of N for no.	Name	Coun	ty	State	Zip Code	CBSA	FTE/Campus	
	0	1. 0	0	2. 00	3. 00	4. 00	5.00	
166.00 If line 165 is yes, for each							0.0	0 166. 00
campus enter the name in column 0, county in column 1, state in								
column 2, zip code in column 3,								
CBSA in column 4, FTE/Campus in								
column 5 (see instructions)								
							1.00	-
Health Information Technology (HIT					nent Act			
167.00 ls this provider a meaningful user							Υ	167. 00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H			er (IIne	: 16/ IS "Y	), enter	tne		168. 00
168.01 If this provider is a CAH and is n			provi der	qualify f	or a hard	lshi p		168. 01
exception under §413.70(a)(6)(ii)?	Enter "Y" for yes or	"N" for no	. (see i	nstructi on	s)	•		
169.00 If this provider is a meaningful u		and is not	a CAH (	line 105 i	s "N"), ∈	enter the	9.9	9169.00
transition factor. (see instruction	115)							+

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						
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Υ	167. 00				
168.00 f this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the		168. 00				
reasonable cost incurred for the HIT assets (see instructions)						
168.01  f this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship		168. 01				
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						
169.00 f this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the	9. 99	169. 00				

	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 period respectively (mm/dd/yyyy)			170. 00
	1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	N	C	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)

SPI T	Financial Systems COMMUNITY HOS AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0128	Period: From 01/01/2020 To 12/31/2020	8/2/2021 3: 42	epared:
				Y/N 1,00	Date	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lfor all NO re	esponses. Ente	1.00 er all dates in t	2.00 The	
	Provider Organization and Operation Has the provider changed ownership immediately prior to the	, boginning of	the cost	N		1 00
00	reporting period? If yes, enter the date of the change in a	column 2. (see	instructions)			1.00
			Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, including	nn 3, "V" for	N Y			3.00
00	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provid officers, 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				3.00
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difference.	for Compiled, ailable in	Y	A	03/26/2020	4.00
00	those on the filed financial statements? If yes, submit rec		IN IN			5.00
	, , , , , , , , , , , , , , , , , , , ,			Y/N	Legal Oper.	
				1. 00	2. 00	
00	Approved Educational Activities  Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	ne provider is	S N		6. 00
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N N		7. 00 8. 00
00	Are costs claimed for Interns and Residents in an approved		cal education	Υ		9. 00
. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	N		10.00
. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	oroved	N	Y/N	11. 00
					1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12. 00
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement				N	14.00
. 00	Did total beds available change from the prior cost reporti		yes, see inst ^t A	ructions. Par	t B	15.00
		Y/N	Date	Y/N	Date	
	DC#D Doto	1. 00	2.00	3. 00	4. 00	
00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	N		N		16.0
00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	06/26/2020	Y	06/26/2020	17. 00
00	in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R  Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.00
. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 00

	Financial Systems COMMUNITY HOS			In Lie	u of Form CM	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der 0	Provider CCN: 15-0128 Pe Fr Tc		Worksheet S Part II Date/Time F 8/2/2021 3:	Prepared:
		Descr	iption	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 (EXCI	EPT CHILDRENS I	HOSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, se					22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprais	sais made dui	ring the cost		23. 00
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter-	ed into during	this cost re	eporting period?		24. 00
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repo	rtina periodí	7 If ves see		25. 00
20.00	instructions.	·	0 .			
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	he cost report	ing period?	lf yes, see		26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? I	f yes, submit		27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit e	ntered into du	ring the cos	t reporting		28. 00
	period? If yes, see instructions.		Ü	. 0		
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst	ructi ons		·		29. 00
30. 00	Has existing debt been replaced prior to its scheduled matinstructions.	urity with new	debt? If yes	s, see		30.00
31. 00	Has debt been recalled before scheduled maturity without is instructions.  Purchased Services	ssuance of new	debt? If yes	s, see		31. 00
32. 00	Have changes or new agreements occurred in patient care se	rvi ces furni sh	ed through co	ontractual		32. 00
33. 00	arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 approximately see instructions.		ng to competi	tive bidding? If		33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an a lf yes, see instructions.	rrangement witl	h provider-ba	ased physi ci ans?		34.00
35. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in		nts with the	provi der-based		35. 00
				Y/N	Date	
	Home Office Costs			1. 00	2. 00	
36. 00	Were home office costs claimed on the cost report?					36.00
37. 00	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	repared by the	home office	?		37. 00
38. 00	If line 36 is yes , was the fiscal year end of the home of			f		38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year en- If line 36 is yes, did the provider render services to oth			5,		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see			40. 00
	instructions.					
		1.	. 00	2.	00	
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	SHI RLEY		BI SHOP		41. 00
	held by the cost report preparer in columns 1, 2, and 3, respectively.					
42. 00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEAL	_TH NETWORK			42. 00
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-4135		SBI SHOP@ECOMMUI	NITY. COM	43. 00
				'		

552-10
ared:
41.00
42.00
43.00
_

| Peri od: | Worksheet S-3 | From 01/01/2020 | Part | | To 12/31/2020 | Date/Time Prepared: Health Financial Systems COMMUNI
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0128

					T	o 12/31/2020	Date/Time Pre	
							8/2/2021 3:42 I/P Days / 0/P	pili
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	30p0.10.112	Line Number		o. Bous	Avai I abl e	57 II 1 1 1 5 GI 5		
		1.00		2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		157	57, 462	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and				·			
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			157	57, 462	0.00	0	7. 00
	beds) (see instructions)							
8. 00	INTENSIVE CARE UNIT	31. 00		12	4, 392	0. 00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)			169	61, 854	0. 00	0	14. 00
15. 00	CAH visits						0	15. 00
16. 00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC						_	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			169			_	27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30. 00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF			_	_			31. 00
32. 00	Labor & delivery days (see instructions)			0	0			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
22.00	outpatient days (see instructions)							22.00
33.00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges		l		l			33. 01

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2020 | Part | | Date/Time Prepared: | 8/2/2021 3: 42 pm | Full Time Equivalents

		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	10, 425	1, 586	33, 562			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)	0 170	/ 50/				2 00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider	8, 173	6, 506				2. 00 3. 00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	10, 425	1, 586	33, 562			7. 00
7.00	beds) (see instructions)	10, 120	1, 000	00,002			7.00
8.00	INTENSIVE CARE UNIT	1, 040	0	2, 987			8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		1, 308				13. 00
14. 00	Total (see instructions)	11, 465	2, 894	39, 078	9. 69	915. 95	
15. 00	CAH visits	0	0	0			15. 00
16.00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00 19. 00
19. 00 20. 00	SKILLED NURSING FACILITY NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			218			24. 10
25. 00	CMHC - CMHC			_			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)				9. 69	915. 95	
28. 00	Observation Bed Days		521	4, 062			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			493			30.00
31.00	Employee discount days - IRF	_		0			31.00
32.00	Labor & delivery days (see instructions)	0	38	610			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days	0					33.00
	LTCH non-covered days LTCH site neutral days and discharges	0					33.00
33.01	LIGHT SITE HEUTER Ways and UI Schal ges	ı Y		1		1	J 33. UT

| Peri od: | Worksheet S-3 | From 01/01/2020 | Part | | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-0128

				To	12/31/2020	Date/Time Prep 8/2/2021 3:42	
		Full Time		Di scha	arges		
		Equi val ents					
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13.00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	2, 530	250	8, 984	1. 00
2.00	HMO and other (see instructions)			1, 617	1, 566		2.00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2, 530	250	8, 984	14.00
15.00	CAH visits						15. 00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)				[		
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01

| In Lieu of Form CMS-2552-10 | Period: Worksheet S-3 | From 01/01/2020 Part II | To 12/31/2020 Date/Time Prepared: 8/2/2021 3: 42 pm

							8/2/2021 3: 42	pm
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries		Related to	Average Hourly Wage (col. 4 ÷	
				(from Wkst. A-6)	(col.2 ± col. 3)	Salaries in col. 4	col. 5)	
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	68, 215, 998	-375, 051	67, 840, 947	1, 905, 183. 00	35. 61	1. 00
1.00	instructions)	200.00	00, 213, 770	373,031	07, 040, 747	1, 703, 103. 00	33.01	1.00
2. 00	Non-physician anesthetist Part A		548, 284	0	548, 284	4, 499. 00	121. 87	2. 00
3. 00	Non-physician anesthetist Part		0	0	О	0.00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		190, 616	0	190, 616	1, 120. 00	170. 19	4. 00
4. 01	Physicians - Part A - Teaching		000.447		-	0.00	l e	1
5. 00	Physician and Non Physician-Part B		302, 116		302, 116	4, 160. 00		
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	U	0. 00	0.00	6. 00
7. 00	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		0	0	О	0.00	0.00	7. 01
8. 00	programs) Home office and/or related		0	0	0	0.00	0. 00	8. 00
9. 00	organization personnel	44. 00	0	0	0	0.00	•	
10. 00	Excluded area salaries (see instructions)		384, 547	-8, 484	376, 063	14, 556. 00	25. 84	10.00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		1, 544, 924	0	1, 544, 924	14, 994. 00	103. 04	11. 00
12. 00	Care Contract Labor: Top Level		0	0	0	0.00	0. 00	12. 00
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		2, 043, 898	0	2, 043, 898	21, 905. 00	93. 31	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14. 00
14. 01	Home office salaries		17, 835, 207	0	17, 835, 207	406, 017. 00	43. 93	14. 01
14. 02	Related organization salaries		0	0	0	0.00	0. 00	14. 02
15. 00	Home office: Physician Part A - Administrative		335, 132	0	335, 132	3, 078. 00	108. 88	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 00
16. 01	Home office Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 01
16. 02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 02
	WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		16, 226, 521	0	16, 226, 521			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		115, 525 43, 904		115, 525 43, 904			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0		0			21. 00
22. 00	B Physician Part A -		12, 183	0	12, 183			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		45, 250 0	0	45, 250			23. 00 24. 00
25. 00	Interns & residents (in an		0	o o	o o			25. 00
25. 50	approved program) Home office wage-related		3, 522, 889	0	3, 522, 889			25. 50
25. 51	(core) Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	0	О			25. 52
	wage-related (core)							

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0128

Peri od: Worksheet S-3 From 01/01/2020 Part II 12/31/2020 Date/Time Prepared:

8/2/2021 3:42 pm Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Number on of Salaries Sal ari es Related to Wage (col. 4 Reported col . 5) (from Wkst. (col.2 ± col. Salaries in A-6)3) col. 4 1.00 2.00 5.00 6.00 3.00 4.00 25.53 Home office: Physicians Part A 0 25.53 - Teaching - wage-related (core) OVERHÉAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4 00 0 00 26.00 0.00 27.00 Administrative & General 5.00 7, 220, 134 -3, 835 7, 216, 299 143, 127. 00 50. 42 27.00 28.00 Administrative & General under 4, 962, 583 4, 962, 583 46, 926. 00 105. 75 28.00 contract (see inst.) Maintenance & Repairs 6.00 29.00 0.00 0.00 29.00 Operation of Plant 1, 530, 232 1, 524, 668 58, 302. 00 26. 15 30.00 7.00 -5, 564 30.00 31.00 Laundry & Linen Service 8.00 0.00 0.00 31.00 90, 419. 00 15. 95 32.00 Housekeepi ng 9.00 1, 449, 420 -7, 000 1, 442, 420 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Di etary 10.00 1, 252, 986 -827, 466 425, 520 24, 302. 00 17. 51 34.00 Di etary under contract (see instructions) 288, 868 4, 160. 00 69. 44 35.00 288, 868 35.00 815, 781 45, 345. 00 17. 99 36, 00 Cafeteri a 11.00 815, 781 36.00 Maintenance of Personnel 0.00 37.00 12.00 0.00 37.00 38.00 Nursing Administration 13.00 267, 483 -416 267, 067 16, 355. 00 16. 33 38.00 39.00 Central Services and Supply 14.00 0.00 0.00 39.00 0 40.00 40.00 Pharmacy 15.00 C 0 0.00 0.00 41.00 Medical Records & Medical 16.00 286, 009 -587 285, 422 6, 205. 00 46.00 41.00 Records Library Social Service 17.00 34, 311. 00 40. 83 42. 00 42.00 1, 403, 968 -3, 181 1, 400, 787 43.00 Other General Service 0.00 43.00 18.00 0.00

| Peri od: | Worksheet S-3 | From 01/01/2020 | Part III | To 12/31/2020 | Date/Time Prepared:

					''	0 12/31/2020	8/2/2021 3: 42	
		Worksheet A	Amount	Reclassi 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		72, 617, 049	-375, 051	72, 241, 998	1, 947, 610. 00	37. 09	1. 00
	instructions)							1
2.00	Excluded area salaries (see		384, 547	-8, 484	376, 063	14, 556. 00	25. 84	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		72, 232, 502	-366, 567	71, 865, 935	1, 933, 054. 00	37. 18	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		21, 759, 161	0	21, 759, 161	445, 994. 00	48. 79	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		19, 761, 593	0	19, 761, 593	0.00	27. 50	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		113, 753, 256	-366, 567	113, 386, 689	2, 379, 048. 00	47. 66	6. 00
7.00	Total overhead cost (see		18, 661, 683	-32, 268	18, 629, 415	469, 452. 00	39. 68	7. 00
	instructions)							1

COMMUNITY HOSPITAL SOUTH	In Lieu of Form CMS-2552-10
Provi der CCN: 15-0128	Peri od: Worksheet S-3
	From 01/01/2020 Part IV

	To 12/31/202	0   Date/lime Prep   8/2/2021 3:42	parea: pm
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 406, 100	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	23, 970	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	618, 803	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)	5, 855, 051	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	874, 111	9. 00
10.00	Dental, Hearing and Vision Plan	49, 817	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	1, 931, 976	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)	685, 992	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	6, 232	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		
	FICA-Employers Portion Only	4, 913, 779	
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	1 1 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0	19. 00
20. 00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00		0	21. 00
	instructions))	_	
22. 00		0	22. 00
	Tuition Reimbursement	77, 550	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	16, 443, 381	24. 00
05.00	Part B - Other than Core Related Cost		05.00
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	1	25. 00

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lie	u of Form CMS-2	552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0128	Peri od: From 01/01/2020 To 12/31/2020		
Cost Center Description		Contract Labor	Benefit Cost	

			8/2/2021 3: 42	pm
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1, 544, 924	16, 443, 381	1. 00
2.00	Hospi tal	1, 544, 924	16, 327, 856	2. 00
3.00	Subprovi der - I PF			3. 00
4.00	Subprovi der - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA			11. 00
12.00	Separately Certified ASC			12. 00
13.00	Hospi tal -Based Hospi ce			13. 00
14.00	Hospital-Based Health Clinic RHC			14. 00
15.00	Hospital-Based Health Clinic FQHC			15. 00
16.00	Hospi tal -Based-CMHC			16. 00
17. 00	Renal Dialysis	0	0	17. 00
18. 00	Other	0	115, 525	18. 00

	AL UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovider CCN: 1		Peri od:	Worksheet S-10	0
				From 01/01/2020 To 12/31/2020	Date/Time Pre	nared
				12/31/2020	8/2/2021 3: 42	
					1. 00	
	Uncompensated and indigent care cost computation					
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide	ed by line 2	202 column	8)	0. 206174	1. (
00	Medicaid (see instructions for each line) Net revenue from Medicaid				38, 112, 404	2.
00	Did you receive DSH or supplemental payments from Medicaid?				36, 112, 404 Y	3.
00	If line 3 is yes, does line 2 include all DSH and/or supplemental	payments fr	om Medica	i d?	Ϋ́	4.
00	If line 4 is no, then enter DSH and/or supplemental payments from	Medi cai d			-14, 289, 637	5.
00	Medi cai d charges				169, 585, 560	•
00	Medicaid cost (line 1 times line 6)		6 !!	2 5 : 6	34, 964, 133	•
. 00	Difference between net revenue and costs for Medicaid program (lin < zero then enter zero)	ne / minus s	sum of lin	es 2 and 5; IT	11, 141, 366	8.
	Children's Health Insurance Program (CHIP) (see instructions for e	each line)				
. 00	Net revenue from stand-alone CHIP	,			0	9.
0. 00	Stand-alone CHIP charges				0	
1.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.
2. 00	Difference between net revenue and costs for stand-alone CHIP (linenter zero)	ne 11 minus	line 9; i	f < zero then	0	12.
	Other state or local government indigent care program (see instruc	ctions for e	each Line)			
3. 00	Net revenue from state or local indigent care program (Not include			)	0	13.
1. 00	Charges for patients covered under state or local indigent care pr	rogram (Not	i ncl uded	in lines 6 or	0	14.
	[10]				_	
5. 00	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indige	on+ ooro nr	aram (lin	o 15 minus lins	0	
5. 00	13; if < zero then enter zero)	ent care pro	ogram (IIII	e is minus iine	0	10.
	Grants, donations and total unreimbursed cost for Medicaid, CHIP a	and state/lo	ocal indig	ent care program	ns (see	
	instructions for each line)			ent care program		
	instructions for each line) Private grants, donations, or endowment income restricted to fundi	ing charity	care	ent care program	0	
7. 00 8. 00	instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp	ing charity pital operat	care ti ons		0	18.
	instructions for each line) Private grants, donations, or endowment income restricted to fundi	ing charity pital operat	care ti ons		0	18. (
8. 00	instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , CHIP and state and local in	ing charity pital operat ndigent care	care tions e programs	(sum of lines	0 0 11, 141, 366 Total (col. 1	17. ( 18. ( 19. (
8. 00	instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , CHIP and state and local in	ing charity pital operat ndigent care	care tions e programs ninsured patients	(sum of lines	0 0 11, 141, 366 Total (col. 1 + col. 2)	18.
3. 00	instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid , CHIP and state and local in 8, 12 and 16)	ing charity pital operat ndigent care	care tions e programs	(sum of lines	0 0 11, 141, 366 Total (col. 1	18.
8. 00 9. 00	instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid , CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line)	ing charity pital operat ndigent care	care tions e programs uninsured patients 1.00	(sum of lines  Insured patients 2.00	0 0 11, 141, 366 Total (col. 1 + col. 2) 3.00	18. 19.
3. 00 9. 00	instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid , CHIP and state and local in 8, 12 and 16)	ing charity pital operat ndigent care	care tions e programs ninsured patients	(sum of lines  Insured patients 2.00	0 0 11, 141, 366 Total (col. 1 + col. 2) 3.00	18. 19.
8. 00 9. 00 0. 00	instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts	ing charity pital operat ndigent care U	care tions e programs uninsured patients 1.00	(sum of lines  Insured patients 2.00  1 2,220,085	0 0 11, 141, 366 Total (col. 1 + col. 2) 3.00	18. 19.
8. 00 9. 00 0. 00 1. 00	Instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions)	ing charity pital operat ndigent care  U ity s (see	care ti ons e programs in insured pati ents 1.00 15,030,43	(sum of lines  Insured patients 2.00  1 2,220,085 4 2,220,085	0 0 11, 141, 366 Total (col. 1 + col. 2) 3.00 17, 250, 516 5, 318, 969	18. 19. 20. 21.
8. 00 9. 00 0. 00	instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off	ing charity pital operat ndigent care  U ity s (see	care tions e programs Ininsured patients 1.00	(sum of lines  Insured patients 2.00  1 2,220,085 4 2,220,085	0 0 11, 141, 366 Total (col. 1 + col. 2) 3.00	18. 19. 20. 21.
8. 00 9. 00 0. 00 1. 00 2. 00	Instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions)	ing charity pital operat ndigent care  U ity s (see	care ti ons e programs in insured pati ents 1.00 15,030,43	(sum of lines  Insured patients 2.00  1 2,220,085 4 2,220,085 9 0	0 0 11, 141, 366 Total (col. 1 + col. 2) 3. 00 17, 250, 516 5, 318, 969 15, 589	20. ( 21. ( 22. (
3. 00 9. 00 0. 00 1. 00 2. 00	instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	ing charity pital operat ndigent care  U ity s (see	care ti ons e programs ini nsured pati ents 1.00 15,030,43 3,098,88 15,58	(sum of lines  Insured patients 2.00  1 2,220,085 4 2,220,085 9 0	0 0 11, 141, 366 Total (col. 1 + col. 2) 3. 00 17, 250, 516 5, 318, 969 15, 589	18. 19. 20. 21. 22.
3. 00 9. 00 0. 00 1. 00 2. 00	instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)	ing charity pital operat ndigent care  ity s (see f as	care tions e programs in insured patients 1.00 15,030,43 3,098,88 15,58 3,083,29	(sum of lines  Insured patients 2.00  1 2,220,085 4 2,220,085 9 0 5 2,220,085	0 0 0 11, 141, 366  Total (col. 1 + col. 2) 3.00  17, 250, 516 5, 318, 969 15, 589 5, 303, 380  1.00	18. 19. 20. 21. 22. 23.
0. 00 0. 00 1. 00 2. 00	Instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)	ing charity pital operat ndigent care  ity s (see f as	care tions e programs in insured patients 1.00 15,030,43 3,098,88 15,58 3,083,29	(sum of lines  Insured patients 2.00  1 2,220,085 4 2,220,085 9 0 5 2,220,085	0 0 0 11, 141, 366  Total (col. 1 + col. 2) 3.00  17, 250, 516 5, 318, 969 15, 589 5, 303, 380	18. 19. 20. 21. 22.
3. 00 9. 00 1. 00 1. 00	instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written officharity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care proof of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for pa	ing charity pital operat ndigent care  ity s (see f as  days beyond ogram?	care tions e programs ni nsured patients 1.00 15,030,43 3,098,88 15,58 3,083,29	(sum of lines    Insured patients   2.00	0 0 0 11, 141, 366  Total (col. 1 + col. 2) 3.00  17, 250, 516 5, 318, 969 15, 589 5, 303, 380  1.00	20. 21. 22. 23.
33. 00 3. 00 3. 00 3. 00 3. 00 4. 00 5. 00	Instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written officharity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care profif line 24 is yes, enter the charges for patient days beyond the istay limit	ing charity pital operat ndigent care  u ity s (see f as  days beyond ogram? indigent care	care tions e programs ni nsured patients 1.00 15,030,43 3,098,88 15,58 3,083,29	(sum of lines    Insured patients   2.00	0 0 0 11, 141, 366  Total (col. 1 + col. 2) 3.00  17, 250, 516  5, 318, 969  15, 589  5, 303, 380  1.00  N	20. 21. 22. 23.
33. 00 30. 00 31. 00 32. 00 33. 00 44. 00 55. 00	instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written officharity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care proof of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for patient days beyond the interest of the charges for pa	ing charity pital operat ndigent care  ity s (see f as  days beyond ogram? indigent care uctions)	care tions e programs lni nsured patients 1.00 15,030,43 3,098,88 15,58 3,083,29 a length re program	(sum of lines    Insured patients   2.00	0 0 11, 141, 366  Total (col. 1 + col. 2) 3.00  17, 250, 516 5, 318, 969 15, 589 5, 303, 380  1.00 N	20. 21. 22. 23. 24. 25.
33. 00 30. 00 31. 00 32. 00 44. 00 55. 00 66. 00 77. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in Research 198, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilia (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care profit in the second patients covered by Medicaid or other indigent care profit in the 24 is yes, enter the charges for patient days beyond the install bad debt expense for the entire hospital complex (see instructions)	ing charity pital operat ndigent care  ity s (see f as  days beyond ogram? indigent care uctions) see instruct	care tions e programs ni nsured patients 1.00  15,030,43 3,098,88 15,58 3,083,29  a Length re program	(sum of lines    Insured patients   2.00	0 0 0 11, 141, 366  Total (col. 1 + col. 2) 3.00  17, 250, 516 5, 318, 969 15, 589 5, 303, 380  1.00 N 0 18, 350, 237	20. 21. 22. 23. 24. 25. 26. 27.
8. 00 9. 00 1. 00 1. 00 3. 00 4. 00 7. 00 7. 00 7. 01 8. 00	Instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care profif line 24 is yes, enter the charges for patient days beyond the istay limit Total bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	ing charity pital operat ndigent care  ity s (see f as  days beyond ogram? indigent care uctions) see instruct instruction	care tions e programs ni nsured patients 1.00 15,030,43 3,098,88 15,58 3,083,29 a length re program tions) ns)	(sum of lines    Insured patients   2.00	0 0 11, 141, 366  Total (col. 1 + col. 2) 3.00  17, 250, 516 5, 318, 969 15, 589 5, 303, 380  1.00 N 0 18, 350, 237 284, 534 437, 745 17, 912, 492	20. 21. 22. 23. 24. 25. 26. 27. 27. 28.
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Instructions for each line) Private grants, donations, or endowment income restricted to fundition for the private grants, appropriations or transfers for support of hose that the provided HTML restriction for each line)  Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilia (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of the charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care profif line 24 is yes, enter the charges for patient days beyond the istay limit Total bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (see	ing charity pital operat ndigent care  ity s (see f as  days beyond ogram? indigent care uctions) see instruct instruction	care tions e programs ni nsured patients 1.00 15,030,43 3,098,88 15,58 3,083,29 a length re program tions) ns)	(sum of lines    Insured patients   2.00	0 0 0 11, 141, 366  Total (col. 1 + col. 2) 3.00  17, 250, 516  5, 318, 969  15, 589  5, 303, 380  1.00  N  0  18, 350, 237 284, 534 437, 745	20. 21. 22. 23. 24. 25. 26. 27. 27. 28. 29.

16. 00   01600   MEDI CAL RECORDS & LI BRARY   226, 009   75, 414   361, 423   0   361, 423   16. 00   17. 00   1700   50CI AL SERVI CE   1, 403, 968   372, 207   1, 776, 175   -1, 841   1, 774, 334   17. 00   21. 00   02100   18R SERVI CES-SALARY & FRI NGES APPRVD   0   0   0   0   0   0   0   0   0		Financial Systems	COMMUNITY HOSP	ITAL SOUTH		In Lie	u of Form CMS-	2552-10
Cost Centur Description	RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provi der Co			Worksheet A	
Cost Center Description							Date/Time Pre	nared·
COLOR   20   ORS   See A-6   Tri all Ball surce (col 3)					'	10 12/31/2020		
		Cost Center Description	Sal ari es	0ther	Total (col. 1		Recl assi fi ed	
STREAM SERVICE COST CENTERS					+ col . 2)	ons (See A-6)		
CHINEAL SERVICE COST CINTERS								
CENERAL SERVICE COST ENTERS     0								
00100   CAP REL COSTS-BLDG & FIXT			1.00	2.00	3. 00	4. 00	5. 00	
2.00   0.0200   CAP RELL COSTS-MUSLE EQUIP					1	0 770 407	0.770.407	
3.00 03000 OTHER CAP REL COSTS 4.00 04000 (PAPO) ELEMENT IS DEPARTMENT 5.00 00000 (PAPATRION OF PLANT IS DEPARTMENT 7.20.134 82,418.11 88,838.05 8,920.05 8,9718.249 5,00 9.00 05000 (PAPATRION OF PLANT CE 9.00 00000 (PAPATRION OF PLANT CE 9.00 0				0	(			
0.000   DOMO   DIFFLOWER BENEFITS DEPARTMENT    0   86   84   7.00   80.718, 249   5.00   5.00   5.00   5.00   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000   5.000				0		7, 094, 095		
5.00   00500   ADMINISTRATIVE & GENERAL   7, 220, 134   82, 418, 171   89, 638, 305   -8, 920, 056   80, 718, 249   5.00   80, 000   90, 000   00500   ORBATION OF LEANT   1, 530, 232   4, 044, 799   5, 575, 331   30, 000   00500   ORBATION OF LEANT   1, 249, 240   1, 007, 603   2, 865, 570   0.00   3, 243, 305   3, 000   00500   ORBATION   1, 249, 240   1, 007, 603   2, 865, 570   0.00   1, 13, 305   2, 437, 605   0.00   0.00   ORBATION   1, 249, 240   1, 007, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   2, 865, 589   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 107, 603   1, 10				0			_	
0.0000   ORTON   OPENATION   OF PLANT   1, 300, 232   4, 044, 7499   5, 575, 031   -138, 493   5, 436, 538   7.00   ORTON			7 220 124					1
0.000   00000   LAUNDRY & LINEN SERVICE   1,449,420   0,000,0000   0.000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,0000   0.13,00000   0.13,00000   0.13,00000   0.13,00000   0.13,00000   0.13,00000   0.13,00		1 1						
9.00   00000   HOUSEKERPING   1,444,400   1,038,180   2,487,600   -13,000   2,473,695   9.00   11.00   01000   DETARY   1,252,986   0.00   0   0,887,152   737,437   10.00   10.00   01000   DETARY   280,009   75,414   361,423   0   0   301,423   15.00   303,075   13.00   10.00   01000   DEDICAL RECORDS & LIBRARY   280,009   75,414   361,423   0   0   301,423   16.00   0000   0   0   0   0   0   0   0			1, 530, 232					
10.00   01000   DIETARY   1,252,986   1,007,603   2,860,589   -1,887,152   973,437   10.00   10.00   CAFETERIA   0.00   1300   NURSING ADMINISTRATION   267,483   63,268   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   330,751   30.00   3			1 449 420					
11.00 0 01100 (ASETERIA N. 0 0 0 0 0 1,816,751   1,181,751   1,181,751   13.00 01300 (MISRI MAG MINISTRATION) 267,483 63,266 330,751   3.00 0300 (MISRI MAG ADMINISTRATION) 267,483 63,266 330,751   3.00 0300 (MEDICAL RECORDS & LIBRARY 286,009 75,414 361,423 0 0 341,423   16.00 02100   187,58780   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331   1.774,331								
13.00   01300 NURSING ADMINISTRATION   267, 483   63, 268   330, 751   330, 751   13.00   330, 751   13.00   17.00   01700   DOCIDIO RESCRIPTOR   1,403, 968   372, 207   1,776, 175   1,811   1,774, 334   17.00   2.00   0100   018 SERVICES-SALARY & FRINGES APPRVD   0   0   0   0   0   0   0   0   0		1 1	0					1
16. 00   01600   MEDICAL RECORDS & LIBRARY   286,099   75,414   361,423   0   361,423   17.00   1700   02100   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2010   2			267, 483	63. 268				1
17.00   01700   SOCI AL SERVICE   1.403.968   372.207   1.776.175   -1.841   1.774.334   17.00   21.00   22.00   18R SERVICES-SCHARY & FRINGES APPRVD   0   0   0   0   0   0   21.00   22.00   22.00   18R SERVICES-SCHARY & FRINGES APPRVD   0   0   0   0   0   0   0   21.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   22.00   2								1
21.00   02700   BAS SERVICES-SALARY & FRINCES APPRIVO   0   0   0   0   0   0   0   22.00	17. 00		1, 403, 968					•
INPATI ENT ROUTI NE SERVICE COST CENTERS   22,767,239   14,025,349   36,792,588   -5,339,525   31,652,603   30,00   31,00   03100   INTERSIVE CARE UNIT   3,094,176   1,382,729   4,476,905   -429,939   4,046,966   31,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00   43,00	21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	(	0		1
30.00   03000   ADULTS & PEDIATRICS   22, 767, 239   14, 025, 349   36, 792, 588   -5, 339, 525   31, 452, 063   30.00   310.00   3100   NITENSIN EV CARE UNIT   3, 094, 176   1, 382, 729   4, 476, 905   -4, 29, 999   4, 046, 966   31.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.00   310.0	22.00		О	0	(	0	0	22. 00
31.00   03100   INTERSIVE CARE UNIT   3.094,176   1.382,729   4.76,905   -429,939   4.046,966   31.00		INPATIENT ROUTINE SERVICE COST CENTERS						1
ABOOD   OBJOD   OBJO			22, 767, 239	14, 025, 349			31, 453, 063	30. 00
ANCIL LARY SERVICE COST CENTERS			3, 094, 176	1, 382, 729	4, 476, 905			•
50.00   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   05000   0500	43.00		0	0	(	673, 785	673, 785	43.00
51.00   05100   RECOVERY ROOM   ALABOR ROOM   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.07   5.0								1
S2.00   0S200   DELLYERY ROOM & LABOR ROOM   587,529   2e,6.08   614,137   3,115,732   3,729,869   52.06   40.0   63400   RADIO RADIO LOCY-THERAPEUTI C   632,176   1,822,704   2,130,883   -1,049,500   1,080,883   55.06   635.00   RADIO LOCY-THERAPEUTI C   632,176   1,498,207   2,130,883   -1,049,500   1,080,883   55.07   635.00   63500   RADIO LOCY-THERAPEUTI C   738,697   682,325   1,421,022   139,438   1,560,460   57.00   63500   RADIOLOCY-THERAPEUTI C   738,697   682,325   1,421,022   139,438   1,560,460   57.00   63500   RADIOLOCY-THERAPEUTI C   7,346,677   682,325   1,421,022   139,438   1,560,460   57.00   63500   RADIOLOCY-THERAPEUTI C   7,346,677   7,402,730   8,777,024   -5,895,468   2,881,556   69.00   6000   RADIOLOCY-THERAPEUTI C   7,346,477   7,393,694   -2,253   7,391,441   60.00   60.00   6000   RESPIRATORY   7,393,694   -2,253   7,391,441   60.00   60.00   6000   RESPIRATORY   1,947,510   1,069,415   3,016,925   -386,743   2,630,182   65.00   6500   RESPIRATORY   1,947,510   1,069,415   3,016,925   -386,743   2,630,182   65.00   6500   RESPIRATORY   1,848,740   1,349,131   4,230,991   -1,625,129   2,605,762   66.00   6600   RESPIRATORORY   1,463,045   -95,212   2,367,383   69.00   69.00   6900   RESPIRATORORY   1,463,045   -95,212   1,367,833   69.00   69.00   69.00   RESPIRATORORY   1,463,045   -95,212   1,367,833   69.00   69.00   69.00   RESPIRATORORY   1,463,045   -95,212   1,367,833   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00								•
1.65   0   05400   RADIOLOGY-DIAGNOSTIC   1.813, 023   1.822, 704   3.635, 727   1.079, 259   2,556, 468   54. 00   05500   05500   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0700   0		1 1						
55.00   05500   RADIOLOGY-THERAPEUTIC   632,176   1,498,207   2,130,383   -1,049,500   1,080,883   55.00   55.00   05500   CARDIAC CATHETER LATION   738,697   682,325   1,421,022   139,438   1,560,400   57.00   57.00   05000   CARDIAC CATHETER LATION   1,374,294   7,402,737,566   604,370   -19,393   584,977   58.00   69.00   05000   CARDIAC CATHETER LATION   1,374,294   0,7,393,694   7,393,694   -2,253   7,391,411   60.00   60.00   06500   RESPIRATORY THERAPY   0,0		05200 DELIVERY ROOM & LABOR ROOM						
57.00   05700   05700   05700   05700   05700   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   05800   0580								
S80   OSBOO   MAGNETIC RESONANCE IMAGING (MRI)   366, 774   237, 596   604, 370   -19, 393   584, 977   58. 05   0590   CADDIAC CATHETERIZATION   1, 374, 294   7, 402, 730   8, 777, 7024   -5, 895, 468   2, 881, 556   59, 00   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600   0600								
59.00   05900   CARDIA C CATHETERI ZATION   1,374,294   7,402,730   8,777,024   -5,895,468   2,881,556   59.00								1
60.0   06000   LABORATORY   0   7, 393, 694   7, 393, 694   -2, 253   7, 391, 441   60.0 064.00   604.00   10400   10400   1011   10400   1011   1064.00   0   0   0   0   0   0   0   0   0								1
64.00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   64.00   65.00   06500   RESPIRATORY THERAPY   1, 947, 510   1, 069, 415   3, 016, 925   -386, 743   2, 630, 182   65.00   66.00   06600   PHYSI CAL THERAPY   2, 881, 760   1, 349, 131   4, 230, 891   -1, 625, 129   2, 605, 762   66.00   67.00   06700   0500   0500   0   0   0   0   0   0								
65.00   06500   RESPI RATORY THERAPY   1, 947, 510   1, 069, 415   3, 016, 925   -386, 743   2, 630, 182   65. 00   06600   PHYSI CAL THERAPY   2, 881, 760   1, 349, 131   4, 230, 891   -1, 625, 129   2, 605, 762   66. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   892, 180   892, 180   67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   236, 219   236, 219   68. 00   06900   ELECTROCARDI OLGCY   940, 854   522, 191   1, 463, 045   -95, 212   1, 367, 833   69. 00   06900   ELECTROCARDI OLGCY   364, 731   343, 433   708, 164   -122, 201   585, 963   70. 00   70. 00   07100   ELECTROENCEPHALOGRAPHY   364, 731   343, 433   708, 164   -122, 201   585, 963   70. 00   71. 00   07100   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0, 91, 77. 048   9, 177, 048   72. 07. 07300   IMPL. DEV. CHARGED TO PATI ENTS   2, 971, 720   8, 445, 418   11, 417, 138   -4, 437   11, 412, 701   73. 00   7300   ORUGS CHARGED TO PATI ENTS   2, 971, 720   8, 445, 418   11, 417, 138   -4, 437   11, 412, 701   73. 00   7400   ORAD   INJURY   10, 10, 10, 10, 10, 10, 10, 10, 10, 10,		1 1	0	7, 393, 094 ∩				
66. 00   06600   PHYSICAL THERAPY   2,881,760   1,349,131   4,230,891   -1,625,129   2,605,762   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0 0 0 0 0 892,180   892,180   67. 00   68. 00   06800   SPEECH PATHOLOGY   940,854   522,191   1,463,045   -95,212   1,367,833   69. 00   69. 00   06900   ELECTROCARDI OLOGY   940,854   522,191   1,463,045   -95,212   1,367,833   69. 00   710. 00   7000   ELECTROCREDHALOGRAPHY   364,731   343,433   708,164   -122,201   585,963   70. 00   710. 00   70100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   418,538   1,407,665   1,826,203   9,865,190   11,691,393   71. 00   712. 00   07200   IMPL   DEV. CHARGED TO PATI ENTS   2,971,720   8,445,418   11,417,138   -4,437   11,412,701   73. 00   713. 00   07300   DRUGS CHARGED TO PATI ENTS   2,971,720   8,445,418   11,417,138   -4,437   11,412,701   73. 00   714. 00   07400   RENAL DI ALYSIS   0 543,396   543,396   543,396   -2,063   541,333   74. 00   715. 00   07300   DRUGS CHARGED TO PATI ENTS   2,971,720   8,445,418   11,417,138   -4,437   11,412,701   73. 00   716. 00   03330   IMAGI NG CENTER   879,282   857,383   1,736,665   -534,615   1,202,050   76. 00   716. 07   07697   CARDI ALO REHABILITATION   226,802   94,049   320,851   -19,028   301,823   717. 00   07900   07900   07900   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1 047 510	1 060 415		-	_	
67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   892, 180   892, 180   67. 00   68. 00   06800   SPEECH PATHOLOGY   940, 854   522, 191   1, 463, 045   -95, 212   1, 367, 833   69. 00   69. 00   06900   ELECTROCARDI OLOGY   940, 854   522, 191   1, 463, 045   -95, 212   1, 367, 833   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   364, 731   343, 433   708, 164   -122, 201   585, 963   70. 00   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   418, 538   1, 407, 665   1, 826, 203   9, 865, 190   11, 691, 393   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   2, 971, 720   8, 445, 418   11, 417, 138   -4, 437   11, 412, 701   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   2, 971, 720   8, 445, 418   11, 417, 138   -4, 437   11, 412, 701   73. 00   74. 00   07400   RENAL DI ALLYSIS   0   543, 396   543, 396   -2, 063   541, 333   74. 00   76. 06   03330   IMAGING CENTER   879, 282   857, 383   1, 736, 665   -534, 615   1, 202, 050   76. 06   76. 07   07697   CARDII AC REHABI LITATION   226, 802   94, 049   320, 851   -19, 028   301, 823   76. 07   07697   CARDII AC REHABI LITATION   226, 802   94, 049   320, 851   -19, 028   301, 823   76. 07   07697   CARDII AC REHABI LITATION   226, 802   94, 049   320, 851   -19, 028   301, 823   76. 07   07697   CARDII AC REHABI LITATION   226, 802   94, 049   320, 851   -19, 028   301, 823   76. 07   07697   CARDII AC REHABI LITATION   226, 802   94, 049   320, 851   -19, 028   301, 823   76. 07   07697   CARDII AC REHABI LITATION   226, 802   94, 049   320, 851   -19, 028   301, 823   77. 00   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   070								
68.00 06800 SPECH PATHOLOGY 9.0 0 0 0 0 236, 219 236, 219 68.00 69.00 06900 ELECTROCARDI OLOGY 940, 854 522, 191 1, 463, 045 -95, 212 1, 367, 833 69.00 77.0 00 07000 ELECTROCREPHALOGRAPHY 364, 731 343, 433 708, 164 -122, 201 585, 963 70.00 77.0 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 418, 538 1, 407, 665 1, 826, 203 9, 865, 190 11, 691, 393 71.00 72.0 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 2, 971, 720 8, 445, 418 11, 417, 138 -4, 437 11, 412, 701 73.00 7300 DRUGS CHARGED TO PATI ENTS 2, 971, 720 8, 445, 418 11, 417, 138 -4, 437 11, 412, 701 73.00 7400 RENAL DI ALYSI S 0 543, 396 543, 396 543, 396 -2, 063 541, 333 74.00 76.00 03950 ENDOSCOPY 546, 556 998, 088 1, 544, 644 -651, 730 892, 914 76.00 76.07 (ARD) I ACREMABILI TATI ON 226, 802 94, 049 320, 851 -19, 028 301, 823 76.97 07697 (ARD) I ACREMABILI TATI ON 226, 802 94, 049 320, 851 -19, 028 301, 823 76.97 09.00 09000 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	2,001,700	1,017,101	1, 200, 07			1
69.00   06900   ELECTROCARDI OLOGY   940, 854   522, 191   1, 463, 045   -95, 212   1, 367, 833   69, 00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.00   70.			o	0				1
70. 00 07000   ELECTROENCEPHALOGRAPHY   364, 731   343, 433   708, 164   -122, 201   585, 963   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   418, 538   1, 407, 665   1, 826, 203   9, 865, 190   11, 691, 393   71. 00   72. 00   07200   MPL. DEV. CHARGED TO PATIENTS   0 0 0 9, 177, 048   9, 177, 048   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   2, 971, 720   8, 445, 418   11, 417, 138   -4, 437   11, 412, 701   73. 00   73. 00   74. 00   07400   RENAL DI ALYSIS   0 543, 396   -2, 063   541, 333   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74.			940, 854	522, 191	1, 463, 045			1
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   418, 538   1, 407, 665   1, 826, 203   9, 865, 190   11, 691, 393   71, 00   72. 00   07200   MPL. DEV. CHARGED TO PATIENTS   0 0 0 0 0 9, 177, 048   72. 00   07300   DRUGS CHARGED TO PATIENTS   2, 971, 720   8, 445, 418   11, 417, 138   -4, 437   11, 412, 701   73. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00	70. 00							1
72. 00   07200   IMPL   DEV CHARGED TO PATIENTS   0   0   0   9, 177, 048   9, 177, 048   72. 05   73. 00   07300   DRUGS CHARGED TO PATIENTS   2, 971, 720   8, 445, 418   11, 417, 138   -4, 437   11, 417, 701   73. 00   73. 00   07400   RENAL DI ALYSIS   0   543, 396   -2, 063   541, 333   74. 00   03950   ENDOSCOPY   546, 556   998, 088   1, 544, 644   -651, 730   892, 914   76. 06   76. 06   76. 06   76. 076   76. 076   76. 076   76. 076   76. 076   76. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076   77. 076		07100 MEDICAL SUPPLIES CHARGED TO PATIENTS						•
74. 00 07400 RENAL DIALYSIS 0 543, 396 543, 396 -2, 063 541, 333 74. 00 76. 00 03950 ENDOSCOPY 546, 556 998, 088 1, 544, 644 -651, 730 892, 914 76. 00 76. 06 03330 IMAGI NG CENTER 879, 282 857, 383 1, 736, 665 -534, 615 1, 202, 050 76. 07 07 07 07 07 07 07 07 07 07 07 07 07	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	(	9, 177, 048	9, 177, 048	72. 00
76. 00 03950 ENDOSCOPY	73.00		2, 971, 720	8, 445, 418	11, 417, 138	-4, 437	11, 412, 701	73. 00
76. 06 03330   IMAGING CENTER			0	543, 396	543, 396	-2, 063	541, 333	74. 00
76. 97 O7697 CARDI AC REHABILITATION 226, 802 94, 049 320, 851 -19, 028 301, 823 76. 97 OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
90. 00   09000   CLINIC   0   0   0   0   0   0   0   0   0			879, 282			-534, 615		
90. 00	76. 97		226, 802	94, 049	320, 851	1 -19, 028	301, 823	76. 97
90. 01								
90. 02			0	0				
90. 03		1 1	-1	0			_	•
90. 04   04953   SPI NE CENTER   160, 973   138, 809   299, 782   -69, 136   230, 646   90. 04   91. 00   09100   EMERGENCY   5, 265, 055   2, 203, 703   7, 468, 758   -255, 731   7, 213, 027   91. 00   92. 00   OSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   SPECIAL PURPOSE COST CENTERS   18. 00   SUBTOTALS (SUM OF LINES 1 through 117)   67, 831, 451   161, 637, 736   229, 469, 187   12, 432   229, 481, 619   18. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   190. 00   191. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   121, 719   121, 719   0   121, 719   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00   193. 00			517, 020	162, 971	679, 991	-15, 309	664, 682	
91. 00   09100   EMERGENCY   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   5, 265, 055   2, 203, 703   7, 468, 758   -255, 731   7, 213, 027   91. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   92. 00   SPECIAL PURPOSE COST CENTERS   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   67, 831, 451   161, 637, 736   229, 469, 187   12, 432   229, 481, 619   118. 00   NONREI MBURSABLE COST CENTERS   0   0   0   0   0   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00   190. 00			1/0 073	120,000	200 700	(0.12)	220 (4(	
92. 00   9200   OBSERVATI ON BEDS (NON-DISTINCT PART)   92. 00								
SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)   67,831,451   161,637,736   229,469,187   12,432   229,481,619   118.00			5, 265, 055	2, 203, 703	7, 408, 758	-255, /31	7, 213, 027	
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 67, 831, 451 161, 637, 736 229, 469, 187 12, 432 229, 481, 619 118. 00 NONREI MBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 190. 00 191. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 121, 719 121, 719 0 121, 719 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 194. 00 194. 06 07956 HOME OFFI CE 0 0 0 0 0 0 0 194. 06 194. 08 07958 MI SC NONREI MBURSABLE COST CENTERS 384, 547 593, 206 977, 753 -12, 432 965, 321 194. 08	92.00							92.00
NONRE   MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   190. 00     191. 00   19100   RESEARCH   0   0   0   0   0   0   191. 00     192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   121, 719   121, 719   0   121, 719     193. 00   19300   NONPAI D WORKERS   0   0   0   0   0   0     194. 00   07950   HOME OFFI CE   0   0   0   0   0   0     194. 06   07956   LEASED OFFI CE SPACE   0   0   0   0   0     194. 08   07958   MI SC NONREI MBURSABLE COST CENTERS   384, 547   593, 206   977, 753   -12, 432   965, 321   194. 08	118 00		67 931 451	161 637 736	220 /60 183	7 12 /32	220 /191 610	118 00
190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   190. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00   191. 00	110.00		07, 031, 431	101, 037, 730	227, 407, 107	12, 432	227, 401, 017	1110.00
191. 00   19100   RESEARCH	190 00		0	0		0	0	190 00
192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES 0   121, 719   121, 719   0   121, 719   192. 00   193. 00   193.00   193.00   193.00   193.00   193.00   193.00   193.00   193.00   193.00   193.00   193.00   193.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00			o	0				
193. 00   19300   NONPAI D WORKERS       0       0       0       0       193. 00         194. 00   07950   HOME OFFI CE       0       0       0       0       0       194. 00         194. 06   07956   LEASED OFFI CE SPACE       0       0       0       0       0       0       194. 06         194. 08   07958   MI SC NONREI MBURSABLE COST CENTERS       384, 547       593, 206       977, 753       -12, 432       965, 321   194. 08	192.00	19200 PHYSICIANS' PRIVATE OFFICES	ol ol	121. 719		-		
194. 00 07950 HOME OFFICE 0 0 0 0 0 194. 00 194. 06 07956 LEASED OFFICE SPACE 0 0 0 0 0 194. 06 194. 08 07958 MISC NONREIMBURSABLE COST CENTERS 384, 547 593, 206 977, 753 -12, 432 965, 321 194. 08			ol	0	.2.,,,,	ol ő		
194. 06 07956 LEASED OFFI CE SPACE 0 0 0 0 0 194. 06 194. 08 07958 MI SC NONREI MBURSABLE COST CENTERS 384, 547 593, 206 977, 753 -12, 432 965, 321 194. 08			ol	0	l	ol o		
194. 08 07958 MISC NONREI MBURSABLE COST CENTERS 384, 547 593, 206 977, 753 -12, 432 965, 321 194. 08			ol	0		ol o		
			384, 547	593, 206	977, 753	-12, 432		
	200.00	TOTAL (SUM OF LINES 118 through 199)	68, 215, 998	162, 352, 661	230, 568, 659			200.00

| Period: | Worksheet A | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: 8/2/2021 3: 42 pm |

					8/2/2021 3: 42	pm ?
		Cost Center Description	Adjustments	Net Expenses		
				For Allocation		
	_		6. 00	7. 00		
		AL SERVICE COST CENTERS				
1.00		CAP REL COSTS-BLDG & FIXT	-2, 067, 573	1		1. 00
2.00		CAP REL COSTS-MVBLE EQUIP	3, 250, 867	1	l .	2. 00
3.00	1	OTHER CAP REL COSTS	0	1	l .	3. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	1, 872, 620			4. 00
5.00		ADMINISTRATIVE & GENERAL	-48, 579, 321	32, 138, 928		5. 00
7.00		OPERATION OF PLANT	-161, 917			7. 00
8.00		LAUNDRY & LINEN SERVICE	0	1,		8. 00
9.00		HOUSEKEEPI NG	14 211	2, 473, 695		9.00
10.00		DI ETARY CAFETERI A	-14, 211	959, 226		10.00
11.00	1	•	-1, 092, 139	1		11.00
13.00	1	NURSING ADMINISTRATION	2, 096, 822	1		13.00
16. 00 17. 00	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	1, 450, 671 0	1		16. 00 17. 00
21. 00		I &R SERVICES-SALARY & FRINGES APPRVD	794, 286	.,		21. 00
22. 00	1	I &R SERVICES-OTHER PRGM. COSTS APPRVD	1, 177, 937	1		22. 00
22.00		I ENT ROUTINE SERVICE COST CENTERS	1, 177, 737	1, 177, 737		22.00
30. 00		ADULTS & PEDIATRICS	-307, 760	31, 145, 303		30.00
31. 00		INTENSIVE CARE UNIT	-307, 700	ľ	·	31. 00
43. 00	1	NURSERY	0	1	·	43. 00
43.00		LARY SERVICE COST CENTERS	0	073,703		43.00
50. 00		OPERATING ROOM	-353, 786	6, 384, 826		50. 00
51. 00	1	RECOVERY ROOM	0	l		51.00
52. 00		DELIVERY ROOM & LABOR ROOM	0	3, 729, 869	·	52. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	-179, 395	1		54.00
55. 00		RADI OLOGY-THERAPEUTI C	0	1, 080, 883		55. 00
57.00		CT SCAN	0	1, 560, 460		57. 00
58.00	1	MAGNETIC RESONANCE IMAGING (MRI)	0	584, 977		58. 00
59.00	05900	CARDI AC CATHETERI ZATI ON	0	2, 881, 556		59. 00
60.00	06000	LABORATORY	0	7, 391, 441		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPI RATORY THERAPY	0	2, 630, 182		65. 00
66.00	06600	PHYSI CAL THERAPY	-18, 601	2, 587, 161		66. 00
67. 00		OCCUPATI ONAL THERAPY	0	892, 180		67. 00
68. 00		SPEECH PATHOLOGY	0	236, 219		68. 00
69. 00	1	ELECTROCARDI OLOGY	0	1, 367, 833		69. 00
70. 00	1	ELECTROENCEPHALOGRAPHY	0	585, 963		70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 020, 567			71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	9, 177, 048		72. 00
73. 00		DRUGS CHARGED TO PATIENTS	118, 769	1		73. 00
74.00		RENAL DIALYSIS	0	541, 333		74. 00
76.00		ENDOSCOPY	0	892, 914		76. 00
76. 06	1	I MAGING CENTER	-422		·	76. 06
76. 97		CARDI AC REHABI LI TATI ON	-1, 697	300, 126		76. 97
00 00		TIENT SERVICE COST CENTERS CLINIC	0			1 00 00
90. 00 90. 01		DI ABETI C CARE CENTER	0	0		90. 00 90. 01
	1	ANTI-COAGULATION CLINIC	-302, 116	ŀ	l .	90. 01
	1	PALLIATIVE CARE	-302, 110	1		90. 02
		SPINE CENTER	0	1	l .	90. 03
91.00		EMERGENCY	828, 418	l ·	·	91. 00
		OBSERVATION BEDS (NON-DISTINCT PART)	020, 410	0,041,443		92. 00
72.00		AL PURPOSE COST CENTERS			I.	72.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-39, 467, 981	190, 013, 638		118. 00
		I MBURSABLE COST CENTERS	077 1077 701	17070107000		1
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
		RESEARCH	0	0	l .	191.00
		PHYSICIANS' PRIVATE OFFICES	0	121, 719	l .	192. 00
		NONPALD WORKERS	0	. 0	1	193. 00
		HOME OFFICE	0	0		194. 00
	1	LEASED OFFICE SPACE	0	0		194. 06
194. 08	07958	MISC NONREIMBURSABLE COST CENTERS	0	965, 321		194. 08
200.00		TOTAL (SUM OF LINES 118 through 199)	-39, 467, 981	191, 100, 678		200. 00

Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 8/2/2021 3:42 pm

		Increases			0/2/2021 3. 4.	Ţ
	Cost Center 2.00	Li ne # 3.00	Sal ary 4. 00	0ther 5.00		
	A - Chargeable Medical Suppli		4.00	3.00		
	MEDICAL SUPPLIES CHARGED TO	71.00	0	11, 101, 035		1. 00
2. 00	PATI ENTS	0.00	0	0		2. 00
3.00		0.00	0	O		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6. 00 7. 00		0. 00 0. 00	0	0		6. 00 7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10. 00 11. 00		0. 00 0. 00	0	0		10. 00 11. 00
12. 00		0.00	0	0		12. 00
13.00		0.00	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 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
21. 00		0.00	0	0		21. 00
22. 00		0.00	0	0 11, 101, 035		22. 00
	B - Implantable Device Reclas	SS L	0	11, 101, 035		1
1.00	IMPL. DEV. CHARGED TO	72.00	0	9, 177, 048		1. 00
2. 00	PATI ENTS	0.00	0	0		2. 00
3. 00	L	0.00	0	0		3. 00
	TOTALS C - Drugs Charges to Pat		0	9, 177, 048		_
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	472, 496		1.00
2.00		0.00	0	0		2. 00
3. 00 4. 00		0. 00 0. 00	0	0		3. 00 4. 00
5. 00		0.00	0	0		5. 00
6.00		0.00	O	0		6. 00
7. 00 8. 00		0. 00 0. 00	0	0		7. 00 8. 00
9. 00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
13. 00		0.00	0	0		13.00
14.00		0.00	0	0		14. 00
15. 00 16. 00		0. 00 0. 00	0	0		15. 00 16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	<u>0</u> 472, 496		19. 00
	D - Depreciation Expense		<u> </u>			
	CAP REL COSTS-MVBLE EQUIP	2.00	0			1.00
2. 00 3. 00	CT SCAN	57. 00 0. 00	0	126, 697 0		2. 00 3. 00
4.00		0.00	0	0		4. 00
5.00		0. 00 0. 00	0	0		5. 00
6. 00 7. 00		0.00	0	0		6. 00 7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9.00
10. 00 11. 00		0. 00 0. 00	0	0		10. 00 11. 00
12.00		0.00	0	0		12. 00
13. 00		0.00	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16.00		0.00	0	Ö		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
21. 00		0.00	0	0		21. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0128

					8/2/2021 3:	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4.00	5. 00		
22.00		0.00	0	0		22. 00
23.00		0.00	0	0		23. 00
24.00		0.00	0	0		24. 00
25.00		0.00	0	0		25. 00
26.00		0.00	0	0		26. 00
27.00	L	0.00	0	0		27. 00
	TOTALS		0	9, 472, 917		
	E - Interest Expense					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0			1. 00
	TOTALS		0	4, 568, 230		
	F - Other Capital Rental					
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2, 824, 903		1. 00
2.00	RESPIRATORY THERAPY	65. 00	0	775		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11. 00
12. 00		0.00	0	0		12. 00
13. 00		0.00	0	O		13. 00
14. 00		0.00	0	Ö		14. 00
15. 00		0.00	0	Ö		15. 00
16. 00		0.00	0	Ö		16. 00
17. 00		0.00	0	0		17. 00
18. 00	+	0.00	0	0		18. 00
19. 00		0.00	0	0		19. 00
		· •	-	0		1
20.00		0.00	0	0		20.00
21. 00		0.00	0	0		21. 00
	TOTALS		0	2, 825, 678		
1 00	G - STD BENEFIT	F 00	0	2 025		1 00
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3, 835		1.00
2.00	OPERATION OF PLANT	7. 00	0	5, 564		2.00
3.00	HOUSEKEEPI NG	9.00	0	7, 000		3. 00
4.00	DI ETARY	10.00	0	11, 685		4. 00
5.00	NURSING ADMINISTRATION	13.00	0	416		5. 00
6.00	MEDICAL RECORDS & LIBRARY	16. 00	0	587		6. 00
7. 00	SOCIAL SERVICE	17. 00	0	3, 181		7. 00
8.00	ADULTS & PEDIATRICS	30. 00	0	172, 326		8. 00
9.00	INTENSIVE CARE UNIT	31.00	0	11, 454		9. 00
10.00	OPERATING ROOM	50.00	0	26, 690		10. 00
11. 00	RECOVERY ROOM	51.00	0	14, 970		11. 00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 549		12. 00
13.00	RADI OLOGY-THERAPEUTI C	55.00	0	253		13. 00
14.00	CT SCAN	57. 00	0	5, 429		14. 00
15.00	CARDIAC CATHETERIZATION	59. 00	0			15. 00
16.00	RESPIRATORY THERAPY	65.00	0	18, 677		16. 00
17.00	PHYSI CAL THERAPY	66.00	0	21, 764		17. 00
18.00	ELECTROCARDI OLOGY	69. 00	0	5, 470		18. 00
19.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	73		19. 00
	PATI ENTS		Ĭ			
20.00	DRUGS CHARGED TO PATIENTS	73. 00	0	16, 151		20. 00
21. 00	ENDOSCOPY	76. 00	0	5, 334		21. 00
22. 00	I MAGING CENTER	76. 06	n	3, 590		22. 00
23. 00	CARDIAC REHABILITATION	76. 97	n	1, 087		23. 00
24. 00	EMERGENCY	91. 00	0	25, 697		24. 00
25. 00	MISC NONREIMBURSABLE COST	194. 08	0	8, 484		25. 00
23. 30	CENTERS	1,74.00	J	5, 404		20.00
	TOTALS	<del> +</del>		375, 051		1
	H - Labor and Delivery			373,031		
1.00	NURSERY	43.00	475, 047	198, 738		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52. 00	2, 196, 722	919, 010		2.00
2.00	TOTALS		2, 19 <u>6, 7</u> 22 2, 671, 769	1, 117, 748		2.00
			2, 0/1, /09	1, 117, 740		
1 00	I - Cafeteria	11 00	015 701	1 000 070		1 00
1. 00	CAFETERI A		815, 781	1,000,970		1.00
	TOTALS		815, 781	1, 000, 970		_
1 00	J - Therapy	/7 60	/07.007	204 070		4 00
1.00	OCCUPATIONAL THERAPY	67.00	687, 307	204, 873		1.00
2.00	SPEECH PATHOLOGY	6800	18 <u>1, 9</u> 76			2. 00
	TOTALS		869, 283	259, 116		

Heal th	Financial Systems		COMMUNITY HOSPITAL SOUTH			In Lieu of Form CMS-2552-1		
RECLASS	SIFICATIONS			Provi der (	CCN: 15-0128	Peri od: From 01/01/2020	Worksheet A-6	
						To 12/31/2020	Date/Time Prepared: 8/2/2021 3:42 pm	
		Increases						
	0 1 0 1	1 . "	C 1	0.11				

					8/2/2021 3: 42 pm
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	
	K - Building Depreciation				
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	5, 077, 028	1.00
	TOTALS		0	5, 077, 028	
	L - Capital Insurance Costs				
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	133, 929	1.00
	TOTALS		0	133, 929	
	M - Radiology Support Staff				
1.00	RADI OLOGY-THERAPEUTI C	55. 00	55, 142	27, 222	1.00
2.00	CT SCAN	57. 00	142, 659	70, 425	2.00
3.00	MAGNETIC RESONANCE IMAGING	58. 00	29, 123	14, 377	3.00
	(MRI )				
	TOTALS		226, 924	112, 024	
500.00	Grand Total: Increases		4, 583, 757	45, 693, 270	500.00

RECLASSI FI CATIONS

Provider CCN: 15-0128

Peri od: Worksheet A-6 From 01/01/2020 12/31/2020 Date/Time Prepared:

8/2/2021 3:42 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - Chargeable Medical Supplies 1.00 ADMINISTRATIVE & GENERAL 5.00 31, 245 1.00 0 2.00 DI ETARY 10.00 0 2.00 221 ADULTS & PEDIATRICS 30.00 0 1, 033, 945 0 3.00 3.00 4.00 INTENSIVE CARE UNIT 31.00 0 254, 748 0 4.00 OPERATING ROOM 5, 021, 406 0 5.00 50.00 0 5.00 6.00 RECOVERY ROOM 51.00 ol 129, 447 0 6.00 0 RADI OLOGY-DI AGNOSTI C 0 7.00 54.00 324, 438 7.00 8.00 RADI OLOGY-THERAPEUTI C 55.00 0 619, 101 0 8.00 9.00 CT SCAN 57.00 0 27,034 0 9.00 10.00 MAGNETIC RESONANCE I MAGING 58 00 ol 0 10 00 13, 550 (MRI) 11.00 CARDIAC CATHETERIZATION 59.00 0 2, 533, 191 0 11.00 12.00 RESPIRATORY THERAPY 65.00 0 358, 671 0 12.00 PHYSICAL THERAPY 0 13.00 0 3.516 13.00 66,00 01 8, 996 ELECTROCARDI OLOGY 0 14.00 69.00 14.00 15.00 ELECTROENCEPHALOGRAPHY 70.00 0 6, 591 0 15.00 DRUGS CHARGED TO PATIENTS o 0 16.00 73.00 75,046 16.00 0| 0 17.00 RENAL DIALYSIS 74.00 1.595 17.00 0 18 00 ENDOSCOPY 76.00 0 367, 612 18 00 IMAGING CENTER 0 129, 655 0 19.00 19.00 76.06 0 20.00 CARDIAC REHABILITATION 76.97 0 1, 651 20.00 21.00 **IEMERGENCY** 91.00 0 159, 343 0 21.00 22.00 MISC NONREIMBURSABLE COST 194.08 0 33 0 22.00 CENTERS **TOTALS** 0 11, 101, 035 B - Implantable Device Reclass 6, 378, 880 1.00 OPERATING ROOM 50.00 0 0 1.00 2.00 RADI OLOGY-THERAPEUTI C 55.00 o 257, 743 0 2.00 CARDIAC CATHETERIZATION TOTALS 0 3.00 59.00 2, 540, 425 o 3.00 9, 177, 048 C - Drugs Charges to Pat 1.00 ADMINISTRATIVE & GENERAL 5.00 0 11, 108 0 1.00 2.00 ADULTS & PEDIATRICS 30.00 0 43, 890 0 2.00 0 31.00 10, 766 0 3 00 INTENSIVE CARE UNIT 3 00 4.00 OPERATING ROOM 50.00 0 801 0 4.00 RECOVERY ROOM o 9, 283 0 5.00 51.00 5.00 0 6.00 RADI OLOGY-DI AGNOSTI C 54.00 0 124.904 6.00 RADI OLOGY-THERAPEUTI C 55.00 0 0 7.00 3.404 7.00 8.00 CT SCAN 57.00 0 173, 309 0 8.00 CARDIAC CATHETERIZATION 9.00 59.00 o 51, 751 0 9.00 RESPIRATORY THERAPY 0 0 10.00 10.00 65.00 1.133 0 11.00 PHYSICAL THERAPY 66.00 1,041 11.00 12.00 ELECTROCARDI OLOGY 69.00 0 2,009 0 12.00 13.00 ELECTROENCEPHALOGRAPHY 70.00 0 364 0 13.00 0 14.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 14.00 808 PATI ENTS 15.00 RENAL DIALYSIS 74.00 0 468 0 15.00 16.00 **ENDOSCOPY** 76.00 0 549 0 16.00 17 00 IMAGING CENTER 0 20, 696 0 17 00 76 06 18.00 EMERGENCY 91.00 0 14, 682 0 18.00 19.00 MISC NONREIMBURSABLE COST 194.08 o 0 19.00 1,530 CENTERS ō 472, 496 TOTALS D - Depreciation Expense 1.00 ADMINISTRATIVE & GENERAL 5.00 0 3, 974, 959 9 1.00 OPERATION OF PLANT 0 0 2.00 7.00 133,668 2 00 0 0 3.00 HOUSEKEEPI NG 9.00 4.724 3.00 0 4.00 DI FTARY 10.00 70, 020 4 00 5.00 SOCIAL SERVICE 17.00 0 1,805 0 5.00 0 0 6.00 ADULTS & PEDIATRICS 30.00 422, 942 6.00 0 31.00 0 164, 425 7.00 INTENSIVE CARE UNIT 7.00 0 8.00 OPERATING ROOM 50.00 0 2, 394, 609 8.00 RECOVERY ROOM 0 0 9.00 51.00 38, 888 9.00 0 10.00 RADI OLOGY-DI AGNOSTI C 54.00 0 290, 969 10.00 RADI OLOGY-THERAPEUTI C 55.00 0 0 11 00 251, 545 11 00 0 12.00 MAGNETIC RESONANCE IMAGING 58.00 0 49, 343 12.00 (MRI) 13.00 CARDIAC CATHETERIZATION 59.00 0 768, 409 0 13.00 0 I ABORATORY 0 2, 173 14 00 14 00 60.00 15.00 RESPIRATORY THERAPY 65.00 0 27, 714 0 15.00 131, 570 16.00 PHYSICAL THERAPY 66.00 o 0 16.00 0 17.00 ELECTROCARDI OLOGY 69.00 83, 888 0 17.00 ELECTROENCEPHALOGRAPHY

13.673

18.00

70.00

18.00

Health Financial Systems			COMMUNITY HOS	PITAL SOUTH		In Lieu of Form CMS-2552-1		
RECLAS	SIFICATIONS			Provi der (		Period: From 01/01/2020	Worksheet A-6	
						To 12/31/2020	Date/Time Prepar	
		Decreases					8/2/2021 3: 42 pm	n
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.			
10.00	6.00	7.00	8. 00	9. 00	10.00			
19. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	30, 764	0		19	9. 00
20.00	DRUGS CHARGED TO PATIENTS	73.00	О	61, 717	0		20	0. 00
21. 00	ENDOSCOPY	76. 00	0	283, 080			1	1. 00
22. 00 23. 00	IMAGING CENTER CARDIAC REHABILITATION	76. 06 76. 97	0	139, 340 17, 377				2. 00 3. 00
24. 00	ANTI - COAGULATION CLINIC	90. 02	0	15, 309			1	4. 00
25. 00	SPINE CENTER	90.04	0	14, 082			1	5. 00
26. 00	EMERGENCY	91.00	0	81, 626				6. 00
27. 00	MISC NONREIMBURSABLE COST CENTERS	194. 08	U	4, 298	0		2.	7. 00
	TOTALS		0	9, 472, 917				
1 00	E - Interest Expense	F 00	ما	4 5/0 220	11	T		1 00
1. 00	ADMI NI STRATI VE & GENERAL TOTALS			<u>4, 568, 230</u> 4, 568, 230		1		1. 00
	F - Other Capital Rental		<u> </u>	4, 300, 230				
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	200, 585			1	1. 00
2. 00 3. 00	OPERATION OF PLANT HOUSEKEEPING	7. 00 9. 00	0	4, 825 9, 181			1	2. 00 3. 00
4. 00	DI ETARY	10.00	0	160			1	4. 00
5.00	SOCIAL SERVICE	17.00	0	36	0		1	5. 00
6.00	ADULTS & PEDIATRICS	30.00	0	49, 231			1	6.00
7. 00 8. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0	241, 263 4, 498				7. 00 8. 00
9. 00	RADI OLOGY-THERAPEUTI C	55.00	0	71	0		1	9. 00
10.00	CARDIAC CATHETERIZATION	59. 00	0	1, 692				0. 00
11.00	LABORATORY	60.00	0	80			1	1.00
12. 00 13. 00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66. 00 69. 00	0	360, 603 319		l .	1	2. 00 3. 00
14. 00	ELECTROENCEPHALOGRAPHY	70.00	Ö	101, 573			1	4. 00
15. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 204, 273	0		15	5. 00
16. 00	PATIENTS DRUGS CHARGED TO PATIENTS	73. 00	0	340, 170	0		10	6. 00
17. 00	ENDOSCOPY	76.00	Ö	489			1	7. 00
18. 00	I MAGING CENTER	76.06	0	244, 924			1	8. 00
19. 00 20. 00	SPINE CENTER EMERGENCY	90. 04 91. 00	0	55, 054 80				9. 00 0. 00
21. 00	MISC NONREIMBURSABLE COST	194. 08	0	6, 571	0			1. 00
	CENTERS		1					
	TOTALS G - STD BENEFIT		0	2, 825, 678				
1. 00	ADMINISTRATIVE & GENERAL	5.00	3, 835	0	0			1. 00
2.00	OPERATION OF PLANT	7.00	5, 564	0			1	2. 00
3.00	HOUSEKEEPI NG	9.00	7, 000	0	0		1	3.00
4. 00 5. 00	DI ETARY NURSING ADMINI STRATION	10. 00 13. 00	11, 685 416	0	0			4. 00 5. 00
6. 00	MEDICAL RECORDS & LIBRARY	16. 00	587	0	0		1	6. 00
7. 00	SOCIAL SERVICE	17. 00	3, 181	0			1	7. 00
8. 00 9. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	172, 326 11, 454	0				8. 00 9. 00
10. 00	OPERATING ROOM	50.00	26, 690	0	0			0.00
11. 00	RECOVERY ROOM	51.00	14, 970	0	0		1	1. 00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	2, 549	0				2. 00
13. 00 14. 00	RADI OLOGY-THERAPEUTI C CT SCAN	55. 00 57. 00	253 5, 429	0				3. 00 4. 00
15. 00	CARDI AC CATHETERI ZATI ON	59.00	2, 785	0				5. 00
16.00	RESPIRATORY THERAPY	65.00	18, 677	0	0		16	6. 00
17. 00	PHYSI CAL THERAPY	66.00	21, 764	0	0		1	7. 00
18. 00 19. 00	ELECTROCARDI OLOGY MEDI CAL SUPPLI ES CHARGED TO	69. 00 71. 00	5, 470 73	0		l .		8. 00 9. 00
	PATI ENTS	,		, and the second				,, 00
20.00	DRUGS CHARGED TO PATIENTS	73.00	16, 151	0	0			0.00
21. 00 22. 00	ENDOSCOPY IMAGING CENTER	76. 00 76. 06	5, 334 3, 590	0	0			1. 00 2. 00
23. 00	CARDIAC REHABILITATION	76. 97	1, 087	0	0			3. 00
24.00	EMERGENCY	91.00	25, 697	0			24	4. 00
25. 00	MISC NONREIMBURSABLE COST	194. 08	8, 484	0	0		25	5. 00
	CENTERS	$oxed{oxed}$	375, 051	— — <sub>ō</sub>		†		
	H - Labor and Delivery							
1.00	ADULTS & PEDIATRICS	30.00	2, 671, 769	1, 117, 748		t contract to the contract to		1.00
2. 00		0.00	00000000	<u></u> 1, 117, 748	0	1	-	2. 00
	1	, ,		, .,	1	1	I	

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

 RECLASSIFICATIONS
 Provider CCN: 15-0128
 Period: From 01/01/2020
 Worksheet A-6

						To 12/31/2020	epared: 2 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	I - Cafeteria						
1.00	DI ETARY	10.00	<u>815, 7</u> 81	1,000,970	) (	<u>o</u>	1. 00
	TOTALS		815, 781	1, 000, 970	)		
	J - Therapy						
1.00	PHYSI CAL THERAPY	66.00	869, 283	259, 116	6		1.00
2.00		0.00	0_	0	) (	<u>o</u>	2. 00
	TOTALS		869, 283	259, 116	b .		
	K - Building Depreciation						
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	<u>5, 077, 0</u> 28		9	1. 00
	TOTALS		0	5, 077, 028	3		
	L - Capital Insurance Costs						4
1.00	ADMI NI STRATI VE & GENERAL	500	0_	13 <u>3, 9</u> 29		2	1. 00
	TOTALS		0	133, 929	)		
	M - Radiology Support Staff						4
1.00	RADI OLOGY-DI AGNOSTI C	54.00	226, 924	112, 024	1	0	1. 00
2.00		0.00	0	0	)	0	2. 00
3.00		0.00	0_	0		<u> </u>	3. 00
	TOTALS		226, 924	112, 024			1
500.00	Grand Total: Decreases		4, 958, 808	45, 318, 219	)		500.00

Movable Equipment
HIT designated Assets
Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

6. 00 7. 00

8.00

9.00

Provider CCN: 15-0128

6.00 7.00

8.00

9.00

10.00

					10 12/31/2020	8/2/2021 3: 42	
				Acqui si ti ons			
		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	1, 254, 312	567, 320		0 567, 320	0	1. 00
2.00	Land Improvements	2, 722, 362	0		0	0	2. 00
3.00	Buildings and Fixtures	183, 134, 843	5, 351, 380		0 5, 351, 380	2, 869, 684	1
4.00	Building Improvements	1, 737, 035	0		0	0	4. 00
5.00	Fi xed Equi pment	0	0		0	0	5. 00
6.00	Movable Equipment	82, 595, 663	1, 025, 395		0 1, 025, 395	-434, 211	6. 00
7.00	HIT designated Assets	0	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	271, 444, 215	6, 944, 095		0 6, 944, 095	2, 435, 473	1
9.00	Reconciling Items	0	0		0	0	9. 00
10.00	Total (line 8 minus line 9)	271, 444, 215	6, 944, 095		0 6, 944, 095	2, 435, 473	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	DART I ANALYGIC OF QUANCES IN CARLTAL ACCE	6.00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		0				4 00
1.00	Land	1, 821, 632	0				1.00
2.00	Land Improvements	2, 722, 362	0				2.00
3.00	Buildings and Fixtures	185, 616, 539	0				3.00
4.00	Building Improvements	1, 737, 035	0				4. 00
5. 00	Fi xed Equi pment	0	0				5. 00

275, 952, 837

Heal th	Financial Systems	COMMUNITY HOS	HTIOS IATIG		In lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		GOMMONT IT FIGS	Provider CO	CN: 15-0128	Peri od: From 01/01/2020 To 12/31/2020	Worksheet A-7 Part II	pared:
			SL	JMMARY OF CAP	PI TAL	0/2/2021 3.42	pili
	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	SHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	<b>'</b>	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0		·		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0			ļ	2. 00
	T - 1 ( C - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -			I .			

0 0 0

1. 00 2. 00 3. 00

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

Heal th	Financial Systems	COMMUNITY HOS	SPITAL SOUTH		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2020 To 12/31/2020		pared:
					1	8/2/2021 3: 42	pm
		COMI	PUTATION OF RAT	1108	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
	·		Leases	for Ratio	instructions)		
				(col. 1 - col			
				2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FIXT	191, 897, 568		191, 897, 56		0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	84, 055, 268		84, 055, 26			2. 00
3.00	Total (sum of lines 1-2)	275, 952, 836		275, 952, 83			3. 00
		ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Relate	cols. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 5, 077, 028	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 7, 520, 059	2, 824, 903	2. 00
3.00	Total (sum of lines 1-2)	0	0		0 12, 597, 087	2, 824, 903	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
			,	ĺ	d Costs (see	through 14)	
					instructions)	,	
		11. 00	12.00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	CAP REL COSTS-BLDG & FIXT	2, 500, 657	133, 929		0	7, 711, 614	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0	10, 344, 962	2. 00
3.00	Total (sum of lines 1-2)	2, 500, 657	133, 929		0	18, 056, 576	3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provider CCN: 15-0128 

				Expense Classification on	10/ 1 1 1 0	8/2/2021 3: 42	Pill
				Expense of assirt cattron on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00	5. 00 0	1.00
1.00	COSTS-BLDG & FLXT (chapter 2)		0	CAP REL CUSTS-BLDG & FIXT	1.00	١	1.00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	О	2. 00
	COSTS-MVBLE EQUIP (chapter 2)		_			_	
3. 00	Investment income - other		0		0. 00	0	3. 00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	o	4. 00
	discounts (chapter 8)						
5.00	Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
	suppliers (chapter 8)		0		0.00	١	0.00
	Tel ephone services (pay		0		0.00	О	7. 00
	stations excluded) (chapter						
8. 00	21) Television and radio service		0		0.00	0	8. 00
0.00	(chapter 21)		0		0.00	١	0.00
9. 00	Parking Lot (chapter 21)		0		0.00	О	9. 00
	Provider-based physician	A-8-2	-582, 148			O	10.00
11 00	adjustment		0		0.00		11 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization	A-8-1	4, 015, 024			o	12.00
	transactions (chapter 10)						
	Laundry and linen service	_	0		0.00		
	Cafeteria-employees and guests Rental of quarters to employee		-998, 116	CAFETERI A	11. 00 0. 00		14. 00 15. 00
13.00	and others		0		0.00	١	15.00
16. 00	Sale of medical and surgical		0		0.00	О	16.00
	supplies to other than						
17 00	patients		0		0.00	0	17 00
17. 00	Sale of drugs to other than patients		Ü		0. 00	٥	17. 00
18. 00	Sale of medical records and		0		0.00	О	18. 00
	abstracts						
19. 00	Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00	Vendi ng machi nes		0		0.00	О	20.00
21. 00	Income from imposition of		0		0.00	O	21.00
	interest, finance or penalty						
	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
22.00	overpayments and borrowings to		0		0.00	١	22.00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24, 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
	therapy costs in excess of		9		33.00		55
	limitation (chapter 14)				_		
	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
	COSTS-BLDG & FLXT						
	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
1	Physicians' assistant		0	2222 23 231 0100	0.00		29.00
	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of						
	limitation (chapter 14) Hospice (non-distinct) (see		^	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)		U	ADDETO & TEDIMINIOS	30.00		30.77
	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
32 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
J2. UU	Depreciation and Interest		U		0.00		52.00
33. 00	Loss on Assets	A	-69, 786	OPERATING ROOM	50.00	o	33. 00

From 01/01/2020 | Nate/Time Prepared:

				T	o 12/31/2020	Date/Time Prep 8/2/2021 3:42	
				Expense Classification on	Worksheet A	0, 2, 202 : 0: 12	<b>D</b>
				To/From Which the Amount is			
				To, i i om min on the famount i o	to bo haj aotoa		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1.00	2. 00	3.00	4. 00	5. 00	
33. 01	Mi sc Revenue	В	-20, 561	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	Mi sc Revenue	В		OPERATION OF PLANT	7. 00	0	33. 02
33. 03	Mi sc Revenue	В		DI ETARY	10. 00	0	33. 03
33. 04	Mi sc Revenue	В		OPERATING ROOM	50.00	0	33. 04
33. 05	Mi sc Revenue	B		RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 05
33. 06	Mi sc Revenue	B	•	PHYSICAL THERAPY	66. 00	0	33. 06
33. 07	Mi sc Revenue	B		MEDICAL SUPPLIES CHARGED TO	71. 00	0	33. 07
				PATI ENTS		_	
33. 08	Mi sc Revenue	В		DRUGS CHARGED TO PATIENTS	73. 00	0	33. 08
33. 09	Mi sc Revenue	B		I MAGI NG CENTER	76. 06	0	33. 09
33. 10	Mi sc Revenue	B		CARDIAC REHABILITATION	76. 97	0	33. 10
33. 11	Purchased Discounts	В	•	ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33. 12	Space Rental Income	B		OPERATION OF PLANT	7. 00	0	33. 12
33. 13	Investment Income	B		ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
34. 00	HAF Tax Offset	A	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	34. 00
34. 01	LOC Non-Allow Interest Expense			CAP REL COSTS-BLDG & FIXT	1. 00	11	
34. 02	Non-Allowable Interest Expense			CAP REL COSTS-BLDG & FIXT	1. 00	11	
0 11 02	00		277720	5711 N.E.2 99919 BEB9 & 71711			011.02
34. 03	2012B Non- Allow Interest	l A	-42 636	CAP REL COSTS-BLDG & FIXT	1. 00	11	34. 03
	Expense		,				
34. 04	50M BMO Non- Allow Interest	A	-8, 261	CAP REL COSTS-BLDG & FIXT	1. 00	11	34. 04
	Expense						
34.05	12B Non-Allow Interest Expense	A	-157, 209	CAP REL COSTS-BLDG & FIXT	1. 00	11	34. 05
34. 06	50 BMO Loan Non- Allow	A	•	ADMINISTRATIVE & GENERAL	5. 00	0	34. 06
	Interest Expense		,				
34. 07	Non-Allowable Interest Expense	A	-1, 437, 127	CAP REL COSTS-BLDG & FIXT	1. 00	11	34. 07
	00						
34.08	00 Non-Allow Interest Expense	A I	-354, 251	CAP REL COSTS-BLDG & FIXT	1.00	11	34. 08
35.00	Bad Debt	A	-14, 828, 510	ADMINISTRATIVE & GENERAL	5. 00	0	35. 00
35. 01	Sponsorshi p	A		ADMINISTRATIVE & GENERAL	5. 00	0	35. 01
36.00	Meals on Wheels Cost	A	-94, 023	CAFETERI A	11. 00	0	36.00
36. 01	APP	A	-302, 116	ANTI-COAGULATION CLINIC	90. 02	0	36. 01
50.00	TOTAL (sum of lines 1 thru 49)		-39, 467, 981				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(4) D				OMC D 1 45 4			

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

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

  B. Amount Received if cost cannot be determined.
  (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
  Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME

Provider CCN: 15-0128

Worksheet A-8-1

From 01/01/2020 OFFICE COSTS 12/31/2020 Date/Time Prepared: 8/2/2021 3:42

				8/2/2021 3:42	. PIII
Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			Allowable Cost	Included in	
	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
	l .	l .			1. 00
	l .	l .	53, 735	39, 420	2. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	3, 250, 867	0	3. 00
4. 00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1, 872, 620	0	3. 01
5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	28, 801, 779	39, 280, 548	3. 02
7. 00	OPERATION OF PLANT	HOME OFFICE	550, 572	0	3. 03
13. 00	NURSING ADMINISTRATION	HOME OFFICE	2, 096, 822	0	3.04
71. 00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	2, 028, 791	0	3. 05
16. 00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	1, 450, 671	0	3.06
30.00	ADULTS & PEDIATRICS	HOME OFFICE	88, 587	0	3.07
54. 00	RADI OLOGY-DI AGNOSTI C	HOME OFFICE	94, 989	0	3. 08
73. 00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	165, 569	O	3.09
21. 00	I&R SERVICES-SALARY & FRINGE	INTERNS & RESIDENTS	794, 286	o	3. 10
22. 00	I&R SERVICES-OTHER PRGM. COS	INTERNS & RESIDENTS	1, 177, 937	o	3. 11
5. 00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	54, 997	o	4.00
91.00	EMERGENCY	CPN CALL	828, 418	o	4. 01
TOTALS (sum of lines 1-4).			43, 402, 049	39, 387, 025	5.00
Transfer column 6, line 5 to					
Worksheet A-8, column 2,					
line 12.					
	1.00 A. COSTS INCURRED AND ADJUSTMHOME OFFICE COSTS:  5.00 30.00 2.00 4.00 5.00 7.00 13.00 71.00 16.00 30.00 54.00 73.00 21.00 22.00 5.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	1.00 2.00  A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF HOME OFFICE COSTS:  5.00 ADMINISTRATIVE & GENERAL 30.00 ADULTS & PEDIATRICS 2.00 CAP REL COSTS-MVBLE EQUIP 4.00 EMPLOYEE BENEFITS DEPARTMENT 5.00 ADMINISTRATIVE & GENERAL 7.00 OPERATION OF PLANT 13.00 NURSING ADMINISTRATION 71.00 MEDICAL SUPPLIES CHARGED TO 16.00 MEDICAL SUPPLIES CHARGED TO 16.00 MEDICAL RECORDS & LIBRARY 30.00 ADULTS & PEDIATRICS 54.00 RADIOLOGY-DIAGNOSTIC 73.00 DRUGS CHARGED TO PATIENTS 21.00 I &R SERVICES-SALARY & FRINGE 22.00 I &R SERVICES-OTHER PRGM. COS 5.00 ADMINISTRATIVE & GENERAL  TOTALS (sum of lines 1-4).  Transfer column 6, line 5 to Worksheet A-8, column 2,	1.00 2.00 3.00  A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED OR HOME OFFICE COSTS:  5.00 ADMINISTRATIVE & GENERAL 30.00 ADULTS & PEDIATRICS 2.00 CAP REL COSTS-MVBLE EQUIP 4.00 EMPLOYEE BENEFITS DEPARTMENT 5.00 ADMINISTRATIVE & GENERAL 7.00 OPERATION OF PLANT 4.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 EMPLOYEE BENEFITS DEPARTMENT 5.00 ADMINISTRATIVE & GENERAL 7.00 OPERATION OF PLANT 4.00 EMPLOYEE BENEFITS DEPARTMENT 5.00 ADMINISTRATIVE & GENERAL 7.00 ONURSING ADMINISTRATION 4.00 EMPLOYEE SCHARGED TO 6.00 MEDICAL SUPPLIES CHARGED TO 6.00 MEDICAL RECORDS & LIBRARY 4.00 EMPLOYEE SCHARGED TO 6.00 EMPLOYEE	1.00	Allowable Cost   Included in   Wks. A, column   State   Stat

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

			Related Organization(s) and/or Home Office			
Symbol (1)	Name	Percentage of	Name	Percentage of		
		Ownershi p		Ownershi p		
 1. 00	2. 00	3. 00	4. 00	5. 00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00	С	CHNW	100.00	0. 00	6. 00
7.00			0.00	0. 00	7.00
8.00			0.00	0. 00	8.00
9.00			0.00	0. 00	9.00
10.00			0.00	0. 00	10.00
100.00	G. Other (financial or	OTHER			100.00
	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 organi zati on.
- 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
- provi der.

					10 12/31/2020	8/2/2021 3: 42 pm	
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			MENTS REQUIRED AS A RESULT OF TR	ANSACTIONS WITH RELATED O	RGANIZATIONS OR (	CLAI MED	
	HOME OFFICE COS						
1.00	24, 352	0					1.00
2.00	14, 315	0					2. 00
3.00	3, 250, 867	9	9				3. 00
3. 01	1, 872, 620	0					3. 01
3. 02	-10, 478, 769	0					3. 02
3. 03	550, 572	0					3. 03
3.04	2, 096, 822	0					3. 04
3.05	2, 028, 791	0	0			3	3. 05
3.06	1, 450, 671	0				3	3. 06
3.07	88, 587	0				3	3. 07
3.08	94, 989	0				3	3. 08
3.09	165, 569	0				3	3. 09
3. 10	794, 286	0				3	3. 10
3. 11	1, 177, 937	0	o			3	3. 11
4.00	54, 997	0	o			4	1. 00
4.01	828, 418	0	o			4	1. 01
5.00	4, 015, 024					5	5. 00
				6 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			

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

 	cordinate i dilayor 2, the dimedite difference of our a be friended in our aim for this parti-	
Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELA	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00		6.00
7. 00		7. 00
8.00		8.00
9. 00		9.00
10.00	00	10.00
6. 00 7. 00 8. 00 9. 00 10. 00 100. 00	00	100.00

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

| Period: | Worksheet A-8-2 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0128

					-	Γο 12/31/2020	Date/Time Pre 8/2/2021 3:42	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	, p
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00		ADMINISTRATIVE & GENERAL	285, 371	94, 755		211, 500	1, 120	
2.00		ADULTS & PEDIATRICS	410, 662			0	0	
3. 00	0.00		0	1	_	0	0	
4.00	0.00		0	0	0	0	0	
5. 00	0. 00		0	0	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	
7. 00	0.00		0	0	0	0	0	
8.00	0.00		0	0	0	0	0	0.00
9.00	0.00		0	0	0	0	0	9. 00
10. 00	0.00		0	0	0	0	0	10. 00
200.00		2 1 2 1 (2)	696, 033				1, 120	
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE Limit	Continuing	Component Share of col.	of Malpractice Insurance	
				LIIIII	Education	12	i risurance	
	1.00	2. 00	8.00	9. 00	12. 00	13. 00	14. 00	
1.00		ADMI NI STRATI VE & GENERAL	113, 885					1. 00
2. 00		ADULTS & PEDIATRICS	113,000			1	-	2.00
3.00	0.00	ABOLIO & LEDIMINIOS	0	1		0	o o	1
4. 00	0.00		0	0	0	0	0	4. 00
5. 00	0.00		l o	l o	0	l o	0	
6. 00	0.00		0	0	0	0	0	1
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10. 00
200.00			113, 885	5, 694		0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldentifier	Component	Limit	Di sal I owance			
			Share of col.					
	1.00		14	1/ 00	17.00	10.00		
1 00	1.00	2.00	15. 00	16. 00	17. 00	18.00		1 00
1.00		ADMINISTRATIVE & GENERAL	0		·	171, 486		1.00
2.00	1	ADULTS & PEDIATRICS	0	0	_			2.00
3.00	0. 00 0. 00		0	0	-	0		3. 00
4. 00 5. 00	0.00							4. 00 5. 00
6. 00	0.00							6.00
7. 00	0.00							7. 00
8. 00	0.00							8. 00
9. 00	0.00							9.00
10. 00	0.00			0		0		10.00
200.00	3.00		0	113, 885	76, 731	582, 148		200.00
200.00			, ,	1 110,000	, 5, 751	1 552, 140	1	, _00.00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2020 Part I
To 1/21/2020 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0128

				To	12/31/2020	Date/Time Pre	pared:
			CAPI TAL REI	LATED COSTS		8/2/2021 3: 42	pm
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	cost center bescription	for Cost	BLDG & TIXI	WVBLL LQUIF	BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
	T	0	1. 00	2. 00	4. 00	4A	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	7, 711, 614	7, 711, 614	I			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	10, 344, 962	7,711,014	10, 344, 962			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 872, 706	0		1, 872, 706		4. 00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	32, 138, 928 5, 274, 621	434, 437 1, 449, 452		199, 199 42, 087	36, 668, 038 6, 826, 454	5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	658, 570	21, 028		42,007	679, 598	8. 00
9. 00	00900 HOUSEKEEPI NG	2, 473, 695	45, 154		39, 817	2, 572, 123	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	959, 226 724, 612	87, 557 163, 378		11, 746 22, 519	1, 079, 910 954, 526	10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	2, 427, 573	0 0	44, 017	7, 372	2, 434, 945	13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 812, 094	0	1	7, 879	1, 819, 973	16. 00
17. 00 21. 00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD	1, 774, 334 794, 286	21, 124 0	1	38, 667 0	1, 835, 907 794, 286	17. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	1, 177, 937	12, 409	_	o	1, 190, 346	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	31, 145, 303 4, 046, 966	1, 942, 993 583, 194		549, 983 85, 095	33, 891, 762 4, 874, 378	30. 00 31. 00
43. 00	04300 NURSERY	673, 785	50, 079		13, 113	745, 507	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	6, 384, 826 3, 720, 667	699, 417 163, 609		88, 216 74, 230	8, 808, 588 3, 999, 966	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 729, 869	231, 542		74, 230 76, 856	4, 077, 709	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 377, 073	235, 775	249, 120	43, 712	2, 905, 680	54. 00
55. 00 57. 00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	1, 080, 883	0	,	18, 966	1, 341, 662	55. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 560, 460 584, 977	28, 955 32, 399		24, 179 10, 928	1, 613, 594 645, 219	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 881, 556	213, 361		37, 859	3, 676, 235	59. 00
60.00	06000 LABORATORY	7, 391, 441	99, 043		0	7, 490, 561	60.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	2, 630, 182	0 49, 483	-	0 53, 244	0 2, 757, 061	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 587, 161	15, 911		54, 952	3, 223, 243	66. 00
67.00	06700 OCCUPATIONAL THERAPY	892, 180	5, 425		18, 972	946, 945	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	236, 219 1, 367, 833	1, 443 120, 052		5, 023 25, 820	250, 725 1, 568, 094	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	585, 963	48, 136		10, 068	755, 697	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 711, 960	224, 077		11, 551	15, 142, 774	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	9, 177, 048 11, 531, 470	0 121, 841	1	0 81, 586	9, 177, 048 12, 106, 636	
74. 00	07400 RENAL DIALYSIS	541, 333	23, 318	0	0	564, 651	74. 00
76. 00	03950 ENDOSCOPY	892, 914	0		14, 940	1, 141, 273	
76. 06 76. 97	03330 I MAGI NG CENTER 07697 CARDI AC REHABI LI TATI ON	1, 201, 628 300, 126	0		24, 173 6, 231	1, 597, 673 318, 154	
	OUTPATIENT SERVICE COST CENTERS				5, =5 .1		
90.00	09000 CLINIC	0	0		0	0	90.00
90. 01 90. 02	04950 DI ABETI C CARE CENTER 04951 ANTI -COAGULATI ON CLI NI C	362, 566	0		0 14, 272	0 378, 877	90. 01 90. 02
90. 03	04952 PALLI ATI VE CARE	0	0	0	0	0	90. 03
90.04	04953 SPI NE CENTER	230, 646	0	66, 824	4, 443	301, 913	90. 04
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 041, 445	575, 729	61, 914	144, 627	8, 823, 715 0	91. 00 92. 00
72.00	SPECIAL PURPOSE COST CENTERS					<u> </u>	72.00
118.00		190, 013, 638	7, 700, 321	10, 334, 444	1, 862, 325	189, 981, 446	118. 00
190.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	ol	0	190. 00
	19100 RESEARCH	0	0		ō	0	191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	121, 719	0	0	o	121, 719	
	19300  NONPALD WORKERS   07950  HOME OFFICE		0	0	0 0		193. 00 194. 00
194.06	07956 LEASED OFFICE SPACE	0	Ö	o o	ő	0	194. 06
	07958 MISC NONREIMBURSABLE COST CENTERS	965, 321	11, 293	10, 518	10, 381	997, 513	
200. 00 201. 00			0	0	o		200. 00 201. 00
202. 00		191, 100, 678	7, 711, 614			191, 100, 678	

Provider CCN: 15-0128

| Period: | Worksheet B | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared: | 8/2/2021 3: 42 pm

						8/2/2021 3: 42	pm
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
	GENERAL SERVICE COST CENTERS	5.00	7. 00	8.00	9. 00	10. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-BLDG & FIXT						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	36, 668, 038					5. 00
7. 00	00700 OPERATION OF PLANT	1, 620, 853	8, 447, 307	,			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	161, 362	30, 481	1			8. 00
9. 00	00900 HOUSEKEEPING	610, 717	65, 451		3, 248, 291		9. 00
10. 00	01000 DI ETARY	256, 411	126, 914		49, 364	1, 512, 599	10.00
11. 00	01100 CAFETERI A	226, 640	236, 817		92, 111	1, 512, 549	11. 00
13. 00	01300 NURSING ADMINISTRATION	578, 146	230, 617		72, 111 O	0	13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	432, 129	0		0	0	16. 00
17. 00	01700 SOCIAL SERVICE	435, 912	30, 620		11, 910	0	17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	188, 593	30, 020		11, 710	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	282, 632	17, 987	-	6, 996	0	22. 00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	202, 032	17, 707	10	0, 990	0	22.00
30. 00	03000 ADULTS & PEDIATRICS	8, 047, 174	2, 816, 373	408, 818	1, 095, 435	1, 377, 504	30. 00
31. 00	03100 INTENSIVE CARE UNIT	1, 157, 358	845, 341	1			31. 00
43. 00	04300 NURSERY	177, 011	72, 590	1		133, 073	43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	177,011	12, 390	0,415	20, 234	0	43.00
50. 00	05000 OPERATI NG ROOM	2, 091, 485	1, 013, 807	7 0	394, 323	0	50. 00
51.00	05100 RECOVERY ROOM	949, 740	237, 152			0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	968, 199	335, 621			0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	689, 916	341, 756		132, 927	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	1	341, 730		132, 727	0	55. 00
57. 00		318, 560	_	-	14 224	0	57. 00
	05700 CT SCAN	383, 127	41, 970		16, 324	-	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	153, 199	46, 962		18, 266	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	872, 874	309, 268			0	59.00
60.00		1, 778, 536	143, 563		55, 839	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	74.70	_	07.000	0	64.00
65. 00	06500 RESPI RATORY THERAPY	654, 628	71, 726	1	27, 898	0	65.00
66.00	06600 PHYSI CAL THERAPY	765, 317	23, 063		8, 970	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	224, 840	7, 864		3, 059	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	59, 531	2, 092	1	814	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	372, 324	174, 015	1	67, 684	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	179, 430	69, 774	1	27, 139	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 595, 455	324, 801	0	126, 332	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 178, 971	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 874, 563	176, 609	0	68, 693	0	73.00
74.00	07400 RENAL DI ALYSI S	134, 069	33, 799	0	13, 146	0	74. 00
76.00	03950 ENDOSCOPY	270, 980	0	0	0	0	76. 00
76. 06	03330 I MAGI NG CENTER	379, 347	0	0	0	0	76. 06
76. 97	07697 CARDI AC REHABI LI TATI ON	75, 542	0	0	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	0	0	0	0	90. 00
90. 01	04950 DI ABETI C CARE CENTER	0	0	0	0	0	90. 01
90. 02	04951 ANTI-COAGULATION CLINIC	89, 959	0	0	0	0	90. 02
90. 03	04952 PALLI ATI VE CARE	0	0	0	0	0	90. 03
90.04	04953 SPI NE CENTER	71, 685	0	0	0	0	90. 04
91.00	09100 EMERGENCY	2, 095, 076	834, 521	172, 938	324, 589	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	36, 402, 291	8, 430, 937	871, 441	3, 241, 924	1, 512, 599	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191.00	19100 RESEARCH	0	0	0	0	0	191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	28, 901	0	0	0	0	192. 00
193.00	19300 NONPALD WORKERS	o	0	0	0	0	193. 00
	07950 HOME OFFICE	ol	0	0	o	0	194. 00
	07956 LEASED OFFICE SPACE	ol	0	0	o	0	194. 06
	07958 MISC NONREIMBURSABLE COST CENTERS	236, 846	16, 370	o o	6, 367		194. 08
200.00			.,		.,		200. 00
201.00	1 1	o	n	0	o	0	201. 00
202.00		36, 668, 038	8, 447, 307	871, 441	3, 248, 291	1, 512, 599	
_32.00	1 ( 1 1 2 339 201)		=,, 507	3, 1, 111	-, -, -, -, -, -,	., 0.2, 077	

Provider CCN: 15-0128

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

					0 12/31/2020	8/2/2021 3:42	
						INTERNS &	piii
						RESI DENTS	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	
			ADMI NI STRATI ON	RECORDS &		Y & FRINGES	
		11 00	12.00	LI BRARY	17.00	21.00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	16. 00	17. 00	21.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	4 540 004					10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	1, 510, 094 17, 258					11. 00 13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	6, 472		2, 258, 574	1		16. 00
17. 00	01700 SOCIAL SERVICE	34, 516		2, 230, 372			17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0.,010	o	(	_, _, _, _,		21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	o	(	0	·	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	591, 095		283, 620		1	30. 00
31. 00	03100 INTENSIVE CARE UNIT	66, 876		30, 966			31. 00
43. 00	04300 NURSERY	12, 944	47, 349	9, 460	152, 011	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	103, 549	ا	205 244	j 0	25, 512	50. 00
50.00	05100 RECOVERY ROOM	69, 033		285, 246 92, 656			50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	58, 246		43, 743		1	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	45, 303	l ol	81, 124		l	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	17, 258	o	53, 157		0	55. 00
57.00	05700 CT SCAN	25, 887	o	156, 822	0	0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	10, 786		31, 512		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	34, 516		189, 749		0	59. 00
60.00	06000 LABORATORY	0	0	182, 189		0	60.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	51, 775		40, 244	-	0 0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	21, 573		20, 411		12, 756	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	17, 258		7, 229		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	4, 315		1, 914		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	38, 831	o	60, 980	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	10, 786	0	10, 622		8, 321	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 573	0	74, 414		0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	(0.000	0	77, 066		0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	69, 033	0	145, 609 6, 668		0	73. 00 74. 00
76. 00	03950 ENDOSCOPY	12, 944		20, 233		0	76.00
76. 06	03330 I MAGI NG CENTER	2, 157		33, 378		l	76. 06
76. 97	07697 CARDI AC REHABI LI TATI ON	8, 629		2, 956		l e	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	(	0	l e	90.00
90. 01	04950 DI ABETI C CARE CENTER	0	0	(	0	0	90. 01
90. 02	04951 ANTI -COAGULATION CLINIC	0	0	3, 320	0	0	90. 02 90. 03
90. 03	04952 PALLI ATI VE CARE 04953 SPI NE CENTER		0	830		0 0	90. 03
	09100 EMERGENCY	157, 481	576, 082	312, 456		85, 123	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	137, 401	370,002	312, 430		05, 125	92. 00
	SPECIAL PURPOSE COST CENTERS	l .				l	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 510, 094	3, 030, 349	2, 258, 574	2, 348, 865	966, 246	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0	<b>l</b>	190. 00
	19100 RESEARCH	0	0	(	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0	0	(	0		192.00
	07950 HOME OFFICE			(			193. 00 194. 00
	07956 LEASED OFFICE SPACE	0		(			194. 00
	07958 MISC NONREIMBURSABLE COST CENTERS		l ol	(	o o	16, 633	
200.00							200. 00
201.00		0	o	(	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	1, 510, 094	3, 030, 349	2, 258, 574	2, 348, 865	982, 879	202. 00

		UTAL SYSTEMS	COMMUNITY HOSP		ON 45 0400 D		u or Form CMS-2	2332-10
COST A	LLUCAI	ION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2020	Worksheet B Part I	
					l't		Date/Time Pre	pared:
					'	0 12/01/2020	8/2/2021 3: 42	pm pm
			INTERNS &					
			RESI DENTS					
		Cost Center Description	SERVI CES-OTHER	Subtotal	Intern &	Total		
		·	PRGM. COSTS		Residents Cost			
					& Post			
					Stepdown			
					Adjustments			
			22.00	24.00	25. 00	26.00		
	GENERA	AL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	1 1	LAUNDRY & LINEN SERVICE						8. 00
9.00		HOUSEKEEPI NG						9. 00
		DI ETARY						10.00
		CAFETERI A						11. 00
		NURSI NG ADMI NI STRATI ON						13. 00
		MEDICAL RECORDS & LIBRARY						16. 00
		SOCIAL SERVICE						17. 00
21. 00		I&R SERVICES-SALARY & FRINGES APPRVD						21. 00
			1 407 041				ŀ	ł
22.00		I &R SERVI CES-OTHER PRGM. COSTS APPRVD ENT ROUTI NE SERVI CE COST CENTERS	1, 497, 961					22. 00
30. 00		ADULTS & PEDIATRICS	1 271 075	54, 797, 784	-2, 106, 409	52, 691, 375		30.00
31. 00		INTENSIVE CARE UNIT	1, 271, 875	7, 905, 72	1	· · · · · · · · · · · · · · · · · · ·		31.00
		NURSERY		1, 253, 52°				43.00
43.00		ARY SERVICE COST CENTERS	<u> </u>	1, 200, 02	1] 0	1, 255, 521		43.00
50. 00	_	OPERATING ROOM	38, 882	12, 761, 392	2 -64, 394	12, 696, 998		50.00
		RECOVERY ROOM	30, 662	5, 567, 32			ŀ	51.00
			1		1			
52.00		DELIVERY ROOM & LABOR ROOM	0	5, 652, 981	1			52.00
		RADI OLOGY - DI AGNOSTI C	0	4, 211, 108	1			54.00
55. 00		RADI OLOGY-THERAPEUTI C	0	1, 730, 637				55. 00
57. 00		CT SCAN	0	2, 286, 176	1	_, _, _, , , , ,		57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	905, 944	1			58. 00
59. 00		CARDI AC CATHETERI ZATI ON	0	5, 213, 163	3 0	5, 213, 163		59. 00
60.00	06000	LABORATORY	0	9, 650, 688	3 0	9, 650, 688		60.00
64.00		INTRAVENOUS THERAPY	0	(	0 (כ	0		64.00
65.00	06500	RESPI RATORY THERAPY	0	3, 603, 332	2 0	3, 603, 332		65. 00
66.00	06600	PHYSI CAL THERAPY	19, 441	4, 094, 774	4 -32, 197	4, 062, 577		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1, 207, 195	5 0	1, 207, 195		67.00
68.00	06800	SPEECH PATHOLOGY	0	319, 391		319, 391		68. 00
69.00	06900	ELECTROCARDI OLOGY	0	2, 281, 928	в о	2, 281, 928		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12, 682	1, 074, 451	1 -21, 003	1, 053, 448		70.00
		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19, 285, 349	1			71.00
		IMPL. DEV. CHARGED TO PATIENTS	0	11, 433, 085				72.00
		DRUGS CHARGED TO PATIENTS	0	15, 441, 143	1			73. 00
		RENAL DIALYSIS	0	752, 333	1			74. 00
	1	ENDOSCOPY		1, 445, 430	.	·		76. 00
		I MAGI NG CENTER		2, 012, 555				76. 06
		CARDI AC REHABILI TATI ON		405, 281	•			76. 97
, 0. , ,		TIENT SERVICE COST CENTERS	9	100, 20	.1	100, 201		1
90.00	_	CLI NI C	0	(	0 (	0		90.00
		DIABETIC CARE CENTER	0	(	ol o	l .		90. 01
		ANTI - COAGULATION CLINIC		472, 156		472, 156		90. 02
		PALLI ATI VE CARE		472, 130		472, 130		90. 03
		SPINE CENTER		374, 428		374, 428		90.03
		EMERGENCY	129, 732	13, 511, 713	1			91.00
		OBSERVATION BEDS (NON-DISTINCT PART)	127, 732	13, 511, 713	-214, 655	l '		92.00
72.00		AL PURPOSE COST CENTERS						72.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	1, 472, 612	189, 650, 980	-2, 438, 858	187, 212, 122		118. 00
110.00		MBURSABLE COST CENTERS	1,472,012	107, 030, 700	J -2, 430, 636	107, 212, 122		110.00
190 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	١	(	0 (	0		190. 00
		RESEARCH		(		l .		191. 00
		PHYSI CLANS' PRI VATE OFFI CES		150 620	1	l .		•
				150, 620	0	150, 620		192.00
		NONPALD WORKERS	0	(		0		193. 00
		HOME OFFICE SPACE		(	J 0	0		194. 00
		LEASED OFFICE SPACE	0 0	1 000 07	J 44 655	1 257 221		194.06
		MISC NONREIMBURSABLE COST CENTERS	25, 349	1, 299, 078	-41, 982	1, 257, 096		194. 08
200.00		Cross Foot Adjustments	0	(	J 0	0		200.00
201.00		Negative Cost Centers	0	101 102 (=	J 0 400 0 :-	0		201. 00
202.00	ן וי	TOTAL (sum lines 118 through 201)	1, 497, 961	191, 100, 678	8 -2, 480, 840	188, 619, 838		202. 00

| Period: | Worksheet B | From 01/01/2020 | Part II | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0128

				To	12/31/2020		pared:
			CAPI TAL REI	LATED COSTS		8/2/2021 3: 42	pm
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs	1.00	2.00	2.4	4.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2. 00	2A	4. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	OO4OO	10, 957	434, 437	0 3, 895, 474	0 4, 340, 868	0	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	0	1, 449, 452		1, 509, 746	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	21, 028		21, 028	0	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	45, 154 87, 557		58, 611 108, 938	0 0	9. 00 10. 00
11. 00	01100 CAFETERI A	0	163, 378		207, 395		11. 00
13.00	01300 NURSING ADMINISTRATION	0	0	-	0	0	13. 00
16. 00 17. 00	01600   MEDICAL RECORDS & LIBRARY   01700   SOCIAL SERVICE	0	0 21, 124	_	0 22, 906	0	16. 00 17. 00
21. 00	02100   &R SERVICES-SALARY & FRINGES APPRVD	0	21, 124	1, 782	22, 900	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	12, 409	0	12, 409	0	22. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS  03000 ADULTS & PEDI ATRI CS	18, 640	1, 942, 993	253, 483	2, 215, 116	0	30. 00
31. 00	03100 INTENSIVE CARE UNIT	18, 640	l		742, 317		31.00
43. 00	04300 NURSERY	0			58, 609	0	43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	1 0	/00 417	1 (2( 120	2 225 54/		1 50 00
50. 00 51. 00	05000   OPERATI NG ROOM   05100   RECOVERY ROOM	0	699, 417 163, 609		2, 335, 546 205, 069		50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	231, 542		270, 984	0	52. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	235, 775		484, 895		54.00
55. 00 57. 00	05500  RADI OLOGY-THERAPEUTI C   05700  CT SCAN	0	0 28, 955		241, 813 28, 955		55. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	Ö	32, 399		49, 314	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	213, 361		756, 820		59.00
60. 00 64. 00	06000   LABORATORY   06400   I NTRAVENOUS THERAPY	0	99, 043	77 0	99, 120 0	0 0	60. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	0	49, 483	- 1	73, 635		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	15, 911		581, 130		66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	5, 425 1, 443		35, 793 9, 483		67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	120, 052		174, 441	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	48, 136		159, 666		70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	224, 077		1, 419, 263 0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	121, 841	-	493, 580	_	73.00
74. 00	07400 RENAL DIALYSIS	0	23, 318	0	23, 318	0	74. 00
76.00	03950 ENDOSCOPY	0	0	233, 419	233, 419 371, 872		76.00
76. 06 76. 97	03330   I MAGI NG CENTER   07697   CARDI AC REHABI LI TATI ON			371, 872 11, 797	371, 872 11, 797	0	76. 06 76. 97
	OUTPATIENT SERVICE COST CENTERS		-	,	,		
90.00	09000 CLINIC	0	0	0	0	0	90.00
90. 01 90. 02	04950  DIABETIC CARE CENTER   04951  ANTI-COAGULATION CLINIC	0	0	0 2, 039	0 2, 039	_	90. 01 90. 02
90. 03	04952 PALLI ATI VE CARE	0	Ö	0	0	0	90. 03
90. 04	04953 SPI NE CENTER	0	0	66, 824	66, 824	0	90.04
	O9100   EMERGENCY   O9200   OBSERVATION   BEDS (NON-DISTINCT PART)	0	575, 729	61, 914	637, 643 0		91. 00 92. 00
72.00	SPECIAL PURPOSE COST CENTERS				<u> </u>		72.00
118.00		29, 597	7, 700, 321	10, 334, 444	18, 064, 362	0	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 0	0	O	O	0	190. 00
191.00	19100 RESEARCH	Ö	ő		Ö		191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
	19300  NONPAID WORKERS   07950  HOME OFFICE	0	0	0	0		193. 00 194. 00
	07956 LEASED OFFICE SPACE				ol		194. 00
194. 08	07958 MISC NONREIMBURSABLE COST CENTERS	0	11, 293	10, 518	21, 811	0	194. 08
200. 00 201. 00			_	0	0		200. 00 201. 00
201.00	1 9	29, 597	7, 711, 614	-	18, 086, 173		201.00
			•			-	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0128

						8/2/2021 3: 42	pm
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
	GENERAL SERVICE COST CENTERS	5. 00	7. 00	8.00	9. 00	10. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT			1			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	4, 340, 868					5. 00
7. 00	00700 OPERATION OF PLANT	191, 878	1, 701, 624				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	19, 102	6, 140				8. 00
9. 00	00900 HOUSEKEEPI NG	72, 297	13, 184		144, 092		9. 00
10.00	01000 DI ETARY	30, 354	25, 566		2, 190	167, 048	10.00
11. 00	01100 CAFETERI A	26, 830	47, 704		4, 086	0	11. 00
13. 00	1 1	68, 441	0	0	0	0	13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	51, 156	0	0	0	0	16. 00
17. 00		51, 604	6, 168	0	528	0	17. 00
21. 00	l l	22, 326	0	o	0	0	21. 00
22. 00		33, 458	3, 623	0	310	0	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		·		'		
30.00	03000 ADULTS & PEDIATRICS	952, 707	567, 332	21, 706	48, 593	152, 128	30.00
31. 00		137, 009	170, 285			14, 920	31. 00
43.00	04300 NURSERY	20, 955	14, 623		1, 252	0	43.00
	ANCILLARY SERVICE COST CENTERS		·				
50.00	05000 OPERATING ROOM	247, 592	204, 221	0	17, 492	0	50.00
51.00	05100 RECOVERY ROOM	112, 431	47, 772	6, 718	4, 092	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	114, 616	67, 607	2, 067	5, 791	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	81, 673	68, 843	765	5, 897	0	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	37, 711	0	0	0	0	55. 00
57.00	05700 CT SCAN	45, 355	8, 454	2, 573	724	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	18, 136	9, 460	0	810	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	103, 332	62, 299	543	5, 336	0	59. 00
60.00	06000 LABORATORY	210, 545	28, 919	0	2, 477	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65.00	06500 RESPIRATORY THERAPY	77, 495	14, 448	0	1, 238	0	65. 00
66.00	06600 PHYSI CAL THERAPY	90, 599	4, 646	0	398	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	26, 617	1, 584	0	136	0	67. 00
68.00	06800 SPEECH PATHOLOGY	7, 047	421	0	36	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	44, 076	35, 054	0	3, 002	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	21, 241	14, 055	0	1, 204	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	425, 633	65, 428	0	5, 604	0	71. 00
72.00		257, 948	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	340, 293	35, 576	0	3, 047	0	73. 00
74.00	07400 RENAL DIALYSIS	15, 871	6, 808	0	583	0	74.00
76.00	03950 ENDOSCOPY	32, 079	0	0	0	0	76. 00
76.06	03330 I MAGI NG CENTER	44, 907	0	0	0	0	76. 06
76. 97	07697 CARDIAC REHABILITATION	8, 943	0	0	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00		0	0	0	0	0	90. 00
90. 01	04950 DIABETIC CARE CENTER	0	0	0	0	0	90. 01
90. 02	1 1	10, 649	0	0	0	0	90. 02
90. 03	04952 PALLI ATI VE CARE	0	0	0	0	0	90. 03
90. 04		8, 486	0	0	- 1	0	90. 04
91. 00		248, 017	168, 106	9, 182	14, 399	0	91. 00
92.00	. ,						92. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	4, 309, 409	1, 698, 326	46, 270	143, 810	167, 048	118. 00
	NONREI MBURSABLE COST CENTERS						
	D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	D 19100 RESEARCH	0	0	0	0		191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	3, 421	0	0	0		192. 00
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	07950 HOME OFFICE	0	0	0	0		194. 00
	6 07956 LEASED OFFICE SPACE	0	0	0	0		194. 06
	B 07958 MISC NONREIMBURSABLE COST CENTERS	28, 038	3, 298	0	282	0	194. 08
200.00							200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	4, 340, 868	1, 701, 624	46, 270	144, 092	167, 048	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| Period: | Worksheet B | From 01/01/2020 | Part II | To | 12/31/2020 | B/2/2021 3: 42 pm |

						8/2/2021 3: 42	pm
						INTERNS &	
						RESI DENTS	
	Cost Center Description	CAFETERI A	NURSI NG	MEDI CAL	SOCIAL SERVICE		
			ADMI NI STRATI ON	RECORDS &		Y & FRINGES	
				LI BRARY			
		11. 00	13. 00	16. 00	17. 00	21. 00	
4 00	GENERAL SERVI CE COST CENTERS						4 00
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	286, 015					11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	3, 269					13. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	1, 226	0	52, 382			16. 00
17. 00	01700 SOCIAL SERVICE	6, 537	0	C			17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0		C		22, 326	
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	0	0	C	0		22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	111, 955		6, 614			30.00
31. 00	03100 INTENSIVE CARE UNIT	12, 666		722			31. 00
43.00	04300 NURSERY	2, 452	1, 120	221	5, 678		43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	19, 612		6, 652			50. 00
51. 00	05100 RECOVERY ROOM	13, 075		2, 161			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	11, 032		1, 020			52. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	8, 580	0	1, 892	0		54.00
55.00	05500   RADI OLOGY-THERAPEUTI C	3, 269		1, 240			55. 00
57.00	05700  CT SCAN	4, 903	0	3, 657	0		57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 043	0	735	0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	6, 537	0	4, 425	0		59. 00
60.00	06000 LABORATORY	0	0	4, 249	o		60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	C	0		64. 00
65.00	06500 RESPI RATORY THERAPY	9, 806	0	939	o		65.00
66.00	06600 PHYSI CAL THERAPY	4, 086	0	476	0		66.00
67.00	06700 OCCUPATI ONAL THERAPY	3, 269	0	169	0		67.00
68.00	06800 SPEECH PATHOLOGY	817	o	45	o o		68. 00
69.00	06900 ELECTROCARDI OLOGY	7, 355	0	1, 422	2 0		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 043	o	248	o o		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 086	0	1, 735	0		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1, 797	o o		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	13, 075	o	3, 396	o		73. 00
74.00	07400 RENAL DIALYSIS	0	0	156	o o		74.00
76.00	03950 ENDOSCOPY	2, 452	o	472	el ol		76. 00
76.06	03330 I MAGI NG CENTER	409	o	778	ol ol		76. 06
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 634	o	69	o		76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	C	0		90.00
90. 01	04950 DIABETIC CARE CENTER	0	o	C	o		90. 01
	04951 ANTI-COAGULATION CLINIC	0	o	77	o		90. 02
90.03	04952 PALLI ATI VE CARE	0	o	C	ol		90. 03
90.04	04953 SPI NE CENTER	0	0	19	o		90. 04
91.00	09100 EMERGENCY	29, 827	13, 632	6, 996	o		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		·	•			92.00
	SPECIAL PURPOSE COST CENTERS	1			·		
118.00		286, 015	71, 710	52, 382	87, 743	0	118. 00
	NONREI MBURSABLE COST CENTERS				, , , , ,		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
	19100 RESEARCH	0	o	C	ol ol		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	o	C	ol ol		192. 00
193.00	19300 NONPALD WORKERS	0	o	C	ol ol		193. 00
	07950 HOME OFFI CE	Ö	ol	C	ol ol		194. 00
	07956 LEASED OFFICE SPACE	Ö	l	d	ol ol		194. 06
	07958 MISC NONREIMBURSABLE COST CENTERS	0	o	C	ol		194. 08
200.00		]				22, 326	200. 00
201.00	,	0	o	C	ol ol	0	201.00
202.00		286, 015	71, 710	52, 382	87, 743		202. 00
					. '		

	ATION OF CAPITAL RELATED COSTS	COMMONTTY		CN: 15-0128 P	eri od:	Worksheet B	2002 10
					rom 01/01/2020 o 12/31/2020	Part II Date/Time Pre	pared:
		LAUTEDNIC				8/2/2021 3: 42	pm
		I NTERNS & RESI DENTS					
	Cost Center Description	SERVI CES-OTHER	Subtotal	Intern &	Total		
		PRGM. COSTS		Residents Cost			
				& Post Stepdown			
				Adjustments			
	CENEDAL CEDALOF COCT CENTEDS	22.00	24. 00	25. 00	26. 00		
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					ı	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					ı	4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT					ı	5. 00 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					ı	8.00
9.00	00900 HOUSEKEEPI NG					ı	9. 00
10.00	01000 DI ETARY					ı	10.00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON					ı	11. 00 13. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY					ı	16.00
17. 00	01700 SOCIAL SERVICE					1	17. 00
	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	40.000				ı	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD INPATIENT ROUTINE SERVICE COST CENTERS	49, 800					22. 00
30. 00	03000 ADULTS & PEDIATRICS		4, 202, 678	3 0	4, 202, 678		30.00
31.00	03100 INTENSIVE CARE UNIT		1, 107, 269	e c	1, 107, 269	1	31.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS		105, 357	7  C	105, 357		43. 00
50. 00	05000 OPERATING ROOM		2, 831, 115	5 0	2, 831, 115		50.00
51. 00	05100 RECOVERY ROOM		391, 318	•		ı	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		473, 117			ı	52. 00
54. 00 55. 00	05400  RADI OLOGY-DI AGNOSTI C   05500  RADI OLOGY-THERAPEUTI C		652, 545 284, 033	•		ı	54. 00 55. 00
57. 00	05700 CT SCAN		94, 621	•		ı	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		80, 498			ı	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON		939, 292	1	1 ' 1	ı	59. 00
60.00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY		345, 310			ı	60.00
64. 00 65. 00	06500 RESPIRATORY THERAPY		177, 561			ı	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY		681, 335		,	ı	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		67, 568		,	ı	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY		17, 849	1	, , , ,	ı	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY		265, 350 198, 457	1	1 ' 1	ı	69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1, 921, 749	1	1 ' 1	ı	71.00
			259, 745			ı	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		888, 967	1	1 ' 1	ı	73. 00 74. 00
	07400   RENAL DI ALYSI S   03950   ENDOSCOPY		46, 736 268, 422			ı	76.00
	03330 I MAGI NG CENTER		417, 966			ı	76. 06
76. 97	07697 CARDI AC REHABI LI TATI ON		22, 443	3 C	22, 443		76. 97
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC			ol c	O		90.00
90. 00	04950 DIABETIC CARE CENTER		C			ı	90.00
90. 02	04951 ANTI-COAGULATION CLINIC		12, 765	5 c	12, 765	ı	90. 02
	04952 PALLI ATI VE CARE		75.000			ı	90. 03
90. 04 91. 00	04953 SPI NE CENTER 09100 EMERGENCY		75, 329 1, 127, 802			ı	90. 04 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1, 127, 002			ı	92.00
	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	0	17, 957, 197	7 <u> </u>	17, 957, 197		118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		C		0		190. 00
	19100 RESEARCH		C	o c	1	ı	191. 00
	19200 PHYSICIANS' PRIVATE OFFICES		3, 421			ı	192. 00
	19300 NONPAID WORKERS 07950 HOME OFFICE		C		_	1	193. 00 194. 00
	07956 LEASED OFFICE SPACE		C		_		194. 06
194. 08	07958 MISC NONREIMBURSABLE COST CENTERS		53, 429	e c	53, 429		194. 08
200.00		49, 800	72, 126	1	1 ' 1		200.00
201. 00 202. 00		49, 800	18, 086, 173	0 3			201. 00 202. 00
30	(	, 500	-,,				

		cial Systems ION - STATISTICAL BASIS	COMMUNITY HOS	PITAL SOUTH Provider CC	:N: 15-0128 Pe	In Lie eriod:	u of Form CMS-2 Worksheet B-1	<u> 2552-10</u>
						rom 01/01/2020 o 12/31/2020	Date/Time Pre	
			CAPITAL REL	ATED COSTS			8/2/2021 3: 42	pm
		Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4. 00	5A	5. 00	
4 00		AL SERVICE COST CENTERS	400 004					4 00
1. 00 2. 00 4. 00 5. 00	00200 00400 00500	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	400, 831 0 22, 581	10, 689, 680 0 4, 025, 279	67, 840, 947 7, 216, 299	-36, 668, 038		1. 00 2. 00 4. 00 5. 00
7. 00 8. 00 9. 00	00800	OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING	75, 339 1, 093 2, 347	62, 303 0 13, 905	1, 524, 668 0 1, 442, 420	0	6, 826, 454 679, 598 2, 572, 123	7. 00 8. 00 9. 00
10.00		DIETARY	4, 551	22, 093	425, 520	0	1, 079, 910	
11. 00		CAFETERI A	8, 492	45, 484	815, 781	0	954, 526	11. 00
		NURSI NG ADMINI STRATI ON	0	0	267, 067	0	2, 434, 945	13.00
		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	1, 098	0 1, 841	285, 422 1, 400, 787	0	1, 819, 973 1, 835, 907	16. 00 17. 00
		I&R SERVICES-SALARY & FRINGES APPRVD	1,070	0	1, 400, 707	0	794, 286	
		I&R SERVICES-OTHER PRGM. COSTS APPRVD	645	Ō	0	0		
		ENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	100, 992	261, 930	19, 923, 144	0		30.00
		NURSERY	30, 313 2, 603	164, 425 8, 814	3, 082, 722 475, 047	0		31. 00 43. 00
43.00		_ARY SERVICE COST CENTERS	2,003	0, 014	473, 047	0	743, 307	43.00
50.00	05000	OPERATING ROOM	36, 354	1, 690, 649	3, 195, 763	0	8, 808, 588	50. 00
51.00		RECOVERY ROOM	8, 504	42, 842	2, 689, 087	0	3, 999, 966	
		DELIVERY ROOM & LABOR ROOM	12, 035	40, 756	2, 784, 251	0	4, 077, 709	52.00
54. 00 55. 00		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	12, 255 0	257, 421 249, 871	1, 583, 550 687, 065	0	2, 905, 680 1, 341, 662	
		CT SCAN	1, 505	247, 071	875, 927	0	1, 613, 594	
		MAGNETIC RESONANCE IMAGING (MRI)	1, 684	17, 479	395, 897	0	645, 219	
		CARDI AC CATHETERI ZATI ON	11, 090	561, 568	1, 371, 509	0	3, 676, 235	59. 00
		LABORATORY	5, 148	80	0	0	7, 490, 561	60.00
64. 00		INTRAVENOUS THERAPY	0 570	0	1 020 022	0	0 757 0/1	64.00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	2, 572 827	24, 957 584, 054	1, 928, 833 1, 990, 713	0	2, 757, 061 3, 223, 243	65. 00 66. 00
67. 00		OCCUPATI ONAL THERAPY	282	31, 380	687, 307	0	946, 945	
68. 00		SPEECH PATHOLOGY	75	8, 308	181, 976	0	250, 725	
69. 00		ELECTROCARDI OLOGY	6, 240	56, 201	935, 384	0	1, 568, 094	69. 00
		ELECTROENCEPHALOGRAPHY	2, 502	115, 246	364, 731	0	755, 697	
		MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 647	1, 235, 013	418, 465	0	15, 142, 774	
	1	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0 6, 333	0 384, 126	0 2, 955, 569	0	9, 177, 048 12, 106, 636	
		RENAL DIALYSIS	1, 212	0	0	0	564, 651	
		ENDOSCOPY	0	241, 197	541, 222	0	1, 141, 273	
		I MAGI NG CENTER	0	384, 264	875, 692		1, 597, 673	
		CARDIAC REHABILITATION FIENT SERVICE COST CENTERS	0	12, 190	225, 715	0	318, 154	76. 97
		CLINIC	0	0	0	0	0	90.00
		DIABETIC CARE CENTER	0	0	0	0	0	90. 01
		ANTI-COAGULATION CLINIC	0	2, 107	517, 020	0	378, 877	
		PALLIATIVE CARE	0	0	1/0 073	0	0	
		SPI NE CENTER EMERGENCY	29, 925	69, 051 63, 977	160, 973 5, 239, 358	0	301, 913 8, 823, 715	
		OBSERVATION BEDS (NON-DISTINCT PART)	27, 723	03, 777	3, 237, 330	J	0,023,713	92.00
	SPECI A	AL PURPOSE COST CENTERS						
118. 00	NONRE	SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	400, 244	10, 678, 811	67, 464, 884	-36, 668, 038		
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
		RESEARCH PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	121, 719	191.00
		NONPALD WORKERS	0	0	0	0		193. 00
		HOME OFFICE	0	0	0	0	0	194. 00
		LEASED OFFICE SPACE	0	0	0	0		194. 06
		MISC NONREIMBURSABLE COST CENTERS	587	10, 869	376, 063	0	997, 513	
200. 00 201. 00	1 .	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
201.00	1 1	Cost to be allocated (per Wkst. B,	7, 711, 614	10, 344, 962	1, 872, 706		36, 668, 038	
		Part I)						
203.00		Unit cost multiplier (Wkst. B, Part I)	19. 239066	0. 967752	0. 027604		0. 237437	
204.00		Cost to be allocated (per Wkst. B, Part II)			0		4, 340, 868	204.00
	1	/	'	ı	l	ı	ı	1

Heal th Fina	ncial Systems	COMMUNITY HOSPITAL SOUTH			In Lieu of Form CMS-2552-10			
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der CO		Period: From 01/01/2020	Worksheet B-1		
					To 12/31/2020	Date/Time Pre 8/2/2021 3:42		
		CAPITAL REI	_ATED COSTS					
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)		Reconciliation	& GENERAL		
				DEPARTMENT (GROSS SALARI ES)		(ACCUM. COST)		
		1.00	2.00	4. 00	5A	5. 00		
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00000	0	0. 028108	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 Provider CCN: 15-0128

				1	To 12/31/2020	Date/Time Pre 8/2/2021 3:42	
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF	HOUSEKEEPING (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	CAFETERI A	
		7. 00	LAUNDRY) 8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 2. 00 4. 00
5. 00 7. 00	O0500 ADMINISTRATIVE & GENERAL O0700 OPERATION OF PLANT O0800 LAUNDRY & LINEN SERVICE	302, 911	14/ 052				5. 00 7. 00
8. 00 9. 00	00900 HOUSEKEEPI NG	1, 093 2, 347	146, 853 0	1	I		8. 00 9. 00
10. 00 11. 00	01000   DI ETARY   01100   CAFETERI A	4, 551 8, 492	0	4, 55 <sup>1</sup> 8, 49 <sup>2</sup>		700	10.00
13. 00	01300 NURSING ADMINISTRATION	0,472	0	) (		8	13. 00
16. 00 17. 00	01600   MEDICAL RECORDS & LIBRARY   01700   SOCIAL SERVICE	0 1, 098	0	1	0	3 16	
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	O		0	0	21. 00
22. 00	02200   1 & R SERVICES-OTHER PRGM. COSTS APPRVD   INPATIENT ROUTINE SERVICE COST CENTERS	645	0	645	5 0	0	22. 00
30. 00	03000 ADULTS & PEDI ATRI CS	100, 992			1	274	
31. 00 43. 00	03100 INTENSIVE CARE UNIT 04300 NURSERY	30, 313 2, 603			1	31	1
43.00	ANCILLARY SERVICE COST CENTERS			2,000	,	0	43.00
50. 00 51. 00	05000   OPERATING ROOM   05100   RECOVERY ROOM	36, 354 8, 504				48 32	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	12, 035				27	1
54. 00 55. 00	05400  RADI OLOGY-DI AGNOSTI C   05500  RADI OLOGY-THERAPEUTI C	12, 255	2, 427	12, 255		21 8	1
57. 00	05700 CT SCAN	1, 505	۷	1	-	12	
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	1, 684 11, 090	•	1 .,		5 16	1
60. 00	06000 LABORATORY	5, 148				0	1
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0	1	-	0 24	
66. 00	06600 PHYSI CAL THERAPY	2, 572 827		_, -,		10	1
67.00	06700 OCCUPATI ONAL THERAPY	282	0			8	
68. 00 69. 00	06800  SPEECH PATHOLOGY   06900  ELECTROCARDI OLOGY	75 6, 240	ł .	1		2 18	1
70.00	07000 ELECTROENCEPHALOGRAPHY	2,502	0	_, -,		5	
71. 00 72. 00	07100  MEDICAL SUPPLIES CHARGED TO PATIENTS   07200  IMPL. DEV. CHARGED TO PATIENTS	11, 647		1,		10 0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 333				32	
74. 00 76. 00	07400  RENAL DI ALYSI S   03950  ENDOSCOPY	1, 212	0	1 .,		0 6	74. 00 76. 00
76. 06	03330 I MAGING CENTER	0			-	1	76. 06
76. 97	O7697   CARDI AC REHABILITATION   OUTPATIENT SERVICE COST CENTERS	0	0	1	0	4	76. 97
90.00	09000 CLINIC	0	O		0	0	
	04950 DIABETIC CARE CENTER 04951 ANTI-COAGULATION CLINIC	0				0	1
90. 03	04952 PALLIATIVE CARE	0	Q		0	0	90. 03
	04953 SPI NE CENTER 09100 EMERGENCY	29, 925	29, 143	29, 925	) 5	0 73	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			<u> </u>			92. 00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	302, 324	146, 853	298, 884	33, 444	700	118. 00
400.00	NONREI MBURSABLE COST CENTERS						1.00.00
	19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   19100   RESEARCH	0	ł .		-		190. 00 191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	O		0	0	192. 00
	19300 NONPALD WORKERS   07950 HOME OFFICE	0					193. 00 194. 00
194.06	07956 LEASED OFFICE SPACE	0	0	) (	0	0	194. 06
194. 08 200. 00	07958 MISC NONREIMBURSABLE COST CENTERS Cross Foot Adjustments	587	C	587	0	0	194. 08 200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	8, 447, 307	871, 441	3, 248, 29	1, 512, 599	1, 510, 094	202.00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I)	27. 887092 1, 701, 624		1		2, 157. 277143 286, 015	
205.00	Unit cost multiplier (Wkst. B, Part	5. 617571	0. 315077	0. 481155	4. 994857	408. 592857	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00

Health Financial Systems	COMMUNITY HOS	COMMUNITY HOSPITAL SOUTH			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1			
				rom 01/01/2020				
			7	Γο 12/31/2020	Date/Time Pre			
					8/2/2021 3: 42	pm		
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A			
	PLANT	LINEN SERVICE	(SQUARE FEET)	(PATIENT DAYS)	(MEALS SERVED)			
	(SQUARE FEET)	(POUNDS OF						
		LAUNDRY)						
	7. 00	8. 00	9. 00	10.00	11. 00			
207.00 NAHE unit cost multiplier (Wkst.	D,					207. 00		
Parts III and IV)								

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

				T		Date/Time Pre 8/2/2021 3:42 RESIDENTS	
	Cost Center Description	NURSI NG	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVICES_OTHER	
	cost center bescription	ADMI NI STRATI ON	RECORDS &	SOCIAL SERVICE	Y & FRI NGES	PRGM. COSTS	
		(DI RECT NURS.	LI BRARY (GROSS	(TOTAL PATIENT DAYS)	(ASSI GNED TIME)	(ASSIGNED TIME)	
		· HRS. )	CHARGES)	DATS)	TTWL)	TTWL)	
	CENIEDAL CEDIUCE COCT CENTEDO	13. 00	16. 00	17. 00	21. 00	22. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT			1			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 5. 00	OO400						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900  HOUSEKEEPI NG  01000  DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11. 00
13. 00 16. 00	O1300   NURSI NG ADMI NI STRATI ON   O1600   MEDI CAL RECORDS & LI BRARY	384	908, 031, 675				13. 00 16. 00
17. 00	01700 SOCIAL SERVICE		900, 031, 073	1			17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	0	1	96, 853		21.00
22. 00	02200   1 & R SERVI CES-OTHER PRGM. COSTS APPRVD   I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0		96, 853	22. 00
30. 00	03000 ADULTS & PEDIATRICS	274	114, 040, 907	1		82, 235	1
31. 00 43. 00	03100   I NTENSI VE CARE UNI T   04300   NURSERY	31	12, 451, 172 3, 803, 616			0	
43.00	ANCI LLARY SERVI CE COST CENTERS	١	3, 003, 010	2, 327	U U	0	43.00
50.00	05000 OPERATING ROOM	0	114, 694, 681		2, 514	2, 514	1
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	0	37, 256, 221 17, 588, 748	1	0	0	51. 00 52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	O	32, 619, 326	0	O	0	54.00
55. 00 57. 00	05500  RADI OLOGY-THERAPEUTI C   05700  CT SCAN	0	21, 373, 916		0	0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		63, 056, 681 12, 670, 661		0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	76, 296, 215	5 O	O	0	
60. 00 64. 00	06000   LABORATORY   06400   INTRAVENOUS THERAPY	0	73, 256, 365	0	0	0	60. 00 64. 00
65. 00	06500 RESPI RATORY THERAPY	o	16, 181, 858	0	0	0	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	8, 207, 032 2, 906, 540	1	1, 257	1, 257 0	1
68. 00	06800 SPEECH PATHOLOGY	0	769, 406	1	o	0	1
69. 00	06900 ELECTROCARDI OLOGY	0	24, 519, 368	1	0	0	
70. 00 71. 00	07000  ELECTROENCEPHALOGRAPHY   07100  MEDICAL SUPPLIES CHARGED TO PATIENTS		4, 271, 005 29, 921, 007	1	820 0	820 0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	30, 987, 651	0	O	0	72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	58, 548, 204 2, 681, 063	1	0	0	
76. 00	03950 ENDOSCOPY		8, 135, 444	1	0	0	76.00
76. 06	03330 I MAGI NG CENTER	0	13, 421, 152		1	0	
76. 97	O7697   CARDI AC REHABI LI TATI ON     OUTPATI ENT SERVI CE COST CENTERS	0	1, 188, 629	9 0	0	0	76. 97
	09000 CLI NI C	0	C	0	-	0	
	04950  DIABETIC CARE CENTER   04951  ANTI-COAGULATION CLINIC	0	0 1, 335, 072	0	· ·	0	
	04952 PALLI ATI VE CARE	0	1, 333, 072		0	0	1
	04953 SPI NE CENTER	0	333, 915		0	0	90.04
	O9100   EMERGENCY   O9200   OBSERVATION BEDS (NON-DISTINCT PART)	73	125, 515, 820	) 0	8, 388	8, 388	91. 00 92. 00
	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	384	908, 031, 675	39, 078	95, 214	95, 214	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	О	0	0	0	190. 00
	19100 RESEARCH	0	0	0	0		191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES  19300 NONPAID WORKERS	0	0		0		192. 00 193. 00
194.00	07950 HOME OFFICE	0	0	0	0	0	194. 00
	07956 LEASED OFFICE SPACE 07958 MISC NONREIMBURSABLE COST CENTERS	0	0	0	0 1, 639		194. 06 194. 08
200.00			O	,	1,037	1,037	200. 00
201.00		2 020 040	0 050 57	2 242 245	000 070	4 407 041	201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	3, 030, 349	2, 258, 574	2, 348, 865	982, 879	1, 497, 961	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7, 891. 533854	0. 002487				1
204.00	Cost to be allocated (per Wkst. B, Part II)	71, 710	52, 382	87, 743	22, 326	49, 800	204. 00
	1	1		•	'	•	

Health Financial Systems	COMMUNITY HOSE	TAL SOUTH		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co	CN: 15-0128	Peri od:	Worksheet B-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 8/2/2021 3:42	
				INTERNS &	RESI DENTS	
Cost Center Description	NURSI NG ADMI NI STRATI ON	RECORDS &		SERVICES-SALAR Y & FRINGES	PRGM. COSTS	
	(DI RECT NURS. HRS.)	LI BRARY (GROSS CHARGES)	(TOTAL PATIEN DAYS)	IT (ASSI GNED TI ME)	(ASSI GNED TI ME)	
	13. 00	16. 00	17. 00	21. 00	22. 00	
205.00 Unit cost multiplier (Wkst. B, Part	186. 744792	0. 000058	2. 24533	0. 230514	0. 514181	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

| Peri od: | Worksheet C | From 01/01/2020 | Part | | To | 12/31/2020 | Date/Time Prepared:

					To 12/31/2020	Date/Time Pre 8/2/2021 3:42	
			Title	XVIII	Hospi tal	PPS	
	·				Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	•	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	.,				
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1		0.00		2.22	
30. 00	03000 ADULTS & PEDIATRICS	52, 691, 375		52, 691, 3	75 0	52, 691, 375	30. 00
31. 00	03100   NTENSI VE CARE UNI T	7, 905, 721		7, 905, 72			31. 00
	04300 NURSERY	1, 253, 521		1, 253, 52			43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS	1,200,021		1, 200, 02	- '	1, 200, 021	10.00
50. 00	05000 OPERATI NG ROOM	12, 696, 998		12, 696, 99	08	12, 696, 998	50.00
51. 00	05100 RECOVERY ROOM	5, 567, 321		5, 567, 32			51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	5, 652, 981		5, 652, 98			52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 211, 108		4, 211, 10		4, 211, 108	1
55. 00	05500 RADI OLOGY - THERAPEUTI C	1					1
57. 00	05700 CT SCAN	1, 730, 637 2, 286, 176		1, 730, 63 2, 286, 1		1, 730, 637 2, 286, 176	
		1 ' ' 1					1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	905, 944		905, 94		905, 944	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	5, 213, 163		5, 213, 10		-, ,	1
60.00	06000 LABORATORY	9, 650, 688		9, 650, 68		.,,	
64. 00	06400 I NTRAVENOUS THERAPY	0			0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	3, 603, 332	0	-,,		3, 603, 332	65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 062, 577	0	4, 062, 5		4, 062, 577	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 207, 195	0	1, 207, 19		1, 207, 195	1
68. 00	06800 SPEECH PATHOLOGY	319, 391	0	319, 39		,	68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 281, 928		2, 281, 92	28 0	2, 281, 928	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 053, 448		1, 053, 44	18 0	1, 053, 448	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19, 285, 349		19, 285, 34	19 0	19, 285, 349	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	11, 433, 085		11, 433, 08	35 0	11, 433, 085	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	15, 441, 143		15, 441, 14	13 0	15, 441, 143	73. 00
74.00	07400 RENAL DIALYSIS	752, 333		752, 33	0	752, 333	74. 00
76.00	03950 ENDOSCOPY	1, 445, 430		1, 445, 43	во о	1, 445, 430	76. 00
76.06	03330 I MAGI NG CENTER	2, 012, 555		2, 012, 5	55 0	2, 012, 555	76. 06
76. 97	07697 CARDI AC REHABI LI TATI ON	405, 281		405, 28			76. 97
	OUTPATIENT SERVICE COST CENTERS			,			
90.00	09000 CLI NI C	0			0 0	0	90.00
	04950 DI ABETI C CARE CENTER	0			0 0		90. 01
90. 02	04951 ANTI - COAGULATION CLINIC	472, 156		472, 1			
	04952 PALLI ATI VE CARE	0		1,2,	0 0		90. 03
	04953 SPINE CENTER	374, 428		374, 42	-		
91. 00	09100 EMERGENCY	13, 296, 858		13, 296, 8			1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 688, 709		5, 688, 70		5, 688, 709	
200.00		192, 900, 831	0				
201.00		5, 688, 709	O	5, 688, 70		5, 688, 709	
201.00		187, 212, 122	0				
202.00	Total (See Histractions)	101, 212, 122	U	107, 212, 12	.21	101, 212, 122	1202.00

Date/Time Prepared: 12/31/2020 8/2/2021 3:42 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 107, 351, 007 03000 ADULTS & PEDIATRICS 107, 351, 007 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 12, 451, 172 12, 451, 172 31.00 04300 NURSERY 3, 803, 616 3, 803, 616 43.00 43.00 ANCILLARY SERVICE COST CENTERS 0.000000 50.00 05000 OPERATING ROOM 59, 293, 364 55, 401, 317 114, 694, 681 0 110703 50.00 51.00 05100 RECOVERY ROOM 14, 002, 999 23, 253, 222 37, 256, 221 0.149433 0.000000 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 17, 588, 748 17, 588, 748 0. 321398 0.000000 52 00 05400 RADI OLOGY-DI AGNOSTI C 32, 619, 326 0.129099 7.034.972 25, 584, 354 0.000000 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 0.080970 0.000000 55.00 7, 329, 313 14, 044, 603 21, 373, 916 55.00 57.00 05700 CT SCAN 17, 852, 352 45, 204, 329 63, 056, 681 0.036256 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 3, 416, 443 9, 254, 218 12, 670, 661 0.071499 0.000000 58.00 46, 222, 811 05900 CARDIAC CATHETERIZATION 30.073.404 76, 296, 215 0.000000 59.00 0.068328 59.00 60.00 06000 LABORATORY 44, 646, 834 28, 609, 531 73, 256, 365 0.131739 0.000000 60.00 06400 I NTRAVENOUS THERAPY 0.000000 0.000000 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 14, 804, 722 1, 377, 136 16, 181, 858 0.222677 0.000000 65.00 5, 328, 946 06600 PHYSI CAL THERAPY 2.878.086 8, 207, 032 0.495012 0.000000 66.00 66,00 67.00 06700 OCCUPATIONAL THERAPY 2, 165, 720 740, 820 2, 906, 540 0.415337 0.000000 67.00 06800 SPEECH PATHOLOGY 598, 680 170, 726 769, 406 0. 415114 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 7, 137, 524 17, 381, 844 24, 519, 368 0.093066 0.000000 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 324, 932 70.00 3, 946, 073 4, 271, 005 0.246651 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 15, 761, 035 14, 159, 972 29, 921, 007 0.644542 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 17, 564, 300 13, 423, 351 30, 987, 651 0.368956 0.000000 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 42, 905, 288 15, 642, 916 58, 548, 204 0 263734 0.000000 73 00 07400 RENAL DIALYSIS 74.00 2, 681, 063 2, 681, 063 0.280610 0.000000 74.00 76.00 03950 ENDOSCOPY 2, 124, 648 6,010,796 8, 135, 444 0.177671 0.000000 76.00 76.06 03330 I MAGING CENTER 141,028 13, 280, 124 13, 421, 152 0.149954 0.000000 76.06 07697 CARDIAC REHABILITATION 3,054 76. 97 1, 185, 575 1, 188, 629 0.340965 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0.000000 90.00 90 01 04950 DIABETIC CARE CENTER 0 O 0.000000 0.000000 90 01 04951 ANTI-COAGULATION CLINIC 90.02 7,525 1, 327, 547 1, 335, 072 0.353656 0.000000 90.02 90.03 04952 PALLIATIVE CARE 0.000000 0.000000 90.03 90.04 04953 SPINE CENTER 333, 915 333, 915 1. 121327 0.000000 90.04 91 00 09100 EMERGENCY 28, 668, 624 96, 847, 196 125, 515, 820 0.000000 91 00 0 105938 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 2, 318, 605 4, 371, 295 6, 689, 900 0.850343 0.000000 200.00 Subtotal (see instructions) 464, 929, 058 443, 102, 617 908, 031, 675 200.00

464, 929, 058

908, 031, 675

443, 102, 617

201.00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0128	From 01/01/2020	Worksheet C Part I Date/Time Prepared:

			10 12/31/2020	8/2/2021 3: 42 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient		<u> </u>	
·	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 110703			50.00
51.00 05100 RECOVERY ROOM	0. 149433			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 321398			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 129099			54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C	0. 080970			55. 00
57. 00 05700 CT SCAN	0. 036256			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 071499			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 068328			59.00
60. 00   06000   LABORATORY	0. 131739			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 222677			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 495012			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 415337			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 415114			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 093066			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 246651			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 644542			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 368956			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 263734			73. 00
74. 00 07400 RENAL DIALYSIS	0. 280610			74. 00
76. 00 03950 ENDOSCOPY	0. 177671			76. 00
76. 06 03330 I MAGI NG CENTER	0. 149954			76.06
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 340965			76. 97
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 04950 DIABETIC CARE CENTER	0. 000000			90. 01
90. 02 04951 ANTI-COAGULATION CLINIC	0. 353656			90. 02
90. 03   04952   PALLI ATI VE CARE	0. 000000			90. 03
90. 04   04953   SPI NE CENTER	1. 121327			90. 04
91. 00 09100 EMERGENCY	0. 105938			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 850343			92.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	1			,

In Lieu of Form CMS-2552-10
Worksheet C
Part I
Bate/Time Prepared:
8/2/2021 3: 42 pm
tal PPS Peri od: From 01/01/2020 To 12/31/2020 Title XIX Hospi tal Costs

Part I, col	
1.00 2.00 3.00 4.00 5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00   03000   ADULTS & PEDI ATRI CS   54, 797, 784   54, 797, 784   0   54, 797, 784	30.00
31. 00   03100   I NTENSI VE CARE UNI T   7, 905, 721   7, 905, 721   0   7, 905, 721	31.00
43. 00   04300   NURSERY   1, 253, 521   1, 253, 521   0   1, 253, 521	43.00
ANCILLARY SERVICE COST CENTERS	
50. 00   05000   0PERATI NG ROOM   12, 761, 392   12, 761, 392   0   12, 761, 392	50.00
51. 00   05100   RECOVERY ROOM   5, 567, 321   5, 567, 321   0   5, 567, 321	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM   5, 652, 981   5, 652, 981   5, 652, 981   0   5, 652, 981	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   4, 211, 108   4, 211, 108   0   4, 211, 108	54.00
55. 00   05500   RADI 0LOGY-THERAPEUTI C   1, 730, 637   1, 730, 637   0   1, 730, 637	55.00
57. 00   05700   CT SCAN   2, 286, 176   2, 286, 176   0   2, 286, 176	57.00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)   905, 944   905, 944   0   905, 944	58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON 5, 213, 163 5, 213, 163 5, 213, 163	59.00
60. 00   06000   LABORATORY   9, 650, 688   9, 650, 688   0   9, 650, 688	60.00
	64.00
65. 00   06500   RESPI RATORY THERAPY 3, 603, 332 0 3, 603, 332 0 3, 603, 332	65.00
	66.00
	67.00
	68. 00
	69.00
	70.00
	71. 00
	72. 00
	73. 00
	74.00
	76. 00
	76. 06
	76. 97
OUTPATIENT SERVICE COST CENTERS	
	90.00
	90. 01
	90. 02
	90. 03
	90. 04
91. 00 09100 EMERGENCY 13, 511, 713 13, 511, 713 0 13, 511, 713	
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   5, 688, 709   5, 688, 709   5, 688, 709	
200.00   Subtotal (see instructions)   195, 339, 689   0   195, 339, 689   0   195, 339, 689	
201.00 Less Observation Beds 5, 688, 709 5, 688, 709 5, 688, 709	
202. 00 Total (see instructions) 189, 650, 980 0 189, 650, 980 0 189, 650, 980	

Date/Time Prepared: 12/31/2020 8/2/2021 3:42 pm Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 107, 351, 007 03000 ADULTS & PEDIATRICS 107, 351, 007 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 12, 451, 172 12, 451, 172 31.00 04300 NURSERY 3, 803, 616 3, 803, 616 43.00 43.00 ANCILLARY SERVICE COST CENTERS 0.000000 50.00 05000 OPERATING ROOM 59, 293, 364 55, 401, 317 114, 694, 681 0.111264 50.00 51.00 05100 RECOVERY ROOM 14, 002, 999 23, 253, 222 37, 256, 221 0.149433 0.000000 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 17, 588, 748 17, 588, 748 0. 321398 0.000000 52 00 05400 RADI OLOGY-DI AGNOSTI C 32, 619, 326 0.129099 7.034.972 25, 584, 354 0.000000 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 0.080970 0.000000 55.00 7, 329, 313 14, 044, 603 21, 373, 916 55.00 57.00 05700 CT SCAN 17, 852, 352 45, 204, 329 63, 056, 681 0.036256 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 3, 416, 443 9, 254, 218 12, 670, 661 0.071499 0.000000 58.00 46, 222, 811 05900 CARDIAC CATHETERIZATION 30.073.404 76, 296, 215 0.000000 59.00 0.068328 59.00 60.00 06000 LABORATORY 44, 646, 834 28, 609, 531 73, 256, 365 0.131739 0.000000 60.00 06400 I NTRAVENOUS THERAPY 0.000000 0.000000 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 14, 804, 722 1, 377, 136 16, 181, 858 0.222677 0.000000 65.00 5, 328, 946 06600 PHYSI CAL THERAPY 2.878.086 8, 207, 032 0 498935 0.000000 66.00 66,00 67.00 06700 OCCUPATIONAL THERAPY 2, 165, 720 740, 820 2, 906, 540 0.415337 0.000000 67.00 06800 SPEECH PATHOLOGY 598, 680 170, 726 769, 406 0. 415114 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 7, 137, 524 17, 381, 844 24, 519, 368 0.093066 0.000000 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 324, 932 70.00 3, 946, 073 4, 271, 005 0.251569 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 15, 761, 035 14, 159, 972 29, 921, 007 0.644542 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 17, 564, 300 13, 423, 351 30, 987, 651 0.368956 0.000000 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 42, 905, 288 15, 642, 916 58, 548, 204 0 263734 0.000000 73 00 07400 RENAL DIALYSIS 74.00 2, 681, 063 2, 681, 063 0.280610 0.000000 74.00 76.00 03950 ENDOSCOPY 2, 124, 648 6,010,796 8, 135, 444 0.177671 0.000000 76.00 76.06 03330 I MAGING CENTER 141,028 13, 280, 124 13, 421, 152 0.149954 0.000000 76.06 07697 CARDIAC REHABILITATION 3,054 76. 97 1, 185, 575 1, 188, 629 0.340965 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0.000000 90.00 90 01 04950 DIABETIC CARE CENTER 0 O 0.000000 0.000000 90 01 04951 ANTI-COAGULATION CLINIC 90.02 7,525 1, 327, 547 1, 335, 072 0.353656 0.000000 90.02 90.03 04952 PALLIATIVE CARE 0.000000 0.000000 90.03 90.04 04953 SPINE CENTER 333, 915 333, 915 1. 121327 0.000000 90.04 91 00 09100 EMERGENCY 28, 668, 624 96, 847, 196 125, 515, 820 0.000000 91 00 0 107649 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 2, 318, 605 4, 371, 295 6, 689, 900 0.850343 0.000000 200.00 Subtotal (see instructions) 464, 929, 058 443, 102, 617 908, 031, 675 200.00 201.00 Less Observation Beds 201.00

464, 929, 058

908, 031, 675

202.00

443, 102, 617

Total (see instructions)

202.00

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0128	From 01/01/2020	Worksheet C Part I Date/Time Prepared:

				10 12/31/2020	8/2/2021 3: 42	
			Title XIX	Hospi tal	PPS	рш
	Cost Center Description	PPS Inpatient				
	·	Ratio				
		11. 00				
	NPATIENT ROUTINE SERVICE COST CENTERS					
	3000 ADULTS & PEDIATRICS					30.00
	3100 INTENSIVE CARE UNIT					31.00
	4300 NURSERY					43.00
	NCILLARY SERVICE COST CENTERS					
	5000 OPERATING ROOM	0. 111264				50.00
	5100 RECOVERY ROOM	0. 149433				51.00
	5200 DELIVERY ROOM & LABOR ROOM	0. 321398				52.00
	5400 RADI OLOGY-DI AGNOSTI C	0. 129099				54.00
	5500 RADI OLOGY-THERAPEUTI C	0. 080970				55. 00
	5700 CT SCAN	0. 036256				57.00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 071499				58. 00
	5900 CARDI AC CATHETERI ZATI ON	0. 068328				59. 00
60.00 06	6000 LABORATORY	0. 131739				60.00
64.00 06	6400 I NTRAVENOUS THERAPY	0. 000000				64. 00
65. 00 06	6500 RESPI RATORY THERAPY	0. 222677				65.00
66.00 06	6600 PHYSI CAL THERAPY	0. 498935				66.00
67. 00 06	6700 OCCUPATI ONAL THERAPY	0. 415337				67.00
68.00 06	6800 SPEECH PATHOLOGY	0. 415114				68. 00
69.00 06	6900 ELECTROCARDI OLOGY	0. 093066				69. 00
70.00 07	7000 ELECTROENCEPHALOGRAPHY	0. 251569				70.00
71. 00   07	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 644542				71.00
72.00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 368956				72.00
73.00 07	7300 DRUGS CHARGED TO PATIENTS	0. 263734				73.00
74. 00 07	7400 RENAL DIALYSIS	0. 280610				74.00
76. 00   03	3950 ENDOSCOPY	0. 177671				76.00
76. 06 03	3330 I MAGI NG CENTER	0. 149954				76.06
	7697 CARDIAC REHABILITATION	0. 340965				76. 97
	UTPATIENT SERVICE COST CENTERS					
	9000 CLI NI C	0. 000000				90.00
	4950 DIABETIC CARE CENTER	0. 000000				90. 01
	4951 ANTI-COAGULATION CLINIC	0. 353656				90. 02
	4952 PALLI ATI VE CARE	0. 000000				90. 03
90. 04 04	4953 SPI NE CENTER	1. 121327				90. 04
91.00 09	9100 EMERGENCY	0. 107649				91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 850343				92.00
200.00	Subtotal (see instructions)					200.00
201. 00	Less Observation Beds					201. 00
202.00	Total (see instructions)					202. 00

					0 12/31/2020	8/2/2021 3:42	
			Ti tI	e XIX	Hospi tal	PPS	РШ
	Cost Center Description	Total Cost		Operating Cos	Capi tal	Operating Cost	
	·	(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reducti on	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
				col . 2)			
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	_					
50. 00	05000 OPERATING ROOM	12, 761, 392				·	50. 00
51. 00	05100 RECOVERY ROOM	5, 567, 321	391, 318				51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 652, 981	473, 117			0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 211, 108				0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 730, 637	284, 033	1, 446, 604		0	55. 00
57. 00	05700 CT SCAN	2, 286, 176				0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	905, 944				0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	5, 213, 163	939, 292	4, 273, 87	0	0	59. 00
60.00	06000 LABORATORY	9, 650, 688	345, 310	9, 305, 378	3 0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	) (	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	3, 603, 332	177, 561	3, 425, 77	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	4, 094, 774	681, 335	3, 413, 439	9 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 207, 195	67, 568	1, 139, 62	7 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	319, 391	17, 849	301, 542	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 281, 928	265, 350	2, 016, 578	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 074, 451	198, 457	875, 994	1 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19, 285, 349	1, 921, 749	17, 363, 600	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	11, 433, 085	259, 745	11, 173, 340	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	15, 441, 143	888, 967	14, 552, 176	0	0	73. 00
74.00	07400 RENAL DIALYSIS	752, 333	46, 736	705, 59	7 0	0	74. 00
76.00	03950 ENDOSCOPY	1, 445, 430	268, 422	1, 177, 008	0	0	76. 00
76.06	03330 I MAGI NG CENTER	2, 012, 555	417, 966	1, 594, 589	0	0	76. 06
76. 97	07697 CARDIAC REHABILITATION	405, 281	22, 443	382, 838	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	) (	0	0	90.00
90. 01	04950 DIABETIC CARE CENTER	0	0	) (	0	0	90. 01
90. 02	04951 ANTI-COAGULATION CLINIC	472, 156	12, 765	459, 39	0	0	90. 02
90. 03	04952 PALLI ATI VE CARE	0	0	) (	0	0	90. 03
90.04	04953 SPI NE CENTER	374, 428	75, 329	299, 099	9 0	0	90. 04
91.00	09100 EMERGENCY	13, 511, 713	1, 127, 802	12, 383, 91	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 688, 709	453, 731	5, 234, 978	3 0	0	92.00
200.00	Subtotal (sum of lines 50 thru 199)	131, 382, 663	12, 995, 624	118, 387, 039	9 0	0	200. 00
201.00	Less Observation Beds	5, 688, 709	453, 731	5, 234, 978	0		201. 00
202.00	Total (line 200 minus line 201)	125, 693, 954	12, 541, 893	113, 152, 06°	0	0	202. 00

Health Financial Systems	COMMUNITY HOSPITAL SOUTH			In Lieu of Form CMS-2552-10			
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICALD ONLY	TO CHARGE RATIOS NET OF	Provider CCN: 15-0128	From 01/01/2020	Worksheet C Part II Date/Time Prepared: 8/2/2021 3:42 nm			

					0 12/31/2020	8/2/2021 3: 4:	
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	·	Capital and	(Worksheet C,	Cost to Charge	9		
		Operating Cost	Part I, column	Ratio (col. 6			
		Reducti on	8)	/ col. 7)			
		6.00	7. 00	8. 00			
A۱	NCILLARY SERVICE COST CENTERS						
50.00 05	5000 OPERATING ROOM	12, 761, 392	114, 694, 681	0. 111264	Į.		50. 00
51.00 05	5100 RECOVERY ROOM	5, 567, 321	37, 256, 221	0. 149433	3		51.00
52. 00   05	5200 DELIVERY ROOM & LABOR ROOM	5, 652, 981	17, 588, 748	0. 321398	3		52. 00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	4, 211, 108	32, 619, 326	0. 129099			54.00
55. 00 05	5500 RADI OLOGY-THERAPEUTI C	1, 730, 637	21, 373, 916	0. 080970			55. 00
57. 00 05	5700 CT SCAN	2, 286, 176	63, 056, 681	0. 036256	5		57.00
58. 00   05	5800 MAGNETIC RESONANCE IMAGING (MRI)	905, 944	12, 670, 661	0. 071499			58. 00
59. 00 05	5900 CARDI AC CATHETERI ZATI ON	5, 213, 163	76, 296, 215	0. 068328	3		59. 00
	6000 LABORATORY	9, 650, 688					60.00
64.00 06	6400 INTRAVENOUS THERAPY	0	1	0. 000000			64. 00
	6500 RESPI RATORY THERAPY	3, 603, 332	16, 181, 858				65. 00
66. 00 06	6600 PHYSI CAL THERAPY	4, 094, 774		0. 498935	5		66. 00
67. 00 06	6700 OCCUPATIONAL THERAPY	1, 207, 195					67. 00
	6800 SPEECH PATHOLOGY	319, 391	769, 406		ļ		68. 00
	6900 ELECTROCARDI OLOGY	2, 281, 928					69. 00
70.00 07	7000 ELECTROENCEPHALOGRAPHY	1, 074, 451					70. 00
71.00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19, 285, 349					71. 00
72. 00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	11, 433, 085	1		b		72. 00
73. 00 07	7300 DRUGS CHARGED TO PATIENTS	15, 441, 143					73. 00
	7400 RENAL DIALYSIS	752, 333	2, 681, 063	0. 280610			74. 00
76. 00 03	3950 ENDOSCOPY	1, 445, 430					76. 00
	3330 I MAGING CENTER	2, 012, 555					76. 06
	7697 CARDIAC REHABILITATION	405, 281					76. 97
	UTPATIENT SERVICE COST CENTERS		,		1		
	9000 CLI NI C	0	0	0.000000	)		90.00
	4950 DIABETIC CARE CENTER	0	0	0. 000000			90. 01
	4951 ANTI-COAGULATION CLINIC	472, 156	1, 335, 072				90. 02
	4952 PALLIATIVE CARE	0	1	0. 000000			90. 03
	4953 SPINE CENTER	374, 428	333, 915				90. 04
	9100 EMERGENCY	13, 511, 713					91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 688, 709					92. 00
200.00	Subtotal (sum of lines 50 thru 199)	131, 382, 663					200. 00
201.00	Less Observation Beds	5, 688, 709					201. 00
202. 00	Total (line 200 minus line 201)	125, 693, 954	l e				202. 00
			, , ,	'	1		1

Health Financial Systems	COMMUNITY HOS	SPITAL SOUTH		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2020		namad.
				Го 12/31/2020	Date/Time Pre 8/2/2021 3:42	
		Ti tl e	e XVIII	Hospi tal	PPS	рш
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	4, 202, 678	0	4, 202, 67	37, 624	111. 70	30. 00
31.00   INTENSIVE CARE UNIT	1, 107, 269		1, 107, 26	9 2, 987	370. 70	31. 00
43. 00 NURSERY	105, 357		105, 35	7 2, 529	41.66	43.00
200.00 Total (lines 30 through 199)	5, 415, 304		5, 415, 30	43, 140		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	10, 425					30. 00
31.00 INTENSIVE CARE UNIT	1, 040	385, 528	3			31. 00
43. 00 NURSERY	0	0	)			43.00
200.00 Total (lines 30 through 199)	11, 465	1, 550, 001				200. 00

Heal th Financial	Systems	COMMUNITY HOSPI			SOUTH		In Lieu of Form CMS-2552-10		
APPORTI ONMENT OF	INPATIENT ANCILLARY	SERVICE CAPITAL	_ COSTS	F	Provider C	CN: 15-0128	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Pre 8/2/2021 3:42	
					Titl∈	XVIII	Hospi tal	PPS	
Cost	Center Description		Capital Related Cost			Ratio of Cos to Charges		Capital Costs (column 3 x	

					To 12/31/2020		
			Ti tl e	e XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpatient	Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	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	
	ICI LLARY SERVI CE COST CENTERS	T			T		
	OOOO OPERATING ROOM	2, 831, 115				433, 634	50. 00
	5100 RECOVERY ROOM	391, 318				1	
	5200 DELIVERY ROOM & LABOR ROOM	473, 117		•		0	52. 00
	7400 RADI OLOGY-DI AGNOSTI C	652, 545					54. 00
	5500 RADI OLOGY-THERAPEUTI C	284, 033					55. 00
	5700 CT SCAN	94, 621	63, 056, 681	l l		1	57. 00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	80, 498		l l			58. 00
	5900 CARDI AC CATHETERI ZATI ON	939, 292					
	5000 LABORATORY	345, 310				l	60.00
	5400 I NTRAVENOUS THERAPY	0	_	1 0.0000			64. 00
	5500 RESPI RATORY THERAPY	177, 561	16, 181, 858				65. 00
	6600 PHYSI CAL THERAPY	681, 335					66. 00
	5700 OCCUPATI ONAL THERAPY	67, 568	2, 906, 540	0. 02324	7 888, 386	20, 652	67. 00
	800 SPEECH PATHOLOGY	17, 849	769, 406				68. 00
	900 ELECTROCARDI OLOGY	265, 350	24, 519, 368	0. 01082	2, 833, 245	30, 661	69. 00
	7000 ELECTROENCEPHALOGRAPHY	198, 457	4, 271, 005			6, 564	70. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 921, 749	29, 921, 007			274, 489	71. 00
	7200 IMPL. DEV. CHARGED TO PATIENTS	259, 745	30, 987, 651			50, 455	
	7300 DRUGS CHARGED TO PATIENTS	888, 967	58, 548, 204	0. 01518	4 13, 241, 482	201, 059	73. 00
	7400 RENAL DIALYSIS	46, 736	2, 681, 063	0. 01743	2 1, 446, 217	25, 210	74.00
	3950 ENDOSCOPY	268, 422	8, 135, 444				76. 00
	3330 IMAGING CENTER	417, 966	13, 421, 152				76. 06
76. 97 07	7697 CARDIAC REHABILITATION	22, 443	1, 188, 629	0. 01888	1 337	6	76. 97
	ITPATIENT SERVICE COST CENTERS						
	POOO CLINIC	0	C	0.00000		1	90. 00
	1950 DIABETIC CARE CENTER	0	C	0.00000		0	90. 01
	1951 ANTI-COAGULATION CLINIC	12, 765	1, 335, 072			0	90. 02
	1952 PALLI ATI VE CARE	0	C	1 0.0000		0	90. 03
	1953 SPI NE CENTER	75, 329				0	90. 04
	P100 EMERGENCY	1, 127, 802		l l			
	0200 OBSERVATION BEDS (NON-DISTINCT PART)	453, 731	6, 689, 900				1
200. 00	Total (lines 50 through 199)	12, 995, 624	784, 425, 880	)	105, 975, 320	1, 694, 504	200. 00

Health Financial Systems	COMMUNITY HOSP	TAL SOUTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COSTS	S Provi der Co		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part III Date/Time Pre 8/2/2021 3:42	pared:
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School N	lursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdown		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00   04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions) r	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS	0	0	37, 62		10, 425	
31.00   03100   INTENSIVE CARE UNIT		0	2, 98	7 0.00	1, 040	31. 00
43. 00   04300   NURSERY		0	2, 52	9 0.00	0	43.00
200.00 Total (lines 30 through 199)		0	43, 14	0	11, 465	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0					30. 00
31. 00 03100 I NTENSI VE CARE UNI T	0					31. 00
43. 00   04300   NURSERY	0					43. 00
200.00   Total (lines 30 through 199)	0					200. 00

				'	0 12/31/2020	8/2/2021 3: 42	
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	·		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	C	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	C	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	o	0	(	0	0	55. 00
57.00	05700 CT SCAN	o	0	l	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	o	0		0	0	59. 00
60.00	06000 LABORATORY	o	0	1	0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	o	0		0	0	64. 00
65.00	06500 RESPIRATORY THERAPY	o	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	o	0		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	o	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	o	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	o	0		0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	o	0		0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	o	0		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0		0	0	73. 00
74.00	07400 RENAL DIALYSIS	o	0		0	0	74. 00
76. 00	03950 ENDOSCOPY	o	0		0	0	76. 00
76. 06	03330 I MAGI NG CENTER	o	0		0	0	76. 06
76. 97	07697 CARDI AC REHABI LI TATI ON	o	0		0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	,					
90.00	09000 CLI NI C	0	0	C	0	0	90.00
90. 01	04950 DI ABETI C CARE CENTER	0	0		0	0	90. 01
90. 02	04951 ANTI-COAGULATION CLINIC	0	0		0	0	90. 02
	04952 PALLIATIVE CARE	0	0		o	0	90. 03
	04953 SPI NE CENTER	o	0		0	0	90. 04
	09100 EMERGENCY	l o	0	1	o	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	l		1 6		0	92. 00
200.00	,	0	0		0	0	200. 00

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS Provider Co	From 01/01/2020	Worksheet D Part IV Date/Time Prepared:

THROUG	H CUSIS			-	Γο 12/31/2020		
				XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
					7.00	instructions)	
	ANOLLI ADV CEDVI CE COCT CENTEDO	4.00	5. 00	6. 00	7. 00	8. 00	
F0 00	ANCILLARY SERVICE COST CENTERS				111 (01 (01	0.000000	F0 00
50.00	05000 OPERATI NG ROOM	0	0		114, 694, 681		1
51.00	05100 RECOVERY ROOM	0	0		37, 256, 221	0.000000	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		17, 588, 748		
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0		32, 619, 326		1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		21, 373, 916		
57. 00	05700 CT SCAN	0	0		63, 056, 681		l
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		12, 670, 661		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		76, 296, 215		59. 00
60.00	06000 LABORATORY	0	0	1	73, 256, 365		1
64. 00	06400 I NTRAVENOUS THERAPY	0	0	1	0	0.00000	
65.00	06500 RESPI RATORY THERAPY	0	0		16, 181, 858		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	1	8, 207, 032		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	2, 906, 540		
68. 00	06800 SPEECH PATHOLOGY	0	0		769, 406		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		24, 519, 368		
	07000 ELECTROENCEPHALOGRAPHY	0	0	1	4, 271, 005		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	i	29, 921, 007		
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		30, 987, 651		1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	58, 548, 204		
	07400 RENAL DI ALYSI S	0	0	1	2, 681, 063		
76. 00	03950 ENDOSCOPY	0	0		8, 135, 444		1
76. 06	03330 I MAGI NG CENTER	0	0	•	13, 421, 152		1
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(	1, 188, 629	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS			1	al .		
	09000 CLI NI C	0	0		0	0.00000	90. 00
	04950 DIABETIC CARE CENTER	0	0		0	0. 000000	1
	04951 ANTI - COAGULATION CLINIC	0	0		1, 335, 072		1
	04952 PALLI ATI VE CARE	0	0		0	0.00000	l
	04953 SPI NE CENTER	0	0		333, 915		
	09100 EMERGENCY	0	0		125, 515, 820		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		6, 689, 900		l
200.00	Total (lines 50 through 199)	0	0		784, 425, 880		200. 00

Health Financial Systems	COMMUNITY HOS	SPITAL SOUTH		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		S Provider C	CN: 15-0128	Peri od:   From 01/01/2020   Worksheet D   Part IV   To 12/31/2020   Date/Time Prepa   8/2/2021 3:42 p			
	Ti tl e	e XVIII	Hospi tal	PPS			
Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program		

Title XVIII   Hospital   PPS   Dutpatient   Ratio of Cost   Center Description   Ratio of Cost   Program					'	0 12/31/2020	8/2/2021 3: 42	
Rati to of Cost Charges				Title	XVIII	Hospi tal		
The Charges	Cost Center	Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
Costs (col. 8   Costs (col. 8   Costs (col. 8   Costs (col. 12)				Program	Program	Program	Program	
NOTICE   N				Charges	Pass-Through	Charges		
ANCILLARY SERVICE COST CENTERS			(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
ANCILLARY SERVICE COST CENTERS								
50.00			9. 00	10.00	11. 00	12.00	13. 00	
51.00   05100   RECOVERY ROOM & LABOR ROOM   0.000000   3,695,862   0   4,755,861   0   51.00						1		
52.00   05200   DELI VERY ROOM & LABOR ROOM   0 0,000000   0 0 0   0 0 0   52.00   54.00   05400   RADI OLOGY-DI AGNOSTIC   0 0,000000   2,524,948   0 5,528,213   0 55.00   55.00   05500   RADI OLOGY-THERAPEUTIC   0 0,000000   2,524,948   0 6,323,332   0 55.00   57.00   05700   CT SCAN   0 0,000000   6,396,512   0 8,822,153   0 57.00   58.00   05800   MAGNETIC RESONANCE I MAGI NG (MRI )   0 0,000000   6,396,512   0 8,822,153   0 57.00   59.00   05900   CARDI AC CATHETERI ZATI ON   0 0,000000   9,958,823   0 16,398,336   0 59.00   60.00   06000   LABORATORY   0 0,000000   0 0 0 0 0 0 0 0 0 0 0 0								
54.00   05400   RADI OLOGY-DI AGNOSTIC   0.000000   2,524,948   0   5,528,213   0   54.00   55.00   05500   RADI OLOGY-THERAPEUTI C   0.000000   3,066,616   0   6,323,332   0   55.00   55.00   05700   CT SCAN   0.000000   1,228,952   0   8,822,153   0   57.00   58.00   05800   MAGNETI C RESONANCE I IMGI NG (MRI )   0.000000   1,228,952   0   2,145,716   0   58.00   59.00   05900   CARDI AC CATHETERI ZATI ON   0.000000   1,228,952   0   2,145,716   0   58.00   60.00   06000   LABORATORY   0.000000   1,58,74,383   0   4,806,647   0.60.00   64.00   06400   INTRAVENOUS THERAPY   0.000000   0   0   0   0   64.00   65.00   05600   RESPI RATORY THERAPY   0.000000   1,083,209   0   54,984   0   66.00   66.00   06600   PHYSI CAL THERAPY   0.000000   1,083,209   0   54,984   0   66.00   66.00   06600   PHYSI CAL THERAPY   0.000000   888,386   0   12,265   0   67.00   66.00   06600   SEPEC PATHOLOGY   0.000000   28,833,245   0   3,464   0   68.00   69.00   06900   ELECTROCARDI OLOGY   0.000000   141,263   0   596,634   0   70.00   71.00   07000   ELECTROENCEPHALOGRAPHY   0.000000   141,263   0   596,634   0   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.000000   1,223,176   0   4,431,101   0   72.00   71.00   07400   RENAL DI ALYSI S   0.000000   1,446,217   0   0   4,431,101   0   72.00   71.00   07400   RENAL DI ALYSI S   0.000000   1,446,217   0   0   0   0   76.06   76.97   07697   CARDI AC REHABI LI TATI ON   0.000000   0   0   0   0   0   0   76.06   03330   IMMGI NG CENTER   0.000000   0   0   0   0   0   0   76.07   07697   CARDI AC REHABI LI TATI ON   0.000000   0   0   0   0   0   76.07   07697   CARDI AC REHABI LI TATI ON   0.000000   0   0   0   0   0   76.08   0.000000   0   0   0   0   0   0   0				3, 695, 862	[ C	4, 755, 861	0	
55.00         05500 RADIOLOGY-THERAPEUTIC         0.000000         3,066,616         0         6,323,332         0         55.00           57.00         05700 CT SCAN         0.000000         0.000000         6,396,512         0         8,822,153         0         57.00           59.00         05800 MAGNETI C RESONANCE I MAGI NG (MRI)         0.000000         1,228,952         0         2,145,716         0         58.00           59.00         05900 CARDI AC CATHETERI ZATI ON         0.000000         1,228,952         0         2,145,716         0         58.00           60.00         0.6000 LABDRATORY         0.000000         1,5874,383         0         4,806,647         0         60.00           64.00         0.6400 I NTRAVENOUS THERAPY         0.000000         1,587,433         0         4,806,647         0         60.00           65.00         0.6500 RESPI RATORY THERAPY         0.000000         4,512,276         0         275,554         0         65.00           66.00         0.6600 PHYSI CAL THERAPY         0.000000         1,083,209         0         54,984         0         6.00           66.00         0.6500 RESPI RATORY THERAPY         0.000000         232,176         0         12,265         0         67.00				-		O O	0	52. 00
57. 00   05700   CT SCAN   0.000000   6,396,512   0   8,822,153   0   57. 00   58. 00   05800   MAGNETIC RESONANCE I MAGI NG (MRI ) 0.000000   1,228,952   0   2,145,716   0   58. 00   05900   CARDI AC CATHETERI ZATI ON   0.000000   9,958,823   0   16,398,336   0   59. 00   06.00   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.0000000   0.00000000							0	
58.00   05800   MAGNETIC RESONANCE I MAGI NG (MRI )   0.000000   1, 228, 952   0   2, 145, 716   0   58.00   59.00   05900   CARDI AC CATHETERI ZATI ON   0.000000   15, 874, 383   0   16, 398, 336   0   59.00   60.00   06000   LABORATORY   0.000000   15, 874, 383   0   4, 806, 647   0   60.00   64.00   06400   INTRAVENOUS THERAPY   0.000000   0   0   0   0   0   65.00   06500   RESPI RATORY THERAPY   0.000000   4, 512, 276   0   275, 554   0   65.00   66.00   06600   PHYSI CAL THERAPY   0.000000   1, 083, 209   0   54, 984   0   66.00   67.00   06700   0CCUPATI ONAL THERAPY   0.000000   888, 386   0   12, 265   0   67.00   68.00   06800   SPECCH PATHOLOGY   0.000000   232, 176   0   3, 644   0   68.00   69.00   06900   ELECTROCARDI OLOGY   0.000000   2, 833, 245   0   5, 032, 334   0   69.00   70.00   07000   ELECTROCARDI OLOGY   0.000000   141, 263   0   596, 634   0   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.000000   4, 273, 738   0   3, 676, 122   0   71.00   72.00   07200   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.000000   13, 241, 482   0   4, 368, 297   0   73.00   74.00   07400   RENAL DI ALYSI S   0.000000   1446, 217   0   0   4, 431, 101   0   72.00   76.00   03950   ENDOSCOPY   0.000000   1446, 217   0   0   74.00   76.00   03950   ENDOSCOPY   0.000000   0   0   0, 341, 956   0   76.00   76.01   04950   DIABETIC CARE CENTER   0.000000   0   0   0   0   0   76.02   04951   ANTI -COAGULATION CLINIC   0.000000   0   0   0   0   0   90.01   04950   DIABETIC CARE CENTER   0.000000   0   0   0   0   0   90.02   04953   SPINE CENTER   0.000000   0   0   0   0   0   90.03   04962   PALLI ATTI VE CARE   0.000000   0   0   0   0   0   90.04   04953   SPINE CENTER   0.000000   0   0   0   0   0   90.05   09000   0BERGENCY   0.000000   0   0   0   0   0   90.00   09000   09000   09000   09000   0	55. 00   05500   RADI OLOGY-T	HERAPEUTI C	0. 000000	3, 066, 616	C			55. 00
59,00         0.5900         CARDI AC CATHETERIZATION         0.000000         9,958,823         0         16,398,336         0         59.00           60.00         0.6000         LABORATORY         0.000000         15,874,383         0         4,806,647         0         60.00           64.00         0.6400         INTRAVENOUS THERAPY         0.000000         0         0         0         64.00           65.00         0.6500         RESPI RATORY THERAPY         0.000000         4,512,276         0         275,554         0         65.00           66.00         0.6600         PHYSI CAL THERAPY         0.000000         4,512,276         0         275,554         0         65.00           67.00         0.6700         0CCUPATI ONAL THERAPY         0.000000         888,386         0         12,265         0         67.00           68.00         06800         SPECH PATHOLOGY         0.000000         232,176         0         3,644         0         68.00           69.00         0.00000         ELECTROCARDI OLOGY         0.000000         141,263         0         596,634         0         70.00           70.00         0.7000         ELECTROENCEPHALOGRAPHY         0.000000         1,273,738			0. 000000	6, 396, 512	C	8, 822, 153	0	57. 00
60. 00   06000   LABORATORY   0. 000000   15, 874, 383   0   4, 806, 647   0   60. 00   64. 00   64. 00   06400   INTRAVENOUS THERAPY   0. 000000   0   0   0   0   0   64. 00   65. 00   06500   RSPI RATORY THERAPY   0. 000000   4, 512, 276   0   275, 554   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 000000   1, 083, 209   0   54, 984   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0. 000000   232, 176   0   3, 644   0   68. 00   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0. 000000   232, 176   0   3, 644   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0. 000000   232, 176   0   5, 032, 334   0   69. 00   07000   ELECTROENCEPHALOGRAPHY   0. 000000   24, 273, 738   0   5, 032, 334   0   70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 000000   4, 273, 738   0   3, 676, 122   0   71. 00   71. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 000000   4, 273, 738   0   3, 676, 122   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 000000   6, 019, 410   0   4, 431, 101   0   72. 00   72. 00   07200   ENAL DI ALYSI S   0. 000000   6, 019, 410   0   4, 436, 297   0   73. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74.	58.00   05800   MAGNETI C RE	SONANCE IMAGING (MRI)		1, 228, 952	C	2, 145, 716	0	58. 00
64. 00   06400   INTRAVENOUS THERAPY   0. 000000   0   0   0   0   0   64. 00   65. 00   06500   RESPIRATORY THERAPY   0. 000000   4. 512, 276   0   275, 554   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   0. 000000   1, 083, 209   0   54, 984   0   66. 00   67. 00   06700   00CUPATI ONAL THERAPY   0. 000000   888, 386   0   12, 265   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0. 000000   232, 176   0   3, 644   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0. 000000   233, 245   0   5, 032, 334   0   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 000000   141, 263   0   596, 634   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 000000   4, 273, 738   0   3, 676, 122   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 000000   4, 273, 738   0   3, 676, 122   0   71. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 000000   13, 241, 482   0   4, 368, 297   0   73. 00   74. 00   07400   RENAL DI ALYSI S   0. 000000   13, 241, 482   0   4, 368, 297   0   73. 00   76. 00   03950   ENDOSCOPY   0. 000000   13, 241, 482   0   4, 368, 297   0   76. 00   76. 07   07697   CARDI ALC REHABI LI TATI ON   0. 000000   22, 560   0   2, 592, 690   0   76. 00   76. 97   07697   CARDI AC REHABI LI TATI ON   0. 000000   0   0   0   0   0   90. 01   04950   DI ABETI C CARE CENTER   0. 000000   0   0   423, 781   0   90. 02   90. 03   04952   PALLI ATI VE CARE   0. 000000   0   0   0   0   0   90. 04   04950   SPINE CENTER   0. 000000   0   0   0   0   0   90. 04   04953   SPINE CENTER   0. 000000   0   0   0   0   0   90. 02   04951   ANTI-COAGULATION CLINIC   0. 000000   0   0   0   0   0   90. 04   04953   SPINE CENTER   0. 000000   0   0   0   0   0   90. 04   04953   SPINE CENTER   0. 000000   0   0   0   0   0   90. 05   04950   DIABETI C CARE CENTER   0. 000000   0   0   0   0   0   90. 02   04951   ANTI-COAGULATION CLINIC   0. 000000   0   0   0   0   90. 04   04953   SPINE CENTER   0. 000000   0   0   0   0   0   90. 05   04950   04950   04950   04950   0	59. 00   05900   CARDI AC   CAT	HETERI ZATI ON	0. 000000	9, 958, 823	C	16, 398, 336	0	59. 00
65. 00   06500   RESPI RATORY THERAPY   0.000000   4, 512, 276   0   275, 554   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   0.000000   1, 083, 209   0   54, 984   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0.000000   888, 386   0   12, 265   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0.000000   232, 176   0   3, 644   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0.000000   2, 833, 245   0   5, 032, 334   0   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   0.000000   141, 263   0   596, 634   0   70. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0.000000   4, 273, 738   0   3, 676, 122   0   71. 00   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0.000000   4, 273, 738   0   3, 676, 122   0   71. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   6, 019, 410   0   4, 431, 101   0   72. 00   74. 00   07400   RENAL DI ALYSI S   0.000000   14, 44, 217   0   0   0   0   0   76. 00   03950   ENDOSCOPY   0.000000   68, 867   0   1, 341, 956   0   76. 00   76. 06   03330   IMAGI NG CENTER   0.000000   337   0   440, 621   0   76. 97   0UTPATI ENT SERVI CE COST CENTERS   0.000000   0   0   0   0   0   90. 01   04950   DI ABETI C CARE CENTER   0.000000   0   0   423, 781   0   90. 02   90. 02   04951   ANTI -COAGULATION CLI NI C   0.000000   0   0   0   0   0   90. 04   04953   SPI NE CENTER   0.000000   0   0   0   0   0   91. 00   09100   EMERGENCY   0.000000   0   0   0   0   0   0   91. 00   09100   EMERGENCY   0.000000   0   0   0   0   0   0   92. 00   09200   0BERGENCY   0.000000   0   0   0   0   0   0   92. 00   09200   0BERGENCY   0.000000   0   0   0   0   0   0   92. 00   09200   0BERGENCY   0.000000   0   0   0   0   0   0   92. 00   09200   0BERGENCY   0.000000   0   0   0   0   0   0   92. 00   09200   0BERGENCY   0.000000   0   0   0   0   0   0   92. 00   09200   0BERGENCY   0.000000   0   0   0   0   0   0   92. 00   09200   0BERGENCY   0.000000   0   0   0   0   0   0   92. 00   09200   0BERGENCY   0.000000   0   0   0   0   0   0   92. 00	60. 00   06000   LABORATORY		0. 000000	15, 874, 383	C	4, 806, 647	0	60.00
66.00 06600 PHYSICAL THERAPY 0.000000 1,083,209 0 54,984 0 66.00 6700 0CCUPATI ONAL THERAPY 0.000000 888,386 0 12,265 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 232,176 0 3,644 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 2,833,245 0 5,032,334 0 69.00 70.00 7000 ELECTROCARDI OLOGY 0.000000 141,263 0 596,634 0 70.00 71.00 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 1,41,263 0 3,676,122 0 71.00 72.00 1 MPL. DEV. CHARGED TO PATI ENTS 0.000000 4,273,738 0 3,676,122 0 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 6,019,410 0 4,431,101 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 13,241,482 0 4,368,297 0 73.00 74.00 76.06 73.30 I MAGI NG CENTER 0.000000 1,446,217 0 0 0 74.00 76.06 76.30 I MAGI NG CENTER 0.000000 22,560 0 2,592,690 0 76.06 76.97 O7697 CARDI AC REHABI LI TATI ON 0.000000 337 0 440,621 0 76.97 O7697 CARDI AC REHABI LI TATI ON 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	64. 00   06400   I NTRAVENOUS	THERAPY	0. 000000	0	C	0	0	64. 00
67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 888, 386 0 12, 265 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 000000 232, 176 0 3, 644 0 68. 00 690. 00 06900 ELECTROCARDI OLOGY 0. 0000000 2, 833, 245 0 5, 032, 334 0 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0. 0000000 141, 263 0 5, 032, 334 0 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 000000 4, 273, 738 0 3, 676, 122 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 0000000 6, 019, 410 0 4, 431, 101 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 0000000 13, 241, 482 0 4, 368, 297 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 0000000 13, 241, 482 0 4, 368, 297 0 73. 00 07400 RENAL DI ALYSI S 0. 0000000 14, 446, 217 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		THERAPY	0. 000000	4, 512, 276	C	275, 554	0	65. 00
68. 00	66. 00   06600 PHYSI CAL TH	ERAPY	0. 000000	1, 083, 209	C	54, 984	0	66. 00
69. 00	67. 00   06700   OCCUPATI ONA	L THERAPY	0. 000000	888, 386	C	12, 265	0	67. 00
70. 00         07000   CLECTROENCEPHALOGRAPHY         0. 000000   141, 263   0   596, 634   0   70. 00         0         70. 00         0         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00         70. 00 <td< td=""><td>68.00 06800 SPEECH PATH</td><td>OLOGY</td><td>0. 000000</td><td>232, 176</td><td>C</td><td>3, 644</td><td>0</td><td>68. 00</td></td<>	68.00 06800 SPEECH PATH	OLOGY	0. 000000	232, 176	C	3, 644	0	68. 00
71. 00	69. 00 06900 ELECTROCARD	I OLOGY	0. 000000	2, 833, 245	C	5, 032, 334	0	69.00
72. 00         07200 IMPL. DEV. CHARGED TO PATIENTS         0.000000 6,019,410         0 4,431,101         0 72.00           73. 00         07300 DRUGS CHARGED TO PATIENTS         0.000000 13,241,482         0 4,368,297         0 73.00           74. 00         07400 RENAL DI ALYSIS         0.000000 1,446,217         0 0         0 74.00           76. 00 03950 ENDOSCOPY         0.000000 68,867         0 1,341,956         0 76.00           76. 06 03330 IMAGING CENTER         0.000000 22,560         0 2,592,690         0 76.06           76. 97 07697 CARDI AC REHABILITATION         0.000000 337         0 440,621         0 76.97           90. 00 09000 CLINIC         0.000000 0         0 0 0         0 90.00           90. 01 04950 DI ABETI C CARE CENTER         0.000000 0         0 0 0 0         0 90.01           90. 02 04951 ANTI -COAGULATI ON CLINIC         0.000000 0         0 0 0 0         0 90.02           90. 03 04952 PALLI ATI VE CARE         0.000000 0         0 0 0 0         0 0 0         0 90.02           90. 04 04953 SPINE CENTER         0.000000 0         0 0 0 0         0 0 0 0         0 90.03           90. 04 06950 ORDICATED         0.000000 0         0 0 0 0 0 0         0 0 0 0         0 0 0 0           90. 05 000000 0         0 0 0 0 0 0 0 0 0 0 0         0 0 0 0 0 0 0	70. 00 07000 ELECTROENCE	PHALOGRAPHY	0. 000000	141, 263	C	596, 634	0	70.00
73. 00	71.00 07100 MEDICAL SUP	PLIES CHARGED TO PATIENTS	0. 000000	4, 273, 738	C	3, 676, 122	0	71. 00
74. 00	72.00 07200 IMPL. DEV.	CHARGED TO PATIENTS	0. 000000	6, 019, 410	C	4, 431, 101	0	72. 00
76. 00	73.00 07300 DRUGS CHARG	ED TO PATIENTS	0. 000000	13, 241, 482	C	4, 368, 297	0	73. 00
76. 06	74.00 07400 RENAL DIALY	'SI S	0. 000000	1, 446, 217	C	0	0	74.00
76. 97   07697   CARDI AC REHABILITATI ON   0.000000   337   0   440, 621   0   76. 97	76. 00 03950 ENDOSCOPY		0. 000000	68, 867	C	1, 341, 956	0	76. 00
OUTPATIENT SERVICE COST CENTERS   O. 000000	76.06 03330 I MAGING CEN	ITER	0. 000000	22, 560	C	2, 592, 690	0	76. 06
90. 00	76. 97 07697 CARDI AC REH	IABI LI TATI ON	0. 000000	337	C		0	76. 97
90. 01	OUTPATIENT SERVICE	CE COST CENTERS						
90. 02	90. 00 09000 CLI NI C		0. 000000	0	C	0	0	90.00
90. 03	90. 01 04950 DIABETIC CA	RE CENTER	0. 000000	0	l c	0	0	90. 01
90. 04   04953   SPI NE CENTER   0. 000000   0   0   0   90. 04   91. 00   09100   EMERGENCY   0. 000000   9, 859, 772   0   11, 696, 991   0   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0. 000000   1, 038, 855   0   2, 650, 791   0   92. 00   92. 00   0   000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	90. 02   04951 ANTI - COAGUL	ATION CLINIC	0. 000000	0	C	423, 781	0	90. 02
91. 00   09100   EMERGENCY	90. 03 04952 PALLI ATI VE	CARE	0. 000000	0	C	0	0	90. 03
92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0.000000   1,038,855   0   2,650,791   0   92.00	90. 04   04953   SPI NE CENTE	R	0. 000000	0	C	0	0	90. 04
	91. 00 09100 EMERGENCY		0. 000000	9, 859, 772	C	11, 696, 991	0	91.00
200.00   Total (lines 50 through 199)   105, 975, 320   0   95, 932, 841   0   200.00	92. 00 09200 OBSERVATI ON	BEDS (NON-DISTINCT PART)	0. 000000	1, 038, 855	C	2, 650, 791	0	92.00
	200.00 Total (line	s 50 through 199)		105, 975, 320	[ c	95, 932, 841	0	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0128 Peri od: Worksheet D From 01/01/2020 Part V Date/Time Prepared: 12/31/2020 8/2/2021 3:42 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 110703 9, 554, 818 10, 602 1, 057, 747 50.00 51.00 05100 RECOVERY ROOM 0.149433 4, 755, 861 1, 223 0 51.00 710, 683 05200 DELIVERY ROOM & LABOR ROOM 52 00 0.321398 O 52 00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.129099 5, 528, 213 0 713, 687 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.080970 6, 323, 332 0 512,000 55.00 8, 822, 153 57.00 05700 CT SCAN 0.036256 0 0 319, 856 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0.071499 2, 145, 716 153, 417 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.068328 16, 398, 336 1, 120, 466 59.00 60.00 06000 LABORATORY 0. 131739 4, 806, 647 0 0 633, 223 60.00 06400 I NTRAVENOUS THERAPY 0 64 00 0.000000 64 00 0 0 65.00 06500 RESPIRATORY THERAPY 0. 222677 275, 554 61, 360 65.00 06600 PHYSI CAL THERAPY 0.495012 54, 984 0 0 27, 218 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 0.415337 12, 265 0 5,094 67.00 67.00 0 06800 SPEECH PATHOLOGY 68.00 0.415114 3, 644 1, 513 68 00 69.00 06900 ELECTROCARDI OLOGY 0.093066 5, 032, 334 0 0 468, 339 69.00 07000 ELECTROENCEPHALOGRAPHY 596, 634 0 147, 160 70.00 0. 246651 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.644542 3, 676, 122 0 0 2, 369, 415 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72 00 0.368956 4, 431, 101 1, 634, 881 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 263734 4, 368, 297 0 73, 450 1, 152, 068 73.00 07400 RENAL DIALYSIS 74.00 0.280610 0 0 0 74.00 03950 ENDOSCOPY 76.00 0.177671 1.341.956 1,767 0 238, 427 76.00 03330 I MAGING CENTER 76.06 0.149954 2, 592, 690 0 0 388, 784 76.06 07697 CARDIAC REHABILITATION 0.340965 440, 621 0 150, 236 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 90.00 0 0 04950 DIABETIC CARE CENTER 0 90.01 0.000000 0 Λ 90.01 149, 873 04951 ANTI-COAGULATION CLINIC 0.353656 0 0 90.02 423, 781 90.02 0 0 90. 03 04952 PALLIATIVE CARE 0.000000 90.03 90 04 04953 SPINE CENTER 0 0 90 04 1. 121327 Ω 91.00 09100 EMERGENCY 0. 105938 11, 696, 991 0 0 1, 239, 156 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.850343 2, 650, 791 C 0 2, 254, 082 92.00 13, 592 200.00 Subtotal (see instructions) 95, 932, 841 15, 508, 685 200.00 73, 450 Less PBP Clinic Lab. Services-Program 201.00 201.00

95, 932, 841

13, 592

73, 450

15, 508, 685 202. 00

Only Charges

Net Charges (line 200 - line 201)

202.00

Cost   Cost   Cost   Cost   Cost   Rel mbursed   Services   Services   Services   Services   Subject   To   Ded. & Coins   Cost   Cost   Rel mbursed   Services   Subject   To   Ded. & Coins   Cost   Cost						To 12/31/2020	Date/Time Pro 8/2/2021 3:42	epared:
Cost Center Description				Title	: XVIII	Hospi tal		<u> </u>
Rei mbursed   Services   Subject To   Ded & Coins.   Subject To   Ded & Coins.   See inst.)   7.00		·	Cos			<u> </u>		
Services   Subject To   Ded. & Coins.   See inst.   Ded. & Coins.   Subject To   Ded. & Coins.   See inst.   Ded. & See inst.   Ded.		Cost Center Description	Cost	Cost				
Subject To   Ded & Coins   Subject To   Ded & Coins   See inst   Ded & Coins   Ded &			Reimbursed	Reimbursed				
Ded. & Col ns.   (see inst.)			Servi ces					
See Inst.   See								
ANCILLARY SERVICE COST CENTERS								
ANCILLARY SERVICE COST CENTERS   50.00								
50.00	0.01	OLLIADV CEDVI CE COCT CENTERS	6.00	7. 00				
51.00   05100   RECOVERY ROOM & LABOR ROOM   0   0   0   0   0   0   0   0   0			1 174		I			
52.00   05200   05200   05200   05200   05200   05200   05200   054.00   054.00   054.00   054.00   054.00   054.00   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500   05500					1			
54.00   05400   RADI OLOGY-DI AGNOSTIC   0 0 0 0   0 55.00   05500   RADI OLOGY-THERAPEUTIC   0 0 0 0 0   0 55.00   05700   CT SCAN   0 0 0 0 0   0 0 0   0 57.00   CT SCAN   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 0 0 0 0 0 0 0 0			1		•			1
55. 00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0   0   0   0			0	0				
57.00   05700   CT SCAN   0   0   0   0   0   0   58.00   58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0   0   0   0   0   0   0   0   0		l	0	0				
58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0   0   0   59. 00   05900   CARDIAC CATHETERI ZATION   0   0   0   0   0   0   0   0   0			0	0				1
59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0   0   0   0			0	0				1
60.00   06000   LABORATORY   0 0 0   0   0   0   0   0   0   0			0	0				
64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   0   0				0				
65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   0   0   0   0   0				0				
66. 00   06600   PHYSI CAL THERAPY   0   0   0   06700   0CCUPATI ONAL THERAPY   0   0   0   0   068.00   0CCUPATI ONAL THERAPY   0   0   0   0   068.00   06800   SPECH PATHOLOGY   0   0   0   0   068.00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   0   0				0				1
67. 00				0				1
68. 00 06800 SPEECH PATHOLOGY 0 0 0 69.00 69.00 69.00 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0				
69. 00		l		0				1
70.00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   0   0   0   0	1			0				1
71. 00				0				1
72. 00	1	l		0				
73. 00			0	-	1			1
74. 00			0	19. 371				
76. 00			o		1			1
76. 97   O7697   CARDI AC REHABILITATION   O O O   O			314	0				76. 00
OUTPATIENT SERVICE COST CENTERS   90.00   09000   CLINIC   90.00   90.00   90.01   90.01   90.01   90.01   90.01   90.01   90.02   90.02   90.03   90.02   90.03   90.04   90.04   90.04   90.04   90.04   90.04   90.04   90.04   90.04   90.04   90.05   90.04   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   90.05   9	76. 06 03	330 I MAGI NG CENTER	o	0				76. 06
90. 00	76. 97 07	697 CARDI AC REHABI LI TATI ON	0	0				76. 97
90. 01								
90. 02			0	0				90. 00
90. 03   04952   PALLI ATI VE CARE   0 0 0 90. 03   90. 04   91. 00   91. 00   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0 0 0 0   92. 00   00 0 0   00 0 0   00 0 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0   00 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0 0   00 0 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0 0   00 0 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0 0   00 0   00 0 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0   00 0			0	0				1
90. 04   04953   SPI NE CENTER   0 0 0 0 91. 00 92. 00 09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l	0	0				1
91. 00   09100   EMERGENCY   0   0   0   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0			0	0				
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   0   92. 00   200. 00   Subtotal (see instructions)   1,671   19,371   200. 00	1	•	0	0				1
200.00 Subtotal (see instructions) 1,671 19,371 200.00		l	0	0				1
			0	0				
201 00L LL DDD (Limit Lab Compiler Document L			1, 671	19, 371				
	201. 00	Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges	000 00			40.074				000 00
202.00   Net Charges (line 200 - line 201)   1,671   19,371   202.00	202.00	Net charges (Tine 200 - Tine 201)	1,6/1	19, 3/1	I			J202. 00

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH	TAL SOUTH In Lie			2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Peri od:	Worksheet D	
				From 01/01/2020 To 12/31/2020		
					Date/Time Pre 8/2/2021 3:42	
		Ti tl	Title XIX		PPS	рш
Cost Center Description	Capi tal	Swing Bed	Reduced	Hospital 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 & PEDI ATRI CS	4, 202, 678	0	4, 202, 67	8 37, 624	111. 70	30. 00
31.00 INTENSIVE CARE UNIT	1, 107, 269		1, 107, 26	9 2, 987	370. 70	31.00
43. 00 NURSERY	105, 357		105, 35	7 2, 529	41. 66	43.00
200.00 Total (lines 30 through 199)	5, 415, 304		5, 415, 30	43, 140		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	1, 586	177, 156	,			30. 00
31.00   INTENSIVE CARE UNIT	0	0				31.00
43. 00 NURSERY	1, 308	54, 491				43. 00
200.00 Total (lines 30 through 199)	2, 894	231, 647	1			200. 00

Health Financial Systems	COMMUNITY HOS	PI TAI	L SOUTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		F	From 01/01/2020 To 12/31/2020		Worksheet D Part II Date/Time Pre 8/2/2021 3:42		
			Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Tota	al Charges	Ratio of Cos	t Inpatient	Capital Costs	

					From 01/01/2020 Fo 12/31/2020		pared·
						8/2/2021 3: 42	
				e XIX	Hospi tal PI		
	Cost Center Description	Capi tal		Ratio of Cost		Capital Costs	
		Related Cost	(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	
	LARY SERVICE COST CENTERS		,				
	OPERATING ROOM	2, 831, 115		•			
	RECOVERY ROOM	391, 318					
	DELIVERY ROOM & LABOR ROOM	473, 117				6, 678	
	RADI OLOGY-DI AGNOSTI C	652, 545					
	RADI OLOGY-THERAPEUTI C	284, 033					
57.00 05700	CT SCAN	94, 621	63, 056, 681	0. 00150	653, 638	981	57. 00
	MAGNETIC RESONANCE IMAGING (MRI)	80, 498	12, 670, 661	0. 00635		853	
	CARDI AC CATHETERI ZATI ON	939, 292			670, 809		59. 00
	LABORATORY	345, 310	73, 256, 365			8, 801	60.00
64. 00 06400	INTRAVENOUS THERAPY	0	C	0. 00000	0	0	64. 00
	RESPI RATORY THERAPY	177, 561	16, 181, 858	0. 01097	770, 721	8, 457	65. 00
66. 00 06600	PHYSI CAL THERAPY	681, 335	8, 207, 032	0. 08301	100, 710	8, 361	66. 00
67.00 06700	OCCUPATI ONAL THERAPY	67, 568	2, 906, 540	0. 02324	54, 731	1, 272	67. 00
68. 00 06800	SPEECH PATHOLOGY	17, 849	769, 406	0. 02319	23, 856	553	68. 00
69. 00 06900	ELECTROCARDI OLOGY	265, 350	24, 519, 368	0. 01082	218, 940	2, 369	69. 00
70. 00 07000	ELECTROENCEPHALOGRAPHY	198, 457	4, 271, 005	0. 04646	15, 195	706	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 921, 749	29, 921, 007	0. 06422	499, 862	32, 105	71. 00
72. 00 07200	IMPL. DEV. CHARGED TO PATIENTS	259, 745	30, 987, 651	0. 008383	219, 815	1, 842	72. 00
73. 00 07300	DRUGS CHARGED TO PATIENTS	888, 967	58, 548, 204	0. 01518	2, 051, 098	31, 144	73. 00
74. 00 07400	RENAL DIALYSIS	46, 736	2, 681, 063	0. 01743	20, 554	358	74.00
76. 00 03950	ENDOSCOPY	268, 422	8, 135, 444	0. 03299	49, 622	1, 637	76. 00
76. 06 03330	I MAGING CENTER	417, 966	13, 421, 152	0. 03114:	0	0	76. 06
76. 97 07697	CARDI AC REHABI LI TATI ON	22, 443			1 0	0	76. 97
OUTPAT	FIENT SERVICE COST CENTERS				*		
90. 00 09000	CLI NI C	0	C	0.00000	0	0	90.00
90. 01 04950	DIABETIC CARE CENTER	0	l c	0. 00000	0	0	90. 01
90. 02 04951	ANTI-COAGULATION CLINIC	12, 765	1, 335, 072	0.00956	1 0	0	90. 02
90. 03 04952	PALLI ATI VE CARE	0	C	0. 00000	0	0	90. 03
90. 04 04953	SPI NE CENTER	75, 329	333, 915	0. 22559	3 0	0	90. 04
91.00 09100	EMERGENCY	1, 127, 802		0. 00898	959, 016	8, 617	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	453, 731	6, 689, 900	0. 06782	21, 532	1, 460	92. 00
1 1	Total (lines 50 through 199)	12, 995, 624	784, 425, 880	)	10, 289, 608	156, 677	200. 00

Health Financial Systems	COMMUNITY HOSE	PITAL SOUTH		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	ASS THROUGH COST	S Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part III Date/Time Pre 8/2/2021 3:42	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng School I Post-Stepdown Adj ustments	-	Post-Stepdowr Adjustments	Cost	All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	0	1	0	0	
31. 00   03100   INTENSIVE CARE UNIT	0	0	1	0	0	
43. 00 04300 NURSERY	0	Ü		0	0	43.00
200.00 Total (lines 30 through 199)	Cwing Rod	Total Costs	Total Dotions	U U	Inpati ent	200. 00
Cost Center Description	Swing-Bed Adjustment	(sum of cols.	Days	Per Diem (col. 5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	Days	3 - (01. 0)	Frogram bays	
		minus col. 4)				
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>			<u> </u>		
30. 00 03000 ADULTS & PEDIATRICS	0	0	37, 62	4 0.00	1, 586	30. 00
31.00 03100 INTENSIVE CARE UNIT		0	2, 98	7 0.00	0	31.00
43. 00   04300   NURSERY		0	2, 52		1, 308	
200.00 Total (lines 30 through 199)		0	43, 14	0	2, 894	200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x					
	col . 8)					
LAIDATI ENT. DOUTLAG CERVI OF COOT CENTERS	9.00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00   03100   NTENSIVE CARE UNIT						31.00
43. 00   03100  TNTENSIVE CARE UNIT						43.00
200.00 Total (lines 30 through 199)						200. 00

TTIKOOC	66516			Т	o 12/31/2020	Date/Time Prep 8/2/2021 3:42	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(	0	0	50. 00
	05100 RECOVERY ROOM	0	0	) C	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	) C	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	) C	0	0	54. 00
55.00	05500  RADI OLOGY-THERAPEUTI C	0	0	) C	0	0	55. 00
57.00	05700 CT SCAN	0	0	) C	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	) C	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	) C	0	0	59. 00
60.00	06000 LABORATORY	0	0	) C	0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	) c	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	) c	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	) c	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	) c	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	) c	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	) c	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	) c	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	) c	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	) c	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	) c	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	) c	0	0	74.00
76.00	03950 ENDOSCOPY	0	0	) c	0	0	76. 00
76.06	03330 I MAGI NG CENTER	0	0	) c	0	0	76.06
76. 97	07697 CARDIAC REHABILITATION	0	0	) c	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	C	0	0	90.00
90. 01	04950 DIABETIC CARE CENTER	0	0	) c	0	0	90. 01
90. 02	04951 ANTI-COAGULATION CLINIC	0	0	) c	0	0	90. 02
90. 03	04952 PALLI ATI VE CARE	0	0	l c	0	0	90. 03
90. 04	04953 SPI NE CENTER	0	0	l c	0	0	90. 04
91.00	09100 EMERGENCY	0	0	ol c	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		c	)	0	92. 00
200.00	Total (lines 50 through 199)	0	0	ol c	0	0	200. 00

Health Financial Systems	COMMUNITY HOSPIT	AL SOUTH	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0128	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2020	Part IV

THROUGH	1 COSTS				Γο 12/31/2020		
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	1	114, 694, 681	0. 000000	1
	05100 RECOVERY ROOM	0	0	1		0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM	0	0		,,		
	05400 RADI OLOGY-DI AGNOSTI C	0	0		32, 619, 326		1
	05500 RADI OLOGY-THERAPEUTI C	0	0		2.707077.0		
	05700 CT SCAN	0	0		63, 056, 681	0. 000000	l
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(	12, 670, 661	0. 000000	
	05900 CARDI AC CATHETERI ZATI ON	0	0	(	76, 296, 215		
	06000 LABORATORY	0	0	(	73, 256, 365		
	06400 I NTRAVENOUS THERAPY	0	0	(	0	0.000000	1
1	06500 RESPI RATORY THERAPY	0	0		16, 181, 858		ı
1	06600 PHYSI CAL THERAPY	0	0	1	8, 207, 032		1
	06700 OCCUPATI ONAL THERAPY	0	0		2, 906, 540		ı
	06800 SPEECH PATHOLOGY	0	0	(	7077 100		
	06900 ELECTROCARDI OLOGY	0	0	(	2 1/ 0 1 // 000		
	07000 ELECTROENCEPHALOGRAPHY	0	0	(	4, 271, 005		1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	30, 987, 651	0. 000000	1
	07300 DRUGS CHARGED TO PATIENTS	0	0		58, 548, 204		1
	07400 RENAL DIALYSIS	0	0		2, 681, 063		74. 00
	03950 ENDOSCOPY	0	0	1			1
	03330 I MAGI NG CENTER	0	0	1	13, 421, 152		
	07697 CARDIAC REHABILITATION	0	0	(	1, 188, 629	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS			1	T		
	09000 CLI NI C	0	0		0	0.000000	1
	04950 DIABETIC CARE CENTER	0	0	1	0	0. 000000	1
	04951 ANTI-COAGULATION CLINIC	0	0	1	1, 335, 072		90. 02
	04952 PALLIATIVE CARE	0	0		0	0.00000	1
	04953 SPI NE CENTER	0	0		333, 915		
	09100 EMERGENCY	0	0				l
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		-,,		1
200.00	Total (lines 50 through 199)	0	0	(	784, 425, 880		200. 00

Health Financial Systems	COMMUNITY HOSPIT	AL SOUTH		In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0128	Peri od:	Worksheet D

Health Financial Systems COMMUNITY HOSPITAL SOUTH In Lieu of Form CMS-2552-10								
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PA			Provi der C	CN: 15-0128	Peri od:	Worksheet D		
THROUGH COSTS					From 01/01/2020			
					To 12/31/2020			
						8/2/2021 3: 42 pm		
				e XIX	Hospi tal	PPS		
Cos	st Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent		
		Ratio of Cost	Program	Program	Program	Program		
		to Charges	Charges	Pass-Through	n Charges	Pass-Through		
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9		
		7)		x col. 10)		x col. 12)		
		9.00	10.00	11.00	12.00	13. 00		
ANCI LLARY	Y SERVICE COST CENTERS				<u>'</u>			
	ERATING ROOM	0. 000000	766, 023		0 0	0	50.00	
	COVERY ROOM	0. 000000	350, 863		0 0	0	51.00	
	IVERY ROOM & LABOR ROOM	0. 000000	248, 251		0 0	0	52. 00	
	DI OLOGY-DI AGNOSTI C	0. 000000	260, 465		0 0	Ö	1	
1 1	DI OLOGY-THERAPEUTI C	0. 000000	332, 642		0	0	55.00	
					0	1		
57. 00 05700 CT		0. 000000	653, 638	l .	0 0	0	57. 00	
	GNETIC RESONANCE IMAGING (MRI)	0. 000000	134, 211		0	0		
	RDI AC CATHETERI ZATI ON	0. 000000	670, 809		0	0	59. 00	
60. 00   06000   LAB		0. 000000	1, 867, 054		0	0	60. 00	
64. 00   06400   I NT	FRAVENOUS THERAPY	0. 000000	0	0		0	64. 00	
65. 00 06500 RES	SPI RATORY THERAPY	0. 000000	770, 721	О		0	65. 00	
66. 00 06600 PHY	/SI CAL THERAPY	0. 000000	100, 710		0	0	66. 00	
67. 00 06700 0CC	CUPATIONAL THERAPY	0. 000000	54, 731		0 0	0	67. 00	
	EECH PATHOLOGY	0. 000000	23, 856		0	0	1	
	ECTROCARDI OLOGY	0. 000000	218, 940		0	0	69.00	
1 1	ECTROENCEPHALOGRAPHY	0. 000000	15, 195		0 0	0	70.00	
	DICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	499, 862		0 0	Ö		
	PL. DEV. CHARGED TO PATIENTS	0. 000000	219, 815	l .		0	72.00	
	JGS CHARGED TO PATTENTS	0. 000000	2, 051, 098	•	0 0	0	73.00	
				•	0			
	NAL DIALYSIS	0. 000000	20, 554	•	0	0		
76. 00 03950 END		0. 000000	49, 622	1	0	0	76. 00	
1 1	AGING CENTER	0. 000000	0	•	0	0	76. 06	
	RDIAC REHABILITATION	0. 000000	0		0 0	0	76. 97	
	NT SERVICE COST CENTERS							
90. 00 09000 CLI	NI C	0. 000000	0		0 0	0	90.00	
90. 01 04950 DI A	ABETIC CARE CENTER	0. 000000	0		0	0	90. 01	
90. 02 04951 ANT	FI-COAGULATION CLINIC	0. 000000	0		0 0	0	90. 02	
90. 03 04952 PAL	LIATIVE CARE	0. 000000	0		0 0	0	90. 03	
1 1	NE CENTER	0. 000000	0		0 0	0	1	
91. 00 09100 EME		0. 000000	959, 016		0 0	Ö	1	
	SERVATION BEDS (NON-DISTINCT PART)	0. 000000	21, 532	•	0 0	Ö		
	tal (lines 50 through 199)	0.000000	10, 289, 608	l .	0 0		200.00	
200. 00    10tal (111les 30 till dugli 177)   10, 267, 000  0  0  0  0 200. 0						1200.00		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0128 Peri od: Worksheet D From 01/01/2020 Part V Date/Time Prepared: 12/31/2020 8/2/2021 3:42 pm Title XIX Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 111264 973, 189 0 50.00 51.00 05100 RECOVERY ROOM 0.149433 358, 819 51.00 05200 DELIVERY ROOM & LABOR ROOM 0. 321398 52 00 0 52 00 C 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.129099 0 796, 937 0 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.080970 234, 781 0 55.00 57.00 05700 CT SCAN 0.036256 0 1.803.940 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0.071499 215, 898 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.068328 536, 498 0 59.00 06000 LABORATORY 60.00 0. 131739 1, 214, 809 0 60.00 06400 I NTRAVENOUS THERAPY 0.000000 64 00 0 64 00 65.00 06500 RESPIRATORY THERAPY 0. 222677 48, 201 0 65.00 06600 PHYSI CAL THERAPY 0.498935 73, 532 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.415337 9, 952 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 1, 461 0.415114 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.093066 0 221, 423 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 251569 44, 770 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 360, 447 0 71.00 0.644542 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72 00 0.368956 96, 658 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 263734 267, 651 0 73.00 07400 RENAL DIALYSIS 0 74.00 0.280610 С 0 74.00 03950 ENDOSCOPY 40, 979 76.00 0.177671 0 0 76.00 03330 I MAGING CENTER Ω 76.06 0.149954 124, 458 Ω 76.06 76. 97 07697 CARDIAC REHABILITATION 0.340965 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 90.00 0.000000 0 0 0 0 0 0 0 0 0 04950 DIABETIC CARE CENTER 90.01 0.000000 0 0 0 90.01 04951 ANTI-COAGULATION CLINIC 0. 353656 90.02 90.02 12, 270 90. 03 04952 PALLIATIVE CARE 0.000000 0 0 90.03 90 04 04953 SPINE CENTER 1. 121327 90.04 0 Λ 91.00 09100 EMERGENCY 0. 107649 0 6, 067, 861 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0.850343 0 0

0

13, 504, 534

13, 504, 534

0 200, 00

0 202.00

201. 00

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

| Period: | Worksheet D | From 01/01/2020 | Part V | To | 12/31/2020 | Date/Time Prepared:

					To 12/31/2020	Date/Time Prep 8/2/2021 3:42	
			Titl	e XIX	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				
	ANCILLARY SERVICE COST CENTERS	100 001		ı			
	05000 OPERATI NG ROOM	108, 281	0				50. 00
51.00	05100 RECOVERY ROOM	53, 619	0				51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	102, 884	0				54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	19, 010	0				55. 00
57. 00	05700 CT SCAN	65, 404	0	1			57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	15, 436	0				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	36, 658	0				59. 00
60. 00	06000 LABORATORY	160, 038	0	ı			60. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0				64. 00
65. 00	06500 RESPI RATORY THERAPY	10, 733	0				65. 00
66. 00	06600 PHYSI CAL THERAPY	36, 688	0	l .			66. 00
67. 00	06700 OCCUPATIONAL THERAPY	4, 133	0				67. 00
68. 00	06800 SPEECH PATHOLOGY	606	0	i .			68. 00
69. 00	06900 ELECTROCARDI OLOGY	20, 607	0	1			69. 00
	07000 ELECTROENCEPHALOGRAPHY	11, 263	0				70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	232, 323	0	i .			71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	35, 663	0				72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	70, 589	0	i .			73. 00
	07400 RENAL DI ALYSI S	0	0	1			74. 00
	03950 ENDOSCOPY	7, 281	0				76. 00
76. 06	03330 I MAGI NG CENTER	18, 663	0	•			76. 06
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0				76. 97
	OUTPATIENT SERVICE COST CENTERS	1		ı			
90.00	09000 CLINIC	0	0	1			90.00
	04950 DI ABETI C CARE CENTER	0	0				90. 01
90. 02	04951 ANTI -COAGULATION CLINIC	4, 339	0				90. 02
	04952 PALLI ATI VE CARE	0	0				90. 03
	04953 SPI NE CENTER	(50.400	0				90. 04
91.00	09100 EMERGENCY	653, 199	0				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92. 00
200.00		1, 667, 417	0				200. 00
201. 00		0					201. 00
202.00	Only Charges (Line 200 Line 201)	1 //7 /17	_				202.00
202. 00	Net Charges (line 200 - line 201)	1, 667, 417	0	I		ļ	202. 00

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0128	Peri od:	Worksheet D-1
		From 01/01/2020	
			Date/Time Prepared:
			8/2/2021 3: 42 pm
	Title XVIII	Hosni tal	PPS

		Title XVIII	Hospi tal	8/2/2021 3: 42 PPS	pm
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS			07.404	
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-be			37, 624 37, 624	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed day	vate room days.	37, 624	3.00	
	do not complete this line.	, , ,			
4.00	Semi-private room days (excluding swing-bed and observation be			33, 562	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roomsting period	om days) through December	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through Docombor	21 of the cost	0	7. 00
7.00	reporting period	3 .		O	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	the Program (excluding	swing-bed and	10, 425	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or	tions)	,	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er		Join days) arter	U	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	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	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
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
10.00	reporting period	<u> </u>		0.00	18. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	0.00	18.00		
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0. 00	19. 00
20. 00	Medical d rate for swing-bed NF services applicable to services reporting period	s after December 31 of the	ne cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		52, 691, 375	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ng 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 reporting	n period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ 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 (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)		52, 691, 375	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)		a. goo)	0	29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27	+ line 28)		0.000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	52, 691, 375	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
20 00	Adjusted general inpatient routine service cost per diem (see			1 400 47	20 00
38. 00 39. 00	Program general inpatient routine service cost per drem (see	•		1, 400. 47 14, 599, 900	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Progra	•		14, 599, 900	40.00
	Total Program general inpatient routine service cost (line 39	,		14, 599, 900	
		•	'		•

Heal th	n Financial Systems COMMUNITY HOSPITAL SOUTH In	Lieu of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST Provider CCN: 15-0128 Period: From 01/01/2	Worksheet D-1	
	To 12/31/2	020 Date/Time Pre	
	Title XVIII Hospital	8/2/2021 3: 42 PPS	рш
	Cost Center Description Total Total Average Per Program Da		
	Inpatient Cost   Inpatient Days   Diem (col. 1 ÷   col. 2)	(col. 3 x col. 4)	
10.00	1.00 2.00 3.00 4.00	5. 00	40.00
42.00	NURSERY (title V & XIX only) 0 0 0.00 Intensive Care Type Inpatient Hospital Units	0 0	42. 00
43. 00	INTENSIVE CARE UNIT         7,905,721         2,987         2,646.71         1,	040 2, 752, 578	43. 00
44. 00 45. 00			44. 00 45. 00
46. 00			46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description		47. 00
	COST Centre Description	1. 00	
48.00		19, 284, 903	48. 00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)  PASS THROUGH COST ADJUSTMENTS	36, 637, 381	49. 00
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I	and 1, 550, 001	50. 00
51. 00		1, 694, 504	51. 00
	and IV)		
52. 00 53. 00	Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	3, 244, 505 33, 392, 876	•
00.00	medical education costs (line 49 minus line 52)	00, 072, 070	00.00
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges	0	54. 00
55.00	Target amount per discharge	0.00	55. 00
56. 00 57. 00		0	56. 00 57. 00
58. 00		ő	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by market basket	the 0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60. 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 which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target	y 0	61. 00
	amount (line 56), otherwise enter zero (see instructions)		
62. 00 63. 00		0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	0	03.00
64. 00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (Solinstructions) (title XVIII only)	ee 0	64. 00
65. 00		0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For	0	66. 00
66.00	CAH (see instructions)		00.00
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	od 0	67. 00
68. 00		0	68. 00
69 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		09.00
70. 00 71. 00			70. 00 71. 00
72. 00			72.00
73. 00 74. 00			73. 00 74. 00
75. 00		nn	75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77. 00			77. 00
78. 00 79. 00			78. 00 79. 00
80.00			80.00
81.00			81.00
82. 00 83. 00			82. 00 83. 00
84.00	Program inpatient ancillary services (see instructions)		84. 00
85. 00 86. 00			85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	1.010	
87. 00 88. 00		4, 062 1, 400. 47	87. 00 88. 00
89. 00	Observation bed cost (line 87 x line 88) (see instructions)	5, 688, 709	

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 8/2/2021 3:42	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	4, 202, 678	52, 691, 375	0. 07976	0 5, 688, 709	453, 731	90.00
91.00 Nursing School cost	0	52, 691, 375	0.00000	5, 688, 709	0	91.00
92.00 Allied health cost	0	52, 691, 375	0.00000	5, 688, 709	0	92.00
93 00 All other Medical Education	0	52 691 375	0 00000	5 688 709	0	93 00

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0128	Peri od: From 01/01/2020	Worksheet D-1
		To 12/31/2020	Date/Time Prepared: 8/2/2021 3:42 pm
	Title XIX	Hosni tal	PPS

		Title XIX	Hospi tal	8/2/2021 3: 42 PPS	pm
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1 00	I NPATI ENT DAYS			27 /24	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			37, 624 37, 624	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed day	vate room days,	0	3. 00	
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		- 21 -6	33, 562	4.00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through December	31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	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 reporting period	m days) through December	31 of the cost	0	7. 00
8. 00	Teporting period  Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days, arts. becomber e		· ·	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	1, 586	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (i neludi na privato re	nom dave)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		Join days)	O	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			0	10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	confy (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	14. 00 15. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			2, 529 1, 308	
10.00	SWING BED ADJUSTMENT			1, 000	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	f the cost	0.00	17. 00
18. 00	reporting period	on often December 21 of	the cost	0.00	18. 00
16.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es arter becember 31 or	the cost	0.00	16.00
19. 00	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	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	-)		54, 797, 784	21. 00
21.00	Swing-bed cost applicable to SNF type services through December		na period (line	0 34, 797, 764	22.00
22.00	5 x line 17)	s. G. G. the Goot report.	ing pointed (intro	· ·	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	c 31 of the cost reporting	na period (line	0	24. 00
24.00	7 x line 19)	31 of the cost reportin	ig perrod (Trile	O	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		54, 797, 784	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	. 11116 20)		0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line		ĺ	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dit	fferential (line	54, 797, 784	37. 00
57.00	27 minus line 36)	p		31, 777, 704	37.30
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)	$\neg$	1, 456. 46	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		2, 309, 946	39. 00
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)	l	2, 309, 946	41.00

00	Financial Systems	COMMUNITY HOSE		ON 45 0455		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0128	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Pre 8/2/2021 3:42	pared:
			_	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	1, 253, 521	2, 529	495.	66 1, 308	648, 323	42.00
43. 00	INTENSIVE CARE UNIT	7, 905, 721	2, 987	2, 646.	71 0	0	43.00
44. 00	CORONARY CARE UNIT	1,100,101	_,	_, _,			44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
						1. 00	
48.00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ine)		1, 962, 165 4, 920, 434	
47.00	PASS THROUGH COST ADJUSTMENTS	+1 till odgir +0) (s	see matruetre	113)		4, 720, 434	77.00
50.00	Pass through costs applicable to Program inp	patient routine s	services (from	Wkst. D, su	m of Parts I and	231, 647	50. 00
51. 00	<pre>                                    </pre>	oatient ancillary	services (fr	om Wkst. D,	sum of Parts II	156, 677	51.00
F0 00	and IV)	·	-				
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu	,	ated non-phy	sician anest	hatist and	388, 324 4, 532, 110	
33. 00	medical education costs (line 49 minus line		atea, non pny	31 Clair ancst	netrat, and	4, 332, 110	] 33.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge					0 0. 00	
56. 00	Target amount (line 54 x line 55)					0.00	1
57.00	Difference between adjusted inpatient operat	ting cost and tar	get amount (I	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	eporting period (	enaing 1996, t	ipdated and c	ompounded by the	0. 00	59. 00
60.00	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					0	61.00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
62. 00	Relief payment (see instructions)	,				0	
63. 00	00 Allowable Inpatient cost plus incentive payment (see instructions)						
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine cos	sts through Decer	nber 31 of the	cost report	ing period (See	0	64. 00
	instructions)(title XVIII only)					_	
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts after Decembe	er 31 of the c	ost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line d	4 plus line 6	5)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	o costs through	Docombor 21 o	of the cost r	operting period	0	67. 00
67.00	(line 12 x line 19)	ie costs till ough	December 31 c	i the cost i	eportring perrou	0	07.00
68. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after De	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (	ine 67 + line	: 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N	IURSING FACILITY,	AND ICF/IID	ONLY			1
70.00	Skilled nursing facility/other nursing facil	-		•	)		70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne 70 ÷ 11ne	2)			71. 00
73. 00	Medically necessary private room cost applic		(line 14 x li	ne 35)			73. 00
74. 00	Total Program general inpatient routine serv				D		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	COSTS (Trom W	югкsneet в,	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						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 Aggregate charges to beneficiaries for exces	,	ovi den irecord	ls)			78. 00 79. 00
80.00	Total Program routine service costs for comp				nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (						82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		-,				84. 00
85.00	Utilization review - physician compensation	(see instruction					85.00
86. 00	Total Program inpatient operating costs (sun PART IV - COMPUTATION OF OBSERVATION BED PAS		ough 85)				86. 00
87. 00	Total observation bed days (see instructions					4, 062	87. 00
			line 2)			1, 456. 46	1
88. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	11110 2)			5, 916, 141	

Health Financial Systems	COMMUNITY HOS	PITAL SOUTH		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST				Peri od: From 01/01/2020	Worksheet D-1	
				To 12/31/2020	Date/Time Pre 8/2/2021 3:42	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST			·		
90.00 Capital -related cost	4, 202, 678	54, 797, 784	0. 07669	4 5, 916, 141	453, 733	90.00
91.00 Nursing School cost	0	54, 797, 784	0.00000	5, 916, 141	0	91.00
92.00 Allied health cost	0	54, 797, 784	0.00000	0 5, 916, 141	0	92.00
93.00 All other Medical Education	0	54, 797, 784	0.00000	5, 916, 141	0	93.00

Health Financial Systems	COMMUNITY HOSPITAL SOUTH		In Li€	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0128	Peri od:	Worksheet D-3	
			From 01/01/2020 To 12/31/2020		
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS			22, 786, 645		30.00
31. 00   03100   NTENSI VE CARE UNI T			4, 072, 557		31.00
43. 00   04300 NURSERY			4,072,337		43.00
ANCILLARY SERVICE COST CENTERS		l			1 43.00
50. 00 05000 OPERATI NG ROOM		0. 11070	17, 567, 431	1, 944, 767	50.00
51. 00   05100 RECOVERY ROOM		0. 14943			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 32139		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 12909	2, 524, 948	325, 968	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 08097			55. 00
57. 00 05700 CT SCAN		0. 03625	6, 396, 512	231, 912	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 07149	1, 228, 952	87, 869	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0. 06832	9, 958, 823		
60. 00   06000   LABORATORY		0. 13173		2, 091, 275	60.00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000	00	0	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 22267			65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 49501			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 41533			67. 00
68. 00   06800   SPEECH PATHOLOGY		0. 41511			
69. 00   06900   ELECTROCARDI OLOGY		0. 09306			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 24665	141, 263	34, 843	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 64454			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 36895			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 26373			73. 00
74.00   07400   RENAL DIALYSIS		0. 28061		405, 823	
76. 00   03950   ENDOSCOPY		0. 17767			
76.06 03330 I MAGI NG CENTER		0. 14995			76. 06
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 34096	5 337	115	76. 97
OUTPATIENT SERVICE COST CENTERS					

0.000000

0.000000

0. 353656

0.000000

1. 121327

0. 105938

0.850343

0

9, 859, 772 1, 038, 855

105, 975, 320

105, 975, 320

90.00

90. 01

0 90.02

90. 03

90.04

91.00

92.00

201. 00 202. 00

0

1, 044, 525

883, 383

19, 284, 903 200. 00

90. 00 09000 CLI NI C

90. 04 04953 SPINE CENTER

91. 00 09100 EMERGENCY

200.00

201.00

202.00

90. 01 04950 DI ABETI C CARE CENTER 90. 02 04951 ANTI - COAGULATION CLINIC 90. 03 04952 PALLIATIVE CARE

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)

Health Financial Systems	COMMUNITY HOSPITAL	SOUTH		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Pr	rovider CC		Peri od: From 01/01/2020	Worksheet D-3	
				To 12/31/2020	Date/Time Prep 8/2/2021 3:42	
		Title	e XIX	Hospi tal	PPS	
Cost Center Description			Ratio of Cos To Charges		Inpatient Program Costs	
				Charges	(col. 1 x col.	

				8/2/2021 3: 42	pm
	Title	XIX	Hospi tal	PPS	
Cost Center Description	Ra	atio of Cost	Inpatient	I npati ent	
•		To Charges	Program	Program Costs	
		J	Charges	(col. 1 x col.	
			3	2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				2. 00	
30. 00 03000 ADULTS & PEDI ATRI CS			5, 910, 273		30.00
31. 00   03100   INTENSIVE CARE UNIT			839, 855		31.00
43. 00   04300   NURSERY			308, 842		43.00
ANCI LLARY SERVI CE COST CENTERS		I.			
50. 00 05000 OPERATI NG ROOM		0. 111264	766, 023	85, 231	50.00
51. 00   05100   RECOVERY ROOM		0. 149433	350, 863	52, 431	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0. 321398	248, 251	79, 787	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 129099	260, 465	33, 626	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C		0. 080970	332, 642	26, 934	55. 00
57. 00   05700 CT SCAN		0. 036256	653, 638	· ·	
58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)		0. 071499	134, 211	9, 596	58.00
59. 00   05900   CARDI AC CATHETERI ZATI ON		0. 068328	670, 809	45, 835	
60. 00   06000   LABORATORY		0. 131739	1, 867, 054	245, 964	
64. 00   06400   INTRAVENOUS THERAPY		0. 000000	1,007,034	243, 704	64.00
65. 00 06500 RESPIRATORY THERAPY		0. 222677	770, 721	171, 622	65.00
66. 00   06600   PHYSI CAL THERAPY		0. 498935	100, 710	50, 248	
67. 00   06700   OCCUPATI ONAL THERAPY		0. 415337	54, 731	22, 732	
68. 00   06800   SPEECH PATHOLOGY		0. 415114	23, 856	9, 903	
69. 00   06900   ELECT PATHOLOGY		0. 093066	218, 940	20, 376	69.00
70. 00   07000   ELECTROENCEPHALOGRAPHY		0. 251569	15, 195	3, 823	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 644542	499, 862	322, 182	71.00
72. 00 07100 MPL. DEV. CHARGED TO PATIENTS		0. 368956	219, 815	81, 102	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 263734	2, 051, 098	540, 944	73.00
					74.00
74. 00   07400   RENAL DI ALYSI S 76. 00   03950   ENDOSCOPY		0. 280610	20, 554	5, 768	
		0. 177671	49, 622	8, 816	76. 00
76. 06   03330   I MAGI NG CENTER		0. 149954	0	0	76.06
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 340965	U	0	76. 97
90. 00 09000 CLI NI C		0. 000000	0	0	90.00
90. 01   04950   DI ABETI C CARE CENTER			0	0	90.00
		0.000000	0		
90. 02   04951   ANTI - COAGULATI ON CLI NI C 90. 03   04952   PALLI ATI VE CARE		0. 353656	0	0	90. 02
		0.000000	0	0	90. 03
90. 04   04953   SPI NE CENTER		1. 121327	050.017	102 227	90.04
91. 00   09100   EMERGENCY		0. 107649	959, 016	103, 237	91.00
92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)		0. 850343	21, 532	18, 310	
Total (sum of lines 50 through 94 and 96 through 98)	(1)		10, 289, 608	1, 962, 165	
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)			10, 289, 608		202. 00

| In Lieu of Form CMS-2552-10 | Worksheet E | Part A | B1/2020 | Date/Time Prepared: 8/2/2021 3: 42 pm | DDS Peri od: From 01/01/2020 To 12/31/2020 Provider CCN: 15-0128

-	Title XVIII	Hospi tal	PPS	рш
		Before GEO	On/After GEO	
		Recl ass	Recl ass	
	PART A LABOR FOR LOOP TAY OF THE PART AND TH	1. 00	1. 01	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	0	0	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1	18, 099, 437	0	1. 00 1. 01
1.01	(see instructions)	10, 077, 437	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	0	7, 129, 987	1. 02
	(see instructions)			
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring	0	0	1. 03
1 04	prior to October 1 (see instructions)	0	0	1 04
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	U	0	1. 04
2.00	Outlier payments for discharges. (see instructions)			2. 00
2. 01	Outlier reconciliation amount	0	0	2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	356, 286	0	2. 03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	69, 297	2. 04
3.00	Managed Care Simulated Payments	11, 848, 718	5, 935, 005	3. 00
4.00	Bed days available divided by number of days in the cost reporting period (see	157. 31		4. 00
	instructions)			
F 00	Indirect Medical Education Adjustment	0.00		F 00
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)	0. 00		5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on	0.00		6. 00
0.00	to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00		0.00
7. 00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR	0.00		7. 00
7.00	\$412.105(f)(1)(iv)(B)(1)	0.00		7.00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR	0.00		7. 01
	§412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see			
	instructions.			
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic	6. 95		8. 00
	programs for affiliated programs in accordance with 42 CFR 413.75(b),			
	413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the	0. 00		8. 01
0.00	ACA. If the cost report straddles July 1, 2011, see instructions.	0.00		0.00
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00		8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02)	6. 95		9. 00
7. 00	(see instructions)	0. 75		7.00
10. 00	FTE count for allopathic and osteopathic programs in the current year from your	8. 25		10.00
	records			
11. 00	FTE count for residents in dental and podiatric programs.	1. 44		11. 00
12.00	Current year allowable FTE (see instructions)	8. 39		12. 00
13.00	Total allowable FTE count for the prior year.	7. 57		13. 00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after	7. 54		14. 00
	September 30, 1997, otherwise enter zero.			
15. 00	Sum of lines 12 through 14 divided by 3.	7. 83		15. 00
16.00	Adjustment for residents in initial years of the program	0.00		16.00
17. 00	Adjustment for residents displaced by program or hospital closure	0.00		17.00
18.00	Adjusted rolling average FTE count	7. 83		18.00
19.00	, , , , , , , , , , , , , , , , , , , ,	0.049774		19.00
	Prior year resident to bed ratio (see instructions)	0.049464		20.00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)	0.049464	100.044	21.00
22. 00 22. 01	IME payment adjustment (see instructions)	482, 477	190, 064	22. 00
22.01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	315, 851	158, 209	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42	0.00		23. 00
23.00	CFR 412.105 (f)(1)(iv)(C).	0.00		25.00
24. 00	IME FTE Resident Count Over Cap (see instructions)	1. 30		24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line	0.00		25. 00
	24 (see instructions)			
26.00	Resident to bed ratio (divide line 25 by line 4)	0. 000000		26. 00
27.00	IME payments adjustment factor. (see instructions)	0. 000000		27. 00
28. 00	IME add-on adjustment amount (see instructions)	0	0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	0	0	28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)	482, 477	190, 064	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	315, 851	158, 209	29. 01
20.00	Disproporti onate Share Adjustment			20.00
30. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (see	2. 64		30. 00
21 00	Instructions)	22 40		21 00
31. 00 32. 00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31	23. 49 26. 13		31. 00 32. 00
32.00	Allowable disproportionate share percentage (see instructions)	26. 13 10. 77	10. 77	32.00
	Disproportionate share adjustment (see instructions)	487, 327	191, 975	
57.00	per oper transite share and astillant (see this tractions)	407, 327	171, 7/3	J - J - J - U - U - U - U - U - U - U -

CALCUL	Financial Systems COMMUNITY HOSE ATION OF REIMBURSEMENT SETTLEMENT			eu of Form CMS-2	2552-1
	ATTON OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0128	Peri od: From 01/01/2020 To 12/31/2020		pared
		Title XVIII	Hospi tal	PPS	рш
				On/After 10/1	
			1. 00	2. 00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)			8, 290, 014, 521 0, 000397191	35.0
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, en	ter zero on this line) (se	0. 000168507 e 1, 407, 133		35. C
55. 02	instructions)	ter zero on tins rine) (se	1, 407, 133	3, 272, 111	35.0
5. 03	Pro rata share of the hospital uncompensated care payment a	mount (see instructions)	1, 053, 428	829, 946	35.0
86. 00	Total uncompensated care (sum of columns 1 and 2 on line 35		1, 883, 374		36.0
	Additional payment for high percentage of ESRD beneficiary			I	
10. 00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, instructions)	684 and 685. (see	0		40. 0
	instructions)		Before GEO	On/After GEO	
			Recl ass	Recl ass	
			1. 00	1. 01	
1.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (see	0	0	41. (
1. 01	instructions) Total ESRD Medicare covered and paid discharges excluding M.	S-DRGs 652 682 683 684	0	0	41. (
	an 685. (see instructions)	5 bittes 652, 662, 665, 664			71.0
2.00	Divide line 41 by line 40 (if less than 10%, you do not qual	lify for adjustment)	0.00		42. (
3. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,	682, 683, 684 an 685. (see	0		43. (
14 00	instructions)	d by lips 41 divided by 7	0.000000		111
14. 00	Ratio of average length of stay to one week (line 43 divided days)	d by Title 41 divided by 7	0. 000000		44. (
15. 00	Average weekly cost for dialysis treatments (see instruction	ns)	0.00	0.00	45. (
6. 00	Total additional payment (line 45 times line 44 times line		0		46. (
17. 00	Subtotal (see instructions)		20, 835, 485		47. (
18. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0	0	48. (
	only. (see instructions)			Amount	
				1. 00	
19. 00	Total payment for inpatient operating costs (see instruction			29, 364, 284	
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I			2, 057, 469	50.0
1.00	Exception payment for inpatient program capital (Wkst. L, P	t. III. see instructions)		0	51. (
:2 NN	Direct graduate modical education payment (from Wkst E 4			245 206	F2 (
	Direct graduate medical education payment (from Wkst. E-4, Nursing and Allied Health Managed Care payment			245, 386	
3. 00	Nursing and Allied Health Managed Care payment			0	53. (
3. 00 4. 00					52. 0 53. 0 54. 0 54. 0
53. 00 54. 00 54. 01 55. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	line 49 see instructions). 69)		0 82, 602 0 0	53. ( 54. ( 54. ( 55. (
3. 00 4. 00 4. 01 5. 00 6. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in	line 49 see instructions).  69) tructions)	annuch 25)	0 82, 602 0 0	53. ( 54. ( 54. ( 55. ( 56. (
53. 00 54. 00 54. 01 55. 00 56. 00 57. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt.	line 49 see instructions).  69) tructions) III, column 9, lines 30 tl	nrough 35).	0 82, 602 0 0 0	53. ( 54. ( 54. ( 55. ( 56. ( 57. (
3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 8. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt.	line 49 see instructions).  69) tructions) III, column 9, lines 30 tl	nrough 35).	0 82,602 0 0 0 0	53. ( 54. ( 54. ( 55. ( 56. ( 57. ( 58. (
53. 00 54. 00 54. 01 55. 00 56. 00 57. 00 58. 00 59. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt.	line 49 see instructions).  69) tructions) III, column 9, lines 30 tl	nrough 35).	0 82, 602 0 0 0	53. ( 54. ( 54. ( 55. ( 56. ( 57. ( 58. ( 59. (
33. 00 44. 00 44. 01 55. 00 66. 00 67. 00 68. 00 69. 00 60. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt Total (sum of amounts on lines 49 through 58) Primary payer payments	69) tructions) III, column 9, lines 30 tl	nrough 35).	0 82, 602 0 0 0 0 0 31, 749, 741	53. ( 54. ( 55. ( 56. ( 57. ( 58. ( 59. (
33. 00 34. 00 34. 01 35. 00 36. 00 37. 00 38. 00 39. 00 30. 00 31. 00 32. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries	69) tructions) III, column 9, lines 30 tl	nrough 35).	0 82, 602 0 0 0 0 0 31, 749, 741 17, 383 31, 732, 358 2, 477, 112	53. ( 54. ( 55. ( 56. ( 57. ( 58. ( 60. ( 61. ( 62. (
53. 00 54. 00 54. 01 55. 00 66. 00 67. 00 68. 00 69. 00 60. 00 61. 00 62. 00 63. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in: Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mini Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries	69) tructions) III, column 9, lines 30 tl	nrough 35).	0 82, 602 0 0 0 0 0 31, 749, 741 17, 383 31, 732, 358 2, 477, 112 83, 776	53. ( 54. ( 55. ( 57. ( 59. ( 60. ( 61. ( 63. (
53. 00 54. 00 54. 01 55. 00 66. 00 67. 00 68. 00 69. 00 60. 00 61. 00 62. 00 63. 00 64. 01	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)	69) tructions) III, column 9, lines 30 tl	nrough 35).	0 82, 602 0 0 0 0 31, 749, 741 17, 383 31, 732, 358 2, 477, 112 83, 776 161, 762	53. ( 54. ( 55. ( 57. ( 58. ( 59. ( 60. ( 61. ( 63. ( 64. (
33. 00 34. 00 34. 01 35. 00 36. 00 37. 00 38. 00 39. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 30. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mini Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	line 49 see instructions).  69) tructions) III, column 9, lines 30 tl . IV, col. 11 line 200)  us line 60)	nrough 35).	0 82, 602 0 0 0 0 31, 749, 741 17, 383 31, 732, 358 2, 477, 112 83, 776 161, 762 105, 145	53. ( 54. ( 55. ( 57. ( 58. ( 59. ( 61. ( 62. ( 63. ( 65. (
33. 00 34. 00 34. 01 35. 00 36. 00 37. 00 38. 00 39. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)	line 49 see instructions).  69) tructions) III, column 9, lines 30 tl . IV, col. 11 line 200)  us line 60)	nrough 35).	0 82, 602 0 0 0 0 31, 749, 741 17, 383 31, 732, 358 2, 477, 112 83, 776 161, 762	53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64.
3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	69) tructions) III, column 9, lines 30 tl IV, col. 11 line 200) us line 60) structions)	ee instructions)	0 82, 602 0 0 0 0 31, 749, 741 17, 383 31, 732, 358 2, 477, 112 83, 776 161, 762 105, 145 69, 356	53. 54. 55. 55. 56. 60. 61. 62. 63. 64. 65. 66. 67.
3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 4. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mine Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96)	69) tructions) III, column 9, lines 30 tl IV, col. 11 line 200) us line 60) structions)	ee instructions)	0 82, 602 0 0 0 0 31, 749, 741 17, 383 31, 732, 358 2, 477, 112 83, 776 161, 762 105, 145 69, 356 29, 276, 615 0	53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67.
3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in: Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mins Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	69) tructions) III, column 9, lines 30 tl IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (so	ee instructions) S)	0 82, 602 0 0 0 0 31, 749, 741 17, 383 31, 732, 358 2, 477, 112 83, 776 161, 762 105, 145 69, 356 29, 276, 615 0	53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68.
33. 00 64. 00 64. 01 65. 00 67. 00 68. 00 69. 00 60. 00 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 60. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see insubtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons	69) tructions) III, column 9, lines 30 tl IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (selections) (For SCH see instructions)	ee instructions) S)	0 82, 602 0 0 0 0 31, 749, 741 17, 383 31, 732, 358 2, 477, 112 83, 776 161, 762 105, 145 69, 356 29, 276, 615 0 0	53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70.
63. 00 64. 00 64. 01 65. 00 66. 00 67. 00 69. 00 69. 00 60. 00 61. 00 64. 00 64. 00 65. 00 66. 00 66. 00 66. 00 67. 00 66. 00 67. 00 67	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see im Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (\$410A Demons Demonstration payment adjustment amount before sequestration	69) tructions) III, column 9, lines 30 tl IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (selections) (For SCH see instructions)	ee instructions) S)	0 82, 602 0 0 0 0 31, 749, 741 17, 383 31, 732, 358 2, 477, 112 83, 776 161, 762 105, 145 69, 356 29, 276, 615 0 0	53. 54. 55. 56. 57. 58. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 70.
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52. 00 53. 00 54. 00 54. 01 55. 00 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 67. 00 67. 00 70. 50 70. 87 70. 88 70. 90 70. 91 70. 93 70. 93 70. 93	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 min Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	69) tructions) III, column 9, lines 30 tl IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (so ). (For SCH see instructions) stration) adjustment (see in	ee instructions) S)	0 82, 602 0 0 0 0 31, 749, 741 17, 383 31, 732, 358 2, 477, 112 83, 776 161, 762 105, 145 69, 356 29, 276, 615 0 0	53.1 54.1 55.1 56.1 57.5 58.1 59.1 60.1 63.1 64.1 65.1 67.1 68.1 70.1 70.1 70.1 70.1 70.1 70.1 70.1

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0128	Peri od: Worksheet E
		From 01/01/2020   Part A
		To 12/21/2020 Doto/Time Dropored.

			1	rom 01/01/2020 o 12/31/2020	Part A Date/Time Pre 8/2/2021 3:42	
		Ti tl e	XVIII	Hospi tal	PPS	
				(уууу)	Amount	
70. 96	Low volume adjustment for federal fiscal year (year) (Enter in co	Lump 0		0	1. 00	70. 96
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in co the corresponding federal year for the period prior to 10/1)	i ullin U		U	U	70.96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in co	lumn O		0	0	70. 97
	the corresponding federal year for the period ending on or after				_	
70. 98	Low Volume Payment-3				0	70. 98
70. 99	HAC adjustment amount (see instructions)				301, 399	
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 &	70)			28, 725, 077	
71. 01	Sequestration adjustment (see instructions)				189, 586	
	Demonstration payment adjustment amount after sequestration				0	
71. 03	Sequestration adjustment-PARHM pass-throughs Interim payments		•		27, 845, 895	71. 03 72. 00
	Interim payments  Interim payments-PARHM				27, 040, 090	72.00
	Tentative settlement (for contractor use only)				0	1
73. 01	Tentative settlement-PARHM (for contractor use only)				Ü	73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 7.	2, and			689, 596	1
	73)					
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordance	wi th			624, 729	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
90. 00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)  Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2	U3			0	90.00
70.00	plus 2.04 (see instructions)	. 03			O	70.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2		•		0	91. 00
	Operating outlier reconciliation adjustment amount (see instruction	ons)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruction	s)			0	93. 00
94.00	The rate used to calculate the time value of money (see instruction	ons)			0.00	94. 00
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 instruction	s)		D:: -:- +- 10/1	0 (15)	96. 00
				Prior to 10/1 1.00	2.00	
	HSP Bonus Payment Amount			1.00	2.00	
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment			'		
101.00	HVBP adjustment factor (see instructions)			0.0000000000	0.0000000000	101. 00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	0	102. 00
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0.0000	0.0000	1
104.00	HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration	an) Adiu	uctmont	0	0	104. 00
200.00	Is this the first year of the current 5-year demonstration period					200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	unaci t	IIC ZISt			200.00
	Cost Reimbursement			'		1
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49	)				201. 00
	Medicare discharges (see instructions)					202. 00
203.00	Case-mix adjustment factor (see instructions)		6.11			203. 00
	Computation of Demonstration Target Amount Limitation (N/A in first	st year	of the current	5-year demonst	ration	
204 00	period) Medicare target amount					204. 00
	Case-mix adjusted target amount (line 203 times line 204)					205. 00
	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement			,		
207.00	Program reimbursement under the §410A Demonstration (see instruct	i ons)				207. 00
208.00		o 50)				208. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, lin	C 37)				
209.00	Adjustment to Medicare IPPS payments (see instructions)	C 37)				209. 00
209. 00 210. 00	Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	e 37)				209. 00 210. 00
209. 00 210. 00	Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	G 37)				209. 00
209. 00 210. 00 211. 00	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					209. 00 210. 00 211. 00
209. 00 210. 00 211. 00 212. 00	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)					209. 00 210. 00 211. 00 212. 00
209. 00 210. 00 211. 00 212. 00 213. 00	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		nbursement)			209. 00 210. 00 211. 00 212. 00 213. 00
209. 00 210. 00 211. 00 212. 00 213. 00	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)		nbursement)			209. 00 210. 00 211. 00 212. 00

Health Financial Systems	COMMUNITY HOSPITAL SOUTH	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0128	From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 8/2/2021 3:42 nm

Medical and other services (see instructions)			Title XVIII	Hospi tal	8/2/2021 3: 42 PPS	- piii
MRI B - MEDICAL AND CHIER HEALT SERVICES   1.00   Mode and other services (see instructions)   15.506.665   2.00   2.00   Medical and other services (see instructions)   15.506.665   2.00   2.00   2.00   Medical and other services (see instructions)   15.506.665   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2					1 00	
New York		PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
0.000   0.000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000		1	`			
0.011   Fire payment (see instructions)		•	ons)			1
But     Friedrich						1
Line 2 times line 5   0   6 00		, , , , , , , , , , , , , , , , , , , ,				1
2.00   Am of lines 3, 4, and 4.01, divided by line 6   0.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7.00   7			i ons)			
Transitional corridor payment (see instructions)						1
Ancil lary service other pass through costs from West. B. Pt. IV, col. 13. line 200   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00		1				1
10.00   Organ acquist it ones   1.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00		1	/. col. 13. line 200			ł
COMPUTATION OF LESSER OF LOST OR CHARGES   Reasonable charges (sum of lines 12 and 13)   12 00   13 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00   10 00						ł
Reasonable charges   12.00   Ancil Tarry service charges   12.00   Ancil Tarry service charges   13.00   Organ acquisit fion charges (from What. D-4, Pt. 111, col. 4, line 67)   0.13.00   37.042   14.00   13.00   13.00   14.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00	11. 00				21, 042	11. 00
12.00						
13.00   Organ acquisition chargies (From Wiskst. D-4, Pt. III., col. 4, line 69)   0.13.00   Costomary charges (sum of Itines 12 and 13)   0.15.00   Organ acquisition actually collected from patients liable for payment for services on a charge basis   0.15.00   Organization actually collected from patients liable for payment for services on a charge basis   0.15.00   Organization actually collected from patients liable for payment for services on a charge basis   0.15.00   Organization actually collected from patients liable for payment for services on a charge basis   0.15.00   Organization actually collected from patients liable for payment for services on a chargebasis   0.15.00   Organization actually collected from patients liable for payment for services on a chargebasis   0.15.00   Organization actually collected from patients liable for payment for services on a chargebasis   0.15.00   Organization actually collected from patients liable for payment for services on a chargebasis   0.15.00   Organization actually collected from patients liable for payment for services on a chargebasis   0.15.00   Organization actually collected from patients liable for payment for services on a chargebasis   0.15.00   Organization actually collected from patients liable for payment for services on a chargebasis   0.15.00   Organization actually collected from patients liable for payment for services   0.15.00   Organization actually collected from patients liable for payment for services   0.25.00   Organization actually collected from patients (see instructions)   0.25.00   Organization actually collected from patients (see instructions)   0.25.00   Organization actually collected from payments (from Wist. E-4, line 50)   0.25.00   Organization (lines 21 and 24 minus lines 25 and 26) plus the sum of lines 22 and 23) (see   0.25.00   Organization actually collected from payments (from Wist. E-4, line 50)   0.25.00   Organization   0.25.00   Organization   0.25.00   Organization   0.25.00   Organization   0.25.00   Orga	12 00				87 042	12 00
14. 00   Initial reasonable charges (sum of lines 12 and 13)   87.042   14. 00			ne 69)			
15.00   Aggregate amount actually collected from patients     10.00						1
1.0   0.0						
had such payment been made in accordance with 42 CFR \$413.13(e)						1
17.00   Ratio of line 15 to line 16 (not to exceed 1.000000)   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   17.00   18.00   18.00   17.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00	16.00	·		n a cnargebasis	0	16.00
18.00   Total customary charges (see instructions)   87,042   18.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00	17. 00				0. 000000	17. 00
Instructions						1
20.00   Excess of reasonable cost over customery charges (complete only if line 11 exceeds line 18) (see   0   20.00	19. 00		if line 18 exceeds lir	ne 11) (see	66, 000	19. 00
Instructions	20.00	,	, if line 11 eyecode lin	20 10) (600	0	20.00
21.00   Lesser of cost or charges (see instructions)   22.00   22.00   23.00   Cost of physicians' services in a teaching hospital (see instructions)   0.22.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   20.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   20.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23	20.00		/ II IIIle II exceeds III	ie 16) (See	0	20.00
23.00   Cost of physicians' services in a teaching hospital (see instructions)   3,230,778   24.00	21. 00				21, 042	21.00
24. 00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   13, 236, 778   24. 00   COMPUTATION OR FLEMBUSSEMENT SETTLEMENT		1				
COMPUTATION OF RELIMBURSEMENT SETTLEMENT   2.50   Deductible sand coinsurance amounts (for CAH, see instructions)   2.718   2.50   Deductible sand coinsurance amounts (for CAH, see instructions)   2.264,622   26.00   Deductible sand coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   2.264,622   26.00   Debut to the sum of lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23   (see instructions)   104,031   28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   104,031   28.00   29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   104,031   28.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00			ıcti ons)			1
25.00   Deductible sand coinsurance amounts (for CAH, see instructions)   2.718   25.00	24.00				13, 236, 778	24.00
26.00   Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   2,264,622   26.00   27.00   28.00   27.00   28.00   27.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00   28.00	25. 00				2, 718	25. 00
Instructions   104,031   28		1		ıctions)		
28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   104, 031   28.00   0.00   29.00   28.00   Stb0 direct medical education costs (from Wkst. E-4, line 36)   0.00   29.00   30.00   Subtotal (sum of lines 27 through 29)   11, 094, 511   30.00   31.00   Pri mary payer payments   11, 094, 511   30.00   31.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.0	27. 00	_ = '	us the sum of lines $22$	and 23] (see	10, 990, 480	27. 00
29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   29.00   30.00   Subtotal (sum of lines 27 through 29)   11,094,511   30.00   31.00   70   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32	20 00	1	22 EO)		104 021	20 00
30.00   Subtotal (sum of lines 27 through 29)   11,094,511   30.00   Primary payer payments   4,791   31.00   31.00   30.00   Subtotal (line 30 minus line 31)   11,089,720   32.00   Subtotal (line 30 minus line 31)   10,089,720   32.00   Subtotal (line 30 minus line 31)   0   0   0   0   0   0   0   0   0			ie 50)			
31.00   Primary payer payments   4,791   31.00   32.00   Subtotal (line 30 minus line 31)   11,089,720   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   275,983   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   275,983   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   179,389   35.00   36.00   Allowable bad debts (see instructions)   245,926   36.00   37.00   Subtotal (see instructions)   11,269,109   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00   37.00		1				1
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I -5, line 11)   0   33.00   33.00   Adjusted reimbursable bad debts (see instructions)   275, 983   34.00   Adjusted reimbursable bad debts (see instructions)   179, 389   35.00   Adjusted reimbursable bad debts for dual eligible beneficiaries (see instructions)   245, 926   36.00   37.00   Subtotal (see instructions)   11, 269, 109   37.00   38.00   MSP-LCC reconciliation amount from PS&R   -169   38.00   MSP-LCT reconciliation amount from PS&R   -169   38.00   39.00   THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.97   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   REQUESTRATION   0   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   39.90   3	31. 00				4, 791	31. 00
33.00   Composite rate ESRD (from Wkst. I - 5, line 11)   33.00   Allowable bad debts (see instructions)   375,983   33.00   36.00   Allowable bad debts (see instructions)   179,389   35.00   Adjusted reimbursable bad debts (see instructions)   245,926   36.00   37.00   Subtotal (see instructions)   245,926   36.00   37.00   Subtotal (see instructions)   11,269,109   37.00   38.00   MSP-LCC reconciliation amount from PS&R   -169,109   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0 39.00   39.50   0 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0 39.00   39.97   0 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)   11,269,278   40.00   40.01   Sequestration adjustment (see instructions)   74,377   40.01   40.01   Sequestration adjustment (see instructions)   0 40.02   Demonstration payment adjustment amount after sequestration   0 40.02   40.03   Sequestration adjustment (see instructions)   11,305,415   41.00   1nterim payments   11,305,415   41.00   1nterim payments   11,305,415   41.00   42.00   Tentative settlement (for contractors use only)   42.01   43.00   Balance due provi der/program (see instructions)   43.01   43.01   43.01   43.00   Balance due provi der/program (see instructions)   43.01   43.01   43.00   Balance due provi der/program (see instructions)   43.01   43.00   43.01   44.00   Fortisted amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	32. 00		-0.		11, 089, 720	32. 00
34. 00	22 00		.S)		0	22 00
35.00						
37.00   Subtotal (see instructions)   37.00   38.00   MSP-LCC reconciliation amount from PS&R   -169   38.00   39.00   MSP-LCC reconciliation amount from PS&R   -169   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0 39.00   39.50   39.50   39.97   Demonstration payment adjustment (see instructions)   0 39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39.97   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39.99   40.00   Subtotal (see instructions)   11,269,278   40.00   40.00   Sequestration adjustment (see instructions)   11,269,278   40.00   40.01   Sequestration adjustment (see instructions)   74,377   40.01   40.02   Demonstration payment adjustment amount after sequestration   40.02   40.03   40.02   40.03   40.03   40.03   40.04   40.04   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05   40.05		1			'	1
38. 00   MSP-LCC reconciliation amount from PS&R   -169   38. 00   39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39. 00   39. 00   39. 00   39. 00   39. 00   39. 00   39. 00   39. 00   39. 00   39. 97   39. 97   Demonstration payment adjustment amount before sequestration   0   39. 97   39. 98   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 98   39. 98   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99   39. 99   30. 00   39. 99   30. 00   39. 99   30. 00   39. 99   30. 00   39. 99   30. 00   39. 99   30. 00   39. 99   30. 00   39. 99   30. 00   39. 99   30. 00   39. 99   30. 00   39. 99   30. 00   39. 99   30. 00   39. 99   30. 00   39. 99   30. 00   39. 99   30. 00   39. 99   30. 00   39. 99   30. 00   39. 99   30. 00   39. 99   30. 00   39. 99   39. 99   30. 00   39. 99   39. 99   30. 00   39. 99   39. 99   39. 99   30. 00   39. 99   39. 99   39. 99   30. 00   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99   39. 99		, ,	ıcti ons)			
39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50						
39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50						1
39. 97 39. 98 39. 88 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 40. 00 39. 99 40. 01 Subtotal (see instructions) 39. 99 40. 01 Sequestration adjustment (see instructions) 39. 99 40. 01 Demonstration payment (see instructions) 39. 99 40. 01 Subtotal (see instructions) 40. 01 Demonstration adjustment (see instructions) 40. 01 Demonstration payment adjustment (see instructions) 40. 01 Demonstration payment adjustment (see instructions) 40. 01 Demonstration adjustment amount after sequestration 40. 02 Demonstration adjustment amount after sequestration and payments and payment		1	1		0	
39. 99 40. 00 5 Subtotal (see instructions) 40. 01 5 Sequestration adjustment (see instructions) 40. 02 40. 03 5 Sequestration payment adjustment amount after sequestration 41. 00 41. 01 42. 00 42. 01 42. 00 42. 01 43. 00 43. 01 43. 00 43. 01 44. 00 45 Bal ance due provider/program (see instructions) 40. 01 41. 01 42. 00 43. 01 44. 00 45 Bal ance due provider/program (see instructions) 45 Bal ance due provider/program (see instructions) 46 Bal ance due provider/program (see instructions) 47 Bal ance due provider/program (see instructions) 48 Bal ance due provider/program (see instructions) 49 Bal ance due provider/program (see instructions) 40 Contested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, spins Completed by Contractors 40 Contractors (see instructions) 41 Contractor (see instructions) 42 Contractor (see instructions) 43 Contractor (see instructions) 44 Contractor (see instructions) 45 Contractor (see instructions) 46 Contractor (see instructions) 47 Contractor (see instructions) 48 Contractor (see instructions) 49 Contractor (see instructions) 40 Contractor (see instructions) 41 Contractor (see instructions) 42 Contractor (see instructions) 43 Contractor (see instructions) 44 Contractor (see instructions) 45 Contractor (see instructions) 46 Contractor (see instructions) 47 Contractor (see instructions) 48 Contractor (see instructions) 49 Contractor (see instructions) 40 Contractor (see instructions) 41 Contractor (see instructions) 42 Contractor (see instructions) 43 Contractor (see instructions) 44 Contractor (see instructions) 45 Contractor (see instructions) 46 Contractor (see instructions) 47 Contractor (see instructions) 48 Contractor (see instructions) 49 Contractor (see instructions) 40 Contractor (see instructions) 41 Contractor (see instructions) 42 Contractor (see instructions) 43 Contractor (see instructions) 44 Contractor (see instructions) 45 Contractor (see instructions) 46 Contractor (see instructions) 47 Contractor (see instructions) 48 Contract					0	
Subtotal (see instructions)   11, 269, 278   40. 00   40. 01   5   5   6   6   6   6   7   7   7   7   7   7		· ·	ed devices (see instruct	ions)		•
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 5 Sequestration adjustment-PARHM pass-throughs 40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Bal ance due provider/program (see instructions) 43.01 Bal ance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Untier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Og 40.02 94.00 Og 40.02 94.00 Og 40.03 94.00 Og 40.00 94.00 Og 94.00 94.00 Og 94.00 95.00 Og 96.00 Og 96.00						•
40.02 Demonstration payment adjustment amount after sequestration  Sequestration adjustment-PARHM pass-throughs  41.00 Interim payments  Interim payments-PARHM  11, 305, 415  Interim payments-PARHM  Tentative settlement (for contractors use only)  42.00 Tentative settlement (for contractor use only)  43.00 Balance due provider/program (see instructions)  Balance due provider/program-PARHM (see instructions)  43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  44.00 Original outlier amount (see instructions)  90.00 Outlier reconciliation adjustment amount (see instructions)  70.00 The rate used to calculate the Time Value of Money  70.00 Time Value of Money (see instructions)  70.01 Time Value of Money (see instructions)  70.02 On Time Value of Money (see instructions)  70.03 Adv. 0.04  71.00 Adv. 0.00  71.00 Adv. 0.00  72.00 Time Value of Money (see instructions)  72.00 Time Value of Money (see instructions)  73.00 Adv. 0.00  74.00 Adv. 0.00  74.00 Adv. 0.00  75.00 Adv. 0.00  76.00 Adv. 0.00  77.00 Adv. 0.00  78.00 Adv. 0.00  78.00 Adv. 0.00  79.00 Adv.						•
40.03   Sequestration adjustment-PARHM pass-throughs   40.03   41.00   Interim payments   11,305,415   41.01   Interim payments-PARHM   41.01   42.00   Tentative settlement (for contractor use only)   42.00   42.01   Tentative settlement-PARHM (for contractor use only)   42.00   43.00   Balance due provider/program (see instructions)   -110,514   43.00   Balance due provider/program-PARHM (see instructions)   43.01   44.00   Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00   Value of Money (see instructions)   0   90.00   91.00   Outlier reconciliation adjustment amount (see instructions)   0   91.00   92.00   The rate used to calculate the Time Value of Money   0   93.00   93.00   Time Value of Money (see instructions)   0   93.00						•
41. 01   Interim payments-PARHM		1				•
42.00 42.01 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 Utlier reconciliation adjustment amount (see instructions) 79.00 The rate used to calculate the Time Value of Money 79.00 Time Value of Money (see instructions) 0 93.00	41.00	Interim payments			11, 305, 415	
42.01  43.00  43.01  Balance due provider/program (see instructions)  43.01  44.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00  90.00  Original outlier amount (see instructions)  91.00  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  Time Value of Money (see instructions)  42.01  43.00  43.01  44.00  45.01  45.01  47.01  47.01  48.00  49.00  49.00  90.00  91.00  91.00  92.00  93.00  Time Value of Money (see instructions)  0 93.00		1				
43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00    90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Outlier reconciliation adjustment amount (see instructions)  93.00 Time Value of Money (see instructions)  93.00 Outlier reconciliation adjustment amount (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  96.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  98.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)					0	1
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00    8115.2 TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions)		1			-110 514	1
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{\frac{5}{115.2}}{10 BE COMPLETED BY CONTRACTOR}  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 O 93.00					110,011	1
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  10 90.00 91.00 92.00 93.00		Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2, o	chapter 1,	0	1
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00	90 00				^	90 00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 0.00 93.00						•
93.00 Time Value of Money (see instructions) 0 93.00		1				
94.00  Total (sum of lines 91 and 93)   0   94.00		Time Value of Money (see instructions)			0	93. 00
	94. 00	lotal (sum of lines 91 and 93)			0	94.00

Health Financial Systems COMMANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2020 Part I
To 12/31/2020 Date/Ti me Prepared: 8/2/2021 3: 42 pm Provider CCN: 15-0128

					8/2/2021 3: 42	pm
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt 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		27, 796, 895		11, 207, 815	1. 00
2.00	Interim payments payable on individual bills, either		C		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	09/25/2020	49, 000	09/25/2020	97, 600	3. 01
3.02			·		o	3. 02
3.03			C		o	3. 03
3.04			C	)	o	3.04
3.05			C	)	0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		C		0	3.50
3. 51			C		0	3. 51
3. 52			C		0	3. 52
3. 53			C		0	3. 53
3.54			40.000		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		49, 000	)	97, 600	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		27, 845, 895		11, 305, 415	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		27, 043, 073	,	11, 303, 413	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5.02			C		0	5. 02
5. 03	Dravi dan ta Dragnam		C	)	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		C	\	1 0	5. 50
5. 50	TENTATIVE TO PROGRAW		C			5. 50
5. 51					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 99
0. , ,	5. 50-5. 98)					0. ,,
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		689, 596		0	6. 01
6.02	SETTLEMENT TO PROGRAM		C		110, 514	6. 02
7.00	Total Medicare program liability (see instructions)		28, 535, 491		11, 194, 901	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor	(	)	1. 00	2. 00	0.00
8. 00	Name of Contractor				1	8. 00

Heal th	Financial Systems COMMUNITY HOSPI	TAL SOUTH	In Lie	u of Form CMS-	2552-10
From 01/01/2020 To 12/31/2020					epared:
		Title XVIII	Hospi tal	PPS	
				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	2 14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9. 00	Sequestration adjustment amount (see instructions)				9. 00
10. 00	Calculation of the HIT incentive payment after seguestration	(see instructions)			10.00
	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH	(555 151. 4511 6115)			1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31. 00
	1.00 Other Adjustment (specify)				

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

30. 00 31. 00 32. 00

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT . EDUCATION COSTS	Provider Co	CN: 15-0128	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prep 8/2/2021 3:42	
		Title	XVIII	Hospi tal	PPS	•
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng periods	0. 00	1.00
. 00	Unweighted FTE resident cap add-on for new programs per 42 CF		1) (see instr	ructions)	0. 00	2. 00
	Amount of reduction to Direct GME cap under section 422 of MM			,	0.00	3. 00
	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)	WITH 42 CFR	( §413.79 (m).	(see	0.00	3. 0
00	Adjustment (plus or minus) to the FTE cap for allopathic and		programs due	to a Medicare	6. 95	4.00
	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) ACA Section 5503 increase to the Direct GME FTE Cap (see inst		cost reporti	na neri ods	0. 00	4. 0 <sup>-</sup>
	straddling 7/1/2011)	ructions for	cost reporti	ng perrous	0.00	4.0
02	ACA Section 5506 number of additional direct GME FTE cap slot	s (see inst	ructions for	cost reporting	0.00	4. 02
	periods straddling 7/1/2011) FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl	us or minus	line 4 nlus l	ines 4 01 and	6. 95	5. 00
	4.02 plus applicable subscripts	as or illinias	Title i prus i	Thes I. or and	0. 70	0.00
	Unweighted resident FTE count for allopathic and osteopathic	programs for	the current	year from your	8. 25	6. 00
	records (see instructions) Enter the lesser of line 5 or line 6				6. 95	7. 00
			Primary Care		Total	
. 00	Weighted FTE count for physicians in an allopathic and osteop	athi c	1.00	2. 00 58 0. 67	3. 00 8. 25	8. 00
	program for the current year.	attiiC	/.:	0.67	0. 23	0.00
	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo		6.3	0. 56	6. 95	9. 0
0. 00	6. Weighted dental and podiatric resident FTE count for the curr	ent vear		1.44		10. 0
	Unweighted dental and podiatric resident FTE count for the cu			1. 44		10.0
	Total weighted FTE count		6. 3	1		11.0
2. 00	Total weighted resident FTE count for the prior cost reportin instructions)	g year (see	5. 5	56 2. 01		12. 0
3. 00	Total weighted resident FTE count for the penultimate cost re	porti ng	5. 4	0. 64		13. 00
1. 00	year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided	by 2)	5.8	30 1. 55		14. 0
	Adjustment for residents in initial years of new programs	by 3).	0.0	1		15. 0
5. 01	Unweighted adjustment for residents in initial years of new p		0.0	I I		15. 0
	Adjustment for residents displaced by program or hospital clo		0.0	I I		16. 0
	Unweighted adjustment for residents displaced by program or h closure	ospi tai	0.0	0.00		16. 0
	Adjusted rolling average FTE count		5.8	1. 55		17. 00
1	Per resident amount		92, 653.	· · · · · · · · · · · · · · · · · · ·	(04,007	18. 0
9.00	Approved amount for resident costs		537, 39	93 143, 614	681, 007	19. 00
					1. 00	
0. 00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots red	ceived under 42	0. 00	20. 00
1. 00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instru	ctions)			1 30	21. 0
- 1	Allowable additional direct GME FTE Resident Count (see instr				0. 00	1
4	Enter the locality adjustment national average per resident a	mount (see i	nstructions)		0. 00	1
- 1	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)				0 681, 007	24. 00 25. 00
J. 00	Total direct own amount (sum of fines 17 and 24)		Inpatient Pa	rt Managed Care	Total	23.00
			1. 00	2. 00	3. 00	
I	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00	
	Inpatient Days (see instructions) (Title XIX - see S-2 Part I 3.02, column 2)	X, line	11, 40			26. 00
- 1	Total Inpatient Days (see instructions)		37, 15	I		27. 0
- 1	Ratio of inpatient days to total inpatient days Program direct GME amount		0. 30853 210, 1		359, 902	28. 00 29. 00
- 1	Percent reduction for MA DGME		210,1	7.00	337, 702	29. 0
			1	I I	10 405	20.0
0. 00	Reduction for direct GME payments for Medicare Advantage Net Program direct GME amount			10, 485	10, 485 349, 417	30.00

Heal th	Financial Systems COMMUNITY HOSPIT	TAL SOUTH	In Lie	u of Form CMS-2	2552-10	
DI REC	DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT Provider CCN: 15-0128 Period:					
MEDI CA	MEDICAL EDUCATION COSTS From 01/01/2020 To 12/31/2020 I					
		Title XVIII	Hospi tal	PPS		
				1. 00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	`		CAL		
32. 00	1	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00	
	and 94)					
33. 00			74 and 94)	2, 681, 063		
34. 00	1	e 32 ÷ IIne 33)		0. 000000		
	Medicare outpatient ESRD charges (see instructions)	24 v line 25)		0		
36.00	Medicare outpatient ESRD direct medical education costs (line APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII			0	36.00	
	Part A Reasonable Cost	ONLY				
37. 00				36, 637, 381	37 00	
38. 00				0, 037, 301	ı	
	Cost of physicians' services in a teaching hospital (see insti	ructions)		0		
	Primary payer payments (see instructions)	1 40 (1 0113)		17, 383		
	Total Part A reasonable cost (sum of lines 37 through 39 minus	s line 40)		36, 619, 998		
	Part B Reasonable Cost			00,011,110		
42.00	Reasonable cost (see instructions)			15, 529, 727	42. 00	
43.00	Primary payer payments (see instructions)			4, 791	43.00	
44.00	Total Part B reasonable cost (line 42 minus line 43)			15, 524, 936	44.00	
45.00	Total reasonable cost (sum of lines 41 and 44)			52, 144, 934	45. 00	
46.00	Ratio of Part A reasonable cost to total reasonable cost (line	e 41 ÷ line 45)		0. 702273	46. 00	
47.00	Ratio of Part B reasonable cost to total reasonable cost (line			0. 297727	47. 00	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR	RT B				
	Total program GME payment (line 31)			349, 417		
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)			245, 386	1	
50. 00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		104, 031	50.00	

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

Provider CCN: 15-0128 Period: From 01/

Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 8/2/2021 3: 42 pm

OH y)					8/2/2021 3: 42	pm
		General Fund		Endowment Fund	Pl ant Fund	
		1 00	Purpose Fund	2.22		
	CHIPDENT ACCETC	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	5, 849	0	0	0	1.00
2.00	Temporary investments	3, 047	0	-	0	2. 00
3. 00	Notes recei vabl e		Ö	Ö	0	3. 00
4.00	Accounts receivable	201, 097, 458	0	0	0	4. 00
5.00	Other recei vabl e	-154, 759, 471		0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	521, 717	0	0	0	6. 00
7.00	Inventory	4, 080, 470		0	0	7. 00
8.00	Prepai d expenses	100, 000		0	0	8. 00
9.00	Other current assets	0	_	0	0	9. 00
10.00	Due from other funds	51 04/ 022	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	51, 046, 023	0	0	0	11. 00
12. 00	Land	1, 821, 632	0	0	0	12. 00
13. 00	Land improvements	2, 722, 362		0	0	13. 00
14. 00	Accumulated depreciation	0	Ö	0	0	14. 00
15. 00	Bui I di ngs	185, 616, 539	0	0	0	15. 00
16.00	Accumulated depreciation	0	0	0	0	16. 00
17. 00	Leasehold improvements	1, 737, 035	0	0	0	17. 00
18.00	Accumulated depreciation	0	0	0	0	18. 00
19. 00	Fi xed equipment	83, 879, 806		0	0	19. 00
20. 00	Accumulated depreciation	0	0	0	0	20. 00
21. 00	Automobiles and trucks	59, 805		0	0	21. 00
22. 00	Accumul ated depreciation	0	0	0	0	22. 00
23. 00	Maj or movable equipment	145 (10 120	0	0	0	23. 00 24. 00
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable	-145, 610, 138	0	0	0	25. 00
26. 00	Accumulated depreciation		0	0	0	26. 00
27. 00	HIT designated Assets		0	0	Ö	27. 00
28. 00	Accumul ated depreciation	0	Ö	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	115, 657	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	130, 342, 698	0	0	0	30. 00
	OTHER ASSETS					
31. 00	Investments	0			0	31. 00
32. 00	Deposits on Leases	0	_	0	0	32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34. 00	Other assets	513, 497, 149		0	0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34)	513, 497, 149		0	0	35. 00 36. 00
30.00	Total assets (sum of lines 11, 30, and 35)  CURRENT LIABILITIES	694, 885, 870	U	U	U	30.00
37. 00	Accounts payable	728, 836	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	0	Ö	0	0	38. 00
39. 00	Payrol I taxes payable	0	Ō	0	0	39. 00
40.00	Notes and Loans payable (short term)	0	0	0	0	40. 00
41.00	Deferred income	0	0	0	0	41. 00
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	0	0	0	0	43. 00
44. 00	Other current liabilities	10, 074, 177		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	10, 803, 013	0	0	0	45. 00
46.00	LONG TERM LIABILITIES		_	ما	0	46 00
46. 00 47. 00	Mortgage payable Notes payable	0			0	
48. 00	Unsecured Loans			0	0	
49. 00	Other long term liabilities	15, 390, 422		0	Ö	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	15, 390, 422		0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	26, 193, 435		-	0	51. 00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	668, 692, 435				52. 00
53.00	Specific purpose fund		0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	668, 692, 435	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	694, 885, 870		0	0	
55. 55	59)	27.,000,070		Ĭ		55. 55
		•		'		-

Provider CCN: 15-0128

					10 12/31/2020	8/2/2021 3:42	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period	1.00	602, 188, 657	3.00	4.00		1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		66, 503, 778		`	1	2.00
3.00	Total (sum of line 1 and line 2)		668, 692, 435				3. 00
4.00	Additions (credit adjustments) (specify)	O			0	0	4. 00
5.00		0			0	0	5. 00
6.00		O			0	0	6. 00
7.00		0			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)		0		(		10.00
11. 00	Subtotal (line 3 plus line 10)		668, 692, 435		(		11. 00
12.00	Deductions (debit adjustments) (specify)	0			0	0	
13. 00		0			0	0	
14. 00		0			0	0	
15. 00		0			0	0	
16. 00		0			0	0	16. 00
17. 00		0	_		0	0	17. 00
18.00	Total deductions (sum of lines 12-17)		0		(		18.00
19. 00	Fund balance at end of period per balance		668, 692, 435		(		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		Eridoniiorre i dild		1 4.14			
		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			0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				8. 00
9.00	T-+-1 - -		U				9.00
10.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0			0		10. 00 11. 00
11. 00 12. 00	Deductions (debit adjustments) (specify)	٩	0		U		12.00
13. 00	beductions (debit adjustments) (specify)		0				13.00
14. 00			0				14. 00
15. 00			0				15. 00
16. 00			0				16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0			0		18. 00
19. 00	Fund balance at end of period per balance				Ö		19. 00
	sheet (line 11 minus line 18)						
				-	•		•

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

		Т	o 12/31/2020	Date/Time Prep 8/2/2021 3:42		
	Cost Center Description	Inpati ent	Outpati ent	Total	p	
		1.00	2. 00	3. 00		
	PART I - PATIENT REVENUES	•				
	General Inpatient Routine Services					
1.00	Hospi tal	116, 692, 677		116, 692, 677	1. 00	
2.00	SUBPROVI DER - I PF				2. 00	
3.00	SUBPROVI DER - I RF				3. 00	
4.00	SUBPROVI DER				4. 00	
5.00	Swing bed - SNF	0		0	5. 00	
6.00	Swing bed - NF	0		0	6. 00	
7.00	SKILLED NURSING FACILITY				7. 00	
8.00	NURSING FACILITY				8. 00	
9.00	OTHER LONG TERM CARE	447 700 777		447 (00 (77	9.00	
10. 00	Total general inpatient care services (sum of lines 1-9)	116, 692, 677		116, 692, 677	10. 00	
11 00	Intensive Care Type Inpatient Hospital Services	10 440 077		12 440 077	11 00	
11. 00 12. 00	INTENSIVE CARE UNIT	12, 440, 977		12, 440, 977	11. 00 12. 00	
13. 00	BURN INTENSIVE CARE UNIT				13. 00	
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00	
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00	
16. 00	Total intensive care type inpatient hospital services (sum of lines	12, 440, 977		12, 440, 977	16. 00	
	11-15)	12, 110, 777		12/ 110/ 777		
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	129, 133, 654		129, 133, 654	17. 00	
18.00	Ancillary services	324, 345, 747	468, 700, 282	793, 046, 029	18. 00	
19.00	Outpati ent servi ces	0	o	0	19. 00	
20.00	RURAL HEALTH CLINIC	0	0	0	20.00	
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00	
22. 00	HOME HEALTH AGENCY				22. 00	
23.00	AMBULANCE SERVICES				23. 00	
24. 00	CMHC				24. 00	
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00	
26. 00	HOSPI CE	_			26. 00	
27. 00	OTHER (SPECIFY)	0	,	51, 686	27. 00	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	453, 479, 401	468, 751, 968	922, 231, 369	28. 00	
	G-3, line 1) PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)	1	230, 568, 659		29. 00	
30. 00	ADD (SPECIFY)	0			30. 00	
31. 00	(SI ESTITI)				31. 00	
32. 00		0			32. 00	
33. 00					33. 00	
34. 00		0			34. 00	
35. 00		0			35. 00	
36.00	Total additions (sum of lines 30-35)		o		36.00	
37.00	DEDUCT (SPECIFY)	0			37.00	
38. 00		0			38. 00	
39. 00		0			39. 00	
40.00		0			40. 00	
41.00		0			41.00	
42. 00	Total deductions (sum of lines 37-41)		0		42.00	
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		230, 568, 659		43. 00	
	to Wkst. G-3, line 4)	1				

Heal th Financial Systems					 	
Total patient revenues (from Wkst. 6-2, Part I, column 3, line 28)   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1			COMMUNITY HOSPITAL SOUTH			
To 12/31/2020   Date/Time Preparents   R/27/2021 3:42 pm	STATE	IENT OF REVENUES AND EXPENSES	Provi der C	CN: 15-0128	Worksheet G-3	
1.00						
1.00					8/2/2021 3: 42	pm
1.00					1 00	
2.00   Less contractual allowances and discounts on patients' accounts   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40   2.40	1 00	Total nations revenues (from West G-2 Part	L column 3 line 28)			1 00
3.00   Net patient revenues (line 1 minus line 2)   Less total operating expenses (from Wkst. G-2, Part II, line 43)   230, 568, 659   3.00						
4.00   Less total operating expenses (from Wkst. G-2, Part II, Line 43)   230, 568, 659   4.00     5.00   Net income from service to patients (line 3 minus line 4)   43, 471, 792     6.00   Contributions, donations, bequests, etc   0   0   0.00     1.00   Income from investments   8, 521, 863   7.00     8.00   Revenue from tel ephone and other miscel laneous communication services   0   8.00     9.00   Revenue from tel evision and radio service   0   9.00     10.00   Purchase discounts   0   10.00     11.00   Rebates and refunds of expenses   0   11.00     12.00   Parking lot receip fts   0   12.00     13.00   Revenue from meals sold to employees and guests   998, 116   14.00     14.00   Revenue from sale of medical and surgical supplies to other than patients   8, 224   16.00     15.00   Revenue from sale of medical records and abstracts   0   18.00     19.00   Tuition (fees, sale of textbooks, uniforms, etc.)   0   19.00     10.00   Rental of hospital space   698, 410   22.00     22.00   Rental of vending machines   913, 168   24.00     24.00   MisC REVENUE   913, 168   24.00     25.00   Total other income (sum of line 27 and subscripts)   0   28.00     10.01   Total other expenses (sum of line 27 and subscripts)   0   28.00     10.02   Total other expenses (sum of line 27 and subscripts)   0   28.00     10.03   Total other expenses (sum of line 27 and subscripts)   0   28.00     10.04   Total other expenses (sum of line 27 and subscripts)   0   27.00     10.05   Total other expenses (sum of line 27 and subscripts)   0   27.00     10.06   Total other expenses (sum of line 27 and subscripts)   0   27.00     10.07   Total other expenses (sum of line 27 and subscripts)   0   27.00     10.08   Total other expenses (sum of line 27 and subscripts)   0   27.00     10.09   Total other expenses (sum of line 27 and subscripts)   0   27.00     10.00   Total other expenses (sum of line 27 and subscripts)   0   27.00     10.00   Total other expenses (sum of line 27 and subscripts)   0   27.00     10.00   Total other exp			patrents accounts			
Net income from service to patients (line 3 minus line 4)			2 Part II line 43)			
OTHER INCOME         O         Contributions, donations, bequests, etc         0         6.00           7.00         Income from investments         8,521,863         7.00           8.00         Revenues from tell ephone and other miscell aneous communication services         0         8.00           9.00         Revenue from tell evision and radio service         0         9.00           10.00         Purchase discounts         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 laundry and linen service         998,116         14.00           15.00         Revenue from laundry and linen service         998,116         14.00           15.00         Revenue from meals sold to employees and guests         998,116         14.00           15.00         Revenue from sale of medical and surgical supplies to other than patients         8,224         16.00           16.00         Revenue from sale of medical and surgical supplies to other than patients         8,224         16.00           17.00         Revenue from sale of medical and surgical supplies to other than pa						
6.00         Contributions, donations, bequests, etc         0         6.00           7.00         Income from investments         8,521,863         7.00           8.00         Revenues from telephone and other miscellaneous communication services         0         8.00           9.00         Revenue from television and radio service         0         9.00           10.00         Purchase discounts         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         12.00           14.00         Revenue from meals sold to employees and guests         998,116 14.00           15.00         Revenue from sale of drugs to other than patients         8,224 16.00           16.00         Revenue from sale of medical and surgical supplies to other than patients         8,224 16.00           17.00         Revenue from sale of ferugs to other than patients         46,800 17.00           18.00         Revenue from sale of ferugs to other than patients         9           20.00         Revenue from gale of drugs to other than patients         9           30.00         Revenue from gale of drugs to other than patients         9<	0.00				10/1/1///2	0.00
7.00       Income from investments       8, 521, 863       7, 00         8.00       Revenues from tel elpohone and other miscel laneous communication services       0       8, 00         9.00       Revenue from tele elvision and radio service       0       9, 00         11.00       Purchase discounts       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       998, 116       14, 00         15.00       Revenue from rental of living quarters       998, 116       14, 00         16.00       Revenue from sale of medical and surgical supplies to other than patients       8, 224       16, 00         17.00       Revenue from sale of medical records and abstracts       46, 800       17, 00         18.00       Revenue from sale of medical records and abstracts       0       18, 00         19.00       Tuit it on (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 hospital spac	6.00				0	6.00
8.00       Revenues from telephone and other miscellaneous communication services       0       8.00         9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       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       998,116       14.00         15.00       Revenue from sale of medical and surgical supplies to other than patients       8,224       16.00         17.00       Revenue from sale of medical records and abstracts       46,800       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         22.00       Rental of hospital space       698,410       22.00         23.00       Governmental appropriations       0       23.00         24.00       MISC REVENUE       913,168       24.50 <td>7. 00</td> <td></td> <td></td> <td></td> <td>8, 521, 863</td> <td>7. 00</td>	7. 00				8, 521, 863	7. 00
10.00       Purchase discounts       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 laundry and linen service       0       13.00         14.00       Revenue from laundry and linen service       0       13.00         15.00       Revenue from meals sold to employees and guests       998, 116       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       8, 224       16.00         17.00       Revenue from sale of medical records and abstracts       46, 800       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.01       Tuit ion (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.01       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of hospital space       698, 410       22.00         22.00       Rental of hospital space       698, 410       22.00		Revenues from telephone and other miscellane	ous communication services			8. 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   998, 116   14.00     15.00   Revenue from rental of living quarters   0   15.00     16.00   Revenue from sale of medical and surgical supplies to other than patients   8, 224   16.00     17.00   Revenue from sale of drugs to other than patients   46, 800   17.00     18.00   Revenue from sale of medical records and abstracts   0   18.00     19.00   Tuition (fees, sale of textbooks, uniforms, etc.)   0   19.00     20.00   Revenue from gifts, flowers, coffee shops, and canteen   0   20.00     21.00   Rental of vending machines   0   21.00     22.00   Rental of hospital space   698, 410   22.00     23.00   Governmental appropriations   913, 168   24.00     24.50   COVID-19   PHE Funding   913, 168   24.00     25.00   Total other income (sum of lines 6-24)   23, 031, 986   25.00     27.00   OTHER EXPENSES (SPECIFY)   0   28.00     28.00   Total other expenses (sum of line 27 and subscripts)   0   28.00     28.00   Total other expenses (sum of line 27 and subscripts)   0   28.00     29.00   29.00   29.00   29.00     20.00   29.00   29.00   29.00     20.00   20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20.00     20.00   20.00   20	9.00	Revenue from television and radio service			0	9. 00
12.00	10.00	Purchase di scounts			0	10.00
13.00   Revenue from laundry and linen service   0   13.00     14.00   Revenue from meals sold to employees and guests   998, 116   14.00     15.00   Revenue from rental of living quarters   0   15.00     16.00   Revenue from sale of medical and surgical supplies to other than patients   8, 224   16.00     17.00   Revenue from sale of drugs to other than patients   46, 800   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     19.00   Revenue from gifts, flowers, coffee shops, and canteen   0   20.00     19.00   Rental of vending machines   0   21.00     22.00   Rental of hospital space   698, 410   22.00     23.00   Governmental appropriations   0   23.00     24.00   MISC REVENUE   913, 168   24.00     24.50   COVID-19   PHE Funding   11, 845, 405   24.50     25.00   Total other income (sum of lines 6-24)   23, 031, 986   25.00     27.00   OTHER EXPENSES (SPECIFY)   0   27.00     28.00   Total other expenses (sum of line 27 and subscripts)   0   28.00	11. 00	Rebates and refunds of expenses			ol	11. 00
13.00   Revenue from laundry and linen service   0   13.00     14.00   Revenue from meals sold to employees and guests   998, 116   14.00     15.00   Revenue from rental of living quarters   0   15.00     16.00   Revenue from sale of medical and surgical supplies to other than patients   8, 224   16.00     17.00   Revenue from sale of drugs to other than patients   46, 800   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     19.00   Revenue from gifts, flowers, coffee shops, and canteen   0   20.00     19.00   Rental of vending machines   0   21.00     22.00   Rental of hospital space   698, 410   22.00     23.00   Governmental appropriations   0   23.00     24.00   MISC REVENUE   913, 168   24.00     24.50   COVID-19   PHE Funding   11, 845, 405   24.50     25.00   Total other income (sum of lines 6-24)   23, 031, 986   25.00     27.00   OTHER EXPENSES (SPECIFY)   0   27.00     28.00   Total other expenses (sum of line 27 and subscripts)   0   28.00	12.00	Parking Lot receipts			ol	12. 00
15. 00 Revenue from rental of living quarters 16. 00 Revenue from sale of medical and surgical supplies to other than patients 17. 00 Revenue from sale of drugs to other than patients 18. 00 Revenue from sale of medical records and abstracts 19. 00 Revenue from gale of textbooks, uniforms, etc.) 19. 00 Revenue from gifts, flowers, coffee shops, and canteen 19. 00 Revenue from gifts, flowers, coffee shops, and canteen 19. 00 Rental of vending machines 19. 00 Rental of hospital space 19. 00 Rental of hospital space 20. 00 Rental of hospital space 21. 00 Governmental appropriations 22. 00 Governmental appropriations 24. 00 MISC REVENUE 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) 20 Incomplete than patients 28, 224 16. 00 46, 800 17. 00 18. 00 15. 00 46, 800 17. 00 18. 00 15. 00 46, 800 17. 00 46, 800 17. 00 46, 800 17. 00 46, 800 17. 00 46, 800 17. 00 46, 800 17. 00 46, 800 17. 00 46, 800 17. 00 46, 800 17. 00 46, 800 17. 00 47. 00 48. 00 Total other expenses (sum of line 27 and subscripts)	13.00				0	13. 00
16.00       Revenue from sale of medical and surgical supplies to other than patients       8, 224 16.00         17.00       Revenue from sale of drugs to other than patients       46, 800 17.00         18.00       Revenue from sale of medical records and abstracts       0 18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0 19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0 20.00         21.00       Rental of vending machines       0 21.00         22.00       Rental of hospital space       698, 410 22.00         23.00       Governmental appropriations       0 23.00         24.00       MISC REVENUE       913, 168 24.00         24.50       COVID-19 PHE Funding       11, 845, 405 24.50         25.00       Total other income (sum of lines 6-24)       23, 031, 986 25.00         26.00       Total (line 5 plus line 25)       66, 503, 778 26.00         27.00       OTHER EXPENSES (SPECIFY)       0 27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0 28.00	14.00	Revenue from meals sold to employees and gue	sts		998, 116	14. 00
17. 00       Revenue from sale of drugs to other than patients       46,800       17. 00         18. 00       Revenue from sale of medical records and abstracts       0       18. 00         19. 00       Tui ti on (fees, sale of textbooks, uniforms, etc.)       0       19. 00         20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       698, 410       22. 00         23. 00       Governmental appropriations       913, 168       24. 00         24. 00       MI SC REVENUE       913, 168       24. 00         24. 50       COVI D-19 PHE Funding       11, 845, 405       24. 50         25. 00       Total other income (sum of lines 6-24)       23, 031, 986       25. 00         26. 00       Total (line 5 plus line 25)       66, 503, 778       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00	15.00	Revenue from rental of living quarters			ol	15. 00
18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       698,410       22.00         23.00       Governmental appropriations       0       23.00         24.00       MISC REVENUE       913, 168       24.00         24.50       COVID-19 PHE Funding       11, 845, 405       24.50         25.00       Total other income (sum of lines 6-24)       23, 031, 986       25.00         26.00       Total (line 5 plus line 25)       66, 503, 778       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00	16.00	Revenue from sale of medical and surgical su	pplies to other than patients	3	8, 224	16. 00
19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       698, 410       22.00         23.00       Governmental appropriations       0       23.00         24.00       MI SC REVENUE       913, 168       24.00         24.50       COVID-19 PHE Funding       11, 845, 405       24.50         25.00       Total other income (sum of lines 6-24)       23, 031, 986       25.00         26.00       Total (line 5 plus line 25)       66, 503, 778       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00	17.00	Revenue from sale of drugs to other than pat	ents		46, 800	17. 00
20. 00       Revenue from gifts, flowers, coffee shops, and canteen       0       20. 00         21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       698, 410       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       MI SC REVENUE       913, 168       24. 00         24. 50       COVID-19 PHE Funding       11, 845, 405       24. 50         25. 00       Total other income (sum of lines 6-24)       23, 031, 986       25. 00         26. 00       Total (line 5 plus line 25)       66, 503, 778       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00	18.00	Revenue from sale of medical records and abs	tracts		0	18. 00
21. 00       Rental of vending machines       0       21. 00         22. 00       Rental of hospital space       698, 410       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       MI SC REVENUE       913, 168       24. 00         24. 50       COVI D-19 PHE Funding       11, 845, 405       24. 50         25. 00       Total other income (sum of lines 6-24)       23, 031, 986       25. 00         26. 00       Total (line 5 plus line 25)       66, 503, 778       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00	19. 00	Tuition (fees, sale of textbooks, uniforms,	etc.)		0	
22. 00       Rental of hospital space       698, 410       22. 00         23. 00       Governmental appropriations       0       23. 00         24. 00       MI SC REVENUE       913, 168       24. 00         24. 50       COVI D-19 PHE Funding       11, 845, 405       24. 50         25. 00       Total other income (sum of lines 6-24)       23, 031, 986       25. 00         26. 00       Total (line 5 plus line 25)       66, 503, 778       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00	20.00	Revenue from gifts, flowers, coffee shops, a	nd canteen		0	20. 00
23. 00 Governmental appropriations 0 23. 00 24. 00 MI SC REVENUE 913, 168 24. 00 24. 50 COVI D-19 PHE Funding 11, 845, 405 24. 50 25. 00 Total other income (sum of lines 6-24) 23, 031, 986 25. 00 26. 00 Total (line 5 plus line 25) 27. 00 OTHER EXPENSES (SPECIFY) 0 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 0 28. 00	21. 00	Rental of vending machines			0	
24.00       MISC REVENUE       913, 168       24.00         24.50       COVID-19 PHE Funding       11,845,405       24.50         25.00       Total other income (sum of lines 6-24)       23,031,986       25.00         26.00       Total (line 5 plus line 25)       66,503,778       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00	22. 00	Rental of hospital space			698, 410	
24. 50     COVID-19 PHE Funding     11,845,405     24. 50       25. 00     Total other income (sum of lines 6-24)     23,031,986     25. 00       26. 00     Total (line 5 plus line 25)     66,503,778     26. 00       27. 00     OTHER EXPENSES (SPECIFY)     0     27. 00       28. 00     Total other expenses (sum of line 27 and subscripts)     0     28. 00	23. 00	Governmental appropriations			0	
25. 00       Total other income (sum of lines 6-24)       23, 031, 986       25. 00         26. 00       Total (line 5 plus line 25)       66, 503, 778       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0 27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0 28. 00		· ·				
26. 00       Total (line 5 plus line 25)       66, 503, 778       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00	24. 50					
27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00						
28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00					66, 503, 778	
					_	
29.00  Net income (or loss) for the period (line 26 minus line 28)   66,503,778   29.00					-	
	29. 00	Net income (or loss) for the period (line 26	minus line 28)		66, 503, 778	29. 00

Heal th	Financial Systems COMMUNITY HOSPI	TAL SOUTH	In Lie	eu of Form CMS-:	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0128	Peri od: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Pre 8/2/2021 3:42	pared:
		Title XVIII	Hospi tal	PPS	
			Urban	Rural	
			1. 00	1. 01	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				1
1.00	Capital DRG other than outlier		1, 425, 704	537, 823	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	0	1
2.00	Capital DRG outlier payments		51, 333		2.00
2. 01	Model 4 BPCI Capital DRG outlier payments		0		2. 01
3.00	Total inpatient days divided by number of days in the cost re	norting period (see	102. 87		3.00
0.00	instructions)	por tring period (see	102.07		0.00
4.00	Number of interns & residents (see instructions)		7. 83		4. 00
5. 00	Indirect medical education percentage (see instructions)		2. 17	1	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1 01		l	6. 00
0.00	columns 1 and 1.01) (see instructions)	Sum of Trites I and 1.01	, 42,007		0.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A p	atient days (Worksheet E	, 0.00		7.00
7.00	part A line 30) (see instructions)	attent days (worksheet E	, 0.00		7.00
8. 00	Percentage of Medicaid patient days to total days (see instru	ctions)	0.00		8.00
9. 00	Sum of lines 7 and 8	Ct1 0113)	0.00	l	9.00
10. 00	Allowable disproportionate share percentage (see instructions	)	0.00	l .	10.00
11. 00	Disproportionate share adjustment (see instructions)		0.00	1	11.00
	Total prospective capital payments (see instructions)		2, 057, 469	l	1
12.00	Total prospective capital payments (see mistructions)		2, 037, 409		12. 00
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)				2.00
3. 00	Total inpatient program capital cost (line 1 plus line 2)			Ō	
4. 00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)				5. 00
0.00	Trotal Tripatrione program dapreal door (Tribe o X Tribe ty			J	0.00
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	
1.00	Program inpatient capital costs (see instructions)				
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)			0	
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	
4.00	Applicable exception percentage (see instructions)			0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	
6.00	Percentage adjustment for extraordinary circumstances (see instructions)			0.00	6. 00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)			0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00
9.00	Current year capital payments (from Part I, line 12, as applicable)			0	9. 00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)			0	10.00
11.00				0	11. 00
	Worksheet L, Part III, line 14)				
12.00				0	12.00
13.00				0	13. 00
14.00				0	14. 00
	(if line 12 is negative, enter the amount on this line)		<b>.</b>		
15. 00				0	15. 00
16.00				0	16. 00
17. 00	00 Current year exception offset amount (see instructions)			0	17. 00
	,			•	